

# West Virginia Strategic Plan for **Suicide Prevention** 2021-2024



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In 2019, West Virginia ranked 16th in the nation for suicide deaths. From 2009 to 2019, there were 3445 suicide deaths. One is too many.



Together, as individuals, friends, family members and communities, it is time we learn the human behaviors that signal suicidal thoughts, feelings, and actions. It is time that we destigmatize the darkness, fear and shame surrounding those who wrestle with the desire to live. The only way to end death by suicide is to accept both feelings and people all too familiar with the fight.

“We know exactly when to show up and what to do when someone is physically ill or has experienced a physical injury... we pray for them, send cards in the mail, and carry casseroles to their homes in an effort to love, help, and support them. Why don't we do those SAME THINGS when someone we know has experienced brain health illness or mental health conditions? (Those make you physically sick also.) We have to do better. We do so by checking in on ALL of our friends - because the strong ones need help too. If you think someone is struggling they probably are. Pay attention to those around you, really pay attention.

We CAN create a safe space for them and show our support by having the courage to say 'I'm worried about you, how is your mental health...' OR 'I really care about how you're doing...' Every time we do that, a piece of the stigma and shame associated with suicide and mental health is taken away; because we just made it okay to talk about it.”

Michelle Toman  
Founder, Brother Up/AFSP WV Founder

### **Dedication:**

*In honor of those who have lost their lives to suicide, those who have lost a loved one to suicide, those who are struggling to stay alive, and those who work tirelessly to prevent suicide.*

# SUICIDE: A Complex Problem

Suicide is the seven-letter word that is often unmentionable in our communities, yet it continues to occur. Suicide is a complex, multidimensional event arising from the interaction of individual mental and emotional risk factors and family, social, and community factors. It therefore warrants comprehensive, integrative, and multidisciplinary prevention and intervention efforts. Suicide is a serious preventable public health problem that negatively affects communities and individual community members, leaving hurt hearts and traumatized souls behind. It touches people of all ages and from all walks of life. No one is immune.

Suicide is about the individual experiencing unbearable psychological pain, feeling alone, trapped, and isolated, as if there is no way out. Prevention and intervention efforts acknowledge that experience and understand that this work is done within the context of a relationship. Societal attitudes and conditions have a profound effect on suicide and suicide prevention. Everyone with mental health concerns, including those with suicidal thoughts, is to be accepted and supported, without stigma or discrimination.

Suicide prevention is the responsibility of everyone and within the capability of everyone. Knowing when and how to ask about suicide saves lives. It is important for everyone to have the competence and confidence to intervene with persons at risk for suicide. We all have the honor and privilege to be the one to be there. Additionally, suicide prevention is about promoting hope and resiliency and protective factors for all individuals.

This plan acknowledges that the complexity of suicide warrants a comprehensive, integrative, multidisciplinary prevention and intervention effort. Such efforts need to incorporate multiple approaches at multiple levels. WV intends to provide effective prevention programs that address risk factors, mental health and substance abuse services, and access to crisis response services for those struggling with suicide ideation and behaviors. In consideration for those touched by suicide, efforts must include the establishment of policies and model practices in preparation for post-suicide response. Overall, the plan will work towards producing a statewide infrastructure for culturally competent, caring, comprehensive, and sustainable suicide prevention and intervention, and a follow-up system of care. This will require the continued development and implementation of a collaborative and coordinated statewide prevention and intervention strategy that is integrated into the existing public and private service delivery system.

Barri Sky Faucett, MA  
*Prevent Suicide WV Director*

## OUR HISTORY: Progression of Suicide Prevention Initiatives Within Our State

Suicide prevention continues to be a core priority in the state. There is a focus on fostering strong partnerships with entities interacting with suicide affected individuals.



In 2001, Valley HealthCare System responded to an Announcement of Fund Availability from the Children's Division of the Office of Behavioral Health Services in the West Virginia Department of Health and Human Resources Bureau for Behavioral Health and Health Facilities. Valley HealthCare System proposed the development and implementation of a public awareness and information project to create awareness and understanding of a "silent epidemic": suicide among adolescents in West Virginia. The small grant, funded through the Community-Based Mental Health Services Block Grant, enabled the creation of the Helping Our Teens Thrive Coalition (HOTT Coalition). This coalition was composed of representatives of health and behavioral health providers, educators, and interested individuals. In the beginning years, several seminars and workshops were provided to alert school personnel and the interested public to the number of children who were dying by suicide in West Virginia, as well as what was needed to prevent such untimely and tragic deaths. The workshops and seminars were well received and the HOTT Coalition was re-formed and expanded into the West Virginia Council for the Prevention of Suicide (WVCPS).

WVCPS understood that people of all ages die by suicide. The "target population" addressed by WVCPS was expanded to include adults. The Council began providing bi-annual conferences which attracted the attendance of several hundred health and behavioral health providers and other individuals. The Council proceeded to develop awareness curriculums covering all age groups and providing workshops covering the entire lifespan throughout the state. In addition to information and education, the Council sponsored the development of protocols for suicide assessment with Dr. William Fremouw from the West Virginia University's Department of Psychology. The Council, along with Dr. Fremouw, developed suicide risk assessment for three age groups, the Adolescent Screening and Assessment Protocol-20 (ASAP-20), the Suicidal Adult Assessment Protocol (SAAP), and the Suicidal Older Adult Protocol (SOAP) which have been published.

Efforts to continue suicide prevention focused on the youth of West Virginia. In 2006, the Bureau for Behavioral Health applied for, and received, a Garrett Lee Smith Memorial grant from SAMHSA creating the Adolescent Suicide Prevention and Early Intervention Project (ASPEN). Initially, the ASPEN project focused on suicide prevention education and targeted mobile quick response services for at-risk youth in Kanawha County. Services included assessment, referral, and treatment for youth identified as at-risk. The ASPEN project received additional federal funding in 2009

to focus prevention efforts on youth in West Virginia. The scope of work broadened to provide mobile quick response services in additional counties, as well as introducing a wide array of evidence-based suicide prevention trainings offered throughout the state. Additionally, the program began to implement evidence-based programs and practices in schools and communities.

ASPEN initiatives encompassed a comprehensive base of support for sustaining suicide awareness, prevention, and early intervention efforts to rectify system gaps and provide for a comprehensive system of care for West Virginia youth.

As the ASPEN program was gaining momentum in suicide prevention and intervention initiatives, the West Virginia Council for Prevention of Suicide's programmatic component was transferred to ASPEN resulting in a re-branding of the two previous suicide prevention programs into Prevent Suicide WV. Prevent Suicide WV is West Virginia's suicide prevention program serving the lifespan. The program expanded its capacity to offer increased evidence-based trainings programs, practices, and protocols. In 2013, the Bureau for Behavioral Health was awarded another Garrett Lee Smith Memorial grant under the direction of Prevent Suicide WV. The grant funds continued development and implementation of a collaborative

and coordinated statewide prevention and intervention strategy that is integrated into existing public and private service delivery systems.

Specifically, the program works to: incorporate comprehensive evidence-based protective measures that expand universal prevention messages of hope and help at the regional level; improve identification, referral, and engagement interventions for youth and transitioning youth aged 10-24; increase the number of youth and youth-serving agencies implementing screening and gatekeeper trainings; provide for protective, caring follow-up services for attempt survivors and their families; and build the capacity of organizations serving vulnerable sub-populations to effectively deliver coordinated care.

Suicide prevention continues to be a core priority in the state. There is a focus on fostering strong partnerships with entities interacting with suicide affected individuals. The goal is to provide a culturally competent, caring, comprehensive, and sustainable suicide prevention, intervention, and postvention system of care.

