



Pennsylvania Statewide Suicide Prevention Plan

- September 2020 -



National Suicide Prevention Lifeline

1-800-273-8255

En Español 1-888-628-9454

Crisis Text Line

Text PA to 741741

Trevor Lifeline

1-866-488-7386

Veteran's Crisis Line

1-800-273-TALK (8255)

Trans Lifeline

1-877-565-8860

To submit your thoughts, email RA-PWSuicidePreventn@pa.gov

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Executive Summary

In order to address the growing rates of suicide in Pennsylvania, Governor Wolf announced the formation of a statewide Suicide Prevention Task Force, made up of several state agencies and members of the General Assembly. The Task Force brings together policy and programmatic expertise from multiple state agencies in order to develop a comprehensive statewide suicide prevention plan that addresses suicide as a public health issue, utilizing a cross-sector approach and building off existing suicide prevention plans. The Task Force embarked on a statewide listening tour to hear from hundreds of community members about the impacts of suicide in their lives and listen to their recommendations for a public health approach to address this rising issue. With feedback from the listening tour, the state agencies serving on the Suicide Prevention Task Force developed Pennsylvania's Statewide Suicide Prevention Plan for 2020-2024, which is a comprehensive, four-year plan aimed at reducing suicide across Pennsylvania and decreasing stigma associated with suicide, suicide attempts, and mental health.

The Statewide Suicide Prevention Plan outlines the current landscape of suicide in Pennsylvania, including population specific data and needs, the benefits of a comprehensive state suicide prevention plan, the plan's guiding principles, the process for developing the plan, and specific goals and objectives dedicated to preventing suicide and suicide attempts across Pennsylvania.

The Suicide Prevention Task Force would like to thank each state agency and member of the General Assembly that contributed to the plan, attended the statewide listening sessions, or shared their stories about the impact of suicide for their constituency. Additionally, the Task Force would like to acknowledge the ongoing support of organizations like Prevent Suicide PA, the Mental Health Association in Pennsylvania, the National Alliance on Mental Illness Keystone, Pennsylvania Mental Health Consumers Association, and countless others that helped to make the listening sessions a success. Last but not least, the Commonwealth acknowledges with gratitude the individuals, families, and community members that attended the listening sessions to share their recommendations and stories with the Task Force. These stories, while often personal and difficult to share, showed an enormous amount of strength and resiliency and are crucial to breaking down stigma associated with suicide and mental health challenges. These stories and recommendations helped to identify suicide prevention needs and priorities into a comprehensive, statewide plan to prevent suicide in Pennsylvania.

Pennsylvania's eight suicide prevention goals are as follows:

Goal 1: Increase suicide prevention awareness efforts that reduce stigma and promote safety, help-seeking, and wellness.

Goal 2: Promote trauma-informed approaches to support all Pennsylvania residents as part of upstream, universal suicide prevention efforts.

Goal 3: Provide quality training on the prevention of suicide and management of suicide risk across multiple sectors and settings.

Goal 4: Promote screening across sectors, including health care, behavioral health, educational and correctional settings, to identify individuals at risk for suicide.

Goal 5: Promote and implement effective clinical and professional practices for assessing and treating those identified as at risk for suicidal behaviors.

Goal 6: Provide trauma-informed care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

Goal 7: Promote means safety among individuals with identified suicide risk.

Goal 8: Improve the capacity to utilize data reporting systems relevant to suicide and improve the ability to collect, analyze, and use the information in a timely manner to inform suicide prevention efforts.

The Department of Human Services is accepting feedback on the Statewide Suicide Prevention Plan to inform implementation efforts. Please submit feedback to RA-PWSuicidePreventn@pa.gov.

Introduction

Suicide is a serious public health issue impacting individuals, families, friends, co-workers, schools, organizations, and communities throughout the Commonwealth of Pennsylvania. Historically, both in Pennsylvania and nationwide, suicide prevention has been addressed primarily through the efforts of the mental health system, rather than through a coordinated, cross-sector approach. While mental health disorders are a risk factor for suicide, the vast majority of individuals with a mental health diagnosis do not engage in suicidal behaviors.¹

Now more than ever, given the context of the current COVID-19 pandemic, it is important to consider the broader social and economic factors that contribute to suicide risk, as well as the role of trauma. This global crisis, which will have long-term effects that are yet to be determined, has already affected the general population, underscoring the necessity of a public health approach. Available data from the Centers for Disease Control and Prevention (CDC) also indicates that racial and ethnic minority groups are disproportionately impacted by the pandemic with regard to both illness and death.² A recent Lancet Psychiatry article (Gunnell et al., 2020) highlights that while suicide rates are suggested to increase during and following the pandemic, growing rates are not inevitable

¹ *National Strategy for Suicide Prevention: Goals and Objectives for Action*, U.S. Surgeon General and the National Action Alliance for Suicide Prevention, 2012.

² *COVID-19 in Racial and Ethnic Minority Groups*, Centers for Disease Control and Prevention, 2020.

if meaningful interventions beyond typical mental health services, programs, and policies are employed. As resource needs are intensified during this crisis and suicide risk factors become more widespread, both universal and targeted approaches are needed at the state and local level to improve individuals' overall health and wellness. Furthermore, the mental health system and public at large must remain vigilant in recognizing the signs of suicide risk, referring individuals to available resources, building the capacity for mental health workforce support, and increasing the public's access to the mental health system.

The National Strategy for Suicide Prevention (2012) highlights the many risk and protective factors for suicide at the individual, relational, community, and societal level that play a role in increasing or reducing suicide risk. It is important to underscore that the majority of individuals experiencing risk factors for suicide do not die by suicide, given the role of protective factors that serve as a buffer to suicide risk.³ However, suicide deaths represent only part of this issue, as many more individuals and families are impacted by suicide attempts and serious thoughts of suicide.⁴ Given the scope of the issue, suicide must be addressed at multiple levels of the system by a variety of agencies and through leadership that encourages collaboration to effectively address the problem.⁵

Because suicide is a complex behavior affected by a combination of factors, a comprehensive approach to prevention is warranted. Not only must this incorporate multiple strategies, but it must include diverse partners to work collaboratively and strategically toward designated outcomes. To advance statewide suicide prevention efforts, partnerships must include stronger relationships and alignment of goals across state agencies, as well as between state and local initiatives.⁶ Statewide efforts must also embrace the experiences of individuals who have experienced suicidal thoughts or attempts, and families who have suffered the tragic loss of a loved one to suicide. In prioritizing suicide prevention as a statewide initiative in Pennsylvania, there is increased opportunity for stakeholders to share responsibility for the overarching goal of reducing suicide deaths. Additionally, broadening traditional suicide prevention efforts to incorporate upstream approaches becomes more feasible through cross-systems collaboration.

Overall Prevalence of Suicide Attempts, Deaths, and Behaviors

Nationally, suicide is the tenth leading cause of death, claiming more than twice as many lives each year as homicide.⁷ According to the latest data available from the Centers for Disease Control and Prevention (CDC), 48,344 people died from suicide in the United States in 2018. Within Pennsylvania, 2,017 people took their own lives in 2018 (up from 1,272 suicides in 1999), reflecting a 43.3% increase in the age-adjusted suicide rate.⁷ The rate of suicide within Pennsylvania based upon CDC (2018) data was 15.7 deaths per

³ [Preventing Suicide: A Technical Package of Policy, Programs, and Practices](#), Centers for Disease Control and Prevention, 2017.

⁴ [Suicidal Thoughts and Suicide Attempts](#), Suicide Prevention Resource Center, accessed September 30, 2019.

⁵ [Suicide Care in Systems Framework](#), National Action Alliance: Clinical Care & Intervention Task Force.

⁶ [State Strategies for Averting Early Deaths](#), National Governors Association, 2019.

⁷ [WISQARS Leading Causes of Death Reports](#), Centers for Disease Control and Prevention, accessed March 9, 2020.

100,000 population and the national rate was 14.8 deaths per 100,000 population. Pennsylvania ranks 28th for the rate of deaths by suicide as compared to the other 49 states and the District of Columbia.

In Pennsylvania, five-year suicide rates from 2014-2018 were highest within Carbon county (24.7 per 100,000), and Elk county (23.8 per 100,000). The counties with the lowest five-year suicide rates from 2014-2018 are Centre county (9.8 per 100,000), Philadelphia county (9.9 per 100,000), and Union County (10.0 per 100,000), all of which have lower rates than the national average.⁸ In general, this mirrors national trends indicating that suicide rates in rural counties are nearly double that of urban counties.⁹ While Pennsylvania's overall suicide rates are close to the national median, the wide variation of rates within the Commonwealth will need to be explored to determine which variables increase and decrease one's likelihood of dying by suicide, as well as what factors impact the accurate reporting of suicide deaths. Additionally, it is important to note that significant variability in suicide death rates within certain counties from year to year, particularly within rural counties, may in part be due to relatively small populations.

For every person who dies by suicide, more than 25 others attempt suicide.¹⁰ According to the National Survey on Drug Use and Health (NSDUH) conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA; 2018), approximately 10.7 million adults (aged 18 or older) report having serious thoughts about suicide. Approximately 1.4 million adults attempt suicide annually in the United States, with more than 85% reporting having made a suicide plan prior to their attempt. In addition, an estimated 2.1 million adults in the United States reported making plans for suicide in the year preceding the survey but did not act on those plans. The majority of individuals communicate suicidal intentions in advance,¹¹ thereby demonstrating the need to engage health care, social services, schools, faith-based and other community agencies, and the general public to learn the warning signs for suicide, how to intervene, and how to offer support to someone at risk of suicide. Beyond the emotional impact of suicide attempts and deaths, there is also an economic impact given that the highest suicide rates are among adults of working age.

According to the CDC, estimated costs from all fatal injuries (as compared to non-fatal injuries) represented approximately one-third of the total work loss and medical costs associated with all injuries in 2013.¹² Suicide accounted for \$50.8 billion (24%) of the total fatal injury costs, as compared to unintentional injuries and homicide (64% and 12% of total fatal injury costs, respectively).

Health Equity and Social Determinants

⁸ [Enterprise Data Dissemination Informatics Exchange \(EDDIE\)](#), Pennsylvania Department of Health, accessed September 19, 2019.

