Written Public Comments

June 6th thru June 20th, 2023

- Shannon Priem and William Smalldone – Representatives of Southeast Salem Neighborhood Association – Vision Zero for Salem-Keizer with SKATS MTSAP update
- Bruce and Sue Purdy – Keizer – Keizer Little League
- Kathryn Lincoln – Keizer – City Hall Trellis Repair

Southeast Salem Neighborhood Association

June 8, 2023

ATTN:

Salem City Council
555 Liberty St SE #240, Salem, OR 97301

and

Keizer City Council
930 Chemawa Rd NE, Keizer, OR 97303

RE: Vision Zero for Salem-Keizer with SKATS MTSAP update

Dear Mayor Hoy, Mayor Clark and City Councilors:

The US government recognizes that for roads to be safe, they must be consistent. Proof is found in the existence of the 862 page Manual for Uniform Traffic Control Devices, which has been around for 85 years and serves as the principal authority for transportation engineering in this country.

However, in the face of a 33% increase in road deaths over the past decade, questions around efficacy have been raised.

As a result, In January 2022 the US Department of Transportation announced a strategy change, dropping the legacy "car-first" thinking in favor of the Swedish-conceived Vision Zero concept, already implemented by two dozen other countries over the past 26 years. As an example: the Netherlands reduced road fatalities by 76.2% by 2013 (source: en.wikipedia.org/wiki/Vision_Zero).

Vision Zero is a road safety policy that aims to eliminate fatalities and serious injuries by promoting a safe, systemic approach that takes into account human fallibility and the inevitability of human error. It involves designing roads, vehicles, and signage that are forgiving of human error and minimizing the consequences of crashes. The goal is to create a transport system that prioritizes safety and livability over speed and capacity, and to shift the responsibility for safety from individual road users to the system as a whole.

For the United States, the new approach is documented as the National Roadway Safety Strategy. The accompanying 42-page document explains current problems and strategies to deal with those problems. - transportation.gov/NRSS

Going forward, and for the first time in 13 years, the Manual for Uniform Traffic Control Devices is being updated, and possibly reframed and rewritten if the voices of national transportation groups are heeded.

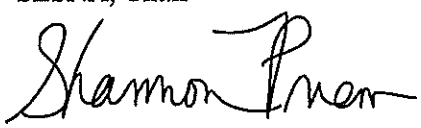
During the coming months, and years, the SKATS (Salem-Keizer Area Transportation Study) MTSAP (Metropolitan Transportation Safety Action Plan) is being updated. This will set restrictions and opportunities for decades to come. There is especially an opportunity to invest the sparse funds in the future, by immediately embracing 'Vision Zero' and the ''National Roadway Safety Strategy'. Portland, Eugene and more than 40 major U.S. cities have implemented Vision Zero standards with positive results: https://visionzeronetwork.org/resources/vision-zero-communities/

As a neighborhood association, we believe mobility is a basic human right. Nobody should have to risk their life to get to work, school, or basic services. We also recognize that leaving a century of established practices behind will be hard. Going forward often is.

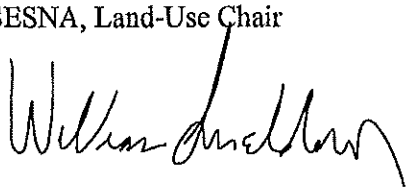
SESNA stands behind the proven Vision Zero concept and asks the City Council to choose safer traffic, to choose a more livable city, to invest in a brighter future for all Salem-Keizer constituents by implementing Vision Zero today for all transportation upgrade projects, both in development (e.g. McGilchrist) and upcoming!

Sincerely,

Shannon Priem
SESNA, Chair



William Smalldone
SESNA, Land-Use Chair



Davis, Tracy

From: Bruce Purdy <brucepurdy1955@gmail.com>
Sent: Sunday, June 18, 2023 1:12 PM
To: Wood, Tim; Administrator; Davis, Tracy
Subject: Keizer Little League

CAUTION: This email originated from Outside Your Organization. Exercise caution when opening attachments or on clicking links from unknown senders. Please contact Information Technology for assistance.

Respected councilmen and women,

My wife and I had dinner with some friends last night, and were informed about the council considering a plan for an indoor stadium. We were alarmed! Currently, we have 1 of the best - if not the best L.L complexes in the state. Also, 1 of the best maintained.

We have been residents of Keizer for nearly 35 years. I was a parent and coach for close to a decade. My wife was a team mother and helped at concessions. The fields have been a integral part of our community. To hear you are seriously considering privatizing this unique and special community complex, is beyond our comprehensive understanding.

If it's about money and the need keeping the fields public, why not ask the voting community?

A concerned couple,
Bruce and Sue Purdy
.

Davis, Tracy

From: Kathryn Lincoln <klincoln@q.com>
Sent: Tuesday, June 20, 2023 4:28 PM
To: Davis, Tracy
Subject: City Hall Trellis Repair

CAUTION: This email originated from Outside Your Organization. Exercise caution when opening attachments or on clicking links from unknown senders. Please contact Information Technology for assistance.

Please forward this email to the City Council in response to their proposal to award a contract to Remodeling by Classic Homes, Inc. in tonight's meeting.

To the Mayor and City Council:

I question the item you have on the agenda this evening, to award a contract for repairing and replacing a trellis at city hall, to a company owned by a fellow city councilor. For several reasons, you should re-think this action.

1. Awarding a lucrative business opportunity to a fellow city councilor reeks of conflict of interest and favoritism.
2. The original proposal was to spend $100,000, not the $246,944, which is in the current resolution. There is no explanation of why the cost is over twice what was originally budgeted.
3. Surely there are other capable builders who could be contacted for a bid. Have you seen the list of who was contacted by Public Works? And what their response was?
4. Does Remodeling by Classic Homes, Inc. have the experience necessary for this type of project? I understand it is in the business of remodeling homes.
5. Even if the trellis is not currently safe, it is not an area that employees have to use, such as a part of their office. Surely the city could postpone the repairs and do a more thorough search for a suitable contractor who does not pose such an obvious conflict of interest.

I urge you to reconsider this resolution for civic center trellis repair.
Thank you.

Kathy Lincoln

handed out @ CC meeting 6-20-23

A BILL

ORDINANCE NO. 2023-_____

FOR

AN ORDINANCE

AMENDING ORDINANCE NO. 2020-812 PROHIBITING CAMPING ON SIDEWALKS, PUBLIC PROPERTY AND PUBLIC RIGHTS-OF-WAY; DECLARING AN EMERGENCY

The City of Keizer ordains as follows:

Section 1. Ordinance 2020-812 (Prohibiting Camping on Sidewalks, Public Property and Public Rights-of-Way) is amended by deleting Section 2 and replacing it with the following:

Section 2. CAMPING PROHIBITED ON PUBLIC SIDEWALKS, PUBLIC PROPERTY AND PUBLIC RIGHTS-OF-WAY.

(A) Definitions. Unless the context specifically requires otherwise, as used in this Section, the following words and phrases mean:

(1) To "Camp" or the act of "Camping" means to pitch, use, or occupy camp materials or a camp for the purpose of occupancy, habitation, or sheltering for survival, and in such a way as will facilitate sleeping or storage of personal belongings, taking measures to keep protected from the elements including heat and cold, or any of these activities in combination with one another or in combination with either sleeping or making preparations to sleep. A "Camp" is a location where people Camp or are Camping.

(2) "Camp Materials" may include, but are not limited to, tents, awnings, lean-tos, chairs tarps or tarpaulins, cots, beds, sleeping bags, blankets, mattresses, sleeping or bedding materials, food or food storage items, and/or similar items that are or appear to be used as living and/or sleeping accommodations, or to assist with living and/or sleeping activities.

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PO Box 21000
Keizer, Oregon 97307
503-856-3433

(3) "Public Rights of Way" means all City-owned or controlled rights-of-way, whether in fee title, by dedication, or as holder of a public easement for right-of-way or public access purposes. Public rights-of-way includes, but are not limited to, any public road, street, sidewalk, or private street or other property that is subject to a public access easement dedicated or granted to the City for vehicular, pedestrian, or other means, and any planter strip or landscaped area located adjacent to or contained within streets that is part of the public right-of-way.

(4) "City Property" includes all real property, land and public facilities owned, leased by the City, controlled, or managed by the City of Keizer including City parking lots or parking structures, but excluding public rights-of-way.

(5) "Relocate" means to move off of Public Rights-of-Way or City Property to a different City Property or to another lawful location. The definition does not include moving to another portion of the same City Property.

(B) Except as set forth below, it is unlawful for any person to camp in or upon any public sidewalk, city property, or public rights-of-way.

(C) In express recognition of the need for those experiencing homelessness to sleep and rest and if they have nowhere else to go, camping is not prohibited in public rights-of-way, except in the following right-of-way areas:

(1) Vehicular and bicycle travel lanes and five (5) feet adjacent to such travel lanes.

(2) Stormwater facilities.

(3) Adjacent to any residential uses.

(4) Within 100 feet of any school~~, church~~ or daycare facility.

(5) Within 100 feet of any church, except for on property that is accommodating camping or camping like activities under ORS 195.520.

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(6) Within ten (10) feet of the intersection of a street and driveway or a private pedestrian path, or within ten (10) feet of a building entry.

(~~7~~6) Within a five foot (5') clear pedestrian path on any public sidewalk.

(D) For those experiencing homelessness, in areas where camping is not prohibited, persons must relocate within 24 hours after arrival.

(E) Individuals may not build or erect structures, whether by using plywood, metal, wood materials, pallets, or other materials. Items such as tents and similar items used for shelter that are readily portable are not structures for purposes of this Section.

(F) The City Manager may adopt administrative rules or policies governing or guiding enforcement of this Ordinance, including but not limited to ensuring consistent and appropriate enforcement for various circumstances.

(G) Upon emergency declaration of the City Council, City Manager or Emergency Manager, other areas may be authorized for limited short-term camping.

(H) Upon finding it to be in the public interest, the City Manager or City Council may exempt a special event from compliance with this Section, ~~by Resolution. The Resolution~~ The City Manager or City Council shall specify the period of time and location covered by the exemption, as well as other reasonable conditions.

(I) Violations of this Ordinance are infractions, and the violators may be cited under the Keizer Civil Infraction Ordinance. The minimum fine is $50. The presumptive fine is $100. The maximum fine is $150. In lieu of or in addition to a fine, the judge may impose other measures, consistent with ORS 153.008, that are reasonably calculated to aid the individual in not engaging in the conduct that led to the citation again in the future.

(J) Subject to applicable state statutes, persons violating this Ordinance may

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be ejected and/or excluded under Ordinance No. 2023-854 (Adopting Rules of Conduct for City Property).

(K) Methods of enforcement for violations of this Ordinance are not exclusive and may consist of multiple enforcement mechanisms where legally authorized and appropriate. However, the intent of the city is to always resolve violations at the lowest possible level, and to engage to seek compliance and solve problems while maintaining the dignity of all involved. To that end, violations of this Ordinance should only result in citations when other means of achieving compliance have been unsuccessful, or are not practicable for the particular situation.

Section 23. SEVERABILITY. If any section, subsection, sentence, clause, phrase, or portion of this Ordinance is for any reason held invalid or unconstitutional, or is denied acknowledgment by any court or board of competent jurisdiction, then such portion shall be deemed a separate, distinct, and independent provision and such holding shall not affect the validity of the remaining portions hereof.

Section 34. EFFECTIVE DATE. This Ordinance being necessary for the immediate preservation of the public health, safety and welfare, an emergency is declared to exist and this Ordinance shall take effect immediately upon its passage.

PASSED this _____ day of _____, 2023.

SIGNED this _____ day of _____, 2023.

_____
Mayor

_____
City Recorder

Keizer City Attorney
930 Chemawa Road NE
PO Box 21000
Keizer, Oregon 97307
503-856-3433

handed out @ CC Meeting 6-20-23

A BILL ORDINANCE NO. 2023-_____

FOR

AN ORDINANCE

AMENDING ORDINANCE NO. 2020-812 PROHIBITING CAMPING ON SIDEWALKS, PUBLIC PROPERTY AND PUBLIC RIGHTS-OF-WAY; DECLARING AN EMERGENCY

The City of Keizer ordains as follows:

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Section 2. CAMPING PROHIBITED ON PUBLIC SIDEWALKS, PUBLIC PROPERTY AND PUBLIC RIGHTS-OF-WAY.

(A) Definitions. Unless the context specifically requires otherwise, as used in this Section, the following words and phrases mean:

(1) To "Camp" or the act of "Camping" means to pitch, use, or occupy camp materials or a camp for the purpose of occupancy, habitation, or sheltering for survival, and in such a way as will facilitate sleeping or storage of personal belongings, taking measures to keep protected from the elements including heat and cold, or any of these activities in combination with one another or in combination with either sleeping or making preparations to sleep. A "Camp" is a location where people Camp or are Camping.

(2) "Camp Materials" may include, but are not limited to, tents, awnings, lean-tos, chairs tarps or tarpaulins, cots, beds, sleeping bags, blankets, mattresses, sleeping or bedding materials, food or food storage items, and/or similar items that are or appear to be used as living and/or sleeping accommodations, or to assist with living and/or sleeping activities.

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(5) "Relocate" means to move off of Public Rights-of-Way or City Property to a different City Property or to another lawful location. The definition does not include moving to another portion of the same City Property.

(B) Except as set forth below, it is unlawful for any person to camp in or upon any public sidewalk, city property, or public rights-of-way.

(C) In express recognition of the need for those experiencing homelessness to sleep and rest and if they have nowhere else to go, camping is not prohibited in public rights-of-way, except in the following right-of-way areas:

(1) Vehicular and bicycle travel lanes and five (5) feet adjacent to such travel lanes.

(2) Stormwater facilities.

(3) Adjacent to any residential uses.

(4) Within 100 feet of any schoolor daycare facility.

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(6) Within ten (10) feet of the intersection of a street and driveway or a private pedestrian path, or within ten (10) feet of a building entry.

(7) Within a five foot (5') clear pedestrian path on any public sidewalk.

(D) For those experiencing homelessness, in areas where camping is not prohibited, persons must relocate within 24 hours after arrival.

(E) Individuals may not build or erect structures, whether by using plywood, metal, wood materials, pallets, or other materials. Items such as tents and similar items used for shelter that are readily portable are not structures for purposes of this Section.

(F) The City Manager may adopt administrative rules or policies governing or guiding enforcement of this Ordinance, including but not limited to ensuring consistent and appropriate enforcement for various circumstances.

(G) Upon emergency declaration of the City Council, City Manager or Emergency Manager, other areas may be authorized for limited short-term camping.

(H) Upon finding it to be in the public interest, the City Manager or City Council may exempt a special event from compliance with this Section.The City Manager or City Council shall specify the period of time and location covered by the exemption, as well as other reasonable conditions.

(I) Violations of this Ordinance are infractions, and the violators may be cited under the Keizer Civil Infraction Ordinance. The minimum fine is $50. The presumptive fine is $100. The maximum fine is $150. In lieu of or in addition to a fine, the judge may impose other measures, consistent with ORS 153.008, that are reasonably calculated to aid the individual in not engaging in the conduct that led to the citation again in the future.

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Section 2. SEVERABILITY. If any section, subsection, sentence, clause, phrase, or portion of this Ordinance is for any reason held invalid or unconstitutional, or is denied acknowledgment by any court or board of competent jurisdiction, then such portion shall be deemed a separate, distinct, and independent provision and such holding shall not affect the validity of the remaining portions hereof.

Section 3. EFFECTIVE DATE. This Ordinance being necessary for the immediate preservation of the public health, safety and welfare, an emergency is declared to exist and this Ordinance shall take effect immediately upon its passage.

PASSED this _____ day of _____, 2023.
SIGNED this _____ day of _____, 2023.

_____
Mayor

_____
City Recorder

Keizer City Attorney
930 Chemawa Road NE
PO Box 21000
Keizer, Oregon 97307
503-856-3433

CITY COUNCIL, CITY OF KEIZER, STATE OF OREGON

Resolution R2023-_____

AUTHORIZING CITY MANAGER AND CHIEF OF POLICE TO SIGN 2023-2026 COLLECTIVE BARGAINING AGREEMENT WITH KEIZER POLICE ASSOCIATION

WHEREAS, the City Council authorized the City Manager and Chief of Police to enter into a Collective Bargaining Agreement with the Keizer Police Association by Resolution R2021-3169;

WHEREAS, such Collective Bargaining Agreement was effective from July 1, 2021 through June 30, 2023;

WHEREAS, the City desires to enter into a new Collective Bargaining Agreement for the period of July 1, 2023 through June 30, 2026;

WHEREAS, from time-to-time amendments need to be made to the Collective Bargaining Agreement to modify provisions and change job classifications as authorized by the Council;

WHEREAS, such amendments are made with the use of Memoranda of Understanding;

WHEREAS, Memoranda of Understanding must be authorized by the City Council;

WHEREAS, the City Council desires to allow the City Manager and Chief of Police to sign Memoranda of Understanding relating to the 2023-2026 Collective Bargaining Agreement without further authorization by the City Council except for

Keizer City Attorney
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PO Box 21000
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503-856-3433

amendments relating to provisions that relate to wages, benefits, budgetary matters, or job classification additions, except as noted below;

WHEREAS, the City Council desires to allow the City Manager and Chief of Police to sign Memoranda of Understanding relating to the 2023-2026 Collective Bargaining Agreement without further authorization by the City Council relating to classification additions if such job classification additions have been budgeted for by Council;

WHEREAS, the City Council desires to allow the City Manager and Chief of Police to sign Memoranda of Understanding relating to the 2023-2026 Collective Bargaining Agreement without further authorization by the City Council relating to individual new-hire vacation/sick leave beginning bank and/or accrual;

NOW, THEREFORE,

BE IT RESOLVED by the City Council of the City of Keizer that the City Manager and Chief of Police are authorized to sign the 2023-2026 Collective Bargaining Agreement with the Keizer Police Association based on the attached tentative agreements approved by the Keizer Police Association representatives.

BE IT FURTHER RESOLVED by the City Council of the City of Keizer that the City Manager and Chief of Police are authorized to sign Memoranda of Understanding relating to the 2023-2026 Collective Bargaining Agreement without further Council authorization unless such Memoranda pertain to provisions that relate to wages, benefits, budgetary matters, or job classification additions, except as noted below.

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BE IT FURTHER RESOLVED by the City Council of the City of Keizer that the City Manager and Chief of Police are authorized to sign Memoranda of Understanding relating to the 2023-2026 Collective Bargaining Agreement without further Council authorization relating to job classification additions if Council has budgeted for the job classification addition.

BE IT FURTHER RESOLVED by the City Council of the City of Keizer that the City Manager and Chief of Police are authorized to sign Memorandum of Understanding relating to the 2023-2026 Collective Bargaining Agreement without further Council authorization relating to individual new-hire vacation/sick leave beginning bank and/or accrual as long as any changes are budgeted.

BE IT FURTHER RESOLVED that this Resolution shall take effect immediately upon the date of its passage.

PASSED this _____ day of _____, 2023.

SIGNED this _____ day of _____, 2023.

_____
Mayor

_____
City Recorder

Keizer City Attorney
930 Chemawa Road NE
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TENTATIVE INTERLINEATED COLLECTIVE BARGAINING AGREEMENT

Between

CITY OF KEIZER

And

KEIZER POLICE ASSOCIATION

July 1, 20~~21~~23 through June 30, 20~~23~~26

Changes denoted in ~~strikeout~~ and **bold double underline**

The attached documents are the signed Tentative Agreements covering all Articles and Appendices concluding bargaining activities as of June 14, 2023.

1/26/2023

ARTICLE 1 – RECOGNITION

Section 1.1 Bargaining Unit

The City recognizes the Association as the exclusive collective bargaining agent for matters concerning direct or indirect monetary benefits, hours, vacations, sick leave, grievance procedures, and conditions of employment for all regular and regular part-time employees in the following classifications:

A. Police Officer
B. Police Support Specialist
C. Community Service Officer
~~D. Investigative Services Specialist~~
E. Property and Evidence Specialist (I and II)
F. Crime Analyst

Section 1.2 Regular Part-Time Employees

The term "regular part-time employee" means any employee of the City who regularly works and receives salary from the City for thirty (30) hours or less per week or less than 1500 hours in any calendar year, but does not include:

A. Persons engaged as independent contractors.

B. Seasonal, emergency or casual workers whose periods of employment with the City do not total 600 hours in any calendar year.

Nothing in this Section shall prevent a regular part-time employee from working forty (40) hours per week, provided the hours are authorized by the City and the employee consents to the additional work hours and provided total work hours do not exceed 1500 hours in any calendar year. In the event, however, that a regular part-time employee is required by the City to work more than thirty (30) hours in a week, the employee shall be entitled to accrue vacation and sick leave at the accrual rate for regular full-time employees. Otherwise, regular part-time employees will accrue such benefits, leaves, etc. on a prorated basis based on budgeted FTE.

Section 1.3 Spouses and Domestic Partners

For the purposes of this Agreement, where insurance benefits are extended to "spouses," domestic partners shall be considered "spouses." Additionally, other types of benefits, such as sick leave pay and FMLA/OFLA benefits to care for a member of the employee's immediate family, are extended to domestic partners. Whenever the term "domestic partner" is used in this Agreement, it will be defined as an individual of the same or opposite sex who lives with the employee and has fulfilled the requirements contained in and completed the "Affidavit of Domestic Partnership" form which is available from Human Resources, ~~except as prohibited by carrier contract.~~ Domestic partners that have fulfilled the requirements set forth in this form will be eligible for all benefit insurance options available to "spouse" ~~as limited by carrier contracts~~, as well as other benefits

1/26/23

extended to domestic partners under this Agreement. Employees are obligated to promptly notify the Chief of Police and Human Resources when domestic partnerships begin and end in situations for which they are eligible to receive insurance or other types of City benefits.

Section 1.4 New Classifications

When any new classification not listed in Section 1.1 above is established by the City and assigned to the bargaining unit, the City shall designate a pay rate for the new classification. The City shall then notify the Association in writing of the pay rate and furnish the Association with a copy of the new classification specification. In the event the Association does not concur with the pay rate, the Association shall notify the City in writing of such within fourteen (14) days of its receipt of the City notice. The City is not precluded from hiring the new classification upon notice to the Association, and the City acknowledges any bargaining obligations.

Pursuant to ORS 243.698, if after ninety (90) days of negotiations the parties have not resolved the issue, an arbitrator shall be mutually agreed upon or selected in accordance with the procedure established in Section 15.1, Step Four, except the arbitrator shall be bound by the applicable provisions of ORS 243.746. ~~In the event no agreement is reached, the City may proceed to fill the position using its designated pay rate. However, if the City elects to do so,~~ Any higher pay rate negotiated with the Association or obtained through an arbitration decision must be paid retroactively to the employee's date of hire, along with any additional overtime pay that was earned during that time. Nothing contained herein shall be construed to limit the City's ability to create or combine job classifications.

In the event the City intends to establish a new classification within the Keizer Police Department, hereinafter referred to as the "Department," and outside the bargaining unit, the City will notify the Association in writing of its intentions; will provide a copy of the classification description and, if requested to do so, will discuss with the Association whether the classification should be a bargaining unit position. If the parties are unable to agree, the dispute will be resolved under the Public Employee Collective Bargaining Act (PECBA) unit clarification procedures before the Employment Relations Board (ERB).

TA 1/26/2023

ARTICLE 2 – MANAGEMENT RIGHTS

Section 2.1 Management Rights

Subject to the requirements of the PECBA relating to the obligation to bargain, the City retains all the customary, usual, and exclusive rights connected with the responsibility to manage the affairs of the Department. The City shall retain the exclusive right to exercise all the customary functions of management, including but not limited to:

A. ~~To~~ Determine the specific programs and services offered by the City, and the methods, means and facilities by which they shall be effectuated.

B. ~~To~~ Determine the size, nature and qualifications of the work force, to assign duties and equipment, to direct and evaluate the employees in the performance of their work assignments.

C. ~~To~~ Develop work rules and operating procedures not inconsistent with this Agreement.

D. ~~To~~ Promote, transfer, lay-off, discipline, demote and discharge employees.

Section 2.2 Subcontracting

The City shall notify the Association in writing when it appears reasonably probable that the City will subcontract work currently performed by the bargaining unit. In the event the Association demands to bargain over the decision and/or impact of the subcontracting of bargaining unit work within fourteen (14) calendar days in accordance with ORS 243.698, the City will negotiate regarding the decision and/or impact of subcontracting. Negotiations shall continue for no longer than ninety (90) calendar days from the receipt of the City's written notice. If not settled after ninety (90) days, the issue will be submitted to an arbitrator who shall be mutually agreed upon or selected in accordance with the procedure established in Section 15.1, Step Four. The arbitrator shall be bound by the applicable provisions of ORS 243.746.

Section 2.3 Volunteer Utilization

A. Reserves, Cadets and other volunteers may be used to perform police related tasks and auxiliary functions as determined by the Chief of Police, including but not limited to providing law enforcement services at public events and providing law enforcement related services not restricted by Section 2.4.

B. The City may utilize Reserve Police Officers or Cadets to perform the following duties without violating Section 5.3, Overtime, or Section 2.4, Work Preservation:

1. Prisoner supervision and transports.
2. Police Officer Custody (POC) supervision and transports.

3. Selective enforcement details, provided the City has afforded the opportunity to Association members.

4. Crime scene security, provided the City has afforded the opportunity to Association members.

5. School event security, provided the City has afforded the opportunity to Association members.

6. Selective enforcement details such as holiday residential patrol, vacation checks, Christmas lighting routes, disabled parking violation checks, residential security checks, or similar duties customarily performed by Reserve Police Officers or Cadets, consistent with past practice.

7. Search and rescue operations.

8. Any other duties mutually agreed between the City and the Association. Nothing in this Section prevents Reserve Police Officers or Cadets from performing their primary duties, supplementing the Patrol Division or furthering their own experience as outlined in the Department Policy and Procedures Manual.

C. In addition, other volunteers may be utilized, consistent with past practice, to perform data entry, property and evidence functions, vehicle fleet maintenance and miscellaneous support staff services.

Section 2.4 Work Preservation

Reserves, Cadets and other volunteers will not be utilized to replace bargaining unit employees in the performance of their primary and customary job responsibilities, nor take away overtime opportunities other than those instances described in Section 2.3.

TA 2/16/23

ARTICLE 3 – ASSOCIATION RIGHTS

Section 3.1 Association Activities

Employees shall have the right to form, join and participate in the activities of employee organizations of their own choosing, for the purpose of representation on matters of employee relations. Employees shall also have the right to refuse to join or participate in the activities of the Association. No employee shall be interfered with, intimidated, restrained, coerced or discriminated against by the City or by any employee organization because of their exercise of their rights.

Section 3.2 Non-Discrimination

The provisions of this Agreement shall be applied equally to all employees in the bargaining unit without discrimination as to age, marital status, race, color, sex, creed, religion, national origin, union affiliation, disabled status, political affiliation or other protected status or protected activity in accordance with applicable law. Nothing in this Section shall prohibit the City from establishing bona fide occupational criteria.

Section 3.3 Negotiations

The composition of the Association's negotiating team shall be determined by the Association. Not more than three (3) employees shall be permitted to attend negotiating meetings with the City's representatives as part of the Association's negotiating team without loss of pay relative to securing Agreement renewal, to the extent that such meetings are scheduled during the duty hours of the members so attending. Negotiating team members who are on duty for all or a portion of any negotiating session, if any, must be assigned to different shifts or be from different units of the Department. The date, time and place for negotiating sessions shall be established by mutual agreement between the parties. Employees shall notify their shift supervisor as soon as possible in advance of their expected absence for the purpose of this Section. Such absences shall not hamper the normal operations of the Department and the City shall not incur any liability for overtime pay under the provisions of this Section.

Section 3.4 Grievances

The City also agrees to allow time off without loss of pay for employees directly involved in meetings under the Grievance Procedure in Article 15. No more than two (2) employees shall be off without loss of pay for this purpose at any one time.

Section 3.5 Association Membership ~~and Fair Share~~

Membership or non-membership in the Association shall be the individual choice of employees covered by this Agreement.

TA SOS
2/16/23

Section 3.6 Check-off

The City agrees to deduct bi-weekly Association membership dues from the pay of employees covered by this Agreement who are members of the Association. Dues will be automatically deducted from the pay of bargaining unit employees who are Association members starting with their 30th day of employment. The Association agrees to provide the Human Resources Director with a list of all bargaining unit employees who were members of the Association prior to June 2, 2018. The Association agrees to notify the Human Resources Director as soon as practicable when an employee elects to opt out of membership in the Association. Written authorization may be by email.

Section 3.7 Bulletin Boards

The City agrees to allow wall space, not to exceed three (3) feet by four (4) feet, for a bulletin board within the Department to be used exclusively by the Association for the posting of notices and other information relating to Association activities, meetings and other matters of legitimate interest to Association members. In the event items are posted on the bulletin board that do not fall within this description, or items are posted that violate the City's anti-harassment/discrimination prohibitions or other legal restrictions, the City will notify the Association and request removal.

Section 3.8 Right of Access

Subject to the due process provision of this Agreement, Association representatives and agents of the Association shall have the right to reasonable access to the Department for the purpose of investigating grievances and other business related to the representation of employees for the purpose of employment relations. Prior to admittance to the non-public areas of the Department, the Association representative and/or agent of the Association shall obtain permission from the senior, non-bargaining unit member (supervisor) on duty at the time the request is made. Prior to gaining access, the Association or agent of the Association shall advise the duty supervisor of the purpose of the visit, approximate length of time required and the name of the person(s) to whom he or she wishes to speak. Such permission shall not be unreasonably withheld and, if withheld, the reasons for the withholding shall be given to the Association agent or representative at that time. Association representatives and agents shall not unreasonably interfere with an employee's work. This Section is not intended to be used for membership drives or recruiting of new members.

Section 3.9 Use of Buildings

The Association may use, in accordance with established City rules applicable to other groups within the community, City facilities during employees' non-work hours (as defined in this Agreement) for Association meetings, provided such space is available. Request for use of facilities within the Department shall be approved by the Chief of Police or designee. Such meetings shall not be permitted for Association organizing activities or membership drives of City employees.

~~The parties agree to the primary principle that Association activities will normally be performed outside an employee's duty and working hours.~~

Section 3.10 Association Meetings

Association members shall be permitted to attend regular monthly membership meetings on duty time. On-duty members will be expected to respond to their duty responsibilities during membership meetings. Except for emergency meetings, the Association agrees to schedule these meetings during non-peak periods of the Department's business and such Association meetings shall not conflict with the regularly scheduled Department briefing periods. Members attending Association meetings on duty will limit their attendance to one (1) hour.

Section 3.11 Association Business

The Association agrees that the Chief of Police will be notified in writing of the members of the Association selected to serve as official representatives. The Association agrees that Association business shall not interfere with the operations of the Department or the police duties of certified Association representatives.

Association representatives will be allowed reasonable time on duty for Association activities without loss of pay consistent with applicable law including when attending meetings relating to the processing of grievances as provided within this Agreement. Such absences shall not hamper the normal operations of the Department and the City shall not incur any liability for overtime pay under the provisions of this Article. Any concerns related to reasonable use of time for on duty Association activities will be addressed through labor management meetings. *(bargaining note: update in regards to HB2016)*

TA 1/26/23 QR

ARTICLE 4 – CITY SECURITY

Section 4.1 No Strike

During the term of this Agreement, there will be no strike, slowdown or recognition of any picket line while in the performance of official duties. For purposes of Section 4.1, "strike" means an employee's refusal in concerted action with others to report for duty, or the employee's willful absence from the position of the employee, or stoppage of work by the employee, or absence of the employee in whole or in part from the full, faithful or proper performance of the duties of employment of that employee for the purpose of inducing or coercing a change in the conditions, compensation, rights, privileges or obligations of employment. In the event of a violation of this provision by the Association, or employees in the bargaining unit, the City may discipline for such cause, including discharge of any employee involved in such activity either on a uniform or selective basis. Nothing in this Agreement shall preclude recourse by the City to such other legal or equitable remedies as may be available to it.

Section 4.2 Productivity

The parties to this Agreement recognize that delivery of essential municipal services, in the most efficient and effective manner, is of paramount importance and interest to the City and the Association. In return to the City for the wage rates and conditions herein provided and consistent with the principle of a fair day's work for a fair day's pay, the Association pledges agreement with the objective of achieving the highest level of employee performance and efficiency, safety, good health and sustained effort. The parties may agree to meet at mutually convenient times to discuss means of increasing Departmental productivity.

(bargaining note: grammar fix in 4.2)

PS 1/26/23

City What If Package If Proposal
Version II

This 'what-if' offer is intended as a limited offer for the purpose of resolving successor bargaining. This offer is valid today. This is not to be considered a formal proposal, nor subject to future reference for the purposes of bargaining as related to PECBA bargaining. This offer is valid through June 8, 2023. All current tentative agreements and otherwise current contract language remain in effect.

Articles of "what-if" offer include: 5, 7, 8, 10, 16, 17

"What if" includes package offer on Articles 13, 14, 15, policy B/C/D.

Tentative Agreements include: 1, 2, 3, 4, 6, 9, 11, 12.

6-8-23

TA 5 6/8/23

ARTICLE 5 – WORKING CONDITIONS

ONLY

Section 5.1 Definitions and Hours of Work

X. Definitions: The following definitions apply to Article 5: *(bargaining note: from 5.10. Will renumber for final CBA)*

1. The terms *regular shift, regularly scheduled work shift, regular work schedule* and *regularly scheduled workday* refer to those shifts, hours and days the employee was assigned to work as they appear on the master schedule.

2. The term *scheduled days off* refers to those days an employee was not assigned to work as they appear on the master schedule.

3. The term *regular business hours* refers to the workdays and hours Monday through Friday, 0800 to 1700.

A. Regular Hours: The regular hours of work each day shall be consecutive except for interruptions for rest periods and unpaid meal periods. For employees working 5/8, 4/10, Community Response Unit schedules or utilizing Flex Time, the workweek shall commence at midnight (0000 hours) on Monday and end at 2359 hours on Sunday.

B. Regular Work Schedules: All employees shall be assigned a regular work schedule. The City and the Association have recognized the following regular work schedules for employees in the bargaining unit:

1. Modified Louisiana Plan Schedule: This schedule shall consist of a consecutive twelve (12) hour and 20 minute workday. This work schedule shall consist of two (2) consecutive ~~twelve (12) hour~~ workdays followed by two (2) consecutive days off, three (3) consecutive ~~twelve (12) hour~~ workdays followed by two (2) consecutive days off, two (2) consecutive ~~twelve (12) hour~~ workdays followed by three (3) consecutive days

off. Day Shift shall be 0650 to 1910 ~~0700 to 1900~~ hours. Night Shift shall be from 1850 to 0710 hours ~~1900 to 0700 hours~~. This schedule includes time for shift preparedness, assigned duties, and for attending briefings at the start and end of shifts. *(bargaining note: MOU Shift Time and Rounding Overtime dated February 2023 is considered expired)*

2. Patrol Overlap Schedule: The overlap shift is a patrol shift, normally assigned to the night shift team, with a temporary start time as early as 1400 hours as determined by the night shift supervisor. No employee may be involuntarily assigned to an overlap shift without fourteen (14) days written notice. Employees assigned to an overlap shift without such notice will be paid overtime for hours worked outside their previously scheduled shift during the fourteen (14) day notice period.

3. 5/8 Work Schedule: This schedule shall consist of:

   a. Five (5) consecutive eight (8) hour days followed by two (2) consecutive days off. The workday shall consist of eight (8) consecutive hours of work with a one-half (1/2) hour paid meal period.

   b. Five (5) consecutive eight (8) hour days followed by two (2) consecutive days off. The workday shall consist of eight (8) hours of work with a one (1) hour unpaid meal period approximately midway through the shift. Members may occasionally request a one-half (1/2) hour unpaid meal period, which a supervisor shall endeavor to allow but with priority given to operational needs.

4. 4/10 Work Schedule: The 4/10 work schedule shall consist of four (4) consecutive ten (10) hour days followed by three (3) consecutive days off, with the exception of days off that necessarily occur before or following any rotation. The workday shall consist of ten (10) consecutive hours of work.

5. 4/12 Work Schedule: The 4/12 work schedule shall consist of four (4) consecutive twelve (12) hour days followed by four (4) consecutive days off. The workday shall consist of twelve (12) consecutive hours of work. Day Shift shall be from 0700 to 1900 hours followed by Night Shift from 1900 to 0700 hours.

6. ~~Community Response Unit (CRU) Schedule: The shift hours of the CRU will be in accordance with Section 5.1.B. Although there is an assigned regular work schedule, CRU, by its very nature, may work varied hours and days. Short term or casual deviations during a CRU member's regular work schedule will be determined by the unit supervisor. Long term or substantial deviations shall be afforded a fourteen (14) day notice, unless that notice is waived by members assigned to CRU. Overtime will be in accordance with Section 5.3.~~ *(bargaining note: concept moved below)*

C. 12-Hour Shift Time: Officers working a 12-hour 20 minute work schedule pursuant to Section 5.1.B.1, B.2, or B.5 will be scheduled to work 7 shifts/86 hours and 20 minutes ~~total of 168 hours~~ in each FLSA 7(k) 14 day ~~28 day~~ work period. ~~cycle~~. As determined by the City, this shift includes time for assigned duties to be ready for work when their shift starts and for end of shift work duties ~~post shift~~, including briefings, ~~which accounts for 10 minutes of additional work duties before and 10 minutes after the 12 hour shift.~~ Employees are compensated hourly ~~salaries,~~ as set forth in Appendix A. *(bargaining note: Employees are paid hourly.* ~~shall compensate the straight time portion of one hundred sixty (160)~~

~~hours. Effective for the 2018-2021 Agreement, the 28-day work cycle shall commence at the beginning of the pay period starting June 25, 2018 and end on the last day of the pay period on July 22, 2018, and shall continue in consecutive 28-day cycles. To compensate officers working 12-hour work schedules for being scheduled to work eight (8) hours in excess of the one hundred sixty (160) hours in each 28-day work cycle that officers working on other shifts are regularly scheduled to work, The City will credit each officer working a 12-hour shift with four (4) hours of shift time for each 14-day pay period. The four (4) hours of shift time will be credited to the officer's shift time bank. The shift time bank shall not exceed sixteen (16) hours. Consequently, officers working 12-hour shifts will not accrue shift time for any pay period that would result in their accruals exceeding the sixteen (16) hour maximum.~~

(bargaining note: See Section 5.3(b) FLSA overtime is over 86 hours in the 14-day pay period).

An employee may elect to convert six (6) ~~four (4)~~ hours of actual hours worked during the employee's regular work schedule in the pay period to the employee's compensatory time bank at the employee's regular straight time rate. The employee must physically work at least six (6) ~~four (4)~~ hours during their regular work schedule in the pay period to be eligible to convert the six (6) ~~four (4)~~ hours to compensatory time. No overtime will be paid for hours taken when using accrued leaves. ~~Use of accrued leaves does not count as hours worked for this conversion.~~ *(bargaining note: If an employee takes a full shift off, the employee will need to use 12 hours and 20 minutes of accrued time)*

~~Section 5.3 D and Section 5.3 E do not apply to this Section. Each officer is responsible for monitoring his or her shift time bank to avoid situations where they will exceed their sixteen (16) hour maximum accrual and scheduling shift time off at times which do not disrupt operations, cause the City undue hardship, or incur otherwise avoidable overtime expense. Officers are also required to obtain supervisory approval prior to taking shift time off. In the event an officer's shift time bank reaches twelve (12) hours and the officer has not scheduled shift time off to occur within that twenty-eight (28) day work cycle, the City will schedule time off for the officer in increments of one or more four (4) hour blocks to assure the officer stays within the sixteen (16) hour maximum accrual. In the event the City is unable to schedule such time off due to operational needs, the officer will be paid for shift time in excess of the sixteen (16) hour maximum.~~

~~If an officer terminates or otherwise separates from employment, any accrued 12-hour shift time will be paid at the final regular rate earned by the employee.~~

(bargaining note: Upon execution of the CBA, Shift Time banks will no longer accrue time. Employees will have until June 1, 2024 to schedule and take the time off. Thereafter, any remaining balances will be paid to the employee in the next regular payroll)

D. Regular Work Schedules: Generally, the following regular work schedules for bargaining unit members listed will be recognized by the City and the Association:

1. Patrol Units: Pursuant to Section 5.1.B.1.

2. Criminal Investigations Unit (CIU) ~~Detective Unit~~: A 4/10 work schedule pursuant to Section 5.1.B.4. Half of the unit shall be scheduled to work Monday through Thursday; the other half of the unit shall be scheduled to work Tuesday through Friday. CIU

Detectives shall adjust their schedules to avoid overtime for court and Grand Jury that is scheduled during regular business hours, Monday through Friday, 0800 to 1700 as defined in Section 5.10.

If a detective adjusts the employee's ~~his or her~~ schedule to avoid overtime for court or Grand Jury, the work schedule adjustment must occur within in the same workweek as described in Section 5.1.A.

3. ~~Investigative Services Specialist: A 5/8 work schedule pursuant to Section 5.1.B.3.b.~~

4. Traffic Safety Unit: A 4/10 work schedule pursuant to Section 5.1.B.4.

5. Safety and Support Response Team (SSRT) detective ~~School Resource Officer Unit~~: A 5/8 work schedule pursuant to Section 5.1.B.3.a. *bargaining note: from MOU*

6. Police Support Specialist: A 5/8 work schedule pursuant to Section 5.1.B.3.b.

7. Property and Evidence Specialist: A 5/8 work schedule pursuant to Section 5.1.B.3.b.

8. Community Services Officer: A 5/8 work schedule pursuant to Section 5.1.B.3.a.

9. Community Response Unit (CRU): The shift hours of the CRU will be in accordance with Section 5.1.B. Although there is an assigned regular work schedule, CRU, by its very nature, may work varied hours and days. Short-term or casual deviations during a CRU member's regular work schedule will be determined by the unit supervisor. Long-term or substantial deviations shall be afforded a fourteen (14) day notice, unless that notice is waived by members assigned to CRU. Overtime will be in accordance with Section 5.3. *(from 5.1.B.6)*

10. Crime Analyst: A 5/8 or 4/10 work schedule pursuant to Section 5.1.B.3.a. or b, or 5.1.B.4, as directed by the supervisor.

11. Youth Safety and Support Officer (YSSO) detective : May work a 4/10 work schedule pursuant to Section 5.1.B.4 or 5/8 work schedule pursuant to Section 5.1.B.3.a at the discretion of the YSSO and with the concurrence of their supervisor. *(bargaining note: from MOU)*

E. Changes In Work Schedules: After having given fourteen (14) days written notice to the Association, an employee, or a group of employees, the City may implement a change from one to another of the regular work schedules recognized in Section 5.1.B or may adjust start/stop times for any employee or group of employees for bona fide operational reasons. The Association, employee, or a group of employees may waive the fourteen (14) day notice to implement the change upon a mutually agreeable date.

Prior to making a change from one to another of the regular work schedules recognized in Section 5.1.B, a committee comprised of up to three (3) Association members and three (3) members of Management will meet for a period of not more than seven (7) days to discuss the change and make recommendations to the Chief of Police. The Association and the City may employ, by written agreement, any other work schedule as a regular work schedule.

Notwithstanding other language in Section E, members assigned to a 12-hour or 10-hour per day regular work schedule who, due to illness or injury, have a doctor's order of no work for a period exceeding seven (7) scheduled workdays or a member placed on administrative leave as described in Appendix B, Section 810.9.D, may be immediately assigned to a 5/8 work schedule pursuant to Section 5.1.B.3.b, without a fourteen (14) day notice. The member will be given written notice of a work schedule change fourteen (14) days prior to being reassigned back to the 12-hour or 10-hour per day work schedule, unless the involved member waives the fourteen (14) day notice. Both the Association and the City agree that timing within the pay period will be considered when moving injured, ill, or members placed on administrative leave to or from 5/8 work schedules in order to facilitate minimal inconvenience to the City and the member.

F. Shift Trading: The Association and the City agree that shift trades will continue to be allowed in accordance with current practice. Two (2) employees may agree solely at their option, but with the advance written approval of the supervisor(s) of the affected shifts, to substitute for one another during scheduled hours of work. Every shift trade agreement must be documented, whether on paper or electronically, and the documentation must clearly demonstrate the approval of both employees and the supervisor(s).

Substitutions may be denied by a supervisor(s) or by management on a case-by-case basis due to operational or training needs, overtime, or other scheduling impacts.

Even though one employee substitutes for another, each employee will be credited as if they ~~he or she~~ worked their ~~his or her~~ regular work schedule and as if the substitution had not occurred; nevertheless, the substituting employee is responsible for the shift. For example, if a substituting employee shows up to work but then requests half of the shift off, the time off shall be taken from the substituting employee's time accruals. Similarly, if a substituting employee calls in or goes home sick, the sick leave shall come from the substituting employee's time accruals.

The City shall have no obligation to keep track of substitutions or to ensure that a substitution is reciprocated.

The hours worked during the substitution shall be excluded from the hours for which the substituting employee would otherwise be entitled for purposes of overtime and wage computations.

G. Patrol Schedule Rotation:

1. Patrol schedule rotations will occur on a quarterly basis, as near as possible to the months of March, June, September and December or as otherwise agreed to by the City and the Association.

2. Police officers assigned to the Patrol Unit are required to work at least one quarter in each fiscal year on a different schedule, i.e. officers who work Day Shift will be required to work at least one quarter on Night Shift and vice versa.

3. The new schedule will be posted a minimum of thirty (30) days in advance of scheduled rotations. The creation of a new schedule should be intended to not create overtime expense to the City by virtue of rotation. ~~This schedule is based on no overtime expense to the City by virtue of rotation~~, and no officer who is working a 12-hour work schedule

will work more than 86 hours ~~168 hours~~ without overtime in the 14-day ~~28-day~~ work cycle when rotation is affected.

4. Patrol schedule rotations shall be bid and awarded based on classification seniority, as defined in Section 12.1, except in circumstances where the Chief of Police or a designee determines that a different distribution of police officers assigned to patrol is necessary to meet the reasonable operating needs of the Department. Additionally, between regular patrol schedule rotations, the Chief of Police or a designee may, for good cause and based upon a good faith analysis of the reasonable operating needs of the Department, reassign police officers assigned to patrol to different shifts.

5. The Chief of Police may suspend Section 5.1.G.2 annually.

H. Training, Not In-Service: The City may flex (see Section 5.4) the regular work schedule of an employee to enable the employee to attend training that the City requires the employee to attend without incurring overtime, if the employee is notified of the flexed schedule at least fourteen (14) days before the training is attended. No fourteen (14) days' notice is required for employees whose work schedules are changed at their request to attend non-mandatory training. In the event a flex schedule is not used to attend training, and the training is attended outside an employee's regular work schedule, the employee will be paid only as overtime. Compensatory time is not available for this section.

Notwithstanding the 14-day notice requirements of this Section, because DPSST determines the 40-hour work schedule of City of Keizer employees who are attending Basic Police (i.e., recruit) training at DPSST such employees shall flex their 40-hour work schedules in accordance with Section 5.4.

Training will be scheduled in a manner that provides trainees with at least eight (8) hours off between the training and the trainee's regularly scheduled work hours.

Time spent traveling directly to and from the Department for training will be considered "time worked" for the purpose of computing wages. Time spent traveling directly to and from an employee's home to training will also be considered "time worked" unless the distance from the employee's home to training is greater than the distance from the Department to the training, in which case the employee will be allowed to count the time it would have taken to travel from the Department to the training as "time worked." Training will also be considered on-duty time. Notwithstanding the compensation for travel described in this Section, employees choosing to commute to Basic Police training at DPSST (instead of staying in a residence hall provided by DPSST) will not be compensated for travel time to and from DPSST.

I. In-Service Training: In-service training is training required to be attended by all sworn personnel. Examples of in-service training include firearms, defensive tactics (DTs), legal updates, ConSim, policing strategies, and department policies. Announcements of in-service training will be specifically titled as being In-Service Training.

In-service training will be scheduled in a manner that provides trainees with at least eight (8) hours off between the training and the trainee's regularly scheduled work hours.