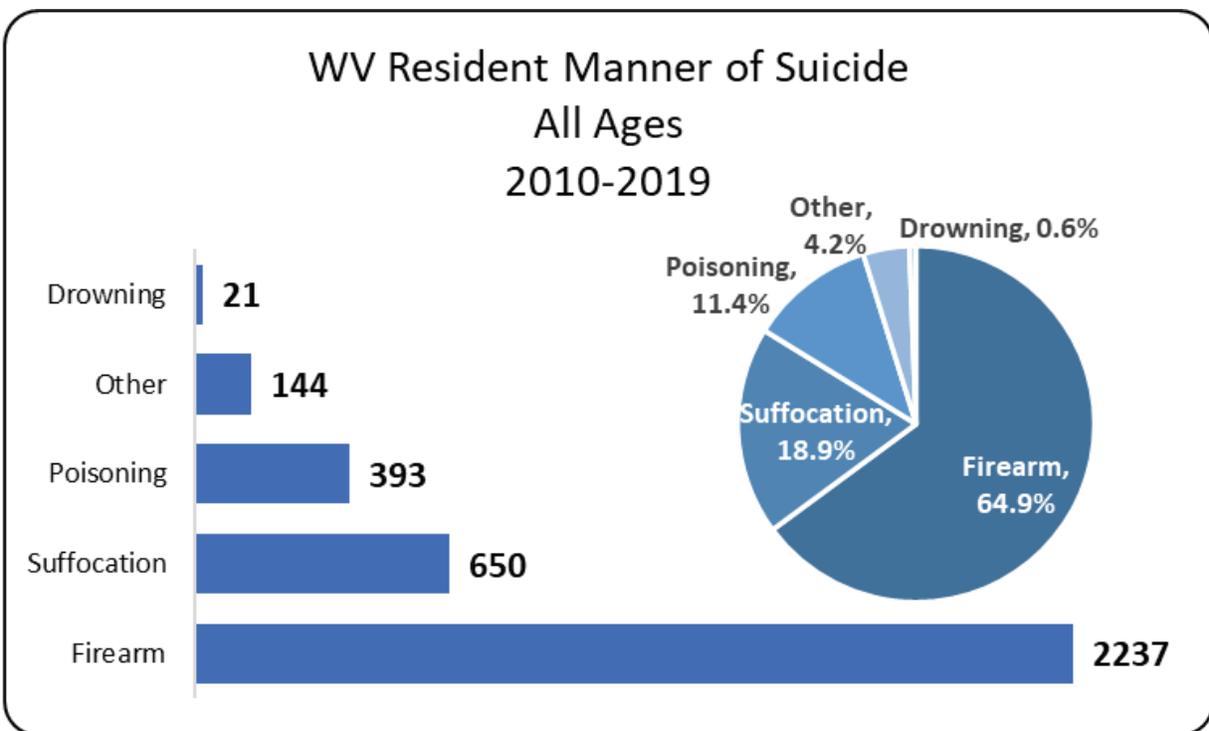




## West Virginia's Relevant Data and Findings

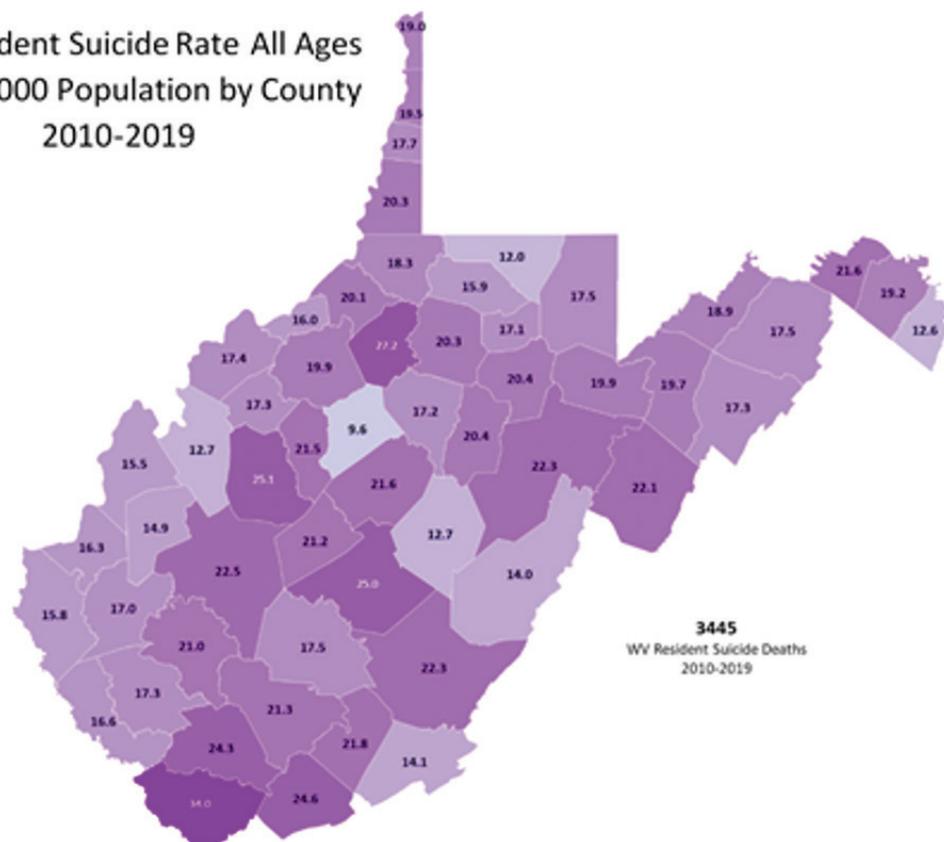
West Virginia's 2019 suicide rate is 16th in the nation with a rate of 18.4/100,000. US Suicide rate is 14.5/100,000.

**Manner:** Suicide by firearm is the leading manner of suicide by a wide margin. Firearms accounted for 64.9% of suicide deaths between 2010-2019.



Source: West Virginia Health Statistics Center,  
Vital Statistics Center, March 2021  
Note: 2019 data are preliminary

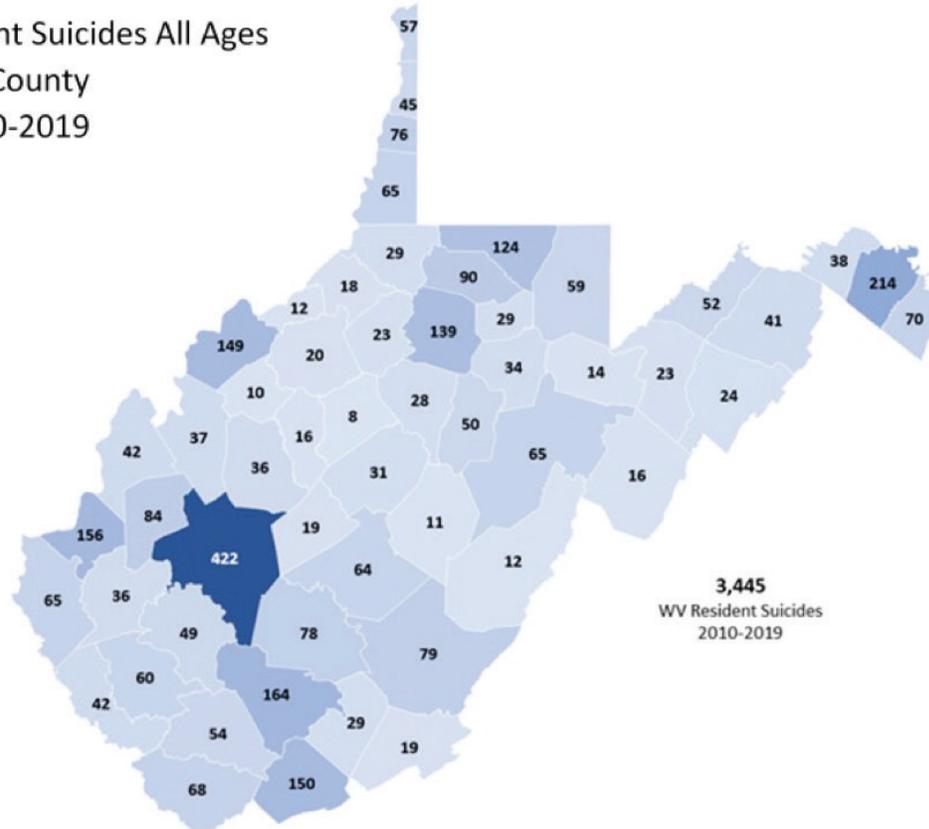
WV Resident Suicide Rate All Ages  
Per 100,000 Population by County  
2010-2019



Source: West Virginia Health Statistics Center,  
Vital Statistics System, March 2021  
Note: 2019 data are preliminary

Barbour	20.4	Hancock	19.0	Mineral	18.9	Ritchie	19.9
Berkeley	19.2	Hardy	17.3	Mingo	16.6	Roane	25.1
Boone	21.0	Harrison	20.3	Monongalia	12.0	Summers	21.8
Braxton	21.6	Jackson	12.7	Monroe	14.1	Taylor	17.1
Brooke	19.5	Jefferson	12.6	Morgan	21.6	Tucker	19.9
Cabell	16.3	Kanawha	22.5	Nicholas	25.0	Tyler	20.1
Calhoun	21.5	Lewis	17.2	Ohio	17.7	Upshur	20.4
Clay	21.2	Lincoln	17.0	Pendleton	22.1	Wayne	15.8
Doddridge	27.2	Logan	17.3	Pleasants	16.0	Webster	12.7
Fayette	17.5	McDowell	34.0	Pocahontas	14.0	Wetzel	18.3
Gilmer	9.6	Marion	15.9	Preston	17.5	Wirt	17.3
Grant	19.7	Marshall	20.3	Putnam	14.9	Wood	17.4
Greenbrier	22.3	Mason	15.5	Raleigh	21.3	Wyoming	24.3
Hampshire	17.5	Mercer	24.6	Randolph	22.3	West Virginia	18.8

Total WV Resident Suicides All Ages  
by County  
2010-2019



Source: West Virginia Health Statistics Center,  
Vital Statistics Center, March 2021  
Note: 2019 data are preliminary