⁹ [Suicide Mortality in the United States, 1999-2017](#), Centers for Disease Control and Prevention, 2018.

¹⁰ [National Survey of Drug Use and Health \(NSDUH\)](#), Substance Abuse and Mental Health Services Administration, 2018.

¹¹ [Risk Factors and Warning Signs](#), American Foundation for Suicide Prevention, accessed September 18, 2019.

¹² [Lifetime Medical and Work Loss Costs of Injury](#), Centers for Disease Control and Prevention, 2013.

Disparities in health, mental health, and health care refer to the differences that exist between populations with regard to the incidences of illness, injury, disability, or mortality that a particular subgroup experiences relative to other subgroups.¹³ Factors that contribute to these disparities are referred to as social determinants of physical and mental health, defined by the Office of Disease Prevention and Health Promotion as “the environments in which 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.”¹⁴ Social determinants include a range of variables such as race, ethnicity, gender, age, income, education, disability, gender, sexual orientation, geographic location, language proficiency, housing instability, food security, and others. Many of these factors will be discussed further in the sections below, based on current available research and data.

Age Differences

According to the CDC, the age-adjusted suicide rate increased by 33% between 1999 and 2017, with significantly higher rates for both females and males ages 10 to 74 in 2017 than in 1999.¹⁵ Suicide is currently the second leading cause of death for those between the ages of 10 and 34. This includes college students, with The Jed Foundation reporting that college age is generally the time when many mental health conditions surface.¹⁶ Suicide is the fourth leading cause of death among 35 to 54-year-olds. Suicide disproportionately affects middle-aged adults between the ages of 45 to 64, whereas individuals in this age range comprised 25.6% of the 2018 population but represented 34.9% of all suicides. According to Pennsylvania Department of Health data from 2018, men and women in this age group constituted 38.3% of suicide deaths (772 out of 2,017) in Pennsylvania.¹⁷

Older adults (65 years and older) engage in fewer suicide attempts than those in other age groups but have a higher rate of death by suicide. For this age group, there is one estimated suicide for every four attempted suicides, compared to one suicide for every 100-200 attempts among youth and young adults ages 15-24. The CDC (2017) indicates that there are higher rates of suicide when transitioning from work to retirement.¹⁸ As the baby boomer generation and future generations continue to retire, more work needs to be done to develop and implement evidence-based practices to ensure older adults can fully enjoy their hard-earned retirement.

Suicide rates among seniors have been consistently high, with rates among men over age 75 remaining the highest of any age group between 1999-2017. However, during that timeframe, this was the only age group in which suicide rates decreased significantly, by approximately 3%.¹⁹ About 60% of elderly patients who take their own lives see their primary care physician within a few months

¹³ [Health Disparities](#), Centers for Disease Control and Prevention, 2018

¹⁴ [Social Determinants of Health](#), Office of Disease Prevention and Health Promotion, 2020

¹⁵ [Suicide Mortality in the United States, 1999-2017](#), Centers for Disease Control and Prevention, 2018.

¹⁶ [Campus Mental Health Action Planning Guide](#), The Jed Foundation.

¹⁷ [Enterprise Data Dissemination Informatics Exchange \(EDDIE\)](#), Pennsylvania Department of Health, accessed September 19, 2019.

¹⁸ [Preventing Suicide: A Technical Package of Policy, Programs, and Practices](#), Centers for Disease Control and Prevention, 2019.

¹⁹ [Suicide Mortality in the United States, 1999-2017](#), Centers for Disease Control and Prevention, 2018.

prior to their death, thus demonstrating the critical role that health care professionals play in recognizing the signs of suicide, particularly in older adults (Ahmedani et al., 2014).

According to the Pennsylvania Youth Survey (PAYS), a biennial survey of school students in grades 6, 8, 10, and 12 conducted by the Pennsylvania Commission on Crime and Delinquency (PCCD) in partnership with the Departments of Education (PDE) and Drug and Alcohol Programs (DDAP), rates of mental health concerns and self-harm, including suicidal ideation and attempted suicide, have increased among youth in recent years.²⁰ When asked about mental health concerns, 38.0% of Pennsylvania students report feeling sad or depressed most days – up from 31.7% in 2013. In 2019, 16.2% of surveyed youth reported seriously considering suicide within the past 12 months, while 12.9% made a suicide plan, and 9.7% attempted suicide – up from 7.6% in 2013. On the 2019 PAYS survey, 2.0% of students reported needing medical treatment for a suicide attempt.

These trends were mirrored in data compiled by the Pennsylvania Office of Attorney General’s *Safe2Say Something* anonymous reporting program, which showed a majority of tips received related to students struggling with mental health issues, including cutting/self-harm (11%, or 2,529 reports); suicide and suicide ideation (9%, or 2,184 reports); and depression/anxiety (9%, or 2,121 reports).²¹ In a recent statewide survey of school districts published by the Pennsylvania School Boards Association (PSBA), 78.9% of superintendents reported their biggest safety and security challenge is meeting the mental health needs of students, and most frequently pointed to a lack of qualified mental health professionals as a primary barrier.²²

Gender and Sexual Identity

According to national data, men die by suicide 3.5 times as often as women (rate of 22.9 per 100,000 versus 6.3 per 100,000), with male suicides representing 78.0% of all U.S. suicides.²³ In Pennsylvania, the statistics are almost identical with 77% of suicide deaths by men (rate of 24.9 per 100,000) and 23% of suicide deaths by women (rate of 7.0 per 100,000).²⁴ A CDC (2018) data brief reviewing trends from 1999-2017, however, found that there has been a narrowing in the gender gap for suicide, with women experiencing a greater percent increase in suicide rate than men within that timeframe (53% increase versus 26% increase). Women attempt suicide three times as often as men.²⁵ A CDC (2016) data brief examining trends in suicides from 1999-2014 found that firearms remained the most commonly used method of suicide among men, accounting for 55.4% of male suicides versus 31.0% of female suicides, while poisoning became the most common method for women, accounting for 34.1% of all female suicides versus 10.6% of male suicides.²⁶ Suffocation was used in a similar percentage of suicides for men (26.8%) and women (26.2%).

²⁰ [Pennsylvania Youth Survey \(PAYS\)](#), Pennsylvania Commission on Crime and Delinquency.

²¹ [Safe2Say Something Annual Report](#), Pennsylvania Office of Attorney General.

²² [2019 State of Education](#), Pennsylvania School Boards Association.

²³ [U.S.A. Suicide: 2017 Official Final Data](#), American Association of Suicidology.

²⁴ [Enterprise Data Dissemination Informatics Exchange \(EDDIE\)](#), Pennsylvania Department of Health, accessed September 19, 2019.

²⁵ [Suicide Mortality in the United States, 1999-2017](#), Centers for Disease Control and Prevention, 2018.

²⁶ [Increase in Suicide in the United States, 1999-2014](#), Centers for Disease Control and Prevention, 2016.

While the actual suicide rates among lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) individuals are not known, studies in recent years have indicated a higher prevalence of suicidal thoughts and behavior among LGBTQ individuals.²⁷ According to the 2015 U.S. Transgender Survey, 40% of transgender adults reported a prior suicide attempt, with the vast majority (92%) indicating that their attempt occurred before the age of 25.²⁸ In a recent study by Toomey, Syvertsen, and Shramko (2018), the prevalence of reported suicide attempt among youth ages 11 to 19 was 14% overall, yet 50.8% among those female-to-male transgender youth, 41.8% among youth not exclusively male or female, 29.9% among male-to-female transgender youth, and 27.9% among youth questioning their gender identity.

According to a survey of students conducted by the CDC (2016), more than 4.5 times as many LGBTQ-identified high school students reported attempting suicide in the past 12 months compared to non-LGBTQ students (29.4% vs. 6.4%), and 42.8% of surveyed LGB youth seriously considered suicide. Bisexual youth and those questioning their sexual orientation and/or gender identify are even more at risk compared with their LGBTQ-identified peers. LGBTQ adults are twice as likely to attempt suicide compared to other adults.²⁹

While this data demonstrates a noticeable increased risk for suicide among LGBTQ individuals, it is important to recognize that research demonstrates no direct link between suicide and sexual orientation or gender identity and expression. Instead, studies have found several risk factors associated with suicidal behavior among LGBTQ people. These stressors include but are not limited to bullying, stigma and discrimination in a variety of settings (e.g., at work, with housing), isolation, exposure to violence, and family conflict, and may contribute to anxiety, depression, and other behavioral health challenges that increase one's risk for suicide. Conversely, studies have found that supportive and affirming environments at the home, community, and state-wide level serve as a critical protective factor mitigating suicide risk for this population.³⁰

Race and Ethnicity

Nationally, the rates of suicide by race and ethnicity are highest for White/non-Hispanic individuals (16.5 per 100,000).³¹ American Indian/Alaska Native individuals have the second highest suicide rate (13.6 per 100,000), with suicide disproportionately affecting this population. Asian/Pacific Islanders die by suicide at a rate of 6.8 per 100,000, while Black/African-American and Hispanic/Latino

²⁷ *Suicide Risk and Prevention for LGBTQ People*, National LGBT Health Education Center, 2018.

²⁸ *Preventing Suicide: Facts about Suicide*, The Trevor Project, accessed September 19, 2019.

²⁹ *Suicide Risk and Prevention for LGBTQ People*, National LGBT Health Education Center, 2018.

³⁰ *Mental Health and the LGBTQ Community*, Human Rights Campaign Foundation, accessed September 19, 2019.

