Utah Suicide Prevention State Plan 2022-2026

Utah Suicide Prevention Coalition

Dedication

The Utah Suicide Prevention State Plan is dedicated to those who have lost their lives to suicide, those who are struggling with thoughts of suicide, those who have made an attempt on their own lives, survivors of suicide attempts and suicide loss, those in recovery, and to all those who work tirelessly to prevent suicide and suicide attempts in Utah.

Preface From the Utah Suicide Prevention Coalition

We are pleased to share with you Utah's Suicide Prevention Plan for 2022-2026, which outlines the collaborative prevention work of suicide prevention professionals, researchers, health and behavioral healthcare workers, LGBTQ+ advocates, survivors, family members, and others affected by suicide.

Suicide is a leading cause of death in Utah, and each year we lose too many family members, friends, neighbors and coworkers to suicide; more than breast cancer, motor vehicle crashes, homicide, and many chronic physical health problems. We know that prevention works, treatment is effective, and people can and do recover from suicidal thoughts, feelings and behaviors. Together we can make a difference to prevent suicide by providing caring, culturally appropriate, and evidenced-based interventions, and fostering environments that promote acceptance, respect, healing and recovery. With a problem as complex as suicide, no single solution will be enough. Our health and behavioral health systems, schools, workplaces, and communities need to collectively work together to implement best practices for suicide prevention.

The Utah Suicide Prevention Coalition (USPC) utilizes a protective factor model to outline the core strategies of the Utah Suicide Prevention State Plan. The key protective factors outlined in this plan are:

- Increase Availability and Access to Quality Physical and Behavioral Health Care
- Increase Social Norms Supportive of Help-seeking and Recovery
- Reduce Access to Lethal Means
- Increase Connectedness to Individuals, Family, Community and Social Institutions by Creating Safe and Supportive School and Community Environments
- Increase Coping and Problem Solving Skills
- Increase Support to Survivors of Suicide Loss
- Strengthen Economic Supports

Other priorities in this plan include 1) Increasing comprehensive data collection for suicide to guide prevention efforts, and 2) Engaging and supporting high risk or underserved groups.

We want to thank those who have been instrumental in moving suicide prevention work forward in Utah, including the many dedicated family members, friends and professionals. As we work together collaboratively to address this problem, we will save lives and reduce the impact suicide has on individuals, families, and communities in Utah.

Sincerely,
Executive Committee of the Utah Suicide Prevention Coalition

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The purpose of the 2022-2026 Utah Suicide Prevention Plan is to lay out long-term and short-term goals detailing the strategies and metrics that will be used to reduce suicide deaths and attempts in Utah. The 2022-2026 Utah Suicide Prevention Plan aims to continue previous prevention efforts and describe new understanding of the many dynamics impacting suicide deaths and the statewide efforts to reduce deaths.

Section 1 of the plan describes Utah's state infrastructure for suicide prevention, which includes the state agency roles, coalition organization and membership, data systems, community partnerships, the crisis response system, and postvention efforts. Additionally, two newer efforts are described. First, is the inter-agency/organization suicide surveillance during the coronavirus pandemic. Second, is the SAMHSA/VA Governor's and Mayor's Challenges to Prevent Suicide Among Service Members, Veterans, and their Families (SMVF).

Section 2 includes high quality data and an in-depth understanding of the rates and demographics of suicide morbidity and mortality. On average, 640 Utahns die by suicide each year, and another 6,500 are treated in emergency departments for suicide-related behaviors. Timely, accurate, and quality data collection helps to inform prevention efforts, identify gaps and emerging trends, and serve as benchmarks for suicide prevention work through Utah.

Section 3 of the 2022-2026 Utah Suicide Prevention Plan provides context for identified risk factors for suicide at the individual, relationship, community, and societal levels. To maximize impact on risk and protective factors, the Utah Suicide Prevention Coalition (USPC) recognizes the need to unite across disciplines, agencies, and funding streams in a shared risk and protective factor approach. Risk factors can also vary by age group, culture, sex, and other characteristics. This section discusses high risk groups, and includes additional considerations such as comprehensive approaches using the social ecological model, social determinants of health, and adverse childhood experiences.

Section 4 contains the prioritized goals and objectives to address suicide in Utah. Six overarching principles have guided the creation of this plan: equity, infrastructure, lived experience/peer support, empowering local coalitions, evidence-based practice, sustainability, and collaboration. Each goal and objective incorporates all or some of these principles, emphasizing Utah's commitment to these values.

The USPC utilizes a **protective factor model** to outline the core strategies of the Utah Suicide Prevention Plan. Seven key protective factors outlined in this plan are:

- Increase availability and access to quality physical and behavioral health care;
- Increase social norms supportive of help-seeking and recovery;
- Reduce access to lethal means;
- Increase connectedness to individuals, family, community and social institutions by creating safe and supportive school and community environments;
- Increase coping and problem solving skills;
- Increase support to survivors of suicide loss; and
- Strengthen economic supports.

In addition to the seven key protective factors, two additional priority areas are also identified. They are:

- Increasing comprehensive data collection for suicide to guide prevention efforts, and
- Engaging and supporting high risk or under-served groups.

Finally, the Appendices contain supporting information and resources that support the implementation of this plan. A Glossary of Terms used in this plan is also included. The 2022-2026 Utah Suicide Prevention Plan is intended to be a living, changing, working document that instills an essential, additional element of suicide prevention: Hope. Hope empowers individuals, families, and communities to do the work laid out in this plan, and further develop community action plans. By aligning efforts on state and community levels, we can prevent suicide in Utah. Prevention works, treatment is effective, and people can and do recover from suicidal thoughts, feelings and behaviors.

Suicide is a major preventable public health problem in Utah and has historically been higher than the national average. Every suicide death causes a ripple effect of immeasurable pain to individuals, families, and communities throughout the state. However, this issue is far reaching beyond suicide deaths. For every suicide death, there are 25 attempts, and even more individuals that seriously consider suicide. Utah has made considerable progress over the past five years (2017-2021) to build state level infrastructure and implement suicide prevention policy and strategies.

This plan outlines state level goals and objectives for the next five years (2022-2026). This includes information for improving infrastructure, building capacity, increasing community collaboration, and empowering local communities to implement comprehensive strategies in prevention, intervention, and postvention in their jurisdictions. The purpose of this plan is to:

1. Provide guidance to the Utah Suicide Prevention Coalition (USPC) and workgroups;
2. Provide guidance to local communities for developing their own strategic plans for suicide prevention;
3. Outline priorities for state agencies and legislators to consider for legislation and policy-making;
4. Report on current trends in suicide data in Utah; and
5. Provide a basic understanding of Utah's suicide prevention structure, goals, and strategies for anyone interested in this work.

Health Equity in Suicide Prevention

Health equity is an important component of suicide prevention because it ensures everyone has the opportunity to be as healthy as possible. Unfortunately, health disparities continue to impact health outcomes for many people in marginalized groups, so it is imperative that all suicide prevention strategies are planned and implemented through a health equity framework. Public health is guided by data, and prevention efforts are focused on populations with the greatest need. Oppressed and marginalized groups, such as people of color, LGBTQ+ and those living in poverty experience higher rates of nearly all negative health outcomes. White men die by suicide at a far higher number and rate, however, than many other groups. For this reason, a great deal of suicide prevention resources are geared to white men.

However, when we take a closer look at the data, we also see that American Indian/Alaska Native males and females are at an equally high or higher risk of suicide death. That is, the rate of suicide death among American Indian/Alaska Natives is high, but the count is relatively low.

Health Equity

One very important addition to this plan from Utah's previous plan is a focus on health equity. Health equity is an important component of suicide prevention to ensure that everyone can live as healthy as possible. Unfortunately, health disparities continue to impact the health outcomes for many people in historically marginalized groups, so it is imperative that all suicide prevention strategies, plans, goals, and interventions should be designed, implemented, and evaluated through a health equity framework. In every goal and objective throughout this plan, readers should ask themselves: how does this objective include and assist underrepresented and under-served people and communities in Utah?

Introduction

Equity-minded suicide prevention recognizes the impact of suicide death not simply across the population, but within the population and requires resources be devoted to groups who experience a higher burden of suicide. Further, equitable suicide prevention means there must be strategies to prevent suicide among all people—not just those with relatively high rates or counts (see page 57 of this document for further detail). A comprehensive approach to suicide prevention is an equitable approach to suicide prevention and must be inclusive of women, people of color, those who live outside of Utah's urban core, young and old people, people living with disabilities, LGBTQ+ folks, immigrants and refugees, those without medical insurance or who are under-insured, house-less and unsheltered people, the food insecure, people living with a substance abuse disorder, and—everyone.

An important facet of health equity is providing services that are driven by community needs and accessible to all Utahns. Aside from the groups mentioned previously, there is a vast difference between people who live in urban, rural and very rural places in Utah. Rural and very rural places in Utah are disproportionately impacted by suicide death and at the same time have fewer resources prevent these tragic deaths. This plan seeks to increase access and reduce barriers for people in rural and very rural places to participate in virtual and online programs and services, such as tele-health services and gatekeeper training. Attending to the needs of underserved populations will help Utahns find solutions to obstacles that face all communities, and promote mental wellness more equitably and more efficiently.

The USPC's commitment to health equity in suicide prevention includes:

1. Define targeted strategies throughout the plan to be inclusive of historically marginalized and high risk groups;
2. Support greater systemic equity and institutional anti-racism, particularly in relation to behavioral health access and care; and
3. Engage individuals with lived experience from historically marginalized or high risk groups to inform suicide prevention, intervention, and postvention efforts during the development, implementation, and evaluation of the Utah Suicide Prevention Plan.

Section 1: Infrastructure for Suicide Prevention in Utah

State Suicide Prevention Infrastructure

A strong state infrastructure serves as a solid foundation for effective, comprehensive, and sustained suicide prevention. After convening a working group of **experts**, the Suicide Prevention Resource Center (SPRC) developed specific recommendations to identify and help strengthen key elements of suicide prevention infrastructure in states and local communities. The recommendations were developed to help state leaders develop and establish a solid foundation for suicide prevention programs, and to guide policy making, funding and administrative decisions, with a view toward improving sustained suicide prevention efforts.

The recommendations are organized into six essential elements with specific guidance in each area. You can read the recommendations and real-life examples from around the United States on each essential element page: **Authorize, Lead, Partner, Examine, Build and Guide**. You can view a summary of these **recommendations,** or download a **PDF of the full recommendations.**[1]

Critical Suicide Prevention State Infrastructure in Utah

Utah has developed a team of state-level experts to review the SPRC recommendations and assess the status of Utah's current suicide prevention infrastructure to **identify gaps and needed resources** to improve the foundation for suicide prevention in the state. During this process, these recommendations will also be used to identify and engage important partners, support the development of action plans in congruence with the Utah Suicide Prevention Plan, and build a strong infrastructure to support and sustain suicide prevention efforts.

The Utah State Legislature has demonstrated a strong commitment to suicide prevention, crisis intervention, and suicide postvention supports. A summary of legislative successes in Utah from 2012-2021 can be found **here**. Utah is also receiving a tremendous amount of **federal support** for suicide prevention efforts.

The following sections outline Utah's current suicide prevention state infrastructure.

Utah Prevention Infrastructure

Utah Suicide Prevention Coalition & State Plan

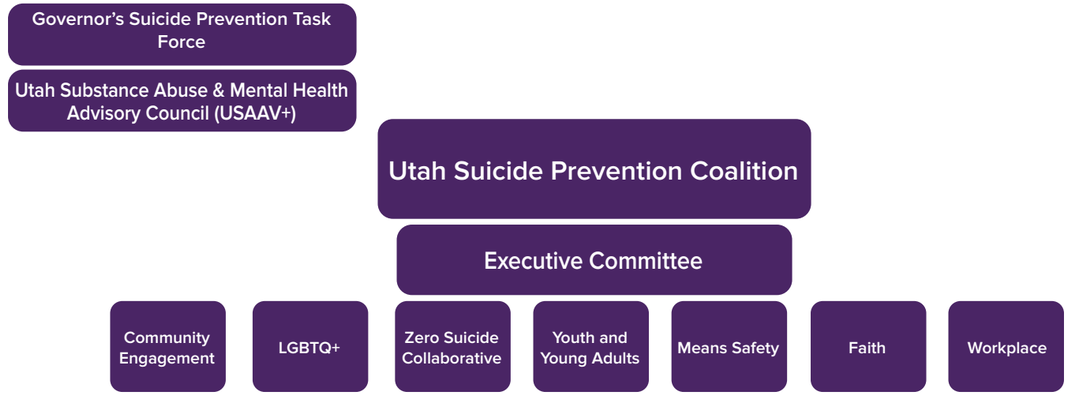
The Utah Suicide Prevention Coalition (USPC) was established in 2012, and is a partnership of community members, suicide survivors, service providers, prevention professionals, researchers, and others dedicated to saving lives and advancing suicide prevention efforts in Utah. Every five years, the USPC produces a state plan for Utah, and provides technical assistance to communities and organizations interested in implementing elements of the plan. This technical assistance could include:

- Delivery of resources, tools, and training to community-based coalitions,
- Evidence-based suicide risk assessment tools and training,
- Town hall meetings for building community-based suicide prevention strategies,
- Suicide prevention gatekeeper training,
- Training to identify warning signs and to manage an at-risk individual's crisis, and
- Evidence-based intervention training, intervention skills training, and postvention training.

Local suicide prevention coalitions, or shared risk and protective factor coalitions, are critical to the implementation of the Utah Suicide Prevention Plan.

The USPC has eight additional subcommittees who are dedicated to implementation of the Utah Suicide Prevention Plan. Utah Division of Substance Abuse and Mental Health (DSAMH) provides leadership and coordination to all of the committees. The USPC collaborates with and has representation on the **Utah Substance Abuse and Mental Health Advisory Council** (USAAV+) and the Governor's Suicide Prevention Task Force. The coalition structure is depicted in the following image.

Section 1: Infrastructure for Suicide Prevention in Utah



Executive Committee of the Utah Suicide Prevention Coalition

The Executive Committee is a collaborative of leaders in suicide prevention from community, business, healthcare, and government entities, dedicated to the promotion of quality of life and the reduction of suicide towards the aspirational goal of zero suicides, for individuals of all ages, ethnicities, cultures, creeds, socio-economic status, and backgrounds. This group of leaders provide guidance and oversight to the USPC and the state plan, and implement elements of the state plan within their respective organizations.