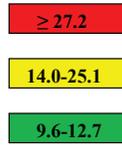
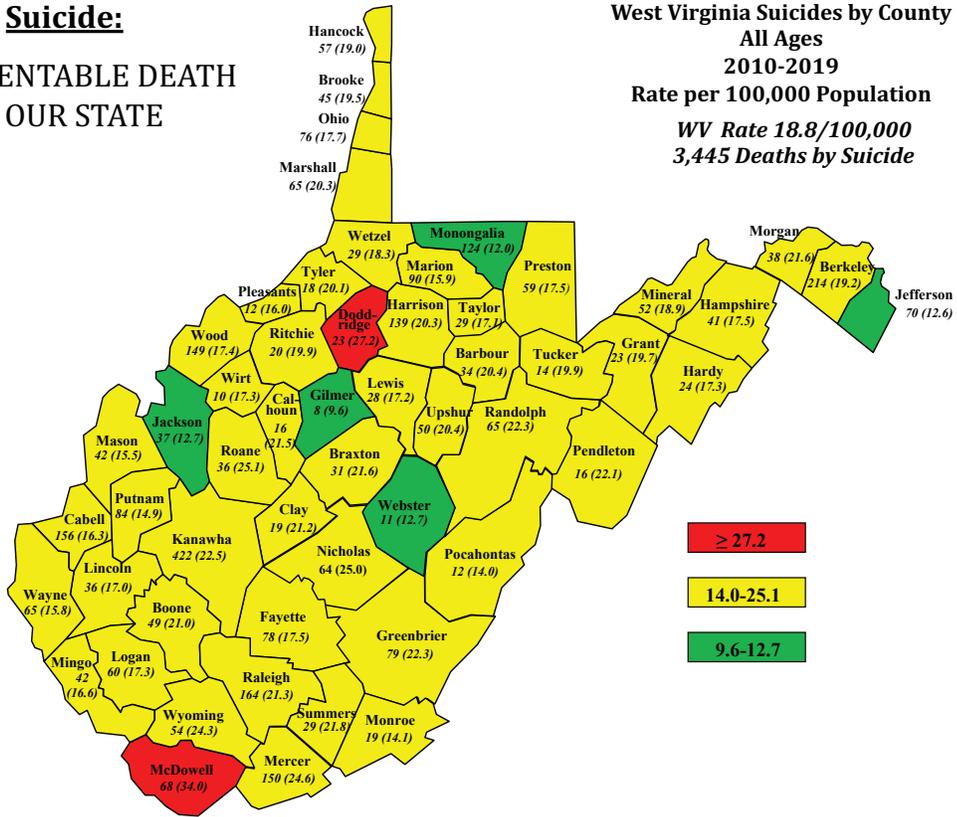
Barbour	34	Hancock	57	Mineral	52	Ritchie	20
Berkeley	214	Hardy	24	Mingo	42	Roane	36
Boone	49	Harrison	139	Monongalia	124	Summers	29
Braxton	31	Jackson	37	Monroe	19	Taylor	29
Brooke	45	Jefferson	70	Morgan	38	Tucker	14
Cabell	156	Kanawha	422	Nicholas	64	Tyler	18
Calhoun	16	Lewis	28	Ohio	76	Upshur	50
Clay	19	Lincoln	36	Pendleton	16	Wayne	65
Doddridge	23	Logan	60	Pleasants	12	Webster	11
Fayette	78	McDowell	68	Pocahontas	12	Wetzel	29
Gilmer	8	Marion	90	Preston	59	Wirt	10
Grant	23	Marshall	65	Putnam	84	Wood	149
Greenbrier	79	Mason	42	Raleigh	164	Wyoming	54
Hampshire	41	Mercer	150	Randolph	65	West Virginia	3445



**Suicide:**

A PREVENTABLE DEATH  
IN OUR STATE

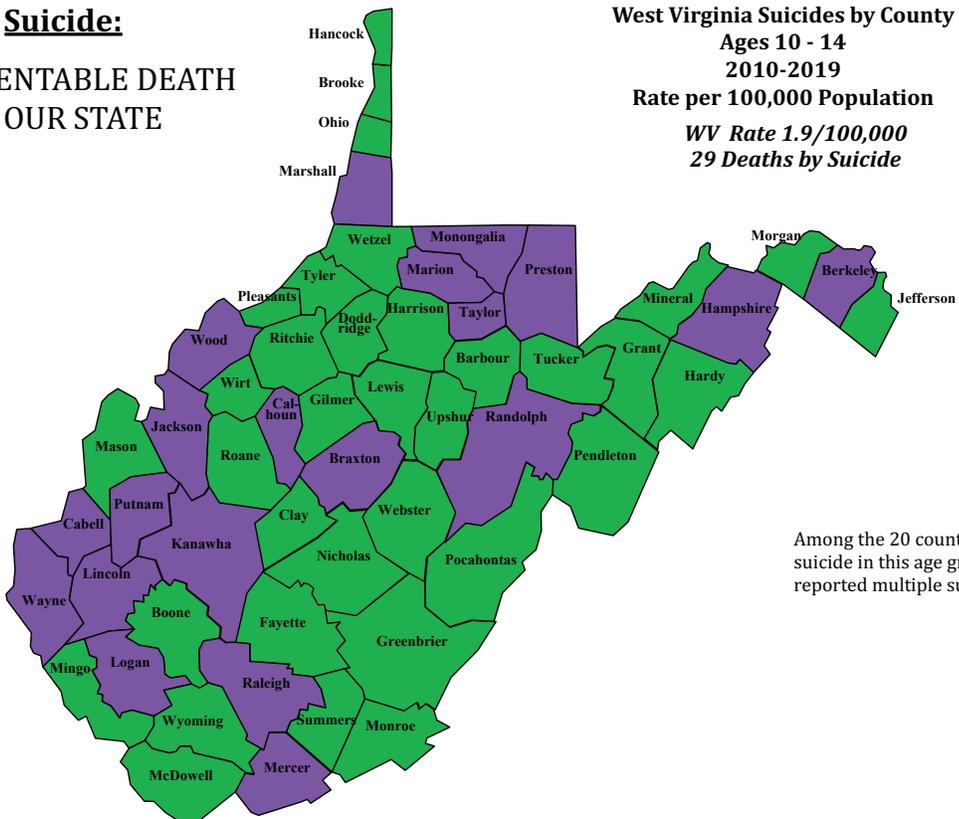
**West Virginia Suicides by County**  
All Ages  
2010-2019  
Rate per 100,000 Population  
*WV Rate 18.8/100,000*  
*3,445 Deaths by Suicide*



**Suicide:**

A PREVENTABLE DEATH  
IN OUR STATE

**West Virginia Suicides by County**  
Ages 10 - 14  
2010-2019  
Rate per 100,000 Population  
*WV Rate 1.9/100,000*  
*29 Deaths by Suicide*

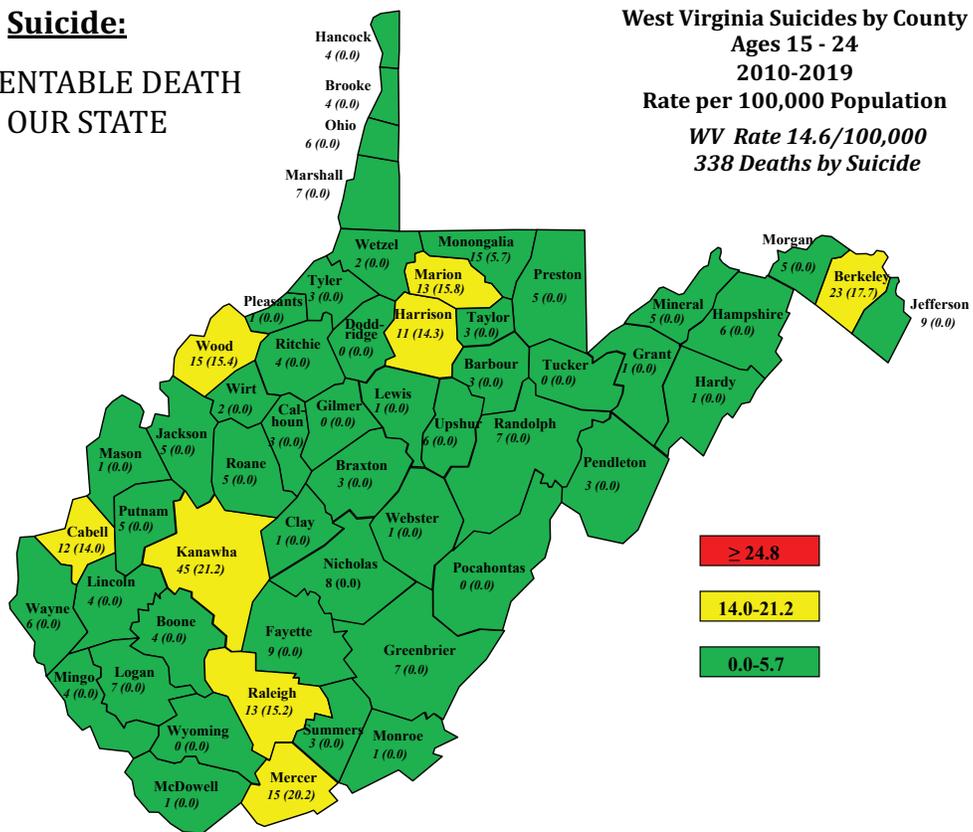


Among the 20 counties reporting a suicide in this age group, 6 counties reported multiple suicides.