³¹ *U.S.A. Suicide: 2017 Official Final Data*, American Association of Suicidology.

individuals die by suicide at a rate of 6.7 per 100,000. In Pennsylvania (2018), the rates of suicide were highest among White individuals (15.9 per 100,000), followed by Hispanic/Latino individuals (8.6 per 100,000), and Black individuals (7.4 per 100,000) and Asian/Pacific Islanders (7.4 per 100,000).³²

There is limited research on racial and ethnic differences in suicide risk, yet some recent studies have focused on racial differences in suicidal thoughts, behaviors, and deaths among children and adolescents. Bridge et al. (2015) found that racial differences between Black and White children aged 5 to 11 were masked by stable overall suicide rates between 1993 and 2012. Within this timeframe, suicide rates increased significantly among Black children, particularly by hanging/suffocation, and decreased significantly among White children. Lindsey and colleagues (2019) analyzed data from the Youth Risk Behavior Survey from 1991 to 2017 and found that reported suicide attempts among Black adolescents of high school age increased during this time period. Additionally, for Black boys specifically, there was a significant increase in injury resulting from a suicide attempt (i.e., requiring medical treatment), suggesting that the method utilized may be increasing in lethality. In a 2019 report to Congress by the Congressional Black Caucus, an Emergency Task Force on Black Youth Suicide and Mental Health highlighted that this trend is inconsistent with prior data suggesting that suicide rates among Black individuals are generally lower than other racial or ethnic groups.³³

The National Hispanic and Latino Mental Health Technology Transfer Center (2020) recently highlighted mental health disparities among Hispanic and Latino populations, including disparities in rates of psychiatric disorders, access to evidence-based and culturally relevant treatment options, and treatment outcomes.³⁴ Regarding suicide risk, available data suggests that the suicide rate for Hispanic women has increased significantly in the past two decades, and prevalence of suicide ideation and attempts among Hispanic adolescents has been found to be higher than their non-Hispanic peers (Silva & Van Orden, 2018). However, the authors point out that variations and gaps in data for this population may be attributed, in part, to barriers to inclusion in research (e.g., language).

Suicide prevention efforts within communities of color require culturally and linguistically competent approaches that recognize that contributing factors may include acculturative stress, racism and prejudice, and a sense of alienation and marginalization.³⁵ These factors also serve as barriers to help-seeking, as well as access to and quality of treatment. It is necessary to engage stakeholders from diverse cultural backgrounds in both local and statewide suicide awareness and prevention efforts. Furthermore, data and research should be utilized to better understand and address suicide risk both within and between racial and ethnic subpopulations, including unique risk and protective factors that may be addressed through upstream prevention efforts. This must be aligned with

³² [Enterprise Data Dissemination Informatics Exchange \(EDDIE\)](#), Pennsylvania Department of Health, accessed September 19, 2019.

³³ [Ring the Alarm: The Crisis of Black Youth Suicide in America](#), Congressional Black Caucus, Emergency Task Force on Black Youth Suicide and Mental Health, 2019

³⁴ [Mental Health Disparities Among Hispanic and Latino Populations](#), National Hispanic and Latino Mental Health Technology Transfer Center Network, 2020

³⁵ [Cultural Competency: Developing Strategies to Engage Minority Populations in Suicide Prevention](#), National Organization for People of Color Against Suicide, 2003-2004.

recommendations for equitable and trauma-informed policy and practice regarding the health and mental health of individuals of color.

Individuals with Mental Health Conditions

Studies have found that the overwhelming majority of people who die by suicide, 90% or more, had a mental health condition at the time of their deaths (Arsenault-Lapierre, Kim, & Turecki, 2004; Bertolote & Fleischmann, 2002). However, a recent data brief from the CDC indicated that approximately 54% of those that die by suicide did not have a known mental health diagnosis.³⁶ These more recent findings may be consistent with prior research if underlying mental health conditions had not been recognized, diagnosed, or adequately treated, yet these conclusions cannot be drawn based on the data alone. Thus, both health professionals and the general public should be vigilant to the broad range of risk factors that may impact suicide risk.

Among individuals with a serious mental health condition, the rate of suicide is six to 12 times higher than the general population (Chesney, Goodwin, & Fazel, 2014). The mental health system has relied on a small group of specialized staff who work in crisis intervention programs to support individuals with the highest risk. However, the bulk of the behavioral healthcare workforce has not received dedicated training in how to help people who are having thoughts of suicide.³⁷ Training is essential since research has shown that it is insufficient to treat only the mental health condition.³⁸ Targeting and treating suicidal ideation and behaviors, independent of diagnosis, hold the greatest promise for care of suicide risk. Additionally, The Joint Commission (2016) has underscored that such evidence-based treatments should be implemented within the least restrictive environment appropriate.³⁹

Substance Misuse and Dependence

Substance misuse is a significant risk factor for suicide attempts and deaths. However, given that an overdose from a substance does not necessarily imply a suicide attempt, and that a suicide attempt involving the use of substances is not necessarily indicative of a substance use disorder (SUD), this topic proves particularly difficult to study. According to SAMHSA (2016), alcohol intoxication is a factor in approximately 22% of suicide deaths, as well as in 30-40% of suicide attempts.⁴⁰ SAMHSA (2016) also reported that opiates, including heroin and prescription painkillers were found in a similar percentage of suicide deaths (20%), while other drugs were found to a lesser degree, including marijuana (10.2%), cocaine (4.6%), and amphetamines (3.4%). Thus, there are considerable intersections between substance misuse and the opioid epidemic with suicide both nationally and within Pennsylvania.

³⁶ [Suicide Rising Across the US](#), Centers for Disease Control and Prevention, accessed September 19, 2019.

³⁷ [Suicide Prevention and the Clinical Workforce: Guidelines for Training](#), National Action Alliance for Suicide Prevention, 2014.

³⁸ [Treat Suicidal Thoughts and Behaviors Directly](#), Education Development Center, Inc., 2017.

³⁹ [Sentinel Event Alert: Detecting and treating suicide ideation in all settings](#), The Joint Commission, 2016.

⁴⁰ [Substance Use and Suicide](#), Substance Abuse and Mental Health Services Administration, 2016.

Individuals with a diagnosis of alcohol misuse, or alcohol or substance use disorder, have been found to have a 10 times greater risk of suicide than the general population, particularly due to decreased inhibitions and increased depressed mood. Additional factors linking acute alcohol intoxication with suicidal behavior include increased psychological distress, increased aggression, motivation to act or belief that alcohol will lessen the pain associated with suicidal behavior, and cognitive constriction that may preclude the identification and use of alternate coping strategies.

Trauma and Violence

Multiple forms of violence may contribute to increased risk of suicide and suicidal behaviors. Experiences of trauma are prevalent in society, among both children and adults.⁴¹ Approximately 90% of individuals receiving public behavioral health services reportedly have a trauma history.⁴² Adverse childhood experiences (ACEs) have been found to contribute to increased risk of developing a mental health condition and may lead to a range of challenges later in life related to finances, employment, family, relationships, poor physical health, and other difficulties that also contribute to suicide risk. Furthermore, ACEs directly increase the risk of suicide ideation and attempts in adulthood, and Thompson, Kingree, and Lamis (2019) found increased risk of seriously considering or attempting suicide in adulthood among individuals who reported a history of multiple ACEs. In adulthood, intimate partner violence serves as a significant risk factor for suicide, with women exposed to such violence at five times greater risk of attempting suicide than women not exposed. Additional forms of violence, including bullying, harassment, and assault may contribute to feelings of helplessness and hopelessness that also increase suicide risk.⁴³ According to the Pennsylvania Youth Survey (2019), more than 1 in 4 youth in grades 6, 8, 10, and 12 reported that they experienced bullying in the past year.⁴⁴

Efforts to increase protective factors for suicide risk at the individual, family, community, and societal level may overlap significantly with the strategies employed to help address other types of violence. According to the CDC (2017), key protective factors include connectedness (to other individuals, family, school or workplace, and community), healthy coping skills and effective problem-solving, access to quality mental health care, reduced access to lethal means, and moral beliefs that oppose suicide.

Economic Support and Stability

⁴¹ *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, Centers for Disease Control and Prevention, 2017.

⁴² *Trauma*, Substance Abuse and Mental Health Services Administration, accessed December 2, 2019.

⁴³ *The Relationship Between Bullying and Suicide: What We Know and What it Means for Schools*, Centers for Disease Control and Prevention, 2014.

⁴⁴ *Pennsylvania Youth Survey (PAYS)*, Pennsylvania Commission on Crime and Delinquency.

Economic factors play a significant role in suicide risk, as demonstrated through historical trends that have found fluctuations in suicide rates during times of economic recession and expansion.⁴⁵ During periods of economic instability, high unemployment rates lead to reduced income, which in turn contributes to stressors that include covering necessary expenses (e.g., housing, food, medical) and that may exacerbate existing physical or mental health conditions.

According to a recent study published in the *Journal of Epidemiology and Community Health* (Kauffman et al., 2020), found that an estimated \$1 increase in the minimum wage was associated with a 3.5% decrease in the suicide rate for individuals with a high school education or less. The study researched how suicide rates were affected by minimum wage changes, in all 50 states and District of Columbia. This data highlights the need for suicide prevention strategies to consider comprehensive approaches, including not only a job with a livable wage, but also access to food security, transportation, community safety, health care, and education.

Military and Veterans

The U.S. military reflects an important subset of the population with both shared and unique characteristics when compared to the general population. Historically, military suicide rates have been lower than those rates found in the general population. Rising suicide rates among service members and veterans over the past decade have raised public and professional concerns. Suicide is the second leading cause of death in the U.S. military.⁴⁶ According to the Department of Defense (DoD) Suicide Event Report (DoDSER) 2017 annual report, the suicide rate was 21.9 per 100,000 for active military service, including the Air Force, Army, Marine Corps, and Navy. For the Selected Reserves, the rate was 25.7 per 100,000 combined across all military services and regardless of duty status, and for the National Guard, the rate was and 29.1 per 100,000 combined across the Air and Army National Guard and regardless of duty status. The Pennsylvania National Guard suicide rate in 2015 was significantly higher than other components and other states' National Guard entities. During this period, the Pennsylvania National Guard had a total of 11 suicides. This would equate to a rate of 55.0 per 100,000 population.

A number of psychosocial factors are associated with suicide risk for military personnel and veterans. The most common individual stressors identified for both military suicide decedents and military suicide attempts were relationship problems, administrative/legal issues, and workplace difficulties. Health conditions that are associated with an increased risk for suicide include traumatic brain injury (TBI), posttraumatic stress disorder, chronic pain, and sleep disorders. These conditions can contribute substantially to increased suicide risk in affected individuals.