In-service training will consist of ten (10) consecutive hours of training, including a paid thirty (30) minute meal period approximately midway through the training. Generally, in-

service training will be conducted quarterly, providing forty (40) hours of in-service training per year.

Employees who were scheduled to attend in-service training during their regularly scheduled shift or regularly scheduled day off but who, of their own volition, do not attend (e.g. vacationing instead) may be required to temporarily change or flex their regularly scheduled work hours to attend a make-up or different in-service training date without incurring overtime.

~~J. Training Adjust Time: The purpose of Training Adjust Time is to compensate employees for attending in-service training during regularly scheduled time off without incurring overtime.~~

Employees who attend in-service training may flex their regularly scheduled work hours in accordance with Section 5.4; otherwise, they shall receive compensatory time ~~accrue Training Adjust Time, accrued~~ at the rate of time and one-half.

To accommodate 10 (ten) hour in-service training days attended during regularly scheduled time off, trainees and training officers will accrue compensatory time, as provided under 5.3, ~~Training Adjust Time~~ at the rate of time and one half (1 ½) for time spent in in-service training. This provision does not preclude flex time if mutually agreed. ~~and compensable travel up to a maximum of fifteen (15) straight time hours of Training Adjust Time. In order to facilitate adequate time off, Training Officers may accrue an additional fifteen (15) hours (for a maximum of thirty (30) straight time hours) while instructing or preparing to instruct any training, including training that is not in-service training.~~

~~Not less than one month prior to the next scheduled in-service training, every employee shall have taken off enough Training Adjust Time to ensure that the employee he or she can accrue fifteen (15) hours more of Training Adjust Time at the training, without exceeding the maximum. If the employee does not schedule the time off, the employee's supervisor shall do so for the employee prior to the next scheduled in-service training. If the above does not occur and the Training Adjust Time is not scheduled or is cancelled, any hours in excess of the fifteen (15) or thirty (30) hour maximums will be paid at the applicable rate.~~

~~A request to take off Training Adjust Time can be denied for operational necessity, including the avoidance of overtime. Training Adjust Time cannot be cashed out except upon separation or as described above.~~

~~K. Compensation for Training Officers Providing In-Service Training: Training Officers providing in-service training during regularly scheduled time off and not during their scheduled in-service training hours shall be compensated with Training Adjust Time or overtime.~~

Night Shift Adjustment for Training Officers: In lieu of adjusting a Training Officer's night-shift work hours that occur adjacent and prior to, or adjacent and following, in-service training, a Training Officer shall be afforded up to a full shift ~~12 hours~~ of paid administrative leave to ensure the Training Officer is rested for training as a trainer and for their ~~his or her~~ return to adjacent, regularly scheduled work shift. The leave may be taken incrementally, before and/or after the training and, unless otherwise approved by the Chief of Police or designee, shall b scheduled no less than fourteen (14) days prior to it being

used. The leave may be taken at the rate of one hour of paid leave for each hour of in-service instruction or preparation to instruct, must be taken adjacent to the in-service instruction provided, and may not be banked. The City is under no obligation to provide the leave when Training Officers do not attempt to schedule it before a minimum staffing conflict exists.

Training Officers providing multi-day, multi-agency in-service training may be subject to temporary schedule changes to avoid overtime.

L. Compensation for Training Officers that is not Inservice Training ~~for Other Training~~: Training Officers providing training that is not in-service training may, with mutual agreement, flex their regular work schedule in order to present the training without incurring overtime and will be given a minimum of fourteen (14) days' notice of any shift adjustments in accordance with Section 5.1.H. Training that is not temporarily changed in accordance with Section 5.1.H or flexed in accordance with Section 5.4 shall be compensated with ~~Training Adjust Time or~~ overtime. This section is eligible for compensatory time.

M. K9 Training: K9 handlers may be approved to attend the 4-hour weekly K9 training. Each K9 handler's shift shall be flexed (see §5.4) to allow attendance and to avoid overtime. Flexing the K9 handler's shifts should provide at least eight (8) hours off between trainings and shifts. All or part of the weekly K9 training may be denied by the on-duty supervisor based on the operational and staffing needs during the shift.

N. Reassignments: When an employee is reassigned to a different regular work schedule, unit or assignment, the employee's hours of work may be adjusted without cost to the City to ensure the employee does not work more hours than the regular work schedule they are being reassigned to without causing overtime.

Officers who voluntarily leave an assignment, other than patrol, may be placed on the patrol shift vacated by the officer who replaces him or her, provided the officer's replacement is reassigned from the Patrol Unit.

Officers in assignments other than patrol who are involuntarily reassigned to the Patrol Unit shall be assigned to the new assignment/vacancy for the remainder of the current shift bid schedule.

Section 5.2 Rest Periods and Meal Periods

A. Rest Periods: Except for emergencies, employees shall receive rest periods of fifteen (15) minutes each for every four (4) hours worked during each workday. These periods are compensated as hours of work and an employee shall not be entitled to additional compensation in the event these rest periods cannot be taken. In the event employees are assigned to a ten (10) or twelve (12) hour shift, employees may take reasonable breaks subject to the operational needs as determined by their supervisor.

B. Meal Periods: All sworn officers who are able to perform all of the duties of a police officer (not on modified duty, shift or assignment – see Section 8.6) and CSOs shall have uninterrupted thirty (30) minute paid meal periods as close as reasonably possible to the middle of their shift. These meal periods are compensated as hours of work. Sworn

officers shall not be entitled to additional compensation in the event these paid meal periods cannot be taken.

While situations in which sworn officers on modified duty, shift, or assignment typically involve medical restrictions that encumber them from being available to work upon demand (as inferred in Section 5.2.B and Section 8.6), each situation is different and may be reviewed to determine whether the officer can and should be available to work upon demand and thus be afforded a paid meal period. Due to the almost unlimited variables, such determinations shall be at the discretion of the Chief of Police, taking into consideration the officers' restrictions and modified duties.

All other employees shall have a regular uninterrupted meal periods up to one (1) hour without pay. If an occasion arises where an employee is required to work through their meal period, they shall be paid for that meal period and they shall take a rest or meal period as soon as possible.

Section 5.3 Overtime

No overtime shall be worked unless authorized by the Chief of Police, ~~his~~ designee or a supervisor.

A. Hours Worked Defined: The following shall be regarded as hours worked for the purpose of computing overtime hours for employees.

1. Time worked, including time spent engaging in briefings, meetings, or conferences, if so directed by the City, and time spent engaging in other activities, as required by law.

2. Paid leave, excluding nonwork related jury or witness duty.

B. Overtime: Except as otherwise required by this Agreement, including employees at Basic Police training at DPSST, overtime shall be compensated for all time worked outside the employee's regularly scheduled shift. Employees at Basic Police training at DPSST shall accrue overtime for hours worked in excess of a 40-hour workweek, not an eight-hour workday. See also Section 5.1.H regarding the schedules of employees at Basic Police training.

Patrol officers on the modified Louisiana Plan Schedule under Article 5.1.C will be paid contractual overtime after 12 hours and 20 minutes per shift or overtime for hours worked over 86 hours per 14-day work period, with the understanding that when taking accrued leaves, such leaves are paid at the employee's regular straight time rate. ~~no overtime will be paid for hours taken when using accrued leaves.~~ *[bargaining note: If taking a full week off using paid leaves, the last 20 minutes, which is normally paid at overtime under FLSA when worked, is paid at the employee's regular straight time rate.]*

C. Overtime Compensation: Compensation for authorized overtime shall be paid at the rate of time and one-half ~~per hour rounded to the nearest quarter hour~~. Each payment shall be made at the employee's rate of pay that is being earned at the time of payment.

D. Payment for Overtime: Payment for overtime shall be paid no later than the next pay day following the pay period in which the overtime was worked.

X. **Compensatory Time.** When allowed by this agreement, an employee may accrue compensatory time in lieu of overtime. Accrual of compensatory time will be banked up to a cap of 60 ~~40~~ hours. Any hours worked that are accrued as compensatory time that exceed the 60 ~~40~~-hour cap will be paid in the next regular pay period. Upon separation of employment, the City will pay any remaining compensatory bank accruals at the employee's current regular rate of pay.

Overtime eligible for compensatory time bank accruals: 5.1(I): in-service training; 5.1(J): training officer that is not in-service, and daily or for hours worked over 86 hours per 14-day work period (at the election of the employee), that is not otherwise flexed or restricted by this agreement.

Compensatory time is accrued for all in-service training.

The City shall limit overtime compensation as paid overtime for work performed under specific grants at its discretion. *(for example: seat belt grants, DUII grants)*

E. Notice of Overtime: Overtime work shall be assigned by the Chief of Police, ~~his~~ designee or a supervisor. Whenever possible, the Chief of Police, ~~his~~ designee or a supervisor shall give twenty-four (24) hours advance notice of overtime to be worked. Verbal notice shall be sufficient to comply with the advance notice requirement.

F. Work in Excess of Sixteen (16) Hours: Any employee who works sixteen (16) or more hours in the twenty-four (24) hour period beginning at the time the employee reports to work may be allowed the use of paid administrative leave in lieu of working all or a part of their ~~his or her~~ next regularly scheduled consecutive work shift. Using paid administrative leave to take time off must be approved by the employee's supervisor or his or her designee. This provision is intended to be reserved for those rare times when an employee is too fatigued to continue to safely perform their ~~his or her~~ duties or work all or part of their ~~his or her~~ current or next regularly scheduled consecutive work shift.

At the sole discretion of the Department, in certain circumstances an employee's supervisor may approve the use of paid administrative leave prior to the employee reaching sixteen (16) hours of work. Any such history or practice of this discretion is not subject to establishing any precedent or subject to grievance. *(Bargaining note: City has management right to assign employees to not work (aka: paid admin leave) at its discretion)*

G. Work in Excess of Twenty-Four (24) Consecutive Hours: Any employee who is required to work in excess of twenty-four (24) consecutive hours and is also required to begin working their ~~his or her~~ next regularly scheduled work shift without time off (i.e. where the work in excess of twenty-four (24) hours runs into his or her next regularly scheduled work shift) shall be paid at the rate of time and a one-half for all hours worked during that next regularly scheduled work shift or the employee may be allowed to use paid administrative leave in lieu of working all or a portion of that shift. Any hours worked in excess of twenty-four (24) consecutive hours or the taking of any paid administrative leave time off in lieu of working all or a portion of the employee's next regularly scheduled work shift must be approved by the employee's supervisor prior to either occurring. This section does not offer compensatory time.

Section 5.4 Flex Time

Employees may be permitted to "flex" their work schedule with supervisory approval. However, the change in work schedule must occur during the same workweek (as defined in Section 5.1.A) for employees who work 5/8 or 4/10 workdays, or within the same 14-day ~~28-day~~ work cycle for employees who work 12-hour workdays. Notwithstanding any other provision of this Agreement, the employee will receive regular straight-time pay for the hours flexed.

Section 5.5 Call-Back Time *(bargaining note: changes below from MOU)*

An employee called back to work outside their regular work schedule shall be paid for a minimum of three (3) overtime hours at the rate of time and one-half.

A. Exceptions to Call-Back Time Minimum: The obligation to pay the call-back time minimum shall not apply in the following situations:

1. When an employee is called in to start work one (1) hour or less before the beginning of his or her regular shift or when the employee's shift is extended;

2. If an employee has completed their ~~his or her~~ shift and less than thirty (30) minutes has elapsed;

3. If an employee is called back to work to correct a mistake or to complete a task that, in the City's view, must be completed prior to the employee's next regularly scheduled shift.

4. Electronic Call-Back. Employees called back ~~contacted by a supervisor, or by another employee with a supervisor's approval,~~ who are required to work outside their regular work schedule from their residence or location where they received the communication shall be paid overtime for the actual time spent (by the minute). ~~rounded to the nearest quarter hour, provided the contact lasts seven-and-a-half (7.5) minutes or longer. Such communication with the employee that is less than 7.5 minutes or is administrative in nature shall be considered *de Minimis* and will not be compensated.~~

B. Emergency Call Back ~~Out~~: In an emergency (act of God, natural disaster, civil unrest, major crime or incident, or governmental declaration of emergency with less than eight (8) hours prior notice), the City may call back ~~out~~ members for overtime without regard to seniority.

C. Non-Emergency Call Back ~~Out~~:

Non-emergency overtime shall be offered to members by seniority and classification (per Section 1.1) unless the City determines the work to be performed may require a specific skill set (e.g. language fluency, canine handler) or where a statute requires a specific type of officer.

Bargaining unit members may opt out of or back in to the Non-Emergency Call-Back list (hereafter, in this section, referred to as the Call-Back List) by notifying the KPA president of designee, who will update the list. Notwithstanding the changes to this section, members

may not opt out of Emergency Call-Back as described in Section 5.5.B, nor may members opt out of being ordered back to work (as described below, in this section) if all other members decline the opportunity.

The City may skip bargaining unit members, if the overtime work performed would unreasonably conflict ~~interfere~~ with a ~~the~~ member's ~~next regularly~~ scheduled work shift.

When a non-emergency overtime call-back ~~out~~ of a member is required, the City will make a reasonable attempt to contact and offer members the opportunity to work the non-emergency overtime in the order of the highest seniority to lowest seniority, not including members who opt out. ~~In cooperation with~~ The Association president or designee, ~~the City~~ shall maintain the Call-Back a list, sorted by seniority (highest to lowest), not including members who opt out, that includes each member's name, and one phone number of their designation. The Call-Back List will be maintained by the Association president or designee on a shared network drive accessible to all Police Department personnel. In addition, the City shall maintain a Seniority List (distinct from the Call-Back List) of all Police Department personnel, sorted by classification, and maintained on a shared network drive, and a free-form space in which members may opt out of specific non-emergency call-out types (e.g. patrol coverage, crime scene security).

For each non-emergency call-back ~~out~~, a supervisor (or designee) shall begin at the top of the Call-Back List ~~seniority list~~ and talk with ~~contact~~ or leave a message (~~including~~ with a call back number) for each member offering the non-emergency overtime opportunity. Regardless of seniority, the first member to accept the overtime opportunity shall be considered the called-back ~~out~~ member. (This is relevant in case a member volunteers for ~~the~~ overtime, but then a more senior member shortly thereafter returns a call to accept the overtime opportunity; in such case, the senior member will not receive the overtime opportunity.)

The supervisor or designee conducting the call-back shall document efforts (including who was skipped due to a work-shift conflict), the member's responses, and the results (including who was called back). The supervisor or designee shall save a copy of the documented efforts to the same folder on the shared network drive. (A scanned and save copy of handwritten notes is sufficient).

In lieu of ~~immediately~~ ordering a member to work the non-emergency overtime, a supervisor (or designee) may place a member on "hold" ~~"standby"~~ for 10 minutes, without compensation, and ~~to~~ continue calling from the Call-Back List ~~seniority list~~ in an effort to find a member who will accept the non-emergency call-back ~~out~~ overtime. If all members contacted decline the non-emergency overtime opportunity, the City may order a member to report for work; this shall be done by reverse seniority (choosing the least senior officer available ~~officer~~) using the Seniority List, not the Call-Back List, and the member placed on standby shall remain on standby until a less-senior member can be ordered back.

A list of Association members ordered to work non-emergency call-back ~~out~~ overtime shall be maintained on network file titled ~~in a binder entitled~~ "Non-Emergency Call-Back Mandated. ~~Out.~~" The members and dates of call-backs ~~outs~~ shall be recorded and members shall not be subject to being ordered to work a non-emergency call-back ~~out~~ again until the list starts over or is reset at the beginning of each ~~the~~ calendar year.

Notwithstanding Section 2.3 and 2.4, if no members of the Association are available to work non-emergency overtime or long-term personnel considerations are an issue (e.g. natural disaster or similar emergency), the City has the option of calling Reserve Officers in for duty to supplement regular officers if those Reserve Officers are presently capable and authorized to perform the overtime duties. The use of Reserve Officers is to supplement or assist regular police officers. The Association takes it on good faith that in such circumstances it is not the intent of the City to use Reserve Officers to supplant Association members. *(bargaining note: Language from KPA)*

D. Call-Back from Approved Time Off:

1. Call-Back from Vacation: A member will not be called back to duty from an approved vacation day for a non-emergency call back except for situations involving a court of law, grand jury or DMV hearing, as outlined in Section 5.6, Court Appearances.

2. Call-Back from Floating Holiday: If a member's Floating Holiday is cancelled by the Department for operational reasons, it will be paid. See Section 10.2.C.

3. Call-Back from Floating Holiday on Recognized Holidays: If a member's Floating Holiday, scheduled to be taken on a recognized holiday as recognized in Section 10.3.A is cancelled, the member shall be paid for the Floating Holiday in addition to receiving overtime for hours worked.

4. Call-Back from Holiday, Not Floating Holiday: For members not receiving Floating Holiday accruals, work performed on holidays recognized in Section 10.3.A shall be compensated with overtime in addition to holiday pay.

5. ~~Call-Back from Shift Time: If a member's "shift time" is cancelled by the Department for operational reasons, it will be paid at straight time rate.~~ *(bargaining note: Now moot, see 5.1(C).*

6. Call-Back from Training-Adjust Time: If a member's "adjust time" is cancelled by the Department for operational reasons, it will be paid at applicable rates.

Section 5.6 Court Appearances

Except as set forth below, off-duty employees who are required to attend ~~appear before~~ a court of law, grand jury or job related administrative hearings ~~DMV hearing~~ in connection with duties as an employee of the Department shall receive a minimum of three (3) hours overtime pay at the ~~that~~ rate of time and one-half for each court appearance when the appearance occurs on the employee's time off on the employee's regularly scheduled workday.

~~Video and telephone appearances: Employees appearing by video or telephone for court, grand jury, job related administrative hearings or other assigned work meetings when not working their regular scheduled hours will receive a minimum overtime payment of 1 hour. Note: These provisions do not apply to attendance to PECBA related hearings. See Article 3 for those. (City withdraws)~~

This obligation shall not apply if the scheduled court appearance, grand jury or DMV hearing occurs two (2) hours or less before the beginning of the employee's regular shift or if the appearance extends the employee's regular shift.

Except as set forth below, employees who are required to attend ~~appear~~ before a court of law, grand jury or DMV hearing in connection with duties as an employee of the Department shall receive a minimum of four (4) hours overtime pay at the ~~that~~ rate of time and one-half for each court appearance when the appearance is required on the employee's regularly scheduled day off or an approved day off, unless the employee was notified of the court appearance prior to approval.

In situations where an employee has more than one court appearance, grand jury or DMV hearing on the same day, the employee is only eligible for additional overtime pay for the second appearance when the second appearance occurs outside the time period for which the employee has already received overtime compensation; e.g., an employee who has a court appearance on their regularly scheduled day off at 8:00 a.m. would not be entitled to additional overtime compensation unless the second court appearance occurred after 12:01 p.m.

Section 5.7 Outside Employment

Employees must receive permission to work at outside employment in writing from the Chief of Police. In order to be approved, the outside employment must:

A. Be compatible with the employee's City duties.

B. In no way detract from the efficiency of the employee in City duties.

C. In no way be a discredit to City employment.

D. Not take preference over extra duty required by City employment.

However, such approval shall not be withheld arbitrarily. In the event the City believes an employee's outside employment conflicts with the provisions above, the City may rescind permission upon giving the employee at least 14 days notice and an opportunity to be heard.

Section 5.8 On-Call Criminal Investigations Unit Detective

The following provisions shall apply to on-call detectives:

A. Each week of seven (7) consecutive days, at least one (1) CIU detective will be assigned as the On-Call Detective. ~~In the event any members of the CRU or SRO units are temporarily assigned (via Personnel Order) to the Detective Unit, they may enter the On-Call rotation.~~ *bargaining note: from MOU*

B. Members assigned as an On-Call Detective shall remain ready to respond to work when called upon. Such readiness includes, but is not limited to, sobriety, a well-rested state, constant availability by cell phone (or other prearranged method), and no more than a one-hour response time to the Department.

On-Call Detectives who are unable to fulfill their on-call responsibility for any reason shall notify the Criminal Investigations Division supervisor immediately, and the On-Call Detective shall be responsible for finding another detective to fulfill their On-Call Detective responsibility.

C. The On-Call Detective assignment shall begin at 0700 hours on Monday and end at 0659 hours on the following Monday. The detective assigned to the On-Call week shall be compensated with $350 or as prorated weekly.

D. A rotation schedule for the On-Call Detective assignment shall be established between the detectives and their supervisor. Establishment of the schedule shall not prohibit the trading of On-Call weeks between detectives, nor shall it prevent the trading of mid-week On-Call Detective responsibilities as long as the Criminal Investigations Division supervisor or designee approves the trade. The affected detectives may request the City to prorate the compensation accordingly; however, prorates shall be figured on a whole-day basis, from 0700 to 0659 hours, regardless of how many hours were traded.

E. Generally, On-Call Detectives will not be approved to schedule time off during their On-Call week, unless the detective has arranged for a substitute for their ~~his or her~~ on-call status and the Criminal Investigations Division supervisor approves the trade.

F. Except when temporarily assigned to the CIU, this section does not apply to YSSO, SSRT or CRU detectives.

G. A member who is temporarily assigned (via Personnel Order) to the Criminal Investigations Unit may be assigned to the On-Call rotation by the Criminal Investigations Division Commander or designee.

Section 5.9 On-Call Status, Not On-Call Detective

Notwithstanding the provisions of Section 5.8, any member of the Department may be placed on on-call status by Command Staff or a designee. Members placed on on-call status shall remain ready to respond as described in Section 5.8.B and shall receive $50 for each 24-hour period or part thereof that the employee ~~he or she~~ is required to remain in such status. ~~This Section shall sunset at the completion of this Agreement unless reaffirmed.~~

~~Section 5.10 Definitions~~

(bargaining note: moved to 5.1).

~~The following definitions apply to Article 5:~~

~~A. The terms *regular shift, regularly scheduled work shift, regular work schedule* and *regularly scheduled workday* refer to those shifts, hours and days the employee was assigned to work as they appear on the master schedule.~~

~~B. The term *scheduled days off* refers to those days an employee was not assigned to work as they appear on the master schedule.~~

~~C. The term *regular business hours* refers to the workdays and hours Monday through Friday, 0800 to 1700.~~

TA 2/16/23

ARTICLE 6 – FUNDING

Current contract language

Section 6.1 Funding

The parties of this Agreement recognize that revenue needed to fund this Agreement must be approved annually by established budget procedures and in certain circumstances, by a vote of the citizens of the City. All compensation provided for by this Agreement is therefore contingent upon sources of revenue, and where applicable, voter budget approval. The City will not reduce the compensation specified in this Agreement because of budgetary limitations. The City agrees to include in its budget request amounts sufficient to fund the compensation provided in this Agreement. In the event that the City does not receive the required voter approval needed to fund the annual budget, the parties agree to meet to seek the best possible alternatives to layoff and/or reduction of services for the City.

TA 5 of 8
2/16/23

TA 6/14/2023

City What If Package If Proposal

6-9-23

This 'what-if' offer is intended as a limited offer for the purpose of resolving successor bargaining. This offer is valid to Tuesday 6-13-23. This is not to be considered a formal proposal, nor subject to future reference for the purposes of bargaining as related to PECBA bargaining. This offer is valid through June 8, 2023. All current tentative agreements and otherwise current contract language remain in effect.

Articles of "what-if" offer include: 7, 8, 10, 17, Appendix A.

"What if" includes package offer on Articles 13, 14, 15, policy B/C/D.

Tentative Agreements include: 1, 2, 3, 4, 5, 6, 9, 11, 12, 16.

ARTICLE 7 – WAGES

Section 7.1 Wages

A. Pay Schedule: Each employee covered by this Agreement shall be compensated in accordance with the Hourly Pay Schedule attached.

Effective July 1, 2023 or in the next pay period following execution of this agreement, the later of either, step 1 will be increased by 5%. Thereafter, steps are 5% apart.

Effective July 1, 2024, step 1 will be increased by 4%. Thereafter, steps are 5% apart.

Effective July 1, 2025, step 1 will be increased by 3.5%. Thereafter, steps are 5% apart.

Note: Step 7 for Police Officer is subject to section B below.

~~1. Effective July 1, 2021, wages shall be increased by two-and-one-half percent (2.5%).~~

~~2. Effective July 1, 2022, wages shall be increased by two-and-one-half percent (2.5%).~~

(bargaining note: City acknowledges recent MOU #7 effective October 2022 with a 1.5% increase in wages as status quo. In addition, the MOU included the one-time opportunity to cash out up to 80 hours leave until June 30, 2023)

B. Step 7 Increases for Police Officers: Police officers who complete ten (10) years of service as a police officer with the City of Keizer will be eligible for step advancement to Step 7 based on a "satisfactory" performance evaluation as described in Section 7.1.D effective the first pay period after completion of ten (10) years. Step 7 for Police Officers will be 2.5% above Step 6.

C. Placement of New Hires: The City reserves the right to place a newly hired employee on any step on the pay schedule based on its review of that employee's education, training and experience ~~and ability~~.

D. Step Increases: Eligibility for step increases is not automatic but shall be based on a "satisfactory" performance evaluation by the employee's immediate supervisor.

Employees shall be eligible for a step increase upon the satisfactory completion of twelve (12) months of employment, regardless of their probationary status, and eligible for their next step increase on the following July 1st.

Regular employees will continue to be eligible for step increases on July 1st.

E. Early Step Increase: An employee, who is performing at a level above satisfactory as determined by a performance evaluation by the employee's immediate supervisor related to the employee's demonstrated experience, education and training, may be recommended for an early step increase by the Chief of Police. Such early step increases shall not change the employee's eligibility date for future step increases.

Section 7.2 Working Out of Classification

Any employee designated by the City as acting in a capacity in a higher position than that employee's regular classification, shall receive the pay for the position designated or receive an incentive of five (5%) of their base hourly rate ~~a 5% increase above their regular salary~~, whichever is greater, in such assignment for the remainder of the assignment. This Section does not apply to employees who are temporarily in charge per Section 7.3.E.7.

Section 7.3 Incentives and Premium Pay

A. Premiums: Police Officers shall be eligible for DPSST incentives ~~bonuses~~ as follows.

1. Intermediate Certificate: Upon submittal of evidence satisfactory to the City that the employee has received DPSST Intermediate Certification, the employee shall receive an incentive of two and one-half percent (2.5%) of their base hourly rate for hours worked in the pay period, ~~receive two and one half percent (2.5%) over and above his or her monthly base pay~~; or

2. Advanced Certificate: Upon submittal of evidence satisfactory to the City that the employee has received DPSST Advanced Certification, the employee shall receive an incentive of five percent (5%) of their base hourly rate for hours worked in the pay period, ~~receive an additional two and one half (2.5%) percent (or a total of five (5%) percent) per month over and above monthly base pay~~.

Certificate Incentives are not cumulative.

B. Education Incentives:

1. The City shall pay an incentive of two and one-half percent (2.5%) ~~percent~~ of an employee's base hourly rate for hours worked in the pay period, ~~per month over and above monthly base pay~~ for an employee holding an Associate's degree.

2. The City shall pay an incentive of five percent (5%) of an employee's base hourly rate for hours worked in the pay period. ~~an additional two and one-half percent (2.5%) percent or a total of five (5%) percent per month over and above monthly base pay~~ to an employee holding a Bachelor's degree from an accredited college or university.

   Education Incentives are not cumulative.

C. Language Incentives: Fluency is to be determined by the City based on a standard and testing program approved by the City.

   1. Critical Languages: An employee who is determined to be fluent in the Spanish language shall receive an incentive of five percent (5%) of their base hourly rate for hours worked in the pay period. ~~over and above his or her base pay.~~

   2. Non-Critical, Recurring Languages: An employee who is determined to be fluent in Russian or American Sign Language (ASL) shall receive an incentive of five percent (5%) of their base hourly rate for their entire shift, inclusive of any extension of shift, when ~~percent over and above base pay for the shift during which he or she was~~ required to use the language and for which the use has been documented. ~~in the CAD system.~~ The employee will be responsible for reporting the premium pay on their time sheet.

D. Probationary Employees: Except for language fluency, the incentives and premiums required by this Section shall not be paid during an employee's initial probationary period. ~~except at the discretion of the Chief of Police.~~ This provision does not apply for lateral hires on probation. *(bargaining note; current practice)*

E. Special Assignment Premiums:

   1. K-9 Handler Pay: To compensate the K-9 handler for the off-duty care of the canine, the handler will receive an incentive of five percent (5%) of their base hourly rate for hours worked in the pay period ~~be paid five percent (5%) per month of the employee's current pay step~~ when assigned as the Department K-9 officer. The 5% differential is intended to compensate the K-9 Officer for off-duty grooming, feeding and care of the animal at applicable overtime rates. In addition, the handler shall be allowed thirty (30) minutes per shift for these activities on scheduled workdays. The parties agree that this Section fully compensates the K-9 handler for these activities and that 30 minutes per day on average is an appropriate amount of time for care and feeding. *(bargaining note: If handler exceeds the 30 minute time, handler should report the additional time)*

   2. Field Training Officer (FTO): An employee designated by the City as a Field Training Officer shall receive an incentive of five percent (5%) of their base hourly rate ~~be paid five percent (5%) above the employee's base pay~~ when the Field Training Officer is assigned to train a recruit officer or a reserve officer who is in the field training process. The FTO will be responsible for reporting the premium pay on their time sheet.

   3. Motorcycle Officer: Officers assigned as a Motorcycle Officer shall receive an incentive of five (5%) of their base hourly rate for hours worked in the pay period. ~~To compensate the Motorcycle Officer for the hazards of working from a motorcycle and for the off-duty care of the police motorcycle, e.g., daily maintenance, etc., the~~

~~Motorcycle Officer will be paid five percent (5%) above the employee's regular pay step when assigned as a motorcycle officer.~~

4. Interagency Bomb Squad and Interagency SWAT Team: Employees designated by the City to serve on the Interagency Bomb Squad or the Interagency SWAT Team shall receive an incentive of five percent (5%) of their base hourly rate for hours worked in the pay period. ~~will be paid an additional five percent (5%) of their regular base pay.~~

5. Fleet Manager: Employees assigned as the Fleet Manager for the Department shall receive an incentive of two and one-half percent (2.5%) of their base hourly rate for hours worked in the pay period. ~~will be paid an additional two and one-half percent (2.5%) of their regular base pay.~~

6. Training Officers: An employee designated by the City as a Training Officer shall receive an incentive of five percent (5%) of their base hourly rate ~~be paid five percent (5%) above the employee's base pay~~ for the time the Training Officer is scheduled to attend training as a trainer or for trainer development. For purposes of this Section, training time includes reasonable time for curriculum development, set-up, and tear-down. The Training Officer will be responsible for reporting the premium pay on their ~~his or her~~ time sheet.

7. Temporarily-in-Charge: An ~~employee officer who~~ is designated or assigned to Temporarily-in-Charge capacity ~~serve as Officer-in-Charge~~ shall receive an incentive of five percent (5%) of their base hourly rate ~~will receive a 5% increase in the wage to which the employee would be otherwise entitled~~ for the duration of the assignment. ~~This provision also applies to an employee designated or assigned to serve in the same capacity in the Support Services Unit (Records).~~ The employee will be responsible for reporting the premium pay on their time sheet.

F. Incentives and Special Assignment Pay - Limitations on Cumulative Effect: A maximum of five percent (5%) ~~percent~~ may be received by any employee by virtue of education incentives provided for above. A maximum of five percent (5%) ~~percent~~ may be received by any officer qualifying for DPSST incentives provided for above. A maximum of ten percent (10%) may be received by any employee for premium pay assignments. The total amount of all incentive and premium pay (education, certification, premium pay assignments) may not exceed 20% per month for any employee, except any employee certified as bilingual in Spanish may receive a maximum of five percent (5%), in addition to the above maximums. Likewise, any employee certified as bilingual in Russian or American Sign Language may receive five percent (5%) ~~percent~~, in addition to the above maximums during the shift in which the language was used and documented. ~~in the CAD system.~~ All incentives and special assignment pay premiums shall be based on regular base hourly rate. ~~pay.~~

Section 7.4 Payday

The regular payday for the issuance of paychecks shall be every other Thursday of the month. At the discretion of the City, modifications to the payday schedule may be made where necessary.

Section 7.5 Travel Allowance

A. Travel Reimbursement: When an employee is authorized to use the employee's own vehicle in the performance of official City duties, the employee shall be compensated at the current Internal Revenue Service rate.

B. Expense Reimbursement: Employees will be reimbursed actual and reasonable travel expenses pursuant to the City-wide travel reimbursement policy, as it presently exists or is subsequently modified. The policy will not be changed to the detriment of employees without bargaining as required by PECBA. *(bargaining note: City is revising the policy to simplify it without any change in benefits provided. Suggestion that HR and Association Representative review revisions separately)*

Section 7.6 Uniforms

A. Uniforms Provided: The City shall provide all uniforms and equipment as required by the City. The City agrees to provide a duty weapon and all necessary duty rig accessories. In addition, for those employees so selecting, the City shall provide external ballistic vest carriers.

B. Cleaning: The City shall provide for the care and cleaning of up to eight (8) uniforms per month. If an employee is assigned as a Detective, the employee's clothes ~~worn~~ will be cleaned, up to eight (8) sets per month. The City will pay for the cleaning of up to eight (8) uniforms per month for non-sworn employees. *bargaining note: from MOU*

C. Clothing Allowances:

1. Employees assigned as CIU, YSSO, or SSRT detectives, requiring business-like attire will be paid six hundred ($600) dollars per fiscal year clothing allowance. *bargaining note: from MOU*

2. Employees assigned as Police Support Specialist, ~~Investigative Services Specialist~~, Property and Evidence Specialist, and Crime Analyst, shall be paid three hundred dollars ($300) per fiscal year clothing allowance. Employees ~~Officers~~ assigned as ~~to~~ CRU detectives will be paid two hundred dollars ($200) per fiscal year clothing allowance.

3. These allowances shall be payable to the employee upon appointment and annually on July 1st of each subsequent year. The City reserves the right to prorate the allowances provided to employees during their first and last fiscal years of assignment. When an employee enters an assignment where a clothing allowance is due, it shall be dispensed as follows:

   a. During the first nine months of the fiscal year (July 1 through March 31), the full clothing allowance shall be paid, or

   b. During the last three months of the fiscal year (April 1 through June 30), half of the clothing allowance shall be paid.

4. An employee may receive only one clothing allowance per fiscal year, but shall receive the higher amount if the employee works in an assignment with a higher amount.

D. Damage: When a uniform is returned to the City because of wear or damage, it shall be replaced within a reasonable amount of time.

E. Personal Items: The City agrees to repair or replace personal items of the employee that are damaged, destroyed, or lost while the employee is on duty, unless the damaged or lost personal item is attributed to the negligence of the employee. The repair or replacement of personal items shall not exceed reasonable costs. Expensive items of jewelry or personal property which are over $100 in value, excluding wedding rings and prescription eyeglasses, will not be worn while on duty without prior written approval, and shall not be subject to repair or replacement by the City if the item is damaged, destroyed or lost. Wireless phones will be reimbursed pursuant to City policy.

Section 7.7 Education Tuition Assistance

A. Tuition Aid Defined: Tuition aid is defined as full or partial payment or reimbursement of the costs of training sessions, classes or formal academic course work pursued on a part-time basis either during or after regular work hours.

B. ~~City-Assigned-Training; Travel-Reimbursement: When-an-employee-is-assigned-by-the City-to-attend,-on-a-part-time-basis,-designated-courses-either-during-or-after-regular working-hours,-the-employee-shall-be-reimbursed-for-all-of-the-costs-of-course-registration and-necessary-travel-expenses. Employees-will-cooperate-in-pooling-rides-when-such pooling-is-available.~~ *(bargaining note: Training is moved to new section below)*

C. Tuition Aid: Contingent upon the availability of funds that have been budgeted for this purpose, tuition aid for attendance to a bona fide college or equivalent will be provided for one-half the cost of the course tuition to employees who successfully complete classes with a grade of C or better, for the purpose of self-development, when such training will also be beneficial to the employer as determined by the City. Presentation of the employee's grades from the school shall be sufficient proof. The petitioning employee shall submit request for tuition aid to the City for approval or disapproval prior to enrollment. The City's obligation shall be limited up to one half of the hourly tuition cost for an undergraduate degree course at Western Oregon University, not the promised rate.

Section 7.x Training: City Assigned Training and Travel Reimbursement: When an employee is assigned by the City to attend designated training courses either during or after regular working hours, the employee shall be reimbursed for all of the costs of course registration and necessary travel expenses consistent with BOLI rules and City policy. Employees will cooperate in pooling rides when such pooling is available.

Section 7.8 Personal Wireless Phone Allowance

Employees are eligible for personal wireless phone allowances (stipends) as outlined in City policy.

Section 7.9 City Health and Wellness Plan ORPAT Incentive.

Employees will be provided the opportunity to participate in the DPSST certified ORPAT course twice per fiscal year. Scheduling of this testing shall be determined by the Chief of Police.

Recognizing that participation in this incentive program is purely voluntary, all ORPAT testing will be done off-duty and without compensation (includes both members taking test and ORPAT instructors conducting test). However, members scheduled to be on duty at the time scheduled for testing will be provided the opportunity to participate while on duty if requested. The City will provide the location and all testing equipment, including a certified ORPAT instructor to facilitate the testing.

Prior to participating in the fitness incentive, employees will be required to sign a waiver indicating they understand the physical challenges of ORPAT and the risks of participating. If at any time, in the opinion of the ORPAT instructor or on scene supervisor, the employee appears to be in physical distress, the testing will be stopped and the employee will not be eligible for an incentive.

Employees who successfully complete the ORPAT course in a time that is considered passing on their first attempt will receive an incentive bonus of two hundred and fifty dollars ($250.00). An employee may take the ORPAT twice per fiscal year, with a maximum incentive of $500/fiscal year.

The parties recognize that the City will reflect any and all amounts paid as allowances, bonuses, and/or incentives as subject to the IRS and Oregon payroll tax deduction. For purposes of this Agreement, the minimum standard for passing will be the time established as passing by DPSST for an entry level Police Officer.

If an employee fails to pass the ORPAT on the first date for testing that employee may retake the test at the next scheduled ORPAT testing.

If an employee is unable to participate in the scheduled ORPAT test due to court, bona fide illness or injury or other reasonable conflict, the employee may make-up the test during any ORPAT testing conducted at DPSST (with DPSST permission) without penalty so long as the make-up test is completed and passed within a mutually agreed time frame between the employee and the Chief of Police.

Employees who choose not to participate or who seek this incentive, but do not meet the minimum ORPAT passing standard as defined-in this Agreement will not be subject to discipline.

Employees who choose not to participate in the ORPAT have the option to participate in the City's Health & Wellness Program. Such employees may request to switch programs at approximately six (6) month intervals based on the ORPAT testing schedule, ensuring they are participating in only one program at a time.

The City's Health & Wellness Program is a voluntary program available to all City regular full-time and part-time employees. The program provides resources to support group education, individual and team health and wellness contests as well as individual incentives for employee participation in City-sponsored activities and challenges. Individual incentives vary by participation up to $40 per month given appropriate activity minutes recorded within required timeframes. Qualified individuals with disabilities will have equal access to the Health & Wellness Program through customized alternative activities coordinated through the Human Resources Department. *(bargaining note: Employees are also eligible for $50 yearly for completing a confidential self-assessment and related).*

7.10 Practice Ammunition: The City will provide each sworn officer the opportunity to purchase additional practice ammunition for approved duty firearms in support of sworn officers maintaining their skill set. Each sworn officer will have the opportunity to purchase at cost one (1) case each of pistol and long rifle ammunition for their assigned duty firearm using the City approved vendor. The opportunity to purchase will be once per year for all officers. This provision is considered part of the employee's compensation. *(bargaining note: City will prepare a procedural policy for review)*

ARTICLE 8 – INSURANCE AND RETIREMENT

Section 8.1 Health Insurance and Dental Insurance

A. The City will pay ninety five percent (95%) of the premium to provide medical and dental insurance coverage for full-time members who are participating in the City's current Health Net Plan and Guardian Dental Plan.

Employees participating in those plans shall be responsible for paying the remaining five percent (5%) of the premium, irrespective of level of coverage through payroll deduction or, in the event of unpaid leave, through direct payment.

Employees who elect to be covered by lower cost medical and/or dental plans made available by the City shall receive contributions from the City up to the same amount as required for employees participating in the above plans. Any premium costs in excess of that amount shall be the employee's responsibility.

B. For regular part-time employees, the City will split the cost of employee-only medical and dental insurance using the same ninety-five/five percent (95%/5%) split as described above.

C. All employee contributions shall be paid through payroll deductions. The City will six provide an IRC Section 125 flexible spending account plan.

D. The City may select a different plan or provider of health and/or dental insurance benefits which are, on the whole, substantially comparable to those currently provided. The City and the Association shall consult within fourteen (14) days of the City's written notice to the Association E-Board but need not bargain over a change in plans permitted by this Article. If the Association believes a change in health and/or dental insurance benefits is not substantially comparable, then the Association may demand to bargain over the change.

Notwithstanding the above, the City reserves its right to change carriers without bargaining, consistent with PECBA.

E. This Section shall be automatically reopened in the event the excise tax will be triggered, in accordance with Article 17 of the Agreement.

Section 8.2 Life Insurance

The City agrees to provide $60,000 24-hour life insurance protection to all regular and probationary full-time employees covered by this Agreement.

Section 8.3 Retirement

A. The City agrees to participate in the Oregon Public Employees Retirement System (PERS) Plans for all members of the bargaining unit and will not reduce employee compensation in order to generate funds needed to pay the contribution.

B. The City will contribute six percent (6%) of an employee's gross salary to an employee's individual deferred compensation plan as provided by the City. Employees are responsible to initiate their own plan. Employees may continue to contribute individually to their plan at their election. Contributions are subject to IRS regulations. ~~Employees may contribute voluntarily to one deferred compensation plan administered for the City. The City shall match the employee's contribution up to six (6%) percent of the employee's gross salary.~~

~~This Section shall not obligate the employee or the City to contribute more than twenty-five (25%) percent of wages or such other amount as is imposed as a maximum contribution by the Internal Revenue Code or the retirement plan.~~

Section 8.4 Workers Compensation

All employees are covered for on-the-job injuries and occupational illnesses under the state workers' compensation law. When an employee must take time off by reason of an occupational illness or on-the-job injury, the employee will receive workers compensation in accordance with state law, and the employee will retain any time loss benefits received by the carrier. *(bargaining note: OAR 436-060-0025)*

In addition, for the first one hundred and eighty (180) days following such illnesses or injuries or an aggravation of an original occupational illness or on-the-job injury, notwithstanding whether the illness or injury has been accepted by the City's workers' compensation carrier, the City agrees to supplement the employee's workers' compensation time loss benefits up to the employee's regular salary after taxes. After one hundred and eighty (180) days following an occupational illness or on-the-job injury or aggravation, the employee may elect to ~~shall~~ use available sick leave or, at the employee's option, another paid leave bank (adjust time, ~~shift time~~, holiday banks or accrued vacation) to make up the difference between workers' compensation time loss payments and their ~~his or her~~ regular salary after taxes, until such time as the employee is eligible to receive disability benefits under PERS or the City's long-term disability insurance policy. In the event the employee does not elect to use another paid leave bank in advance of issuance of their ~~his or her~~ first paycheck following the commencement of the absence, the employee's sick leave bank will be used first. If the employee's sick leave is exhausted, the employee's ~~his or her~~ paid leave accruals will be used to make up the differential between the employee's workers' compensation benefits and the employee's regular salary after taxes until such time as the employee is eligible to receive disability benefits under PERS or the City's long-term disability plan or the employee's paid leave banks have been depleted. Employees may designate the order in which they want to use other paid leave accruals. In the event an employee fails to make such a designation in advance of issuance of their ~~his or her~~ first paycheck following the commencement of the absence, the City will use accrued ~~his or her~~ sick leave, followed by adjust time, ~~shift time~~, holiday banks, then accrued vacation.

Employees may be allowed to use other paid leave accruals, as described above, before depleting sick leave with the City's approval.

In the event the City makes supplemental wage payments to an employee for an injury or illness that is later denied as a workers' compensation claim by the City's carrier, the City will deduct the equivalent number of hours for which supplemental wage payments were made, including any payment for the three-day waiting period, if applicable, from the employee's sick leave bank. If the employee's sick leave bank is not sufficient to recoup those hours the City will deduct the remaining amount hours from the employee's paid leave accruals. Employees may designate the order in which they want to use other paid leave accruals for the overpayment, with the City reserving the right to use adjust time first, followed by ~~shift time,~~ holiday banks, then accrued vacation, if no designation is made in advance. Deductions in sick leave or other paid leave banks will be made within fourteen (14) calendar days of the City's receipt of notification of denial from the workers' compensation carrier or by the end of the next subsequent pay period. The City will not be required to pay sick leave and/or other paid leave that duplicates Temporary Total Disability (TTD) time loss benefits paid to an employee.

In the event an employee timely objects to denial of a workers' compensation claim pursuant to ORS 656.319, and the denial is reversed, the City will restore the employee's sick leave and/or other paid leave banks no later than the end of the pay period following receipt of notice of reversal.

In the unlikely event that the hours cannot be recouped from an employee's sick leave and/or other paid leave banks, the City will notify the Association of the amount of the overpayment and will bargain with the Association regarding the method of repayment of the balance of overpayment due.

Employees who must take time off from work due to on-the-job injuries and occupational illnesses are entitled to reinstatement for up to three (3) years, consistent with applicable law.

Section 8.5 Long Term Disability Insurance

The City will pay the full premium to provide salary protection for long-term disability as a result of illness or injury to full-time employees. Employees shall be eligible for long-term disability coverage ninety (90) calendar days from the date of injury of disability. Eligibility for benefits is governed by the terms of the City's long-term disability insurance policy.

Section 8.6 Modified Duty

The parties recognize that the nature of law enforcement restricts the City's ability to accommodate employees who, for medical reason, are unable to perform all of the duties of a police officer.

When an employee who is recovering from an injury or illness is certified as fit for modified duty, but not full duty, the City may assign modified duty work within the employee's medical restrictions, subject to the Department's determination that actual modified duty work suited to employee's medical limitation is available.

Generally, to be eligible for a modified duty assignment, an employee must be temporarily unable to return to their ~~his or her~~ regular duties as the result of an injury or illness and not medically stationary. Once an employee becomes medically stationary, that employee is no longer eligible to participate in modified duty assignments. The City will, however, comply with its obligation to assign modified duty work to employees who qualify as disabled due to on-the-job or off-the-job injuries or illnesses, as required under the reasonable accommodation provisions of the ADA and state disability discrimination law.

It is understood that the City may assign an employee who is on modified duty assignment to a different shift or assignment without regard to seniority, and if the employee is a sworn officer who is not expected to immediately respond to calls for service, their meal period will not be paid. The City may require a medical verification of the employee's ability to safely perform the modified duties as a condition to placing an employee in a modified duty assignment. The City shall have the right to obtain a second medical opinion at its own expense in order to verify any medical opinion it has received from the employee's healthcare provider.

In the event modified duty assignments are granted as a result of a nonwork-related injury or illness, the employee will receive their ~~his or her~~ regular rate, including incentive pay. However, employees shall not receive special assignment premium pay pursuant to Section 7.3.E if they are placed on modified duty as the result of a nonwork-related injury or illness and are not performing those duties. During the time an employee is on modified duty, sick leave, holiday pay and vacation pay will continue to accrue at the employee's regular rate. There shall be no charge to the employee's sick leave, holiday or vacation pay banks for the time spent working in a modified duty capacity.

Section 8.7 Continuation of Coverage

Employees shall continue to receive medical, dental, long term disability and life insurance benefits during the time they are on paid leave (holiday, vacation, sick leave, etc.) or during the time they are on FMLA leave, whichever is greater. Benefit coverage through the City's payment of the premiums will continue until the last day of the month in which the employee's paid leave is depleted or FMLA leave expires, whichever occurs later, except as otherwise required by law.