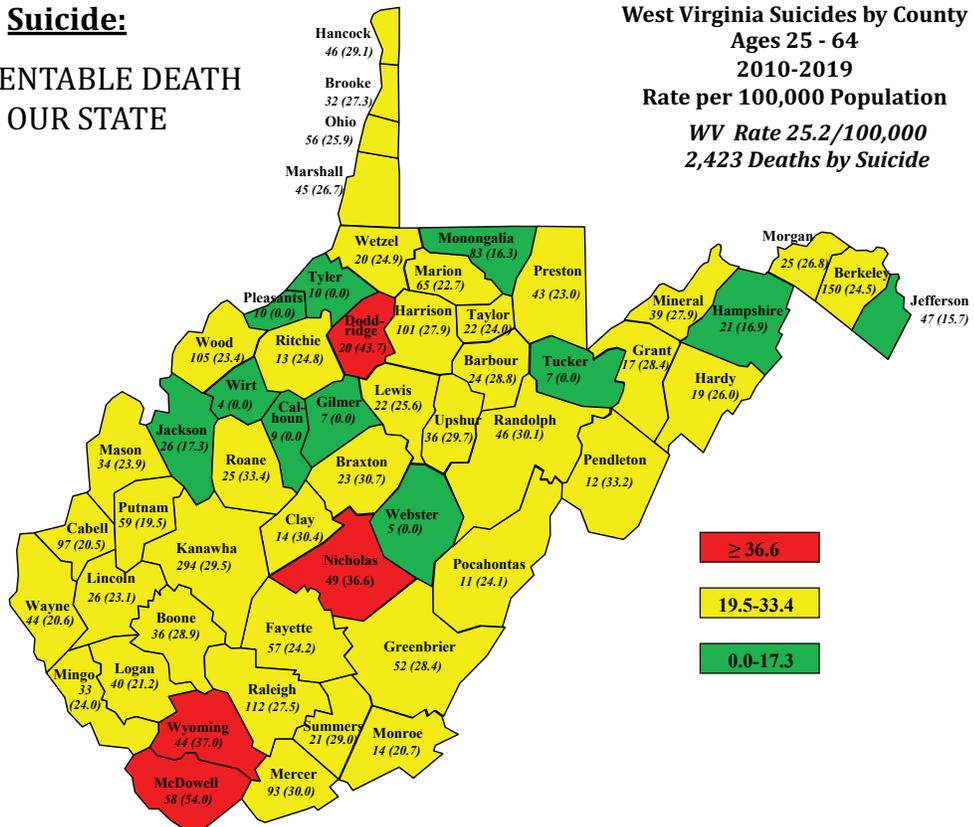
**Suicide:**  
A PREVENTABLE DEATH  
IN OUR STATE

**West Virginia Suicides by County**  
Ages 15 - 24  
2010-2019  
Rate per 100,000 Population  
*WV Rate 14.6/100,000*  
*338 Deaths by Suicide*



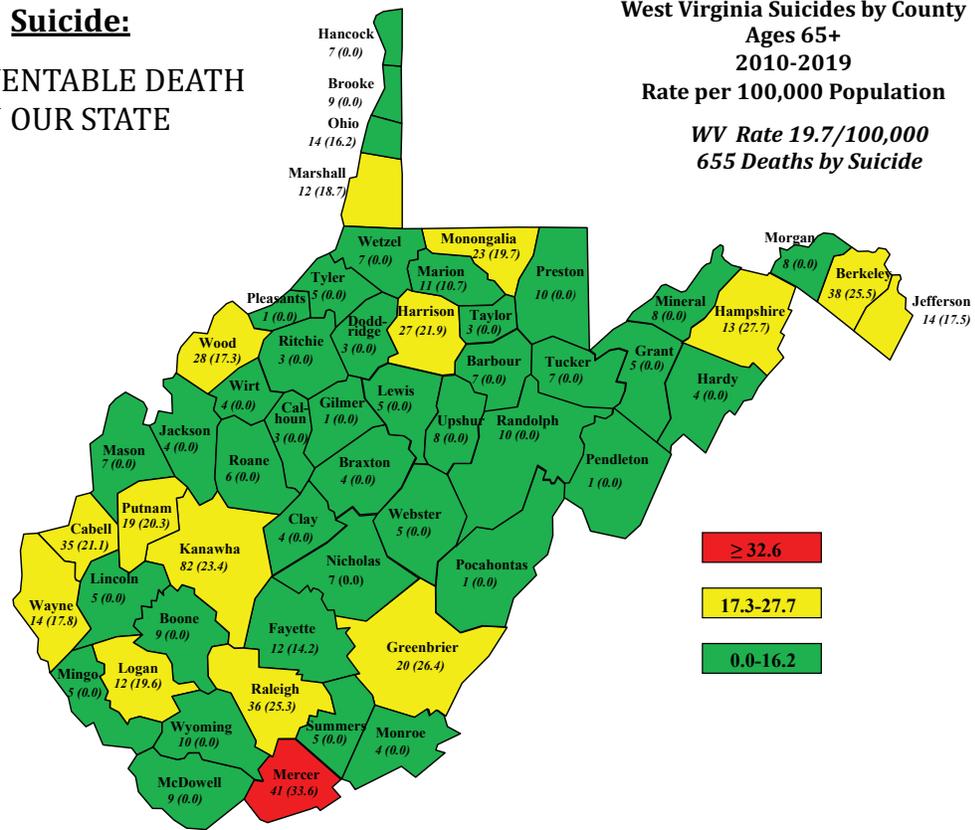
**Suicide:**  
A PREVENTABLE DEATH  
IN OUR STATE

**West Virginia Suicides by County  
Ages 25 - 64  
2010-2019  
Rate per 100,000 Population  
WV Rate 25.2/100,000  
2,423 Deaths by Suicide**



**Suicide:**  
A PREVENTABLE DEATH  
IN OUR STATE

**West Virginia Suicides by County  
Ages 65+  
2010-2019  
Rate per 100,000 Population  
WV Rate 19.7/100,000  
655 Deaths by Suicide**



The numbers of suicides in West Virginia are tragic and disheartening. However, regardless of the numbers, we know that one is too many. Every one of these people is somebody's someone: someone's father, mother, brother, sister, husband, wife, son, daughter, or grandchild.

## Risk Factors and Protective Factors

Suicide is complex and multifaceted involving many factors with various levels of influence. Suicide prevention efforts focus on reducing risk factors that contribute to suicidal thoughts and behavior, as well as strengthening protective factors that make suicide less likely.

*"We live in a culture that does not actively honor our pain and suffering, nor gives us adequate space and connection with others to heal from and make sense of trauma, which is something every single human experiences just by way of living." A.P. Looze, 28-year-old from Minnesota<sup>1</sup>*

Creating avenues of connection that offer resources and strengthen relationships can help to heal the trauma that leads to suicide thoughts and actions. Points of entry to community support need to be many and varied. Individuals are unique and community places of safety that offer room for expression and acceptance must be connected to a broader web of supports. To increase access to services, there must be a greater understanding of suicide and its predecessor, trauma. The foundation is knowing what creates risk and protection for those who grapple with the will to live.

The social-ecological model illustrated below, further explores how various risk and protective factors intersect at the societal, community, relationship, and individual levels. The examples below are not comprehensive. Factors vary across individuals and settings.

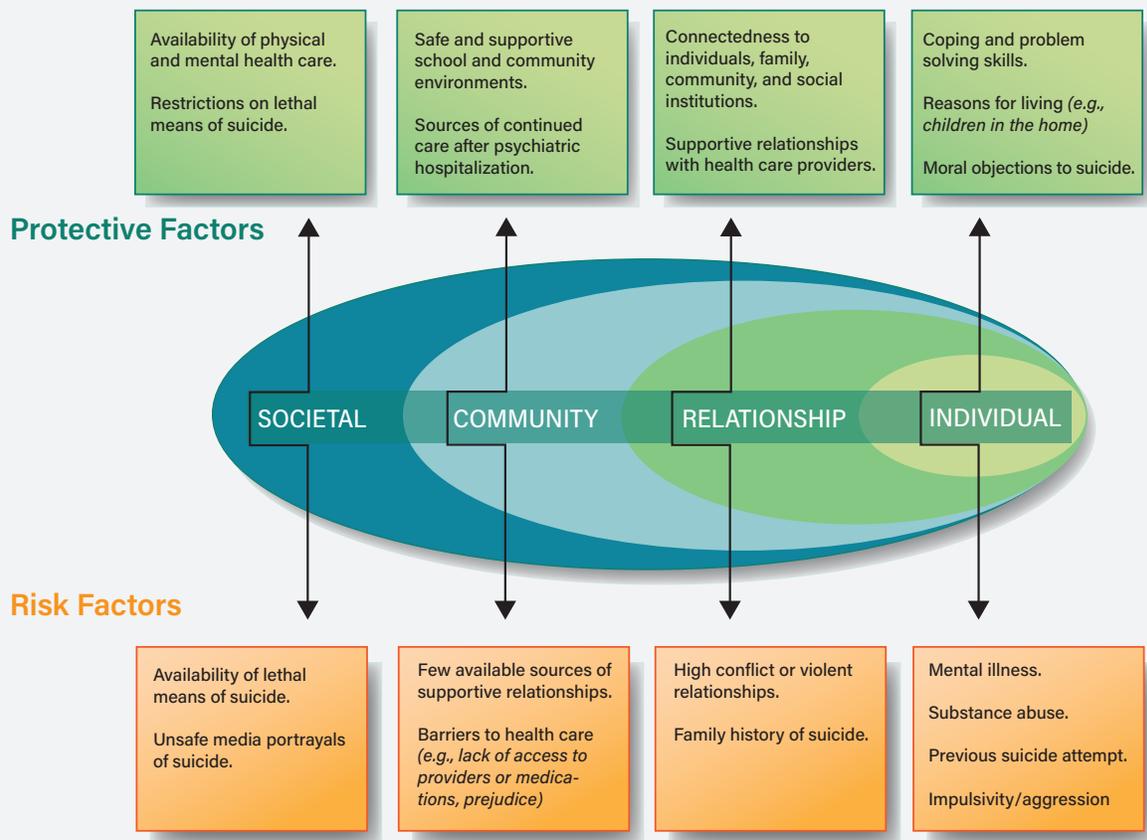
### Risk Factors

*"Suicide doesn't stand alone. It doesn't just happen as a result of nothing, out of nowhere. It's the result of something. My husband's illness and death really became the catalysts that brought a lot of other things to the forefront that I had been grappling with my whole life. If you've gone through your life and you've had trauma or you've had difficulties or things that you think you've buried and then you have a significant loss or significant trauma as I did...all the things that had been on simmer in your life come to a full boil." – I Survived a Suicide Attempt: Terry Wise<sup>2</sup>*

Every one of these people  
is somebody's someone.