The most common method for suicide according to DoD data is firearms, accounting for over 60% of all suicide deaths in the military. The Pennsylvania National Guard has seen similar stressors with their forces, including relationship challenges, financial and unemployment/under-employment issues. White males in the age group 18-26 years old have experienced the highest number of suicides, with the majority of these individuals having fewer than two years of service. Firearms have accounted for the majority

⁴⁵ [Preventing Suicide: A Technical Package of Policy, Programs, and Practices](#), Centers for Disease Control and Prevention, 2017.

⁴⁶ [Department of Defense Suicide Event Report](#), Psychological Health Center of Excellence, 2017.

(73%) of the Pennsylvania National Guard's suicides, followed by hanging (17%) and other means. Additionally, investigations have determined that substance and/or alcohol abuse was a factor in the majority of suicides by service members within the Pennsylvania National Guard.

Elevated suicide risk has been shown to endure well beyond military service, with veterans carrying a much greater risk for suicide than their civilian counterparts. According to the Office of Suicide Prevention (2016), while veterans account for only 8.5% of the U.S. population, they comprise approximately 18% of all adult suicide deaths. Approximately 20 veterans die each day by suicide. Like service members, the most common method for suicide among U.S. veterans is firearms, accounting for over two-thirds of all veteran suicides. Of the Pennsylvania veterans that died by suicide in 2017, 95.7% were male and 65.8% used a firearm, notably higher than the percentage of suicides by firearm in the general population both in Pennsylvania and nationally. Additionally, 40.0% were between the ages of 55-74, 26.0% were between the ages of 35-54, 22.1% were age 75 or above, and 11.7% were between the ages of 18-34. The most recent Pennsylvania data from 2017 indicates that the veteran suicide rate of 31.3 per 100,000 population was not significantly different from the national veteran suicide rate of 31.0 per 100,000 population, overall.⁴⁷

Because of the significantly higher suicide rates within our military populations, it is imperative that we provide evidence-based psychotherapies designed specifically to target suicidal thoughts and behaviors.

Incarcerated Individuals

Incarceration increases an individual's risk of suicide. The latest national report on prison suicides published by the Department of Justice's Bureau of Justice Statistics (BJS) indicated that the suicide mortality rate in prisons increased nationally by 25% between 2007 and 2014.⁴⁸ In Pennsylvania during the same time, the suicide mortality rate in prisons increased by 13%, which fell below the national increase outlined in the report. However, since 2014, the Pennsylvania Department of Corrections (DOC) has experienced an upward trend in suicides, reporting an average of 11.4 per year. Given that suicides in Pennsylvania communities increased by more than 30% since 1999,⁴⁹ individuals incarcerated in the Pennsylvania DOC may import many of the same risk factors experienced by those individuals in the community, accounting for at least some of this increase. Finally, it is well-established that both individual (e.g., history of suicide attempts) and correctional setting-specific risk factors (e.g., being housed alone) are associated with prison suicides (Fazel et al., 2008). Enhancing protective factors, developing safety plans, and reliably assessing chronic and acute risk factors for suicide remain some of the many ongoing efforts at reducing suicides in state prisons within Pennsylvania.

First Responders and Law Enforcement

⁴⁷ [Pennsylvania Veteran Suicide Data Sheet, 2017](#), U.S. Department of Veterans Affairs, 2019.

⁴⁸ [Mortality in State Prisons, 2001-2014 – Statistical Tables](#), U.S. Department of Justice, 2016.

⁴⁹ [Suicide rates rising across the U.S.](#), Centers for Disease Control and Prevention, 2018.

First responders play a critical role in suicide prevention efforts, given that they are often at the forefront of intervention and response efforts with individuals that may be suicidal. However, various job-related factors, including highly stressful working conditions and repeated exposure to trauma and traumatic events, contribute to an increased risk of mental health challenges and suicide for this population. Accessing mental health resources and help-seeking behavior among this population is impacted both by logistical barriers, such as demanding schedules, and by cultural barriers associated with shame and stigma.⁵⁰

Given these issues, first responders, including emergency medical services personnel, firefighters, correctional officers and police officers, are at increased risk of depression, stress symptoms and posttraumatic stress symptoms/disorder, and suicidal thoughts and behaviors.⁵¹ According to a white paper by the Ruderman Family Foundation (2018), both police officers and firefighters were found to have higher rates of suicide than the general population and were more likely to die by suicide than in the line of duty.⁵² Additionally, according to the U.S. Department of Justice's Office of Justice Programs Diagnostic Center, correctional officers experience unique sources of stress related to the correctional profession and work environment, which contribute to increased risk of suicide among correctional officers. These findings suggest more research is needed on suicide and wellness programs for correctional professionals.⁵³ There is a general lack of public awareness and understanding of these challenges among first responders, especially given the professional persona of bravery and strength often highlighted in the media. Consequently, there is a need for targeted efforts to protect and support the mental wellness of first responders working on the front lines to keep the public safe.

Process for Developing the Statewide Suicide Prevention Plan

In January of 2018, Prevent Suicide PA, Pennsylvania's statewide suicide prevention organization, began the process of updating the plan to be inclusive of all ages. Prior to that time, Pennsylvania had three distinct but related suicide prevention plans, one specifically designed for youth, one for adults, and one for older adults. The previous plans were modeled after the original National Strategy for Suicide Prevention issued in 2001, and later on, the revised National Strategy updated in 2012. To guide and direct this combined effort, Prevent Suicide PA convened a cross-sector panel of experts from multiple state and local agencies and stakeholder organizations. Prevent Suicide PA provided a draft plan to the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) in the summer of 2018, which acted as a framework for the 2020-2024 Pennsylvania Statewide Suicide Prevention Plan.

⁵⁰ *Study: Police Officers and Firefighters Are More Likely to Die by Suicide than in Line of Duty*, Ruderman Family Foundation, 2018.

⁵¹ *Disaster Technical Assistance Center Supplemental Research Bulletin: First Responders: Behavioral Health Concerns, Emergency Response, and Trauma*, Substance Abuse and Mental Health Administration, 2018.

⁵² *Study: Police Officers and Firefighters Are More Likely to Die by Suicide than in Line of Duty*, Ruderman Family Foundation, 2018.

⁵³ *Correctional Officer Wellness and Safety Literature Review*, U.S. Department of Justice Office of Justice Programs Diagnostic Center, 2013.

In 2019, the Wolf Administration announced the formation of a statewide Suicide Prevention Task Force (Task Force). The purpose of the Task Force has been to develop Pennsylvania's statewide suicide prevention plan, a four-year strategy to reduce suicide in Pennsylvania and fight the stigma associated with suicide, suicide attempts, and mental health issues.

The Task Force was made up of leadership and staff from multiple state agencies, members of the General Assembly, and Prevent Suicide PA. State agencies include the departments of Human Services (DHS), Health (DOH), Corrections (DOC), Aging (PDA), Education (PDE), Military and Veterans Affairs (DMVA), Transportation (PennDOT), Agriculture (PDA), Drug and Alcohol Programs (DDAP), the Pennsylvania Commission on Crime and Delinquency (PCCD), and the Pennsylvania State Police (PSP). Task Force members brought forth a wide array of knowledge of constituencies they represent or serve professionally, from their own lived experiences as loss survivors or attempt survivors of suicide, or as individuals who experience or support someone facing mental health challenges. The creation of the Task Force highlights the importance of cross-sector collaboration and a comprehensive approach to suicide prevention, and the role of all Pennsylvanians in addressing this far-reaching public health issue.

From late August through early December 2019, the Task Force held 10 listening sessions across Pennsylvania. In total, more than 800 community members, state and local officials, and representatives from county suicide prevention task forces convened to tell their stories of how suicide and mental health impacts their lives and communities, to provide educational information, and to share recommendations for the Task Force to consider in the development of the statewide suicide prevention plan.

The Pennsylvania National Alliance on Mental Illness (NAMI) chapter, the Mental Health Association in Pennsylvania (MHPA), and the Pennsylvania Mental Health Consumers' Association (PMHCA) facilitated the sessions and county mental health crisis workers were on-site at each session to support those who needed to talk during or after the sessions.

In January 2020, the Task Force released an initial report which included key themes heard during the Task Force listening sessions. The following high-level themes informed the goals and objectives developed for the statewide suicide prevention plan:

- Stigma associated with mental health, suicide, and suicide attempts can affect the likelihood of individuals seeking help or continuing treatment, and how policymakers make decisions that affect mental health systems;
- Resources needed to elevate mental health as a public health issues, incentivize the integration of physical and behavioral health, and improve suicide prevention resources at the local level;
- Barriers to treatment such as cost, coverage confusion, and insurance gaps;
- Access to more detailed suicide and suicide attempt data to help policymakers make effective, meaningful decisions;
- Issues with mental health workforce, such as pay, suicide prevention training, and barriers to entry, to improve quality of care;
- With proper resources, Pennsylvania's schools and educators are uniquely positioned to save lives with suicide prevention strategies and resources; and

- Exploration of legislative strategies to address key themes identified, such as enacting safe storage requirements for firearms and enacting timely suicide death data reporting and a Suicide Death Review Team.

During the plan development, Task Force members reviewed information collected throughout the listening sessions, identified key recommendations, and incorporated actionable themes into specific goals and objectives. The goals and objectives were expanded and refined through an iterative process as the Task Force reviewed and integrated public feedback. For more information on the regional listening sessions and the initial report from the sessions, please refer to the [Task Force Initial Report](#).

The 2012 National Strategy has continued to serve as a foundation in the development of the final 2020-2024 Pennsylvania plan. Key objectives from both the National Strategy, as well as several other national guidance documents, highlight the importance of sustaining and strengthening collaboration across agencies operating at the state level to advance suicide prevention efforts. National recommendations further underscore the need to establish strategic partnerships across sectors, between state and local partners, and with policymakers.^{54 55}

Building upon the prior draft developed by Prevent Suicide PA in 2018, feedback from the Task Force and public listening sessions was also utilized to help identify current priorities specific to and inclusive of the diversity within the commonwealth. Successful implementation of the plan will rely on a shared commitment to the overarching goals and objectives of this plan over the next four years.

Benefits of a Comprehensive State Plan

- Guides the statewide agenda for suicide prevention and to target resources to the highest priority needs.
- Encourages public-private partnerships at the state, county and local levels to support collaboration and avoid duplication across a broad spectrum of agencies, groups, and community leaders as well as suicide attempt and loss survivors.
- Links information about evidence-based and best practices for prevention, to share data that can be used to track trends, and to share information about training opportunities and resources across the state.
- Creates a baseline of efforts within the state and to track success in reaching the goals outlined within the plan.