Utah Suicide Prevention Coalition Work Groups (see Appendix A)

- Community Engagement Work Group
- Faith Work Group
- Means Safety Work Group
- LGBTQ+ Work Group
- Workplace Work group
- Youth and Young Adult Work Group
- Zero Suicide Collaborative

Live On Utah Campaign (see Appendix C)

Under HB 393 (2019), the Utah Legislature generously agreed to match up to $1 million in private funds to the Governor's Suicide Prevention Fund. These funds were raised for creation of a statewide suicide prevention campaign. Private donors rallied to support this effort. Private sector donations came from Intermountain Healthcare, Greg and Julie Cook (the co-founders of doTERRA), The Church of Jesus Christ of Latter-day Saints, the University of Utah, Rocky Mountain Power, Utah Shooting Sports Council, and approximately $25,000 from individuals making the donation through their tax returns.

To continue this campaign long term, ongoing donations may be made to the Governor's Suicide Prevention Fund. For more information on how to donate, email **info.suicideprevention@gmail.com**.

Visit **liveonutah.org** for more information.

Utah Intervention/Crisis Response Infrastructure

Gatekeeper Trainings

According to the Surgeon General's National Strategy for Suicide Prevention (2012)[2], a gatekeeper is someone in a position to recognize a crisis and the warning signs that someone may be contemplating suicide. Gatekeepers can be anyone, but include parents, friends, neighbors, teachers, ministers, doctors, nurses, office supervisors, squad leaders, foremen, police officers, advisors, caseworkers, firefighters, and many others who are strategically positioned to recognize and refer someone at risk of suicide. Utah supports and implements best practices for gatekeeper trainings including: QPR (Question Persuade. Refer.), Mental Health First Aid (MHFA), Youth Mental Health First Aid (YMHFA), Working Minds, Creating Safety, Talk Saves Lives, ASIST, and safeTALK.

DSAMH has created a process for managing, tracking, and reporting on gatekeepers in an organized and consistent manner. This includes a master list of all QPR gatekeeper instructors in the state to be able to provide them with updated data, resources, and training information. This also allows DSAMH to make referrals to classes in different areas in the state. There are over 500 instructors in this database as of May 2021.

DSAMH has also created an online gatekeeper training database to track the number of people in Utah receiving QPR training and to measure improvements in knowledge and comfort around having a conversation about suicide and other prevention strategies. Data is collected via QR code embedded in all Utah QPR PowerPoints for QPR Gatekeeper training.

Crisis Response Services

Crisis response services are a gateway to the continuum of behavioral health services needed by individuals and families who are in the midst of a crisis. A comprehensive crisis system is an effective strategy for suicide prevention; it provides rapid response and support services by mental health professionals, reduces law enforcement interaction, and the costs associated with unnecessary hospitalizations.

Utah's comprehensive **crisis services** include:

- Statewide crisis line (**1-800-273-TALK** (8255) or 988)
- Note: Utah will be transitioning to use of the national 3-digit suicide prevention
- lifeline number 988 in July 2022.
- Statewide warmline (**833-SPEAKUT** [773-2588])
- **SafeUT** app
- Centrally deployed Mobile Crisis Outreach Teams (MCOT)
- **Stabilization and Mobile Response** (SMR) teams
- 23 Hour Crisis receiving Centers

To learn more about crisis services in Utah, click **here**.
For a full list of crisis services available in Utah **here**.

Section 1: Infrastructure for Suicide Prevention in Utah

Crisis Worker Certification

In 2018, H.B 41 directed DSAMH to establish a Crisis Worker Certification training program. This training established standards of care, practices, and basic skills development for all crisis workers across the state. The curriculum follows the American Association of Suicidology (AAS) recommendations on crisis worker certification. The education and training for crisis workers focuses on improving confidence and competence in working with people in crisis and most importantly those at risk of suicide.

DSAMH is responsible for certifying crisis workers who are qualified by training, experience, and certification. Certification requires successful completion of a 40 hour training. Individuals eligible to apply for this certification include individuals licensed under Utah Department of Professional Licensing for any health or behavioral health license; individuals with a minimum of a bachelor's degree in a human service related field, individuals certified as a Certified Peer Support Specialist for a minimum of one year, individuals certified as Case Managers for a minimum of one year; or individuals certified as Certified Family Peer Support for a minimum of one year. Every two years a certified crisis worker must complete 8 hours of continuing education to maintain certification. From 2018 to 2020, approximately 340 crisis workers from across the state have received their Crisis Worker Certification.

Utah Postvention Infrastructure

Postvention, as defined by the SPRC[3], is an organized response in the aftermath of a suicide to accomplish any one or more of the following:

- To facilitate the healing of individuals from the grief and distress of suicide loss
- To mitigate other negative effects of exposure to suicide
- To prevent suicide among people who are at high risk after exposure to suicide

Postvention must be implemented by multiple groups to be successful, including state, local, and community governments, schools, churches and places of worship, families, friends, and affinity groups. Utah has developed several resources to help communities prepare and respond to suicide deaths, which are outlined below.

Postvention Task Force and Community Postvention Toolkit

The demand for postvention resources in Utah has grown exponentially over the past several years as schools, employers, and other organizations have realized the devastation that comes in the wake of a suicide death. In response to this need, the USPC formed a Postvention Task Force in 2019, comprised of partners from Utah Department of Health (UDOH), DSAMH, the Office of the Medical Examiner (OME), and the Utah State Board of Education (USBE). This task force developed a **Community Postvention Toolkit**, which was released in 2021. This toolkit provides guidance and tools for a community response after a suicide death, and follows the **key postvention principles** outlined by the **SPRC**: 1) Planning ahead to address individual and community needs, 2) Providing immediate and long-term support, 3) Tailoring responses and services to the unique needs of suicide loss survivors, and 4) Involving survivors of suicide loss in planning and implementing postvention efforts.

For additional postvention resources, click **here**.

Suicide Bereavement and Cleanup Support

Suicide survivors experience unique grief. For most suicide survivors, the grieving process includes intense feelings of anger, guilt, and shame. In addition, a suicide death can sometimes result in significant damage to property, which requires cleanup by a professional service that specializes in biohazard clean up.

Under HB 393 in 2019, Utah create an account to provide survivors of suicide loss with support for bereavement and/or cleanup services. Cleanup services may be requested **here**.

Outreach to Survivors of Suicide Loss

Survivors of suicide loss are an increased risk of dying by suicide themselves. Survivors who are connected to other survivors who normalize the experience of losing someone fare better than those who remain isolated or turn to damaging modes of coping (e.g., substance use, self-harm). The Office of the Medical Examiner (OME) in Utah serves all families who lose someone to suicide in Utah, and is therefore strategically positioned to provide bereavement outreach. The OME sends bereavement cards with links to quality bereavement resources as soon as the manner of death has been determined to be suicide—typically within hours or as long as eight weeks. Additionally, the OME attempts to call families impacted by suicide loss within 90 days of the manner of death determination. Families are asked how they are coping, and referred to the appropriate level of bereavement care or crisis care. The OME refers families to additional, such as financial relief for funeral costs in the wake of COVID-19, financial relief when personal property has been damaged or soiled with biological material, and other help as appropriate.

Utah Data Infrastructure

Since the 2017 legislative session, the Utah Office of the Medical Examiner (OME) has employed a suicidologist who performs near-real time surveillance of suicide death. The suicidologist, in conjuction with the National Violent Death Reporting System (NVDRS), identify trends, hot spots, clusters, and provides early warning to other state and local authorities to respond appropriately. The suicidologist also conducts psychological autopsies for the purposes of enhanced death investigation, fatality review, and special projects, such as the Utah Youth Suicide Research Project (UYSRP), the largest study of teen suicide in the country. The suicidologist also oversees short form interviews of next-of-kin that provide rich data, such as sexual orientation and gender identity, employment, treatment history, and other items that may not be collected as part of a routine death investigation. Finally, following state and federal guidelines, the suicidologist aids in making medical examiner data more available to other agencies for the purposes of quality improvement and research. Utah leads the nation in suicide and drug overdose surveillance because of the centralized nature of the OME and the robust data infrastructure made available by state and federal funding.

Section 1: Infrastructure for Suicide Prevention in Utah

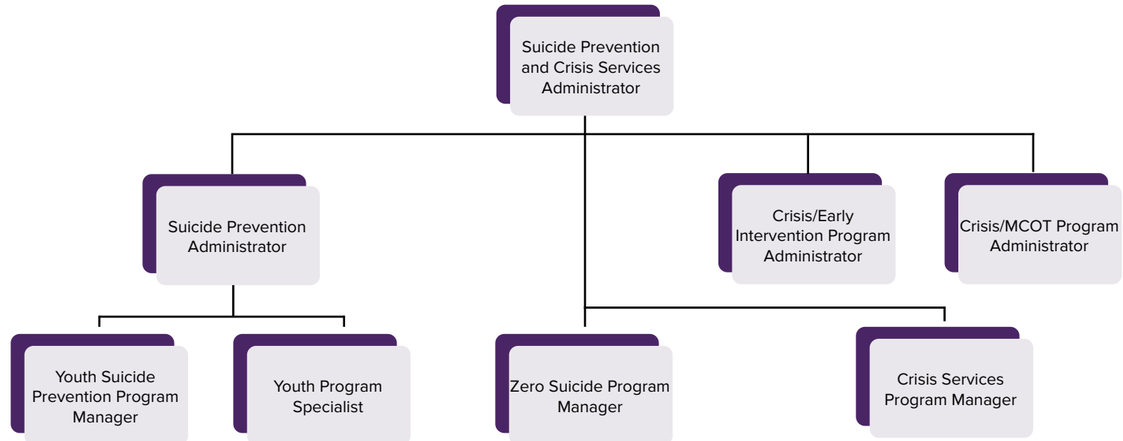
Lead State Agencies

Utah Department of Human Services (DHS), Division of Substance Abuse and Mental Health (DSAMH)

DSAMH was created as Utah's substance use disorder and mental health authority by **Utah statute §62A-15-103**. DSAMH is charged with ensuring a comprehensive continuum of mental health and substance use disorder services are available throughout the state. DSAMH is responsible to appoint a state suicide prevention coordinator to administer a state suicide prevention program composed of suicide prevention, intervention, and postvention programs, services, and efforts as outlined in 62A-15-1101.

In order to carry out these requirements DSAMH coordinates the USPC, oversees the Utah Suicide Prevention Plan, and collaborates and contracts with partners to implement suicide prevention, intervention and postvention strategies.

Additionally, DSAMH provides guidance and oversight to 13 Local Mental Health Authorities (LMHA)/Local Substance Abuse Authorities (LSAA) across the state. These local authorities provide substance abuse and mental health prevention, treatment, and crisis services for their designated areas. To view the full list of local authorities, click **here**.



NOTE: The Utah Department of Health and the Utah Department of Human Services, including DSAMH, will consolidate in 2022, after the publication of this plan, and will be known as the Utah Department of Health and Human Services.

Utah State Board of Education (USBE)

Since 2013, USBE has employed a Suicide Prevention Education Specialist who develops model programs to provide program training and resources to school districts and charter schools. The USBE Suicide Prevention Specialist oversees the youth suicide prevention programs of schools districts and charter schools, coordinates prevention and postvention programs and services, and manages grant funding for elementary and secondary schools. USBE's full implementation plan for Safe and Healthy Schools can be found **here**.

USBE provides guidance and oversight to the Local Education Agencies (LEA) across the state. These local education agencies provide elementary or secondary education services for their designated areas. To view the full list of local education agencies, click **here**.

Utah Department of Health (UDOH)

UDOH, Violence and Injury Prevention Program (VIPP), works closely with other state and local partners to build capacity for comprehensive suicide prevention across the state. UDOH coordinates with the USPC to plan and implement the Utah Health Improvement Plan (UHIP). This 3-year plan is a statewide collaborative to address chosen priority health issues identified by public health partners. The goal of the UHIP is to positively impact complex health concerns and reduce duplication of work by collaborating to align goals and maximize resources. This plan comprises four priority areas, including improving mental health and reducing suicides in Utah. For more information about this document, the UHIP can be accessed **here**.

The UDOH, Office of the Medical Examiner (OME) communicates trends in suicide death to key stakeholders, such as the Executive Committee of the State Suicide Prevention Coalition, policy makers, health care providers, state, county and local governments, local education agencies, and suicide prevention advocates. These data inform state and local suicide prevention efforts across the state.

UDOH provides guidance and oversight to 13 Local Health Departments (LHD) across the state. These local health departments provide a variety of public health and prevention services for their designated areas. To view the full list of local health departments, click **here**.

NOTE: The Utah Department of Health and the Utah Department of Human Services will consolidate in 2022, after the publication of this plan, and will be known as the Utah Department of Health and Human Services.

Sector Involvement & Partnerships

The integration and coordination of prevention activities across sectors and settings is critical for expanding the reach and impact of suicide prevention efforts. Other sectors vital to the overall success of the coalition and implementation of this state plan include, but are not limited to: education, government (local, state, and federal), social services, health and behavioral healthcare services, business, labor, justice, housing, media, and organizations that comprise the civil society sector such as faith-based organizations, youth-serving organizations, foundations, and other non-profit organizations. Collectively, these sectors can make a difference in preventing suicide by impacting the various contexts and underlying risks that contribute to suicide.

Section 1: Infrastructure for Suicide Prevention in Utah

Governor's Suicide Prevention Challenge

The Substance Abuse and Mental Health Services Administration (SAMHSA) has partnered with the United States Department of Veterans Affairs (VA) to bring the Governor's and Mayor's Challenges to Prevent Suicide Among Service Members, Veterans, and their Families (SMVF) to states and communities across the nation. Utah is taking part in the Governor's Challenge to develop and implement statewide suicide prevention best practices for SMVF, and has created a team made up of suicide prevention coordinators representing the state public/behavioral health agency, VA, and National Guard. More information about the Governor's Challenge can be found **here**. At the conclusion of this challenge, states will have a state plan for suicide prevention for SMVFs.

Inter-Agency/Organization Suicide Surveillance During COVID-19

Early in the emergence of COVID-19 in Utah, several partners across the state formed a surveillance group to monitor factors related to suicide and substance use, in an effort to identify trends, monitor the impact of COVID, and develop strategies to respond and to mitigate the impact. This emergency planning group includes the DSAMH, UDOH, OME, Intermountain Healthcare, University of Utah Health, and MountainStar Healthcare systems. The group reviews the following data provided by their individual organizations:

- Suicide ideation;
- Suicide attempt;
- Suspected suicide deaths;
- Nonfatal overdoses, including opioid, heroin and stimulant;
- Suspected fatal overdoses;
- Crisis Evaluations at Intermountain Healthcare, the University of Utah Healthcare and Mountain Star Healthcare, including emergency departments; and
- Crisis line contacts, including state Crisis Line, Warm Line and SafeUT app.