## Examples of Risk and Protective Factors in a Social Ecological Model



Adapted from: Dahlberg LL, Krug EG. Violence—a global public health problem. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World report on violence and health. Geneva, Switzerland: World Health Organization; 2002:1–56.

A combination of individual, relationship, community, and societal factors contribute to the risk of suicide. Risk factors are characteristics associated with suicide; however, they are not necessarily direct causes. Risk factors include:

- Family history of suicide
- Family history of child maltreatment
- Previous suicide attempt(s)
- History of mental disorders, particularly clinical depression
- History of alcohol and substance abuse
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma)
- Local epidemics of suicide
- Isolation, a feeling of being cut off from other people
- Barriers to accessing mental health treatment
- Loss (relational, social, work, or financial)
- Physical illness
- Easy access to lethal methods
- Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders, and to suicidal thoughts.

## Protective Factors

*“This month will be 12 years since my suicide attempt. I created a career I love out of thin air. I have an incredible wife and a new son. We own a house on a block we love. I have a wonderful therapist and feel more mentally healthy than I ever have. And I still struggle with suicidal thoughts. The difference now is that I have better coping skills, I have an amazing support system, and I know how to ask for help when I need it.” — Dese’Rae L. Stage, 35 year old<sup>3</sup>*

Identification of protective factors is equally, if not more, important than acknowledging risk factors. Increasing protective factors can serve to decrease suicide risk. Strengthening protective factors is important not only during the presence of suicidal risk, but also as an ongoing process to increase overall resiliency.

Protective factors include:

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Family and community support (connectedness)
- Support from ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes
- Cultural and religious beliefs that discourage suicide and support instincts for self-preservation

## Groups With Increased Risk

The stories that we tell our children in American culture shape their vision of what is and what can be. On television and in children’s storybooks we continually see images of white families with a female mother, a male father and two little white children. This portrayal leaves many human beings lost, feeling alone, out-of-place, and unlovable. Disconnection from what is displayed as normal puts children and youth outside this narrow story at risk.

*“Growing up, I never thought I was gay. As a child, surrounded by the stories of Disney princesses and *The Notebook*, I developed romantic tunnel vision, seeing the only path to happiness as one that ended like the stories I so happily devoured.” — Anna<sup>4</sup>*

Support is crucial for people who experience life differently than what is depicted in our societal stories as normal. When Max returned from military service, he needed support from others who had made a similar journey and left with both physical and emotional scars. “Max returned from the Marines and sought treatment to combat his internal conflicts. Returning to school and utilizing the support around him was crucial to his recovery. “You can understand those negative cycles and get out of them and understand that what you went through...you can change that if you’re aware of what’s happening.”<sup>5</sup>

We know the link between suicide, suicidal thoughts and suicide attempts is strongly linked to trauma. Early identification of trauma in groups with increased risk of suicide can go a long way in preventing suicide in high-risk populations.

*“At the end of the day, I was different than everyone around me as the only Black person in an all-white school.” “The main message is that you are not the only one going through these problems or ideas... you can verbalize them, and you can cope with them in a healthy way to get you through that.” — Jordan Burnham<sup>6</sup>*

Many factors make it difficult to identify the subgroups of the population that may have an increased risk for suicidal behaviors. As noted in *2012 National Strategy for Suicide Prevention – Goals and Objectives for Action: A report of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention*, “risk and protective factors are varied, interact in different ways, and may change over time. Some risk and protective factors may be more important to one group than to another. The types of suicidal behaviors that are most common also vary across groups. For example, suicide rates may be particularly high in some groups, but suicide attempts may be more common in others. In addition, limitations associated with the collection of suicide-related data can also make it difficult to obtain prevalence estimates for specific groups.”

The following groups have been identified as being at a higher risk for suicidal behaviors than the general population:

- American Indians/Alaska Natives;
- Individuals bereaved by suicide;

- Individuals in justice and child welfare settings;
- Individuals who engage in nonsuicidal self-injury (NSSI);
- Individuals who have attempted suicide;
- Individuals with medical conditions;
- Individuals with mental and/or substance use disorders;
- Lesbian, gay, bisexual, and transgender (LGBT) populations;
- Members of the Armed Forces and veterans;
- Men in midlife; and
- Older men.

It is important to note, however, that while these groups are at increased risk, suicide is not exclusive or inclusive of these groups. Additional information on these groups is available from the Suicide Prevention Resource Center's (SPRC) online library ([www.sprc.org/search/library](http://www.sprc.org/search/library)).

## Warning Signs: A Call to Action

*"I saw the signs. I just didn't know they led to suicide."* – Survivor of suicide loss

Part of the struggle that precedes a suicide attempt is the feeling of worthlessness compounded by confusion.

*"If we truly felt that we were capable of staying for you, we would have. Before my attempt, I wanted nothing more than to get better and be strong enough to stay. But as the walls closed in on me, I stopped believing I could."* – Sam Dylan Finch<sup>7</sup>

The lack of emotional energy, mental clarity, and the ability to see options are characteristics that accompany suicide attempts. Given that, it is up to us - family, friends, and the wider community to know and understand the warning signs and to act when our loved ones cannot.

"Once you see someone telling their story, it's less hard to tell your own," Whiteside said. In 2017, more than 47,000 Americans died by suicide, but the number who attempted it was almost 30 times that — meaning 1.4 million survived such incidents, according to federal statistics.<sup>8</sup>

The community can learn from those who have experienced what we focus on preventing. The most effective interventions come from those who have been there.

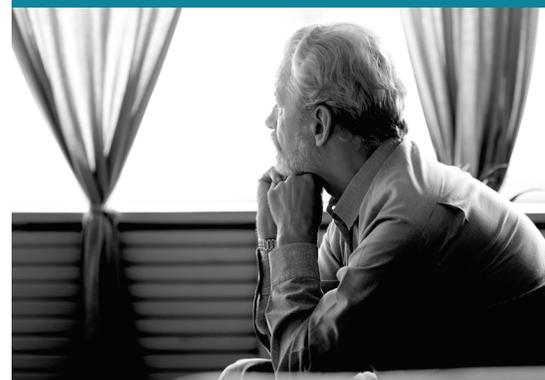
*"Suicide prevention is the responsibility of everyone and within the capability of everyone"* – Barri Sky Faucett

*"I saw the signs. I just didn't know they led to suicide."*

– *Survivor of suicide loss*

*"Suicide prevention is the responsibility of everyone and within the capability of everyone"*

– *Barri Sky Faucett*





### **Recognize the Signs**

Individuals thinking about suicide often demonstrate their intentions, indirectly asking for help, by exhibiting signs. It may be difficult to see the signs but that does not mean they are not there. In general, changes in behavior or interactions is a sign there is something going on. Though all people do not exhibit the same signs, there are some common factors identified with increased risk. All signs are worth recognizing and deserve a response. Look for the following signs:

- **Ideation:** Thinking, talking, or writing about suicide
- **Substance Abuse:** Increased or new use in alcohol or other drugs
- **Purposelessness:** No reason for living, nor future thinking/talking/planning
- **Anxiety:** Feeling anxious or worrying about something to the point of irrational thinking
- **Trapped:** No way out; unable to think of a clear next step
- **Hopelessness:** Believing nothing can help; there is no possibility of life ever getting better in the future
- **Withdrawn:** Pulling away from loved ones, social groups, or activities
- **Anger:** Expressing rage, intense irritability or seeking revenge
- **Recklessness:** Engaging in risky behavior, acting without thinking
- **Mood Changes:** Unusual or dramatic changes in mood

Additionally, there are clues that an individual is thinking about suicide. These clues can be verbal, behavioral, and/or emotional expressions.

### ***Verbal Clues***

- Being a burden to others
- Experiencing unbearable pain
- Having no reason to live
- Wanting a way out

### ***Behavioral Clues***

- Looking for a way to kill themselves, such as searching online for materials or means
- Sleeping too much or too little
- Visiting or calling people to say goodbye
- Giving away prized possessions
- Aggression

### ***Emotional Clues***

- Depression
- Loss of interest
- Rage
- Irritability
- Humiliation
- Shame
- Desperation
- Guilt

### **Respond by Asking About Suicide**

If the word suicide has crossed your mind about a person who seems to exhibit depression or is in significant psychological pain, then it has probably crossed his or her mind as well.

### **YOU MUST RESPOND BY ASKING THE QUESTION... SUICIDE?**

Saying the word SUICIDE is most effective. Saying the word is not going to make someone more likely to think or act on thoughts of suicide. There is nothing to lose and much to gain by asking if the person has thought about suicide. This is an opportunity to save someone's life. It is important to allow the individual to have a meaningful, caring conversation about their life or death situation instead of remaining in isolation.

### **Seek Help**

Seek the appropriate help for the person at risk and to assist in their immediate safety. It is not your responsibility to solve all the issues and guide them through every step of the crisis. You are the initial link in helping the person at risk.