Section 8.8 Retirement Health Savings Account (RHS)

C. The City shall contribute two percent (2%) of an employee's base hourly rate ~~wage rates~~ into a n Retirement Health Savings (RHS)A account per pay period for employees covered by this Agreement. The "base" value paid is calculated on 80 hours per 14 day pay period for a full-time employee. Part-time employees are prorated consistent with this agreement.

ARTICLE 10 – VACATION AND HOLIDAYS

10.1 Vacation

A. Accrual of Vacation Benefits: Regular and probationary full-time employees shall accrue vacation time as noted below with bi-weekly payroll. ~~on a monthly basis. The amount of an employee's vacation accrual will be adjusted for the City's bi-weekly payroll periods.~~ Vacation pay is earned from an employee's first day of employment but cannot be used until completion of twelve (12) months of continuous employment, except at discretion of the Chief of Police or designee. Regular and probationary full-time employees shall earn vacation pay as follows:

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ARTICLE 9 – LEAVE WITH AND WITHOUT PAY

Section 9.1 Sick Leave

A. Accrual: All employees accrue sick leave as an insurance against the impact of illness or injury. Sick leave shall accrue at the rate of 96 hours per calendar year and will be accrued at the rate of 3.7 hours of sick time per pay period (96 hours divided by 26 pay periods = 3.7). Accrual shall begin upon commencement of employment and shall continue to accrue while an employee is on paid leave, including leave for which an employee is receiving workers' compensation benefits. Paid sick leave benefits do not accrue during periods an employee is on unpaid leaves of absence or long-term disability. Unused sick leave shall accumulate to a maximum of 2,520 hours. Part-time employees shall accrue sick leave on a pro-rata basis up to a maximum of 1,260 hours in accordance with Section 1.2.

B. Use of Sick Leave: ~~Employees may utilize their~~ Earned sick leave is for the following purposes:

1. When the employee is unable to perform ~~his or her~~ work duties by reason of off-the-job illness, injury or pregnancy, exposure to contagious disease under circumstances which the health of the employees with whom associated or members of the public necessarily deal with would be endangered by attendance of the employee.

2. When the employee is unable to perform ~~his or her~~ work duties by reason of on-the-job injury or illness in the amount of the differential between the employee's time loss benefits and their ~~his or her~~ regular wage.

3. For medical or dental appointments (including diagnosis, care, treatment and preventative medical care) when, due to the employee's work schedule, the employee is unable to schedule such appointments outside of work hours. In this instance, appointments will be scheduled to minimize interference with the work schedule; it is recognized that each employee has the responsibility to make every effort to schedule appointments during off-duty hours.

4. When required to provide care for an ill or injured member of the immediate family in order to make arrangements for alternative care. For the purpose of this Section, "immediate family" includes the employee's spouse, parents or children as defined in the federal Family Medical Leave Act, the employee's parents-in-law, grandparents, grandchildren and domestic partner as defined in Section 1.3, as well as the parents, children, grandparents and grandchildren of such domestic partner.
5. When an employee who is eligible for leave under the Oregon Family Leave Act (OFLA) or the Family and Medical Leave Act (FMLA) is absent for an OFLA or FMLA qualifying reason, including caring for a minor child.

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6. For any purposes covered by Oregon's domestic violence leave rules.

7. For time off due to a public health emergency such as the closure of the employee's child's school or place of care by order of a public official due to public health emergency or the closure of the City due to a public health emergency.

8. If the employee is excluded from the workplace by state or county rule or order, or by notice from their health care provider ~~by the City under any law or rule~~.

9. To donate leave, only when permitted by and consistent with Donation of Sick Leave as referenced below.

~~6.~~ 10. When otherwise required by applicable law.

C. Donation of Sick Leave: An employee may donate up to forty (40) hours of sick leave or vacation leave per calendar year ~~to a donated leave bank administered by the City~~, as long as they maintain at least 40 hours total ~~in both~~ their sick and vacation leave banks after the donation ~~on an ongoing basis~~. To be eligible to apply for donated leave, an employee must:

1. have a serious illness or medical condition or be caring for a family member with a serious illness or medical condition that requires a prolonged absence from work (anticipate to be absent from work at least two consecutive weeks beyond exhaustion of all leave banks),

2. have exhausted all sick leave and other accrued time, and

3. not be eligible for ~~disability benefits under PERS or the City's long term disability benefits prior to receipt of any donated sick leave.~~ or receiving time loss compensation from an outside insurance provider (e.g., unemployment insurance, workers' compensation insurance, disability insurance, PERS disability, social security disability, etc.

Applications for donated leave must be made to Human Resources, in writing, and must describe the serious illness or medical condition necessitating the leave. All applications for donated leave must be approved by the City in advance and require provision of medical verification, consistent with other protected leave, of the need for leave. Donated sick and/or vacation leave will be based on a one (1) hour for one (1) hour (1:1) exchange ~~two (2) hour for one (1) hour (2:1) exchange. Donated vacation leave will be based on a one (1) hour for one (1) hour (1:1) exchange~~. Donations will be made without regard to differences in the pay rate between the employee donating and the employee receiving the donation and will be paid out at the receiving employee's normal rate of pay.

All donations of paid leave benefits are voluntary and irrevocable. However, any unused leave will remain in the donor's accrual bank. Availability of donated leave is not guaranteed and availability of donated leave does not guarantee that extended leaves of absence will be approved. Eligible employees are only eligible to receive leave donations

up to the amount of time off that the City has approved, that the healthcare provider has certified that they are unable to work as a result of their own or family member's qualifying illness or medical condition, or until the employee becomes eligible to receive long-term disability, social security disability, or PERS disability benefits, whichever time period is the shortest.

Employees do not accrue sick leave, vacation pay or other benefits during the time they are on donated leave. Donated time cannot be used to extend the employment of an employee who will not be returning to work.

D. Substantiation: For extended absences from a sick leave exceeding three (3) consecutive days due to the employee's own illness or injury, a release from the employee's healthcare provider is required to ensure the employee can safely return to work. The City may require an employee to submit verification of eligibility for sick leave from an employee's doctor or healthcare professional whenever ~~the employee's sick leave usage exceeds three (3) consecutive workdays or whenever~~ the City can articulate a good faith concern (e.g., questionable patterns of absence, suspicious explanations, etc.), regarding the employee's eligibility to receive sick leave. Receipt of verification may be required as a condition of payment. In the event verification is required, out-of-pocket cost billed by the doctor or healthcare professional to obtain the necessary verification shall be paid by the City to the extent such costs are not covered by insurance. Verification may be required for absences due to illnesses and injuries of the employee or to substantiate that the employee's attendance is needed to care for an ill or injured family member or otherwise when the City determines necessary to ensure compliance with applicable laws regarding time off from work, consistent with applicable law.

E. Reporting Absence: Any employee who is ill and unable to report to work shall notify the on-duty supervisor or, in the event the on-duty supervisor cannot be reached, their ~~his or her~~ immediate supervisor at least one (1) hour prior to the employee's reporting time. In case of a continuing illness or injury, the employee shall keep their ~~his or her~~ immediate supervisor advised of their ~~his or her~~ inability to report to work on a daily basis. However daily notice will not be required in situations where the employee has submitted written verification from their ~~his or her~~ doctor or health care professional of the ~~his or her~~ need to be absent from work for a definite period or as otherwise approved by their ~~his or her~~ supervisor.

F. Payment of Sick Leave Benefits: Sick leave benefits are paid out at the employee's regular hourly rate of pay for the hours the employee would otherwise be scheduled to work the day the benefits are used. Employees are not permitted to use or be paid for sick leave benefits that have not yet been earned. Note: Employees are required to use any earned and unused paid sick leave benefits for all absences covered by this policy before using other accrued leave benefits or taking time off without pay, except when otherwise prohibited law.

G. Sick Leave on Retirement: For PERS Tier I and II employees, upon retirement ~~of an employee,~~ as permitted by applicable law, fifty percent (50%) of an employee's unused sick leave shall be credited to retirement. Employees who are in the OPSRP retirement program shall be paid upon retirement an amount equal to fifty percent (50%) of their unused sick leave.

H. Upon the death of a regular status or retired/rehired limited duration employee, up to fifty percent (50%) of their unused sick leave accrual is paid to the beneficiary listed on the employee's life insurance policy carried by the City.

Section 9.2 Family ~~and~~ Medical Leave, Parental or Pregnancy Leave (~~FMLA~~)

The City will comply with the Family and Medical Leave Act (FMLA) and Oregon Family Leave Act (OFLA). Generally these laws provide leave for the employee's own serious health condition, for the serious health condition of specified family members, for parental leave purposes, for pregnancy leave purposes, to care for a child who needs home care but does not have a serious health condition or requires home care due to the closure of school or childcare as a result of a public health emergency, and leave to deal with the death of a family member under OFLA.

Leave is also to provide care to an immediate family member or next of kin (applicable as defined by FMLA and a OFLA) who is recovering from serious injury or illness incurred in the performance of military service or for absences due to "qualifying exigencies" arising out of the fact that an immediate family member has been called or notified of a call to active military duty. Eligible employees may also take leave to care for a military member's parent who is incapable of self-care when the care is necessitated by the member's covered activity duty. Such care may include arranging for alternative care, providing care on an immediate need basis, admitting or transferring the parent to a care facility, or attending meetings with staff at a care facility.

The employee may be required to have a ~~his or her~~ healthcare provider complete a medical certification form to substantiate eligibility for FMLA and OFLA Leave and as necessary to obtain a second and/or third opinion. Should the employee be required to provide a certification or to obtain a second or third certification for family leave purposes, the employer shall bear the cost of such certifications. ~~Employees may be required to provide a fitness for duty certification before returning from family leave, except in the case of childbirth or adoption, and only if the employee has taken leave for a serious health condition or if the City believes the employee is not fit or may be unable to perform duties as assigned.~~ A Return-To-Work Release Form completed by a healthcare provider is required upon return to work when the leave is for the employee. It is not applicable when the leave is to care for a family member.

~~When sick leave is used for FMLA/OFLA qualifying purposes, the leave will be counted against the employee's FMLA and/or OFLA entitlement, as permitted by applicable law.~~ An employee may be entitled to more than one type of leave for the same absence. If so, the leaves will run concurrently unless prohibited by law. It is important to note that neither FMLA nor OFLA leave is paid leave. In simplest terms, they are federal and state acts that protect the employee's right to take leave and have a job when they return.

While out on such leave, an employee shall utilize any accrued sick leave they are ~~he or she is~~ eligible to receive under Section 9.1.B above until such time as the employee is eligible to receive disability benefits under PERS or the City's long-term disability insurance policy. Employees who are absent from work for FMLA or OFLA qualifying reasons, but who are not eligible to receive sick leave benefits or have depleted sick leave benefits may designate the order in which they want to use other paid leave accruals. In the event an employee fails to make such a designation in advance of issuance of their ~~his or her~~ first paycheck following the commencement of the absence, the City will make the designation, using accrued vacation as the last choice. After using all paid time, the employee may take leave without pay for the remainder of the family leave year designated by the City. Except as provided by law, family leave shall not exceed twelve (12) weeks within the family leave year specified by the City. In addition to the 12 weeks of family leave, an eligible employee may take an additional 12 weeks for an illness, injury or condition related to the employee's own pregnancy or childbirth as well as 12 weeks for the purpose of sick child leave if applicable.

Section 9.3 Other Leaves

A. Jury Service and Appearances: Employees may be granted leave with or without pay as follows:

1. Service with Jury: Employees may be granted leave with pay to appear for jury service. Employees who are excused from jury service before the end of their regularly scheduled work shift shall immediately report their availability for assignment to their supervisor.

   Pay for jury service shall be limited to the pay an employee would receive for their ~~his or her~~ regularly scheduled work shift. Employees are not entitled to overtime pay for jury service. All monies received for jury service will be surrendered to the City.

   Employees who are scheduled to work a regular work schedule that does not fall within the same hours of their jury service may be allowed to use administrative leave to take a portion of their regular work schedule off prior to their jury service, after their jury service, or both, to allow for at least eight (8) hours of rest prior to their jury service, after their jury service, or both, with written approval of their supervisor.

2. Appearances on Non-City Related Business: Employees who appear on non-City related business before a court, legislative committee or administrative agency as a party or a witness in response to a subpoena or other order by proper authority may be granted leave without pay or the employee may choose to use any accrued leave, except sick leave.

3. PECBA Related Appearances: Employees subpoenaed or compelled to appear for PECBA related proceedings, including interest and grievance arbitrations, shall be paid for their time testifying, as well as their travel time to and from the Department to the hearing. The City and the Association agree that all reasonable steps will be taken to

subpoena witnesses in PECBA proceedings to testify during their regular work schedule and to limit the time employees are called to testify to periods when their testimony is expected to occur. Employees who are subpoenaed or compelled to appear for PECBA procedures are not entitled to minimum call back pay for their appearances. The City may also adjust the work schedules of employees who are scheduled to appear in PECBA related proceedings with seven (7) days written notice in order to avoid overtime.

B. Personal Unpaid Leave: Employees may be granted leave of absence without pay when the work of the Department will not, in the view of the City, be unduly burdened ~~handicapped~~ by this absence. Requests for such leaves must be in writing and must establish justification for the approval by the Chief of Police or City Manager. Leaves of absence up to two (2) weeks without pay may be granted by the Chief of Police. Leaves of absences for longer than two (2) weeks must be approved by the City Manager.

C. Military and Peace Corps Leave: Military and Peace Corps leave shall be granted in accordance with applicable law.

D. Bereavement Leave: Following a death in the employee's immediate family, the employee is entitled to a maximum of three (3) days bereavement leave with pay, plus two (2) additional days available chargeable to any accrued leave at the discretion of the Chief of Police. For the purpose of this Subsection, immediate family includes: mother, father, son, daughter, siblings, husband, wife, mother-in-law, father-in-law, sister-in-law, brother-in-law, grandchild and grandparent. It also includes domestic partners, as defined in Section 1.3, as well as the mother, father, son, daughter, siblings, grandparents and grandchildren of such domestic partners. Employees may utilize sick leave for additional time off in accordance with OFLA. Use of bereavement leave is concurrent and consistent with OFLA rules.

E. Domestic Violence Leave and Accommodation: Victims of domestic violence, sexual assault, harassment or stalking and the parents of a minor child or dependent victim are eligible for reasonable unpaid leaves of absence to seek legal or law enforcement assistance or remedies, medical treatment, counseling, to obtain services from a prosecutor or non-profit victim services provider and to relocate or take steps to secure their home.

F. Other Crime Victim Leave: Unpaid leave provided to attend criminal proceedings if the employee or immediate family member has suffered financial, social, psychological or physical harm as a result of being a victim of certain felonies such as kidnapping, rape, arson and assault.

G. Extended Medical Leave: Additional leave without pay may be offered as a reasonable accommodation to an employee who is also a qualified individual with a disability, unless it would be an undue hardship on the City in accordance with the ADA and state law. The City may impose conditions or restrictions as permitted by Oregon or federal law.

Section 9.4 General Rules

A. Failure to Return from Leave: Any employee who has been granted a leave of absence and who, for any reason, fails to return to work at the expiration of said leave of absence shall be considered as having resigned employment with the City and the position shall be declared vacated, except and unless the employee, prior to the expiration of the employee's leave of absence or as allowed by family leave laws, has furnished evidence that the employee is unable to return to work by reason of sickness, physical disability or other legitimate reasons beyond the control of the employee.

B. Absence Without Leave: Except as allowed by family leave laws with respect to unanticipated need for family leave, an absence of an employee from duty, including any absence for a single day or part of a day, that is not authorized or taken pursuant to a leave of absence, shall be deemed to be an unauthorized absence. An employee who has an unanticipated need for family leave must comply with the notice requirements under to disciplinary action.

C. Paid Leave Oregon (PLO): Upon an accepted claim under PLO, and employee may elect to use available sick leave, then if exhausted, other accrued paid leave banks to make up the difference between PLO benefits paid by the carrier and their regular net salary (after taxes) through the duration of the accepted PLO leave.

Bargaining note: City will follow provisions of "Paid Leave Oregon" as administered by the State.

It is understood that the City may assign an employee who is on modified duty assignment to a different shift or assignment without regard to seniority, and if the employee is a sworn officer who is not expected to immediately respond to calls for service, their meal period will not be paid. The City may require a medical verification of the employee's ability to safely perform the modified duties as a condition to placing an employee in a modified duty assignment. The City shall have the right to obtain a second medical opinion at its own expense in order to verify any medical opinion it has received from the employee's healthcare provider.

In the event modified duty assignments are granted as a result of a nonwork-related injury or illness, the employee will receive their ~~his or her~~ regular rate, including incentive pay. However, employees shall not receive special assignment premium pay pursuant to Section 7.3.E if they are placed on modified duty as the result of a nonwork-related injury or illness and are not performing those duties. During the time an employee is on modified duty, sick leave, holiday pay and vacation pay will continue to accrue at the employee's regular rate. There shall be no charge to the employee's sick leave, holiday or vacation pay banks for the time spent working in a modified duty capacity.

Section 8.7 Continuation of Coverage

Employees shall continue to receive medical, dental, long term disability and life insurance benefits during the time they are on paid leave (holiday, vacation, sick leave, etc.) or during the time they are on FMLA leave, whichever is greater. Benefit coverage through the City's payment of the premiums will continue until the last day of the month in which the employee's paid leave is depleted or FMLA leave expires, whichever occurs later, except as otherwise required by law.

Section 8.8 Retirement Health Savings Account (RHS)

C. The City shall contribute two percent (2%) of an employee's base hourly rate ~~wage rates~~ into a ~~n~~ Retirement Health Savings (RHS) ~~A~~ account per pay period for employees covered by this Agreement. The "base" value paid is calculated on 80 hours per 14 day pay period for a full-time employee. Part-time employees are prorated consistent with this agreement.

ARTICLE 10 – VACATION AND HOLIDAYS

10.1 Vacation

A. Accrual of Vacation Benefits: Regular and probationary full-time employees shall accrue vacation time as noted below with bi-weekly payroll. ~~on a monthly basis. The amount of an employee's vacation accrual will be adjusted for the City's bi-weekly payroll periods.~~ Vacation pay is earned from an employee's first day of employment but cannot be used until completion of twelve (12) months of continuous employment, except at discretion of the Chief of Police or designee. Regular and probationary full-time employees shall earn vacation pay as follows:

1. From one (1) through two (2) years of employment at a rate of six point seven (6.7) hours per month of employment and will be reflected on the employee's bi-weekly pay stub as 3.10 hours.

2. Commencing with the third (3rd) year of employment at a rate of eight (8) hours per month of employment and will be reflected on the employee's bi-weekly pay stub as 3.70 hours.

3. Commencing with the fifth (5th) year of employment at a rate of ten (10) hours per month of employment and will be reflected on the employee's bi-weekly pay stub as 4.62 hours.

4. Commencing with the tenth (10th) year of employment at a rate of twelve (12) hours per month of employment and will be reflected on the employee's bi-weekly pay stub as 5.54 hours.

5. Commencing with the fifteenth (15th) year of employment at a rate of sixteen point seven (16.7) hours per month of employment and will be reflected on the employee's bi-weekly pay stub as 7.70 hours.

Effective the pay period that begins July 3rd, vacation accruals will change as follows:

Commencing with the date of employment at a rate of 4.62 hours per pay period.

Commencing with 49 months of employment at a rate of 5.54 hours per pay period.

Commencing with 109 months of employment at a rate of 6.15 hours per pay period.

After the 168th month of employment, at a rate of 7.7 hours per pay period.

(bargaining note: pay periods are every 14 days)

B. Accrual for Regular and Probationary Part-Time Employees: "Regular part-time" employees shall accrue vacation in accordance with Section 1.2.

C. Eligibility for Continued Accrual: Regular and probationary full-time and part-time employees will continue to accrue vacation pay, as long as they are actively employed or on paid leave.

D. Maximum Accrual: An employee may accrue a maximum of 400 hours of vacation time. Any excess hours over 400 will be forfeited without compensation.

E. Effect of Separation: Upon separation of employment, vacation accruals up to the maximum will be included in the employee's final pay. ~~Any vacation owed to a terminating employee shall be added to the employee's final pay.~~

F. Pay in Lieu of Vacation: An employee, subject to availability of budgeted funds and approval from the Chief of Police, may elect to be paid 40 hours of vacation pay in lieu of taking 40 hours of vacation time off, if such pay is taken concurrently with 40 hours of vacation time off.

G. Vacation Selection: Employees shall be permitted to request vacation time off either on a split or an entire basis. Employees shall have the right to determine the vacation time, subject to scheduling required for public service. The Chief of Police or designee shall make the determination of whether an employee's request for vacation time off will be granted based upon the needs of an efficient operation, the availability of vacation relief and the City's right to arrange the schedule so that each employee who is eligible has an opportunity to take vacation time off.

Vacation time shall be selected on the basis of bargaining unit seniority within the employee's work unit provided, however, that employees will be permitted to exercise their right of seniority only once annually for a one (1) block of time period (i.e. member may select one consecutive period, one time), not to exceed four (4) consecutive calendar weeks, unless otherwise approved by the Chief of Police. Thereafter, conflicting requests for the same vacation time shall be resolved on the basis of prior scheduling. Each employee must make a good faith effort to schedule at least one (1) block of time, at least one (1) week off, during each year.

One (1) officer per patrol team will be allowed to be on vacation at any one time, unless more are approved by the Chief of Police or designee. This limitation shall not apply if an officer with previously approved vacation is reassigned to a different patrol team provided, however, that vacation may be disapproved or canceled in the event of a staff reduction or an unforeseen emergency.

H. Concurrent Leaves: If the leave is for a qualified state or federal family leave purpose, all leaves of absence, no matter how classified, shall be counted against the employee's family leave entitlement. In such a case, upon request, the employee shall provide health care provider certifications, including second and third opinions and fitness for duty certifications, as provided by family leave laws.

Section 10.2 Floating Holidays

A. Affected Members. All sworn members, except those ~~assigned as School Resource Officers or~~ attending DPSST Academy BP Class and those ~~assigned to regular business hours~~ working a 5/8 schedule (as defined in Section 5.1.B.3 ~~5.10~~) shall accrue floating holidays. *bargaining note: from MOU*

B. Floating Holiday Accrual Rates. Members accruing floating holidays shall be entitled to accrue thirteen (13) ~~twelve (12)~~ floating holidays per year, accrued at the following rates, based on their work schedules:

1. A member assigned to a twelve (12) hour work schedule will accrue ~~twelve (12) hours of floating holiday time off per month (5.54~~ 6.00 hours per pay period.

2. A member assigned to a ten (10) hour work schedule will accrue ~~ten (10) hours of floating holiday time off per month (4.62~~ 5.00 hours per pay period.

3. A member assigned to an affected eight (8) hour work schedule will accrue ~~eight (8) hours of floating holiday time off per month (3.70~~ 4.00 hours per pay period.

(bargaining note: update from MOU)

C. Floating Holiday Time Off

1. Scheduling, Generally. Scheduling floating holiday time off is a member's responsibility. Floating holiday time off may be requested up to ninety (90) days in advance, and will be granted on a first come, first served basis.

   Members will schedule floating holidays in good faith based on days available and must receive their supervisor's approval. Supervisory approval can be withheld only to meet operational and staffing needs. Floating holiday time off not taken in accordance with this Section will be lost, unless it is not taken or is cancelled by the Department for operational reasons, in which case it will be paid. Members may not accrue more than twenty-four (24) hours of floating holiday time.

2. Scheduling 4/10 Work Schedule. Except for police officers assigned to a patrol unit, members working a 4/10 schedule shall recognize and take off each holiday recognized in Section 10.3.A, unless they request and receive their supervisor's approval to work on a recognized holiday.

Section 10.3 Holidays for Members Not Accruing Floating Holidays

A. The following days shall be recognized and taken off as ~~guaranteed~~ paid holidays. On these holidays, the business office will be closed.

1. New Year's Day
2. Martin L. King Day
3. President's Day
4. Memorial Day
5. Juneteenth
6. Independence Day
6. Labor Day
7. Veteran's Day
8. Thanksgiving Day
9. Day after Thanksgiving
10. Christmas Day

(bargaining note: Juneteenth from prior MOU)

For the purposes of Section 10.3, a day is equal to your regular shift schedule during the period of the holiday.

B. Personal Leave: The purpose of personal leave is to give additional time off as noted below ~~two (2) additional days off~~ to members who work regular business hours and who do not accrue floating holidays. This matches them day-for-day with other members who accrue the equivalent of thirteen (13) day off per year as described in Section 10.2. ~~one holiday off per month.~~ For a new hire, the personal leave is prorated for the first calendar year of employment. Accrued personal leave is use it or lose it each calendar year and is not subject to compensation upon separation of employment.

Members who work regular business hours and who do not accrue floating holidays shall receive 16 hours of personal leave per fiscal year. Nonsworn members who work regular business hours and who do not accrue floating holidays shall receive twenty-four (24) hours of personal leave per fiscal year. At the completion of 15 years of service with the Keizer Police Department, nonsworn members who work regular business hours and who do not accrue floating holidays shall receive thirty-two (32) hours of personal leave per fiscal year. Personal leave will be granted on July 1 of each fiscal year and must be utilized by June 30 of the same fiscal year. Employees are to request time off with their supervisor in advance.

Time off will be granted on the following basis: for each unit of time off requested, an equal amount of time must be given (for example: for one-hour off, one-hour advance notice must be given, for two-hours off, two-hours advance notice must be given, etc.).

Personal leave may not be carried over to the following fiscal year or credited to another type of leave. Personal leave days are not considered to be vested compensation and are not paid at separation.

C. Weekend Holiday: For members working regular business hours and who do not accrue floating holidays, whenever a holiday falls on Saturday, the preceding Friday shall be considered to be the holiday. Whenever a holiday falls on Sunday, the following Monday shall be considered to be the holiday.

Section 10.4 Effect of Holidays During Time Taken Off

For employees working regular business hours who do not accrue floating holiday hours, whenever a holiday falls during paid leave (e.g., vacation or sick leave), the holiday shall be observed, and no charge shall be made against the employees' paid leave account(s) for that day.

Section 10.5 Holiday Pay

For employees not accruing floating holidays, work performed on any holidays recognized in Section 10.3 shall be paid at overtime rates, in addition to holiday pay in accordance with Section 5.5.D.4. For purposes of holiday compensation, an employee whose shift begins on the holiday shall receive holiday pay for the full regular shift.

Sworn employees whose regularly scheduled shift begins on Thanksgiving Day and/or Christmas day (i.e. shifts beginning between midnight and 2359) will be compensated at time and one half (1.5) for all hours worked on that regularly scheduled workday.

ARTICLE 16 – SAVINGS CLAUSE

Section 16.1 Savings Clause

Should any Article, Section or provision of this Agreement be held unlawful and unenforceable by final order of any court of competent jurisdiction or administrative agency having jurisdiction over the subject matter, or by legislation of the State of Oregon, or federal government, or issuance of a final regulation by an administrative agency, such decision, legislation or regulation shall apply only to the specific Article, Section or portion of the Agreement directly affected. Upon issuance of any such decision, legislation or administrative regulation, the parties agree immediately to negotiate a substitute, if possible, for the invalidated Article, Section or portion of the Agreement, in accordance with PECBA. All other portions of this Agreement, and the Agreement as a whole, shall continue in effect. Nothing in this Article constitutes a waiver of the right of either party to assert that the Article, Section or provision in question is not unlawful or unenforceable.

3 pm

ARTICLE 11 – PROBATION

Section 11.1 Probation

All new hires and rehires shall serve a probationary period. The probationary period for sworn personnel may be any time period up to eighteen (18) months and may be extended up to 6 months after passing the FTEP program, ~~to a maximum of twenty-four (24) months~~, if mutually agreed to by the Chief of Police and the Association. For a lateral sworn hire who is Oregon DPPST certified at the time of hire, the probationary period will be 12 months. For a lateral sworn hire who is not Oregon DPSST certified, the probationary period will be 18 months.

Non-sworn personnel shall serve a probationary period of up to twelve (12) months and may be extended to a maximum of eighteen (18) months, if mutually agreed to by the Chief of Police and the Association.

The probationary period shall be a part of the training and evaluation process and shall be used to evaluate the skills and abilities of the newly hired or rehired employee to be assigned to regular employee status. Probationary employees serve at the will of the City and may be disciplined, suspended or discharged without cause and without appeal through the grievance and arbitration procedures set forth in Article 15 of this Agreement.

Any current employee with the City who is accepting to the position of sworn police officer will serve a new 18 month probationary period, and may be subject to termination without grievance or just cause, regardless of any prior initial probationary period with another City position. In the event such employee does not successfully complete their probationary period, the City is not precluded from offering an employee their previous position with the City.

TS 803
2/16/23

ARTICLE 12 – SENIORITY

4-28-23

Section 12.1 Seniority

A. Seniority Defined: Bargaining unit seniority is determined by the length of an employee's continuous service with the Department in the bargaining unit from last date of hire. Classification seniority is determined by the length of an employee's service in the employee's current classification, as described by Section 12.5, below and is used for the purpose of patrol schedule rotation and vacation bidding in accordance with Articles 5 and 10.

B. Seniority List: The City will make electronic copies of bargaining unit and classification seniority lists available to the Association and employees upon request.

Section 12.2 Layoff and Recall

A. Layoff: The City may lay off an employee when the City determines it necessary to eliminate a position or that a shortage of funds or work exists. Layoff shall be by specific job classification as listed in Appendix A. Probationary employees in the classification(s) affected by layoff will be laid off first. In the event the City determines that it is necessary to layoff regular employees, employees in the classification(s) affected shall be ~~in~~-laid off in ascending order (bottom to top) based on bargaining unit seniority.

An employee shall be given written notice at least fifteen (15) days before the effective date stating the reasons for the layoff.

B. Recall: Employees shall be recalled from layoff to the classification held at the time of layoff in inverse order of layoff according to their bargaining unit seniority. No new employees shall be hired in one of the classifications until all employees in that classification on layoff status desiring to return to work have been recalled or have otherwise suffered a break in seniority, as set forth in Section 12.3 below.

C. Layoff List: Layoff status shall be maintained for a two (2) year period. It shall be the obligation of the employee to maintain a current address with the City during this period.

D. Bumping: An employee scheduled to be laid off may utilize their ~~his or her~~ bargaining unit seniority to bump the employee with the lowest bargaining unit seniority in a lower classification, if the employee is presently qualified and certified to perform, immediately, all of the duties and responsibilities of the different classification. Employees who wish to exercise bumping rights must notify the City in writing within ten (10) calendar days of receipt of layoff notice.

TA 503
4/20/23

Section 12.3 Continuity of Service

Service requirements for advancement within salary range, extended steps, holidays and vacation shall be based upon continuous and total service as a regular employee.

A. Employees will continue to accrue seniority. Seniority will be broken and the employment relationship will be severed if any of the following events occur:

1. Voluntary resignation or retirement.

2. Discharge of a regular employee for just cause or separation of a probationary employee at will.

3. Layoff or absence from work due to off-the-job illness or off-the-job injury for more than twenty-four (24) months' duration.

4. Failure to notify the City of intent to return to work pursuant to a recall notice sent by certified mail, return receipt requested, to the last address provided to the City through personnel records within ten (10) business days of delivery.

5. Failure to report for work immediately upon expiration of an authorized leave of absence or, in the case of an absence due to off- or on-the-job injury or illness, failure to report for available work within seven days of receipt of notice of a limited or a full medical release to return to work.

6. Absence from work due to an on the-job-injury or on-the-job illness in accordance with ORS Chapter 659A.

7. Failure to return from military leave, in accordance with applicable law.

8. Separation of employment due to medical disability or inability to meet the essential qualifications of the position.

4-28-23

Section 12.4 Retention of Seniority for Promotions

Employees who are promoted to positions within the Department that are outside the bargaining unit, but are returned to bargaining unit positions by the City will return with the seniority they had accrued at the time of their promotion restored. The time an employee spends in such a position will not, however, be applied toward his or her seniority. Instead, the employee's bargaining unit and classification seniority date will be adjusted by an amount equal to the time he or she served in the non-bargaining unit position.

Section 12.5 Retention of Classification Seniority upon Reemployment

In the event an employee voluntarily resigns from employment with the City but is rehired within one (1) year from the date of the resignation, the classification seniority the employee had on the date of resignation will be restored.

to KPA 1/1:20

City What If Package Proposal

5-25-23
Version 2

This 'what-if' offer is intended to resolve the following proposals: Article 13, 14, 15, Appendix B, C, and D. This is not to be considered a formal proposal, nor subject to future reference for the purposes of bargaining as related to PECBA bargaining. This offer is valid through the next scheduled session June 8, 2023.

ARTICLE 13 – COMPLAINTS, INVESTIGATIONS AND DISCIPLINE

Section 13.1 Complaints, Investigations and Discipline

All discipline and termination actions shall be only for just cause using the principles of progressive discipline and adhering to the procedure set forth in Appendix B and Appendix C. The definition and application of just cause for sworn law enforcement officers is subject to applicable law, ~~including ORS 243.808 and 243.812, and the rules set forth by the Law Enforcement Standards Commission.~~ *(bargaining note: City withdraws reference to ORS)*

Additional conditions and procedures are found in Appendices B and C of this agreement which shall not be changed without bargaining subject to PECBA obligations. Any dispute shall be resolved by the procedure set forth under PECBA.

ARTICLE 14 – PERSONNEL RECORDS

Section 14.1 Personnel Record

The City shall maintain a personnel record of each employee in the City service. This record shall be the official record of the City and shall contain copies of all official reports, memos, letters, personnel actions, Guardian Tracking, etc., relating to the employee's performance and employment status.

Section 14.2 Inspection of Record

An employee may inspect the contents of the employee's personnel record, except for confidential reports from previous employers and background investigations, upon the employee's oral request to do so. An employee's official representative, with the permission of the employee, may inspect all records pertaining to the employee except confidential reports from previous employers. Should the employee's personnel record contain a psychological or psychiatric report which could be harmful for the employee to review, the City may elect to disclose the report to the employee's physician of choice.

Section 14.3 Critical Entries

5-25-23

TA 8:05
5/25/23

No disciplinary action, evaluation document, or complaint will be placed into an employee's personnel file without a copy being provided to the employee. Documentation of written reprimands, suspensions, demotions, and termination shall be maintained in the member's personnel file. *(bargaining note: concept from Appendix B : 810.15b)* The employee will be asked to acknowledge receipt by signing a copy of the document. Such a signature is not to be construed as indicating agreement with the contents thereof.

Documentation of negative performance shall be discussed with the employee and a copy of any entry will be provided to the employee prior to the submission into the Guardian Tracking system. *(bargaining note: City will update policy as already provided on 4-28-23)*

Section 14.4 Rebuttal Material

If an employee believes that there is material in the personnel record which is incorrect or derogatory, the employee shall be entitled to prepare in writing an explanation or opinion regarding the particular material, and this shall be included as a part of the personnel record. If the employee believes that such specific information should be removed entirely from the files, the employee may petition for such consideration to the City.

Section 14.5 Entries Dated

Each entry into the employee's personnel file shall be dated.

Section 14.6 Removal

An employee may request the removal of disciplinary documents from the employee's personnel file as follows: If the disciplinary document the employee is seeking to remove ~~is a verbal or~~ a written reprimand, the employee may request removal after eighteen (18) months from the issuance of the discipline, if the employee has not engaged in the same or similar conduct during that period. If the disciplinary document the employee is seeking to remove is a suspension or other economic sanction, the employee may request removal after three (3) years from the date of issuance of the discipline, if the employee has not engaged in the same or similar conduct during that period. In the event materials are required to be kept for a longer period under the Oregon Administrative Rules, the materials shall be removed and kept in a sealed file. Any such request shall be made to the Chief of Police in writing and, if denied, the decision may be appealed to the City Manager in writing. Requests for removal will not be unreasonably denied. *(bargaining note: documented verbal actions will not be placed in the personnel file. City uses Guardian)*

Documents removed from an employee's personnel file will not be used against an employee for the purpose of establishing progressive discipline but may be used in any arbitration and civil proceeding for the purpose of establishing consistency of disciplinary action, lack of discrimination, notice of rule, compliance with legal obligations and to defend against legal actions.

Personnel records for sworn employees will be retained consistent with applicable law. *(bargaining note: New law up to 10 years post-employment)*

ARTICLE 15 – GRIEVANCE PROCEDURE

Section 15.1 Grievance Procedure

Grievance, for the purpose of this Agreement, is defined as a dispute regarding the meaning or interpretation of a particular clause of this Agreement or regarding an alleged violation of this Agreement. Such grievance shall be settled in the following manner:

Step One: Should an employee believe that an employee's rights under this Agreement have been violated, within twenty-one (21) calendar days of the date of such grievance or knowledge thereof, the employee shall report the matter in writing to the employee's immediate supervisor. The written grievance shall be on a form approved by the City and Association and shall include:

1. A statement of the grievance and relevant facts,
2. Provision of the Agreement violated, and
3. Remedy sought.

Within twenty-one (21) calendar days after receipt of such report, the immediate supervisor shall attempt to resolve the matter and submit an answer in writing to the employee.

Step Two: If the grievance still remains unsettled, within twenty-one (21) calendar days after the reply of the immediate supervisor is received or the date that such reply is due, the Association or a nonmember of the Association grieving discipline may submit the grievance in writing to the Police Chief. The Chief shall respond in writing to the employee within twenty-one (21) calendar days

Step Three: If the grievance still remains unresolved, within twenty-one (21) calendar days, the Association or a nonmember of the Association grieving discipline may submit the matter in writing to the City Manager. The City Manager shall respond in writing to the employee within twenty-one (21) calendar days.

Step Four: If the grievance still remains unsettled, within twenty-one (21) days after the reply of the City Manager is due, the Association may serve written notice to the City Manager of the Association's intention to arbitrate the grievance.

After the grievance has been so submitted, the Association or a nonmember of the Association grieving discipline may request from the Oregon Employment Relations Board a list of seven (7) Oregon and Washington arbitrators. For grievances contesting disciplinary actions imposed upon a sworn law enforcement officer, the parties will follow applicable law relating to the selection of an arbitrator. *(bargaining note: City agrees to Union language from 3/15/23)* For other grievances, the parties shall select an arbitrator from the list by alternatively striking a name, with the first strike being determined by lot. The final name left on the list shall be the arbitrator. The arbitrator's decision shall be final and binding, but the arbitrator shall have no power to alter, modify, add to or detract from the terms of the contract. The arbitrator's decision shall be within the scope and terms of the contract and applicable law and in writing including detailed findings and conclusions, together with an explanation of the reasoning utilized in making the decision. The arbitrator shall be asked to submit the decision within thirty (30) days of the date of the hearing.

Section 15.2 Cost of Arbitrator

Each party, whether the Association on behalf of a member or an individual nonmember who is challenging a disciplinary decision shall be responsible for paying the costs of presenting its own case in arbitration, including the payment of witness fees, if any. The cost for the arbitrator, court reporter (if any), and the hearing room shall be borne by the losing party. The arbitrator shall designate the "losing party." The arbitrator's designation of the "losing party" shall be final and binding. The cost of a court reporter is contingent on both parties having agreed to utilize the services of a court reporter.

Section 15.3 Time Limits

Any or all time limits specified in the grievance procedure may be waived by mutual written consent of the parties. Failure to submit the grievance in accordance with these time limits without such waiver shall constitute abandonment of the grievance. Failure by the City to respond within the time limit shall permit the grievance to proceed to the next step. The grievance may be terminated at any time upon receipt of a signed statement from the employee that the matter has been resolved through Step Three of the Grievance Procedure.

Time off will be granted on the following basis: for each unit of time off requested, an equal amount of time must be given (for example: for one-hour off, one-hour advance notice must be given, for two-hours off, two-hours advance notice must be given, etc.).

Personal leave may not be carried over to the following fiscal year or credited to another type of leave. Personal leave days are not considered to be vested compensation and are not paid at separation.

C. Weekend Holiday: For members working regular business hours and who do not accrue floating holidays, whenever a holiday falls on Saturday, the preceding Friday shall be considered to be the holiday. Whenever a holiday falls on Sunday, the following Monday shall be considered to be the holiday.

Section 10.4 Effect of Holidays During Time Taken Off

For employees working regular business hours who do not accrue floating holiday hours, whenever a holiday falls during paid leave (e.g., vacation or sick leave), the holiday shall be observed, and no charge shall be made against the employees' paid leave account(s) for that day.

Section 10.5 Holiday Pay

For employees not accruing floating holidays, work performed on any holidays recognized in Section 10.3 shall be paid at overtime rates, in addition to holiday pay in accordance with Section 5.5.D.4. For purposes of holiday compensation, an employee whose shift begins on the holiday shall receive holiday pay for the full regular shift.

Sworn employees whose regularly scheduled shift begins on Thanksgiving Day and/or Christmas day (i.e. shifts beginning between midnight and 2359) will be compensated at time and one half (1.5) for all hours worked on that regularly scheduled workday.

ARTICLE 16 – SAVINGS CLAUSE

Section 16.1 Savings Clause

Should any Article, Section or provision of this Agreement be held unlawful and unenforceable by final order of any court of competent jurisdiction or administrative agency having jurisdiction over the subject matter, or by legislation of the State of Oregon, or federal government, or issuance of a final regulation by an administrative agency, such decision, legislation or regulation shall apply only to the specific Article, Section or portion of the Agreement directly affected. Upon issuance of any such decision, legislation or administrative regulation, the parties agree immediately to negotiate a substitute, if possible, for the invalidated Article, Section or portion of the Agreement, in accordance with PECBA. All other portions of this Agreement, and the Agreement as a whole, shall continue in effect. Nothing in this Article constitutes a waiver of the right of either party to assert that the Article, Section or provision in question is not unlawful or unenforceable.

ARTICLE 17 – TERM OF AGREEMENT

Section 17.1 Term of Agreement

Any specified Article or Articles of this Agreement may be opened for negotiation by mutual written consent of both parties at any time during the life of the Agreement.

Except as set forth in Section 17.2 below, this Agreement commences on effective July 1, 2023 or in the next pay period following execution of this agreement, the later of either ~~July 1, 2021~~, and terminates on June 30, 2026 ~~June 30, 2023~~. The parties will commence negotiations for a successor Agreement on or about January of the expiring year, ~~2023~~. This Agreement will remain in full force and effect during the period of negotiations. *(bargaining note: City seeks a 3 year term)*

Section 17.2 Insurance Re-opener

In the event the insurance and insurance benefits provided under this Agreement trigger the excise ("Cadillac") tax under the Affordable Care Act, the parties agree to automatically reopen Sections 7.1 and 8.1 of this Agreement.

Appendix A

(to be revised consistent with Article 7)
Add note: Employees are paid hourly.
Bi-weekly and Annual values are for references purposes.

APPENDIX B – PERSONNEL COMPLAINTS AND INVESTIGATIONS

~~Version 100716 — Also appears in Policies and Procedures Manual as PPM 810~~

810.1 POLICY

It is the policy of the Keizer Police Department that personnel complaints and investigations will be fair, impartial, and thorough in order to provide accountability to the public, discover improper conduct or performance, protect members from false accusations, assess training needs, facilitate re-evaluation, and/or to promote the formation or reformation of policies and procedures.

810.2 PURPOSE

The purpose of this policy is to explain how and why personnel complaints and investigations are investigated, recorded, disposed, and retained. The term "member" refers to employees of the bargaining unit.

810.3 SUBJECT TO BARGAINING

This policy is subject to the Collective Bargaining Agreement between the City of Keizer and Keizer Police Association for those matters as required by Public Employees Collective Bargaining Act. ~~For members covered by the CBA~~, The CBA shall control in the event of any conflict between this policy and the CBA.

810.4 OBJECTIVES

Personnel investigations shall seek the following three objectives:

- Determine if a member's actions conformed with department policy and, if the member's actions did not conform, attempt to determine why.
- Determine if department policy needs to be changed.
- Determine if a training need exists or if current training needs to be changed.

810.5 DEFINITIONS

Administrative Inquiry (AI) – (1) A complaint, usually requiring more investigation or documentation than a Supervisor Inquiry, and which, if sustained, will normally be resolved with counseling or a reprimand, whether oral or written. (2) An investigation, required or requested by Command Staff, to determine if a member's actions comply with policy.

Incomplete Complaint – A complaint in which the complainant either refuses to cooperate (e.g., an anonymous letter) or the complaint is received from a third party and it is impractical to investigate.

Internal Affairs Investigation (IA) – An investigation which, if sustained, may lead to suspension, demotion, or termination.

Management – Management consists of the Chief of Police, Deputy Chief of Police, all lieutenants and sergeants, and the Support Services Supervisor

Personnel Complaint – An allegation of misconduct or improper job performance regarding a

department member.

Statement – Includes any statement, whether written or oral.

Supervisor – A person who supervises others, whether in a permanent or acting capacity; usually does not refer to Command Staff.

Supervisor Inquiry – A complaint which a member's supervisor has the discretion to handle quickly and informally with very little investigation and which, if sustained, experience and common sense indicate would normally be resolved with counseling.

810.6 ACCEPTANCE AND INVESTIGATION, GENERALLY

A. ACCEPTANCE AND INVESTIGATION. All complaints shall be accepted regardless of the medium, shall be acknowledged as soon as practicable, and shall be investigated, and the complainants shall be advised of the dispositions as described in PPM 810.14, Disposition of Personnel Complaints. Written complaints are unnecessary, except as described in PPM 810.7(A)(4).

B. THIRD-PARTY AND ANONYMOUS COMPLAINTS. Third-party and anonymous complaints shall be accepted if, after a reasonable read of the complaint would lead the supervisor ~~review by the supervisor, it is decided that there is reasonable suspicion~~ to believe that a violation of policy or procedure has occurred. Command Staff shall be advised of all third-party or anonymous complaints whether accepted or not.

C. MEMBERS RESPONSIBLE TO REPORT MISCONDUCT. A member who has reasonable cause to believe ~~becomes aware of~~ alleged misconduct occurred, including violations of department policies, shall notify a supervisor, a Division Commander, or a member of Command Staff without delay.

D. INTERNAL PERSONNEL COMPLAINT. A member may report concerns of unfair treatment; ~~A member who thinks he or she is being treated unfairly may report the problem;~~ however, to facilitate communication among members, members are encouraged to seek an informal resolution to such problems. If the problem is not resolved, the member shall notify a supervisor, a Division Commander, or a member of Command Staff who will ensure a timely investigation. An employee may also contact Human Resources directly. *(New law on reporting sexual harassment complaints)*

E. COMPLAINT OF BIASED POLICING. See PPM 108.7, Complaints of Biased Policing, for special reporting requirements.

F. ASSIGNED INVESTIGATOR. Complaints regarding a specific member shall be forwarded to that member's supervisor or another, uninvolved, member of management; however, a complaint of conduct that is conspicuously bad or offensive, including complaints of biased policing, alleged misconduct as it appears on the Law Enforcement Standards Commission (LESC) discipline matrix, circumstances of administrative leave or possible termination shall be forwarded or copied to the Chief of Police ~~or Deputy Chief of Police~~ and the Human Resources Director. *(management note: CIS carrier needs notice through HR for admin leave and economic sanctions. HR may also contact labor counsel)*

810.7 SUPERVISOR RESPONSIBILITIES UPON RECEIVING A COMPLAINT

A. CONSIDERATIONS BEFORE FURTHERING A COMPLAINT

1. Generally, complaints will not be further investigated unless the alleged misconduct is of a nature which, if true, would normally result in counseling or disciplinary action.
2. When a complainant is satisfied that the matter or incident raised ~~that his or her complaint~~ required nothing more than an explanation of department policy or procedure, a complaint need not be further investigated.
3. When a complainant's credibility can be documented as unreliable and the complaint is patently unfounded on its face, the complaint need not be further investigated; nevertheless, the complainant's contact information shall be collected, and management shall be advised of the complaint.
4. A personnel complaint of criminal activity shall, when possible, be recorded or reduced to writing and signed by the complainant.