This data has been reviewed in comparison to pre-COVID times as well as within the period of COVID to ascertain any trends or emerging concerns. The data continues to be reviewed for gender, age, race, and ethnicity to determine significant differences from pre-COVID times, including comparison to Utah census data.

To view a summary of the mental health-related findings in Utah during the 2020 pandemic, click **here**.

Click **here** to view the full report on Social and Behavioral Health During COVID-19 in Utah.

Section 2: Suicide in Utah

Suicide In Utah

The burden of suicide on Utah is significant. On average 640 Utahns die by suicide each year, and another 6,500 are treated in emergency departments for suicide-related reasons. 91% of surveyed Utahns reported they knew someone who died by suicide, attempted suicide but did not die, or talked about thoughts of suicide. The scope of the problem extends beyond individuals to families, workplaces, places of worship, entire communities, and in every place throughout our state.

Understanding who, when, where, and how suicide impacts Utahns is critical to preventing suicide. Timely, accurate, and quality data identify gaps in suicide, emerging trends, and serve as benchmarks for suicide prevention work through Utah.

This section provides insight into suicide mortality, those who die by suicide, and morbidity, which refers to those who attempt suicide but who do not die and those who seriously consider suicide.

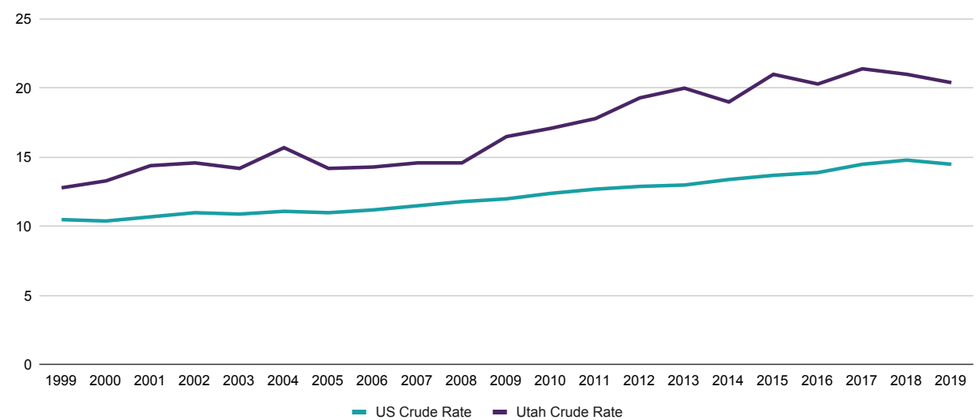
With some exceptions, data is described by crude rate in this plan. A rate is calculated by dividing the number of deaths (e.g., suicide deaths, non-fatal suicide attempts, etc.) by the total number of the population or population group (e.g., all Utah residents, all Utah females, all Hispanic Utahns), then multiplied by either 100,000 or 10,000.

Suicide Mortality In Utah

Utah Compared to the US

The rate of suicide in Utah is historically higher than that of other states, but similar to neighboring Rocky Mountain States. Utah ranks among the top 10 states for its high rate of suicide. Rates of suicide began to increase at a rate higher than that of the increases observed throughout the U.S. beginning in 2008. These rates have largely plateaued since 2016, however (suicide rates are not statistically different year-to-year starting in 2015 (**Figure 1**).

Figure 1. Suicide crude rates per 100,000 in the United States and Utah 1999 – 2019



Suicide Deaths by Age and Sex in Utah

Sex is portrayed as “male” and “female” in the data section of this plan. The Suicide Prevention Coalition recognizes this categorization does not reflect intersex and other gender diverse individuals. Further, gender identity and gender expression are also not shown here because this information is not available at the writing of this report. Of note, research is underway to identify individuals who may have identified as intersex or gender diverse, and training efforts are in process to gather additional information about gender identity at the scene of a death and in health care records.

Three males die by suicide in the U.S. for every female—a trend that has endured through many decades. In Utah, males account for nearly four out of every five suicide deaths. Middle-age adults account for the vast majority of suicide deaths each year in Utah. In the five year period shown in **Figure 2**, there was a shift from middle-age adults (35-44 and 45-54) to a slightly younger age group (18-24 and 35-44), especially among men (Figure 3). Among females, the largest increases in the past five years were among those age 18-24 and 35-44, but females who most often died by suicide were between the ages of 45 and 54 (**Figure 4**), and that trend has remained stable since 1999.

Figure 2. Suicide Death Crude Rate per 100,000 in Utah by Age Category and Sex 2015 – 2019

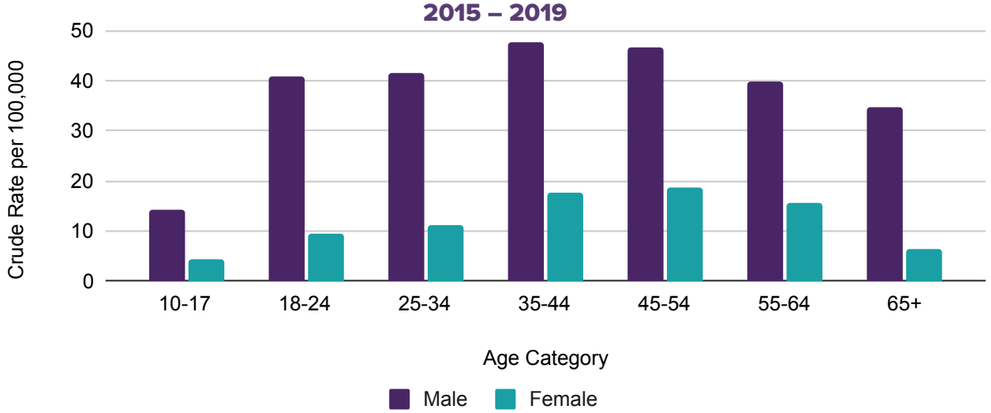


Figure 3. Suicide Crude Rate per 100,000 in Utah Among Males by Age Category 2010 – 2014, 2015 – 2019

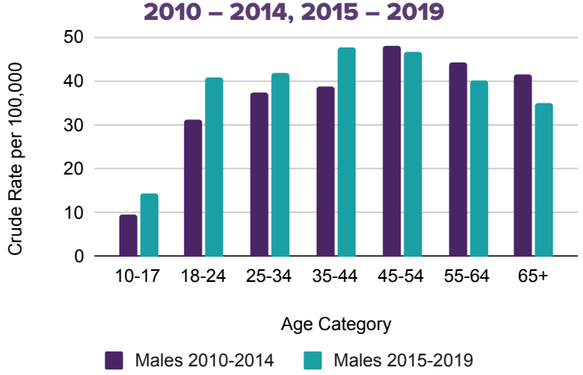
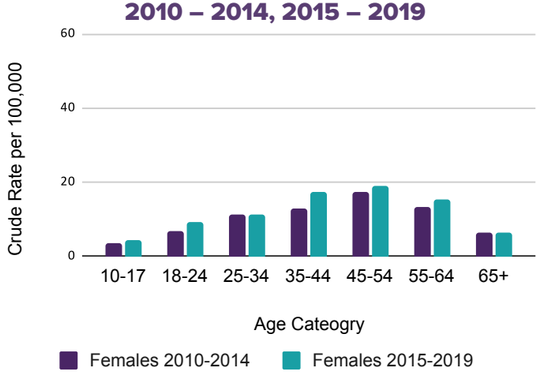


Figure 4. Suicide Crude Rate per 100,000 in Utah Among Females by Age Category 2010 – 2014, 2015 – 2019



Section 2: Suicide in Utah

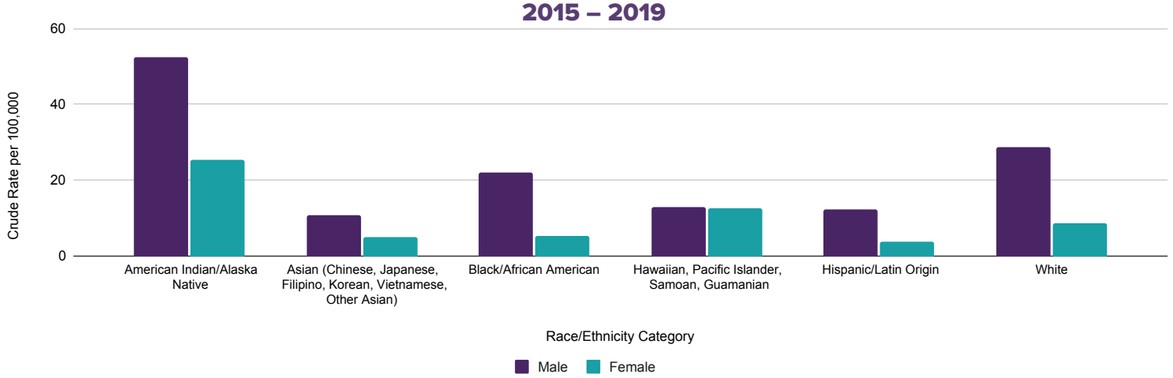
Suicide Deaths by Race and Sex in Utah

Race and ethnicity are reported by next-of-kin—usually a close family member—on a death certificate. In Utah, there are 16 races reported, including “race unknown.” Some race groups—American Indian, Asian, Pacific Islander, and Other Race—are asked to specify their race in further detail. There is currently no way for an individual to identify as being of more than one race, except by selecting “other race,” and then specifying more than one race.

Race and ethnicity are often confused with one-another. In contemporary demography, those whose ancestry is Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. Therefore, an individual can identify as both American Indian and Hispanic, for example. However, Hispanic or of Latin origin is included in Figure 5 as a distinct category.

Figure 5 describes suicide death by race, including Hispanic/Latinx, and sex in Utah between 2015 and 2019. White, Black/African American, American Indian/Alaska Native have higher suicide rates overall, particularly among men. The gap between males and females is much narrower among Asians and those in the category “Hawaiian, Pacific Islander, Samoan, Guamanian.” The suicide rate for both female and male American Indians/Native Alaskan is significantly higher than any other race category.

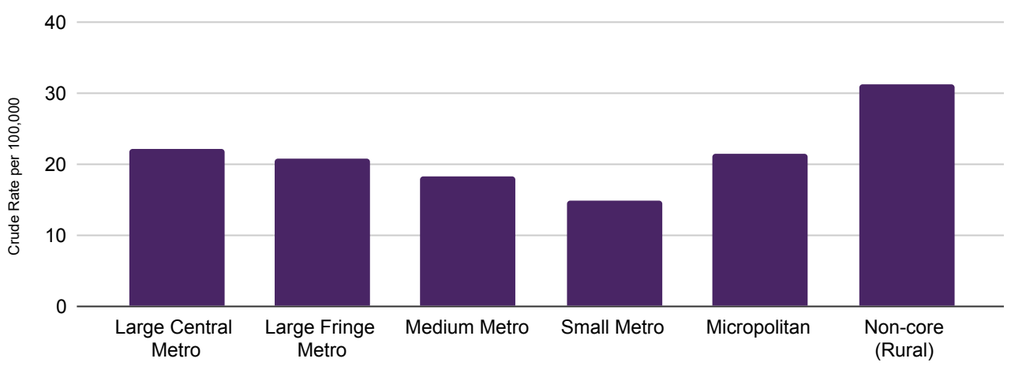
Figure 5. Suicide Death Crude Rate per 100,000 in Utah by Race, Ethnicity, and Sex, 2015 – 2019



Suicide Deaths in Utah by National Center for Health Statistics (NCHS) Degree of Rurality

Utahns who live in the most rural counties died by suicide at a rate significantly higher than Utahns who live in other types of places. Those who live in Large Central Metro places (Salt Lake County), Large Fringe Metro places (Tooele County) and Micropolitan places (Carbon, Iron, Summit, Uintah, and Wasatch Counties) shared similar risk. Those in Medium Metro places (Box Elder, Davis, Juab, Morgan, Utah, and Weber Counties) and Small Metro places (Cache and Washington Counties) had the lowest rates of suicide (**Figure 6**).

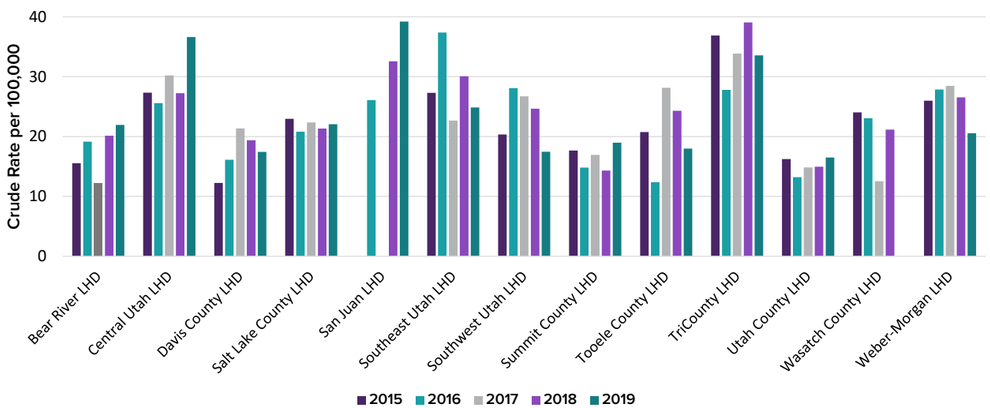
Figure 6. Suicide death rate in Utah by Urban to Rural Categories (National Center for Healthcare Statistics[3]), 2015 – 2019



Suicide Deaths by Local Health District in Utah

Suicide rates were highest overall in San Juan Local Health District (LHD), Central Utah LHD, Southeast LHD, and TriCounty LHD. Suicide rates increased overall in Bear River, Utah County, San Juan, and Central Utah LHDs. Suicide rates decreased in Wasatch County, Weber-Morgan, and Salt Lake County, albeit modestly (**Figure 7**).