Guiding Principles for the State Plan

- Design and implement suicide prevention activities in a culturally relevant and developmentally appropriate manner.

⁵⁴ [National Strategy for Suicide Prevention: Goals and Objectives for Action](#), U.S. Surgeon General and the National Action Alliance for Suicide Prevention, 2012.

⁵⁵ [Preventing Suicide: A Technical Package of Policy, Programs, and Practices](#), Centers for Disease Control and Prevention, 2017. [State Strategies for Averting Early Deaths](#), National Governors Association, 2019.

- Improve suicide prevention efforts and increase access to care by reducing the effects of disparities based on race, ethnicity, gender, education, income, disability, age, sexual orientation, gender identity and expression, geographical location, and other aspects of diversity.
- Address the social determinants of mental health by recognizing how the social, economic, and physical environments in which people live contribute greatly to mental health and mental disorders, as well as suicide risk.
- Reduce the stigma around suicide by promoting person-first language through the reduction of medical and disease-based labels, and by endorsing suicide prevention as “everyone’s business.”
- Promote wellness activities – nutrition, exercise, sleep, family activities, community involvement, hobbies, and positive relationships – for individuals, families, and communities, given that wellness is a core element of healthy living, personal satisfaction, and extended life expectancy.
- Emphasize a public health approach to suicide prevention through prevention and “upstream approaches” to promote protective factors and reduce risk factors for suicide; early identification and referral; and best practice and evidence-based treatment and response to support individuals at risk of suicide, families, and communities.
- Promote the adoption of Zero Suicide as an aspirational goal, particularly within health and behavioral health care settings that provide services and support to defined populations. The Zero Suicide framework reflects a commitment to safer suicide care within organizations, utilizing a systematic approach to address gaps and improve outcomes for both patients and clinical staff.⁵⁶
- Embed trauma-informed practices and approaches within systems and sectors as an overarching component of suicide prevention, intervention, and response efforts.
- Advocate for, invest in, and sustain all statewide suicide prevention efforts.

Pennsylvania Statewide Suicide Prevention Plan

To begin the process of developing the new statewide plan, the goals and objectives within the 2012 National Strategy, the most recent Pennsylvania plans for both youth and adult/older adult groups, and the initial report were reviewed and compared. This resulted in the recommendation to use eight goals within the Pennsylvania plan. The eight Pennsylvania goals and related objectives are parallel in their content to the past plans, but they are more focused on current needs, research, and priorities, and they were further refined based on feedback from the public listening sessions and the Suicide Prevention Task Force. While targeted interventions directed at the specific groups of individuals at risk of suicide identified in earlier sections of the plan would be ideal, such an approach is not feasible. Instead, the plan identifies broad goals that are appropriate to the entire population in Pennsylvania. Following the release of the statewide suicide prevention plan, the Commonwealth will further engage stakeholders on the implementation planning phase, which will focus on developing concrete, measurable, and achievable action items and infrastructure building.

⁵⁶ <http://zerosuicide.edc.org/>

Like the 2012 National Strategy, “the goals and objectives are broad in scope and encompass a wide range of activities” (p. 25). Different stakeholders at the local, regional and state levels, including state agencies, counties (including suicide prevention task forces), managed care organizations, provider organizations, social service agencies, educational institutions, workplaces, health systems, and many others can and should play a role in advancing the goals and objectives. Through shared accountability for suicide prevention, various stakeholders may utilize the articulated goals and objectives to identify their own priority areas, thereby contributing to the full implementation of this statewide Pennsylvania plan.

Goals and Objectives

Goal	Description of Problem	Objectives
<p>Goal #1: Increase suicide prevention awareness efforts that reduce stigma and promote safety, help-seeking, and wellness.</p>	<p>Family members, friends, co-workers, and the general community play an important role in suicide prevention efforts, not only through individual connections and conversations, but also through community-wide efforts to promote awareness and address stigma.</p> <p>Given that cultural beliefs about wellness, suicide, and help-seeking vary widely across the commonwealth, it is essential to engage local communities, including individuals and families with lived experience, in awareness efforts. These efforts may focus on addressing the language used when talking about mental health and suicide, debunking common myths and misconceptions, encouraging open and empathic dialogue, and promoting local, state, and national crisis resources.</p> <p>Additionally, the media plays an important role in suicide prevention. Extensive research has found that the manner in which suicide is portrayed through media outlets can increase the likelihood of suicide among individuals that may be at risk. Conversely, safe messaging about suicide may alter public misperceptions and share resources that promote help-seeking. Guidance on best practices for safe messaging on suicide prevention</p>	<p>Elevate wellness and mental health as public health issues that require promotion and prevention efforts through strengths-based, upstream approaches at system and community levels.</p> <p>Engage youth, adults, older adults, and family members with lived experience, as well as suicide attempt and loss survivors in culturally relevant awareness and stigma reduction campaigns.</p> <p>Promote responsible reporting on suicide and media campaigns that follow national safe and effective messaging guidelines.</p> <p>Promote and disseminate crisis resources (e.g., National Suicide Prevention Lifeline, Crisis Text Line,</p>

	in the media is therefore an essential component to statewide suicide prevention efforts.	Trevor Lifeline, local county and community resources).
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RESOURCES:
 Ad Council, American Foundation for Suicide Prevention, and The Jed Foundation’s Seize the Awkward Campaign: <https://seizetheawkward.org/>
 Prevent Suicide PA’s Annual PSA Contest for High School Students: <http://psa.preventsuicidepa.org/>
 Suicide Prevention Resource Center (SPRC) Safe and Effective Messaging for Suicide Prevention: <https://www.sprc.org/sites/default/files/migrate/library/SafeMessagingrevised.pdf>
National Strategy for Suicide Prevention: Goals and Objectives for Action, U.S. Surgeon General and the National Action Alliance for Suicide Prevention, 2012.
 Recommendations for Reporting on Suicide: <http://reportingonsuicide.org/>
 National Action Alliance’s Framework for Successful Messaging: <http://suicidepreventionmessaging.org/>
 National Suicide Prevention Lifeline: 1-800-273-TALK (8255), <https://suicidepreventionlifeline.org/our-network/>; Crisis Text Line: Text PA to 741741, <https://www.crisistextline.org/>

Goal	Description of Problem	Objectives
<p>Goal #2: Promote trauma-informed approaches to support all Pennsylvania residents as part of upstream, universal suicide prevention efforts.</p>	<p>A trauma-informed approach involves the promotion of safety, trustworthy relationships, opportunities for choice and collaboration, and empowerment, in order to prevent suicidality when possible, and to address suicidality, when it is present. The Office of Advocacy and Reform is launching Trauma-Informed PA in July 2020 in an effort to embed trauma-informed approaches and healing-centered practices in the culture, policy, and practice of every aspect of state government while also encouraging and supporting grass roots efforts and coalitions focused on the same all across the Commonwealth.</p> <p>The COVID-19 pandemic constitutes a significant source of trauma and toxic stress for individuals, families, and communities. In addition to its own direct effects, the persistence of COVID-19 could exacerbate existing trauma or lead to additional trauma as a result of its impact on physical and mental health, social connectedness, financial stability, and family conflict and violence. While the entire population is affected in some way by COVID-19, specific subgroups including health care professionals and essential employees, as well as low-income communities and communities of color, face unique stressors and adversities that may lead to disproportionate impact. The consequences of COVID-19 with</p>	<p>Coordinate with the Pennsylvania’s Trauma-Informed Care Task Force to:</p> <ul style="list-style-type: none"> Provide education about trauma-informed care and trauma-informed practices to a broad range of stakeholders across Pennsylvania. Promote trauma-informed care, policies, and practices across sectors and settings, including health and behavioral health care organizations, schools, colleges, workplaces, correctional institutions, and community organizations. In response to COVID-19, disseminate resources for healing and recovery that promote safety, wellness, social connectedness, help-seeking, and self-advocacy as protective factors for suicide risk.

	<p>regard to suicide risk are not yet known, but nonetheless warrant “urgent consideration” (Gunnell et al., 2020).</p> <p>Given the significance of trauma as a risk factor for suicide, universal trauma-informed approaches should be considered as a key protective factor. These approaches should be both culturally and developmentally appropriate, reflecting a sensitivity to the strengths, needs, and lived experiences of individuals and communities.</p>	
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<p>RESOURCES Department of Human Services (DHS) Coronavirus Resources for Citizens: https://www.dhs.pa.gov/providers/Providers/Pages/Coronavirus-Citizen-Resources.aspx The National Child Traumatic Stress Network: https://www.nctsn.org/ PCCD’s Model Trauma-Informed Approach Plan: Guidelines for School Entities: https://www.pccd.pa.gov/schoolsafety/Documents/Model%20Trauma-Informed%20Approach%20Plan%20-%20Guidelines%20for%20School%20Entities.pdf SAMSHA’s Concept of Trauma and Guidance for a Trauma-Informed Approach: https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf SPRC’s Resources to Support Mental Health and Coping with the Coronavirus (COVID-19): https://www.sprc.org/covid19 Zero Suicide and Trauma-Informed Care: https://zerosuicide.edc.org/webinar/zero-suicide-and-trauma-informed-care</p>
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Goal	Description of Problem	Objectives
<p>Goal #3: Provide quality training on the prevention of suicide and management of suicide risk across multiple sectors and settings.</p>	<p>There are too few people informed of the risk factors and warning signs for suicide, as well as how to effectively respond to individuals who may be at risk of suicide. Gatekeeper training seeks to develop “knowledge, attitudes, and skills to identify (those) at risk...and make referrals when necessary” (Gould et al., 2003). This type of training is a key component of comprehensive suicide prevention approaches.</p> <p>In Pennsylvania, some communities may have less access to evidence-based gatekeeper training due to geography, community readiness or stigma, or available funding, therefore requiring targeted outreach and planning that is culturally and linguistically competent. In addition to gatekeeper training, workforce development is necessary to support those across multiple sectors (e.g., crisis, first</p>	<p>Establish and support a network of qualified trainers in evidence-informed or evidence-based trainings to share resources and promote fidelity of implementation.</p> <p>Promote targeted gatekeeper training efforts to “natural listeners” within diverse community settings.</p> <p>Provide a range of trainings across sectors (e.g., schools, colleges, health care, crisis/mental health, first responders, state correctional institutions, and workplaces) that have a role in the prevention of suicide</p>