We all have the opportunity to be a supporting and caring individual for those suffering in isolation. The good news is that there is Hope. There are effective strategies, practices, and treatments that can support a person in crisis and give them the promise of a better life. It is up to all of us.

## **Frameworks for Suicide Intervention and Prevention: Combating a National Health Crisis**

West Virginia is not alone in the fight against suicide. There is essential research, development, and advocacy taking place at a national level to address this epidemic. West Virginia depends on this important national work to provide critical framework, strategies, best practices, and awareness about the health crisis that is suicide. The strongest, most effective programs are those that are shaped by the experiences of survivors. Creating awareness for program funds and community change is best led by those who have been there. In a message

to survivors, Congressman Kennedy explained how best to fight for the programming and funding needed to stop suicide.

“You are fighting not just for money, but attention in a crowded arena,” said former congressman Patrick J. Kennedy (D-R.I.), in a final pep talk to volunteers. “Use your stories to break the cycle of shame, he urged them. Use your stories to reveal suicide for what it is: a national crisis.”<sup>9</sup>

Strategies for combating suicide come in the form of national approaches to building a coordinated community web of services known to support people at risk of suicide. Those particularly helpful in building the system are:



### **Zero Suicide**

Developed by the Suicide Prevention Resource Center and funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Zero Suicide is a framework dedicated to improving patient care and outcomes by articulating both an aspirational challenge and a way forward. Zero Suicide recognizes that 83% of those who die by suicide have seen a healthcare provider in the year before their death. There are opportunities to identify and provide care to those at risk of suicide in both health and behavioral health care settings. But first, suicide prevention must be viewed as a core responsibility of health care. The Zero Suicide framework is defined by a system-wide, organizational commitment to safer suicide care in health and behavioral health care systems. It is a culture shift away from fragmented suicide care toward a holistic and comprehensive approach to patient safety and quality improvement and to the safety and support of the staff who do the demanding work of treating and caring for suicidal patients. Zero Suicide fills the gaps that patients at risk for suicide often fall through using evidence-based tools, systematic practices, training, and embedded workflows. Embedding knowledge of suicide prevention into the training, skills development, tools, and practices of healthcare providers brings us closer to Zero Suicide.

### **Elements Zero Suicide Approach**

- 1) Lead system-wide culture change committed to reducing suicides
- 2) Train a competent, confident, and caring workforce
- 3) Identify individuals with suicide risk via comprehensive screening and assessment
- 4) Engage all individuals at-risk of suicide using a suicide care management plan
- 5) Treat suicidal thoughts and behaviors using evidence-based treatments
- 6) Transition individuals through care with warm hand-offs and supportive contacts
- 7) Improve policies and procedures through continuous quality improvement



### **Project 2025**

The American Foundation for Suicide Prevention (AFSP) set a bold goal to reduce the nation's annual suicide rate 20 percent by the year 2025. AFSP has identified four critical areas which represent the highest potential to reach the most people at risk for suicide in the shortest amount of time.

### **Firearms and Suicide Prevention**

Nationally, there are nearly 23,000 firearms-related suicides each year: roughly half of all suicides. By making suicide prevention education a basic part of firearms ownership, we can increase awareness of mental health and suicide prevention tools and emphasize the importance of safe storage and other life-saving practices.

### **Healthcare Systems**

An estimated 45 percent of individuals who die by suicide nationally visit their primary care physician in the month prior to their death. By accelerating the acceptance and adoption of evidence-based suicide prevention practices within primary and behavioral healthcare systems, we can identify those at risk. A visit to the doctor's office can become a critical opportunity to connect individuals to care.

### **Emergency Departments**

An estimated 39 percent of individuals who die by suicide in the United States visit an emergency

department in the year prior to their death. By encouraging the acceptance and adoption of suicide screening and delivery of follow-up services as a standard of emergency care, we have a greater chance of preventing suicide in at-risk individuals.

### **Corrections Settings**

Suicide is the leading cause – and accounts for – 35 percent of all deaths in jails in the United States. Enhanced mental health education and improved coordination of suicide prevention care in the corrections system will significantly reduce the rate of suicide in these settings. Education and coordination must also extend to key points of correctional contact that include pre and post incarceration.

By partnering with organizations that can help put these strategies into practice, West Virginia can reach more people in need of help, and save lives. Once people deep in the personal struggle against suicide learn to ask for help, our communities must be connected and able to respond.

## **Evidence-Based Programs and Practices**

To achieve the goals and objectives outlined in the last section, the following evidence-based practices and practices (EBPPs) have been selected. Minimal program modifications will be based on the distinctive features of Appalachian culture and demographics of the recipient populations, while maintaining an appropriate level of fidelity for each practice. The selected EBPPs will be used to meet state goals related to increased identification and referral, intervention, and assessing and managing risk, including means restriction education and treatment. Newly established evidence-based practice swill be reviewed for integration into WV's plan.

*Question, Persuade and Refer (QPR)* is an emergency mental health gatekeeper training intervention that teaches lay and professional gatekeepers working with at-risk youth to recognize early warning signs, question their meaning to determine suicide intent or desire, persuade the person to accept or seek help, and refer the person to appropriate resources and services. QPR is easily adapted to incorporate cultural considerations

of targeted populations. QPR training can be used as an entry level training for anyone who will interact with, or encounter persons with thoughts of suicide, ultimately increasing the number of people identified and referred for suicidal risk in a wide array of settings.

*Applied Suicide Intervention Skills Training (ASIST)*, designed for a varied audience, teaches suicide first-aid to help a person at risk stay safe and seek further help as needed. Participants learn an intervention model to identify persons with thoughts of suicide, seek a shared understanding of reasons for dying and living, develop a safe plan based on a risk review, be prepared to do follow-up, and become involved in suicide-safer community networks. ASIST was chosen as there are many community respondents and infrastructures that are connected to respond, but not trained in formalized suicide intervention skills. ASIST provides for a more consistent evidence-based response in rural areas where there is a shortage of mental health services.

*Emergency Department Means Restriction Education (EDMRE)* is an intervention for the adult caregivers of youth (aged 6 to 19 years) seen in an emergency department (ED) and determined through a mental health assessment to be at risk for completing suicide. EDMRE is designed to help parents and adult caregivers of at-risk youth recognize the importance of taking immediate action to restrict access to firearms, alcohol, and prescription and OTC drugs in the home. The intervention also gives parents and caregivers specific,

practical advice on how to dispose of or lock up firearms and substances that may be used in a suicide attempt. The intervention consists of three components that can be delivered by a trained health care professional in a brief period: (1) informing parents, when their child is not present, that the child is at increased suicide risk and why; (2) telling parents they can reduce this risk by limiting their child's access to lethal means; (3) educating parents and problem solving with them about how to limit access to lethal means. Support for attempt-survivors and their families and means restriction are components of this strategy.

*Collaborative Assessment and Management of Suicidality (CAMS)* is a therapeutic framework in which patient and provider work together to assess the patient's suicidal risk and use that information to plan and manage suicide-specific, patient-driven treatment. The framework involves the patient's engagement and cooperation in assessing and managing suicidal thoughts and behaviors and the therapist's understanding of the patient's suicidal thoughts, feelings, and behaviors. CAMS utilizes a multi-purpose clinical tool developed collaboratively between the patient and practitioner, called the Suicide Status Form (SSF), that guides the patient's assessment and treatment. This framework can be used for a wide range of suicidal patients across various treatment settings and in the context of various psychotherapies and treatment modalities. Incorporation of CAMS into existing practices will help mental health professionals to better





assess suicide risk, as well as plan, treat, and manage ongoing care for clients at risk of suicide in a consistent manner statewide. Using the same model in all mental health settings serving people with thoughts of suicide will contribute to continuity of care as individuals transition through the system of services.

### **Evidenced-Based Treatment Strategies**

In addition to increased evidence-based assessment and management of risk, enhanced treatment specifically addressing suicidality will be increased throughout the state. Specifically, two evidence-based treatment strategies have been chosen to increase the breadth and depth of treatment services currently available. Both approaches focus on talking about thoughts and feelings and identifying alternative ways of coping with heavy, dark feelings. We know from research on effective practices and conversations with suicide survivors that healthy coping skills and a sound knowledge that cataclysmic thoughts and feelings will pass are the essential ingredients in the ability to live with suicidal thoughts. A two-fold treatment approach allows for feasible implementation of services across the rural state of West Virginia and offers behavioral health providers flexibility in delivery.

*Dialectical Behavioral Therapy (DBT)* is a cognitive-behavioral treatment approach with two key characteristics: a problem-solving focus blended with

acceptance-based strategies, and an emphasis on dialectical processes. Problem-solving, acceptance and verbal processing are best used in treating patients with multiple disorders. DBT has five components: (1) capability enhancement; (2) motivational enhancement; (3) generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment); (4) structuring of the environment; (5) capability and motivational enhancement of therapists. DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance.

*Cognitive Therapy for Suicide Prevention (CBT-SP)* is a cognitive-behavioral psychotherapy program designed for patients who have previously attempted or thought of suicide. The intervention teaches patients alternative ways of thinking and behaving during episodes of suicidal crises. CBT-SP assists individuals in building a network of mental health services and social supports to prevent future suicide attempts. It is designed to be provided by individual therapists on a one-to-one basis.