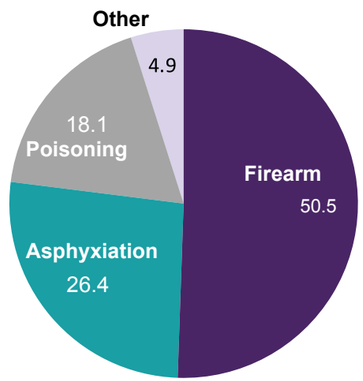
Figure 7. Suicide Death Rate in Utah by Local Health District (LHD) 2015 – 2019



Suicide Deaths by Method in Utah

Firearms continue to be the most lethal form of suicide method. In the four year period depicted here, firearms were involved in 50.5% of all suicide deaths. Second was asphyxiation (26.4%—most often by hanging), then poisoning (18.1%—most often by drug overdose). Just over 5% of suicides occurred by some other method, such as jumping from a height, motor vehicle crash, cut/piercing or some other method. A comprehensive report on suicide and firearm deaths in Utah was released by the Injury Control Research Center at the T.H. Chan Harvard School of Public Health; that report may be found **here** (**Figure 8**).[4]

Figure 8. Suicide Death in Utah by Method of Suicide 2015 – 2019

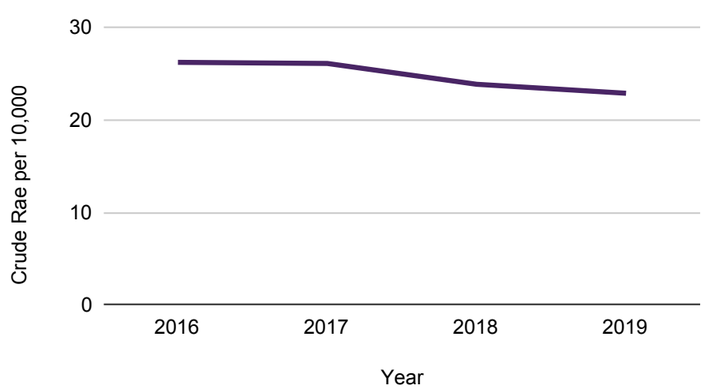


For additional information on firearms and suicide in Utah, you may view our full report here.

Suicide Morbidity In Utah

The impact of suicide extends far beyond suicide death. Thousands of Utahns attempt suicide each year and recover. **Figure 9** depicts the rate of non-fatal self-inflicted injury from 2016 to 2019. In 2015, ICD codes were transitioned from version 9 to version 10. Because codes from years prior to 2016 use a different coding scheme, years prior to 2016 cannot be compared to 2016 and subsequent years.

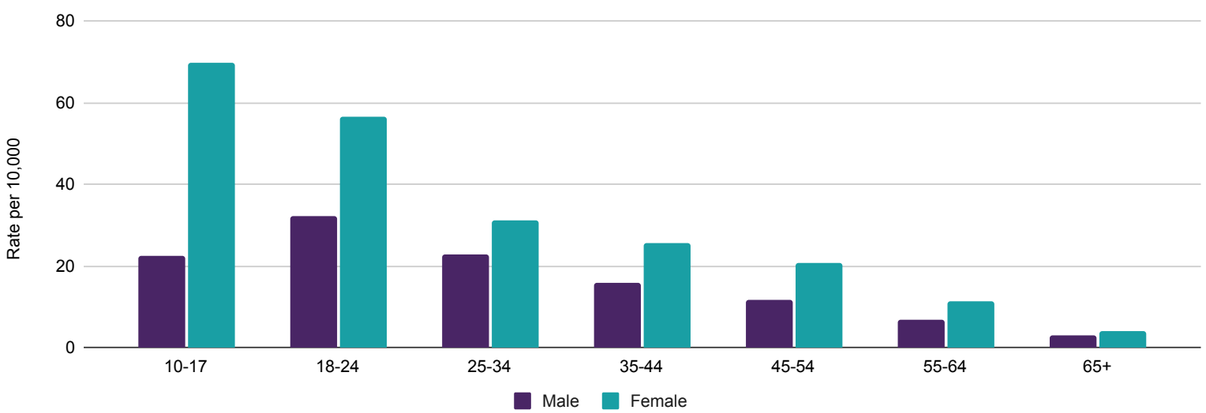
Figure 9. Crude rate per 10,000 of Self-Inflicted Injury Reported to Utah Emergency Departments 2016 – 2019



Suicide Attempts by Age and Sex in Utah

Females continue to attempt suicide at a significantly higher rate than males, particularly in young females (**Figure 10**).

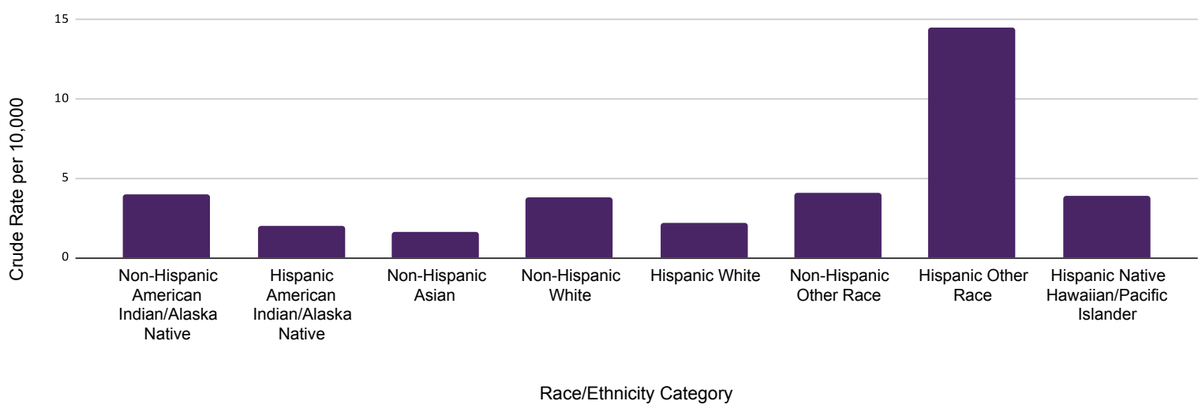
Figure 10. Crude rate per 10,000 of Self-inflicted Injury Reported to Utah Emergency Departments, 2016 – 2019, by Age Group and Sex



Suicide Attempts by Race and Ethnicity in Utah

Hispanic other race-identified individuals had the highest rate of self-inflicted injury. Those who did not identify as Hispanic or Latino had a higher rate of self-inflicted injury (3.78 per 10,000) than Hispanic or Latino identified people (2.64 per 10,000) (**Figure 11**).

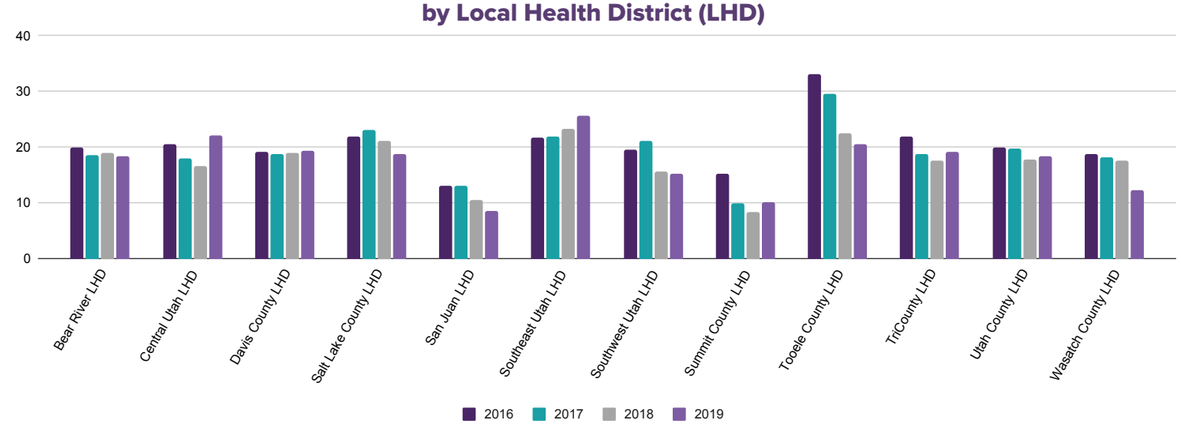
Figure 11. Crude Rate per 10,000 of Self-Inflicted Injury in Utah Emergency Departments, 2016 to 2019 by Race/Ethnicity



Suicide Attempts by Local Health District in Utah

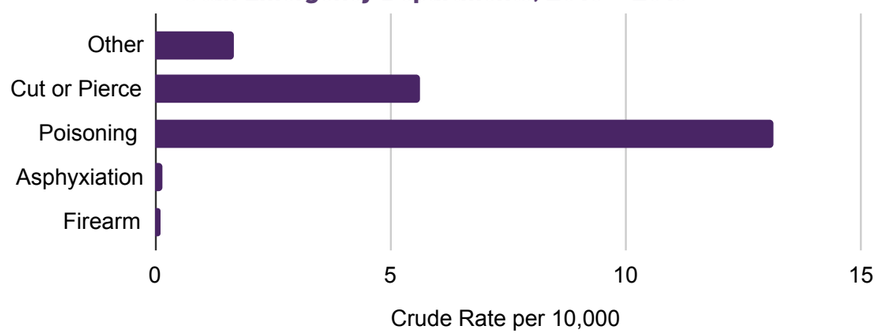
Self-injury decreased in many places throughout Utah, but increased Southeast LHD. Southeast Utah, Tooele County, and Weber-Morgan local health districts report the highest rates of self-injury reported to an emergency department. It is important to note, however, that individuals may be taken to hospitals with more advanced care in places like Weber-Morgan LHD from more rural or very rural places, such as Bear River LHD (**Figure 12**).

Figure 12. Crude Rate per 10,000 Self-inflicted injury in Utah Emergency Departments 2016 – 2019, by Local Health District (LHD)



Poisoning, which is most commonly drug overdose, was the most frequent form of self-inflicted injury, followed by cut/pierce, then other methods. While firearms and asphyxiation deaths account for over 75% of suicide mortality, they account, collectively, for just over 1% of all non-fatal suicide attempts reported to emergency rooms. Indeed, using a firearm or hanging are highly lethal; individuals who employ these methods are far more likely to die than use of some other method (**Figure 13**).

Figure 13. Crude Rate per 10,000 All Self-Inflicted Injury in Utah Emergency Departments, 2016 – 2019



Section 3: Addressing Risk and Protective Factors Using a Comprehensive Approach

Risk and Protective Factors for Suicide

Risk factors are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes. Protective factors are characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact.

Prevention professionals should consider these **key features**[4] of risk and protective factors when planning and evaluating prevention interventions, then prioritize the risk and protective factors that most impact their communities:

- Risk and protective factors exist in multiple contexts
- Risk and protective factors are correlated and cumulative
- Individual factors can be associated with multiple outcomes
- Risk and protective factors are influential over time

The Suicide Prevention Resource Center (SPRC)[5] and the Center for Disease Control and Prevention[6] have highlighted the following as major risk and protective factors for suicide. These factors are addressed throughout the Utah Suicide Prevention Plan:

Individual Protective Factors	Individual Risk Factors
Coping and problem solving skills	Impulsive or aggressive tendencies
Ability to adapt to change	Job problems or loss
Connectedness to individuals, family, community, and social institutions	Serious illness
Self-esteem	Financial problems
Sense of meaning or purpose in life	Criminal or legal problems
	Previous suicide attempts
	Social isolation
	Mental illness, such as depression
	Substance use disorder
	Social isolation

Section 3: Addressing Risk and Protective Factors
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Relationship Protective Factors	Relationship Risk Factors
Connectedness to individuals, family, community, and social institutions	Bullying
Supportive relationships with care providers	Adverse childhood experiences
	Family history of suicide
	Relationship problems such as a break-up, violence, or loss
	Sexual violence
Community Protective Factors	**Community Risk Factors**
Safe and supportive environments	Suicide cluster in a community
Availability of physical and mental health care	Barriers to health care
Cultural, religious, or personal beliefs that discourage suicide	Cultural and religious beliefs such as a belief that suicide is a noble resolution of a personal problem
Effective behavioral health care	
Connectedness to individuals, family, community, and social institutions	
Societal Protective Factors	**Societal Risk Factors**
Connectedness to individuals, family, community, and social institutions	Unsafe media portrayals of suicide
Limited access to lethal means	Stigma associated with mental illness or help-seeking
	Easy access to lethal means such as firearms or medications

Benefits of a Shared Risk and Protective Factor Approach

To maximize impact on risk and protective factors, the Utah Suicide Prevention Coalition (USPC) recognizes the need to unite across disciplines, agencies, and funding streams in a shared risk and protective factor approach. Many behavioral health outcomes, such as substance abuse, interpersonal violence, suicide, child maltreatment, criminal behaviors, and risky sexual behavior, are predicted by shared risk factors. As noted in the **Unleashing the Power of Prevention**[7] discussion paper, for example, "high levels of conflict in families predict substance abuse, delinquency, teen pregnancy, school dropout, violence, depression, and anxiety" (2015).

As Utah communities implement programs and strategies that address these shared risk and protective factors, the results will be greater cost-effectiveness, greater reach and impact of community efforts, and eventually, higher levels of overall health, well-being, and thriving in Utah communities. While more research is needed to fully understand which risk and protective factors are shared between suicide and other behavioral health outcomes and how they interact, two example summaries of shared risk and protective factors from the Social Development Research Group (used as a part of the **Communities that Care model**) and the Centers for Disease Control and Prevention, can be seen on the following pages.