	<p>responders, primary health care professionals) who are on the frontlines of suicide prevention.</p> <p>Furthermore, the vast majority of behavioral health professionals do not receive adequate or routine training in suicide risk management, despite regularly interacting with individuals at risk of suicide. A comprehensive approach to suicide prevention must support a training continuum across both community and clinical settings.</p>	<p>and in the response to individuals with suicidal thoughts and behaviors.</p> <p>Promote culturally competent training in suicide prevention that is tailored to the cultural, linguistic, and other strengths and needs of diverse audiences and the populations they serve.</p>
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RESOURCES:

Prevent Suicide PA’s Suicide Prevention Online Learning Center: <https://pspalearning.com/>
 Suicide Prevention Resource Center’s (SPRC) Comparison Table of Suicide Prevention Gatekeeper Training Programs: http://www.sprc.org/sites/default/files/migrate/library/SPRC_Gatekeeper_matrix_Jul2013update.pdf
 SPRC – Guidance for Culturally Adapting Gatekeeper Trainings – <https://www.sprc.org/resources-programs/guidance-culturally-adapting-gatekeeper-trainings>
 SPRC – Creating Linguistically and Culturally Competent Suicide Prevention Materials – <https://www.sprc.org/resources-programs/creating-linguistically-culturally-competent-suicide-prevention-materials>
 Question, Persuade, and Refer (QPR) – <https://qprinstitute.com/> Applied Suicide Intervention Skills Training (ASIST) – <https://www.livingworks.net/programs/asist/>
 Mental Health/Youth Mental Health First Aid (MHFA/YMHFA): <https://www.mentalhealthfirstaid.org/>
 Veteran-specific training opportunities are available at each VA Medical Center and can be coordinated through the center’s Suicide Prevention Coordinator: https://www.mentalhealth.va.gov/suicide_prevention/resources.asp
 American Foundation for Suicide Prevention - <http://afsp.org/wp-content/uploads/2016/04/Health-Professional-Training-Issue-Brief-9-7-17.pdf>

Goal	Description of Problem	Objectives
<p>Goal #4: Promote screening across sectors, including health care, behavioral health, educational and correctional settings, to identify individuals at risk for suicide.</p>	<p>Physical health care providers, behavioral health providers, educators, and others who have frequent contact with individuals who may be suicidal may have limited training in identifying appropriate screening tools to detect suicide risk.</p> <p>Additionally, screening practices should be integrated into organizational policies and implemented consistently. While screening may be implemented universally or selectively, there are national recommendations for universal screening within certain sectors, such as The Joint Commission’s (2016) recommendation for primary care, emergency, and behavioral health clinicians working within acute or non-acute care settings. However, screening should be pursued only when the setting has the capacity to provide</p>	<p>Increase awareness among physical and behavioral health care providers, as well as educators, of evidence-based screening tools and approaches.</p> <p>Promote screening for suicide risk, as well as other behavioral health needs, across diverse settings, and work to develop necessary resources and partnerships to enable a timely response to screening results.</p>

	<p>additional resources or an immediate referral, in response to a positive screen for suicidality.</p> <p>The Zero Suicide framework that has been applied to health and behavioral health care settings promotes universal screening for all individuals not only at the time of their first contact with the organization, but also at every contact thereafter.</p>	<p>Increase knowledge of strategies for support and follow-up among professionals that identify individuals at risk of suicide via screening.</p>
<p>RESOURCES: Suicide Prevention Resource Center’s (SPRC) Suicide Screening and Assessment – http://www.sprc.org/sites/default/files/migrate/library/RS_suicide%20screening_91814%20final.pdf Substance Abuse and Mental Health Services Administration (SAMHSA) Suicide Risk Screening Tools – https://www.integration.samhsa.gov/clinical-practice/screening-tools#suicide Zero Suicide: Screening for and Assessing Suicide Risk: https://zerosuicide.sprc.org/toolkit/identify/screening-and-assessing-suicide-risk The Joint Commission Sentinel Event Alert: Detecting and Treating Suicide Ideation in All Settings: https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf National Action Alliance (2012) Suicide Care in Systems Framework: http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf National Suicide Prevention Lifeline - Suicide Risk Assessment Standards: https://suicidepreventionlifeline.org/best-practices/ Refer or coordinate with the Suicide Prevention Coordinator at the Regional VA Medical Center for veterans who present as at risk for suicide</p>		

Goal	Description	Objectives
<p><u>Goal #5:</u> Promote and implement effective and culturally grounded clinical and professional practices for assessing and treating those identified as at risk for suicidal behaviors.</p>	<p>National recommendations for assessing and treating individuals with suicidal thoughts and behaviors underscore the need for timely access to evidence-based interventions delivered within the least restrictive environment.</p> <p>While individuals at high risk of suicide are often referred to emergency departments and may be hospitalized for brief periods of time to ensure safety, there is a need to develop and expand alternative supports and services when this approach appears clinically appropriate. This is important, particularly given that the time period immediately following discharge from emergency departments and inpatient psychiatric facilities is one of increased risk of suicide.</p>	<p>Build capacity to provide quality and evidence-based assessment, intervention, and care for individuals at risk of suicide.</p> <p>Promote a continuum of service delivery options as alternatives to emergency department care and/or hospitalization when appropriate.</p> <p>Promote timely and effective clinical and community-based follow-up supports for reentry and</p>

	<p>Treatment, wherever it takes place, needs to involve a direct focus on the individual’s suicidality, not solely of any diagnosed mental health disorders. Evidence-based interventions for suicidal thoughts and behaviors such as safety planning (Stanley & Brown, 2012), and specific therapeutic approaches such as dialectical behavior therapy (DBT), cognitive behavior therapy for suicide prevention (CBT-SP), Collaborative Assessment and Management of Suicidality (CAMS), and Attachment-based Family Therapy (ABFT) have shown effectiveness in directly targeting suicide risk.</p> <p>Such interventions must be implemented in a culturally competent manner that acknowledges and addresses the diverse needs populations in the commonwealth, in addition to barriers in access to care.</p>	<p>reintegration following hospitalization.</p>
<p>RESOURCES: Joint Commission Sentinel Event Alert (2016) on Detecting and Treating Suicide Ideation in All Settings: https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf Suicide Prevention Resource Center (SPRC) Evidence-Based Prevention: https://www.sprc.org/keys-success/evidence-based-prevention Suicide Prevention Resource Center (SPRC) Patient Safety Plan Template: https://www.sprc.org/resources-programs/patient-safety-plan-template Zero Suicide Toolkit (Treat): http://zerosuicide.sprc.org/toolkit/treat Zero Suicide Toolkit (Transition): http://zerosuicide.sprc.org/toolkit/transition#quicktabs-transition=2 Suicide Awareness Voices of Education (SAVE): https://save.org/about-suicide/treatment/</p>		

Goal	Description of Problem	Objectives
<p>Goal #6: Provide trauma-informed care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.</p>	<p>Prior findings from the National Survey of Drug Use and Health indicate that among adults that attempted suicide within the past year, approximately 60% received medical attention for their attempt, yet over 40% received no mental health treatment.</p> <p>The Zero Suicide Framework highlights the importance of “clinical bridging strategies” to promote safer care transitions for individuals at risk of suicide through warm handoffs, rapid referrals, and other innovative approaches.</p>	<p>Promote care coordination between hospitals, crisis, behavioral health providers, families, and community settings to support suicide attempt survivors and their families.</p> <p>Develop and disseminate protocols for postvention efforts to support</p>

	<p>When it comes to a suicide loss, while prior data suggested that only six people are intimately affected by a single suicide, more recent research (Cerel, 2018) found that each suicide death affects as many as 135 individuals. With 40-50% of the population exposed to suicide during their lifetime (Feigelman et al., 2017), the lived experiences of suicide loss and attempt survivors are integral to suicide prevention efforts including research, legislation/policy development, awareness/public messaging, and treatment.</p> <p>Additionally, effective, trauma-informed crisis response and postvention efforts are essential to reduce the likelihood of suicidal behavior among those affected by the loss (i.e., minimizing risk of contagion), as well as to promote healing and recovery within communities.</p>	<p>survivors of suicide and communities.</p> <p>Disseminate national, state, and local resources to those bereaved by suicide or affected by a suicide attempt, including crisis resources.</p>
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RESOURCES:
 Suicide Prevention Resource Center (SPRC) Postvention as Prevention: <https://www.sprc.org/news/postvention-prevention>
 SPRC Spark Talk with Ken Norton, LCSW: <http://sparktalks.sprc.org/video/suicide-postvention>
 SPRC After a Suicide: A Toolkit for Schools: <http://www.sprc.org/sites/default/files/resource-program/AfteraSuicideToolkitforSchools.pdf>
 National Action Alliance and Survivors of Suicide Loss Task Force - Responding to Grief, Trauma, and Distress after a Suicide: U.S. National Guidelines: <https://www.sprc.org/resources-programs/responding-grief-trauma-and-distress-after-suicide-us-national-guidelines>
 American Association of Suicidology – Suicide Attempt Survivors: <https://www.suicidology.org/suicide-survivors/suicide-attempt-survivors>
 American Foundation for Suicide Prevention – Resources for Loss Survivors: <https://afsp.org/find-support/ive-lost-someone/resources-loss-survivors/>
 University of Pittsburgh Services for Teens at Risk (STAR) Center Postvention Standards Manual: <https://www.starcenter.pitt.edu/Manuals/14/default.aspx>
 Refer military and veteran survivors to the Department of Military and Veteran Affairs for targeted support through family support groups or VA resources as eligible.