B. INVESTIGATOR RESPONSIBILITIES

1. The investigator shall contact the complainant as soon as practicable, even if only to let the complainant know the complaint is being investigated. The City is not precluded from using independent outside investigators at its discretion.
2. Investigators shall respect the accused member's due process and procedural rights.
3. If a complaint prompts a Supervisor Inquiry, the supervisor shall advise the accused member of the complaint and investigate it in a timely manner. If in the course of investigation it is determined that more significant investigation may be required or the conduct, if sustained, would normally result in more discipline than counseling, the inquiry should be reclassified as an Administrative Inquiry or Internal Affairs investigation, as appropriate.
4. If a complaint prompts an Administrative Inquiry, the supervisor shall notify the accused member of the complaint, the member's immediate supervisor and Command Staff, and shall commence the Administrative Inquiry.
5. If a complaint may require an Internal Affairs investigation, the supervisor shall notify the ~~his or her~~ division commander or a member of Command Staff as soon as practicable.
6. Before reporting the disposition of an investigation to a complainant, see PPM 810.16, Confidentiality of Personnel Investigations.

810.8 MEMBER RESPONSIBILITIES DURING AN INVESTIGATION

A. Members interviewed pursuant to a personnel complaint shall cooperate fully with the investigation and shall completely and truthfully answer all questions. (A member may be compelled to give a statement, subject to PPM 810.12, Garrity Rights and Criminal Investigations of Members.)

B. Members shall not interfere with or compromise the integrity of a personnel investigation.

810.9 ADMINISTRATIVE LEAVE

At the discretion of a supervisor or the Chief of Police, a member may be placed on paid administrative leave or Critical Incident Leave, as applicable, pending the outcome of a personnel complaint investigation. This action is administrative and does not constitute discipline.

A member placed on administrative leave may be subject to the following:

A. Under such circumstances, a member placed on administrative leave shall continue to receive regular pay and benefits pending the imposition of any discipline.

B. A member placed on administrative leave may be required to relinquish any badge, official department member identification, weapon(s), and other equipment.

C. A member placed on administrative leave may be ordered to refrain from taking any action as a department member or in an official capacity; however, the member shall be required to continue to comply with all policies and procedures and all orders from a supervisor.

D. A member placed on administrative leave may be temporarily assigned to normal business hours during the investigation and the member may be required to remain available for contact at all times during such shift and report as ordered.

E. If a supervisor places a member on administrative leave, the supervisor shall promptly notify the member's immediate supervisor and a member of Command Staff.

810.10 INTERNAL AFFAIRS INVESTIGATION PROCEDURES, GENERALLY

810.10.1 INITIATION OF INVESTIGATION

Any member of management, including supervisors, may initiate an Administrative Inquiry, but only the Chief of Police or City Manager may initiate an Internal Affairs investigation.

810.10.2 INTERNAL AFFAIRS INVESTIGATION PROCEDURES, GENERALLY

A. The Chief of Police/City Manager, or the assigned investigator ~~at the Chief's direction~~, shall cause the accused member and the Association to be notified of the investigation in a timely manner. This will be done by distribution of one copy of the complaint, provided the allegations are not criminal in nature and such notification will not hinder the investigation. It will also include any other witness statements or reports that state facts on which the charges are based, unless doing so will compromise the investigation. This notification shall include the nature of the investigation, and the member will be informed of other information necessary to reasonably describe the nature of the allegations under investigation. Information will be provided at least 24 hours prior to the interview.

B. Prior to the interview, if there is the potential for discipline against the member, the investigator shall advise the member of the following:

1. The nature and circumstances of the subject matter of the interview.

2. The member may have an Association representative present to witness the interview, provided the representative does not interfere with the interview, asking only clarifying questions. See also PPM 810.13, Association Representation. Attendance of persons other than the accused member and representatives of the City and Association are not permitted in administrative investigatory interviews, except upon mutual agreement between the City and Association.

3. The member or representative may suggest witnesses and evidence favorable to the member.

4. ~~The member or representative may record any and all portions of the interview.~~ *(redundant to F below)*

5. That failure to cooperate with the investigation may subject the member to disciplinary action.

C. Interviews will be conducted when the member is on duty unless the seriousness of the investigation or other circumstances dictates otherwise.

D. Ordinarily, interviews will take place at the police department, but the nature of the situation or the need for a walk-through or reenactment may necessitate another location.

E. Interviews shall be conducted under circumstances conducive to obtaining an accurate account of what occurred and with respect for the member interviewed, including allowing the member to take care of their ~~his or her~~ personal needs. *(restroom breaks)*

F. The complete interview of a member may be audio recorded by the City and/or member or Association consistent with applicable laws. If an audio recording is made of the interview, a member under investigation shall have access to the recording. If a transcription of the interview is made, the member under investigation shall be provided a copy of the transcription.

810.11 ADMINISTRATIVE SEARCHES

A member of the department shall not be subject to having their ~~his or her~~ residence, private place of business, or personally owned private vehicle searched without the member's consent unless a valid search warrant has been obtained.

Members who are subject to the CBA may be ordered to submit to a blood, breath, or urine test for alcohol or drugs when there is reasonable suspicion that the member may be or have been under the influence of alcohol or drugs as defined in the Drug and Alcohol Policy incorporated into the CBA. Members who are not subject to the CBA may be ordered to submit to a blood, breath, or urine test for alcohol or drugs in accordance with City's Personnel Policy Manual.

The use of compelled testing results shall be restricted to the personnel investigation.

Members shall have no expectation of privacy in or while using offices, desks, lockers, vehicles, telephones, computers, radios, or other communications provided by the department.

Assigned lockers, offices, desks, vehicles, and storage spaces are the property of the City and may be administratively searched by a supervisor for work-related purposes (e.g., obtaining necessary paperwork or a radio); however, an investigative search of such areas should only be conducted with the approval of the Chief of Police or a designee upon reasonable suspicion that a violation of policy or procedure has occurred.

All other non-assigned areas (e.g., shared desks, common office space, and shared vehicles) may be searched at any time for any reason.

810.12 GARRITY RIGHTS and CRIMINAL INVESTIGATIONS OF MEMBERS

Garrity (Garrity v. New Jersey, 385 US 493 (1967)) protects a member from incriminating themself ~~him-or-herself~~ in a criminal investigation, while allowing the City to conduct a personnel investigation.

A. PERSONNEL INVESTIGATION OF ALLEGED CRIMINAL ACTIVITY

If a member exercises their ~~his or her~~ Fifth Amendment right not to incriminate themself ~~him-or-herself~~ in a personnel investigation of the member's alleged criminal activity, the member may be ordered (compelled) to give a statement, and the statement(s) may not be used against the member in a criminal investigation. If ordered to give a compelled statement in an internal investigation, the member shall

first be given a Garrity admonition. Note: The reading of a Garrity admonishment does not necessarily indicate potential criminal conduct alleged.

When a statement is obtained based on Garrity, care shall be taken to ensure that confidentiality of the statement is maintained. It shall not be shown or communicated by the investigator to any person except the Chief of Police, other members of Command Staff, the Human Resources Director, the City's legal counsel or as otherwise necessary for the investigation for so long as the criminal investigation is ongoing.

B. UNEXPECTED ADMISSION OF CRIMINAL ACTIVITY DURING INTERVIEW

If during an interview a department member unexpectedly admits involvement in activity that the investigator believes may be criminal in nature, the member shall be advised of ~~his/her~~ *Garrity* rights before the interview continues.

C. GARRITY RIGHTS STATEMENT

When Garrity rights are given as a condition of Section A, the following statement shall be copied and signed and dated by the investigator and the member interviewed:

> As part of a personnel investigation, you are about to be questioned. You will be asked questions specifically and narrowly related to the performance of your official duties, compliance with department policies and standards or fitness for duty.
>
> You are entitled to all the rights and privileges guaranteed by the laws and constitutions of the State of Oregon and the of United States, including the right not to be compelled to incriminate yourself; however, if you refuse to provide a statement or answer questions relating to the performance of your official duties, compliance with department policies and standards or fitness for duty, you will be subject to department discipline which may result in the termination of your employment with the police department.
>
> Neither the statements you provide after receiving this Garrity rights notice nor any information or evidence that is gained from them can be used against you in any subsequent criminal investigation, other than a criminal proceeding for perjury, or unless ordered by a court of law.

D. CONCURRENT PERSONNEL AND CRIMINAL INVESTIGATIONS

If a member is suspected of allegations of criminal conduct, ~~investigated for criminal charges~~, Command Staff will ~~may~~ ask another agency to conduct a criminal investigation.

For an internal investigation that may also involve a separate criminal investigation, ~~that investigation, and the Keizer Police Department's~~ a personnel investigation may occur at the same time as the criminal investigation ~~even working in concert with it until the interview of the accused member, at which point the investigations must split.~~

Generally, the criminal investigator should interview the accused member first, followed by the personnel interview (though not necessarily immediately afterwards). The disposition of a personnel investigation may precede the conclusion and disposition of a criminal investigation.

An investigator conducting an internal personnel investigation, which is also being criminally

investigated or involves the possibility of a criminal act may compel a response from a member if the member is given ~~his~~ Garrity rights. The investigator also may choose not to compel a response. During such an interview the following may occur:

1. Having been given Garrity Rights, a member gives a compelled statement, which cannot be used in a criminal investigation, except a criminal proceeding for perjury; or
2. Having been given Garrity Rights, a member refuses to give a compelled statement, and ~~he or~~ she may be subject to discipline for such refusal, up to and including termination; or
3. The personnel investigator may choose not to give the member a ~~his or her~~ Garrity Rights Statement (not to compel a statement) and, in such case, shall discontinue the interview pending discussion with the Chief of Police or designee regarding whether a Garrity Rights notice should be issued.

810.13 ASSOCIATION REPRESENTATION – WEINGARTEN

If a member is represented by the Association and the member reasonably believes ~~he or she may~~ the interview may lead ~~be subject~~ to discipline, the member has a right to have an Association representative present during a personnel investigation interview.

The role of the Association representative, if present at an interview, may be limited as follows:

- The representative may inquire at the outset of the interview regarding its purpose, including inquiring about the general subject matter of the questioning to follow.
- During the questioning of the member, the representative may participate only to the extent of clarifying questions asked of the investigator.
- After the investigator has finished interviewing the member, the representative may ask the member questions designed to clarify previous answers or to elicit further relevant information.
- Before the end of the meeting, the representative may suggest to the investigator other witnesses to interview and may describe relevant practices, prior situations, or mitigating factors that could have some bearing on deliberations concerning discipline.

810.14 DISPOSITION OF PERSONNEL INVESTIGATIONS

A. Generally, a personnel investigation will be classified with one of the following dispositions:

- Unfounded – When the investigation discloses that the alleged act(s) did not occur or did not involve department members. Complaints which are determined to be frivolous will fall within this classification.
- Exonerated – When the investigation discloses that the alleged act occurred but the act was justified, lawful, or proper.
- Not Sustained – When the investigation discloses that there is insufficient evidence to sustain the complaint. The burden of proof is preponderance of evidence.
- Sustained – When the investigation discloses sufficient evidence to establish that the act occurred and that it constituted misconduct. The burden of proof is preponderance of evidence.

- Incomplete – When the investigation is not completed, most often because the member no longer works for the department and there is no compelling reason to finish it. Investigations determined as incomplete will provide a full explanation.
- Policy Issue – When the investigation discloses that the alleged act occurred but arguably should not have and the member acted according to policy, the disposition of the complaint shall be Not Sustained and the policy issue shall be addressed without delay.

B. Boards of Inquiry (see PPM 810.18 and PPM 620) shall find one of the following dispositions, although the boards may make qualifying statements or recommendations.

- The member's actions complied with department policy.
- The member's actions did not comply with department policy.

810.15 DOCUMENTATION, NOTIFICATION, AND RECORD KEEPING

All personnel complaints shall be documented, the affected member shall be notified of the disposition, and the documentation shall be appropriately retained as described below.

A. INCOMPLETE COMPLAINT and SUPERVISOR INQUIRY

1. Shall be reduced to writing. An email or memorandum is sufficient.
2. Documentation of sustained complaints not leading to disciplinary action shall be kept in the supervisor's working file no less than twelve months at which time it shall be removed from the supervisor's file. This does not preclude maintaining documents in Guardian Tracking. *(current practice)* City will retain such records removed in the supervisor's file separately for liability purposes or records laws retention as applicable.
3. The accused member shall be advised of the disposition of the complaint and, upon request, provided with a copy of all investigation materials unless otherwise prohibited by law.
4. All investigation materials shall be forwarded to the Support Lieutenant ~~Deputy Chief~~, who shall make a record of the complaint, disposition, and discipline, if any, in a location separate from the member's personnel file.
5. The Support Lieutenant ~~Deputy Chief~~ shall retain all investigative materials for no less than two years from the date of the complaint, until any window of liability has passed, or as required by state records retention laws.

B. ADMINISTRATIVE INQUIRY and INTERNAL AFFAIRS INVESTIGATION

1. Shall be documented with a *Factfinding Report* and submitted to the Chief of Police, or designee, for disposition consistent with the procedures of this policy and Appendix C, Policy 812.
2. Upon imposition of discipline, the Chief of Police or designee will advise the accused member and the Association of the disposition and, upon request, with a copy of all investigation materials unless otherwise prohibited by law.
3. The Support Lieutenant ~~Deputy Chief~~ shall maintain a record of the complaint, disposition, and discipline, if any.

4. The Support Lieutenant ~~Deputy Chief~~ shall retain all investigative materials ~~for no less than two years from the date of the complaint, until any window of liability has passed, or~~ as required by state records retention laws. *(note: new 10 year retention rule post employment for officers)*

5. Documentation of written reprimands, suspensions, demotions, and termination shall be maintained in the member's personnel file, subject to the Collective Bargaining Agreement and as required by state records retention laws.

6. Counseling documents and related documentation that are not discipline will be maintained consistent with policy 860: *Performance Evaluations and Guardian Tracking*

810.16 CONFIDENTIALITY OF PERSONNEL INVESTIGATIONS

All personnel investigations are confidential and are not subject to disclosure except in accordance with applicable law.

Complainants should be advised of the disposition of their complaints; however, other information, including discipline greater than counseling shall not be disclosed without the approval of Command Staff.

In the event an accused member (or the representative of such member) makes false representations regarding any internal investigation and such false representations are communicated to any media source, the department may disclose sufficient information to refute the false representations.

~~Notices of~~ Disciplinary actions resulting from sustained complaints shall be maintained in the members' personnel files. The underlying complaints and subsequent documentation shall be maintained by Command Staff in a location apart from the members' personnel files. The contents of such files shall not be revealed to persons other than Command Staff, the investigated member, Association representatives, and City legal representatives, except as permitted by law. Disclosure of the contents of such files may also be made pursuant to a member's written consent, e.g. background investigations, etc. Nothing in this Section is intended to prevent the City, the Association, or the member from using disciplinary actions and investigatory materials as evidence in a legal proceeding.

810.17 ANNUAL REVIEW OF PERSONNEL COMPLAINTS

During the first quarter of each year, Command Staff will review the personnel complaints from the preceding year, focusing upon complaint trends, training needs, and policy changes.

810.18 BOARD OF INQUIRY

At the discretion of the Chief of Police, a Board of Inquiry may be established for the purpose of reviewing a member's actions and the relevant policies and procedures.

The composition of the board will be determined by the Chief of Police based upon expertise, objectivity, and other traits deemed desirable. Objectives, the operational guidelines, and the necessary authority to complete the assignment will be provided to the board in writing by the Chief of Police.

The Deadly Force Review Board, PPM 620, is a Board of Inquiry.

APPENDIX C - DISCIPLINE

Version 060518 — Also appears in Policies and Procedures Manual as PPM 812

812.1 POLICY

It is the policy of the Keizer Police Department that discipline will be fair and when determined appropriate rooted in the desire to help the member succeed in meeting job expectations and complying with departmental standards. Disciplinary actions for sworn law enforcement will be consistent with applicable law.

812.2 PURPOSE

The purpose of this policy is to provide an understanding of what discipline is and how it might be exercised with regard to member conduct as it relates to the mission and values of the department.

812.3 AFFECTED MEMBERS

This policy applies to employees of the bargaining unit. The term "member" refers to employees of the bargaining unit.

~~This policy may affect some department members differently depending upon their status (e.g., regular, probationary, volunteer) or membership in a bargaining unit. Nevertheless,~~ Nothing in this policy should be interpreted to convey a property or liberty interest except ~~other than~~ what is described in a Collective Bargaining Agreement, ~~, in the City Personnel Policy Manual~~, or in law.

812.4 INDEMNITY

This policy is intended for internal use only and shall not be construed to increase or establish a member's civil or criminal liability. Nor shall it be construed to create or establish a higher standard of safety or care. A violation of any portion of this policy may only serve as the basis for internal disciplinary and/or administrative action.

812.5 CAUSES FOR DISCIPLINE

Violation of any of the directives and rules contained in this manual, violations of any general or special order, or failure to meet standards which the department may reasonably expect of a professional police officer or other member may be cause for disciplinary action.

The type and severity of disciplinary action depends on the nature of the offense, the totality of circumstances, the number and frequency of previous acts of misconduct, the quality of overall performance, the need to maintain discipline and public trust, and other relevant factors.

Complaints against members, which allege criminal violation(s), may be grounds for investigation or bringing criminal charges. Criminal proceedings are separate and distinct from discipline and will not serve to prevent the internal disciplinary process from dealing with the same matter.

Generally, causes for discipline are violations of the *Performance Standards* presented in PPM 808.

812.6 RESPONSIBILITIES FOR DISCIPLINE PROCESS

812.6.1 CHIEF OF POLICE

Final disciplinary authority and overall responsibility for personnel administration rests with the Chief of Police or designee with authority to impose discipline. The Chief of Police or designee will give notice of disciplinary actions, except for ~~oral and~~ written reprimands, prior to imposition. ~~disciplinary actions must be taken or approved by the Chief of Police or his designee.~~ Supervisors and other managers have shared responsibility to ensure that training, counseling and appropriate discipline occurs.

Disciplinary actions include written reprimands, suspensions without pay, reduction in salary, demotion, and termination of employment.

Coaching and counseling are not considered disciplinary actions, and are not subject to grievance. An employee may provide a written rebuttal to a coaching or counseling within 10 days of imposition. Rebuttals will be maintained with coaching or counseling documents.

812.6.2 SUPERVISORS AND OTHER MANAGERS

Supervisors are responsible for taking action to ensure the performance and conduct of subordinates adheres to department directives, policies and procedures.

Supervisors are authorized to exercise their independent judgment to take disciplinary action up to and including written reprimand. Supervisors may suspend with pay where the suspension is administrative and not as discipline.

Imposition of other disciplinary action may be recommended and will be reviewed and approved in advance by the Chief of Police.

812.6.3 ALL MEMBERS

Any member of the bargaining unit ~~department~~ who commits an offense contrary to law or violates the policies of the department or City, who demonstrates incompetence in job related ~~his or her~~ duties, or otherwise demonstrates unsuitability for further service is subject to discipline. Furthermore, members shall cooperate with the discipline process, including answering all questions regarding the performance or conduct of any other department member, subject to applicable constitutional rights.

812.7 PRE-DISCIPLINARY MEETING ~~MEMBER RESPONSE TO DISCIPLINE~~

For disciplinary actions involving loss of pay, reduction in pay or rank, or discharge, the pre-discipline process is intended to provide the accused member with a voluntary ~~an~~ opportunity to present a written or verbal ~~oral~~ response to the Chief of Police or designee with authority to impose discipline after having had an opportunity to review the supporting materials and prior to imposition of any recommended discipline involving loss of pay, reduction in pay or rank, or termination of employment. ~~discharge.~~ The member shall consider the following:

A. This response is not intended to be an adversarial or formal hearing.

B. Although the member may be represented by an uninvolved Association representative and/or the Association's legal counsel, the response is not designed to accommodate the presentation of testimony or witnesses.

C. The member or designee may suggest that further investigation could be conducted or the member may offer any additional information or mitigating factors for the Chief of Police or designee, to consider.

D. In the event that the Chief of Police or designee elects to cause further investigation to be conducted, the member shall be provided with the results of such subsequent investigation prior to the imposition of any discipline.

E. The member or their designee may thereafter have the opportunity to further respond verbally ~~orally~~ or in writing to the Chief of Police or designee on the limited issue(s) of information raised in any subsequent materials or investigation.

F. Once the member has provided a response, ~~completed his/her response~~ or, if the member has elected to waive any such response, the Chief of Police or designee with authority to impose discipline shall consider all information received in regard to the recommended discipline. The Chief of Police or designee with authority to impose discipline shall thereafter render a timely written decision to the member imposing, modifying or rejecting the recommended discipline. In the event of a termination, the final notice of discipline shall also inform the member of the reason(s) for termination and the process to receive all remaining ~~fringe and retirement~~ benefits. Disciplinary actions will include explanation of reasoning for reaching the imposed action inclusive of application of any aggravating or mitigating circumstances consistent with state law.

G. Once the Chief of Police or designee has issued a written decision, the discipline shall become effective; however, if the decision is for termination, the decision must first be ratified by the City Manager after which it will become effective.

See also Section 812.92 for more pre-disciplinary procedures.

812.8 ~~ADMINISTRATIVE LEAVE~~, SUSPENSIONS, AND DISCHARGE

~~812.8.1 ADMINISTRATIVE LEAVE~~

~~Administrative leave is not discipline. See PPM 810.9, Administrative Leave. (move up to 810)~~

~~812.8.2 SUSPENSION WITH PAY~~

~~Supervisors and Command Staff may suspend a member with pay, when it is in the interest of the member, the department, or the public. A member suspended with pay shall remain in ready communication during normal business hours and shall report to the Chief of Police or his designee as directed.~~ *(repetitive to 810.9. Paid admin leave is for IAs and other conditions, not a condition of discipline.)*

812.8.3 SUSPENSION FOR DISCIPLINE

A member suspended without pay for discipline shall have no department authority, nor shall any such member engage in any police or duty-related function while suspended, except when required by law (e.g., in compliance to a subpoena), for which the member shall be compensated. A member relieved from duty or suspended for discipline shall not be permitted to wear the uniform of the Keizer Police Department nor permitted to use or wear any department clothing, equipment or other items except as otherwise directed by the Chief of Police and shall immediately surrender the badge, identification card, and other issued

equipment as directed.

812.8.4 TERMINATION OF EMPLOYMENT ~~DISCHARGE~~
(bargaining note: The intent to use the LESC term)

Upon successful completion of probation, ~~After the probationary period is completed~~, employees shall not be terminated ~~discharged~~ except as provided in the applicable policies or in the Collective Bargaining Agreement. This policy provides disciplinary procedures and shall not be construed as conferring on any employee any right or expectation of continued employment. Such rights are found in the City personnel policies and the Collective Bargaining Agreement.

812.9 JUST CAUSE AND DUE PROCESS REQUIRED

812.9.1 JUST CAUSE

Excluding sworn law enforcement officers, a member of the Association who has completed the initial probationary period may not be disciplined except for "cause" or "just cause." A number of factors may be taken into account and given appropriate weight. They include the following:

- To what extent has the member been trained in the proper conduct or manner of performance?
- Has the member had the same kinds of performance problems in the past (repeat offender)?
- Has the member been disciplined for the same or similar conduct in the past?
- If the member has been disciplined in the past, how has the member responded to the discipline?
- How serious is the offense? Is it just an annoyance? Has the member caused personal injury or property damage? Has the member done something illegal, engaged in a serious violation of departmental policies or standards or engaged in conduct that renders himself/herself unable to perform the essential functions of the job?
- Have other members had similar performance problems? If so, how have their situations been addressed?
- Are there acceptable explanations for the member's conduct which should be taken into account?
- How has the member performed in other aspects of employment?
- Are there personal problems that account for the conduct?
- Has the department taken reasonable steps to help the member correct the problem?

For sworn law enforcement officers, just cause is defined by applicable law. *(will add link to LESC guide*

812.9.2 PRE-DISCIPLINARY, DUE PROCESS (LOUDERMILL)

For employees who have passed probation and prior to taking disciplinary action involving loss of pay, reduction in pay or rank, or discharge, the Chief of Police or designee shall provide an opportunity for a due process meeting hearing as follows. (see also 812.7 for other conditions)

A. Notification And Right To Respond. The Chief of Police or designee shall notify the member in writing of the nature of the charges and the disciplinary options that are being considered. The

notification shall include a copy of the complaint against the member and any other witness statements or reports which state facts on which the changes are based, unless confidential and disclosure would compromise another investigation. The Chief of Police or designee shall identify the directives, policies, procedures, work rules, regulations, or other order, of the department which are alleged to have been violated. The notice will include a range of disciplinary sanction contemplated inclusive of aggravating and mitigating circumstances considered.

B. The member shall have the right to answer the charges against them ~~him or her~~, which may include written or verbal ~~oral evidence and~~ statements by the member. The meeting or response is voluntary. The member shall have an informal opportunity to respond to the charges (orally or in writing), normally within three business days from receiving such written notice, which shall be extended upon request up to two additional business days. Extensions beyond this time period must be approved by the Chief or designee and will only be granted if determined necessary to enable a member to provide a meaningful response.

C. Conduct Of Meeting ~~Hearing~~. The opportunity to respond may occur at a meeting. If so, the meeting must be presided over by the person who will determine whether the discipline will be imposed and, if so, what disciplinary action will be issued. The meeting shall be informal and sufficient to assure the member full opportunity to be heard, refute the charges, and provide any additional statement or position to be ~~have his/her position~~ considered prior to the imposition of discipline. The meeting shall be audio recorded. The Chief of Police or other person having authority to preside over the meeting will determine when the conference is concluded, who may be present, may request further documentation, and may consider any information deemed pertinent and necessary to assist in reaching a logical determination.

~~In the event an employee has been issued a Garrity notice prior to the meeting, any responses made by the employee to questions presented by the Chief of Police or other person having authority to preside over the meeting will be considered compelled statements and will be Garrity protected.~~ *(The Loudermill opportunity is a voluntary election of the employee, and Garrity does not apply.)*

The member or designee may make any presentations they believe relevant to their case. However, the meeting is not a full hearing and witnesses are not subject to call or examination. The member may provide written statements. Testimony of witnesses or cross-examination of witnesses will not occur at this meeting.

The Chief of Police or other person having authority to preside over the meeting will issue a written decision exonerating the member, imposing discipline, or taking any other action deemed appropriate.

812.10 GRIEVANCE/APPEAL OF DISCIPLINE

A. BARGAINING UNIT MEMBERS. Members of the bargaining unit have the right to appeal as is specified in the collective bargaining agreement. The union agreement provides the sole and exclusive appeal procedure for covered bargaining unit employees.

B. ~~NON-BARGAINING UNIT MEMBERS. Members who are not covered by the collective bargaining agreement may appeal discipline as described in the City Personnel Policy Manual.~~

C. MEMBERS ON PROBATION. Members on probation who are terminated for unsatisfactory performance or failure to meet department standards have no right to grievance or appeal.

812.11 NAME-CLEARING OPPORTUNITY ~~HEARING~~

A name-clearing opportunity ~~hearing~~ is a meeting ~~hearing~~ in which a ~~terminated~~ member has an opportunity

to clear the member's ~~his or her~~ reputation from potentially stigmatizing information prior to a public disclosure of the reasons for termination.

812.11.1 REQUEST FOR NAME-CLEARING OPPORTUNITY ~~HEARING~~

Whether or not a terminated member requests a name-clearing opportunity ~~hearing~~, the department or City may offer a name-clearing opportunity ~~hearing~~ prior to, after termination, or near the same time as the public disclosure of potentially stigmatizing information. The pre-disciplinary meeting, as stated in Section 812.9.2, is considered a name clearing opportunity.

812.11.2 PROCEDURES

While there are no predetermined procedures for a name-clearing opportunity, ~~hearings,~~ the following are guidelines:

- The terminated member may attend the meeting ~~hearing~~ in person or may submit a written response.
- Witnesses should provide their testimony in writing and are not required to attend in person.
- The meeting ~~hearing~~ should be scheduled for a period of time intended to enable the member to be heard but will generally be scheduled for no more than two hours.
- The meeting ~~hearing~~ should be recorded, but is not required. *(note: If employee contests being recorded, proceed and take notes)*
- The member may present any evidence but it must be relevant to the basis for the termination.
- No one who attends or provides statements at the meeting ~~hearing~~ should be placed under oath or cross-examined.
- The department or City should not be expected to and may not present evidence or "respond" to the information presented by the member or designee.

812.11.3 AFTER A NAME-CLEARING OPPORTUNITY ~~HEARING~~

All a name-clearing meeting ~~hearing~~ requires is an opportunity for a terminated member to be heard, thus no action is required during or after the meeting; ~~a hearing; however,~~ A record of the meeting ~~hearing~~ and any evidence presented to the department or City should be kept with the personnel investigation. ~~Furthermore, if the member gives consent, the department or City should consider giving a copy of the member's presentation along with the public disclosure.~~ *Consent to release information is not necessarily required (ie: press release, Unemployment divisions). If an employee provides a consent to release info from a prospective employer, then likely all materials in hand would be released)*

APPENDIX D – DRUG AND ALCOHOL POLICY

PURPOSE. The City considers its employees to be its most valuable asset and is concerned about their safety, health and wellbeing. The misuse of alcohol and other drugs can impair employee performance and general physical and mental health and may jeopardize the safety of co-workers and the general public. The City is committed to maintaining a safe and healthy work place for all employees by identifying the misuse of alcohol and drugs and assisting employees to overcome these problems through appropriate treatment and, if necessary, disciplinary action. The presence or treatment of a substance abuse problem will not excuse an employee from meeting performance, safety or attendance standards or following other City instructions.

The parties also recognize the City's responsibilities pursuant to the Drug Free Work Place Act of 1988. The Association and the City acknowledge that employees shall not report to work under the influence of intoxicating liquor or illegal drugs. All employees understand that the use, sale, possession, manufacture, distribution and/or dispensing by an employee of an intoxicating liquor, controlled or illegal substance as defined by federal law, or a drug not medically authorized, or any other substances which impair job performance or pose a hazard to the safety and welfare of the employee, other employees or the public is strictly prohibited, except for alcohol or medically prescribed controlled substances off-duty, and possession of controlled substances while in the course and scope of employment and the possession of seized evidence while on-duty. The parties recognize that conduct in violation of this policy may result in disciplinary action and/or criminal investigation if appropriate. This policy will be enforced and administered in a manner which is consistent with the value statements set forth in this Section.

PROHIBITED CONDUCT. The following conduct is strictly prohibited:

A. The buying, selling, distributing, transporting, possessing, manufacturing, consuming or using illegal drugs per federal law, including marijuana, or alcohol while on City property or in City vehicles or equipment or during work hours, including paid rest and meal periods, except as necessary in the performances of duties (confiscated evidence; approved undercover operations, etc.).

B. Reporting to work or returning to duty under the influence of alcoholic intoxicants, except as necessary in the performance of an official special assignment or if directed otherwise. Under the influence is defined as "being impaired to a noticeable and perceptible degree" (OAR 265-010-0030). For the purpose of this Policy, an employee will be considered to be under the influence of alcohol if their ~~his or her~~ blood or breath tests greater than .02% BAC. ~~or higher~~. The City may also consider other evidence in determining whether an employee is "under the influence."

It is recognized that employees may be called back to duty during normal off-duty hours. To ensure compliance with this Policy and safety standards, employees who have consumed alcoholic beverages within four (4) hours of responding to the callback or, for any reason, believe they may be impaired from performing the duties of the callback are required to notify the supervisor upon being contacted for callback and provide the supervisor with complete information regarding such consumption. The supervisor will determine whether the employee can safely report for work. The callback of employees who ~~are impaired to a perceptible degree have consumed alcoholic beverages during off-duty hours~~ to perform patrol duties is prohibited, ~~unless the employee's blood alcohol content is less than .02%.~~

C. Consuming or using illegal drugs per federal law, including marijuana or synthetic substances with similar effects of illegal drugs. An employee will be in violation of this policy if the employee tests positive for a listed substance at a value equal to or in excess of the values provided in the Testing Levels chart provided at the end of this policy.

An employee is also considered in violation of this policy for being at work *impaired to a noticeable and perceptible degree* ~~under the influence~~ of illegal drugs, prohibited substances, including marijuana or synthetic substances with similar effects while on duty, excluding any substance lawfully prescribed for the employee's use within the instructions prescribed.

~~An employee shall be deemed to be "under the influence" of prohibited substances cannabinoids (marijuana or hashish) and will be considered to have tested "positive" for cannabinoids (marijuana or hashish), if the employee's urine test indicates fifty (50) or more Nano grams THC metabolites/ml. An employee shall be automatically presumed to be "under the influence" of other illegal drugs, if such substances are "present in the body" (excluding any substance lawfully prescribed for the employee's use which has not been obtained for the purpose of abuse.)~~

The City may also consider other evidence in determining whether an employee is "under the influence."

D. Failing to fully cooperate with any aspect of the City's enforcement of this Policy, including but not limited to, refusing to promptly submit to required testing, giving false, diluted or altered urine samples, failure to authorize the release of information to the City and failure to comply with rehabilitation conditions imposed by the City or rehabilitation counselors.

E. Failure to promptly report conviction, arrest or plea-bargaining for an alcohol or drug related criminal offense. All drug and alcohol related convictions, arrests and plea-bargaining arrangements must be reported to the Chief on the workday immediately following the conviction, arrest or plea-bargaining arrangement.

For purposes of this Policy, the term "drug" shall be defined in accordance with the definition of "controlled substance" set forth in ORS 475.005(6).

Employees who engage in any prohibited conduct will be subject to discipline including discharge.

MEDICAL MARIJUANA

In addition to the above, employees must comply at all times with all federal and state statutes and regulations regarding the illegal use of drugs. It is important to note that marijuana is an illegal drug under the federal Controlled Substances Act, which means that it has no acceptable medical use under federal law. Therefore, any on or off duty use of marijuana which is inconsistent with the "prohibited conduct" listed above will be considered a violation of this policy, even if an employee has a prescription for the use of marijuana under the Oregon Medical Marijuana Act. If the City determines that the employee using medical marijuana is disabled under applicable disability discrimination statutes, the employee will be asked to enter into an interactive discussion with designated representative(s) to determine whether a reasonable accommodation can be made that would allow the employee to continue to be employed without violating Departmental standards.

DISCLOSURE OF MEDICATIONS

Employees are responsible for consulting with their physicians and carefully reviewing medication warnings, including any warnings pertinent to the effects of use of a combination of medications. Each employee who is using over-the-counter or prescribed medications under circumstances where he or she knows or should know that the use of the medication may produce side effects that will affect his or her ability to safely perform all essential job duties must notify the Human Resources Director of the substance taken and the side effects before reporting to work or returning to duty. Medical verification of ability to safely perform job duties may be required before the employee is allowed to work. Employees are eligible to utilize sick leave benefits pending receipt of acceptable verification. In the event sick leave benefits are depleted, the employee may utilize other accrued time. In the event the employee does not designate a paid leave account, the City will make the designation, using accrued vacation as the last choice.

Although the use of prescribed drugs or non-prescription medications, which contain controlled substances as part of a prescribed medical treatment program, is not grounds for disciplinary action, failure to report the use of such substances as described above, illegally obtaining the substance or use which is inconsistent with a prescription or label, may subject the employee to discharge.

MANDATORY TESTING. Employees will be required to undergo mandatory testing as follows:

A. Reasonable Suspicion Testing Where the City has a reasonable suspicion that an employee has reported to work or returned to duty under the influence of any alcoholic intoxicants or controlled substances, including marijuana, or has a control substance including marijuana present in the body, the City may require that the employee immediately submit to field impairment tests, blood, urine or breathalyzer test or any combination thereof. The City shall pay for the costs of the tests.

"Reasonable suspicion" will be based on observations of an employee's other reliable indicators that would cause a reasonable person to believe that an employee has reported to work or returned to duty with alcohol or drugs in his or her system. Whenever practicable, reasonable suspicion will be established by the observations of two or more supervisors or managers.

Employees who are required to submit to reasonable suspicion testing are prohibited from transporting themselves to the collection site. A supervisor or management employee will provide transportation. *(bargaining note: City currently uses Bio-Med services for evaluating samples)*

B. Random Testing: The City may test no more than three (3) Police Officers for drugs on a random basis for each selection event. Testing shall be conducted twice yearly at unannounced times. Employees subjected to random testing will be selected from a pool of identification numbers by the City's contract testing service and tested in accordance with Random Drug Testing Protocols set forth below and consistent with City Testing Policy. Employees selected for random testing will be tested at the Keizer Police Department using a mobile testing unit or, at the employee's option, a testing facility at times designated by the City. *(bargaining note: Per policy, random testing will be unannounced.)*

In the event that an employee who is randomly selected for testing is on vacation, sick leave, FMLA/OFLA leave or is absent from work due to training or other reasons, that employee's random testing may be deferred by the City. However, any employee whose test is deferred may be required to submit to unannounced testing at any time within ninety (90) days of the date he or she would otherwise have been required to submit to testing.

C. Individualized Suspicionless Testing: The City may also require an employee who has requested

assistance to address a drug and/or alcohol dependency or who has been placed on a "Last Chance" or "Rehabilitation and Return to Work Agreement" to undergo rehabilitation assistance to submit to individualized, suspicionless testing.

When the employee is notified that the employee is required to consent and submit to such tests or searches as set forth in this Policy, the employee may request the presence of an Association representative to witness the tests or searches. The test or searches may not be unduly delayed in order to wait for a representative. In the event the City reasonably believes that a delay may affect test results, the right to an Association representative to witness the test or search may be denied. The absence of a representative shall not be grounds for the employee to refuse to submit to such tests or searches. The presence of a representative shall not disrupt or interfere with the tests or searches.

Urinalysis or saliva testing, at the option of the employee, will be conducted for all types of drug testing. Breathalyzer or blood testing will be conducted for all types of alcohol testing, with the employee selecting the testing option without causing any unreasonable delay. In the event the employee does not specify a testing option, the City may make the selection.

SAFEGUARDS. In the event that the blood or urine test results are positive for controlled substance(s) including marijuana, the City shall require that a second confirmatory test from the same sample be conducted, using gas chromatography mass spectrograph techniques or equivalent, which also must be positive before concluding the employee has such substance(s) present in the employee's body.

If a blood or confirmed urine test is positive, the City will instruct the laboratory to retain the blood or urine sample for a period of not less than thirty (30) calendar days from the date the tests are complete for the purpose of allowing the employee to conduct an independent test at the employee's own expense at a laboratory approved by the City.

The procedure followed under this Article to obtain, handle and store blood and urine samples and to conduct laboratory tests shall be documented to establish procedural integrity and chain of evidence. Such procedures shall be administered with due regard for the employee's privacy and the need to maintain the confidentiality of test results to an extent which is not inconsistent with the needs of this policy. The employee shall be notified of the results of all tests conducted pursuant to this policy.

VOLUNTARY REHABILITATION. The primary objectives of the City's drug and alcohol policy are to maintain employee performance and good health and a safe work environment. Although the City will support voluntary treatment efforts for employees with drug and/or alcohol dependency problems, it is up to each employee to pursue treatment before dependency problems result in unsatisfactory performance, attendance, violations of safety or other standards and before the employee violates this policy. If, an employee notifies a supervisor of a ~~that he or she has~~ drug or alcohol problem that requires treatment prior to violating Departmental standards or this Policy, the employee may, as recommended by a Substance Abuse Professional (SAP), be placed on a leave of absence or adjusted work schedule to allow for in-patient or out-patient rehabilitation.

Employees who voluntarily inform the City prior to a Policy violation or testing requirement that they have a drug or alcohol-related problem will be removed from their duties to allow for rehabilitation and treatment. The employee will not be permitted to return to their regular duties until such time as the authorized Substance Abuse Professional provides the City with appropriate documentation verifying that the employee is complying with all rehabilitation and after care requirements. The City may also require written documentation from a Health Care Provider confirming that the employee can safely perform his or her job duties.

Employees who claim drug or alcohol dependencies after violating this Policy are subject to discipline, consistent with this policy, irrespective of such dependencies.

The City may, however, at its discretion, allow an employee a one-time opportunity to undergo evaluation and rehabilitation in lieu of discharge, or other disciplinary action, provided the employee agrees to all treatment, rehabilitation, testing and other conditions as set forth in a written Rehabilitation and Return to Work Agreement required by the City. Such Agreements will be effective for no longer than five (5) years from the date signed. Any employee who violates the terms of the Agreement is subject to immediate termination.

An employee may be required to participate in a drug and/or alcohol treatment program and follow-up care because of disciplinary action arising from a drug and/or alcohol problem, or as a condition of continued employment. A Substance Abuse Professional (SAP) must first evaluate an employee who is so required and determine any necessary assistance.

SEARCHES. The City reserves the right to conduct searches for any reason of City equipment or facilities generally; and may search any thing or area in which the employee has an expectation of privacy (i.e. desk or locker or clothing or personal property) to the extent permitted by the law. Refusal by the employee to submit to a lawful search can result in termination.

CONSEQUENCES OF SEARCH RESULTS. Searches which do not reveal the presence of alcohol or controlled substances, including marijuana (but excluding any substance lawfully prescribed for the employee's use which has not been obtained for the purpose of abuse), shall result in no further action against the employee related to an alleged violation. The employee shall be informed of such search results.

Searches which reveal the presence of alcohol or controlled substances, including marijuana (but excluding any substance lawfully prescribed for the employee's use which has not been obtained for the purpose of abuse), shall result in those consequences specified in this Policy, as though a positive blood or confirmed urine test had been administered.

RANDOM DRUG TESTING PROTOCOLS.

The procedures for random drug tests required pursuant to this Policy are as follows:

A. A listing of all participating employees will be sent to the City's contract testing service.

Each employee will be issued a unique identifying number and identification card. Corresponding numbers will be entered into a database at the testing facility.

B. At semi-annual intervals, the computer program will randomly select from the KPA EMPLOYEE (KPA) POOL who are to be tested. Names are not drawn, ~~"drawn"~~ only the identifying number. At that time, the HR office is notified of these employees who have been randomly selected for testing.

C. The City ~~HR~~ will provide notice to the employee who has been selected for a random test advising them to report to the testing location ~~facility~~ to provide a urine or saliva sample. Random testing will be ordered when the employee is on duty and is considered compensable time worked. Employees will not be recalled to work for random testing. ~~These employees who have been selected will have 24 hours after receiving notification to report for testing. When they report to the testing facility they will be required to show the notice and photo identification to ensure that~~

~~they are the person whose name has been drawn. In addition, they will be required to provide a phone number(s) where they can be contacted. If they fail to appear within the 24 hour testing period HR will be notified. Testing shall be conducted on City paid time.~~ *(bargaining note: Sample provided is done at City facility)*

D. The sample is handled under strict chain-of-custody requirements and is sent to an independent laboratory for analysis using a Gas Chromatography Spectrometry (G.C./M.S) testing process (the laboratory that is used is certified by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA). If the test is negative, ~~"negative,"~~ the laboratory notifies the testing facility who in turn notifies the City of the negative results.

E. Same scenario as D, except the laboratory detects a questionable substance. The laboratory sends the sample to a Medical Review Officer (MRO). An MRO is defined as, a person who is a licensed physician (Doctor of Medicine) and who is responsible for receiving and reviewing laboratory results generated by an employer's drug testing program and evaluating medical explanations for certain drug test results. The MRO acts as an independent and impartial "gatekeeper." The MRO ~~He or she~~ is an advocate for the accuracy and integrity of the drug testing process. The MRO contacts the employee and discusses the test. If the employee is for instance, taking a prescription medication, the MRO will obtain the name of the prescribing physician and verify the prescription. Upon verification, the testing facility is advised of a "negative" test result. The City does not know any more that the fact that a "negative" result was obtained. *(editing note: "" will be removed from words gatekeeper and negative)*

F. Same scenario as D, except employee does not have a valid reason for the substance (i.e. took spouse's pain medication or . . .). After the MRO has or repeatedly tried to contact the employee, the MRO will notify the City's designated representative that this employee has tested positive for substance.

G. A confirmatory test can be done- same sample – not a different one. In addition to the confirmatory test, if there is enough sample, it is possible for the testing facility to send a portion of the sample to another independent lab for testing. The City will pay for the initial screening test and one (1) required confirmation test. If an employee wants additional verification test conducted, the employee is responsible for payment of all associated costs. Should the employee-ordered verification test produce a false positive, the employee will be reimbursed for the cost of said test.

TESTING LEVELS

The following initial and confirmatory levels are used when screening specimens to determine whether they are positive or negative for the following drugs or classes of drugs. Results equaling or above these standards are considered a positive test in violation of policy.
(bargaining note: Chart below is new language)

Initial Test Analyte	Initial Test Cutoff Concentration	Confirmatory Test Analyte	Confirmatory Test Cutoff Concentration
Marijuana metabolites (THCA)	50 ng/mL	THCA	15 ng/mL
Cocaine metabolites (Benzoylecgonine)	150 ng/mL	Benzoylecgonine	100 ng/mL
Codeine/Morphine	2000 ng/mL	Codeine Morphine	2000 ng/mL 2000 ng/mL
Hydrocodone & Hydromorphone	300 ng/mL	Hydrocodone Hydromorphone	100 ng/mL 100 ng/mL
Oxycodone/Oxymorphone	100 ng/mL	Oxycodone Oxymorphone	100 ng/mL 100 ng/mL
6–Acetylmorphine	10 ng/mL	6–Acetylmorphine	10 ng/mL
Phencyclidine	25 ng/mL	Phencyclidine	25 ng/mL
Amphetamine/ Methamphetamines	500 ng/mL	Amphetamine Methamphetamine	250 ng/mL 250 ng/mL
MDMA/MDA	500 ng/mL	MDMA MDA	250 ng/mL 250 ng/mL

These drug and testing levels are intended to be consistent with DOT standards. In the event that DOT testing substances and/or testing cutoff levels change, the above list shall be automatically adjusted to be consistent with DOT standards.

ADDITIONAL INFORMATION AND EDUCATIONAL MATERIALS

Additional information regarding the effects of alcohol and controlled substance use, signs and symptoms of problems and how to respond to drug and alcohol problems in the workplace is available in the City Personnel Policy Manual.

Appendix A

Kenai Police Association Bargaining Unit Employees
Pay Schedule Effective October 10, 2022

Range	Classification	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8	Step 9	Step 10
13		20.49 1,639.20 3,551.60	21.10 1,688.00 3,657.33	21.73 1,738.40 3,766.53	22.38 1,790.40 3,879.20	23.05 1,844.00 3,995.33	23.74 1,899.20 4,114.93	24.45 1,956.00 4,238.00	25.18 2,014.40 4,364.53	25.94 2,075.20 4,496.27	26.72 2,137.60 4,631.47
15	Police Support Specialist	22.57 1,805.60 3,912.13	23.25 1,860.00 4,030.00	23.95 1,916.00 4,151.33	24.67 1,973.60 4,276.13	25.41 2,032.80 4,404.40	26.17 2,093.60 4,536.13	26.96 2,156.80 4,673.07	27.77 2,221.60 4,813.47	28.60 2,288.00 4,957.33	29.46 2,356.80 5,106.40
16	Property & Evidence Specialist I	23.72 1,897.60 4,111.47	24.43 1,954.40 4,234.53	25.16 2,012.80 4,361.07	25.91 2,072.80 4,491.07	26.69 2,135.20 4,626.27	27.49 2,199.20 4,764.93	28.31 2,264.80 4,907.07	29.16 2,332.80 5,054.40	30.03 2,402.40 5,205.20	30.93 2,474.40 5,361.20
17	Community Service Officer* I Property & Evidence Specialist II	24.87 1,989.60 4,310.80	25.62 2,049.60 4,440.80	26.39 2,111.20 4,574.27	27.18 2,174.40 4,711.20	28.00 2,240.00 4,853.33	28.84 2,307.20 4,998.93	29.71 2,376.80 5,149.73	30.60 2,448.00 5,304.00	31.52 2,521.60 5,463.47	32.47 2,597.60 5,628.13
18		26.12 2,089.60 4,527.47	26.90 2,152.00 4,662.67	27.71 2,216.80 4,803.07	28.54 2,283.20 4,946.93	29.40 2,352.00 5,096.00	30.28 2,422.40 5,248.53	31.19 2,495.20 5,406.27	32.13 2,570.40 5,569.20	33.09 2,647.20 5,735.60	34.08 2,726.40 5,907.20
19		27.42 2,193.60 4,752.80	28.24 2,259.20 4,894.93	29.09 2,327.20 5,042.27	29.96 2,396.80 5,193.07	30.86 2,468.80 5,349.07	31.79 2,543.20 5,510.27	32.74 2,619.20 5,674.93	33.72 2,697.60 5,844.80	34.73 2,778.40 6,019.87	35.77 2,861.60 6,200.13
20	Crime Analyst	28.80 2,304.00 4,992.00	29.66 2,372.80 5,141.07	30.55 2,444.00 5,295.33	31.47 2,517.60 5,454.80	32.41 2,592.80 5,617.73	33.38 2,670.40 5,785.87	34.38 2,750.40 5,959.20	35.41 2,832.80 6,137.73	36.47 2,917.60 6,321.47	37.56 3,004.80 6,510.40
21		30.24 2,419.20 5,241.60	31.15 2,492.00 5,399.33	32.08 2,566.40 5,560.53	33.04 2,643.20 5,726.93	34.03 2,722.40 5,898.53	35.05 2,804.00 6,075.33	36.10 2,888.00 6,257.33	37.18 2,974.40 6,444.53	38.30 3,064.00 6,638.67	39.45 3,156.00 6,838.00
PO	Police Officer	30.91 2,472.80 5,357.73	32.46 2,596.80 5,626.40	34.08 2,726.40 5,907.20	35.78 2,862.40 6,201.87	37.57 3,005.60 6,512.13	39.45 3,156.00 6,838.00	**10 Yr 40.44 3,235.20 7,009.60			

**Classification not utilized this fiscal year*

***10-year merit step available pay period following 10 year anniversary with KPD*

All steps above to be adjusted +5.0% effective July 1, 2023 with the exception of PO Step 10, which will be adjusted 2.5% above Step 6.