### **Evidence-Based Best Practices**

WV proposes to use three “Best Practices” listed in the Suicide Prevention Resource Center’s Best Practice Registry to meet goals and objectives related to increasing competency when working with individuals with suicidal thoughts and reducing access to lethal means.

SafeTALK is a training program that teaches participants to recognize and engage persons who may be having thoughts of suicide and connect them with community resources trained in suicide intervention. ‘Safe’ stands for ‘suicide alertness for everyone’. ‘TALK’ stands for the actions that one takes to help those with thoughts of suicide: Tell, Ask, Listen, and Keep Safe. West Virginia has chosen this program as it challenges the attitudes that inhibit talking about suicide that are prevalent in the state’s culture. This training was selected to remove barriers and ensure an increased capacity for help-seekers to have appropriately trained responders. SafeTALK fits well with the community model of prevention and intervention and was chosen to be introduced in communities as a complement to ASIST in order to provide an infrastructure for cultivating suicide safer communities.

Counseling Access to Lethal Means (CALM) is a workshop designed to help providers implement counseling strategies that help clients at risk for suicide and their families reduce access to lethal means, especially, but not exclusively, firearms. This training will be offered to both behavioral health and medical providers to increase the practice of discussion regarding access to lethal means when at-risk individuals are identified. The workshop increases participants’ skill and confidence with clients and their families to reduce access to lethal means through safe storage and other evidence based practices. In consideration of WV culture regarding gun ownership, the training will be tailored with sensitivity to Appalachian culture to ensure means restriction is a provision of safety rather than control. CALM workshops will address the relationship between youth suicide and access to lethal means; negotiation of means restriction; conducting a suicide proofing assessment for the individual’s environment; and implementation of means restriction as a component of intervention.

Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment: A Treatment Improvement Protocol TIP 50 is designed to assist substance abuse counselors in working with adult clients who may be suicidal. TIP 50 will help clinical supervisors and administrators support the work of substance abuse counselors. For counselors, it provides the “what” and the “why” and the “how” of working with clients

in substance abuse treatment with suicidal thoughts and behaviors. It covers background information about suicide and substance use disorders, including risk factors and warning signs for suicide, and a four-step process for addressing suicidal thoughts and behaviors. For administrators, the protocol clarifies why program administrators should be concerned about this clinical issue. The recommendations contained in each TIP are grounded in evidence that a particular practice will produce a specific clinical outcome (measurable change in client status). Evidence includes scientific research findings and the opinion of the TIP consensus panel of experts. In making recommendations, the consensus panel engages in a process of “evidence-based thinking” in which they consider scientific research, clinical practice theory, practice principles and practice guidelines, as well as their own individual clinical experiences.

#### **Evidence-Based Youth Curricula**

In providing for suicide prevention education in youth serving settings, the following curricula will be utilized.

More than SAD is a program with three components for teens, parents, and educators. The teen program focuses on teaching teens to recognize the signs of depression in themselves and others, challenges the stigma surrounding depression, and demystifies the treatment process. The program for parents teaches parents how to recognize signs of depression and other mental health problems, initiate a conversation about mental health with their child, and get help. Finally, the program for educators teaches them to recognize signs of mental health distress in students and refer them for help.

Signs of Suicide Prevention Program (SOS) is a universal, school-based depression awareness and suicide prevention program designed for middle-school (ages 11–13) or high-school (ages 13–17) students. The SOS curriculum includes lessons on raising awareness of depression and suicide, helping students identify the warning signs of depression in themselves and others, identifying risk factors associated with depression and suicidal ideation, and using a brief screening for depression and/or suicidal behavior. Students are taught to seek help using the ACT (Acknowledge, Care, Tell) technique. This technique teaches students to acknowledge when there are signs of a problem in

themselves or a peer, to show that you care and are concerned about getting help, and to tell a trusted adult. Upon completion of the program, students are given response cards to indicate if they would like to speak to a trusted adult about themselves or a friend.

*Lifelines* is a whole school trilogy made up of three unique components: Lifelines: Prevention, Lifelines: Intervention, and Lifelines: Postvention. The goal of Lifelines is to promote a caring, competent school community in which help seeking is encouraged and modeled and suicidal behavior is recognized as an issue that cannot be kept secret. The goal of Lifelines is to increase the likelihood that school staff and students will know how to identify at-risk youth, respond appropriately, and be encouraged to obtain help. The student component gives students the opportunity to learn what to do when faced with a suicidal peer and encourages help-seeking behaviors. Lifelines includes a set of components to be implemented by the schools simultaneously with the student program including: (1) a review of resources and establishment of administrative guidelines and procedures for responding to a student at risk; (2) training for school faculty and staff to enhance suicide awareness and an understanding of the role they can play in identifying and responding to a student with suicidal behavior and a workshop; (3) informational materials for parents. Lifelines Postvention educates everyone in middle and high school community on how to address and respond

to not only suicide, but any type of traumatic death that profoundly affects the school population. The manual includes in-depth references and detailed plans of a response strategy that reflects the action steps in dealing with a death within the school community. Lifelines acknowledges whole-school challenges related to suicide and tragic death. The curriculum offers strategies for addressing the challenges.

*It's Real: College Students and Mental Health* is designed to increase awareness regarding mental health issues experienced by college students with the goal of encouraging help-seeking behaviors for individuals experiencing mental health issues. The program features real stories and experiences of mental health conditions. It's Real demonstrates the real illnesses of depression and other mental health conditions, acknowledging that they can be managed through specific treatments and interventions. The overall intention is to encourage college students to be aware of the state of their mental health, to acknowledge and recognize when they are struggling, and to take steps to seek help.



## Strategic Directions, Goals, and Objectives

West Virginia has chosen its strategic direction, goals and objectives based on guidance from national efforts in cooperation with many groups, agencies, and disciplines across the state. As West Virginians we are committed to working together, learning together, and strengthening our approaches based on taking action and reviewing our results. We are committed to continuous improvement. We start here. We start now.

### STRATEGIC DIRECTION 1: Healthy and Empowered Individuals, Families, and Communities

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

- Objective 1.1:** Increase the number of implemented trainings on the prevention of suicide-related behaviors.
- Objective 1.2:** Increase the incorporation and utilization of best-practice suicide risk screenings and assessments in the existing intake practices of agencies.
- Objective 1.3:** Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.
- Objective 1.4:** Establish effective, sustainable suicide prevention programming as a requirement/practice for state agencies providing for services to at-risk individuals and share with the courts, community groups, and youth serving organizations (*i.e. sport groups, churches, the arts, scouting, foster and residential care, etc.*).

#### GOAL 2: Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.

- Objective 2.1:** Develop, implement, and evaluate communication efforts designed to reach defined segments of the population.
- Objective 2.2:** Reach policymakers with dedicated communication efforts.
- Objective 2.3:** Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.
- Objective 2.4:** Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.

#### GOAL 3: Increase knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery.

- Objective 3.1:** Promote effective programs and practices that increase protection from suicide risk.
- Objective 3.2:** Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.
- Objective 3.3:** Promote the understanding that recovery from mental and substance use disorders is possible for all.

## STRATEGIC DIRECTION 2: Effective Clinical and Community Preventive Services

### GOAL 4: Develop, implement, and monitor effective programs that promote wellness and prevent suicide-behaviors.

- Objective 4.1:** Increase the number of organizations screening, assessing, referring, safety planning and providing follow-up services for individuals interacting within their system.
- Objective 4.2:** Develop a standardized statewide referral network and universal crisis response system for at-risk individuals
- Objective 4.3:** Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.

### GOAL 5: Promote efforts to address means safety among individuals with identified suicide risk.

- Objective 5.1:** Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.
- Objective 5.2:** Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.
- Objective 5.3:** Reduce access to lethal means through a comprehensive approach of increasing awareness and education; enhancing protocols; practices and policy changes.

## STRATEGIC DIRECTION 3: Evidence-Based Treatment and Support Services

### GOAL 6: Promote suicide prevention as a core component of health services.

- Objective 6.1:** Promote the adoption of “zero suicide” as an aspirational goal by health care, corrections and community support systems that provide services and support to defined patient populations.
- Objective 6.2:** Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide presenting to the health care and community support systems.
- Objective 6.3:** Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.
- Objective 6.4:** Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.
- Objective 6.5:** Develop standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs.
- Objective 6.6:** Develop, disseminate, and implement guidelines of the assessment of suicide risk among persons receiving care in all settings.

**GOAL 7: Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.**

- Objective 7.1:** Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among patients receiving care for mental and/or substance use disorders.
- Objective 7.2:** Increase the number of mental health and substance abuse providers trained in evidenced-based clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.
- Objective 7.3:** Develop, disseminate, and implement guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk
- Objective 7.4:** Adopt and implement guidelines to effectively engage individuals and families throughout entire episodes of care

**GOAL 8: Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.**

- Objective 8.1:** Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.
- Objective 8.2:** Provide for direct follow-up services for attempt survivors and their families from Emergency Departments; inpatient hospitals; and lifeline callers in order to provide access to treatment.
- Objective 8.3:** Develop protocols and improve collaboration among crisis centers, law enforcement, the courts, mobile crisis teams, and social services to ensure timely access to care for individuals with suicide risk.
- Objective 8.4:** Develop, disseminate, and implement guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state and community levels.

**STRATEGIC DIRECTION 4: Comprehensive Surveillance, Research, and Evaluation**

**GOAL 9: Increase the timeliness and usefulness of surveillance systems relevant to suicide prevention and improve the ability to collect, analyze and use this information for action.**

- Objective 9.1:** Improve the timeliness of reporting vital records data.
- Objective 9.2:** Improve the usefulness and quality of suicide-related data.
- Objective 9.3:** Improve and expand state and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.