Section 3: Addressing Risk and Protective Factors
Using a Comprehensive Approach

Risk Factors for Multiple Youth Outcomes

	Substance Abuse	Delinquency	Teen Pregnancy	School Drop-Out	Violence	Depression & Anxiety
Individual						
Early & Persistant Antisocial Behavior	✓	✓	✓	✓	✓	✓
Rebeliousness	✓	✓		✓	✓	
Gang Involvement	✓	✓			✓	
Friends Who Engage in the Problem Behavior	✓	✓	✓	✓	✓	
Favorable Attitude Toward the Problem Behavior	✓	✓	✓	✓	✓	
Early Imitation of the Problem Behavior	✓	✓	✓	✓	✓	✓
Constitutional Factors	✓					✓
Family						
Family History of the Problem Behavior	✓	✓	✓	✓	✓	✓
Family Management Problems	✓	✓	✓	✓	✓	✓
Family Conflict	✓	✓	✓	✓	✓	✓
Favorable Parental Attitudes & Involvement in the Problem Behavior	✓	✓			✓	
School						
Academic Failure Beginning in Late Elementary School	✓	✓	✓	✓	✓	✓
Lack of Commitment to School	✓	✓	✓	✓	✓	

Risk Factors for Multiple Youth Outcomes

	Substance Abuse	Delinquency	Teen Pregnancy	School Drop-Out	Violence	Depression & Anxiety
Community						
Availability of Drugs	✓				✓	
Availability of Firearms		✓			✓	
Community Laws & Norms Favorable Toward Drug Use, Firearms, and Crime	✓	✓			✓	
Media Portrayals of the Behavior	✓				✓	
Transitions & Mobility	✓	✓		✓		✓
Low Neighborhood Attachment & Community Disorganization	✓	✓			✓	
Extreme Economic Deprivation	✓	✓	✓	✓	✓	

Section 3: Addressing Risk and Protective Factors
Using a Comprehensive Approach

Protective Factors for Multiple Youth Outcomes

	Substance Abuse	Delinquency	Risky Sexual Behavior	School Drop-Out	Violence	Depression & Anxiety
Individual						
Cognitive Competence	✓	✓	✓	✓	✓	✓
Emotional Competence		✓				
Social/Behavioral Competence	✓	✓	✓		✓	✓
Self-Efficacy			✓			
Belief in the Future	✓	✓	✓		✓	✓
Self-determination			✓			
Pro-social Norms	✓	✓	✓		✓	✓
Spirituality	✓	✓	✓			
Family, School, and Community						
Opportunities for Positive Social Involvement	✓	✓				
Recognition for Positive Behavior	✓	✓			✓	✓
Bonding to Prosocial Others	✓	✓	✓	✓	✓	✓

Risk Factors for Violence Perpetration

	Child Maltreatment	Teen Dating Violence	Intimate Partner Violence	Sexual Violence	Youth Violence	Bullying	Suicide	Elder Maltreatment
Individual								
Low Educational Achievement	✓	✓	✓		✓	✓	✓	
Lack of Non-Violent Social Problem-Solving Skills	✓	✓	✓	✓	✓	✓	✓	✓
Poor Behavioral Control/ Impulsiveness	✓	✓	✓	✓	✓		✓	
History of Violent Victimization	✓	✓	✓	✓	✓	✓	✓	✓
Witnessing Violence	✓	✓	✓	✓	✓	✓	✓	
Mental Health Problems	✓	✓	✓		✓		✓	✓
Substance Use	✓	✓	✓	✓	✓	✓	✓	✓
Relationship								
Social Isolation	✓	✓	✓		✓	✓	✓	✓
Poor Parent-Child Relationships	✓	✓	✓	✓	✓	✓	✓	
Family Conflict	✓	✓	✓	✓	✓	✓		
Economic Stress	✓		✓		✓		✓	✓
Associating with Delinquent Peers		✓	✓	✓	✓	✓		
Gang Involvement		✓	✓	✓	✓			

Section 3: Addressing Risk and Protective Factors
Using a Comprehensive Approach

Risk Factors for Violence Perpetration

	Child Maltreatment	Teen Dating Violence	Intimate Partner Violence	Sexual Violence	Youth Violence	Bullying	Suicide	Elder Maltreatment
Community								
Neighborhood Poverty	✓		✓	✓	✓		✓	
High Alcohol Outlet Density	✓		✓		✓		✓	
Community Violence	✓			✓	✓	✓		
Diminished Economic Opportunities	✓		✓	✓	✓		✓	
Poor Neighborhood Cohesion	✓	✓	✓		✓		✓	
Societal								
Cultural Norms that Support Aggression	✓	✓	✓	✓	✓			✓
Media Violence				✓	✓	✓	✓	
Societal Income Inequity	✓		✓		✓	✓		
Weak Health, Educational, Economic, and Social Policies/Laws	✓		✓	✓			✓	
Harmful Gender Norms	✓	✓	✓	✓	✓	✓		

Protective Factors for Violence Perpetration

Protective Factors for Violence Perpetration	Child Maltreatment	Teen Dating Violence	Intimate Partner Violence	Sexual Violence	Youth Violence	Bullying	Suicide	Elder Maltreatment
Individual								
Skills in Solving Problems Non-Violently	✓	✓			✓		✓	
Relationship								
Family Support/Connectedness	✓	✓			✓	✓	✓	✓
Connection to Caring Adult		✓			✓		✓	
Association with Pro-Social Peers		✓			✓	✓		
Connection/Commitment to School		✓		✓	✓	✓	✓	
Community								
Coordination of Resources and Services Among Community Agencies	✓		✓				✓	✓
Access to Mental Health and Substance Abuse Services	✓						✓	
Community Support/Connectedness	✓		✓	✓	✓		✓	✓

Section 3: Addressing Risk and Protective Factors
Using a Comprehensive Approach

Addressing Distinct Risk and Protective Factors of Higher-Risk Groups

As mentioned above, risk and protective factors interact in many contexts and over time to influence an individual's level of risk for suicide. Risk factors can also vary by age group, culture, sex, and other characteristics.[8] For example:

- Stress resulting from prejudice and discrimination is a known risk factor for suicide attempts among many groups; including Black, Indigenous, and People of Color.
- LGBTQ+ people are **not** at increased risk due to their gender identity or sexual orientation in and of itself, but often experience increased risk factors, specifically around mental health issues and substance abuse, due to lower levels of acceptance and belonging in the broader community.
- Historical trauma, such as that experienced by American Indians, Alaska Natives, and Black Americans, contributes to an increased risk for mental health conditions and suicide in the present day.
- Latin and immigrant populations often experience discrimination, reduced access to mental health services including reduced help seeking, and stress associated with differing levels of acculturation to dominant culture within families.
- For men in the middle years, stressors that challenge traditional male roles, such as unemployment and divorce, have been identified as important risk factors.
- Veterans, service members and their families are at greater risk of suicide death, due to the unique stress associated with combat, trauma, PTSD, deployments, and separation.

The ***2020 Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention***[9] identifies these additional groups as at increased risk of suicide:

- Certain demographic groups, for example:
  - Working-age men
  - Military service members and veterans
  - American Indians and Alaska Natives
  - Sexual and gender minority populations
  - Older adults
  - Individuals in child welfare and justice settings

- Individuals experiencing risk factors linked with suicide, for example:
  - A history of suicidal behaviors
  - A loss of someone to suicide
  - Mental illness, substance misuse, and/or certain medical conditions

In spite of these very real traumas and stressors that can increase risk for suicide, these groups also possess distinct strengths and protective factors that can buffer the effects of adversity, and contribute to thriving and resilience. Individuals are not at higher risk because of their identity and belonging to a particular cultural group; rather, it is the interpersonal, historical, and institutional discrimination that often leads to higher levels of risk factors or absence of protective factors. This type of inequality must be understood within the context of each community. As we implement policies that improve access to quality education, financial stability, healthcare, and safe, connected communities; outcomes for these populations will improve. Individuals and families will be empowered to thrive and contribute meaningfully to society.

Upstream, Midstream, and Downstream Approaches to Addressing Risk and Protective Factors

Public health and suicide prevention professionals, among other organizations and groups, can implement strategies to prevent suicide and other problem behaviors at three levels:

- **Upstream. What can we do to bolster protective factors that prevent mental health problems in the first place?** Build protective factors that can mitigate risk, such as creating a sense of belonging, eliminating stigmatized language and discriminating actions, building resilience through life skills and mental hardiness, strengthening economic supports, and enhancing access and mental health literacy.
- **Mid-stream. How do we identify individuals who are experiencing higher levels of stress or who may be in the early stages of a mental health or substance abuse problem?** Help identify people in emerging risk and then link them to appropriate support before the issues develop into a suicidal crisis. Midstream strategies can include screening for mental health conditions and suicidal thoughts, promoting and normalizing many types of help-seeking/help-giving behavior, and training populations on how to have difficult suicide-specific conversations.
- **Downstream. What do we need to do to ensure we respond in a safe and effective way when mental health or suicide crises occur?** Appropriate response when a suicide crisis has happened, including when people have acute thoughts of suicide, attempt suicide, or die by suicide.[10]

The SPRC has developed a **model** for this comprehensive approach, that the Utah Suicide Prevention Plan emulates. An effective, comprehensive approach to suicide prevention includes a combination of primary prevention (upstream), intervention (midstream), and postvention (downstream) strategies, and addressing as many relevant risk and protective factors as possible in partnership with relevent and diverse stakeholders.

Section 3: Addressing Risk and Protective Factors
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Imagine you are walking along a river and hear a cry for help from someone drowning. You are startled but excited as you dive into the water to save him. Using all your strength, you pull him to shore and start administering CPR. Your adrenaline is racing as he starts to regain consciousness. Just as you are about to get back on your feet, another frantic call comes from the river. You cannot believe it! You dive back into the river and pull out a woman who also needs life-saving care. Now a bit frazzled but still thrilled that you have saved two lives in one day, you mop the sweat from your brow. When you turn around, however, you see more drowning people coming down the river, one after another. You shout out to all the other people around you to help. Now there are several people in the river with you – pulling drowning people out left and right. One of the rescuers swims out to the drowning group and starts teaching them how to tread water. This strategy helps some, but not all. Everyone looks at each other, completely overwhelmed, wondering when this will stop. Finally, you stand up and start running upstream. Another rescuer shouts, “Where are you going? There are so many people drowning; we need everyone here to help!” To which you reply, “I’m going upstream to find out why so many people are falling into the river.”

When it comes to suicide prevention and mental health promotion, most of the focus is on pulling people out of the water. Many find themselves exhausted while resources are depleted, and most are occupied with throwing in the life preservers and performing other heroic and necessary acts. Upstream interventions – like shifting culture, building skills that support wellness, and making environmental changes – can help prevent people from falling into the stream in the first place. If we are only focused on the downstream rescue, then we will never get ahead of all the crises demanding our attention.

Using a Social Ecological Model to Address Risk and Protective Factors in Context

In addition to including upstream, midstream, and downstream approaches to suicide prevention, it is also important to recognize the varying levels in which risk and protective factors exist. Suicide is a complex outcome influenced by individual, family, relational, community, and societal factors. Comprehensive prevention must address the factors that increase risk for suicide and the factors that protect from suicide risk across all of these levels. The Utah Suicide Prevention Plan utilizes the Social Ecological Model (SEM) to address risk and protective factors in all of these domains.[11]

All people have biological and psychological characteristics that make them vulnerable to, or resilient in the face of, potential behavioral health issues. Because people have relationships within their communities and larger society, each person's biological and psychological characteristics exist in multiple contexts. A variety of risk and protective factors operate within each of these contexts. These factors also influence one another. Targeting only one context when addressing a person's risk or protective factors is unlikely to be successful, because people don't exist in isolation. For example:

- On an **individual** level, this may include history of depression and other mental illnesses, hopelessness, substance abuse, certain health conditions, previous suicide attempts, violence victimization and perpetration, and genetic and biological determinants. In this context, protective factors might include family or peer connectedness and healthy coping and problem solving skills.
- In **relationships**, risk factors may include parents who use drugs and alcohol or who suffer from mental illness, child abuse and maltreatment, and high conflict or violent relationships. In this context, parental involvement or access to behavioral health care could be examples of protective factors.
- In **communities**, risk factors may include neighborhood poverty, social isolation, lack of health and mental health resources, and violence. Here, protective factors could include the availability of faith-based resources and connections, and after-school activities.
- In **society**, risk factors can include norms and laws favorable to substance use, as well as racism and a lack of economic opportunity. Protective factors in this context could include policies limiting the availability of alcohol, hate crime laws, or access to Earned Income Tax Credits and other work incentives.[12]

Section 3: Addressing Risk and Protective Factors
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These combined efforts work together to address different aspects of the problem. As a society, we share the responsibility to prevent and respond to societal and community risk factors that could overwhelm an individual and lead to a tragic suicide death.

?

Risk and protective factors interact over time and across the social-ecological model to form a dynamic and complex picture of individual risk. As a society, we share the responsibility to prevent and respond to societal and community risk factors that could overwhelm an individual and lead to a tragic suicide death. We can reduce the presence of risk factors, buffer the effects of risk, and empower individuals and communities to be resilient. For example, imagine a middle aged man who was born with a genetic predisposition to depression, who was abused by an overwhelmed parent, who experienced discrimination and temporary school failure due to a disability, and now is geographically isolated and cannot afford to access behavioral health treatment on a consistent basis. Now imagine that this same man had access to academic services and school based social emotional learning programs starting at a young age, had a teacher who believed in his potential, received first generation college financial assistance, has been a long-term member of a community basketball team, has participated in supported employment programs, and occasionally utilizes local support groups and trained clergy supports. This example shows how societal and community supports can dramatically buffer risk factors and change the trajectory of a life.

Frameworks for Comprehensive Community Coalition Approaches to Prevention

Increasingly, the problems that communities need to resolve are complex, requiring wide-ranging solutions. Addressing issues like health promotion and chronic disease prevention requires the inclusion of people from diverse backgrounds and disciplines. Working in partnerships, collaborations, and coalitions can be challenging-- but these are powerful tools for mobilizing individuals to action, bringing community issues to prominence, and developing policies. In addition, coalitions are an effective means of integrating health services with other human services, so that resources are effectively utilized and efforts are not needlessly duplicated[13]. A key to a successful coalition is understanding and utilizing evidence-based coalition frameworks. Frameworks are visual representations of a system or process that help to explain the relationships between aspects and components of prevention work.

There are **many different frameworks** used in the prevention and public health fields[14] , and we have included two below, the **Strategic Prevention Framework**[15] (SPF) or the **Communities that Care**[16] (CTC) model, that can be especially helpful as communities are developing and implementing action plans.

Learn more about these steps **here**.[17]

Learn more about prevention in Utah **here**, or how to get involved with your **local prevention coalition** by contacting your **local prevention coordinator**.

For training opportunities related to the information covered in this section, contact **Info.SuicidePrevention@gmail.com**.

Other Considerations

Social Determinants of Health

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Social determinants of health (sdoh) have a major impact on people's health, well-being, and quality of life. SDOH also contribute to wide health disparities and inequities. Examples of SDOH include:

- Access to nutritious foods and physical activity opportunities
- Education, job opportunities, and income
- Language and literacy skills[18]
- Polluted air and water
- Racism, discrimination, and violence
- Safe housing, transportation, and neighborhoods[19]

Understanding how social determinants of health impact suicide is necessary to informing the development of, or improvements to, policy and practices that can redress social inequalities and prevent suicide at a population level.

Adverse Childhood Experiences (ACEs)

Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years). These traumatic events may include enduring or witnessing violence, abuse, or neglect in the home or community. Losing a family member to suicide is also considered an Adverse Childhood Experience.