Salem Health®
Hospitals & Clinics

June 2023

CHEC Resources

Buy fresh, buy local

Farmers Market

Say hello to Summer! Enjoy some fresh fruits and vegetables at your local farmers market. If you would like to know the times and locations, learn more at salemcommunitymarkets.com

Join our health educators at the Thursday West Salem Market on July 13. You'll get the opportunity to sample some fresh salsa to enjoy.
Time: 3 to 7 p.m.
Location: 1260 Edgewater St NW, Salem, OR
Greenway between Gerth St & Kingwood Ave

Double Up Food Bucks!

Double up Food Bucks program is here for SNAP shoppers! Stretch your food dollars by getting dollar-for-dollar matches to buy additional fruits and vegetables at our Salem Community Markets. For example, if you spend $20 of your SNAP dollars at a participating farmers market, they will give you another $20 to buy more locally grown fruits and vegetables.

Learn more at salemhealth.org/chec
or call us at 503-814-2432.

Wellness Spotlight

SELF CARE TIP:
Cultivate awe

Go on an "awe" walk.
If you don't have the opportunity to travel to a distant exotic land, find a place near your home that has potential to inspire awe. Maybe a tree-lined path, the bank of a swift river or the ocean.

Register for all classes at salemhealth.org/chec or by calling 503-814-2432.

Programa de Manejo Personal de la Diabetes

Date: Wednesday, June 7
Time: 5:30 to 8 p.m.
Location: CHEC Wellness Kitchen
Cost: Free

Este taller está diseñado para ayudar a los adultos con diabetes tipo 2 o prediabetes a aumentan su confianza en el manejo de su diabetes. El taller se reúne durante 2 horas y media una vez a la semana durante seis semanas.

¿Quién debería asistir al taller?

- Adultos con diabetes tipo 2
- Adultos con prediabetes
- Adultos que viven con alguien que tiene diabetes

Diabetes & Cholesterol Screening

Date: Saturday, June 24
Time: 8 to 10 a.m.
Location: Salem Free Clinics
Cost: Free

Screening tests available include A1c, cholesterol and blood pressure. Health educators will be available at the screening to help you understand your results and what the information means for your health.

IMPORTANT: Please do not eat any food or drink any beverages other than water ("fast") for 9 hours prior to your appointment for more accurate biometric numbers.

Sepsis and its Long Term Implications

Date: Thursday, June 15
Time: 6 to 7 p.m.
Location: CHEC Class room #1 OR Virtually
Cost: Free

Sepsis is an emergency. Every 2.3 seconds someone dies of sepsis. And for others, it can have life-long effects.
Sepsis can affect everyone at any age.
This presentation will help you:

- Discuss what sepsis is and why it is an emergency.
- Understand the importance of early intervention.
- Learn about the long-term effects of sepsis.
- Compare the pros and cons of antibiotics.
- Hear how Salem Health can help treat and help you recover from sepsis.

Empowered Relief

Dates: Thursday, June 29
Time: 5:30 to 7:30 p.m.
Location: CHEC Classroom #1
Cost: Free

Coping with chronic pain can be extraordinarily challenging. Empowered Relief is an evidence-based, single-session pain class that rapidly equips patients with pain management skills.
In this group, you will learn:

- How pain is processed in the brain and how best to manage it
- Simple skills you can use every day
- How to create your personalized plan for long-term relief.

Get updates in your inbox!

Sign up at salemhealth.org/CHEC

EXÁMENES DE DIABETES Y COLESTEROL

Fechas para 2023:

- Sabado, marzo 25
- Sabado, junio 24
- Sabado, septiembre 23
- Sabado, noviembre 11

Horario: 8:00 - 10:00 a.m.

Ubicación: Clinica gratuita de Salem
1300 Broadway St NE Suite 104,
Salem, OR 97301

Cost: Free

Los examenes de detección disponibles incluyen A1C, colesterol, glucosa, y presión arterial.

Atención: asegúrese de haber estado en ayunas durante un mínimo de 9 horas.

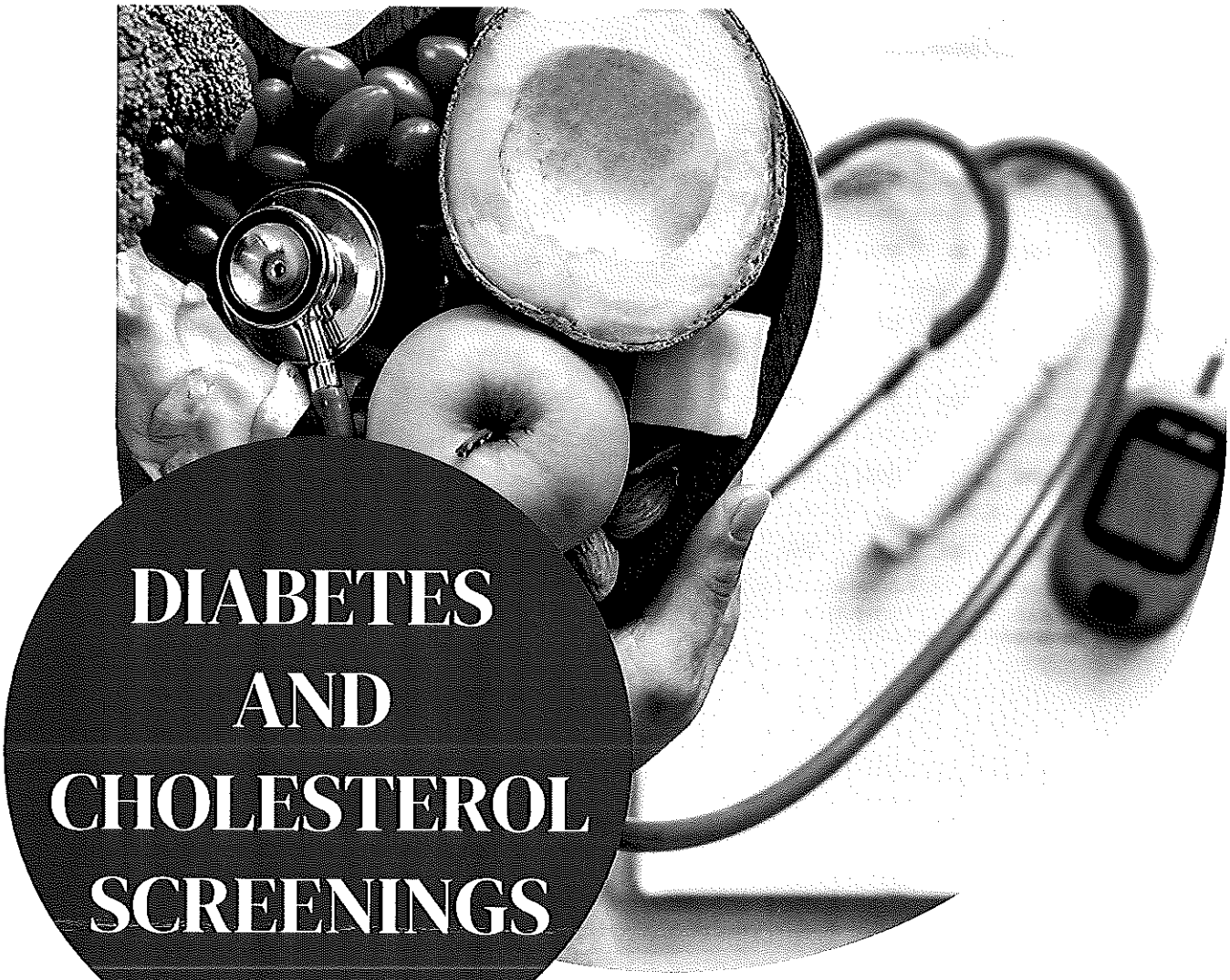
Solo con cita.

Para registrarse escanee el código QR o llámenos:

Centro Educacional de la Salud Comunitaria
503-814-2432

SALEM FREE CLINICS

Salem Health® Hospitals & Clinics



DIABETES AND CHOLESTEROL SCREENINGS

Dates:

- Saturday, March 25th
- Saturday, June 24th
- Saturday, September 23rd

Time: 8:00 to 10:00 a.m.
Location: Salem Free Clinic
1300 Broadway St NE Suite 104,
Salem, OR 97301
Cost: Free

Screening tests available include A1C, cholesterol, glucose, and blood pressure.

Attention: Please make sure you have been fasting for a minimum of 9 hours.

By Appointment only.

To Register scan the QR code or give us a call:

Community Health Education Center
503-814-2432

SALEM FREE CLINICS

Salem Health® Hospitals & Clinics

Youth Mental health and suicide prevention

Satya Chandragiri MD

chandrasclinic@me.com

Chandragiri_satya@salkeiz.k12.or.us

National Response to COVID-19

MENTAL HEALTH & SUICIDE PREVENTION

NATIONAL RESPONSE TO COVID-19

An initiative of the National Action Alliance for Suicide Prevention

visit NationalMentalHealthResponse.org

Americans Say COVID-19 Hurting Mental Health Most

BY **MEGAN BRENAN**

WARNING SIGNS OF SUICIDE:

The behaviors listed below may be some of the signs that someone is thinking about suicide.

TALKING ABOUT:

- Wanting to die
- Great guilt or shame
- Being a burden to others

FEELING:

- Empty, hopeless, trapped, or having no reason to live
- Extremely sad, more anxious, agitated, or full of rage
- Unbearable emotional or physical pain

CHANGING BEHAVIOR, SUCH AS:

- Making a plan or researching ways to die
- Withdrawing from friends, saying goodbye, giving away important items, or making a will
- Taking dangerous risks such as driving extremely fast
- Displaying extreme mood swings
- Eating or sleeping more or less
- Using drugs or alcohol more often

If these warning signs apply to you or someone you know, get help as soon as possible, particularly if the behavior is new or has increased recently.

988 Suicide & Crisis Lifeline
Call or text 988
Chat at 988lifeline.org

Crisis Text Line
Text "HELLO" to 741741

National Institute of Mental Health

nimh.nih.gov/suicideprevention

Strategic Directions and Actions

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

- Action 1: Activate a broad-based public health response to suicide
- Action 2: Address upstream factors that impact suicide

Strategic Direction 2: Clinical and Community Preventive Services

- Action 3: Ensure lethal means safety

Strategic Direction 3: Treatment and Support Services

- Action 4: Support adoption of evidence-based care for suicide risk
- Action 5: Enhance crisis care and care transitions

Strategic Direction 4: Surveillance, Research, and Evaluation

- Action 6: Improve the quality, timeliness, and use of suicide-related data

Suicide Prevention

RESOURCE FOR ACTION

A Compilation of the Best Available Evidence

2022

Division of Injury Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

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American Foundation for Suicide Prevention

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Educational Programs:

Talk Saves Lives
Talk Saves Lives Workplace
Talk Saves Lives for LGBT+
Talk Saves Lives Older Adults
Talk Saves Lives for Fire Arm Owners
Talk Saves Lives LatinX
It's Real: Teens
It's Real: College
Supporting Those at Risk
Finding Hope

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STRATEGIES AND APPROACHES

to achieve and sustain substantial reductions in suicide

STRATEGY	APPROACH
❶ Strengthen Economic Supports	• Improve household financial security • Stabilize housing
❷ Create Protective Environments	• Reduce access to lethal means among persons at risk of suicide • Create healthy organizational policies and culture • Reduce substance use through community-based policies and practices
❸ Improve Access and Delivery of Suicide Care	• Cover mental health conditions in health insurance policies • Increase provider availability in underserved areas • Provide rapid and remote access to help • Create safer suicide care through systems change
❹ Promote Healthy Connections	• Promote healthy peer norms • Engage community members in shared activities
❺ Teach Coping and Problem-Solving Skills	• Support social-emotional learning programs • Teach parenting skills to improve family relationships • Support resilience through education programs
❻ Identify and Support People at Risk	• Train gatekeepers • Respond to crises • Plan for safety and follow-up after an attempt • Provide therapeutic approaches
❼ Lessen Harms and Prevent Future Risk	• Intervene after a suicide (postvention) • Report and message about suicide safely

Student Safety Resources

Policies are periodically revised. For the most recent version, please visit https://salkeiz.sharepoint.com/qam/SitePages/Home.aspx

1. Salem-Keizer School District is committed to health and safety of all members in our school community. This policy covers actions that take place in the school, on school property, at school-sponsored functions and activities, on school buses or vehicles and at bus stops, and at school sponsored out-of-school events where school staff are present. This policy applies to the entire school community, including educators, school and district staff, students, and parents/guardians. Volunteers will be directed by school or district staff as it pertains to this policy. This policy will also cover appropriate school responses to suicidal or high-risk behaviors that take place outside of the school environment when notified.

2. Prevention

2.1. District Policy Implementation – A district-level suicide prevention coordinator shall be designated by the Superintendent or their designee. This may be an existing staff person. The district suicide prevention coordinator will be responsible for planning and coordinating implementation of this policy for the school district.

2.2. Each school administrator shall designate a school employee to act as a point of contact in each school for issues relating to suicide prevention and policy implementation. This may be an existing staff person.

2.3. All staff members shall report the names of students they believe to be at elevated risk for suicide to the administrator and/or designated building staff.

2.4. School employees act only within the authorization and scope of their credentials or licenses. This policy does not authorize or encourage a school employee to diagnose or treat mental illness unless the employee is specifically licensed and employed to do so.

2.4.1. For in-school suicide attempts staff must follow the steps in INS-W054-InSchool Suicide Attempts and for out-of-school suicide attempts staff must follow INS-W055-Out-Of-School Suicide Attempts.

2.5. Staff Professional Development – All staff will receive a minimum of an initial two-hour, in-person training in suicide prevention.

2.6. After the initial training, subsequent annual professional development on risk factors, warning signs, protective factors, response procedures, referrals, postvention, and resources regarding youth suicide prevention will be offered. The professional development may include additional information regarding groups of students at elevated risk for suicide, including those living with mental and/or substance use disorders, those who engage in self-harm or have attempted suicide, those in out-of-home settings, those experiencing homelessness, American Indian/Alaska Native students, LGBTQ (lesbian, gay, bisexual, transgender, and questioning) students, students bereaved by suicide, and those with medical conditions or certain types of disabilities.

2.6.1. Additional professional development in prevention protocols and crisis intervention will be provided to designated school suicide prevention points of contact.

2.7. Youth Suicide Prevention Programming – Developmentally appropriate, student-centered education materials will be integrated into the K-12 curriculum. The content of these age-appropriate materials will include: 1) the importance of safe and healthy choices and coping strategies, 2) how to recognize risk factors and warning signs of mental disorders and suicide in oneself and others, 3) help-seeking strategies for oneself or others, including how to

engage school resources and refer friends for help. In addition, schools may provide supplemental small-group suicide prevention programming for students.

2.8. Publication and Distribution – This policy will be distributed annually and included in all student and teacher handbooks and on the school and district websites.

3. Assessment and Referral

3.1. When a student is identified by a staff person as potentially suicidal, i.e., verbalizes about suicide, presents overt risk factors such as agitation or intoxication, the act of self-harm occurs, or a student self-refers, the student will be seen by the administrator or designated school employee to implement the Suicide Prevention Protocol (SPP).

3.2. For youth at imminent risk of suicide or self-harm:

3.2.1. School staff will continuously supervise the student to ensure their safety.

3.2.2. The principal and school suicide prevention coordinator will be made aware of the situation as soon as reasonably possible.

3.2.3. The designated school employee or administrator will contact the student's parent or guardian, as described in the Parental Notification and Involvement section.

3.2.4. The Parent/Guardian Interview Form will be completed, and the family will be assisted with safety planning based on the information gathered throughout the Suicide Prevention Protocol (SPP). When appropriate, this may include calling emergency services, bringing the student to the local emergency department, or utilizing partnerships with county mental health agencies to complete a Level 2 Suicide Risk Assessment (SRA) onsite.

3.2.5. Staff will ask the student's parent or guardian for written permission to discuss the student's health with outside care, if appropriate.

4. Re-Entry Procedure After Mental Health Crisis

4.1. For students returning to school after a mental health crisis (e.g., suicide attempt or psychiatric hospitalization), an administrator and designated school employee will meet with the student's parent or guardian, and if appropriate, meet with the student to complete the safety planning process and develop the student's safety and support plan with school staff.

4.1.1. An administrator or designated school staff will be identified to coordinate re-entry with the student or their parent or guardian. The designated school staff and/or administrator will seek authorization to coordinate with any outside mental healthcare providers.

4.1.2. The school or district will request that the parent or guardian volunteer documentation from a mental health care provider that the student has undergone examination and provide updated information regarding suicidal ideation and/or behavior.

4.1.3. Confidentiality is critical in protecting the student and enabling school personnel to render assistance. The administrator and/or designated school employee will discuss with the student and parent or guardian the information that identified staff need to know to support the student's academic, social, emotional, and physical needs.

4.1.4. The designated staff person will periodically check in with student and parent or guardian to help the student readjust to the school community and address any ongoing concerns

4.2. Students bereaved by suicide attempts will be supported by the school's administrator and/or counseling staff.

Parent Notification and Involvement

4.3. In situations where there is a concern regarding suicide for a student or there has been a suicide attempt, the student's parent or guardian will be informed by the administrator, designee, or mental health professional unless the exceptions in section 4.6 apply.

4.4. If the student has exhibited any kind of suicidal behavior, the parent or guardian should be counseled on "means restriction," limiting the child's access to mechanisms for carrying out a suicide attempt.

4.5. Staff will also seek parental permission to communicate with outside mental health care providers regarding their child.

4.6. Through discussion with the student, the administrator or designated staff will assess whether there is further risk of harm due to parent or guardian notification. If the administrator, designee, or mental health professional believes, in their professional capacity, that contacting the parent or guardian would endanger the health or well-being of the student, they may delay such contact as appropriate. If contact is delayed, the reasons for the delay will be documented. If necessary, the appropriate authorities will be contacted.

5. Postvention in the Event of a Death by Suicide

5.1. Immediately following a student's death by suicide, the administrator and crisis team will develop an action plan to guide the school's response according to the Crisis Team Manual. The action plan may include, but is not limited to:

5.1.1. Administrator will contact the family of the deceased to provide support.

5.1.2. Administrator will contact the Office of Community Relations and Communications to notify appropriate offices and determine crisis team response.

5.1.3. The administrator, Office of Community Relations and Communications, and crisis team will assess the situation to determine postvention supports.

5.1.4. Designated staff will collaborate with Local Mental Health Agency (LMHA) and administrators to initiate community support services for the impacted school(s).

6. Review of Suicide Intervention Actions

6.1. Persons may request a school district to review the actions of a school in responding to suicidal concerns by contacting the appropriate level director.

6.2. Any review would be reflective of a student's state and federal rights including those under HIPAA and FERPA as well as employee confidentiality laws.

Revision History:

Date	Description
9/23/19	**New policy**
9/30/19	**See archive for more revision history**
10/21/21	**Changed Suicide Risk Assessment to Suicide Prevention Protocols and minor updates throughout.**

Approved By: Cabinet _____

PROCEDURE
Suicide Prevention Protocol Preface
INS-P037

Procedures are continually revised and improved. For the most recent version, please visit https://salkeiz.sharepoint.com/qam/SitePages/Home.aspx

1.0 SCOPE:

1.1 This procedure is a preface to the Suicide Prevention and Intervention Protocols.

2.0 PROCEDURE:

2.1 Salem-Keizer Public Schools (SKPS) values every students' social-emotional health and wellbeing as well as their academic success. The Suicide Prevention Protocol (SPP) process focusses on prevention, intervention, and postvention supports for students who are experiencing suicidal thoughts or behaviors. The purpose of the SPP is to provide training, guidance, support to school staff members, increase student safety by collaborating with students and families, assist in safety planning, and provide linkages to community resources when necessary.

2.2 SKPS aims to partner with students and families when we are notified of a student concern regarding suicidal ideation and behaviors. It is our desire to collaborate and ensure a safe and positive school experience for your student. The administrator, school counselor, and other members of the school's support team will implement the SPP process and coordinate with the student's parent or guardian regarding community referrals and supports.

2.3 Please refer to the Administrative Policy INS-A038-Suicide Prevention and Intervention (available in multiple languages), and Work Instructions INS-W054-In-School Suicide Attempts and INS-W055-Out of School Suicide Attempts.

2.4 If you have questions or concerns, please contact the school counselor. Below are community organizations that provide crisis mental health and suicide prevention supports. If your student is experiencing an emergency, please call 911.

2.4.1 Marion County Youth and Family Crisis

2.4.1.1 (503) 576-4673

2.4.2 Psychiatric Crisis Center

2.4.2.1 (503) 585-4949

2.4.3 Polk County Mental Health

2.4.3.1 (503) 623-9289 and after-hours phone number 1(800) 560 - 5535

2.4.4 National Suicide Prevention Lifeline/Lines for Life:

2.4.4.1 1-800-273-8255

2.4.5 Red Nacional de Prevencion del suicidio:

2.4.5.1 1-888-628-9454

2.4.6 Deaf and Hard of Hearing:

2.4.6.1 1-800-799-4889

2.4.7 Oregon YouthLine:

2.4.7.1 877-968-8491 or Text 'teen2teen' to 839863 - Teens are available to help daily from 4-10pm Pacific Time (adults are available by phone at all other times). YouthLine is a free, confidential teen-to-teen crisis and help line.

2.4.8 Trevor Project:

2.4.8.1 Trevor Project: 866-488-7386 (available 24/7) or Text START to 678678 (Mon.-Fri 12-7pm)

3.0 ASSOCIATED DOCUMENTS:

3.1 INS-A038-Suicide Prevention and Intervention (available in multiple languages),

3.2 INS-W054-In-School Suicide Attempts

3.3 INS-W055-Out of School Suicide Attempts.

4.0 REVISION HISTORY:

Date	Description
9/20/21	New procedure

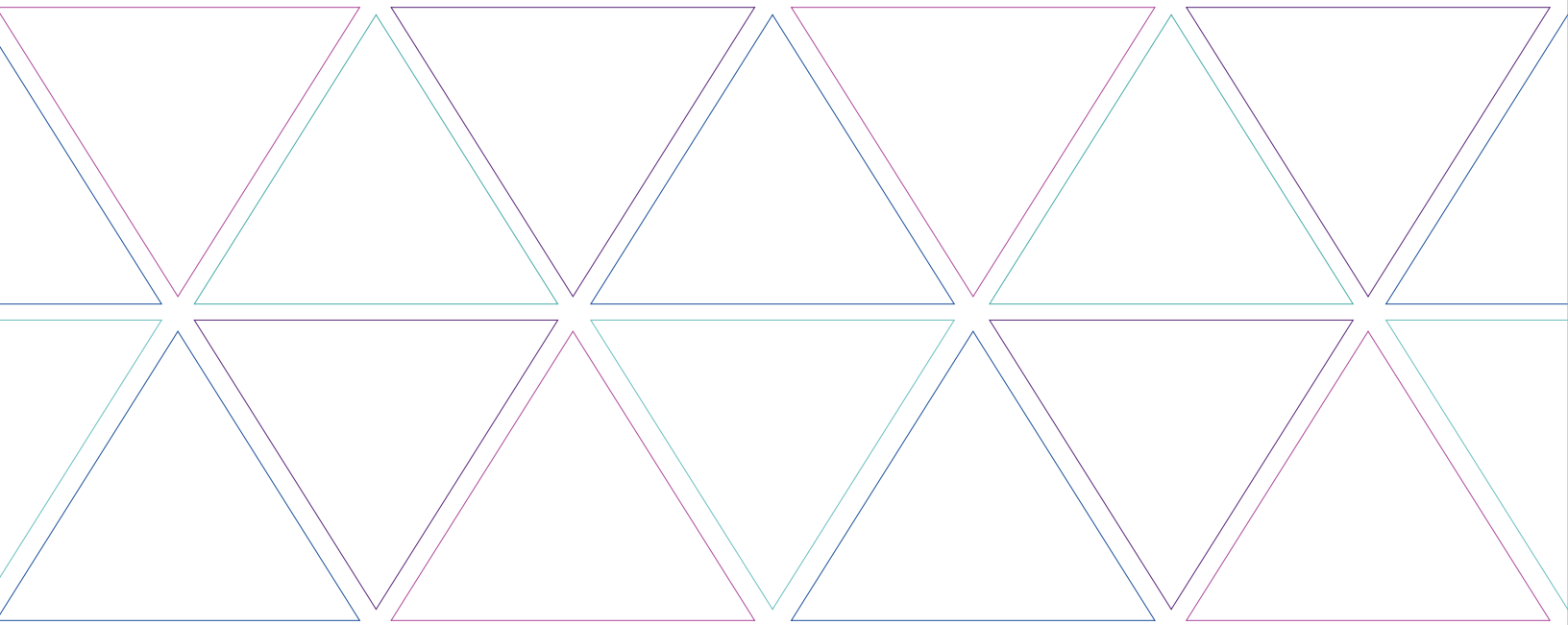
5.0 APPROVAL AUTHORITY:

5.1 Assistant Superintendent

_____ _____
Signature Date

Suicide Prevention

RESOURCE FOR ACTION



Suicide Prevention

RESOURCE FOR ACTION

SUGGESTED CITATION:

CDC. (2022). *Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Suicide Prevention

RESOURCE FOR ACTION

A Compilation of the Best Available Evidence

2022

Division of Injury Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

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The 2022 *Suicide Prevention Resource for Action* (Prevention Resource, for short) is an update to the 2017 *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*. It was a collaborative effort between the National Center for Injury Prevention and Control/Division of Injury Prevention and the Prevention Institute (Cooperative Agreement #NU38OT000305). We thank the following individuals who contributed to the development or design of this new Prevention Resource (listed in alphabetical order):

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Overview

Suicide Can Be Prevented

Like most public health problems, suicide is preventable.[1-3] The National Center for Injury Prevention and Control's vision of "No lives lost to suicide" relies on implementing a comprehensive public health approach to prevention. These efforts rely on timely data and evidence, prompting an update of the 2017 *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*. This 2022 version, now called the *Suicide Prevention Resource for Action* (or *Prevention Resource*, for short), weaves in new evidence that can be implemented and adapted for the community-specific context.

About the Suicide Prevention Resource for Action

This resource is intended to help communities and states learn about the best available evidence for suicide prevention.

The *Suicide Prevention Resource for Action* maintains the features of the 2017 *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*. It lays out a core set of strategies to achieve and sustain substantial reductions in a specific risk factor or outcome, such as suicide.[4] This resource is intended to help communities and states learn about the best available evidence for suicide prevention. Communities and states can pair this information with their local context and experience to prioritize prevention activities. This resource has three components. The first component is the **strategy** or the preventive actions to achieve the goal of preventing suicide. The second component is the **approach** or the specific ways to advance the strategy. This can be accomplished through policy, programs, and practices, which are the third component and are based on the **evidence** for each of the approaches in preventing suicide or its associated risk factors.

This Prevention Resource represents a select group of strategies based on the best available evidence to help communities and states focus on prevention activities with the greatest potential to prevent suicide. These strategies include:

- Strengthen economic supports
- Create protective environments
- Improve access and delivery of suicide care
- Promote healthy connections
- Teach coping and problem-solving skills
- Identify and support people at risk
- Lessen harms and prevent future risk

Preventing Suicide Is a Priority

Suicide is a critical public health problem in the United States (U.S.).[5]

> **SUICIDE** is a death caused by injuring oneself with the intent to die.
>
> **SUICIDE ATTEMPT** is defined as a *nonfatal act* when someone harms themselves with any intent to end their life but does not die as a result of their actions. A suicide attempt may or may not result in injury.

In recent years, the urgency to prevent suicide has heightened as millions of Americans were impacted by the coronavirus disease 2019 (COVID-19) pandemic and the overdose epidemic. These two major crises have taken a mental, emotional, physical, and economic toll on individuals, families, and communities.[2]

Suicide is not caused by any single factor and suicide prevention will not be achieved by any single strategy or approach.[1,2,6] The public health strategies in this resource focus on preventing the risk of suicide in the first place and lessening the immediate and long-term harms of suicidal behavior by helping those in times of crisis get the services and support they need. These strategies support the goals and objectives of the *National Strategy for Suicide Prevention, The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention*, the Action Alliance's priority to strengthen community-based prevention, and the Centers for Disease Control and Prevention's (CDC) comprehensive suicide prevention approach.

Partnering across sectors to leverage expertise and implementing multiple strategies and approaches that are tailored to cultural needs and strengths can address the multiple factors associated with suicide. Commitment, cooperation, and leadership from public health, mental health, education, justice, healthcare, social services, business, labor, and government, among others, can drive significant improvements in suicide prevention.

Suicide is highly prevalent

Suicide presents a major challenge to public health in the U.S. and worldwide. It contributes to premature death, morbidity, lost productivity, and healthcare costs.[1,3] Suicide was responsible for nearly 46,000 deaths in the U.S. in 2020.[7] This is about 1 suicide every 11 minutes.[8] Suicide is a leading cause of death for people ages 10–64 years.[9] Suicide rates rose 30% from 2000 to 2020, including small declines in 2019 and 2020.[7,10]

Suicide rates vary by age, race/ethnicity, and other socio-demographic characteristics. In 2020, suicide was the second leading cause of death for people ages 10–14 years and 25–34 years, the third leading cause for people ages 15–24 years, the fourth leading cause for people ages 34–44 years, the seventh leading cause for people ages 45–54 years, and the ninth leading cause for people ages 55–64 years.[9] Non-Hispanic American Indian or Alaska Native (AI/AN) people have the highest suicide rates, followed by non-Hispanic White people.[10] Racism, historical trauma, and long-lasting inequities such as disproportionate exposure to poverty have contributed to higher suicide rates among non-Hispanic AI/AN youth and other groups who have been marginalized.[11]

Some other population groups disproportionately impacted by higher-than-average suicide rates include veterans, people who live in rural areas, and workers in certain industries and occupations.[12-14] Transition periods are also associated with higher risk of suicide. This includes transitions from work into retirement, from active-duty military status to civilian status, from high school to college, and between levels of healthcare such as from an inpatient psychiatric hospitalization to outpatient care.[15-19]

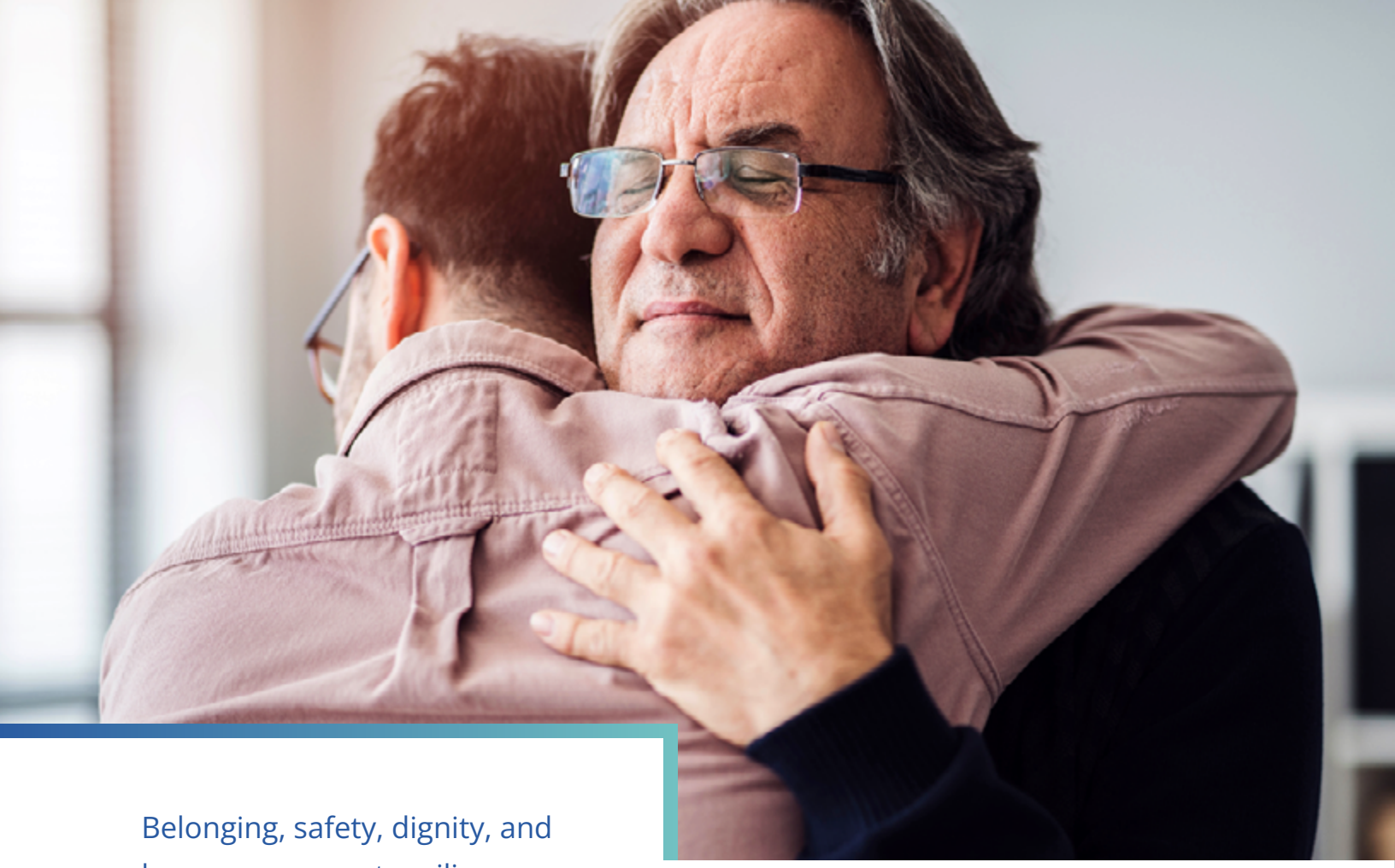
Suicides reflect only a portion of the problem.[20] Substantially more people are hospitalized or treated in ambulatory settings like emergency departments for nonfatal self-harm such as suicide attempts or

Suicide is not caused by any single factor and suicide prevention will not be achieved by any single strategy or approach.

not treated at all.[20] In 2020, 12.2 million American adults seriously thought about suicide, 3.2 million planned a suicide, and 1.2 million attempted suicide.[21] According to recent research, between 1991 and 2017, trends in suicidal ideation and planning among high school students decreased among all sex and racial and ethnic groups except non-Hispanic students of multiple races.[22] Another recent study found that trends in suicide attempts among adolescents from 2009-2019 increased overall, and Black students, both male and female, had the highest prevalence estimates for suicide attempts.[23] Disparities in access to mental health treatment and other factors such as poverty, historical trauma, and adverse childhood experiences (ACEs) may contribute to differences in suicide attempt rates among Black youth.[22] In addition, young people who identify as lesbian, gay, or bisexual have a higher rate of suicidal ideation as compared to their peers who identify as straight. In 2019, suicide attempts were more prevalent among students who reported having sex with persons of the same sex or with both sexes (30%) and students who identified as lesbian, gay, or bisexual (23%).[23] Transgender adolescents are at high risk of suicidal ideation and behavior compared to cisgender adolescents.[24]

Suicide is associated with multiple risk and protective factors

Research indicates that suicide risk varies as a result of the number and intensity of key risk and protective factors experienced.[25] Suicide occurs in response to multiple biological, psychological, interpersonal, environmental, and societal influences that interact with one another, often over time.[3,26,27] The social-ecological model encompasses multiple levels of focus and considers the complex interplay between individual, relationship, community, and societal factors. Characteristics that may increase the likelihood of suicide across populations include:



Belonging, safety, dignity, and hope can support resilience and healing for individuals and communities, and protect against suicide.

- **Individual risk factors:** Previous suicide attempt, history of depression and other mental illnesses, serious illness such as chronic pain, criminal/legal problems, job/financial problems or loss, impulsive or aggressive tendencies, substance misuse, current or prior history of adverse childhood experiences, sense of hopelessness, violence victimization and/or perpetration
- **Relationship risk factors:** Bullying, family/loved one's history of suicide, loss of relationships, high conflict or violent relationships, social isolation
- **Community risk factors:** Lack of access to healthcare, suicide cluster in the community, stress of acculturation, community violence, historical trauma, discrimination
- **Societal risk factors:** Stigma associated with help-seeking and mental illness, easy access to lethal means of suicide among people at risk, unsafe media portrayals of suicide

The presence of risk factors does not predict suicide or suicide attempts for any given person. Most individuals who experience risk factors or who attempt suicide do not die by suicide. The cumulative effect of several risk factors may serve to increase an individual's vulnerability to suicidal behaviors. The relevance of any given risk factor can vary by age, race, gender, sexual orientation, residential geography, and socio-cultural and economic status.[3,27,28]

Protective factors, or those influences that buffer against the risk for suicide and promote resilience, can also be found across the levels of the social-ecological model. Protective factors that improve resilience include:[3,27,28]

- **Individual protective factors:** Effective coping and problem-solving skills, reasons for living (for example, family, friends, pets, etc.), strong sense of cultural identity
- **Relationship protective factors:** Support from partners, friends, and family, feeling connected to others
- **Community protective factors:** Feeling connected to school, community, and other social institutions, availability of consistent and high quality physical and behavioral healthcare
- **Societal protective factors:** Reduced access to lethal means of suicide among people at risk, cultural, religious, or moral objections to suicide

These protective factors can either counter a specific risk factor or buffer against multiple risks associated with suicide. Belonging, safety, dignity, and hope can support resilience and healing for individuals and communities, and protect against suicide.[29]

Suicide, ACEs, and substance use are connected

Exposure to violence is associated with increased risk of depression, post-traumatic stress disorder, anxiety, suicide attempts, and suicide. Types of violence could include child abuse and neglect, bullying, peer violence, dating violence, sexual violence, and intimate partner violence.[30-37] ACEs, such as physical, sexual, and emotional abuse, or living in homes with violence, mental illnesses, or substance misuse, are also associated with increased risk for suicide attempts and suicide.[33,38] The effects of ACEs are often cumulative. Experiencing more ACEs is associated with greater risk for future poor outcomes when compared to people with fewer ACEs.[39]

Unemployment, poverty, and lower educational attainment are overlapping risk factors for ACEs, substance misuse, and multiple forms of violence and suicide,[40,41] which suggests that efforts to prevent these related issues may also prove beneficial in preventing suicide.[42-44] Similarly, many protective factors overlap and may be shared. Connectedness to one's community,[45] school,[46] family,[47] caring adults,[48,49] and pro-social peers[50] can enhance resilience and help reduce risk for suicide and different forms of violence.

Substance use disorders and suicide risk are associated.[51,52] For example, in a study using the National Death Index data and treatment data from electronic health records of 5 million veterans, researchers found diagnosis of substance use disorder was associated with increased suicide risk.[53] Drinking alcohol at an early age, heavy drinking, and mild to severe alcohol use disorder can all lead to increases in suicidal ideation.[54] The relationship is also cyclical. Losing a loved one to overdose or suicide during childhood can increase the risk for overdose or suicide later in life.[55]

Suicide has far-reaching impacts

Suicide and suicide attempts can contribute to lasting impacts on individuals, families, and communities.[56-59] Studies estimate that the number of individuals impacted by a single suicide attempt ranges from 135–456 individuals.[60,61] Other studies have found that 48–58% of adults in the U.S. know at least one person over their lifetime who died by suicide.[61,62] Research also indicates that people with lived experience, such as having attempted suicide, having suicidal thoughts, or having experienced the loss of a friend or family member to suicide, may suffer long-term health and mental health consequences, such as anger, guilt, and physical impairment.[63-66] Survivors of a loved one's suicide may experience ongoing pain and suffering including complicated grief,[67-69] stigma, depression, anxiety, post-traumatic stress disorder, and increased risk of suicidal ideation and suicide.[64,70-72] The economic toll of suicide on society is immense as well. Suicide cost the U.S. more than $460 billion and self-harm $26 billion in 2019.[73,74]

STRATEGIES AND APPROACHES

to achieve and sustain substantial reductions in suicide

STRATEGY	APPROACH
❶ Strengthen Economic Supports	• Improve household financial security • Stabilize housing
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❸ Improve Access and Delivery of Suicide Care	• Cover mental health conditions in health insurance policies • Increase provider availability in underserved areas • Provide rapid and remote access to help • Create safer suicide care through systems change
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❻ Identify and Support People at Risk	• Train gatekeepers • Respond to crises • Plan for safety and follow-up after an attempt • Provide therapeutic approaches
❼ Lessen Harms and Prevent Future Risk	• Intervene after a suicide (postvention) • Report and message about suicide safely

Contextual and Cross-Cutting Themes

Synergistic strategies and approaches

The strategies and approaches in this resource can have complementary and synergistic impacts. They are intended to impact community and societal levels as well as individual and relationship levels. They can work in combination and reinforce each other to prevent suicide (see summary box at left).

Each strategy has a specific focus, but the strategies are not mutually exclusive. For instance, some programs that teach skills like emotional regulation and conflict resolution fall under the *Teach Coping and Problem-Solving Skills* strategy but also include components to change peer norms, which falls under the *Promote Healthy Connections* strategy. However, the primary focus of these programs is to provide children and youth with coping and problem-solving skills to resolve problems in relationships, in school, and with peers and to help youth address other negative influences such as substance use.

Comprehensive action

The overarching goal of this resource is to stress the importance of comprehensive prevention efforts. Comprehensive suicide prevention includes preventing suicide risk, supporting those at increased risk of suicide, preventing reattempts, and supporting survivors of suicide loss. Programs, practices, and policies that span multiple sectors and influence multiple levels of the social ecology are more likely to have a greater effect on the overall burden of suicide.

Assessing local context, needs, and strengths

The effectiveness of the programs, policies, and practices identified here will depend on how well they are implemented and the level of participation from partners and communities. Practitioners in the field and community members are valuable resources for assessing needs and strengths and making decisions about the combination of approaches that are best suited to their community context. Community members can also advance health equity by including and amplifying the voices of underserved populations and assisting with cultural adaptations of prevention

Practitioners in the field and community members are valuable resources for assessing needs and strengths and making decisions.

strategies and approaches that may increase acceptability and effectiveness. Multiple strategies and approaches tailored to the social, economic, cultural, and environmental context will increase the likelihood of developing individual and community resilience and removing barriers to supportive and effective care.[1,2]

Data-driven strategic planning with engagement from multi-sectoral partners can help communities with decision-making.[75-77] This planning process guides its members through activities designed to address the range of risk and protective factors specific to the community using programs, practices, and policies with the best available evidence. Strategic planning can also be used to monitor implementation, track outcomes, and adjust as indicated by the data. The community's readiness to plan, implement, and evaluate prevention efforts can also influence program effects. Implementation guidance to assist practitioners, organizations, and communities is available through the Action Alliance's Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention and the Suicide Prevention Resource Center.[78,79] The Prevention Institute's Suicide Prevention Modules[80] offer specific guidance for suicide prevention planning in the context of catastrophic events.

Collaboration

A comprehensive approach to suicide prevention includes multi-sectoral partnerships as no agency or sector can accomplish suicide prevention on its own. Such partnerships include allies in the public and private sectors like public health, mental health, healthcare, education, employment/labor, housing, social services, business, and others. Public health agencies are well-positioned to bring leadership and resources to implement strategies. The role of other sectors in implementation is described in the section on *Collaboration and Partnerships*.

The COVID-19 Pandemic and Suicide Prevention

The COVID-19 pandemic created unprecedented challenges for communities. Some experts noted that COVID-19 created the "perfect storm" for increased suicide risk due to the consequences of physical/social distancing, increases in economic stressors, decreased access to mental health treatment, and decreased access to typical routines and support systems.[81-83] Prior public health crises were associated with increased suicide risk among some populations. Studies suggest increased suicide rates during the 1918–1920 influenza pandemic in the U.S. and in Taiwan and among older adults in Hong Kong during the 2003 severe acute respiratory syndrome pandemic.[84-86]

At the time of this writing (while the world is deeply embedded in the COVID-19 pandemic), it is too early to assess the full impact of the COVID-19 pandemic on suicide. While overall suicide rates declined in 2019 and 2020, they increased among some populations.[7] Studies showed increases in mental distress and substance use for some populations during the pandemic.[87-89] A CDC study conducted in June 2020 indicated that U.S. adults reported significant mental health distress related to COVID-19.[87] The study also showed that specific sub-populations, including younger adults, people from racial and ethnic minority groups, essential workers, and unpaid adult caregivers, reported experiencing disproportionately worse mental health outcomes, increased substance use, and increased suicidal ideation. Early evidence among older adults paints a different picture. A qualitative study of older adults with pre-existing depression showed no difference in depression, anxiety, and suicidal ideation symptom scores. Instead, older adults exhibited resilience and increased use of technology to connect virtually with social supports.[90]

Organizations are developing strategies to respond to the potential risk presented by COVID-19. For example, telehealth is being used to identify, assess, and treat individuals who are at risk for suicide. Evidence-based suicide prevention programs, such as Collaborative Assessment and Management of Suicidality, have been adapted for use with telehealth to support higher demand for mental health services.[91] The effectiveness of telehealth as a treatment modality has been deemed as equivalent to in-person treatment for many mental health diagnoses, including post-traumatic stress disorder and depression, but the effectiveness for specific suicide interventions is less clear at this time.[92-94] The effectiveness of using telehealth alongside existing suicide prevention strategies is a new area of study, as is consideration for access to technology among people who are at increased risk for suicide.

The Action Alliance has convened diverse sectors to coordinate the Mental Health and Suicide Prevention National Response to COVID-19 to create sustainable and comprehensive solutions to the mental health impacts of the COVID-19 pandemic. The National Response is a public-private partnership engaging leaders from academia, business, government, nonprofits, non-governmental organizations, healthcare, public safety, and media and entertainment.[95,96]

Assessing the Evidence

This *Suicide Prevention Resource for Action* includes policies, programs, and practices with evidence of impact on suicide, suicide attempts, or risk or protective factors. It has been updated from the original 2017 *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* through a review of suicide-related literature published from 2016–2020 and with input from subject matter experts and state and community leaders. Evidence for inclusion had to meet at least one of the following criteria:

- meta-analysis or systematic review showing impact on suicide,
- evidence from at least one rigorous evaluation study (e.g., randomized controlled trial or quasi-experimental design with a control group or multiple pre- and post-assessments) that found significant preventive effects on suicide,
- meta-analysis or systematic review showing impact on risk or protective factors against suicide, or
- evidence from at least one rigorous evaluation study that found significant impacts on risk or protective factors against suicide. International studies were included if they were written in English and could potentially be implemented in the U.S. context. In evidence sections below, the study locations are listed for studies conducted outside the U.S.