Goal	Description of Problem	Objectives
<p>Goal #7: Promote means safety among individuals with identified suicide risk.</p>	<p>Nationally, the leading lethal means for suicide are firearms (50.5%), suffocation/hanging (28.6%), and poisoning (12.9%). In August 2019, Governor Wolf issued an executive order on reducing gun violence in the commonwealth, given that more than 1,650 individuals in Pennsylvania lost their lives to a firearm death in 2018. Between 2012 and 2018, the majority (61.8%) of firearm deaths were by suicide.</p>	<p>Increase training and educational opportunities for key stakeholder groups concerning means safety, including firearms safety.</p> <p>Promote awareness about the relationship between opioids and other substances to increased suicide risk.</p>

	<p>Keeping environments safe by limiting access to any type of lethal means through safe storage, gun locks, temporarily removal, and other strategies is a critical approach to reducing suicide. Creating “time and space” between an individual experiencing a suicide-related crisis and their identified means is especially important, given that many suicide attempts occur with little planning in an acute crisis situation.</p> <p>Effectively addressing this aspect of suicide prevention requires collaboration and partnerships across systems and sectors, as well as with family members and communities.</p>	<p>Disseminate resources and information at awareness events for targeted groups and the general public regarding means safety.</p> <p>Create partnerships with state and local agencies and organizations to promote means safety.</p>
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RESOURCES:
Governor Wolf’s Executive Order on Reducing Gun Violence and Special Council to Reduce Gun Violence Report: <https://www.pccd.pa.gov/criminaljustice/gunviolence/pages/default.aspx>
PA Auditor General’s Firearm Safety Special Report: https://www.paauditor.gov/Media/Default/Reports/RPT_Firearm_safety_112718_FINAL3.pdf
American Association of Suicidology (CDC, 2017) Fact Sheet: <https://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2017/2017datapgsv1-FINAL.pdf>
Harvard’s Means Matter Gun Shop Project: <https://www.hsph.harvard.edu/means-matter/gun-shop-project/>
American Foundation for Suicide Prevention “Firearms and Suicide Prevention”: <https://afsp.org/about-suicide/firearms-and-suicide-prevention/>
SPRC – Reduce Access to Means of Suicide <https://www.sprc.org/comprehensive-approach/reduce-means>
SPRC – Counseling on Access to Lethal Means (CALM) – <https://training.sprc.org/enrol/index.php?id=20>
Suicide Awareness Voices of Education (SAVE) – <https://save.org/about-suicide/preventing-suicide/reducing-access-to-means/>

Goal	Description of Problem	Objectives
<p>Goal #8: Improve the capacity to utilize data reporting systems relevant to suicide and improve the ability to collect, analyze, and use the information in a timely manner to inform suicide prevention efforts.</p>	<p>The underreporting and misclassification of suicide attempts and deaths is a nationwide problem. Statewide data sources can provide valuable information about the scope of suicide in Pennsylvania and can also inform statewide and targeted suicide prevention efforts.</p> <p>However, data on suicide deaths is not current, and data on suicide attempts is not systematically collected. The Pennsylvania Violent Death Reporting System (PAVDRS) is funded through the Centers for Disease Control and Prevention (CDC) and seeks to collect and disseminate accurate, timely, and comprehensive surveillance data on</p>	<p>Analyze available mental health, suicide attempt, and suicide data across local, state, and federal agencies to identify gaps and recommend actions to improve data reporting.</p> <p>Improve and expand state and local capacity to routinely collect, analyze,</p>

	<p>all violent deaths, including suicide. Data gathered through the PAVDRS may be also disaggregated to identify diverse subpopulations at increased risk of suicide that are in need of targeted support through prevention efforts.</p> <p>The Pennsylvania Child Death Review (CDR) program seeks to specifically review child deaths, for the purpose of informing prevention efforts. The Pennsylvania Maternal Mortality Review Committee seeks to specifically review maternal deaths. Without legislation, the proposed Suicide Death Review Team outlined in the Governor’s 2019 Executive Order on Gun Violence would be limited in reviewing deaths by suicide for the purpose of informing prevention efforts.</p> <p>Additional surveillance efforts occur within state and local county systems, as well as through partnerships with the National Suicide Prevention Lifeline and Crisis Text Line that may be better coordinated to inform statewide and targeted prevention efforts.</p>	<p>and disseminate suicide surveillance data to stakeholders.</p> <p>Identify, evaluate, and disseminate information on current data sources and reporting systems for suicide deaths and suicidal behavior.</p> <p>Promote the use of suicide surveillance data from various sources for decision-making related to policy and prevention efforts.</p>
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RESOURCES:
Pennsylvania Violent Death Reporting System (PAVDRS): <https://www.health.pa.gov/topics/programs/violence-prevention/Pages/VDRS.aspx>
Pennsylvania Child Death Review Program (CDR): <https://www.health.pa.gov/topics/programs/Pages/Child-Death-Review-Team.aspx>
Pennsylvania Department of Health (DOH) Enterprise Data Dissemination Informatics Exchange (EDDIE): <https://www.health.pa.gov/topics/HealthStatistics/EDDIE/Pages/EDDIE.aspx>
Centers for Disease Control and Prevention (CDC) Web-based Injury Statistics Query and Reporting System (WISQARS): <https://www.cdc.gov/injury/wisqars/fatal.html>
Pennsylvania Youth Survey (PAYS): [https://www.pccd.pa.gov/Juvenile-Justice/pages/pennsylvania-youth-survey-\(pays\).aspx](https://www.pccd.pa.gov/Juvenile-Justice/pages/pennsylvania-youth-survey-(pays).aspx)

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Appendix B: Pennsylvania Agency Suicide Prevention Initiatives

Multiple suicide prevention programs and initiatives are currently underway among Pennsylvania's state agencies. The below list is a snapshot of existing efforts occurring throughout the commonwealth, including initiatives with community partners. This list is non-exhaustive and will be continuously updated and assessed throughout the implementation phase of the commonwealth's suicide prevention plan to include additional statewide, regional, or county-based initiatives.

Suicide Prevention Resource Center's State Community of Practice

Pennsylvania participates in the national Suicide Prevention Resource Center's state community of practice (CoP), which aims to bring state teams from across the country together to discuss suicide prevention infrastructure. All state teams engage in activities designed to help identify areas of strength and growth and to create actionable steps for infrastructure development. The CoP also provides states with a platform to share suicide prevention best practices and emerging issues related to the COVID-19 pandemic. This work will inform Pennsylvania's implementation planning phase for the 2020-2024 statewide suicide prevention plan.

Prevent Suicide PA and County Suicide Prevention Task Forces

Prevent Suicide PA is a statewide organization focused on providing awareness, training, and education to stakeholders throughout the commonwealth, and on reducing the stigma associated with suicide. The organization also strives to support those affected by suicide, including attempt and loss survivors. Funded in part by the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS), Prevent Suicide PA has actively participated in the statewide Suicide Prevention Task Force and will provide support in implementation of 2020-2024 plan through engagement with local county suicide prevention task forces and other stakeholders in the commonwealth that have helped champion ongoing suicide prevention efforts. More information about Prevent Suicide PA can be found at <https://www.preventsuicidepa.org/>.

Support & Referral Helpline

In response to COVID-19, OMHSAS announced a statewide Support & Referral Helpline, staffed by skilled and compassionate caseworkers who are available 24/7 to counsel Pennsylvanians struggling with anxiety and other challenging emotions due to the COVID-19 emergency and refer them to community-based resources that can further help to meet individual needs. The toll-free, round-the-clock support line is available at 1-855-284-2494. For TTY, dial 724-631-5600.

National Suicide Prevention Lifeline Grant

In October 2019, OMHSAS was awarded a two-year grant to improve statewide capacity to address calls to the National Suicide Prevention Lifeline that originate within Pennsylvania. In collaboration with Thomas Jefferson University, OMHSAS has partnered with three Regional Call Centers – Center for Community Resources, Family Services Association of Bucks County, and New

Perspectives Crisis Services – that are working to have no fewer than 70% of in-state calls answered within Pennsylvania. The grant team is also engaging in several steps to build capacity and provide sustainability beyond the grant period to reach a 90% in-state answer rate by the end of the project.

Grant to Implement the National Strategy for Suicide Prevention

In June 2020, OMHSAS was awarded a three-year grant from SAMHSA to expand Pennsylvania’s continuity of continuity of care efforts in alignment with the National Strategy for Suicide Prevention. This grant targets adults age 25 and older through a two-tiered approach that includes 1) sustaining and expanding prior statewide youth suicide prevention efforts in schools, colleges, and primary care into adult-serving service systems; and 2) enhancing continuity of care in five regions through training and screening within behavioral health systems to improve care transitions for high-risk individuals. This project extends the efforts of the current Garrett Lee Smith youth suicide prevention grant in Pennsylvania while building upon other concurrent initiatives through the Governor’s Suicide Prevention Task Force and Executive Order targeting a reduction in suicide firearm deaths.

Crisis Text Line

OMHSAS established a “keyword partnership” with Crisis Text Line, a national organization that offers free, confidential crisis support via text. While users may access Crisis Text Line anytime by texting 741-741, Pennsylvania has been promoting the unique keyword (Text “PA” to 741-741) as part of mental health awareness and suicide prevention trainings, and more recently, as part of regular outreach and resource dissemination related to COVID-19. OMHSAS has access to a data dashboard that provides aggregate data on user trends for the “PA” keyword.

Garrett Lee Smith Grant

Since 2008, OMHSAS has received four Garrett Lee Smith (GLS) grants from SAMHSA, to implement suicide prevention and early intervention strategies for youth between the ages of 10 and 24. The first two grants (2008-2014) targeted primary care settings, while the third grant (2014-2019) focused on training, screening and awareness efforts in schools and colleges, as well as Pennsylvania’s Student Assistance Program (SAP) infrastructure. The core goal of the current grant (2019-2024) involves use of the Zero Suicide framework to improve continuity of care across youth-serving systems, for youth at risk of suicide and their families. Additionally, the project builds upon prior GLS grants through continued development and dissemination of suicide prevention resources statewide, including through the Suicide Prevention Online Learning Center (<https://pspallearning.com/>) and Higher Education Suicide Prevention Coalition (<https://hespc.org/>).