There are certain environmental factors that also influence a child's sense of safety, stability, and bonding, including things such as growing up in a household with substance abuse or mental health issues, or instability due to parental separation or incarceration. ACEs have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity.[20]

Prevention of ACEs is possible, and many of the strategies align with the upstream strategies identified for suicide prevention and addressing shared risk and protective factors.

Section 4: Core Strategies of the Utah Suicide Prevention Plan

Core Strategies

The Utah Suicide Prevention Coalition (USPC) utilizes a protective factor model to outline the core strategies of the Utah Suicide Prevention Plan. The key protective factors outlined in this plan are:

- Increase Availability and Access to Quality Physical and Behavioral Health Care
- Increase Social Norms Supportive of Help-seeking and Recovery
- Reduce Access to Lethal Means
- Increase Connectedness to Individuals, Family, Community and Social Institutions by Creating Safe and Supportive School and Community Environments
- Increase Coping and Problem Solving Skills
- Increase Support to Survivors of Suicide Loss
- Strengthen Economic Supports

Other priorities include:
1) Increasing Comprehensive Data Collection for Suicide to Guide Prevention Efforts
2) Engaging and Supporting High Risk or Underserved Groups.

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Equity and inclusivity are lenses by which all strategies, plans, goals, and interventions should be designed, implemented, and evaluated. In every goal and objective throughout this plan, readers ought to ask: How does this objective include and benefit underrepresented and historically marginalized people in Utah?

Six overarching principles have guided the creation of this plan: equity, infrastructure, lived experience/peer support, empowering local coalitions, evidence-based practice, sustainability, and collaboration. Each goal and objective incorporates all or some of these principles, emphasizing Utah's commitment to these values.

Increase Availability and Access to Quality Physical and Behavioral Health Care

Lack of access to mental health care is one of the barriers to use of mental health services, and may be particularly pertinent for people with serious mental illness (SMI) and people in ethnic minority groups. Identifying ways to improve access to timely, affordable, quality, and culturally affirming mental health and suicide care for people in need is a critical component to prevention, including among young people. Apart from treatment benefits, these approaches can also normalize help-seeking behavior and increase the use of such services.[21]

Goal 1	**Promote the adoption of targeted elements of Zero Suicide by health and behavioral health care systems and providers statewide with the ultimate goal of full adoption of the Zero Suicide Framework.**
Objective 1.1	Increase the number of healthcare organizations committed to system-wide culture change to reduce suicides in systems of care, evidence by annual **Organizational Self-Study** and annual **Work Plan**.
Objective 1.2	Increase suicide prevention professional development offerings, in order to increase the confidence and competence of Utah health and behavioral healthcare workers to address suicide risk, as measured by the Zero Suicide **Workforce Survey**.
Objective 1.3	Increase the number of organizations with policies and procedures for suicide screening based on best practices outlined in the Zero Suicide model, including **evidence-based screening and assessment tools**.
Objective 1.4	Increase the number of organizations that have developed policies and procedures and updated comprehensive **Suicide Care Management Pathway**.
Objective 1.5	Increase the number of organizations and individual providers that use **evidence-based treatment** to treat suicidal thoughts and behaviors directly.
Objective 1.6	Increase the number of organizations implementing **safe care transitions** after suicide-related psychiatric hospitalization and emergency department discharge, such as warm handoffs, caring contacts, and follow up procedures.
Objective 1.7	Measure implementation of Objectives 1.2-1.6 and utilize data to identify, implement, and apply **data driven quality improvement**.

Section 4: Core Strategies of the Utah Suicide Prevention Plan

Goal 2	**Expand and strengthen Utah's existing crisis services and follow-up after a crisis.**
Objective 2.1	Increase awareness and utilization of existing crisis services through targeted outreach, education, and marketing strategies. Examples include: Utah Crisis Line, Warmline, SafeUT (schools, National Guard, First Responder), Mobile Crisis Outreach Team (MCOT), Stabilization and Mobile Response (SMR), and Crisis Receiving Centers.
Objective 2.2	Utilize data to evaluate community need for crisis services, and continue to build out the crisis services continuum, including, Mobile Crisis Outreach Teams (MCOT), Crisis Receiving centers, crisis residential services, and other stepped interventions and services.
Objective 2.3	Increase the quality and frequency of follow up services to connect individuals at risk of suicide to longer-term community resources, such as caring contacts, MOUs, transition planning with community care providers and schools.
Objective 2.4	Develop infrastructure to sustain the federally mandated 988 resource within Utah in collaboration with federal Lifeline resources and their contracted state facility(ies).
Goal 3	**Partner with state and community organizations to increase access to physical and behavioral healthcare services.**
Objective 3.1	Increase the number of Utahns with health insurance.
Objective 3.2	Increase access to affordable health and behavioral health services for Utahns who remain uninsured.
Objective 3.3	Increase telehealth availability, particularly in rural and other underserved communities.
Objective 3.4	Expand and strengthen behavioral health workforce to include licensed clinicians, psychiatric providers, crisis staff, and crisis-trained first responders.
Objective 3.5	Implement early and regular mental health and substance use screenings and referrals, focused in specific settings, such as schools, primary care, senior centers, correctional facilities, and community settings. Examples of tools include **Healthy Minds Utah** and tools included on the approved list of **USBE mental health screeners**.
Objective 3.6	Expand access to mental healthcare via expansion and enforcement of federal and state parity requirements in health insurance coverage.

Goal 4	**Utilize the Certified Peer Support Specialist infrastructure to support individuals in recovery.**
Objective 4.1	Provide evidence-based/evidence-informed suicide prevention training to Certified Peer Support Specialists annually.
Objective 4.2	Increase utilization of Certified Peer Support Specialists within health and behavioral healthcare settings, particularly to support individuals during transitions in care and throughout the crisis service continuum.
Objective 4.3	Increase the utilization of Peer Support Specialists and evidence-based Supported Employment.
Goal 5	**Promote evidence-based training, policies and protocols for first responders to support them in responding to mental health, substance use and suicide related incidences in the community and connecting them to appropriate community resources.** ***First Responders may include any sworn officer such as: probation and parole, corrections, rangers, sheriffs, marshal, state highway patrol, hospital security, college campus security, Emergency Medical Services (EMS), dispatch, or other first responders as determined appropriate.***
Objective 5.1	Expand Crisis Intervention Team (CIT) Programs statewide and increase the numbers of law enforcement recertifying CIT through continuing education.
Objective 5.2	Partner with first responders to promote mental health and suicide prevention-specific training in communities across the state, such as Mental Health First Aid for First Responders (Public Safety Module), CALM, and QPR.

Section 4: Core Strategies of the Utah Suicide Prevention Plan

Increase Social Norms Supportive of Help-Seeking and Recovery

The current evidence suggests that identifying people at risk of suicide and engaging vulnerable individuals in the continued provision of treatment and support can positively impact suicide and its associated risk factors. Gatekeeper training is one approach that aims to identify people at increased risk of suicide.

Public messaging about suicide prevention is a key communication strategy for educating individuals about warning signs and resources available to help individuals at risk for suicide before a crisis occurs. Safe messaging emphasizes that suicide is a preventable public health problem and promotes actions and resources for preventing suicide. Safe reporting following a suicide is also important as the manner in which information on a recent suicide is communicated to the public (e.g., school assemblies, mass media, social media) can heighten the risk of suicide among vulnerable individuals and can inadvertently contribute to suicide contagion. Reports that avoid sensationalizing events or reducing suicide to one cause and include links to helping resources (e.g.,Utah Crisis Line), suicide prevention messages, stories of hope and resilience, and information about risk and protective factors can help reduce the likelihood of suicide contagion.[22]

Goal 1	**Increase Utahns' knowledge of suicide as a preventable public health problem by utilizing data-informed communication and training that is designed to prevent suicide by changing knowledge, attitudes, and behaviors.**
Objective 1.1	Distribute data and resource information annually to partners including information about the burden of suicide, prevention resources, and information about assisting someone experiencing a crisis. Partners may include: policy makers, local health departments, local mental health authorities, local education agencies, healthcare organizations, suicide prevention advocate organizations, and Utahns.
Objective 1.2	Continue to increase Utah capacity and reach of evidence-based gatekeeper trainings such as, ASIST, Mental Health First Aid, QPR (Question, Persuade, Refer), Working Minds, etc. Examples of populations to engage should include: parents, faith leaders, workplaces, school personnel, and community members.
Objective 1.3	Develop, implement, and evaluate public messaging to increase positive social norms, build skills, and promote help seeking and recovery (e.g., **Live On Utah**).

Goal 2	**Provide education and training to stakeholders, media channels, prevention professionals, and community members on how to talk about suicide in ways that support safety, help-seeking, and healing.**
Objective 2.1	Disseminate safe messaging training and resources, such as the **National Action Alliance for Suicide Preventions' Framework for Successful Messaging** and **Utah's Safe Messaging Toolkit**.
Objective 2.2	Share stories of lived experience and stories of recovery from suicide and mental health conditions through various platforms such as media interviews, social media, and public speaking engagements, utilizing the American Foundation for Suicide Prevention's **guidelines** for sharing your story safely.
Objective 2.3	Provide education and training to local media partners on the **safe messaging principles** for suicide prevention, postvention, and sharing personal stories.

Section 4: Core Strategies of the Utah Suicide Prevention Plan

Reduce Access to Lethal Means

Creating time and distance between individuals experiencing a suicidal crisis and highly lethal means is a key strategy to prevent suicide. Means of suicide such as firearms, asphyxiation, or jumping from heights provide little opportunity for rescue. Research also indicates that the interval between deciding to act, and attempting suicide can be as short as 5 or 10 minutes, making access to lethal means a critical issue. Additionally, people tend not to substitute a different method when a highly lethal method is unavailable or difficult to access. Therefore, reducing access to lethal and accessible means of suicide may contribute to fewer attempts. Research in Utah also indicates a strong correlation between substance use (alcohol, opioids, etc.) and suicide deaths. Alcohol reduces inhibitions and increases risk-taking behaviors; an intoxicated person experiencing a crisis who has easy access to a firearm is in a particularly dangerous predicament.[23]

Goal 1	**Provide education and training to stakeholders, community members, and organizations related to means safety and prevention strategies to reduce firearm and overdose deaths.**
Objective 1.1	Increase the number of individuals trained in **Counseling on Access to Lethal Means (CALM)** among professionals, stakeholders, and community members across Utah.
Objective 1.2	Incorporate means safety education modules as a regular part of community gatekeeper curricula to increase the number of participants that receive means safety education statewide.
Goal 2	**Increase opportunities for safe storage of firearms and prescription medications for all Utahns.**
Objective 2.1	Increase partnerships with firearm retailers and owners to incorporate suicide awareness and prevention as a basic tenet of firearm safety and responsible firearm ownership.
Objective 2.2	Distribute tools and strategies to reduce access to lethal means, such as gun locks, gun safes, and medication lock boxes, etc.
Objective 2.3	Promote community-based means safety education and strategies, such as drug take back events, Rx drop off, and Know your Script, and Utah Naloxone.
Objective 2.4	Increase distribution and use of Naloxone for overdose prevention.

Goal 3	**Increase the number of organizations that have policies and procedures that include Counseling on Access to Lethal Means (CALM) as a part of their clinical interventions.**
Objective 3.1	Provide Counseling on Access to Lethal Means (CALM) training to providers who interact with individuals who may be at risk for suicide, such as pharmacists, counselors, and physicians.
Objective 3.2	Increase distribution of tools and strategies to reduce access to lethal means, such as gun locks, gun safes, and medication lock boxes in clinical settings.
Goal 4	**Support and implement strategies and policies that reduce excessive alcohol use in Utah.**
Objective 4.1	Support and implement policies related to zoning that limits local and density of alcohol outlets, taxes on alcohol, and bans on the sale of alcohol for individuals under the legal drinking age.
Objective 4.2	Increase resources and access to treatment for substance use and misuse.

Section 4: Core Strategies of the Utah Suicide Prevention Plan

Increase Connectedness to Individuals, Family, Community and Social Institutions by Creating Safe and Supportive School and Community Environments

Connectedness is the degree to which an individual or group of individuals are socially close, interrelated, or share resources with others. Related to connectedness, social capital refers to a sense of trust in one's community and neighborhood, social integration, and also the availability and participation in social organizations. Connectedness and social capital together may protect against suicidal behaviors by decreasing isolation, encouraging adaptive coping behaviors, and by increasing belongingness, personal value, and worth, to help build resilience in the face of adversity. Connectedness can also provide individuals with better access to formal supports and resources, mobilize communities to meet the needs of its members, and provide collective primary prevention activities to the community as a whole. Promoting connectedness among individuals and within communities through modeling peer norms and enhancing community engagement may protect against suicide.[24]

Goal 1	**Utilize community coalitions to increase opportunities for prosocial involvement for all community members.**
Objective 1.1	Increase the number and diversity of community coalitions and state level partners working to reduce suicide in Utah in order to have strategic representative and community-driven prevention.
Objective 1.2	Increase the percentage of public health professionals and community suicide prevention coalitions who are trained in, and implementing, comprehensive evidence-based suicide prevention.
Objective 1.3	Increase the number of community engagement activities that bring together members of the community, such as walking programs or community gardens.
Goal 2	**Partner with businesses to implement workplace wellness and suicide prevention, intervention, and postvention strategies.**
Objective 2.1	Increase technical assistance and training for worksites to implement elements the **Suicide Prevention in the Workforce: Employer Toolkit.**
Objective 2.2	Increase the number of workplaces trained in evidence based gatekeeper training such as Mental Health First Aid, QPR and Working Minds.
Objective 2.3	Promote Employee Assistance Programs (EAP) and other mental health resources in workplaces such as mental health and substance use screenings, insurance coverage, wellness programs, and crisis resources.
Objective 2.4	Increase number of workplaces utilizing best practices for postvention in the workplace, in alignment with the **Manager's Guide to Postvention Toolkit.**

Goal 3	**Build safe and healthy school climates throughout the state by supporting the implementation of the Utah State Board of Education (USBE)'s Safe and Healthy Schools Framework in public, private, charter, juvenile justice services, and other school-based schools.**
Objective 3.1	Establish a positive and supportive school culture by implementing strategies such as Positive Behavioral Interventions and Supports, restorative practices, and social-emotional learning.
Objective 3.2	Provide opportunities for prosocial involvement in school-based settings such as afterschool programs and volunteer opportunities.
Objective 3.3	Increase training and resources for school staff and parents related to suicide and mental health, such as professional development and parent seminars.
Objective 3.4	Support development and implementation of crisis and emergency response protocols related to suicide.
Objective 3.5	Increase collaboration with community-based treatment and prevention partners for **suicide prevention** and **postvention** response.
Objective 3.6	Increase access to school-based mental health for students using evidence-based and evidence-informed practices, informed by the Utah School-Based Behavioral Health Toolkit.
Goal 4	**Increase cross collaboration with partners addressing shared risk and protective factors for suicide, mental health, violence and injury prevention, and substance abuse.**
Objective 4.1	With cultural and geographic sensitivity, examine how social determinants of health and shared risk and protective factors may increase the risk of suicide, or protect individuals, families, or communities.
Objective 4.2	Combine resources across agencies, where possible, to implement strategies that address shared risk and protective factors for suicide, substance use, domestic and dating violence, child maltreatment and family conflict, severe mental illness, and other persistent social problems.
Objective 4.3	Increase prevention and early identification of Adverse Childhood Experiences (ACEs) using partnerships with government, health and behavioral health providers, schools and non-profit organizations. Examples include: CDC Parent Essentials, Zero to Three, Prevent Child Abuse Utah, and professional development for teachers and school personnel.