Some approaches do not yet have research evidence demonstrating impact on suicide rates but are supported by evidence indicating impacts on risk or protective factors against suicide. Programs that have demonstrated effects on suicide or suicide attempts provide a higher level of evidence, but the evidence base is not that strong in all areas. For instance, less evaluation has been done on the effects of the community engagement and family programs on suicidal behavior. The approaches provided in this resource that have effects on risk or protective factors related to suicidal behaviors reflect the developing nature of the evidence base and use of the best available evidence at a given time.

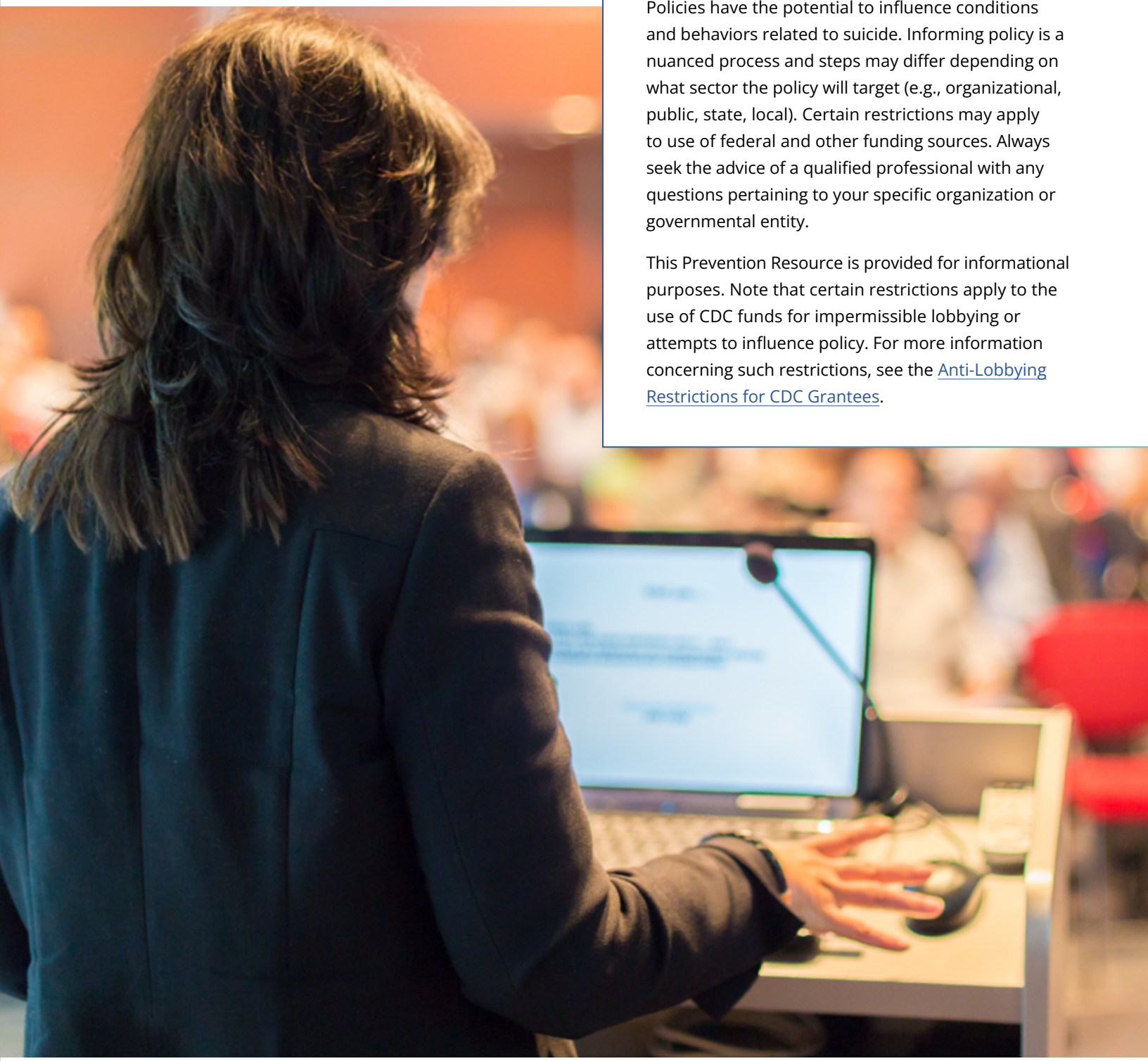
Importantly, significant heterogeneity in the nature and quality of the available evidence often exists among the policies, programs, or practices in a given strategy or approach. Not all policies, programs, or practices that utilize the same approach are equally effective, and even those that are effective may not work across all populations. Tailoring programs for specific populations that are culturally relevant and conducting more evaluations may be necessary to address different population groups. *The policies, programs, and practices included in the resource are not intended to be a comprehensive list for each approach but rather serve as examples that have shown impact on suicide or suicide risk or protective factors.* Learning modules from the Prevention Institute are available to guide state and community leaders in adapting and applying the evidence to meet local community needs.

Each chapter shares evidence from published literature that was confirmed by experts for each of the seven suicide prevention strategies. They include the rationale for the strategy, an overview of the broad approaches, potential outcomes resulting from the strategy and approaches, and evidence citations for each of the approaches. Finally, a section on future directions describes where additional studies are being conducted or need to be conducted to expand the evidence and identify additional approaches.

Informing Policy

Policies have the potential to influence conditions and behaviors related to suicide. Informing policy is a nuanced process and steps may differ depending on what sector the policy will target (e.g., organizational, public, state, local). Certain restrictions may apply to use of federal and other funding sources. Always seek the advice of a qualified professional with any questions pertaining to your specific organization or governmental entity.

This Prevention Resource is provided for informational purposes. Note that certain restrictions apply to the use of CDC funds for impermissible lobbying or attempts to influence policy. For more information concerning such restrictions, see the Anti-Lobbying Restrictions for CDC Grantees.



Strengthen Economic Supports

Rationale

Historical trends in the U.S. indicate that suicide rates increase during economic recessions marked by high unemployment rates, job losses, and economic instability and decrease during economic expansions and periods marked by low unemployment rates, particularly for working-age individuals 25–64 years old.[77,97-100] Economic and financial strain may increase an individual's risk for suicide or may indirectly increase risk by exacerbating existing physical and/or mental illnesses.[101,102] Financial strains could include job loss, long periods of unemployment, poverty, reduced income, difficulty covering medical, food, and housing expenses, and even the anticipation of such financial stress. Evictions and homelessness are also related to suicide.[97,103] Reducing these stressors can potentially buffer suicide risk. For example, strengthening economic support systems can help people stay in their homes or obtain affordable housing. They may also pay for necessities such as food and medical care, job training, childcare, and other expenses required for daily living. Providing economic support may reduce stress, anxiety, and the potential for a crisis, thereby preventing risk of suicide. More research is needed on how economic factors interact with other factors to increase suicide risk, but the available evidence suggests that strengthening economic supports may be one opportunity to buffer suicide risk.

Providing economic support may reduce stress, anxiety, and the potential for a crisis, thereby preventing risk of suicide.

Approaches

Economic supports for individuals and families can be strengthened by increasing household financial security and ensuring stability in housing during periods of economic stress.

Improve household financial security

This approach can buffer the risk of suicide by providing individuals with the financial means to lessen the stress and hardship associated with a job loss or other unanticipated financial problems. The provision of unemployment benefits and other forms of temporary assistance, livable wages, medical benefits, and retirement and disability insurance to help cover the cost of necessities or to offset costs in the event of disability are examples of ways to strengthen household financial security.

Stabilize housing

This approach seeks to keep people in their homes and provides housing options for those in need during times of financial insecurity. Housing stabilization may occur through programs that provide affordable housing to those who are experiencing homelessness or are at risk of homelessness. It could happen through government subsidies, loan modification programs, and financial counseling services to help minimize the risk or impact of foreclosures and eviction.

Potential Outcomes

Potential outcomes include reductions in:

- Financial stress
- Emotional distress
- Poverty
- Foreclosure and eviction rates
- Suicide

Evidence

Evidence suggests that strengthening household financial security and stabilizing housing can reduce suicide risk.

Improve household financial security

Some studies have shown that **unemployment insurance benefits** may offset the relationship between unemployment and suicide. One study found that an increase in the maximum benefits allowed through unemployment insurance was protective against increasing suicide rates during times of increased unemployment.[104] This was particularly the case among those ages 20–34. Another study in the U.S. examined recipiency rates (the percentage of unemployed individuals receiving unemployment insurance benefits) by state over time and found that this was also related to reduced suicide rates but only among men, non-Hispanic White Americans, and those ages 45–64 years.[105]

Other unemployment support practices. Government municipalities in Japan implemented a broad community-based intervention that provided both financial and non-financial support to unemployed individuals, such as consultations about unemployment, bankruptcy, debt problems, and human resource training.[106] Researchers found that this comprehensive intervention reduced suicide rates among older males. A meta-analysis of the impact of unemployment support practices (in studies from the U.S., the United Kingdom, Spain, Australia, and

Finland) found that job skills training or group support interventions reduced levels of depressive symptoms, a suicide risk factor, particularly among those at highest risk for clinical depression.[107]

Other household financial security measures. One study in the U.S. found that state suicide rates decreased as per capita spending increased on total **transfer payments, medical benefits, and family assistance** such as Temporary Assistance for Needy Families.[108] Researchers estimated 3,000 fewer suicides would occur nationally per year if every state increased its per capita spending on these types of assistance by $45 per year.[108]

A more rigorous evaluation was carried out in Indonesia examining the impact of cash *transfer payments* on suicide rates.[109] The program offered conditional cash transfers of 10% of the household's annual consumption for six consecutive years in subdistricts with high levels of poverty. Results indicated that the cash transfers reduced annual suicide rates by 18% in the participating subdistricts.

Other household benefits that may impact suicide rates in the U.S. are state supplements to federal **earned income tax credits**, **Supplemental Nutrition Assistance Program (SNAP)** participation, and **Social Security early retirement benefits**.[110-113] Two independent studies found that states that supplemented the federal earned income tax credit at 10% or more had a 3–4% reduction in suicide rates compared to states with no state supplement.[111,112] Another study estimated that a 1% increase in SNAP participation could result in approximately 7,000 fewer suicide deaths.[113] A fourth study indicated that early access to Social Security benefits reduced suicide rates by 7–8% among those turning 62 years of age.[110]

Finally, there is growing evidence that **increasing minimum wages** may reduce suicide rates. One study in the U.S. estimated that a $1 increase in

Programs offering support for individuals and families threatened by potential eviction or foreclosure may help prevent suicide.

minimum wages was associated with a 2% decrease in annual suicide rates.[114] Two other studies examined the impact among those with a high school education or less. The first study found that a 10% increase in minimum wages was related to a 2.7% decrease in non-drug suicide deaths among those with a high school education or less.[112] A second study indicated that a $1 increase in minimum wages was associated with a 6% decrease in suicide rates.[115] Increasing minimum wages can help minimize the disparities between increased suicide rates among those of lower versus higher socioeconomic status.[116]

Stabilize housing

A longitudinal analysis of the association between suicides and foreclosures demonstrated that as the proportion of foreclosed properties increased, so did the state suicide rate, particularly among working-aged adults.[117] Another study analyzing data from 16 U.S. states found that suicides associated with home foreclosures and evictions increased more than 100% from before the housing crisis began in 2005 to after it peaked in 2010.[97] Most of the suicides occurred prior to the actual loss of the person's home. Programs offering support for individuals and families threatened by potential eviction or foreclosure may help prevent suicide.

A particularly understudied area is the impact of financial assistance and eviction support on suicide risk for individuals with lower incomes who rent rather than own a home. Studies have not found that **rent assistance** can reduce suicide, but there is an association between financial assistance programs for renters with lower incomes in the U.S. and United Kingdom and self-reported depression, a suicide risk factor.[118,119]

Programs that offer **low-barrier housing for individuals experiencing chronic homelessness** may also help reduce suicide. Housing First is one such program.[120] One study in Canada found individuals with alcohol problems who entered Housing First experienced a 43% reduction in severity of suicidal ideation after two years.[121] A more rigorous randomized controlled trial done in Canada among individuals experiencing homelessness with major mental health illnesses also observed decreases in suicidal ideation over two years. However, this impact was not substantially different from a control group who were referred to existing community supports.[122]

The Veterans Health Administration's programs for homeless veterans significantly reduced both all-cause and suicide mortality among veterans self-reporting housing instability. These programs included:

- Emergency housing services such as Health Care for Homeless Veterans and Safe Haven programs
- Rapid rehousing and homelessness prevention programs such as Supportive Services for Veteran Families
- Permanent supportive housing programs such as the U.S. Department of Housing and Urban Development-Veterans Affairs Supportive Housing
- Transitional housing[123]

Future Directions

Evidence is still accumulating around many approaches for strengthening economic supports and their relationship with suicide. Many studies show promising correlations between the interventions and the outcomes at the population level. This evidence can be strengthened as states and communities continue to monitor changes and impacts using rigorous study designs.

Create Protective Environments

Rationale

Prevention efforts that focus on changes to the environment can increase the likelihood of positive behavioral and health outcomes.[124] Creating environments that address risk and protective factors where individuals live, work, and play can help prevent suicide.[1,125] Suicide rates are high among middle-aged adults who comprise about 43% of the workforce;[126] among certain occupational groups;[12,127] and among people in detention facilities such as jails or prisons.[128] Settings where these populations work and reside are ideal for implementing policies, programs, and practices to buffer against suicide. Implementing supportive policies can change organizational culture by changing social norms, encouraging help-seeking, and demonstrating that health and mental health are valued.[129,130] Modifying characteristics of the physical environment such as access to lethal means among people at risk can prevent harmful behavior and reduce suicide rates, particularly in times of crisis or transition.[131-136]

Creating environments that address risk and protective factors where individuals live, work, and play can help prevent suicide.

Approaches

The current evidence suggests three potential approaches for creating environments that protect against suicide.

Reduce access to lethal means among persons at risk of suicide

Means of suicide such as firearms, hanging or suffocation, or jumping from heights provide little opportunity for rescue. These means have high case-fatality rates. Almost 90% of people who use a firearm in a suicide attempt die from their injury.[137] Research also indicates that the interval between deciding to act and attempting suicide can be as short as 5 or 10 minutes[138,139] and people tend *not* to substitute a different method when a highly lethal method is unavailable or difficult to access.[140-142] Reducing access to lethal means among people at risk and increasing the time interval between deciding to act and the suicide attempt can be lifesaving. The following are examples of approaches intended to reduce access to lethal or available environmental means for persons at risk of suicide:

- **Interventions to reduce readily accessible environmental means.** A person's environment can significantly influence the accessibility of lethal suicide means. Places where suicides may take place relatively easily include tall structures (such as bridges, cliffs, balconies, and rooftops), railway tracks, or isolated areas. Efforts to prevent suicide at these locations include erecting barriers or limiting access to prevent jumping and installing signs and telephones to encourage individuals who are considering suicide to seek help.[143-147]
- **Safe storage practices and policies.** Safe storage of medications, firearms, and other household products can reduce the risk for suicide by separating individuals at elevated risk of suicide from easy access to lethal means. Such

practices may include storing firearms in a gun safe or lock box, unloaded and separate from the ammunition, and keeping medicines in a locked box or other secure location. The provision of a safe storage device may also be combined with education and counseling about access to lethal means to enhance safe storage practices.[146] Finally, approaches that effectively limit children's access to firearms in the home by enhancing safe storage practices may help prevent youth suicide.

- **Approaches to put time and space between lethal means and suicidal individuals** may help save lives. Mandatory waiting periods are laws that delay the possession of firearms for a period of time after purchase. These laws may help insert time and space between an individual's impulse or decision to attempt suicide and an actual suicide attempt.[148]

Create healthy organizational policies and culture

Protective environments that promote positive behaviors and norms may be implemented in places of employment, detention facilities, and other secured environments such as residential settings. Such policies and cultural values include strong leadership support of policies and programs and promote pro-social behavior (such as asking for help), skill building, and positive social norms among all people in the organization or setting. These policies can also improve access to assessments, referrals, and helping services such as mental health treatment, substance misuse treatment, and financial counseling. Crisis response plans, postvention, and other measures can also foster a safe physical environment. These policies and cultural shifts can positively impact organizational climate and morale to help prevent suicide and its related risk factors such as depression and social isolation.[130,149]

Reduce substance use through community-based policies and practices

Research studies in the U.S. have found that greater alcohol availability is positively associated with alcohol-involved suicides.[150-152] A review of the literature found that acute alcohol use was associated with more than one-third of suicides and approximately 40% of suicide attempts.[153] **Policies to reduce excessive alcohol use** include zoning to limit the location and density of alcohol outlets, taxes on alcohol, and bans on the sale of alcohol for individuals under the legal drinking age.[152] Studies have also revealed a connection between suicide attempts and other substance misuse, such as opioids.[51,154] One analysis revealed a dose-response relationship between suicide and opioids prescribed for pain, depicting higher suicide rates among those with higher dose prescriptions.[154]

Potential Outcomes

Potential outcomes include increases in:

- safe storage of lethal means, and
- access points to low and no cost help-seeking.

Potential outcomes also include reductions in:

- stigma associated with mental illness and suicide-related outcomes,
- suicide, and
- substance-related suicide deaths.

Crisis response plans, postvention, and other measures can also foster a safe physical environment. These policies can positively impact organizational climate.

Evidence

The evidence suggests that creating protective environments can reduce suicide and suicide attempts by increasing the time and space between a suicidal individual's decision to act and an actual suicide attempt. As with other strategies, the evidence is continually evolving. People using this Prevention Resource may wish to seek out the latest evidence since release of this publication.

Reduce access to lethal means among persons at risk of suicide

Interventions to reduce readily accessible environmental means. Erecting a barrier on the Jacques-Cartier Bridge in Montreal, Canada, reduced the suicide rate from people jumping off the bridge from about 10 suicide deaths per year to about 3 deaths per year.[155] The reduction in suicides by jumping was sustained even when all bridges and nearby sites were considered. This suggests little to no displacement of suicide deaths to other jumping sites.[155] Similar results were seen at the Bloor Street Viaduct in Toronto, Canada. Installing a barrier decreased the average annual deaths by suicide at the viaduct from 9 to 0.1, with only 1 suicide death over the 11 years following its installation.[147]

Safe storage. In a case-control study of firearm-related events in 37 counties in Missouri, Oregon, and Washington, and five trauma centers in Washington and Missouri, researchers found that firearms being stored unloaded, separate from ammunition, and in a locked place (or secured with a safety device) was protective of suicide attempts among adolescents.[156] The Israeli Defense Forces administration enacted a prevention strategy that included mandatory storage of soldiers' firearms on base when soldiers went home for the weekends. This effort resulted in a 40%–50% decrease in suicide rates of soldiers over the weekends.[157,158]

Counseling on Access to Lethal Means (CALM) is a suicide prevention program designed to reduce access to lethal means in times of crisis.[163] CALM was initially developed for use by mental health providers but has been tailored for use in emergency departments. The Emergency Department Counseling on Access to Lethal Means (ED CALM) was used to train psychiatric emergency clinicians in a large children's hospital to provide lethal means counseling and safe storage boxes to parents of patients under age 18 receiving care for suicidal behavior. In a pre-post quality improvement project, Runyan and colleagues found that 76% of the 55% of parents who were followed up with (n = 114) reported that all medications in the home were locked as compared with fewer than 10% at the time of the initial emergency department visit.[131] Among parents who indicated the presence of guns in the home at pre-test (67%), all (100%) reported guns were currently locked at post-test.[131]

Another study evaluated a CALM implementation program with case managers to understand the impact of the training on service providers. Case managers reported that most beliefs, attitudes, and behavioral intentions about counseling clients and families on lethal means improved after the training. Most participating providers believed CALM provided them with concrete ideas to use in their work (78%), and it addressed an important, often overlooked aspect of suicide prevention (77%).[159]

A CALM online training is available to the public on the Suicide Prevention Resource Center (SPRC; listed under Resources and Programs). This video describes a CALM partnership between National Center for Injury Prevention and Control's Core State Violence and Injury Prevention Program and Injury Control Research Centers.

Approaches to put time and space between lethal means and suicidal individuals. A review of **child access prevention laws** concluded that they have been associated with lower rates of youth firearm self-injury and suicide.[148] These laws, called CAP laws, are intended to limit a child's access to firearms within the home. Two types of CAP laws exist: those that hold the firearm owner liable for directly providing the firearm to a minor (recklessness laws) and those that hold the firearm owner liable for the unsafe storage of the firearm (negligence laws). In a study of state-level

CAP firearm laws throughout the U.S. between 1991–2016, negligence CAP laws were associated with a 12% relative reduction in firearm suicides among children and youth under 15 years old.[160] However, authors acknowledge that due to the study design, the results cannot be used to indicate causality and that residents' awareness of these laws in a particular state is unknown. Some research suggests that gun owners are often not aware of negligent storage CAP laws in their state and that the presence of the law is not associated with a significant difference in storage practices.[161] Lastly, the results do not account for differences between states, misclassification in the data, or enforcement of CAP laws.[160]

Other policies to put time and space between lethal means and people with suicidal thoughts or intent include **mandatory waiting periods.** A systematic review concluded that there is "moderate" evidence (i.e., two or more studies found significant effects in the same direction and no contradictory evidence was found in other studies with stronger methods) that mandatory waiting periods are associated with lower firearm suicide rates.[148] As above, causality cannot be inferred due to the correlational nature of the study design, and the extent to which laws impacted individuals directly is unknown. Also, the effects of waiting periods can be limited because they are likely to only have protective benefits for those who do not already own a firearm, and the possibility remains that waiting periods might only delay suicide for some individuals.[148]

Create healthy organizational policies and culture

The United States Air Force Suicide Prevention Program is an example of healthy organizational policies and culture.[162] The program includes 11 policy and education initiatives and was designed to change the culture within the Air Force surrounding suicide. The program uses leaders as role models and agents of change, establishes expectations for behavior related to awareness of suicide risk, develops skills and knowledge in the population through education and training, and investigates every suicide to understand what contributed to the death.[163] Researchers using a time-series design found the program was associated with a 33% relative risk reduction in suicide.[163] A longitudinal assessment of the program over the period 1981–2008 (16 years before the 1997 launch of the program and 11 years after the launch) found significantly lower suicide rates after the program was launched than before.[129] These effects were sustained over time, except in 2004, which the authors found was associated with less rigorous implementation of the program.[129]

Together for Life is a workplace program the Montreal Police Force implemented to address suicide among officers. Policy and program components were designed to foster an organizational culture that promoted mutual support and solidarity among all members of the force. The program included training for supervisors, managers, and all units to improve competencies in identifying suicide risk and use and awareness of existing resources. The program also included an education campaign to improve awareness and help-seeking.[164] Police suicides were tracked over 12 years and compared to rates in the control city of Quebec. The suicide rate in the intervention group decreased significantly by 79% to a rate of 6.4 suicides per 100,000 population per year compared to an 11% increase in the control city (29 per 100,000).[164] Suicide decreases were evaluated 10 years later in a follow-up study. Results indicated that the decrease in suicides observed 12 years after initiation of the Together for Life program were sustained in the following 10 years of program's operation.[165]

Primary and secondary school-based organizational initiatives have also demonstrated effectiveness in improving staff knowledge and confidence recognizing and properly addressing student self-injury and suicidality. **Strong Schools Against Suicidality and Self-Injury** depicted such results immediately after implementation of two-day workshops and at six-month follow-up evaluations (U.S. and Germany).[166,167]

Correctional suicide prevention that involves comprehensive policies and practices can reduce suicide among incarcerated populations through:

- routine suicide prevention training for all staff,
- standardized intake screening and risk assessment,
- provision of shared information between staff members (especially in transitioning or transferring of inmates),
- varying levels of observation,
- safe physical environment,
- emergency response protocols,
- notification of suicidal behavior through the chain of command, and
- critical incident stress debriefing and death review.[149]

As a result of this approach, suicide rates among those incarcerated in 11 state prisons in Louisiana dropped 46%, from a rate of 23.1 per 100,000 before the intervention to 12.4 per 100,000 the following year.[168] Similar programs both in the U.S. and in other countries have resulted in declines in suicide.[169]

Reduce substance use through community-based policies and practices

A meta-analysis of over 870,000 participants in cross-sectional, case-control, and cohort studies identified a strong relationship between substance use disorders and suicide-related outcomes, including suicidal ideation, attempts, and deaths.[170] Several studies examining **reduced alcohol outlet density** in the U.S., Canada, Denmark, Lithuania, Russia, Slovenia, Switzerland, Sweden, the United Kingdom, and the Soviet Union[171-175] suggest that such measures can potentially reduce alcohol-involved suicides. Additionally, a longitudinal analysis of alcohol outlet density, suicide mortality, and hospitalizations for suicide attempts over six years in 581 California ZIP codes indicated that greater density of bars, specifically, was related to greater suicide and suicide attempts, particularly in rural areas.[176] Although correlational, researchers discovered a positive effect on suicide rates from **prescription drug supply restrictions** (as measured by the implementation of Prescription Drug Monitoring Programs) in locations with a strong presence of drug treatment facilities and prescribing of medication-assisted therapy.[177]

Future Directions

Research on how to create protective environments is ongoing and continually evolving, with evaluations underway. For example, the Gun Shop Project is currently active in many states and communities. This program educates gun shop owners and customers about how to identify and respond to a customer who is potentially at risk of suicide.[178,179] This program was created by community members, a gun shop owner, behavioral health and suicide prevention organization representatives, and public health researchers. Work is underway to evaluate this program and other similar programs.

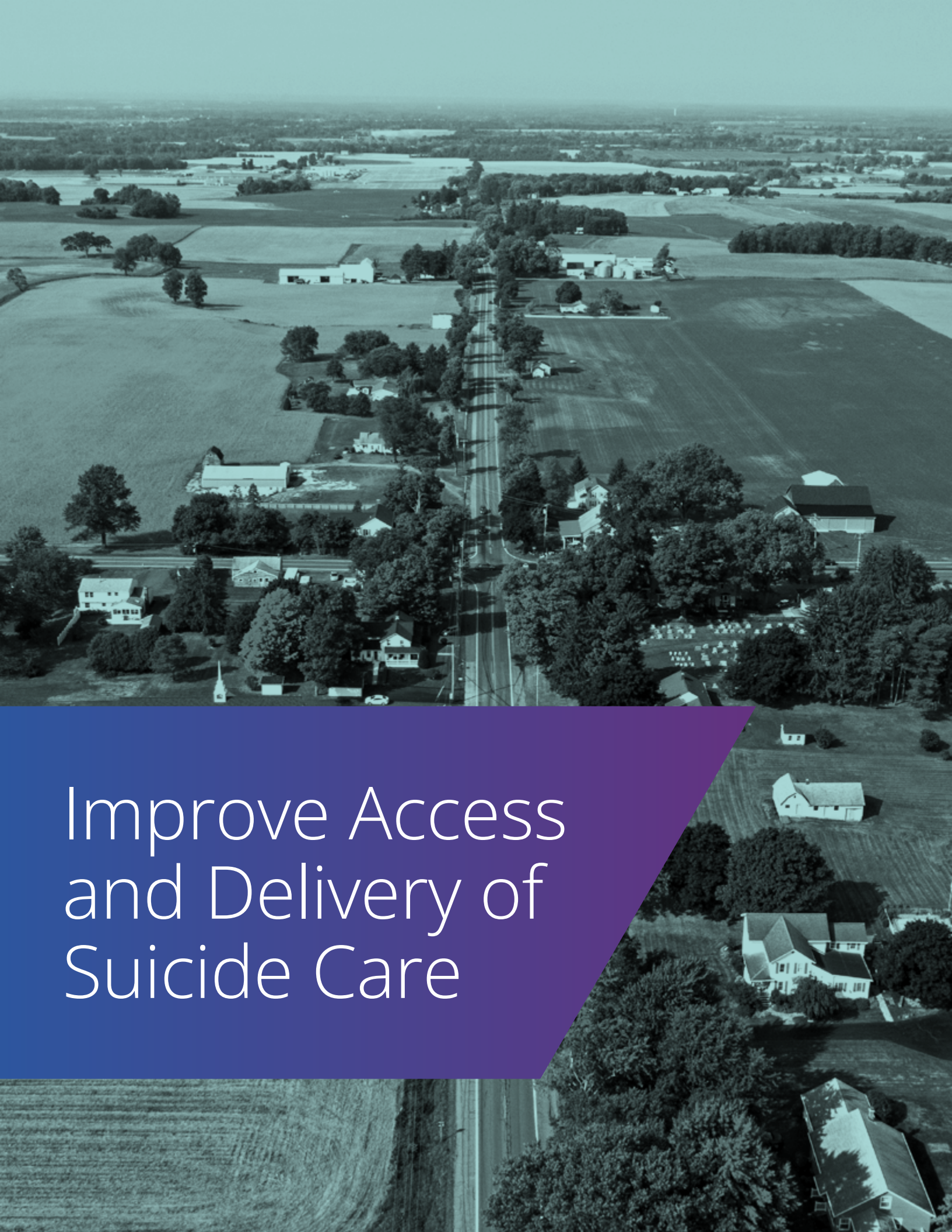
Additional research is needed to replicate and extend prior studies related to approaches to reduce access to firearms among persons at risk for suicide. This research could include evaluations of strategies to promote and incentivize safe storage practices and to enhance awareness of relevant laws and programs to encourage and sustain consistent safe storage. Future research could also address the evidence limitations of CAP laws, mandatory waiting periods, and other policies that are implemented to prevent firearm suicide but could benefit from additional research on their effects.[148]

Primary and secondary school-based initiatives have shown some promising methods for improving schools' suicide safety.

There is ongoing research related to the impact of discrimination on suicide and the effects of creating healthy organizational cultures and policies. Some evidence suggests the implementation of same-sex marriage policies is associated with reduced numbers of suicide attempts among adolescents who identify as sexual minorities.[180] Similarly, state-level nondiscrimination policies towards LGBTQ+ communities has been associated with decreased suicide-related hospitalizations.[181] A third study including more than 200,000 middle and secondary school-aged youth found that the presence of a gay-straight alliance club on a school's campus lessened connections between gay-bias victimization and suicide attempts through reductions in hopelessness.[182]

Future research may further solidify the relationship between discriminatory policies and practices and suicide to inform prevention efforts moving forward, particularly amongst those with historical trauma and adverse social conditions.[183] Adaptations for specific populations could be explored and tested, such as the recommendations for AI/AN people in the community prevention manual "To Live To See the Great Day That Dawns."[184] Adaptations for college and university settings are being explored through programs such as the 2021 Garrett Lee Smith Campus Suicide Prevention grant program, which could provide important lessons for future prevention efforts.

Primary and secondary school-based initiatives have shown some promising methods for improving schools' suicide safety and further work could strengthen such programs. For example, a Creating Suicide Safety in Schools workshop demonstrated increased knowledge about suicide prevention practices, enhanced beliefs in the importance of school-based prevention and perceived administrative support, and greater confidence in the roles staff play in suicide safety. At the three-month follow-up, however, school staff experienced barriers to implementing change, primarily insufficient time for suicide-focused programming. The authors then recommended that suicide prevention trainings be accompanied by broader organizational changes.[185]



Improve Access and Delivery of Suicide Care

Rationale

Most people with mental health conditions never attempt or die by suicide,[186,187] but these disorders are important risk factors for suicide.[3,188] Findings from the 2020 National Survey on Drug Use and Health (NSDUH) indicate that less than half (46%) of adults in the U.S. with mental health disorders received treatment for those conditions.[21] Lack of access to mental healthcare is one of the contributing factors related to the underuse of mental health services. This may be particularly pertinent for people with serious mental illness, people from racial and ethnic minority groups, underserved communities, those living in rural communities, and people who are uninsured.[189-191] The intersection of ethnicity with underuse of mental health services is associated with poverty. It may also be explained by a combination of factors including social stigma, mistrust of the behavioral health system, and lack of cultural adaptation of interventions. Identifying ways to improve access to timely, affordable, culturally appropriate, and quality care for people at risk for suicide is a critical component to prevention.[3,192,193] Research suggests that services are maximized when health and behavioral healthcare systems are set up to effectively and efficiently deliver care.[194]

Over 121 million Americans live in areas without enough mental health providers to meet their needs. This shortage is particularly severe among low-income urban and rural communities.

Approaches

Several approaches can be used to improve access and delivery of suicide care.

Cover mental health conditions in health insurance policies

Federal and state laws include provisions for coverage of mental health services in health insurance plans that is on par with coverage for other health concerns, called **mental health parity**.[73] Benefits and services covered include the number of visits, co-pays, deductibles, inpatient/outpatient services, prescription drugs, and hospitalizations. If a state has a stronger mental health parity law than the federal parity law, then insurance plans regulated by the state must follow the state parity law. If a state has a weaker parity law than the federal parity law, that is, includes coverage for some mental health conditions but not others, then the federal parity law will replace the state law. Equal coverage does not necessarily imply coverage of quality care, as health insurance plans vary in the extent to which benefits and services are offered to address various health conditions.

Increase provider availability in underserved areas

Access to effective and state-of-the-art mental healthcare is largely dependent upon the training and the size of the mental healthcare workforce. Over 121 million Americans live in areas without enough mental health providers to meet their needs. This shortage is particularly severe among low-income urban and rural communities.[195,196] Particular populations that remain underserved include

veterans and people from racial and ethnic minority groups.[191,197] Increasing the number and distribution of mental health providers in underserved areas may include offering financial incentives through existing state and federal programs, such as loan repayment programs, and expanding the reach of health services through telephone, video, and web-based technologies such as telehealth. Additionally, community mental health clinics bring providers directly into underserved communities. These small, government-funded clinics focus on mental health and substance use services. Such approaches can increase the likelihood that those in need will be able to access affordable quality care for mental health disorders, which can reduce risk for suicide. Some models of care use the existing workforce, such as collaborative care described in the Identify and Support People at Risk chapter.

Provide rapid and remote access to help

Telemental health (TMH) services refer to the use of telephone, video, and web-based technologies for providing psychiatric or psychological care at a distance. TMH may offer improved access to mental healthcare, and it may also ensure continuity of care. Technological advances in the delivery of TMH have also resulted in innovations such as use of transcripts and recordings of mental health services in identifying suicide risk. TMH can be used to treat a wide range of mental health conditions in a variety of settings, including outpatient clinics, hospitals, and military treatment facilities. It can also improve access to care for patients in isolated areas, as well as reduce travel time and expenses, reduce delays in receiving care, and improve satisfaction about interacting with the mental healthcare system. TMH services increased during the COVID-19 pandemic because health insurance providers loosened restrictions around delivery of services via video conference, telephone, and other telecommunications such as text-based services.

Create safer suicide care through systems change

Access to health and behavioral healthcare services is critical for people at risk of suicide. Care that is delivered efficiently and effectively can help reduce risk of suicide. For example, systems will see benefits when suicide prevention and patient safety are supported through strong leadership, workforce training, systematic identification and assessment of suicide risk, implementation of evidence-based treatments (see Identify and Support People at Risk), continuity of care, and continuous quality improvement.[198 193] Care that is patient-centered and promotes equity for all patients is also critically important.[198]

Potential Outcomes

Potential outcomes include increases in:

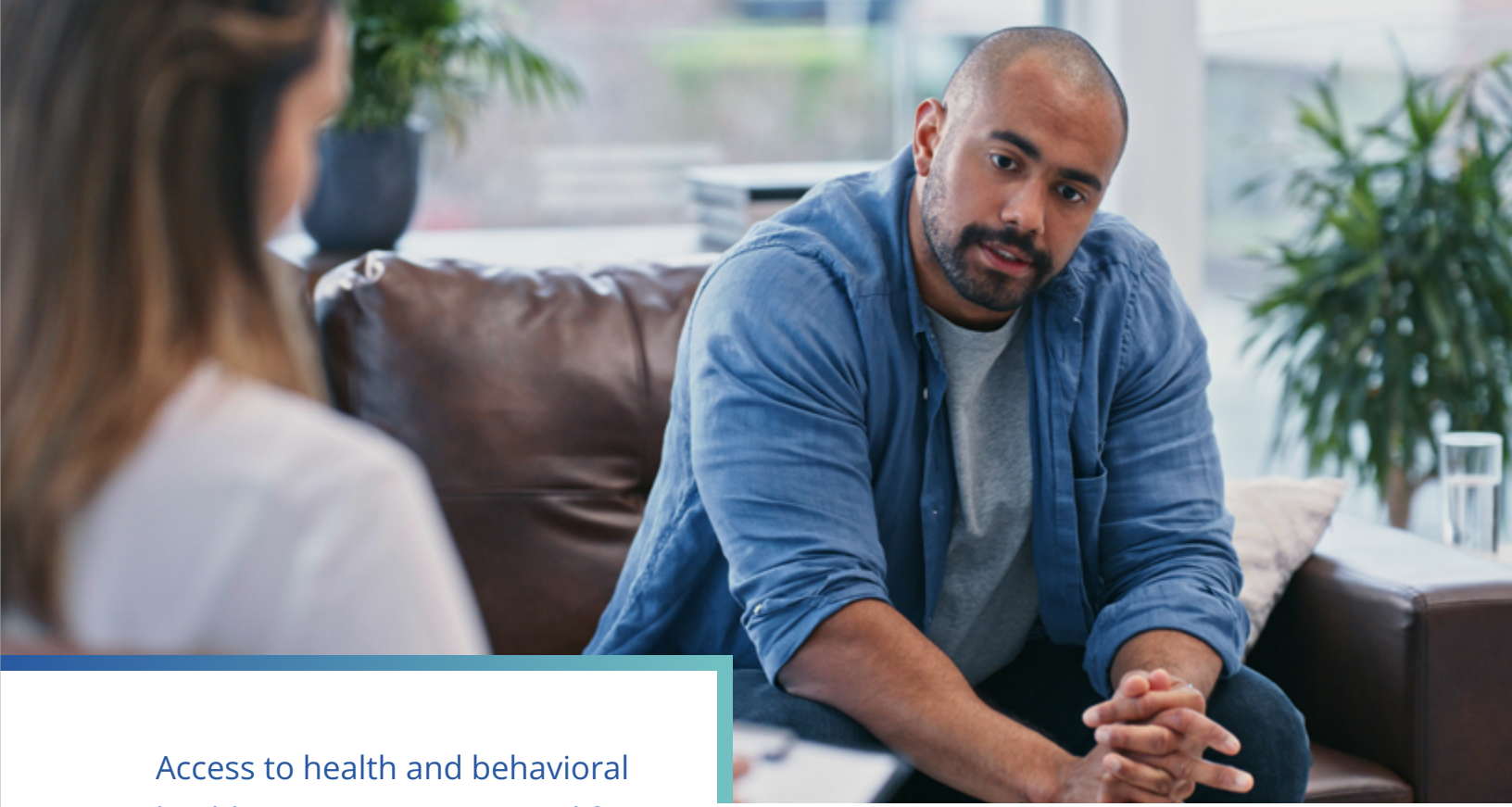
- use of a variety of clinical services,
- consistent and improved risk detection across a variety of healthcare settings, and
- support for help-seeking.

Outcomes may also include reductions in:

- rates of treatment attrition,
- symptoms of mental health disorders,
- suicide attempt rates among individuals engaged in clinical care, and
- suicide rates among individuals engaged in clinical care.

Evidence

The following evidence suggests that coverage of mental health conditions in health insurance policies and improved access to and delivery of quality suicide care can reduce risk factors associated with suicide and may directly impact suicide rates.



Access to health and behavioral healthcare services is critical for people at risk of suicide. Care that is delivered efficiently and effectively can help reduce risk of suicide.

Cover mental health conditions in health insurance policies

NSDUH is a nationally representative survey of the U.S. population that provides data on substance use, mental health conditions, and service utilization.[199] Harris, Carpenter, and Bao used data from this survey and found that 12 months after states enacted **mental health parity laws**, the self-reported use of mental healthcare services significantly increased, which is a protective factor against suicide.[200-202] Similarly, a recent review of the literature suggested that overall mental healthcare utilization was associated with the presence of mental health parity laws, including among children and adolescents living in households with incomes below the federal poverty level.[202] An early study found no effects on state suicide outcomes.[203] However, a later study by Lang examined state mental health laws and suicide rates between 1990 and 2004 and found that mental health parity laws, specifically, were associated with about a 5% reduction in suicide rates. This reduction equated to the prevention of 592 suicides per year in the 29 states with parity laws.[204]

Increase provider availability in underserved areas

Incentive programs such as the **National Health Service Corps** (NHSC) encourage individuals to work in the mental health profession in locations designated as Health Professional Shortage Areas (HPSAs) in exchange for student loan debt repayment.[205] One study suggested that NHSC providers accounted for the majority of significant increases in behavioral healthcare providers in rural areas of the country between 2013 and 2017 and that 61% of mental and behavioral healthcare providers continued to practice in designated HPSAs after their four-year NHSC commitment.[206] This program has not been evaluated for impact on suicide, but it addresses access to care, which is a critical component and protective factor for suicide prevention.

Internet-delivered cognitive behavior therapy between a patient and therapist has been shown to significantly decrease suicidal ideation among patients with severe depression.

Increasing provider availability in underserved areas using **community mental health clinics** has also shown some relationship to preventing suicides in communities in the U.S. and in international studies. In a retrospective study examining the availability of mental health clinics and suicide rates in the U.S., the number of community mental health clinics decreased by 14% from 2014 to 2017, while suicides increased by almost 10%. Statistical models controlling for other variables suggested that most of the increase could be attributed to the reduction in community mental health clinics.[207] Rates of hospitalizations for suicide attempts decreased, but suicide rates did not decrease in a study of community mental health clinics established to increase service availability across municipalities in Brazil.[213]

Provide rapid and remote access to help

A systematic review of TMH services (country locations not stated) found that services rated as high or good quality were effective in reducing symptoms in patients with disorders such as depression, schizophrenia, and substance use.[208] Mohr and colleagues conducted a meta-analysis examining the effect of psychotherapy delivered specifically via telephone and found that it significantly reduced depressive symptoms and resulted in lower attrition rates (country locations not stated).[209]

As part of **telemental health**, synchronous clinical video telehealth (CVT) may be increasing. Patients can receive therapy or medication management via a variety of video conferencing tools using CVT.[210] CVT was employed during the COVID-19 pandemic due to

temporary loosening of federal and state regulations. A meta-analysis of 21 CVT studies specifically for populations of rural areas showed initial evidence that it can be used to manage suicide risk by providing screening, treatment, and safety planning remotely.[94]

Another growing method of providing rapid and remote access to services is through **mobile applications** (apps) where brief interventions occur on mobile phones. Evidence in a comparative effectiveness trial of three mobile apps for depression showed improvement in symptoms in individuals with moderate depression.[211] Similarly, **internet-delivered cognitive behavior therapy** between a patient and therapist has been shown to significantly decrease suicidal ideation among patients with severe depression (U.S. and Ireland).[211,212]

Create safer suicide care through systems change

Zero Suicide seeks to eliminate suicide among patients engaged with health systems. The Henry Ford Health System (HFHS) implemented a program that screened and assessed each behavioral health patient for suicide risk and implemented coordinated, continuous follow-up care systemwide.[213] The Zero Suicide model was derived from the HFHS program and other models of health systems change to improve suicide care, as detailed in the Suicide Care in Systems Framework from the Action Alliance. An examination of the impact of the program found a dramatic and statistically significant decrease in the rate of suicide between the baseline years, 1999 and 2000, and the intervention years, 2002–2009. The suicide rate fell by 82% during this time period.[213,214] Specifically, while the rate of suicide in the general Michigan population increased over the period, the suicide rate significantly decreased over time among HFHS members who received mental health specialty services.[215] Further, the suicide rate increased for HFHS members who accessed only general medical services as opposed to specialty mental health services.[215]

Based on these results, the Zero Suicide model was developed, incorporating seven components (lead, train, identify, engage, treat, transition, improve) of a quality improvement model, to transform the way health systems care for people with suicidal thoughts and behaviors. Studies in Australia and the U.S. have shown the effectiveness of the Zero Suicide model in reducing suicide attempts and ideation.[216,217]

Future Directions

Access to mental health and substance use disorder treatment services is critical for suicide prevention. Unfortunately, many people at risk for suicide do not meet criteria for these treatments, delay treatment, or do not seek treatment.[21] Suicide prevention efforts that focus on the above approaches can support people at risk and help prevent risk in the first place. Access to care also relies on the cultural relevance of the care, and additional information is needed on how cultural adaptations improve access and utilization of suicide care. Reaching out to people through other methods, including primary care and community outreach as described in the *Identify and Support People at Risk* chapter, can also be beneficial. More methods that utilize existing medical providers in the service of suicide prevention are also supported in the literature and growing in practice.

Promote Healthy Connections

Rationale

Sociologist Emile Durkheim theorized in 1897 that weak social bonds, or lack of connections, were among the chief causes of suicidality.[218] Connectedness is the degree to which an individual or group of individuals are socially close or interrelated or share resources with others. Social connections can be formed within and between multiple levels of the social ecology, for instance, between individuals such as peers, neighbors, and co-workers; families; schools; neighborhoods; workplaces; faith communities; cultural groups; and society as a whole.[125] Literature consistently depicts social connection and school connectedness as protective factors against physical and psychological disorders, all causes of mortality, and suicidal ideation and attempts.[219,220] Those who are more socially connected also report greater well-being and life satisfaction.[221] The quality of connections and the social norms of the group are important components to consider. For example, unhealthy social norms within a group could constrain individual group members' behaviors, beliefs, and identities.[222]

Connectedness and social capital together may protect against suicidal behaviors by decreasing isolation and encouraging adaptive coping behaviors.

Social capital is related to connectedness and refers to a sense of trust in one's community and neighborhood, social integration, and also the availability of and participation in social organizations.[223,224] Ecological cross-sectional and longitudinal studies have examined the impact of aspects of social capital on depression symptoms, depressive disorder, mental health more generally, and suicide. Existing studies, though limited, suggest a positive association between social capital (as measured by social trust and community/neighborhood engagement) and improved mental health.[225,226]

Connectedness and social capital together may protect against suicidal behaviors by decreasing isolation; encouraging adaptive coping behaviors; and increasing belongingness, personal value, and worth to help build resilience in the face of adversity. Connectedness and social capital can also provide individuals with better access to formal supports and resources, mobilize communities to meet the needs of their members, and provide collective primary prevention activities to the community as a whole.[227] Connection to a group in which members reinforce healthy behaviors may be protective.[228] Evidence that some social ties may increase an individual's risk for suicidal behavior,[229] however, is also consistent with Durkheim's formulation that connections and norms within relationships influence suicide risk in positive and negative ways.

Finally, schools can be especially well-suited to provide connectedness interventions that reach youth. Rich literature supports the association between school connectedness and reduced self-report of suicidal ideation or suicide attempt.[220] Increased school connectedness is associated with reduced reports of suicidal thoughts and behaviors across adolescents, including adolescents who identify as sexual minorities, as well as other individuals including those residing in communities with increased risk of suicide and those experiencing physical

abuse, sexual abuse, and/or bullying.[220] The research suggests that school psychologists and other student support personnel have an important role to play in facilitating school connectedness.[220]

Approaches

Promoting healthy connections among individuals and within communities through modeling healthy peer norms and enhancing community engagement may protect against suicide.

Promote healthy peer norms

This approach seeks to normalize protective factors for suicide, such as help-seeking, reaching out, and adaptive coping. Healthy peer norms can be achieved through leveraging the influence that members of natural social networks have on each other day to day and can be used to shift group-level beliefs and promote positive social and behavioral change. These approaches typically focus on youth and are delivered in school settings, but they have also been implemented in community and military settings.[228,230]

Peer support programs that connect individuals with mental health and substance use disorders with peers that have lived experience can facilitate a sense of connectedness and belonging. Peer support is provided by individuals who have demonstrated success in their recovery process and help others experiencing similar situations. Peer support workers help individuals become and stay engaged in the recovery process through shared understanding, respect, and mutual empowerment.[231]

Engage community members in shared activities

Community engagement is an aspect of social capital.[232] Community engagement approaches may involve residents participating in a range of activities, including religious activities, community clean-up and greening activities, and group physical exercise. These activities provide opportunities for residents to become more involved in the community and to connect with other community members, organizations, and resources. Participation results in enhanced overall physical health, reduced stress, and decreased depressive symptoms, thereby reducing risk of suicide.