Suicide Prevention in Education

Priorities for the Pennsylvania Department of Education (PDE) include interagency and community collaboration to support educational entities and higher education institutions in addressing 1) safety and security of students and staff; 2) evidence-based suicide awareness

and prevention; and 3) addressing preventative factors related to mental health services for students and staff. Pennsylvania is participating in assisting schools to address threat assessment, including risk of harm to self, and trauma informed approaches to education that address school climate and social emotional learning. Comprehensive mental health services in the school have been a focus and are targeted through School Climate Resource Coordinators, Bullying Prevention Point of Contacts, technical assistance provided for school climate and mental health services, interagency and local/community collaboration, and Pennsylvania Career Ready Skills. School entities are required to have policies for suicide prevention education for students and provide professional development to staff on suicide prevention and trauma informed approaches. Through interagency collaboration, Pennsylvania is addressing gun violence, school safety and security, alcohol and other drugs, mental health supports for students, suicide prevention, and trauma informed approaches. In Higher Education, Pennsylvania offers the opportunity to be a "Certified Suicide Prevention Institution of Higher Education" by submitting an Act 110 of 2018 compliant campus suicide prevention plan to PDE. Plans submitted to PDE prior to August 1st of the year are posted on the PDE website.

PAYS Survey

The Pennsylvania Commission on Crime and Delinquency (PCCD) conducts the Pennsylvania Youth Survey (PAYS), which is a biennial survey of Pennsylvania school students in the 6th, 8th, 10th, and 12th grades to learn about their behavior, attitudes, and knowledge concerning alcohol, tobacco, other drugs, mental health and violence. Since 1989, PCCD has sponsored and conducted the PAYS, in collaboration with PDE and the Department of Drug and Alcohol Programs (DDAP), to assess use/misuse of harmful substances and behaviors as well as risk factors related to these behaviors and the protective factors that help guard against them. More information about PAYS, including the latest available 2019 PAYS Report, is available on PCCD's website:

[https://www.pccd.pa.gov/Juvenile-Justice/Pages/Pennsylvania-Youth-Survey-\(PAYS\).aspx](https://www.pccd.pa.gov/Juvenile-Justice/Pages/Pennsylvania-Youth-Survey-(PAYS).aspx)

State Health Improvement Plan

The Pennsylvania Department of Health (DOH) oversees Pennsylvania's State Health Improvement Plan (SHIP), which is a stakeholder-driven strategic plan focused on priorities identified by the multi-sectoral partnership, the Healthy Pennsylvania Partnership. One of its three priorities is Mental Health and Substance use, and as part of that priority the associated task force developed evidence-based strategies and partners dedicated to reducing suicide. The SHIP is informed by and progress is tracked by the State Health Assessment (SHA). The strategies aim to reduce suicides in adults and adolescents through public awareness and prevention training programs, health care provider training, improving health literacy on suicide and reducing stigma surrounding mental health.

Pennsylvania Violent Death Reporting System

The PAVDRS program, located within DOH, is a state level surveillance system funded and overseen by the Centers for Disease Control and Prevention (CDC). The program is part of the larger National Violent Death Reporting System (NVDRS). There is a Violent Death Reporting System in each of the 50 states and some U.S. territories. PAVDRS collects data on suicides, homicides, deaths of

undetermined intent, and accidental firearm deaths. PAVDRS data comes directly from death certificates, coroner/medical examiner records, and law enforcement reports. The goal is to use these three sources to develop the most comprehensive understanding possible of each violent death. PAVDRS data sheds light on what was happening in the victim's life leading up to their death. PAVDRS/NVDRS data is used for research, policy-making, and ultimately to develop violence prevention programs and strategies that will enhance community safety.

Department of Human Services (DHS) Trauma-informed Care Workgroup

DHS leads a workgroup to implement Trauma-informed care across all Residential and Day Treatment Facilities licensed under Pennsylvania's 3800 regulations. The workgroup includes individuals from the DHS Secretary's Office, the Office of Children, Youth, and Families, the Office of Mental Health and Substance Abuse Services, and the Governor's Office of Advocacy and Reform.

Reach Out PA/Mental Health Parity Workgroup

Governor Tom Wolf's focused, multi-agency effort and anti-stigma campaign, Reach Out PA began in early 2020 as an effort to evaluate and expand mental health resources for Pennsylvanians. As a result of the overwhelming response to Reach Out PA, the Governor's office, in conjunction with the Pennsylvania Insurance Department (PID) and DHS, created a workgroup to address the needs and barriers presented by the feedback, which focuses on lack of access, challenges to youth, stigma, social determinants of health, and government access and barriers. In conjunction with the Reach Out PA feedback, PID conducted a Mental Health Parity survey to send to providers across Pennsylvania. The feedback from that survey echoes much of the feedback from Reach Out PA and the themes presented in this State Plan. The workgroup is moving forward to address the issues presented in a coordinated effort.

VA/SAMHSA Governor's Challenge to Reduce Suicides Among Service Members, Veterans, and their Families

Pennsylvania is a participant in the VA/SAMHSA Governor's Challenge to Reduce Suicide Among Service Members, Veterans, and their Families, along with several other states. The Department of Military and Veterans Affairs (DMVA) leads this effort, along with support from DHS, DOH, DDAP, and PCCD. Pennsylvania's team includes representation from various stakeholders including county veteran affairs, mental health, and substance use disorder agencies, educational institutions, advocacy groups, Prevent Suicide PA, and peer support. The three priority areas for the Governor's challenge team include 1) identify and screen SMVF for suicide risk; 2) promote connectedness and improve care transitions; and 3) increase lethal means safety and safety planning.

PAVETConnect

DMVA's PAVETConnect is a grass roots, community-based outreach initiative that is focused on providing comprehensive resource and referral capabilities to Service members, Veterans, and their Families within this communities where they live. DMVA has divided the commonwealth into 5 regions and each region has a dedicated Regional Outreach Coordinator. A priority mission for these

coordinators is suicide prevention and referral to appropriate resources, as they work with sister departments and agencies to meet the emerging mental and behavioral health needs of more than 800,000 SMVF who live and work within the commonwealth.

Governor’s Executive Order to Reduce Gun Violence

Signed into effect by Governor Tom Wolf on August 16, 2019, Executive Order 2019-06 tasks state agencies with working together to identify and implement evidence-based initiatives to help address the public health and public safety crisis of gun violence in Pennsylvania. The Order established entities within state government to support these efforts, including an Office of Gun Violence Prevention at PCCD (housed within the Office of Justice Programs) and a Division of Violence Prevention at DOH, as well as an 18-member Special Council on Gun Violence. In March 2020, the Special Council released a Report of Findings, Recommendations & Action Steps outlining recommendations to reduce incidents of community violence, mass shootings, domestic violence, suicide, and accidental shootings within the Commonwealth. The Special Council's report will serve as a blueprint for the Office of Gun Violence Prevention's strategic priorities, in addition to the responsibilities outlined in the Governor’s Executive Order.

Pennsylvania State Police Member Assistance Program

The Pennsylvania State Police (PSP) Member Assistance Program advocates for the mental and emotional welfare of all PSP personnel and their families. The Member Assistance Program (MAP) is made up of peers who are both civilians and members of the PSP. All peers are extensively trained and are required to have at least eight (8) hours of training per year. The MAP is available to all state police, members, employees, and their families 24/7 and is confidential, with the exceptions of harm to self, harm to others, or commission of a serious crime. MAP provide confidential services, by listening, supporting, and providing referrals for professional resources and programs.

Pennsylvania Link to Aging and Disability Resources

The PA link provides Suicide Prevention training as a regular part of the PA Link Monthly Webinar series. This series is open to all PA Link partner agencies and is held the second Wednesday of each month. The August 14, 2020 webinar will be on suicide prevention and the presenter is a Local Lead Coordinator who is certified in suicide prevention techniques. In addition to statewide training, each local PA Link ADRC assesses local suicide prevention needs and secures presenters to conduct training to consumers and local partners.

Pennsylvania Bridge Fencing Safety Act of 2018

Pennsylvania enacted legislation in 2018 that requires bridges under design for construction, replacement or superstructure rehabilitation to consider installing protective fencing. This fencing can be installed on bridges where there is a history of suicides or suicide attempts. Evaluation of the bridge’s history of suicides and viability/necessity of protective fencing occurs during project planning. In implementing the legislation, protective fencing has already been installed on a number of bridges and others are planning to install fencing.

Support of Public Service Announcements for the Suicide Prevention Hotline

Pennsylvania can utilize the Department of Transportation's 511PA website to help promote the 3 digit hotline number when other non-critical traveler information is not being presented for safety reasons. Pennsylvania can also utilize the existing Community Traffic Safety Program grantee network to help disseminate any hotline materials that exist to local communities. This program is part of the National Highway Traffic Safety Administration's national efforts to improve behavioral safety aspects that effect our highways. The individuals that work with local communities and schools through these grants have the opportunity to provide handout materials on suicide prevention while they are at events in the communities they represent.

Department of Corrections Suicide Risk Assessment

In 2019, the Department of Corrections developed a new Suicide Risk Assessment tool and trained all +300 Psychology staff on the utilization of this tool within the department's electronic health record. The tool incorporates the completion of a mental status exam, the review and identification of chronic and acute risk factors of suicide, protective factors against suicide, the determination of level of risk, as well as the development and incorporation of Safety Plans. Policy revisions also now include regular competency assessments of all Psychology staff in completing Suicide Risk Assessments, as part of clinical supervision. Additionally, a recent internal review of Suicides in the Department of Corrections that occurred over the past 13 years revealed that approximately 96% of suicides occurred with individuals that were alone in a cell at the time of their suicide. Consequently, the department developed a committee to review procedures associated with housing decisions to identify best practices and ways to improve outcomes. An initiative that was developed out of this finding was the regular monitoring of the number of individuals housed alone at each State Correctional Institution as well as procedural changes regarding the criteria of contraindications for housing someone alone in a cell.

Department of Corrections Suicide Prevention Training

In 2019, the Department of Corrections completed a significant augmentation to both the Basic Training and Annual In-Service Suicide Prevention Training Programs, for all employees. The Pre-Service Training program for new hires at Basic Training was augmented from 2.5 hours to 4 hours, and the annual in-service training was expanded from 2 hours to 3 hours. The new training programs integrate information from suicide expert Mr. Lindsay Hayes and data mined specifically on individuals incarcerated in Pennsylvania state prisons.

Appendix C: Pennsylvania Statewide Suicide Prevention Task Force

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