Section 4: Core Strategies of the Utah Suicide Prevention Plan

Increase Coping and Problem Solving Skills

Building life skills prepares individuals to successfully tackle challenges and adapt to stress and adversity. Life skills encompass many concepts, but most often include coping and problem solving skills, social skills, emotional regulation, conflict resolution, and critical thinking. Life skills are important in protecting youth and adults from suicidal behaviors. Healthy relationships throughout the lifespan are also important in protecting against negative developmental and health outcomes and bolstering effective problem-solving skills.[25]

Goal 1	**Increase access and utilization of universal and indicated evidence-based health education and social emotional learning programs for youth in school settings and other youth serving organizations.**
Objective 1.1	Increase capacity (training, knowledge, skills, funding) for local school districts and local coalitions to use evidence-based programs in schools. Examples may include: DBT Steps A, Positive Behavioral Interventions and Supports, The Good Behavior Game, Botvin's Life Skills, etc.
Objective 1.2	Support schools in the adoption of the **Utah State Board of Education Core Health Standards** that includes mental health and social-emotional health as core components of the curricula.
Objective 1.3	Conduct evidence-based safety planning and follow-up with students, as appropriate, to reduce the risk of future harm.
Goal 2	**Increase availability and access to skill-based programs designed to increase positive mental health and coping skills for adults.**
Objective 2.1	Provide resources and technical assistance to workplaces, higher education institutions, and other partners to implement evidence-based programs and other educational opportunities related to positive mental health and healthy coping skills, such as the JED campus program and the Penn Resiliency Program.
Objective 2.2	Increase awareness and access to mental health and crisis resources available for workplaces, higher education institutions, and other partners.
Objective 2.3	Provide caregivers with parenting and family relationship programs to support and strengthen parenting skills, enhance positive parent-child interactions, and improve children's social and emotional skills, such as Guiding Good Choices and Strengthening Families.
Objective 2.4	Conduct evidence-based safety planning to reduce the risk of future harm.

Increase Support to Survivors of Suicide Loss

Risk of suicide has been shown to increase among people who have lost a friend/peer, family member, co-worker, or other close contact to suicide. Care for and attention to suicide loss survivors is therefore of high importance. Postvention includes debriefing sessions, counseling, and/or bereavement support groups for surviving friends, family members, other close contacts, or those indirectly impacted by the death.[26]

Goal 1	**Improve the quality and increase the quantity of resources available to suicide loss survivors.**
Objective 1.1	Increase skills and training opportunities for mental health providers for suicide bereavement.
Objective 1.2	Increase access to suicide loss-specific grief supports for suicide loss survivors in urban and rural areas across the state.
Objective 1.3	Provide bereavement resources to 95% of families who lost someone close to suicide within eight weeks of death.
Objective 1.4	Conduct proactive bereavement outreach to 60% of families who lost someone close to suicide within 90 days of death. Make appropriate referrals to crisis and bereavement resources as necessary.
Goal 2	**Provide ongoing support to local communities and organizations after a suicide to promote healing and reduce risk of contagion.**
Objective 2.1	Increase local capacity for postvention planning through utilization of the **Utah Community Postvention Toolkit**.
Objective 2.2	Disseminate population-specific postvention protocols and toolkit to partners. Partners may include: funeral directors, workplaces, schools, clinical settings, communities, and faith groups.
Objective 2.3	Maintain organizational and community-level postvention plans, response protocols, and calling trees to ensure competent responses to suicide deaths.
Objective 2.4	Increase number of health and behavioral healthcare providers that have policies and procedures to provide support to staff and clients when a client under their care dies by suicide.

Section 4: Core Strategies of the Utah Suicide Prevention Plan

Strengthen Economic Supports

Strengthening household financial security and stabilizing housing can reduce suicide risk. Although local suicide prevention programs may not be able to directly address these economic factors, they can monitor trends (e.g., increases in unemployment, evictions, or homelessness) and partner with others in the community to recognize and reduce associated distress.[27]

Goal 1	**Partner with community organizations to monitor trends, provide cross-training, share resources, and improve policy, in order to recognize and reduce distress associated with economic hardship.**
Objective 1.1	Strengthen household financial security through partnerships with state and community agencies to provide services and work incentives. Examples include: unemployment benefit programs, transfer payments related to retirement and disability, medical benefits, Medicaid and Social Security work incentives, Earned Income Tax Credit, and Housing Work Incentive, and other forms of family assistance.
Objective 1.2	Implement housing stabilization policies, such as programs to protect homeowners from foreclosures and evictions.
Objective 1.3	Conduct outreach to individuals, families, community partners to increase access to existing services and resources.
Objective 1.4	Support the implementation and expansion of tools (i.e. Electronic Platforms) designed to help link community members with **SDOH** needs to organizations that can help to address the needs.

Additional Priorities

Suicide is an evolving and complex issue. The Centers for Disease Control and Prevention (CDC)[28] and the Office of the Surgeon General[29] have identified key priorities that expand beyond shared risk and protective factors for suicide. We have prioritized:

1. Improving comprehensive data collection and analysis to guide prevention efforts
2. Engaging and supporting high risk and underserved groups, as a part of this plan

Improve Comprehensive Data Collection and Analysis to Guide Prevention Efforts

Suicide prevention efforts must be driven by data-informed decisions. Monitoring and evaluation of data are necessary components of the public health approach to suicide prevention. It is important to have timely and reliable data to monitor the extent of the problem and to evaluate the impact of prevention efforts Data are also necessary for prevention planning and implementation. Consistent data allow public health and other entities to better gauge the scope of the problem, identify high risk groups or communities, and monitor the effects of prevention programs and policies.[30]

Goal 1	**Promote research on suicide surveillance, screening, treatment, bereavement and community-level prevention.**
Objective 1.1	Identify and explore opportunities for funding suicide-related research on a state level.
Objective 1.2	Foster collaboration among suicide researchers throughout Utah's colleges and universities.
Goal 2	**Increase access to data for state and local partners, including data for historically marginalized populations, regarding suicidal behavior and mortality to inform prevention efforts across the state of Utah.**
Objective 2.1	Coordinate suicide fatality review committees to reduce gaps in services, improve inter-agency collaboration, and reduce barriers to accessing care.
Objective 2.2	Increase timely availability of suicide data to key stakeholders involved in prevention efforts.
Goal 3	**Facilitate partnerships across multiple disciplines to consistently analyze, interpret, disseminate, and use suicide related data.**
Objective 3.1	Provide education and data literacy training to stakeholders on how to appropriately interpret and publicly communicate suicide related data.
Objective 3.2	Increase capacity of partners to utilize suicide related data, and data related to shared risk and protective factors, to inform prevention efforts.
Objective 3.3	Expand utilization of the Death Notification Service to assist health care partners' ability to conduct quality improvement and assurance.

Section 4: Core Strategies of the Utah Suicide Prevention Plan

Engage and Support High Risk and Underserved Groups

As discussed in previous sections, the prevalence of suicidal behaviors—and of risk and protective factors for suicide—varies across groups and subgroups and changes over time. Suicide prevention efforts should focus on populations disproportionately impacted by suicide in different ways. Some groups may have high or increasing rates of suicidal thoughts and behaviors. Others may experience factors that can increase the risk for suicidal behaviors, such as social isolation and unemployment, or have fewer protective factors in their lives, such as access to effective mental health care. To develop and implement suicide prevention efforts tailored to each group's unique needs and strengths, program planners must review the data available from existing sources and conduct their own data-gathering efforts, as needed.

To be effective, efforts aimed at preventing suicide must include members of the affected group— particularly persons with lived experience—and organizations already working with this population, not only as key informants but also as leaders, experts, and partners. This will help ensure that suicide prevention efforts are grounded in a thorough understanding of the relevant risk and protective factors, consider local strengths and assets, and are tailored to address the unique factors that may contribute to suicide prevention in the most effective and sustainable ways.[31]

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Suicide prevention relies heavily on connection and relationships. We carry our implicit biases and prejudices--harmful beliefs we are not aware of--into the ways we engage with our neighbors and communities. These beliefs impair our ability to connect to each other meaningfully. It is important to become aware of our own biases and prejudices and to address them in order to engage in the most effective form of suicide prevention possible.

Goal 1	**Support safe and equitable environments for Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning (LGBTQ+) youth and adults by implementing the Utah LGBTQ+ Suicide Prevention Plan.**
Objective 1.1	Disseminate information on best practices and policies that contribute to safe, accepting, and equitable environments in the workplace, schools, government, and other institutions.
Objective 1.2	Expand LGBTQ+ -specific mental health and crisis resources, and increase knowledge and utilization of existing resources, such as the **Trevor Project** and the **Trans Lifeline**.
Objective 1.3	Provide training, education, and resources to increase safe, affirming, and effective health and behavioral health care for LGBTQ+ individuals.
Objective 1.4	Provide education to partners and the public on the unique risk and protective factors of LGBTQ+ individuals, and their role in enacting culture change and ending discrimination.

Goal 2	**Create safe and equitable environments for black, indigenous, and people of color, upholding the principle – "nothing about us, without us".**
Objective 2.1	Engage individuals and organizations that focus on racial and ethnic disparities to help inform suicide prevention and crisis funding and efforts, and increase engagement and equitable representation across social, cultural, and racial lines.
Objective 2.2	Disseminate information on best practices and policies in the workplace, schools, government, and other institutions, that provide equal opportunity and access to education, employment, housing, and health and behavioral healthcare.
Objective 2.3	Provide and disseminate education to partners and the public on the unique risk and protective factors of black, indigenous, and people of color, and their role in enacting culture change and ending discrimination.
Objective 2.4	Increase the access, quality, and use of data collection for black, indigenous, and people of color.
Objective 2.5	Participate in opportunities to engage and understand the elements of culture, including an understanding of race, sex, ethnicity, age, gender identity, historical trauma, bias, etc. to inform local and state suicide prevention efforts.
Goal 3	**Engage high risk groups such as the construction industry, immigrants, and service members, veterans, and their families in prevention planning, implementation, and evaluation of suicide prevention efforts.**
Objective 3.1	Disseminate information on best practices and policies that contribute to safe, accepting, and equitable environments in the workplace, schools, government, and other institutions.
Objective 3.2	Provide education to partners and the public on the unique risk and protective factors of these populations, and their role in enacting culture change and ending discrimination.
Goal 4	**Share stories of recovery for high risk and underserved groups.**
Objective 4.1	Identify and share stories of marginalized individuals whose stories underscore the relationship between suicidality and co-occurring conditions and circumstances, such as the nexus of suicidality, substance misuse, and termination of child custody; or the intersection/interplay of discrimination, employment opportunities, homelessness, and suicidality.

Conclusion

The 2022-2026 Utah Suicide Prevention Plan continues the tradition of broad outreach and implementation to increase protective factors, reduce risk factors, reduce suicide mortality and morbidity, and create hope in the state and local communities. This state plan is built on a long history of action. In the preceding five years, data collection and research has increased. Toolkits and model programming have been developed. Local coalitions have been established and expanded across the state. State and private partners have joined to produce a statewide suicide prevention media campaign to encourage Utahns to get through, reach out, lift up, look ahead and live on.

In the next five years, state and local governments, mental health organizations, health departments, local businesses, and Utah citizens have the opportunity and responsibility to continue to discuss and identify ways assist families, coworkers, and neighbors, to reduce suicide in Utah communities. This requires open communication and collaborative action, something Utahns have a history of doing.

This 2022-2026 Utah Suicide Prevention Plan was developed for each Utahn, in every capacity, to use as communities strive to reduce suicide ideation, attempts, and deaths by reducing risk factors and increasing protective factors.

Collectively, we can save lives.

Appendices

Appendix A: Coalition Workgroups

LGBTQ+ Workgroup

The intention of this work group is to be an educational resource for Utahns serving LGBTQ+ people, and to ensure appropriate care for all LGBTQ+ Utahns. In September 2020, the LGBTQ+ workgroup released a five-year suicide prevention strategic plan to specifically address suicide risk among LGBTQ+ Utahns. Highlights of the plan include plans to provide education about this community and the unique challenges faced by LGBTQ+ Utanhs. Learn more about preventing suicide in LGBTQ+ communities in Utah and view the entire Utah LGBTQ+ Suicide Prevention Plan **here**.

Workplace Workgroup

The intention of the Workplace Workgroup is to empower workplaces to implement comprehensive suicide prevention policies and strategies in their organizations by providing state-level guidance through training, resource development, and technical assistance. Learn more about workplace suicide prevention in Utah **here**.

Youth and Young Adult Workgroup

The purpose of the Youth and Young Adult Work Group is to increase collaborations with and among youth and young adult-serving organizations, institutions, and clinical practices, and address core components of the Utah Suicide Prevention Plan, including, but not limited to, evidence-based programs, school climate, coping and problem solving skills, access to mental health services, and increasing protective factors. To learn more about suicide in our youth and young adult populations in Utah, click **here**.

Community Engagement Workgroup

The mission of the Community Engagement Workgroup (CEW) is to increase community engagement in statewide suicide prevention efforts through the lens of equity, individual empowerment, and community connectedness. The vision for CEW is that communities across Utah have the tools and skills to mobilize suicide prevention efforts. To view resources related to safe messaging and public communications for suicide and suicide prevention, click **here**.