Potential Outcomes

Potential outcomes include increases in:

- healthy coping attitudes and behaviors,
- referrals for youth in distress,
- help-seeking behaviors among youth and adults, and
- positive perceptions of adult and peer support.

Potential outcomes may also include reductions in feelings of social isolation.

Evidence

Current evidence suggests several positive benefits of healthy peer norms and community engagement activities.

Promote healthy peer norms

Evaluations show that programs such as **Sources of Strength** can improve school norms and beliefs about suicide that are created and disseminated by student peers. A randomized controlled trial of Sources of Strength conducted with 18 high schools (6 metropolitan, 12 rural) found that the program improved adaptive norms regarding suicide, connectedness to adults, and school engagement.[50] Peer leaders were also more likely than controls to refer a friend at risk for suicide to an adult. For students, the program resulted in increased perceptions of adult support for youth at risk for suicide, particularly among those with a history of suicidal ideation, and the acceptability of help-seeking behaviors. Trained peer leaders also reported a greater decrease in maladaptive coping attitudes compared with untrained leaders.[50]

Peer support programs that connect individuals with mental health and substance use disorders with peers that have lived experience can facilitate a sense of connectedness and belonging.

The **Wingman-Connect** program is an adaptation of Sources of Strength as an upstream suicide and depression prevention program for a general, non-clinical Air Force population. *Wingman-Connect* trains all unit members together to incorporate skills into unit culture and build cohesion and shared purpose. Group skill building within the natural organizational units emphasizes social bonds, meaning in work, and managing career and personal stressors. In a cluster randomized clinical trial, personnel in technical training classes assigned to *Wingman-Connect* reported lower suicidal ideation severity and depression symptoms at one month post-intervention and lower depression symptoms at one and six months post-intervention when compared to a control group that participated in a stress management program.[228] Participants' perception of belonging to a more cohesive class with healthier norms accounted for a significant portion of the program's impact on reducing suicidal ideation and depression symptoms.[228]

Engage community members in shared activities

Community building programs may also have mental health effects. A **vacant lot greening initiative** was undertaken in Philadelphia between 1999 and 2008 where local residents and community members worked together to clean up and plant flowers and

trees in 4,436 lots (or 7.8 million square feet) in four areas of the city.[233] Researchers found significant reductions in community residents' self-reported level of stress, a risk factor for suicide, and engagement in more physical exercise, a protective factor for suicide, than residents in control vacant lot areas. There is some evidence for other cross-cutting benefits including fewer firearm assaults and less vandalism.[233-235]

Future Directions

Promising practices emphasizing connection with peers in adult populations may become more common ways of preventing suicide in the future. For example, the **Peers for Valued Living** (PREVAIL) program incorporates peers with lived experience to provide support to adults who are at high risk of suicide immediately after an inpatient psychiatric hospitalization. Initial research has supported the acceptability, feasibility, and fidelity of the intervention.[236]

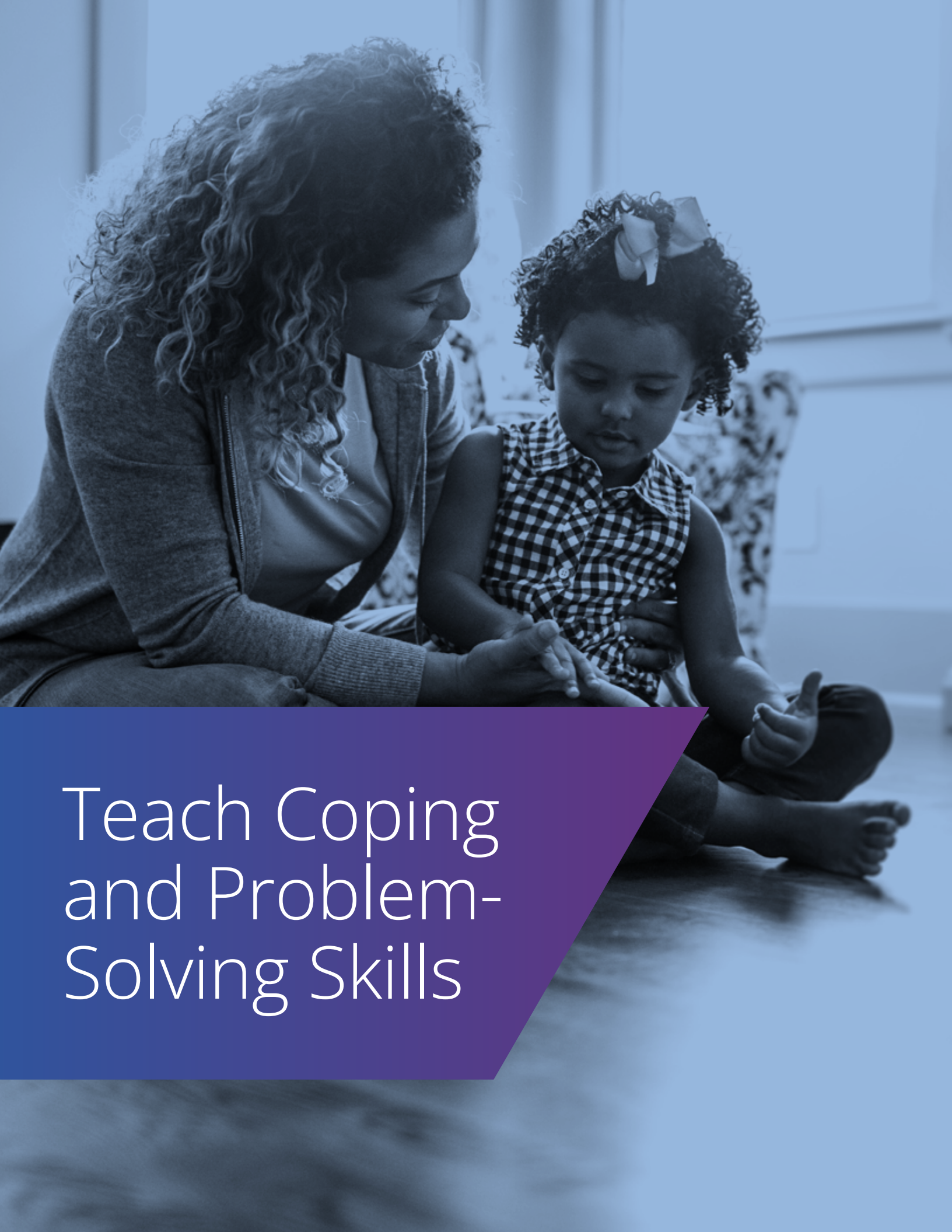
Men's Shed presents another promising practice to promote social connectedness among adult peers.[237] *Men's Shed* started in Australia and spread to the United Kingdom and the U.S. It provides a communal space for older men to socialize, learn new skills, and engage in practical activities with other men, such as woodworking. One preliminary study suggests increased social connectedness, health, and well-being among men participating in *Men's Shed*.[238] Both *PREVAIL* and *Men's Shed* focus on specific populations. Other population groups may also benefit from healthy peer norm programs that pay particular attention to cultural norms and conditions.

The COVID-19 pandemic has presented serious challenges to healthy connections among all people. The pandemic has forced people into using novel formats for engagement and connection, such as video conferencing, online chat, and mobile apps. Stack Up is a nonprofit veteran organization whose goal is to use video games to bring veterans together, using a virtual space to increase connectedness in an online peer support program.[239] Stack Up created the **Stack Up Overwatch Program (StOP)** because

they recognized a need in the gaming-focused online community. This suicide prevention and crisis intervention program is delivered entirely through the internet by trained peers using a gaming platform text and voice chat feature. The program combines elements of virtual gaming communities, veteran mental health, and community-based peer support and provides an innovative format for implementing a suicide prevention program. Another program by **Objective Zero Foundation** utilizes mobile application technology for peer-to-peer support to enable global connection of service members, veterans, family members, and caregivers.[240]

The app provides free 24/7 access to online health and wellness resources, peer-to-peer support, and volunteer opportunities to users.

Finally, the pandemic has raised concerns about the mental well-being of children, particularly those with pre-existing behavioral health conditions.[241] Additional research is warranted regarding strategies to engage children, help them connect with community members and community resources, and prevent suicide.[242,243] There is still a lot to learn about changes in connectedness during COVID-19 and at other times of infrastructure disruptions.



Teach Coping and Problem-Solving Skills

Rationale

Building life skills prepares individuals to successfully tackle everyday challenges and adapt to stress and adversity. These skills encompass many concepts but most often include coping and problem-solving skills, emotional regulation, conflict resolution, and critical thinking. Life skills are important in protecting individuals from suicidal behaviors and in reaching key developmental milestones that impact psychological health, such as success at school and work.[230,244] Suicide prevention programs focusing on life skills training are drawn from social cognitive theories.[245] They suggest that suicidal behavior is influenced by a combination of direct learning and environmental and individual characteristics. Teaching and providing youth with both education and skills to manage everyday challenges and stressors is an important developmental component to suicide prevention. It can help prevent suicide risk factors such as adverse childhood experiences (abuse and neglect), substance use, and more.[246,247] Acquiring coping and problem-solving skills also occurs and is beneficial in adulthood. Adults often face new and challenging life events requiring the need for education, coping and problem-solving skills essential for maintaining well-being and protecting against suicide. For example, healthy parent-child relationships can promote safe, stable, nurturing family environments and relationships.[248]

Life skills are important in protecting individuals from suicidal behaviors and in reaching key developmental milestones that impact psychological health.

Approaches

Programs that teach coping and problem-solving could include lessons on social-emotional skills, parenting skills and family relationship building, and resilience.

Support social-emotional learning (SEL) programs

This approach focuses on developing and strengthening communication and problem-solving skills, emotional regulation, conflict resolution, and coping skills in youth. Such programs are designed to foster the development of five interrelated sets of cognitive, affective, and behavioral competencies: self-awareness, self-management, social awareness, relationship skills, and responsible decision-making.[249] These approaches are typically delivered to all students in a particular grade or school. However, some programs also focus on groups of students considered to be at increased risk for suicide, including those who have experienced ACEs. Opportunities to practice and reinforce skills are an important part of programs that work.[250]

Teach parenting skills to improve family relationships

This approach provides caregivers with support and is designed to strengthen parenting skills, enhance positive parent-child interactions, and improve children's behavioral and emotional skills and abilities.[250] Programs are typically designed for parents or caregivers with children in a specific age range and can

be self-directed or delivered to individual families or groups of families. Some programs have sessions primarily with parents or caregivers, while others include sessions for parents or caregivers, youth, and the family. Specific program content typically varies by the age of the child but often has consistent themes of child development, parent-child communication and relationships, positive parenting and problem-solving skills, and youth interpersonal and problem-solving skills.[251]

Support resilience through education programs

This approach provides adults with skills to effectively manage new and challenging life events, such as going to college, entering the job market, or becoming a parent. Programs are typically time-limited with an emphasis on education, resiliency, emotion regulation, coping skills, and problem-solving skills. Specific program content varies by life circumstances, but all programs emphasize the didactic nature of skill building and interactive practice exercises. Education programs in adulthood are usually provided by universities for students, employers for their employees, or healthcare providers.

Potential Outcomes

Potential outcomes include improvements in:

- social competence and emotion regulation skills,
- problem-solving and conflict management skills, and
- help-seeking behavior.

They may also include reductions in:

- stigma surrounding mental health concerns,
- depression, anxiety, conduct problems, and substance use,
- suicidal ideation, and
- suicide attempts.

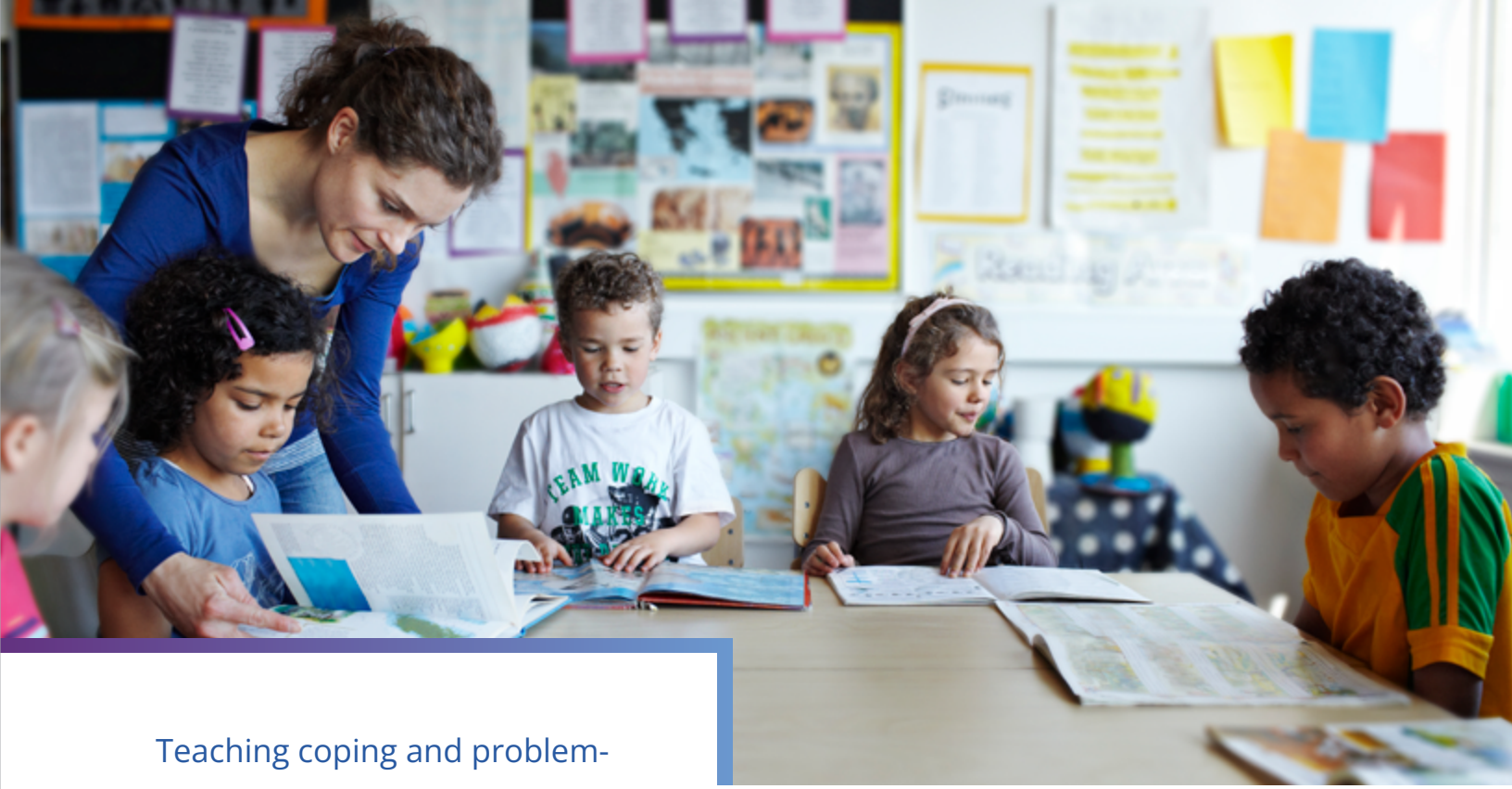
Evidence

Several SEL programs, parenting and family relationship programs, and resilience and education programs in adulthood have improved resilience and reduced risk factors for suicide, such as depression, internalizing behaviors, and substance use.[252]

Support social-emotional learning programs

SEL programs are associated with positive outcomes including reduced emotional distress, improved well-being, and better social and academic adjustment, based on studies from the U.S. and other countries.[253-256] SEL components related to suicide prevention and help-seeking reduce stigma and increase help-seeking behavior. SEL programs provide children and youth with skills to resolve problems in relationships, in school, and with peers and help youth address other negative influences such as substance use associated with suicide.[230]

The **Youth Aware of Mental Health Program** (YAM) is a universal school-based program for teenagers ages 13–17. It uses interactive dialogue, small group discussions, and role-playing to teach adolescents about themes related to mental health; self-help advice; stress and crisis, depression, and suicidal thoughts; helping a friend in need; and asking for advice/help. YAM also includes a student booklet that provides information about the risk and protective factors associated with suicide and education about depression and anxiety. YAM is designed to enhance adolescents' problem-solving skills for dealing with adverse life events, stress, school concerns, and other problems. A cluster randomized controlled trial conducted in 168 schools in 10 European Union countries showed that students in schools randomized to YAM were significantly less likely to attempt suicide or have severe suicidal ideation at the 12-month follow-up when compared with students in control schools, which received educational materials and care as usual. The relative risk of youth suicide attempts among the YAM group was reduced by over 50% and relative risk related to severe suicidal



Teaching coping and problem-solving skills can help children deal with issues in relationships, in school, and with peers in a healthy way.

ideation also fell by about 50%.[257] These reductions are partially attributed to reported changes in coping strategies. The results also suggest that socialization occurring during the YAM program may play a major role in its efficacy.[258]

Another example is the **Good Behavior Game** (GBG), a classroom-based program for elementary school children ages 6–10. The program uses a team-based behavior management strategy that promotes good behavior by setting clear expectations for good behavior and consequences for maladaptive behavior. The goal of GBG is to create an integrated classroom social system that is supportive of all children being able to learn with little aggressive or disruptive behavior.[259] An evaluation of GBG indicated that first-graders in the first cohort in GBG reported half the adjusted odds of suicidal ideation and suicide attempts when assessed approximately 15 years later, compared with peers who had been in a standard classroom setting. In the second cohort of GBG, neither suicidal ideation nor suicide attempts were significantly different between GBG and the control interventions.[259] This result may have been due to a lack of implementation fidelity including less mentoring and monitoring of teachers. GBG was also associated with reduced risk of later substance use and other suicide risk factors among the first cohort. Results for the second cohort were generally smaller but in the desired direction.[260] Students' positive integration into peer groups partially explains the relationship between GBG and reduction of risk for later suicide attempts, particularly for more disruptive students.[261]

International research provides additional support for SEL programs. The **Aussie Optimism Program** is a universal prevention strategy designed to reduce mental health concerns among children in sixth and seventh grade by teaching social, emotional, and cognitive skills including identifying feelings, decision-making, and coping skills. A randomized controlled trial examining the efficacy of the program found significantly greater increases in pro-social behavior and lower rates of suicidal ideation compared with control groups.[262]

Signs of Suicide (SOS) is a universal school-based suicide prevention program that uses psychoeducation to modify behavior in middle and high school students. It also includes screening for elevated depression and substance use disorders. SOS is not an SEL program, but it uses psychoeducation as the primary tool for training and skill building. The program is designed to:

- increase understanding that major depression is an illness,
- improve awareness of the link between suicide and depression,
- improve attitudes toward intervening with peers showing signs of depression and suicidal ideation, and
- increase help-seeking behavior for students personally experiencing depression and suicidal thoughts.[263]

A randomized controlled trial found that individuals completing the program were 64% less likely to report a suicide attempt within the past three months when compared with the control group, but the program was not associated with changes in suicidal ideation.[263]

Teach parenting skills to improve family relationships

Parenting and family skills training approaches have well-established impacts in reducing common risk factors for suicide[264] and strengthening family bonds, a protective factor against suicide.[265] Several programs have shown promising impacts on reducing suicidal thoughts and behaviors. **The Incredible Years** (IY) is a comprehensive group training program for parents, teachers, and children. It is designed to reduce conduct problems and substance use (two important suicide risk factors in youth) by improving protective factors such as responsive and positive parent-teacher-child interactions and relationships, emotional self-regulation, and social competence.[250] The program includes 9–20 sessions offered in community-based settings, such as religious centers, recreation centers, mental health treatment centers, and hospitals. Several studies have demonstrated the effect of the IY program on reducing internalizing symptoms, such as anxiety, depression, and child conduct problems.[266-268] The program is also

associated with improved problem-solving and conflict management, which were skills the participants were able to maintain at the one-year follow-up.[266-268] The program demonstrated greater benefits in mother-rated child internalizing symptoms, when compared with the waitlisted control group.[250]

The **Strengthening Families Program** involves sessions for parents, youth, and families to teach parenting skills, children's social skills, and family life skills. The goals include:

- improving parents' skills for disciplining, managing emotions and conflict, and communicating with their children,
- promoting youths' interpersonal and problem-solving skills, and
- creating family activities to build cohesion and positive parent-child interactions.

The premise of the program is that developing these skills for both parents and children will reduce internalizing behavior and adolescent substance use, two important risk factors for suicide.[269] *Strengthening Families* has significantly decreased externalizing behaviors, such as aggression, alcohol use, and drug use among youth participants, as well as reduced depression, alcohol use, and drug use among participating families.[269]

Other parenting skills and family programs initially developed to prevent substance use or other behavioral problems have shown impacts on reducing likelihood of suicidal thoughts and behaviors based on long-term follow-up of participants.[270] The **Family Check-Up**, for example, is a multi-level intervention that integrates assessment with motivation-enhancement strategies and tailored intervention goals to meet the needs of each family. Long-term follow-up of participants in a school-based version of *Family Check-Up* beginning in sixth grade found reduced risk for suicidal thoughts and behaviors through late adolescence.[271]

Parenting and family skills training programs have also been developed and tailored for family-specific situations. The **Family Bereavement Program**

combines parenting and youth skill building in 12 sessions for children who have experienced the death of a parent. A randomized trial that contrasts the program with a self-study curriculum found short-term positive impacts on children's coping skills and behavioral and emotional well-being. Participants were up to 5 times less likely to report suicidal thoughts and/or behaviors at the 6-year and 15-year follow-up.[272]

Familias Unidas is a prevention program focused on parenting that is culturally specific to Latino families going through acculturation. The program utilizes eight multi-family group visits and four family visits with a focus on parent-child communication and effective discipline. Preliminary evidence found lower rates of suicide attempts for youth reporting poor parent-child communication who were randomized to *Familias Unidas*.[273]

After Deployment Adaptive Parenting Tools (ADAPT) is a parenting program for active duty military members, veterans, first responders, and immigrant and refugee families with school-aged children.[274] ADAPT provides training in emotional regulation and parenting skills to parents who have experienced stress and/or trauma in their lives and/or work. Given the suicide risk associated with poor parental mental health and/or suicidality on children, ADAPT seeks to improve the parents' mental health, with the hope to subsequently reduce suicidal ideation in children. ADAPT has been found to significantly improve parenting locus of control, strengthen emotion regulation skills, and reduce suicidal ideation in parents when compared with those assigned to the control condition.[274]

Support resilience through education programs

Major life events commonly occur in adulthood, requiring new or refreshed coping and problem-solving skills to manage stress and maintain resilience. Primary prevention programs to boost resilience have been examined in first-year college students. A four-week resilience training program was tested in a pragmatic clinical trial. The program taught skills related to value-driven behavior, mindfulness, and thinking about things using a growth mindset. First-year students completing the **resilience training program** reported significantly lower self-reported depression and perceived stress compared with first-year students in the control condition.[275]

Future Directions

The continued stigma that surrounds talking about mental health and suicide is a major barrier to implementing coping and problem-solving skills groups despite the benefit to individuals across the lifespan.[185] There is also a need for additional program development and research to ensure that coping and problem-solving skills are useful for a wide range of individuals taking into account gender, race and ethnicity, socioeconomic status, sexual orientation, gender identity, and disability status.[276]

Although promising, additional trials and replication of findings are needed to confirm benefits of other college and adult programs. One study developed a two-semester-long college course titled **Risk and Resilience in Urban Teens** for college students to complete and receive course credit. The first semester provides didactic training in evidence-based skills to manage stress and boost resilience. The second semester is devoted to service learning in which college students teach stress reduction and coping skills to high school students in the community. Compared with a control group of students from a different course, students completing the course reported significantly lower perceived stress, engaged in more coping skills, and experienced fewer dysfunctional attitudes such as "If a person asks for help, it is a sign of weakness" or "If I fail at my work, then I am a failure as a person." The study group maintained the positive intervention effects over the second semester.[277]

Occupational stress in adulthood is associated with risk factors for suicide, including anxiety, depression, and post-traumatic stress disorder.[278] Programs that

The continued stigma that surrounds talking about mental health and suicide is a major barrier to implementing coping and problem-solving skills groups.

teach skills like problem-solving, self-regulation, and emotional awareness have been implemented across a diverse range of occupations including nurses, first responders, sales managers, and administrative staff.[279] A systematic review found that these programs can reduce negative mental health outcomes including depression and anxiety.[279] Some occupational programs are specifically developed to reduce suicide risk and improve prevention (see *Creating Protective Environments* chapter).

Finally, parenthood is another life period with many new challenges and stressors. Perinatal mood and anxiety disorders are the number one complication of pregnancy and childbirth and are associated with maternal depression, anxiety, and increased risk of depression and anxiety in children.[280] **Perinatal education and training programs** have been developed to increase coping skills and problem-solving abilities. One such program in Hong Kong was tested by adding three additional one-hour sessions to a standard childbirth education program. These sessions included an overview of stress, expected emotional changes during the perinatal period, coping skills training related to parenting, and problem-solving and decision-making strategies specific to childcare and parenting. Women who received this training reported significantly lower levels of depressive symptoms from baseline to six months postpartum and significantly higher learned resourcefulness from baseline to six weeks postpartum when compared with the control group.[281]

Identify and Support People at Risk

Rationale

Identifying and supporting people at risk for suicide is critical to suicide prevention. Groups disproportionately impacted by suicidal thoughts, attempts, and/or suicide include:

- males (suicide),
- females (suicide attempts),
- middle-aged and older adults (suicide),
- people living with a mental health disorder,
- people who have previously attempted suicide,
- people with a history of non-suicidal self-injury,
- veterans and active-duty military personnel,
- individuals who are institutionalized,
- people with exposure to adverse childhood experiences, violence, or traumatic stress,
- people experiencing unstable housing,
- individuals with substance use disorders,
- individuals of sexual and gender minority status,
- some displaced persons or refugees,
- people with lower incomes, and
- some racial and ethnic groups, including non-Hispanic American Indian or Alaska Native, non-Hispanic Black, and non-Hispanic White adolescents and young adults.[27,183,282-294]

Different methods are needed for interventions and treatments that are culturally sensitive and tailored to meet the needs of populations.

Supporting people at risk requires proactive case finding and effective response, crisis intervention, and evidence-based treatments. However, improving and expanding services does not guarantee those who need the services the most will utilize them. For example, some people living in communities experiencing disadvantage may face social and economic issues that can adversely affect their ability to access supportive services.[195,295] Different methods are needed for interventions and treatments that are culturally sensitive and tailored to meet the needs of populations disproportionately impacted by suicide and suicide risk. Key priorities are developing optimal ways of identifying individuals at risk, customizing services to make them more accessible (such as internet-based or mobile technology telehealth services when appropriate), and engaging people in evidence-based care,[213,296,297] especially during times of infrastructure disruption like the COVID-19 pandemic.[296,298,299]

Approaches

Gatekeeper training and suicide risk screening and assessment are two approaches that can identify and help people at increased suicide risk. Crisis response interventions, proactive planning and outreach interventions, and therapeutic approaches are intervention and treatment approaches to support disproportionately affected populations.

Train gatekeepers

Gatekeepers can come from all sectors of the community. They can help prevent suicide by being trained to identify people who may be at risk for suicide or suicidal behavior and to respond effectively by facilitating referrals to treatment and other support services. Gatekeepers could include peers, teachers, coaches, clergy, emergency responders, primary and urgent care providers, and others. This training may be implemented in a variety of settings to identify and support people at risk.[300]

Respond to crises

These approaches take place in real time when a crisis occurs and provide support, risk assessment, and referral to emergency services or treatment. Typically, a person in crisis (or a friend or family member of the person at risk) is connected to trained volunteers or professional staff via telephone hotline, online chat, text messaging, or in person.[301] Crisis response interventions are intended to reduce key risk factors for suicide, including feelings of depression, isolation, and hopelessness, and promote subsequent mental healthcare utilization.[302] Crisis response interventions can put space or time between an individual who may be considering suicide and harmful behavior.

Plan for safety and follow-up after an attempt

Preventing reattempts includes safety and crisis response plans, follow-up contact, and brief contact interventions that use diverse modalities such as home visits, mail, telephone, or text messages. These strategies are designed to help individuals get treatment when they have recently attempted suicide. They can also increase adherence to treatment and promote continuity of care.[303,304]

Provide therapeutic approaches

These approaches can increase retention in treatment and decrease suicide risk by:

- developing integrated care teams (such as linkage between primary care and behavioral healthcare),
- promoting collaboration between patient and therapist or care manager, and
- engaging and motivating patients.[305-307]

Therapeutic approaches include various forms of suicide-focused psychotherapy delivered by clinically trained providers. They address underlying mental health disorders and suicide risk factors such as poor problem-solving and emotional regulation skills. Treatment usually takes place in a one-on-one or group format between patients, family members, and clinicians. It can vary in duration from several weeks to ongoing therapy, as needed. It appears to be particularly important for children and adolescents to enhance protection and support through work with families or other safe adults within the youth's environment. More detailed information about identifying and supporting young people at risk for suicide can be found in comprehensive guide from SAMHSA.

Potential Outcomes

Potential outcomes include:

- enhancements in care transitions,
- increases in treatment engagement and adherence, and
- improvements in coping skills.

Potential outcomes can also include reductions in:

- depression and feelings of hopelessness,
- suicidal ideation,
- suicide attempts and reattempts, and
- suicide rates.

Evidence

The current evidence suggests that identifying people at risk for suicide, engaging individuals in suicide-focused treatment, and engaging in crisis care as needed can reduce risk factors for suicide and ultimately suicide deaths.

Train gatekeepers

There are many gatekeeper trainings available with varying degrees of evidence as well as duration of program effects. **Applied Suicide Intervention Skills Training** (ASIST) is a widely implemented training program that helps hotline counselors, emergency workers, and other gatekeepers identify and connect with individuals with suicidal thoughts and/or behaviors, understand their reasoning for living and dying, and assist with safely connecting those in need to available resources.[308,309] Researchers evaluated the ASIST training in a randomized controlled trial using data from 1,410 individuals experiencing suicidal thoughts who called 17 National Suicide Prevention Lifeline centers. The researchers found that callers who spoke with ASIST-trained counselors reported feeling significantly less depressed, less suicidal, less overwhelmed, and more hopeful by the end of their call when compared with callers who spoke to counselors not trained with ASIST.[302,309] ASIST training did not result in more comprehensive suicide risk assessments than usual care training.[302,309]

Gatekeeper training has been a primary component of the **Garrett Lee Smith (GLS) Suicide Prevention Program**, which has been implemented in 50 states and 50 tribes. A multi-site evaluation assessed the impact of community gatekeeper training as a part of GLS implementation on suicide attempts and deaths among young people ages 10–24. Counties that implemented GLS trainings had significantly lower youth suicide rates up to two years following the training when compared with similar counties that did not offer GLS trainings.[310,311]

There is emerging literature on crisis response services that utilize mobile technology to provide real-time crisis support.

Other examples of widely implemented gatekeeper training programs include **Question, Persuade, and Refer** (QPR), **Mental Health First Aid** (MHFA), and **teen Mental Health First Aid** (tMHFA). QPR is an hour-long training that aims to reduce stigma and increase knowledge about suicide risk factors, warning signs, and available resources. QPR training also focuses on skill building to improve gatekeepers' abilities to ask individuals about their suicidal thoughts or plans and persuade them to seek help. QPR training results improve gatekeeping skills like inquiring about suicidal ideation and referring individuals for treatment (studies in U.S. and Australia).[312,313] MFHA is a skills-based program that teaches participants about mental health (studies in multiple countries).[314] MHFA was developed for community members, and tMHFA was adapted specifically for adolescents. Both programs focus on reducing stigmatizing attitudes and increasing mental health literacy.[314] In addition, tMHFA promotes supportive behaviors toward peers and help-seeking from trusted adults.[315] Both programs were effective at improving self-efficacy related to helping individuals at risk and increasing the likelihood of engaging in gatekeeping behaviors (studies in multiple countries).[312-317]

Most studies of gatekeeper training demonstrate that these programs increase knowledge, skills, and self-efficacy or confidence in the gatekeeper's ability to identify an individual who is at risk and provide support in the short term. The long-term effects of these programs are unclear and little is known regarding how to improve the sustainability of these outcomes in those who are trained.[318]

Respond to crises

The **National Suicide Prevention Lifeline (the Lifeline), now called 988 Suicide & Crisis Lifeline**, and Crisis Text Line provide crisis response intervention. An evaluation of the Lifeline effectiveness to prevent suicide included 1,085 suicidal individuals who called the hotline and completed a standard risk assessment for suicide

and 380 of those people who completed a follow-up assessment between 1 and 52 days after their call (mean = 13.5 days). Researchers found that over half of the initial sample were seriously considering suicide and had a suicide plan when they called. Significant decreases in psychological pain, hopelessness, and intent to die occurred during the phone call, with sustained decreases in psychological pain and hopelessness up to three weeks later.[319] These results are promising and underscore the importance of continued care following the call.[319,320] It is unclear whether these services lead to increased use of treatment services or reduced future suicidal thoughts and behaviors.[302]

There is emerging literature on crisis response services that utilize mobile technology to provide real-time crisis support. Two examples include the **Virtual Hope Box** (VHB) and **Jaspr Health**. VHB is a smartphone application that:

- reminds individuals of positive experiences,
- reminds individuals about reasons for living (such as messages from loved ones),
- provides contact information for people who care about them and are available in a time of crisis, and
- supports coping resources (such as relaxation exercises).

A randomized controlled trial with veterans who experienced suicidal ideation and who used VHB for 12 weeks reported significantly greater improvements in their ability to cope with unpleasant emotions when compared with their peers who received printed materials about coping with suicidal thoughts.[321]

Jaspr Health is a tablet-based application that delivers four evidence-based practices through an artificial intelligence-powered virtual guide to acutely suicidal individuals in an emergency department. The virtual guide conducts a comprehensive suicide assessment, discusses the importance of lethal means safety, and generates a crisis stabilization plan with the patient. Psychoeducation videos delivered by people with lived experience on what to expect in the emergency department and when returning home, coping with shame, strategies for staying well, and messages inspiring hope are also included. Patients who used the Jaspr Health app reported significant decreases in distress and agitation and significant increases in learning to cope effectively with current and future suicidal thoughts compared with patients who received care as usual.[322] Emerging literature suggests that opportunities to offer personalized and just-in-time interventions when it is most needed to prevent the escalation of potentially dangerous and lethal suicidal behaviors may become more common as wearables and mobile devices work together to monitor key risk variables in real time.[323]

Plan for safety and follow-up after an attempt

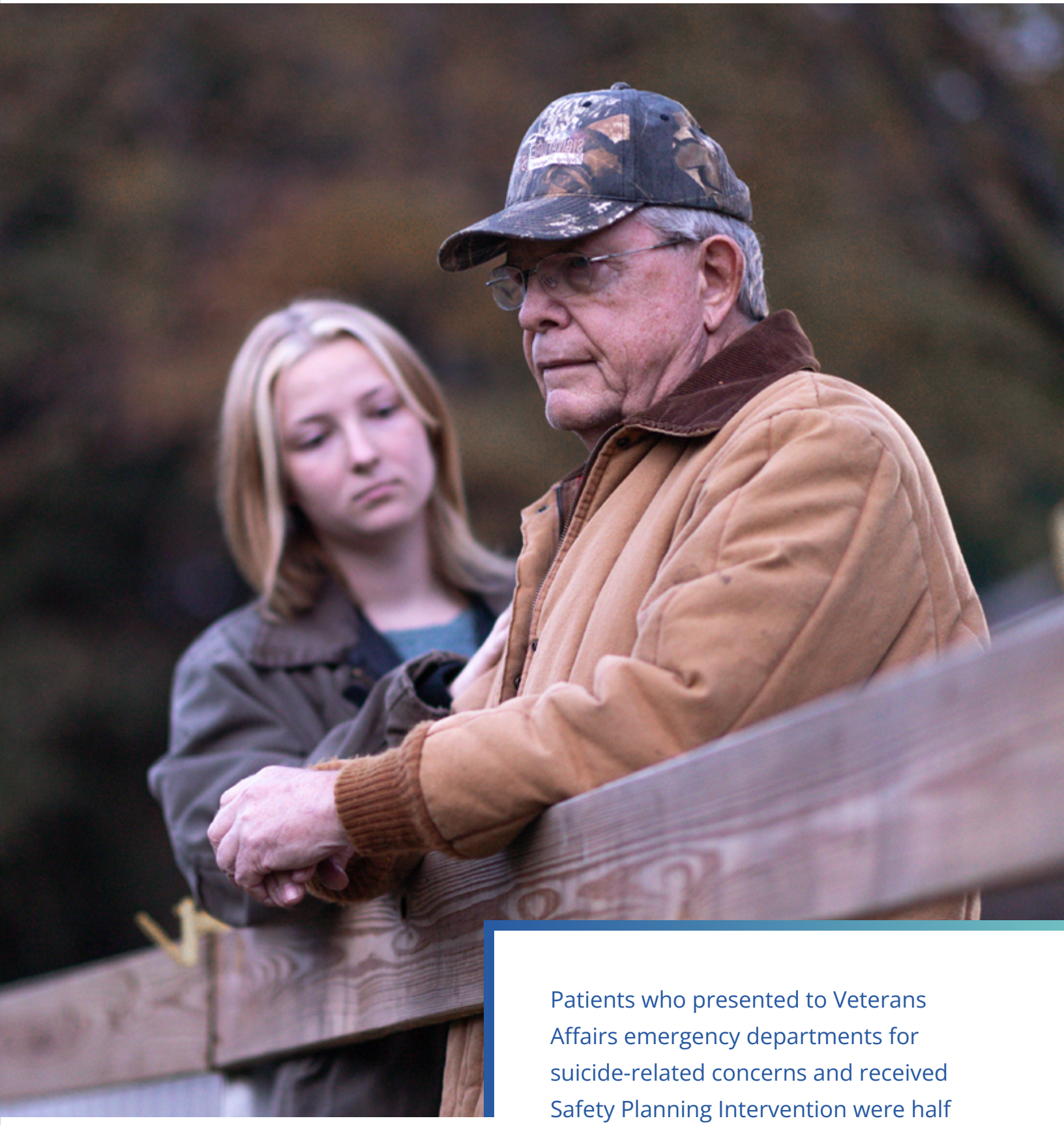
Interventions that support engagement and safety during care transitions are critical to suicide prevention. The Action Alliance outlines comprehensive best practices in care transitions for individuals with suicide risk. **Safety planning** is one example of

proactive planning. Safety planning involves outlining what to do during a crisis, including steps for identifying personal warning signs, using coping strategies, activating social support, and accessing professional services. The effectiveness of safety planning was examined through a randomized controlled trial of active-duty soldiers at risk for suicide. Soldiers who received a crisis response plan (a form of safety planning) experienced faster reduction in suicidal ideation and were significantly less likely to make a suicide attempt during a six-month follow-up period than soldiers who received treatment as usual.[324] Safety planning is a key component of the **Safety Planning Intervention with structured follow-up** (SPI+) that is widely used across the Veterans Health Administration. SPI+ combines strategies for reducing suicidal behavior including coping strategies and counseling to reduce access to lethal means with a minimum of two follow-up telephone calls. Patients who presented to Veterans Affairs emergency departments for suicide-related concerns and received SPI+ were half as likely to exhibit suicidal behavior and more than twice as likely to attend treatment during a six-month follow-up period compared with patients who received care as usual.[325]

Follow-up contact and **brief contact interventions** are two examples of proactive and ongoing outreach approaches. Follow-up contact strategies use postcards, letters, text messages, and telephone calls to express care and support for patients and typically invite patients to reconnect with their provider. Contacts are made periodically. This could be monthly or every few months in the first 12 months after discharge with some programs continuing contact for two or more years.[303] One meta-analysis examining interventions to prevent repeat suicide attempts in patients admitted after an emergency department visit for a suicide attempt found reductions in reattempts by approximately 17% for up to 12 months after discharge. The effects of these approaches on reattempts beyond 12 months has not yet been demonstrated.[303] A randomized controlled trial of long-term follow-up contact approaches found that patients who refused ongoing care but who were randomized to be contacted by letter four times per year had a lower rate of suicide over two years of follow-up than patients in the control group who received no further contact.[326] Other studies have also indicated that post-crisis letters, coping cards, telephone calls, and text messages were protective against suicidal ideation, attempts, and suicide (studies from U.S., Iran, Taiwan, and France).[304,327-331]

An accumulating number of brief contact interventions have shown effectiveness. The **Emergency Department Safety Assessment and Follow-up Evaluation** (ED-SAFE) is a brief intervention initiated by the emergency department staff that takes place during and after a visit related to suicidal ideation or attempt. The intervention consisted of a suicide risk screening by emergency department physicians, suicide prevention resources including a personalized safety plan, and a series of telephone calls to the individual for one year after the visit. In a clinical trial evaluating the effect of the intervention, suicide risk detection almost doubled because of suicide risk screening. Participants who received the intervention had 30% fewer suicide attempts than participants who received treatment as usual.[332,333] Collectively, these findings highlight the utility of a multi-component screening and intervention for preventing suicide in emergency department settings.

Attempted Suicide Short Intervention Program is another brief intervention that provides a combination of many strategies including three in-person therapy sessions, safety planning, and regular letters across 24 months. Results of a randomized controlled trial of the program in Switzerland indicated recipients had an 80% reduced risk of suicide reattempts and 72% fewer days of hospitalization when compared with individuals in the control group.[334,335]



Patients who presented to Veterans Affairs emergency departments for suicide-related concerns and received Safety Planning Intervention were half as likely to exhibit suicidal behavior.

Cognitive Behavioral Therapy is a well-studied form of psychotherapy that focuses on changing patients' thoughts and behaviors, which reciprocally influence the other.

Provide therapeutic approaches

Improving Mood—Promoting Access to Collaborative Treatment (IMPACT) and **Prevention of Suicide in Primary Care Elderly: Collaborative Trial** (PROSPECT) are two collaborative care programs designed to prevent suicide among older primary care patients by reducing suicidal ideation and depression. IMPACT and PROSPECT create a therapeutic alliance that includes a combination of evidenced-based medication or psychosocial treatments and proactive follow-up by a depression care manager throughout treatment.[289,336] Both programs have shown significant quality of life improvements and reduced functional impairment, depression, and suicidal ideation over 24 months of follow-up relative to patients who received care as usual.[289,336,337]

Another example of evidenced-based therapeutic approaches is **Dialectical Behavior Therapy** (DBT).[338] DBT is a multi-component therapy for individuals who may struggle with impulsivity and regulating emotions. The components of DBT include individual therapy, group skills training, between-session telephone coaching, and a therapy consultation team. A randomized controlled trial of women with recent suicidal or self-injurious behavior found those receiving DBT were half as likely to make a suicide attempt at the two-year follow-up than women receiving community treatment (23% vs. 46%, respectively) and had fewer hospitalizations for suicidal ideation.[339] Similar findings were documented among adolescents receiving DBT following a recent suicide attempt. Adolescents who received DBT reported significantly lower levels of suicidal ideation and fewer suicide attempts during the six-month treatment period than did those who received individual and group supportive therapy. At the 12-month follow-up, there were no significant group differences because adolescents in the latter group also reported fewer suicide attempts over time.[340]

SAFETY is another DBT-informed cognitive behavioral family treatment approach that focuses on strengthening protective supports within the family and other social systems, skill building that leads to safer behavioral reactions to stressors, means reduction, and safety planning. Adolescents with recent suicide attempts who participated in SAFETY were significantly less likely to report experiencing a suicide attempt over the course of treatment compared with enhanced treatment as usual.[341]

Cognitive Behavioral Therapy is a well-studied form of psychotherapy that focuses on changing patients' thoughts and behaviors, which reciprocally influence the other. A systematic review of 10 randomized controlled trials from multiple countries that compared CBT to treatment as usual among individuals who recently engaged in a suicide attempt found that CBT reduced the risk of repeated suicide attempts by half.[342] Two programs, **Cognitive Behavior Therapy for Suicide Prevention** (CBT-SP) and **Brief CBT** (BCBT), are examples of CBT approaches that were tailored to meet the needs of individuals who have recently attempted suicide. CBT-SP uses a risk-reduction, relapse-prevention approach that includes safety plan development, skill building, psychoeducation, and an analysis of proximal risk factors and stressors such as relationship problems and school- or work-related difficulties leading up to and following the suicide attempt. CBT-SP also has family skill modules focused on family support and communication patterns as well as improving the family's problem-solving skills. A randomized controlled trial of CBT-SP found that 10-session outpatient cognitive therapy designed to prevent repeat suicide attempts resulted in a 50% reduction in the likelihood of a suicide reattempt among adults who had been admitted to an emergency department for a suicide attempt relative to treatment as usual.[343] BCBT is a brief version of CBT that is focused on skill development and internal self-management. Soldiers who recently attempted

suicide or experienced suicidal ideation and participated in 12 BCBT sessions were 60% less likely to attempt suicide during the two years following treatment than their peers who received treatment as usual.[344] **Problem Solving Therapy** (PST) is a form of CBT that has been shown to reduce suicidal ideation and hopelessness among individuals experiencing depression and distress related to problem-solving skills.[345,346]

Collaborative Assessment and Management of Suicidality (CAMS) is another therapeutic framework for guiding suicide-focused assessment and treatment. The intervention's flexible approach can be used across treatment settings and clinicians' theoretical orientations. It involves the clinician and patient working together in an interactive assessment process to develop patient-specific treatment plans. Sessions are collaborative and involve continual patient input about what is and is not working to enhance the therapeutic alliance and increase treatment motivation in the suicidal patient. There are five published randomized controlled trials of CAMS (U.S. and Denmark) in which suicidal individuals were randomly assigned to CAMS or comparison treatments.[347-351] Improvements were observed across both treatment groups. However, replicated CAMS results show significant reductions in suicidal ideation, overall symptom distress, depression, and hopelessness relative to comparison care. There are promising data for decreasing suicide attempts and self-harm (Denmark),[349] and a meta-analysis of nine CAMS trials shows that CAMS is a well-supported intervention for suicidal ideation (U.S. and multiple countries).[352] CAMS is currently being evaluated as part of a systems-level approach to reducing suicide risk within a National Health Service clinic that serves a population of 158,000 people in the United Kingdom.[353] Efforts are also underway to develop versions of CAMS to support teenagers at high risk for suicide (CAMS-4Teens), children at high risk for suicide (CAMS-4Kids), and their families.[354] Additionally, V-CAMS is a virtual version that uses a patient-facing avatar and electronic caring contacts to facilitate best-practice suicide prevention interventions.[355]

Future Directions

Several promising approaches are on the horizon in addition to the practices described above. Help-seeking is a key protective factor for suicide that needs additional research. More research is needed on policies and practices that help reduce stigma associated with seeking or receiving help and that protect individuals, like the ability to maintain employment.

Standardized tools such as self-report questionnaires or clinician-administered interviews can help mental health professionals, medical personnel, and others identify and evaluate people at risk. Suicide risk screening and assessment are two different methods that should be administered sequentially. Screening is a method used to rapidly identify someone who needs further evaluation. Assessment is a more comprehensive evaluation to confirm risk, estimate immediate danger to the individual, and guide next steps. Suicide screening may be applied either universally or selectively. Universal screening applies to everyone in large settings such as K–12 schools and colleges or correctional facilities, regardless of risk. Universal screening may also occur as part of routine healthcare in primary care settings or emergency departments. Selective screening may be conducted in mental health settings or in emergency departments when individuals are experiencing a mental health crisis. Toolkits for guiding implementation of screening programs are available from Zero Suicide and the National Institute of Mental Health.