**GOAL 10: Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.**

- Objective 10.1:** Establish common measures across systems to evaluate the effectiveness of suicide prevention interventions.
- Objective 10.2:** Evaluate the effectiveness of suicide prevention interventions.
- Objective 10.3:** Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.

# GLOSSARY

**Affected by suicide**

All those who may feel the impact of suicidal behaviors, including those bereaved by suicide, as well as community members and others.

**At-risk behaviors**

Anything that puts an individual at-risk for future negative consequences, such as injury or death

**At-risk individuals**

Individuals with thoughts of suicide.

**Behavioral health**

A state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. The term is also used to describe the service systems encompassing the promotion of emotional health; the prevention of mental and substance use disorders, substance use, and related problems; treatments and services for mental and substance use disorders; and recovery support.

**Bereaved by suicide**

Family members, friends, and others affected by the suicide of a loved one (also referred to as survivors of suicide loss).

**Best practices**

Activities or programs that are in keeping with the best available evidence regarding what is effective.

**Community**

A group of individuals residing in the same locality or sharing a common interest.

**Comprehensive suicide prevention plans**

Plans that use a multifaceted approach to address the problem, for example, including interventions targeting biopsychosocial, social, and environmental factors.

**Comorbidity**

The co-occurrence of two or more disorders, such as depressive disorder and substance use disorder.

**Complicated grief**

Feelings of loss, following the death of a loved one, which are debilitating and do not improve even after time passes. These painful emotions are so long lasting and severe that those who are affected have trouble accepting the loss and moving on with their lives. Also referred to “traumatic grief” or “prolonged grief”.

**Connectedness**

Closeness to an individual, group, or individuals within a specific organization; perceived caring by others; satisfaction with relationship to others; or feeling loved and wanted by others.

**Contagion**

A phenomenon whereby susceptible persons are influenced toward suicidal behavior through knowledge of another person’s suicidal acts.

**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, including the ability of the program to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.

**Culture**

The integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, faith, or social group.

**Deliberate self-harm**

See suicidal self-directed violence.

**Epidemiology**

The study of statistics and trends in health and disease across communities.

**Evaluation**

The systematic investigation of the value and impact of an intervention or program.

**Evidence-based programs and practices**

Programs and practices that have undergone scientific evaluation and have proven to be effective.

**Gatekeepers**

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. Examples include clergy, first responders, pharmacists, caregivers, and those employed in institutional settings, such as schools, prisons, and the military.

**Goal**

A broad and high-level statement of general purpose to guide planning on an issue; it focuses on the end result of the work.

**Health**

The complete state of physical, mental, and social well-being, not merely the absence disease or infirmity.

**Indicated intervention**

Intervention designed for individuals at high risk for a condition or disorder or for those who have already exhibited the condition or disorder.

**Intervention**

A strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as providing lithium for bipolar disorders, educating providers about suicide prevention, or reducing access to lethal means among individuals with suicide risk).

**Means**

The term means can be used specifically to refer to suicide. Within the context of suicide, the term

‘means’ refers to the instrument or object used to carry out a self-destructive act (e.g., chemicals, medications, illicit drugs).

**Means restriction**

Techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

**Methods**

The term methods can be used specifically to refer to suicide. Within the context of suicide, the term ‘methods’ refers to actions or techniques that result in an individual inflicting self-directed injurious behavior (e.g., overdose).

**Mental disorder**

A diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual’s cognitive, emotional, or social abilities; often used interchangeably with mental illness.

**Mental health**

The capacity of individuals to interact with one another and the environment in ways that promote subjective well-being, optimal development, and use of mental abilities (cognitive, affective, and relational).

**Mental health services**

Health services that are specifically designed to promote emotional wellness and to provide care and treatment to persons with mental health problems, including mental illness. Mental health services include hospitals and other 24-hour services, intensive community services, ambulatory or outpatient services, medical management, case management, intensive psychosocial rehabilitation services, and other intensive outreach approaches for the care of individuals with severe disorders.

# GLOSSARY

## **Mood disorders**

A term used to describe all mental disorders that are characterized by a prominent or persistent mood disturbance; disturbances can be in elevated expansive emotional states or, in depressed emotional states. These disorders include depressive disorders, bipolar disorders, mood disorders because of a medical condition, and substance-induced mood disorders.

## **Morbidity**

The relative frequency of illness or injury, or the illness or injury rate, in a community or population.

## **Mortality**

The relative frequency of death, or the death rate, in a community or population.

## **Nonsuicidal self-injury**

Self-injury with no suicidal intent. Same as nonsuicidal self-directed violence

## **Objective**

A specific and measurable statement that clearly identifies what is to be achieved in a plan; it narrows a goal by specifying who, what, when, and where or clarifies by how much, how many, or how often.

## **Older adults**

Persons aged 60 or more years.

## **Outcome**

A measurable change in the health of an individual or group of individuals that is attributable to an intervention.

## **Population subgroup**

A designated group within the larger population.

## **Postvention**

Response to and care for individuals affected in the aftermath of a suicide attempt or suicide death.

## **Prevention**

A strategy or approach that reduces the likelihood of risk of onset or delays the onset of adverse health problems, or reduces the harm resulting from conditions or behaviors.

## **Protective factors**

Factors that make it less likely that individuals will develop a disorder. Protective factors may encompass biological, psychological, or social factors in the individual, family, and environment.

## **Psychiatry**

The medical science that deals with the origin, diagnosis, prevention, and treatment of mental disorders.

## **Psychology**

The science concerned with the individual behavior of humans, including mental and physiological processes related to behavior.

## **Rate**

The number per unit of the population with a particular characteristic for a given unit of time.

## **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**

Factors that make it more likely that individuals will develop a disorder. Risk factors may encompass biological, psychological, or social factors in the individual, family, and environment.

## **Safety plan**

Written list of warning signs, coping responses, and support sources that an individual may use to avert or manage a suicide crisis.

**Screening**

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

**Screening tools**

Instruments and techniques (e.g., questionnaires, check lists, self-assessment forms) used to evaluate individuals for increased risk of certain health problems.

**Selective intervention**

Intervention targeted to subgroups of the population whose risk of developing a health problem is significantly higher than average.

**Self-inflicted injuries**

Injuries caused by suicidal and nonsuicidal behaviors such as self-mutilation.

**Sexual orientation**

An individual's sexual, physical, and/or romantic attraction to men, women, both, or neither.

**Social support**

Assistance that may include companionship, emotional backing, cognitive guidance, material aid, and special services.

**Specialty treatment centers**

(e.g., *mental health, substance abuse*)

Health facilities where the personnel and resources focus on specific aspects of psychological or behavioral well-being.

**Stakeholders**

Entities including organizations, groups, and individuals that are affected by and contribute to decisions, consultations, and policies.

**Substance use disorder**

A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use; includes maladaptive use of legal substances such as alcohol; prescription

drugs such as analgesics, sedatives, tranquilizers, and stimulants; and illicit drugs such as marijuana, cocaine, inhalants, hallucinogens, and heroin.

**Suicidal-related or related behaviors**

Behaviors related to suicide, including preparatory acts, as well as suicide attempts and deaths.

**Suicidal self-directed violence**

Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.

**Suicidal ideation**

Thoughts of engaging in suicide-related behavior.

**Suicidal intent**

There is evidence (explicit and/or implicit) that at the time of injury the individual intended to kill him or herself or wished to die and that the individual understood the probable consequences of his or her actions.

**Suicidal plan**

A thought regarding a self-initiated action that facilitates self-harm behavior or a suicide attempt; often including an organized manner of engaging in suicidal behavior such as a description of a time frame and method.

**Suicide**

Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

**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 injury.

**Suicidal behaviors**

Acts and/or preparation toward making a suicide attempt, suicide attempts, and deaths by suicide.

# GLOSSARY

## **Suicide crisis**

A suicide crisis, suicidal crisis, or potential suicide, is a situation in which a person is attempting to kill him or herself or is seriously contemplating or planning to do so. It is considered a medical emergency, requiring immediate suicide intervention and emergency medical treatment.

## **Suicide attempt survivors**

Individuals who have survived a prior suicide attempt.

## **Suicide loss survivors**

See bereaved by suicide.

## **Surveillance**

The ongoing, systematic collection, analysis, and interpretation of health data with timely dissemination of findings.

## **Unintentional**

Term used for an injury that is unplanned; in many settings, these are termed accidental injuries.

## **Universal intervention**

Intervention targeted to a defined population, regardless of risk (this could be an entire school, for example, and not the general population, per se).

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<sup>8,9</sup> Once they hid their stories. But now, survivors of suicide are 'coming out' to combat a national crisis. By William Wan, The Washington Post, July 29, 2019, [https://www.washingtonpost.com/health/once-they-hid-their-stories-but-now-survivors-of-suicide-are-coming-out-to-combat-a-national-crisis/2019/07/26/62b6a742-a193-11e9-bd56-eac6bb02d01d\\_story.html](https://www.washingtonpost.com/health/once-they-hid-their-stories-but-now-survivors-of-suicide-are-coming-out-to-combat-a-national-crisis/2019/07/26/62b6a742-a193-11e9-bd56-eac6bb02d01d_story.html)

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<https://preventsuicidewv.com/>