Faith Workgroup

The Faith Workgroup seeks to increase faith leader's engagement in statewide suicide prevention efforts by connecting with faith leaders of all denominations to train, educate, and advocate for mental health and suicide prevention within their congregations and communities. The vision of the group is for all faith leaders across Utah will have the tools and skills to implement suicide prevention efforts within their faith communities. "We join together in recognizing our blessed ability and sacred responsibility to act in addressing and preventing suicide." Learn more about faith and suicide prevention in Utah **here**.

Appendix A: Coalition Workgroups

Means Safety Workgroup

This work group strives to implement strategies to reduce firearm suicides by providing education and resources. These include suicide prevention training, education on temporarily limiting firearm access for people at risk for suicide, distribution of safe storage items such as cable gun locks and safes, and policy advocacy. Learn more about firearm suicide prevention in Utah **here**.

Zero Suicide Collaborative

Zero Suicide is a way to improve suicide care within health and behavioral health systems. The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving patient safety, Zero Suicide presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care. Read more about this framework **here**. The Zero Suicide Collaborative seeks to expand and improve structured, system initiatives to reduce suicide deaths of individuals receiving care within Utah's healthcare systems. This Collaborative consists of key healthcare system administrators, as well as Local Mental Health Authorities, private practitioners and clinicians, and Utah Department of Human Services.

Appendix B: Utah Toolkits and Resources

Suicide Prevention in The Workforce: Employer Toolkit (Utah)

This guide is a call to action for employers to implement and improve strategies focused on improving the mental health of their employees. This is a crucial part of a comprehensive approach to suicide prevention, outlined in the Utah Suicide Prevention State Plan, that can empower employees and save lives. The toolkit can be accessed **here**.

Utah Community Postvention Toolkit

This toolkit reflects consensus of national experts, including school-based administrators and staff, clinicians, researchers, public health professionals, and crisis response professionals. It provides guidance and tools for a community response after a suicide death, also known as "postvention". Postvention refers to activities that help individuals and communities cope with the emotional distress resulting from a suicide, and prevent additional trauma that could increase risk for suicidal behavior and death in the broader community. Find the toolkit **here**.

Safe Messaging Resources

The way we talk about suicide in our communities should be done thoughtfully, strategically and with the goal of contributing to a recovery narrative. Effective safe messaging is a form of suicide prevention. The National Action Alliance has robust resources to assist in creating safe messaging around suicide. Taken from the National Action Alliance's guidance on safe messaging, the following is a list of don'ts for public communication:

- Don't show or describe suicide methods or locations
- Don't include personal details of people who have died by suicide
- Don't glorify or romanticize suicide
- Don't portray suicidal behavior as more common than it is or as a typical way of coming with adversity
- Don't use data or language that suggests suicide is inevitable or unsolvable
- Don't oversimplify causes
- Don't reinforce negative stereotypes, myths, or stigma related to mental illnesses or suicidal persons

Additional safe messaging resources can be found on the **Live On Utah website**.

Appendix C: Live On Utah

Campaign Goals

Live On is a public-private mental health and suicide prevention campaign that aims to modify attitudes and social norms to reduce suffering and save lives. The population-oriented, evidence-informed effort brings together diverse partners to develop, launch, and evaluate powerful and effective content to:

1. Establish Mental Health and Suicide Prevention as a Priority for all Utahns
2. Promote Protective Behaviors and Beliefs – increase knowledge and acceptance around help-seeking, safe firearm storage, and stigma reduction
3. Provide Hope and Encourage Social Connection – amplify voices of healing and resiliency, especially from those with lived experience around loss and recovery, and encourage supportive relationships.

Live On is the first time Utah has taken on a comprehensive, large-scale, multi-platform effort of this type around the issue of mental health and suicide—one that goes beyond individual marketing efforts or one-off messaging initiatives. Under HB 393 (2019), the Utah Legislature generously matched funds from private donors for this endeavor, supporting a three-year period of robust campaign development, implementation, and evaluation.

Campaign Oversight

Effective prevention efforts of this magnitude demand intentional coordination and alignment with local stakeholders and their respective activities. Accordingly, this campaign is led by a steering committee of faith, healthcare, advocacy, and government leaders. The steering committee reports to the Executive Committee of the State Suicide Prevention Coalition—the leading body for suicide prevention activities, expertise, and guidance, coordinated by DSAMH—while collaborating and aligning with key leaders and advisory groups convened by the Governor's Office and Legislature.

Evaluation and Outcomes

The effectiveness of the campaign will be studied by collecting the following information:

- Behavioral Risk Factor Surveillance System (BRFSS) and the Student Health and Risk Prevention Survey (SHARP) data to monitor progress and improve the campaign's efforts and targets;
- Household survey and focus groups conducted by the Kem Gardner Policy Institute to measure changes in attitudes and beliefs related to help seeking, firearm storage, knowledge of resources, and other social norms related to suicide in Utah; and
- Other relevant indicators from local healthcare institutions and community partners.

Campaign Assets

Live On has produced a variety of tv and radio spots, billboards, posters, brochures, social media posts, and other print collateral. These assets are available for free download **here**.

NOTE: The LiveOn Utah website has now replaced the Utah Suicide Prevention Coalition (USPC) website making it the one source for all credible suicide prevention information in Utah.

Website: Liveonutah.org **Facebook**: Live On Utah **Instagram**: @liveonutah **YouTube**: Live On Utah

Appendix D: Resources Used to Write This Plan

Centers for Disease Control and Prevention (CDC)
Preventing Suicide: A Technical Package of Policy, Programs, and Practices
Preventing Adverse Childhood Experiences
Suicide Prevention: Risk and Protective Factors
The Social Ecological Model: A Framework for Prevention

Communities that Care
The Center for Communities That Care

Harvard T. H. Chan School of Public Health
Suicide and Firearm Injury in Utah (2018)

Health and Human Services
Surgeon General's Call to Action 2021
Surgeon General's National Strategy for Suicide Prevention (2012)
Healthy People 2030 Social Determinants of Health
National Strategy for Suicide Prevention: Goals and Objectives for Action

National Academy of Medicine
Unleashing the Power of Prevention

Oregon Health Authority
Crosswalk the Language and Frameworks of Public Health and Prevention

Prevention Institute
Developing Effective Coalitions: An Eight Step Guide

Prevention Network
Coalition Building

Substance Abuse & Mental Health Services Administration (SAMHSA)
National Strategy for Suicide Prevention Glossary
Risk and Protective Factors

Suicide Prevention Resource Center (SPRC)
A Comprehensive Approach to Suicide Prevention
Risk and Protective Factors: Hispanic Populations (2013)
State Suicide Prevention Infrastructure
Topics and Terms

Utah Department of Health
Utah Health Improvement Plan

Utah State Board of Education
Safe and Healthy Schools

Utah Worksite Suicide Prevention Toolkit
Suicide Prevention in the Workforce: Employer Toolkit (Utah 2020)

Workplace Suicide Prevention
A Comprehensive Approach — The Stream Parable

Appendix E: Resources

If you or someone you know is struggling, please utilize these resources.

CRISIS RESOURCES

Utah Crisis Line (in affiliation with the National Suicide Prevention Lifeline)
1-800-273-8255 (Veterans: press 1. Spanish speaking: press 2.)

Safe UT App
Download for free on the App Store or Google Play Store.

Crisis Text Line
741741

Trevor Project
Call 1-866-488-7386
Or live chat on the website at
TheTrevorProject.org

OTHER RESOURCES

Healthy Minds Utah
healthymindsutah.org

Division of Substance Abuse and Mental Health
dsamh.utah.gov

NAMI Utah
www.namiut.org

AFSP Utah
afsp.org/chapter/utah

WARNING SIGNS

LISTEN FOR:

- Talk of suicide: "I just want to go to sleep and never wake up." "If _____ happens, I'll kill myself."
- Talk of feeling hopeless, such as "What is the point?" or "Nothing is going to get better."
- Talk of feeling like a burden to others: "They would be better off without me."

WATCH FOR:

- Increased use of alcohol or drugs
- Withdrawing from activities
- Looking for a way to kill themselves, such as purchasing a firearm, stockpiling medications, or searching online for materials or methods
- Isolating themselves from family and friends
- Saying goodbyes or tying up loose ends
- Significant changes in mood, such as anger or irritability or a sudden unexplained euphoria after a long period of depression

Live On.
Find more resources at **LiveOnUtah.org**

Utah Crisis Line
1-800-273-TALK

SAFE UT
Reach out anonymously on the **SafeUT app.**

Appendix F: Glossary of Terms

Adverse Childhood Experiences (ACEs): potentially traumatic events that occur in childhood (0-17 years). These traumatic events may include enduring or witnessing violence, abuse, or neglect in the home or community. Losing a family member to suicide is also considered an Adverse Childhood Experience.

Advocacy groups: organizations that work in a variety of ways to foster change with respect to a societal issue.

Best practices: activities or programs that are in keeping with the best available evidence regarding what is effective.

Comprehensive suicide prevention plans: plans that use a multi-faceted approach to addressing the problem; for example, including interventions targeting biopsychosocial, social and environmental factors.

Connectedness: closeness to an individual, group or people within a specific organization; perceived caring by others; satisfaction with relationship to others, or feeling loved and wanted by others.

Crisis intervention: refers to the methods used to offer immediate, short-term help to individuals who have experienced a suicide death of someone close that produces emotional, mental, physical, and behavioral distress or problems.

Crisis response: refers to all action taken after a death to the point of debriefing that is carried out to ameliorate immediate negative effects and improve outcomes among impacted individuals and groups.

Crisis services: a gateway to the continuum of behavioral health services needed by individuals and families who are in the midst of a crisis. A comprehensive crisis response system is an effective strategy for suicide prevention; it provides rapid response and support services by mental health professionals, reduces law enforcement interaction, and the costs associated with unnecessary hospitalizations.

Culturally appropriate: a set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures; includes the ability of the program to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.

Ethnicity: a demography or a grouping of people who identify with each other on the basis of shared attributes that distinguish them from other groups such as a common set of traditions, ancestry, language, history, society, culture, nation, religion or social treatment within their residing area. NOTE: Race includes phenotypic characteristics such as skin color, whereas ethnicity also encompasses cultural factors such as nationality, tribal affiliation, religion, language and traditions of a particular group.

Evidence-based: programs that have undergone scientific evaluation and have proven to be effective.

Gatekeeper: those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate.

Appendix F: Glossary of Terms

Groups at high risk of suicide: people at increased risk for suicide who experience risk factors at higher levels. This includes; people of color; refugees and migrants; indigenous peoples; lesbian, gay, bisexual, transgender, queer (LGBTQ+) persons; people experiencing historical trauma; Latino and immigrant populations; men in the middle years; prisoners; and veterans, service members and their families.

Health Equity: means that everyone has a fair and just opportunity to attain their full health potential and that no one is disadvantaged, excluded, or dismissed from achieving this potential.
Help-seeking behavior: seeking care or assistance for emotional distress, a mental health condition, or suicidal thoughts.

Lethal Means: a means by which someone chooses to end his or her life, including firearms, medications, etc.

Lived Experience: knowledge gained from having lived through a suicide attempt or suicidal crisis.
Local health department (LHD) refers to the local public health authority.

Local mental health authority (LMHA): refers to county authorities that oversee the provision of mental health and SUD services to all county residents, including Medicaid enrollees. LMHAs are funded and overseen by the Utah Division of Substance Abuse and Mental Health (DSAMH).
Means safety strategies: techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Morbidity: those who attempt suicide but do not die.

Mortality: those who die by suicide.

Postvention: an organized response in the aftermath of a suicide to accomplish any one or more of the following: to facilitate the healing of individuals from the grief and distress of suicide loss; to mitigate other negative effects of exposure to suicide; and to prevent suicide among people who are at high risk after exposure to suicide.

Prevention: suicide prevention: a collection of efforts to reduce the risk of suicide. These efforts may occur at the individual, relationship, community, and society level.

Protective factors: characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact.

Public Health Approach: the systematic approach using five basic evidence-based steps, which are applicable to any health problem that threatens substantial portions of a group or population. The five steps include defining the problem, identifying causes, developing and testing interventions, implementing interventions and evaluating interventions.

Race: includes phenotypic characteristics such as skin color. Race is often confused with ethnicity which encompasses cultural factors such as nationality, tribal affiliation, religion, language and traditions of a particular group.

Appendix F: Glossary of Terms

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

Risk factors: characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes
Safe messaging: consensus of national suicide experts' recommendations for reporting and communicating to the public about suicide. The intent is to promote help-seeking behaviors among individuals at risk for suicide, promote healing and resiliency in the community, and prevent further diffusion of suicide.

Screening: administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.

Screening tools: those instruments and techniques (questionnaires, check lists, self assessment forms) used to evaluate individuals for increased risk of certain health problems.

Social determinants of health: conditions in the environment where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.

Social Ecological Model: a framework to further understand the dynamic interrelations among various personal and environmental factors.

Stakeholders: entities, including organizations, groups and individuals, which are affected by and contribute to decisions, consultations and policies.

Stigma: an object, idea, or label associated with disgrace or reproach.

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

Suicidal ideation: passive or active thoughts about wanting to be dead or, killing oneself, but not accompanied by preparatory behavior.

Suicide cluster: a series of three or more linked suicidal events, including suicide attempts and deaths. Mass suicide clusters occur when there is a increase in suicide or suicidal behavior within a given time period and geographic boundary, such as a school district or county. Individuals who engage in suicidal behavior in a mass cluster are not socially or otherwise linked to one-another. Point clusters occur when individuals engage in suicidal behavior after someone they knew who died by suicide or attempted suicide.

Suicide contagion: a process by which exposure to the suicide or suicidal behavior of one or more persons influences others' suicidal behavior, especially those who already have suicidal thoughts or a known risk factor for suicide. A subsequent suicide(s) is often called a copycat suicide. Postvention aims to prevent or interrupt such events.

Appendix F: Glossary of Terms

Suicide loss survivor: surviving family and friends of someone who has died by suicide.

Suicide Rate: a rate is a quantity, amount, or degree of something measured per unit of something else. In the case of this Suicide Prevention Plan, the rate of suicide death is measured on the number of deaths in 100,000 of the population.

Surveillance: the ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings.

Warning signs: Behaviors and symptoms that may indicate that a person is at immediate or serious risk for suicide or a suicide attempt.

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Live on.

Utah Suicide Prevention Coalition