The *Ask Suicide-Screening Questions*,[356] *Patient Safety Screener-3*,[357] *Columbia Suicide Severity Rating Scale*,[358] and *Concise Health Risk Tracking Self-Report*[359] are brief, validated, and commonly used tools to screen for suicide risk. They can be used in a wide range of settings including primary care, emergency departments, and mental health settings. Individual tools are not sufficiently accurate predictors of suicide risk and should only be used as part of a wider comprehensive assessment according to the reserach.[360,361] Some tools do screen for a broader

set of suicide risk factors and may also provide valuable information about risk for suicidal ideation and attempts. The *Convergent Functional Information for Suicidality* (CFI-S) 22-item checklist has shown moderate to high sensitivity and specificity. It outperforms physicians' predictive ratings of repeat visits to the emergency department and completed suicides during a six-month follow-up period.[362]

Emerging efforts to improve risk identification involve techniques such as machine learning and artificial intelligence to analyze medical records and other information to identify people at risk for suicide. Advances in predictive computer modeling show promising methods for using readily available data (such as those available in electronic health records) to detect populations at risk who might not otherwise be recognized.[52,363,364] Applying machine learning to electronic health records has the potential to improve risk detection, but these methods are currently not being routinely implemented in clinical settings.

Ongoing efforts to provide more effective support and treatment for individuals at risk of suicide include the 988 Suicide & Crisis Lifeline, mobile and community crisis response teams, and continued adaptation of therapeutic approaches for specific groups. Mobile and community crisis teams consists of mental health professionals who provide crisis services as well as follow-up stabilization services. These teams will travel to homes and community locations to help an individual experiencing a crisis.

Lessen Harms and Prevent Future Risk

Rationale

Millions of people are bereaved by suicide every year.[3,60] Risk of suicide can increase among people who have lost a friend or peer, family member, coworker, or other close contact to suicide.[365] We need better understanding of the potential long-term effects among survivors. Public messaging and media reporting also play an important role in preventing and reducing future suicide risk. Suicide-related media campaigns, for example, intend to prevent suicide by promoting resiliency and encouraging help-seeking behaviors. Research also suggests that media reports following a suicide that include exposure to sensationalized or otherwise uninformed reporting can inadvertently contribute to what is known as suicide contagion.[366-368] The Suicide Prevention Resource Center provides a comprehensive set of resources including materials, programs, and trainings to help communities support the needs of survivors of suicide loss. Awareness and compassionate care for the bereaved is critical.

Public messaging about suicide prevention is a key communication strategy for educating individuals about warning signs and resources available to help individuals at risk for suicide.

Approaches

Two approaches that can lessen harms and prevent future risk of suicide include postvention and safe reporting and messaging about suicide.

Intervene after a suicide

Postvention happens after a suicide has taken place. It is an important preventive measure that may reduce future suicide risk by proactively and comprehensively supporting the needs of loss survivors. Postvention efforts may involve key partners in the community such as first responders, mental health and healthcare providers, social service providers, local and indigenous leaders, and persons with lived experience. Postvention may include debriefing sessions, counseling, and/or bereavement support groups for surviving friends, family members, or other close contacts.

Report and message about suicide safely

Public messaging about suicide prevention is a key communication strategy for educating individuals about warning signs and resources available to help individuals at risk for suicide before a crisis occurs. Safe messaging emphasizes that suicide is preventable and promotes actions and resources for prevention. Safe reporting following a suicide is critical. Reporting that sensationalizes suicide or glamorizes the person who died by suicide and the venue in which suicide is communicated (like during school assemblies) can heighten the risk of suicide among at-risk individuals and can inadvertently contribute to suicide contagion.[369]

Potential Outcomes

Potential outcomes include reductions in:

- suicidal ideation,
- suicide attempts,
- suicide rates,
- psychological distress, and
- contagion effects related to suicide.

Other potential outcomes include improvements in public perceptions about suicide and media reporting following a suicide.

Evidence

Current evidence suggests that postvention and safe reporting and messaging can impact risk and protective factors for suicide.

Intervene after a suicide

The **StandBy Support After Suicide** (StandBy) is one example of a postvention program that shows initial promise of reducing risk factors for suicide. StandBy provides clients with face-to-face outreach, telephone support, and referrals to additional community services matched to their needs through a professional crisis response team. Site coordinators develop customized case management plans and refer clients to other existing community services as needed.[370] A StandBy study in Australia found that clients were significantly less likely to be at high risk for suicidal ideation and attempts than a suicide-bereaved comparison group that had not been involved with the StandBy program (48% and 64%, respectively).[370] The effectiveness of StandBy at reducing suicidality was replicated in a later study in Australia but only for clients bereaved by suicide within the last 12 months.[371] Individuals who received StandBy services within 12 months of experiencing a loss to suicide were also less likely to experience social loneliness when compared with bereaved individuals who did not use StandBy. These findings underscore the importance of accessing postvention services at the time of, or soon after, experiencing the death of a loved one by suicide.

Two other programs show initial promise for reducing suicidal ideation and/or suicide attempts among bereaved individuals and families: **Complicated Grief Treatment** and the **Family Bereavement Program** (FBP). Neither program was designed to address the needs of suicide survivors, but initial evidence suggests they can reduce suicidal ideation and suicide attempts among people who have experienced the death of a loved one by suicide. Complicated Grief Treatment is a short-term therapy that focuses on understanding and resolving grief complications and promoting resilience. Thoughts of suicide were reduced from 52% before treatment to 9% after treatment among individuals bereaved by suicide loss.[372] FBP promotes the resilience of children who have lost a parent to suicide and includes a component for caregivers that teaches positive parenting and a component for children that focuses on effective coping skills. The long-term effectiveness of FBP was documented in one study. It reports significantly less suicidal ideation and fewer suicide attempts at 6-year and 15-year follow-ups among children who participated in FBP when compared with a group of children who have lost a parent to suicide but did not participate in FBP.[272]

Additional research suggests that there are benefits when active postvention approaches occur at the scene of a suicide. They are associated with intake into treatment sooner, greater attendance at support group meetings, and attendance at more meetings when compared with passive postvention such as approaches where survivors self-refer for services.[373]

Report and message about suicide safely

One way to ensure safe reporting about suicide is to encourage news media to adhere to **Recommendations for Reporting on Suicide**. The most compelling evidence supporting these recommendations for reporting comes from Austria. Media guidelines were introduced after a sharp increase in suicides on the

Postvention is an important preventive measure that may reduce future suicide risk by proactively and comprehensively supporting the needs of loss survivors.

Viennese subway, and an interrupted time-series design was used to evaluate the guidelines' national impact on subsequent suicides. Changes in the quality and quantity of media reporting in Austria resulted in a nationwide significant reduction of 81 suicides annually.[366] A systematic review and meta-analysis, which included the U.S. and multiple other countries, indicated that following guidelines for responsible reporting is especially important when covering celebrity suicides because the public may be more likely to identify with individuals of high social standing.[374] Research suggests that sensationalist media reports have harmful effects on suicide, but reporting on positive coping skills in the face of adversity can demonstrate protective effects against suicide (U.S. and multiple countries).[375] Reports of individual suicidal ideation along with reports describing a "mastery" of a crisis situation where adversities were overcome was associated with significant decreases in suicide rates in the period immediately following such reports.[375]

Future Directions

There is an ongoing need to adopt and evaluate public health approaches to postvention that are culturally sensitive and tailored to meet the needs of individuals and communities affected by suicide loss. Comprehensive postvention responses that recognize both the immediate and long-term effects of suicide loss are needed to reduce risk and promote healing.

The Action Alliance Survivors of Suicide Loss Task Force developed guidelines to help communities and organizations provide immediate and effective services and support to everyone who is affected by suicide. The guidelines are based on a social-ecological approach and are intended to promote compassionate and integrated postvention efforts across all levels of society. National guidelines are relevant to broader communities and organizations, but there are resources for smaller groups of people too. After a Suicide: A Toolkit for Schools is a postvention toolkit that offers comprehensive, practice-informed, and evidence-based guidance tailored to the specific needs of school communities when responding to and managing the detrimental effects of suicide. These resources have not been evaluated for their impact on suicide, attempts, or ideation, but they may reduce the effects of trauma including feelings of guilt, distress, depression, and complicated grief.[371,376]

Improved and consistent adherence to safe messaging recommendations across all forms of media is another area for future directions and research. Suicide prevention media campaigns, for example, are an evolving and popular approach intended to reduce risk of suicide by reaching individuals before crisis occurs.[377] Media campaigns often focus on the public's perceptions about suicide by providing information regarding warning signs and resources and encouraging help-seeking behaviors. Preliminary evidence from two systematic reviews link media campaigns to modest improvements in knowledge, beliefs, and attitudes toward suicide.[377,378] However, some research has found negative impacts associated with campaigns.[377] These mixed results, and even potential for harm, strongly suggest that media campaigns are most effective when they are delivered as part of a multi-component approach to suicide prevention. They are more effective when they also incorporate active engagement strategies, like lectures or face-to-face distribution of promotional materials, versus relying on incidental exposure to passive media platforms such billboards and radio or television advertisements (studies from multiple countries).[377]

The Action Alliance developed a framework for safe messaging and recommendations for news and entertainment media on depicting suicide. These resources can help all sectors of the community develop messages that are strategic, safe, positive, and based on best practices. Engaging all sectors of communities in understanding and implementing safe messaging about suicide may prevent future risk. These guidelines can be applied to all forms of communication such as casual conversations, formal meetings, and traditional and social media platforms. More research is needed on how these guidelines are implemented in different settings and for diverse audiences.

We can save lives and offer hope and healing by using the best available evidence and working to build out future directions with robust evaluation.

Collaboration and Partnerships

A comprehensive approach to suicide prevention extends beyond primary and behavioral healthcare settings to all places where people live, work, study, worship, and play. Communities can achieve this by creating partnerships to share the responsibility and investment in suicide prevention. Collaborations can also create meaningful linkages across public health, mental health, primary care, and other sectors.

The Role of Public Health

Public health can play an important and unique role in comprehensive suicide prevention. Public health agencies bring critical leadership to suicide prevention for broad population-level impact. The public health approach uses data to define the problem, science to determine what works for prevention, and widespread adoption of effective programs, practices, and policies with a particular focus on upstream prevention that seeks to prevent suicide risk in the first place. To carry out this approach, public health professionals serve as conveners of multi-sectoral partnerships that together use data and the best available evidence to plan, prioritize, and coordinate suicide prevention efforts in state, territorial, local, and tribal communities, with a focus on populations disproportionately affected by suicide. Public health collects and disseminates data and prevention information, implements and evaluates preventive measures, and tracks and monitors prevention progress for continuous quality improvement.

Integrating and coordinating prevention activities across sectors and settings can expand the reach and impact of suicide prevention efforts.

Partners and People with Vested Interest

The strategies and approaches outlined in this Prevention Resource cannot be accomplished by the public health sector alone, nor can suicide prevention rely solely on the mental health system, which touches some but not all of the strategies described in this resource. Integrating and coordinating prevention activities across sectors and settings (see *National Strategy for Suicide Prevention*[1]) can expand the reach and impact of suicide prevention efforts. The following list describes some of the vital partners needed to implement the strategies and approaches in this resource, along with examples of the types of roles they can play in preventing suicide.

- **Community members, including individuals with lived experience** are essential, and it is important that they are involved at every stage of the planning and implementation process. Those who are directly impacted by suicide have firsthand experience and can contribute ideas for how to prevent it.
- **Individuals from populations disproportionately affected by suicide** offer vital expertise for preventing suicide. Collaborating with representatives and leaders from diverse backgrounds is particularly important to disrupt patterns

of inequity and help ensure relevance and reach. Also consider engaging non-traditional partners who have rapport in particular communities.

- **Non-governmental and community-based organizations** often serve as points of connection and engagement across the populations they serve. They can identify people at risk and coordinate across organizations to provide supportive services. Community organizations can deliver programs such as those that promote healthy norms and teach coping skills. They can leverage their connections to increase awareness of, and garner support for, policies that help reduce suicide on a broader scale. They can also create safe spaces for community members to grieve and process their experience following a suicide in the community, which can lessen harms and prevent future risk.
- **Education systems** can implement and evaluate policies and practices geared toward creating safe, healthy, and supportive classroom environments. Schools can teach coping and problem-solving skills and promote healthy connections through healthy peer norms and community engagement activities.
- **Local, state, and federal government** are especially important in addressing underlying environmental contexts that increase the risk for suicide. Government agencies can implement programs and policies that improve housing stability, economic security, and care access and delivery. Public health and other governmental agencies can work together to establish policies and support practices that create protective environments where people live, work, and play.
- **Social services** can collaborate with the health, education, and justice sectors to support individuals at high risk for suicide and their families, improve access to care, and coordinate service provision with community organizations. This could include public agencies and departments at the county and municipal level.
- **Health and behavioral healthcare** insurers, providers, and health systems can implement programs and policies that improve access and delivery of suicide care. The health sector is well-positioned to identify and support people at risk through activities delivered in hospital, primary care, behavioral healthcare, and community settings that require the expertise of professionals who are licensed and trained to deliver intensive critical intervention support. Clinicians can help reduce access to lethal means among people at risk of suicide through education and counseling.

- **Businesses** can implement programs and policies that strengthen household financial security. They can also partner with public health entities to establish policies and practices that create protective workplace environments.
- **Housing authorities and agencies** can adopt policies that prevent homelessness and minimize eviction and foreclosure. Affordable housing advocates can promote a range of policies to improve housing stability, alleviate financial strain, and decrease risk of suicide. Supportive housing providers can ensure strong linkages to care and promote healthy connections among residents, their families, and community.
- **News media** can lessen harms and prevent future risk by promoting help-seeking and following responsible reporting guidelines, including when communicating information on a recent suicide to the public.
- **Policymakers** can advance changes in policies, systems, and environments that will help reduce suicide. This includes strengthening economic supports, improving access to and delivery of suicide care, and creating protective environments.
- **First responders** can identify those at risk and connect them to support.
- **Foundations** can support comprehensive action across strategies and fund evaluation efforts to expand the evidence base, with flexibility in funded approaches to encourage cultural responsiveness and adaptation. Funders can structure initiatives to include time for thorough planning and partnership building that foster collaboration.

These groups can work together to prevent suicide by impacting the various contexts and underlying risks that contribute to suicide. Suicide prevention efforts can involve partners in a wide variety of configurations. The list of partners and sample roles provided above is not meant to be exhaustive.

Many states and communities already have strategic plans for suicide prevention, as well as coalitions and task forces in place that engage these partners.[379] The Action Alliance is a cross-sector, public-private partnership that brings together federal agencies* with the private sector† and the nonprofit sector to implement the National Strategy for Suicide Prevention and the Surgeon General's Call to Action.

The summary table in the Appendix notes sectors that may be well-positioned to lead implementation efforts within the strategies and approaches described in this document. All sectors can play an important and influential role in preventing the risk of suicide in the first place and lessening the immediate and long-term harms of suicidal behavior by helping those in times of crisis get the services and support they need.

Complementary resources:

The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention.

The National Strategy for Suicide Prevention outlines sample actions that various sectors, levels of government, organizations, individuals, and families can take to prevent suicide.

* Centers for Disease Control and Prevention, Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration, National Institute of Mental Health, Department of Defense, Indian Health Services, Office of Self Governance – Department of the Interior, Department of Justice, Department of Homeland Security

† Construction, healthcare, news media, sport, entertainment, finance, forestry, etc.

Monitoring and Evaluation

Monitoring and evaluation are necessary components of a public health approach to preventing suicide. Prevention efforts require timely and reliable data to monitor the extent of the problem and evaluate the impact. Data are also necessary for prevention planning and implementation to understand what works and does not work to address risk factors, reinforce protective factors, and decrease suicide rates.

Gathering ongoing, uniform, and consistent data across systems is important. Consistent data allow public health and other entities to better gauge the scope of the problem, identify groups at high risk, and monitor the effects of prevention policies and programs. It is common for different sectors, agencies, and organizations to employ varying definitions of suicidal ideation, behavior, and death that can make it difficult to consistently monitor specific outcomes across sectors and over time. For example, the manner in which deaths are classified can change from one jurisdiction to another or based on local medical and/or medico-legal standards.[380]

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Monitoring Resources

Surveillance systems exist at the federal, state, and local levels. A list of available data sources for suicide prevention can be found on CDC's Suicide Prevention website. It is important to assess the availability of surveillance data and data systems across these levels to identify and address gaps in the systems. CDC's National Vital Statistics System data, with data available at WISQARS™ and CDC WONDER[381] and the National Violent Death Reporting System,[382] are examples of surveillance systems that provide data on deaths from suicide. The National Vital Statistics System is a nationwide surveillance system that collects demographic, geographic, and cause-of-death data from death certificates.[381] The National Violent Death Reporting System is a state-based surveillance system (currently in all 50 states, the District of Columbia, and Puerto Rico) that combines data from death certificates, law enforcement reports, and coroner or medical examiner reports to provide detailed information on the circumstances of violent deaths, including suicide, which can assist communities in guiding prevention activities.[382] Data from state and local Child Death Review Teams[383] and Suicide Death Review Teams (in a few states) offer another source to identify deaths and obtain insight into the gaps in services, systems, and modifiable risk factors for suicide.

The National Electronic Injury Surveillance System-All Injury Program provides nationally representative data about all types and causes of nonfatal injuries treated in a subset of U.S. hospital emergency departments and can be used to assess national rates of, and trends in, self-harm injuries by cause, age, race and ethnicity, sex, and disposition.[9]

CDC's National Syndromic Surveillance Program has additional information regarding suicidal behavior from electronic patient encounter data obtained from

emergency departments, urgent and ambulatory care centers, inpatient healthcare settings, and laboratories.[384] Emergency department syndromic surveillance data contains information on suicidal ideation and suspected suicide attempts that can be analyzed by age, sex, and geographic location. It can provide timely information on trends which can be used to support targeted public health investigation and response.[87,385-387] The program can be particularly helpful as an early warning system for upticks in suicide-related outcomes in general, and during times of community infrastructure disruptions, such as pandemics, economic recessions, and natural disasters.

Some surveillance systems provide national, state, and some local estimates of suicidal behavior and suicide risk and protective factors. The Youth Risk Behavior Surveillance System collects information from a nationally representative sample of 9th–12th-grade students. It is a key resource in monitoring health risk behaviors among youth. It includes information about youth who have seriously considered attempting suicide, attempted suicide, made a plan, or required treatment by a doctor or nurse for a suicide attempt that resulted in an injury, poisoning, or overdose.[388] The data are obtained from a national school-based survey conducted by CDC as well as from state, territorial, tribal, and large urban school district surveys conducted by education and health agencies.[388] The National Survey on Drug Use and Health (NSDUH)[389] is an annual survey of the civilian, non-institutionalized population ages 12 years and older. NSDUH provides data on:

- national and state-level estimates of substance use such as alcohol, tobacco, illicit drugs, and nonmedical use of prescription drugs,
- mental health, such as past year mental illness and co-occurring illnesses,
- service utilization, and
- suicidal ideation, suicide plans, and suicide attempts.

NSDUH is a key resource to track trends in suicide-related risk factors in the population and to help identify groups at increased risk.[389]

International Classification of Diseases, Tenth Revision–Clinical Modification coded administrative data can provide a means to monitor suicide deaths, nonfatal suicide attempts, and instances of intentional self-harm through claims and encounter data.[390] International Classification of Diseases, Tenth Revision suicide-related codes are distinct from mental health-related codes and provide information about manner of death or method of injury via external cause codes. Administrative data sets can vary in quality and completeness, particularly external cause codes. There is a federal requirement for healthcare providers to include diagnosis codes when submitting claims for reimbursement, but inclusion of external cause codes is voluntary.[391] Administrative data can also be used to evaluate prevention efforts.

The Healthcare Cost and Utilization Project (HCUP) is a collection of healthcare databases that provides longitudinal all-payer encounter-level data for hospital inpatient care, outpatient emergency department care, and ambulatory surgery from hospital-owned facilities. HCUP data can provide national-level trend data on emergency department visits related to suicidal ideation or suicide attempt.[392,393] It can also be used within states to understand the prevalence of suicide attempts requiring hospitalizations by geographic regions.

Evaluation

It is important to address gaps in responses, track progress of prevention efforts, and evaluate the impact of those efforts to improve the quality of suicide prevention programming and/or to eliminate non-effective strategies or activities. Evaluation data are essential to understand what does and does not work to reduce suicide rates and the associated risk and protective factors at the individual, relationship, community, and societal levels. Theories of change and logic models that identify short-, intermediate-, and long-term outcomes are an important part of program evaluation.

Evaluation data are essential to understand what does and does not work to reduce suicide rates and the associated risk and protective factors at the individual, relationship, community, and societal levels.

The evidence base for suicide prevention has advanced greatly over the last few decades. However, we need more information on the impacts of policies, programs, and practices on suicide and suicide attempts. This work needs to go beyond merely examining their effectiveness on risk factors. Research can inform knowledge gaps about the long-term effectiveness of primary prevention strategies (upstream before risk occurs) and community-level strategies to prevent suicide at the population level. Testing the effectiveness of the strategies and approaches in this resource could include evaluating how the strategies interact, identifying the barriers and facilitators to successful strategy implementation, and the impact of key contextual factors, policies, and partnerships on strategy implementation and effectiveness. Most existing evaluations focus on approaches implemented in isolation, but there is potential to understand the synergistic effects within a comprehensive prevention approach. CDC's Comprehensive Suicide Prevention Program seeks to understand these synergies as states and communities implement multiple strategies and approaches from this resource.

Conclusion

Suicide is a serious but preventable[1,2] public health problem that can have lasting impacts and ripple effects that are far-reaching. Each of us likely interacts every day with suicide survivors; those with lived experience; and those with thoughts of suicide either at home, at work, or in our communities. Suicide rates have declined in the past two years,[7] but multiple barriers have impeded progress. Barriers include adequate resources and capacity to carry out the work and stigma related to help-seeking, mental illness, and being a survivor. The good news is that suicide as a preventable public health problem is garnering attention, particularly in the wake of the COVID-19 pandemic. We now have the Surgeon General's Call to Action to implement the National Strategy for Suicide Prevention and the U.S. Department of Health and Human Services' Behavioral Health Coordinating Council and its subcommittee on Suicide Prevention and Crisis Care. Many other expanded efforts such as the 988 Suicide & Crisis Lifeline are underway.

Each of us likely interacts every day with suicide survivors; those with lived experience; and those with thoughts of suicide either at home, at work, or in our communities.

This Prevention Resource includes strategies and approaches designed to be used as part of a comprehensive approach to suicide prevention. Such an approach starts with convening, connecting, and communicating with multi-sectoral partners. It relies on quality data for decision-making; leveraging existing suicide prevention programming in communities; implementing and evaluating multiple strategies and approaches with the best available evidence as found in this document; and communicating lessons learned, progress, and success stories. This Prevention Resource addresses multiple risk and protective factors at the individual, relationship, community, and societal levels. It includes strategies and approaches to prevent the risk of suicide in the first place, as well as strategies focused on lessening the immediate and long-term harms of suicidal behavior. It also includes strategies that range from a focus on the whole population regardless of risk to strategies designed to support people at highest risk. Importantly, this Prevention Resource extends the bounds of typical prevention strategies to consider approaches that go beyond individual behavior change to better address risk factors impacting communities and populations more broadly such as economic policies to strengthen housing and financial security.

The collection of policies, programs, and practices described in this resource can be implemented now while the evidence base continues to emerge. Monitoring and evaluation play a key role in that implementation. In closing, we hope that this resource supports states and communities as you work to prevent suicide, and as we work together, knowing that hope, help, and healing are possible.

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APPENDIX

SUMMARY OF STRATEGIES AND APPROACHES TO PREVENT SUICIDE

STRATEGY: **STRENGTHEN ECONOMIC SUPPORTS**

Approach/Program, Practice or Policy	Suicide	Suicide Ideation or Attempts	Other Risk/ Protective Factors for Suicide	Lead Sectors
IMPROVE HOUSEHOLD FINANCIAL SECURITY				
Unemployment insurance benefits	▲		▲	+ Government (local, state, federal) + Business/ Labor
Other unemployment support practices (e.g., job skills training)	▲		▲	
Other household financial security measures (e.g., transfer payments, medical benefits, and family assistance)	▲		▲	
State supplements to federal Earned Income Tax Credits	▲		▲	
Supplemental Nutrition Assistance Program	▲		▲	
Early access to Social Security benefits	▲		▲	
Increased minimum wages	▲		▲	
STABILIZE HOUSING				
Rent assistance to renters with lower incomes			▲	
Low-barrier housing for individuals experiencing chronic homelessness		▲		
Veterans Health Administration homeless programs	▲			

STRATEGY: **CREATE PROTECTIVE ENVIRONMENTS**

Approach/Program, Practice or Policy	Suicide	Suicide Ideation or Attempts	Other Risk/ Protective Factors for Suicide	Lead Sectors
REDUCE ACCESS TO LETHAL MEANS AMONG PERSONS AT RISK OF SUICIDE				
Interventions to reduce readily accessible environmental means (e.g., bridges, pesticides)	▲			+ Government (local, state) + Public Health + Healthcare + Business/ Labor
Safe storage (e.g., Counseling on Access to Lethal Means (CALM)	▲			
Child Access Prevention (CAP) laws to reduce firearm self-injuries and suicides among young people	▲			
Mandatory waiting periods to reduce firearm suicides	▲			
CREATE HEALTHY ORGANIZATIONAL POLICIES AND CULTURE				
United States Air Force Suicide Prevention Program	▲		▲	+ Government (local, state, federal) + Military + Justice + Education
Together for Life	▲			
Strong Schools Against Suicidality and Self-Injury			▲	
Correctional suicide prevention	▲		▲	
REDUCE SUBSTANCE USE THROUGH COMMUNITY-BASED POLICIES AND PRACTICES				
Reduce alcohol outlet density	▲	▲		+ Government (local, state) + Business/ Labor
Prescription drug supply restrictions (e.g., PDMPs)	▲			

STRATEGY: **IMPROVE ACCESS AND DELIVERY OF SUICIDE CARE**

Approach/Program, Practice or Policy	Suicide	Suicide Ideation or Attempts	Other Risk/ Protective Factors for Suicide	Lead Sectors
COVER MENTAL HEALTH CONDITIONS IN HEALTH INSURANCE POLICIES				
Mental health parity laws	▲		▲	+ Government (state, federal) + Healthcare
INCREASE PROVIDER AVAILABILITY IN UNDERSERVED AREAS				
National Health Service Corps			▲	+ Government (federal) + Healthcare
Community mental health clinics		▲		
PROVIDE RAPID AND REMOTE ACCESS TO HELP				
Telemental health (e.g., telephone, clinical video appointments)			▲	+ Healthcare + Public health + Business/ Labor
Mobile applications			▲	
Internet-delivered cognitive behavior therapy		▲	▲	
CREATE SAFER SUICIDE CARE THROUGH SYSTEMS CHANGE				
Zero Suicide	▲		▲	+ Healthcare

STRATEGY: **PROMOTE HEALTHY CONNECTIONS**

Approach/Program, Practice or Policy	Suicide	Suicide Ideation or Attempts	Other Risk/ Protective Factors for Suicide	Lead Sectors
PROMOTE HEALTHY PEER NORMS				
Sources of Strength			▲	+ Public Health + Education
Wingman-Connect		▲	▲	
ENGAGE COMMUNITY MEMBERS IN SHARED ACTIVITIES				
Greening vacant urban spaces			▲	+ Public Health + Government (local) + Community Nonprofit

STRATEGY: **TEACH COPING AND PROBLEM-SOLVING SKILLS**

Approach/Program, Practice or Policy	Suicide	Suicide Ideation or Attempts	Other Risk/ Protective Factors for Suicide	Lead Sectors
SUPPORT SOCIAL-EMOTIONAL LEARNING PROGRAMS				
Youth Aware of Mental Health Program		▲	▲	+ Public Health + Education + Social Services + Nonprofit
Good Behavior Game		▲	▲	
Aussie Optimism Program			▲	
Signs of Suicide		▲	▲	
TEACH PARENTING SKILLS TO IMPROVE FAMILY RELATIONSHIPS				
The Incredible Years			▲	
Strengthening Families Program			▲	
Family Check-Up		▲		
Family Bereavement Program		▲		
Familias Unidas		▲		
After Deployment Adaptive Parenting Tools (ADAPT)		▲	▲	
SUPPORT RESILIENCE THROUGH EDUCATION PROGRAMS				
Resilience training programs (e.g., colleges, workplaces)			▲	+ Education + Business/ Labor

STRATEGY: **IDENTIFY AND SUPPORT PEOPLE AT RISK**

Approach/Program, Practice or Policy	Suicide	Suicide Ideation or Attempts	Other Risk/ Protective Factors for Suicide	Lead Sectors
TRAIN GATEKEEPERS				
Applied Suicide Intervention Skills Training			▲	+ Government (federal) + Public Health + Healthcare
Garrett Lee Smith Youth Suicide Prevention Program			▲	
Question Persuade Refer (QPR)			▲	
Mental Health First Aid and Teen Mental Health First Aid			▲	
RESPOND TO CRISES				
National Suicide Prevention Lifeline (now called 988 Suicide & Crisis Lifeline)		▲	▲	+ Government (local, state, federal) + Social Services + Healthcare + Business/ Labor
Virtual Hope Box (VHB)			▲	
Jaspr Health			▲	
PLAN FOR SAFETY AND FOLLOW-UP AFTER AN ATTEMPT				
Safety planning		▲		+ Healthcare + Social services
Safety Planning Intervention with Structured Follow-up (SPI+)		▲		
Follow-up contacts	▲	▲		
Emergency Department Safety Assessment and Follow-up Evaluation (ED SAFE)	▲	▲		
Attempted Suicide Short Intervention Program		▲	▲	
PROVIDE THERAPEUTIC APPROACHES				
Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)		▲	▲	+ Healthcare
Prevention of Suicide in Primary Care Elderly Clinical Trial (PROSPECT)		▲	▲	
Dialectical Behavior Therapy (DBT)		▲	▲	

STRATEGY: **IDENTIFY AND SUPPORT PEOPLE AT RISK** (CONTINUED)

Approach/Program, Practice or Policy	Suicide	Suicide Ideation or Attempts	Other Risk/ Protective Factors for Suicide	Lead Sectors
PROVIDE THERAPEUTIC APPROACHES (CONTINUED)				
SAFETY		▲		+ Healthcare
CBT for Suicide Prevention (CBT-SP)		▲		
Brief CBT (BCBT)		▲		
Problem Solving Therapy (PST)		▲	▲	
Collaborative Assessment and Management of Suicidality (CAMS)		▲	▲	

STRATEGY: **LESSEN HARMS AND PREVENT FUTURE RISK**

Approach/Program, Practice or Policy	Suicide	Suicide Ideation or Attempts	Other Risk/ Protective Factors for Suicide	Lead Sectors
INTERVENE AFTER A SUICIDE				
StandBy Support After Suicide		▲	▲	+ Healthcare + Public Health + Social Services
Complicated Grief Treatment		▲		
Family Bereavement Program		▲	▲	
REPORT AND MESSAGE ABOUT SUICIDE SAFELY				
Safe Reporting Guidelines	▲			+ Public Health + Media

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

www.cdc.gov/suicide

The Surgeon General's Call to Action
TO IMPLEMENT THE NATIONAL STRATEGY FOR SUICIDE PREVENTION

A Report of the U.S. Surgeon General and of the
National Action Alliance for Suicide Prevention

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Preface from the Surgeon General

Together with the National Action Alliance for Suicide Prevention (Action Alliance), I am honored to present *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention*. More than 20 years ago, Surgeon General David Satcher issued the landmark report *The Surgeon General's Call to Action to Prevent Suicide*, recognizing suicide as a major public health issue and calling for a national response. Although we have established a solid foundation for suicide prevention in the United States, much work remains to be done.

The *National Strategy for Suicide Prevention (National Strategy)*, first released in 2001 and updated in collaboration with the Action Alliance in 2012, identifies 13 goals and 60 objectives that address every aspect of suicide prevention—from fostering healthy and empowered individuals, families, and communities to providing effective prevention programs and clinical care. The Action Alliance has become a diverse and impactful partnership that is advancing implementation of the *National Strategy* across the public and private sectors every day.

Today we know more about suicide and how it can be prevented than we did in 1999. We understand that like other public health problems, such as obesity and cancer, suicide is influenced by many factors. As a result, suicide prevention efforts must engage all sectors, including public health, mental health, health care, social services, our military and Veterans, business, entertainment, media, faith communities, and education. These efforts must be informed by data, guided by the needs of the groups affected, and shaped by the voices of people who have experienced suicidal thoughts, plans, attempts, and losses.

In the past 20 years, suicide prevention activity has increased dramatically, and we have made progress in implementing the goals and objectives in the *National Strategy*. Adding to the momentum for collaboration around suicide prevention efforts, President Donald Trump signed Executive Order 13861, the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS), thus establishing a cabinet-level Task Force. As a Task Force member and Ambassador for PREVENTS, I have collaborated with federal, state, local, territorial, and tribal governments, as well as non-governmental entities and organizations to prevent suicide deaths. New sectors have become involved, and we have observed an increase in public awareness that suicide is preventable. However, there is still much work to be done to fully implement the *National Strategy*, and suicide remains a serious, and growing, public health problem. In 2019, more than 47,000 people died by suicide, and millions more struggled with serious thoughts of suicide or supported someone close to them who was in distress.

Experiencing a suicidal crisis or losing a loved one to suicide can have deep and long-lasting consequences. Families, friends, colleagues, neighbors, communities—and ultimately our entire nation—feel the effects of this suffering and loss. We can and must do more to prevent these deaths and distress and to help all Americans lead healthy and fulfilling lives.

At the same time, we recognize the substantial challenges ahead of us. A worldwide pandemic continues to impact the health and economic well-being of Americans. This crisis has brought renewed attention to deep-seated inequities in health, education, employment, housing, and other areas that affect the lives of millions of Americans. Problems resulting from the pandemic—including physical illness, loss of loved ones, anxiety, depression, job loss, eviction, and increased poverty—could all contribute to suicide risk.

Today, perhaps more than ever before in our recent history, we need to come together as a nation to strengthen and support one another—to be there for our friends, family members, colleagues, neighbors, and others facing difficult times. All of us have a role to play in spreading kindness and compassion and supporting one another when we are struggling.

Please join us in carrying out the actions outlined in this report to fully implement the *National Strategy* so that we may build strong and healthy communities, support those who may be struggling, and save lives.

Jerome M. Adams, MD, MPH
Vice Admiral, U.S. Public Health Service
Surgeon General
U.S. Department of Health and Human Services

From the National Action Alliance for Suicide Prevention

As co-chairs of the National Action Alliance for Suicide Prevention (Action Alliance), in partnership with U.S. Surgeon General Jerome Adams, we are pleased to release this *Call to Action*, which identifies six priority actions for suicide prevention in the United States. Established in 2010, the Action Alliance is the public-private partnership tasked with advancing the *National Strategy for Suicide Prevention (National Strategy)*. We are fulfilling this charge every day by championing suicide prevention as a national priority and bringing together diverse sectors—including health care, the justice system, first responders, faith leaders, communities of color, the media, and employers—to leverage their leadership roles in supporting efforts to implement the 2012 *National Strategy*. Our mission is fueled by more than 250 partner organizations dedicated to leading a coordinated national response to suicide.

The *National Strategy* recognizes that suicide is a complex issue requiring comprehensive solutions. No single strategy alone will be enough to reduce suicide rates. Suicide prevention efforts must combine strategies that promote resilience and wellness, identify and support individuals and groups at risk, provide effective crisis response and care for suicide risk, and support those who have been affected by suicide. These efforts must be guided by the voices of individuals with lived experience and tailored to the unique strengths and needs of groups who bear a disproportionate burden of suicide, including military service members, Veterans, indigenous communities, and ethnic, racial, sexual, and gender minorities.

We know that the coronavirus disease-2019 (COVID-19) pandemic is taking a tremendous toll on Americans' emotional and economic well-being. While no one is immune from the stress and anxiety resulting from this crisis, these effects are magnified in households that already faced systemic disparities before the pandemic began. During these times, we must focus on strengthening individuals and communities to cope with adversity, and supporting those who may be facing multiple challenges. We also need to ensure that those at risk for suicide are provided with effective care that will support their recovery.

Together with our many partners, we have made much progress in engaging new sectors, building public awareness and momentum, and leveraging resources to identify best practices in suicide prevention. We now know more about what works to prevent suicide than ever before. These evidence-based approaches must be implemented more widely.

Urgent action around suicide prevention is needed at the federal, state, tribal, and local levels to fully implement the goals and objectives of the *National Strategy* and change the trajectory of suicide in our country. The Action Alliance is ready and eager to lead the charge. The six actions and associated strategies outlined in this report will help move us closer to fully implementing the *National Strategy* and achieving our ultimate vision: a nation free from the tragedy of suicide. Please join us.

Sincerely,

Robert W. Turner
Private Sector Co-Chair, Action Alliance
Senior Vice President, Retired
Union Pacific Corporation

Carolyn M. Clancy, MD
Public Sector Co-Chair, Action Alliance
Deputy Under Secretary for Health for Discovery, Education, and Affiliate Networks
U.S. Department of Veterans Affairs

From the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) Office

Suicide is one of the most challenging societal issues of our time, affecting our Veterans at alarming rates. To address suicide within the Veteran community and to create an "all of nation" approach to prevent suicide more broadly, Executive Order 13861, known as The President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS), was signed on March 5, 2019. At the center of PREVENTS' work is the goal of preventing suicide. Achieving this goal requires culture change, seamless access to care, a connected research ecosystem, and robust community engagement. It also requires ongoing coordination with all sectors, institutions, and stakeholders. Because suicide is a national tragedy that affects all of us, in order to be successful, everyone must be engaged.

PREVENTS works to elevate and amplify existing suicide prevention initiatives and to address gaps in the efforts and services outlined in the first (2001) and updated (2012) *National Strategy for Suicide Prevention*. To accomplish the aspirational goals of PREVENTS, a comprehensive plan—or Roadmap—was developed over the course of a year and released to the public in June 2020. Several critical goals have been accomplished since the release of this public health approach:

- Construction of the PREVENTS office, comprising dedicated staff, detailed action officers from the PREVENTS Task Force federal departments, and contract support to operationalize the work of PREVENTS and the REACH campaign
- Launch of the REACH national public health campaign, developed specifically for this effort, which to date has 2.8+ billion media impressions, 642+ million video views, 7.7+ million website visits, and 15,000+ pledges
- Implementation of a scalable operational structure that currently involves more than a thousand individuals and organizations representing federal, state, local, and tribal governments; faith-based communities; nonprofit organizations; academia; Veteran and military service organizations; and other private industry partners, working collaboratively with specified roles and actions, using best-in-practice implementation strategies
- Creation of the framework and partnerships to implement a National Grant Program beginning in 2022, authorized by the Commander John Scott Hannon Act, passed into law in October 2020

Much has changed since the PREVENTS Executive Order was signed in March 2019, including a global pandemic that has created additional challenges and strain on the mental health and well-being of our nation. Recent polls have indicated that as many as a third of Americans are experiencing some form of mental health distress. More than ever before, these challenging times highlight the importance of collaboration and coordination as we engage all Americans to ensure that those in need are able to receive the care and support they deserve.

In 2021, PREVENTS looks forward to working with the Office of the Surgeon General and the Action Alliance to continue this critical work. The six actions and associated strategies outlined in this report are necessary and achievable. No single organization or entity can accomplish this alone, but together we will prevent suicide.

Barbara Van Dahlen, PhD
PREVENTS Executive Order Task Force
Executive Director

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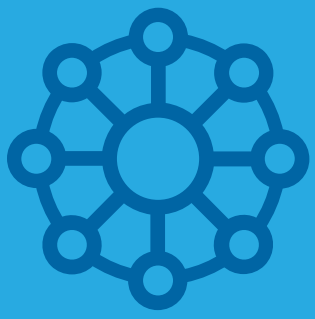


Introduction and Overview

Introduction and Overview

Suicide is a tragedy that touches the lives of millions of Americans. One of the 10 leading causes of death in the United States, suicide claimed more than 47,500 lives in 2019 alone.[1] Moreover, suicide rates are rising across the country.[2] From 1999 to 2019, the national suicide rate increased 32 percent—from 10.5 to 13.9 per 100,000.[1, 3]

These deaths are only the tip of an iceberg. For every person who dies by suicide, thousands more experience suicidal thoughts or attempt suicide. In a 2019 national survey, 1.4 million U.S. adults reported attempting suicide in the past year, 3.5 million adults reported making a suicide plan in the past year, and 12 million adults reported having serious thoughts of suicide in the past year.[4] Additionally, from 2008 to 2017, visits to the emergency department related to suicidal ideation or suicide attempts increased among all age groups.[5]

When someone experiences a suicidal crisis or dies by suicide, countless others—including family members, friends, teachers, and coworkers—are affected. Losing someone to suicide is a tragedy that has long-lasting consequences and may increase the risk for suicidal behaviors,[6, 7] which include preparatory acts, suicide attempts, and deaths.[8] The economic toll is immense as well. Suicide attempts and deaths by suicide are estimated to cost the nation more than $93 billion per year in medical costs and lost productivity.[9]

Although suicide is a complex behavior that can be influenced by many different factors, suicide is preventable. Suicide prevention requires a comprehensive approach that combines multiple strategies to reduce risk and strengthen protective factors at the individual, relationship, community, and societal levels.

1999 Surgeon General's Call to Action

Recognizing the need to make suicide prevention a national priority, in 1999 Surgeon General David Satcher issued *The Surgeon General's Call to Action to Prevent Suicide*.[10] The call came at a time of increased momentum around suicide prevention worldwide. U.S. suicide prevention efforts had been initiated decades earlier by dedicated grassroots activists—many of whom had lost someone to suicide or had faced a suicidal crisis themselves—but in the 1990s these efforts coalesced around the need to develop a national coordinated response. To that end, the United States participated in a landmark international conference in Canada in 1993, and five years later conducted its first-ever National Suicide Prevention Conference, in Reno, Nevada. Guided by the recommendations resulting from the national conference, Dr. Satcher's *Call to Action* introduced a blueprint for suicide prevention and called for the development of a comprehensive national strategy.

National Strategy for Suicide Prevention

In 2000, a federal steering group comprising diverse representatives from the public and private sectors conducted a series of public hearings to guide the development of a national strategy. Released jointly by Dr. Satcher and the National Council for Suicide Prevention in 2001, the *National Strategy for Suicide Prevention (National Strategy)* presented a detailed roadmap for preventing suicide in a comprehensive and coordinated way.[11]

In the years that followed, activity around suicide prevention swiftly expanded, with government agencies at all levels, nonprofit organizations, schools, and other entities initiating suicide prevention programs. Guided by the goals and objectives of the *National Strategy*, states nationwide developed their own state-level suicide prevention plans. At the federal level, key achievements included the enactment of the 2004 Garrett Lee Smith (GLS) Memorial Act, which provides funding for youth suicide prevention, and the 2007 Joshua Omvig Veterans Suicide Prevention Act, which directed the U.S. Department of Veterans Affairs (VA) to implement a comprehensive suicide prevention program for Veterans. GLS-funded suicide prevention programs have been found to have a long-term effect in reducing youth suicide rates.[12] Other accomplishments included the establishment and funding of the Suicide Prevention Resource Center and the National Suicide Prevention Lifeline (1-800-273-8255).

The 2001 *National Strategy* called for the establishment of a public-private partnership to lead the implementation of its 13 goals and 60 objectives. Launched in 2010, the National Action Alliance for Suicide Prevention (Action Alliance) brings together partners from diverse sectors—including health care, faith, news media, criminal justice and law enforcement, and business—and individuals with lived experience to advance suicide prevention in the United States.

As one of its first tasks, the Action Alliance worked closely with U.S. Surgeon General Regina Benjamin and numerous stakeholders from across the country to revise and update the *National Strategy* to reflect a decade of advancements in suicide prevention research and practice. This effort culminated with the release of the 2012 *National Strategy* that guides our suicide prevention efforts today.[8]

The Rationale for Action

Since the *National Strategy* was updated in 2012, suicide prevention efforts have expanded and multiplied. New research is increasing our understanding of how to best implement suicide prevention practices in health care systems and communities. New partners have become engaged in suicide prevention, including organizations and businesses that had not previously viewed suicide prevention as part of their mission. Although funding still may not reflect the serious and wide-reaching impact of suicide on our nation, more attention and resources are being dedicated than ever before. Recent examples include the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS), launched in 2019,[13] and the Federal Communications Commission's (FCC's) decision to designate 988 as the national number for mental health crises[14] (which will be implemented by July 16, 2022).

Throughout these years, the suicide prevention field has also strengthened its commitment to ensuring that suicide prevention is guided by the voices of those with lived experience. Individuals who have personal knowledge of suicide are increasingly contributing their unique and vital insights to all aspects of suicide prevention, including program planning and evaluation, policy development, and service delivery. The voice of lived experience is helping to ensure that, as a society, we talk about mental health and suicide in a more inclusive, informed, and compassionate way. Insights from lived experience are guiding the provision of services and supports that best meet the needs of persons experiencing a suicidal crisis or who have lost someone to suicide, and are informing efforts to better prepare communities nationwide to respond to the aftermath of suicide and to support recovery among all who may be affected.

People with lived experience.
Individuals who have personal knowledge of suicide gained through direct, first-hand experience. They include people who have experienced suicidal thoughts, survived a suicide attempt, or lost a loved one to suicide.

And yet, much remains to be done. Although research has identified many strategies that can be effective in preventing suicide, these evidence-informed approaches have not yet been brought to scale. Findings from a comprehensive assessment of national progress toward implementation of the goals and objectives of the *National Strategy* show that while there are more suicide prevention efforts in the United States than ever before, they vary across states, and few are comprehensive or strong enough to have a measurable impact on reducing suicidal behavior.[15] The *National Strategy* is far from being implemented nationally or in its entirety, and suicide prevention continues to lack the breadth and depth of the coordinated response needed to truly make a difference in reducing suicide.

The urgency to prevent suicide has increased in recent years, as two major crises—the opioid epidemic and the coronavirus disease-2019 (COVID-19) pandemic—have dramatically impacted the health and economic well-being of millions of Americans. As *The Surgeon General's Spotlight on Opioids* notes, opioid misuse and opioid use disorders have contributed to devastating consequences, including thousands of overdose deaths, the transmission of HIV and viral hepatitis, and increased violence and child neglect.[16] The opioid crisis has a direct link to suicide, as substance misuse is a risk factor for suicide, and studies suggest that a significant number of opioid overdose deaths may have suicidal intent.[17] Further, the secondary consequences of overdose deaths, particularly those related to trauma and traumatic loss, may also increase suicide risk among those left behind.

The COVID-19 pandemic continues to cause widespread illness and the loss of loved ones, while increasing social isolation and economic stress and reducing access to community and religious support—all factors that could potentially contribute to suicide risk.[18] These challenges are being felt even more strongly by communities of color, due to systemic factors that place many individuals and their families at an increased risk of being exposed to the virus, becoming seriously ill, failing to receive adequate care, losing their jobs and businesses, and suffering long-lasting health and economic consequences.[19] Although the impact of the pandemic on deaths by suicide is still unknown, new research is detecting increases in mental health problems—including suicidal thoughts—and in the misuse of alcohol and other drugs among U.S. adults.[20] Groups who may be particularly affected include younger adults, racial and ethnic minorities, essential workers, and unpaid adult caregivers.[20]

Conditions resulting from the pandemic could further exacerbate existing structural inequities that impact the health and well-being of groups identified as being at increased risk for suicidal behaviors. For example, high rates of suicidal behaviors among American Indian and Alaska Native youth have been linked to both historical trauma and long-lasting disparities in education, housing, and employment.[21] Sexual and gender minority youth, another group at a higher risk for suicide,[22] are more likely than others in the general population to experience structural inequities, such as discrimination in employment[23] and housing.[24] New research suggests that the pandemic may be seriously impacting the mental health of this population.[25]

While the opioid epidemic and the COVID-19 pandemic represent substantial challenges for suicide prevention, they also shed light on new opportunities. Our national response to the opioid epidemic has shown that effectively countering a serious behavioral health crisis requires a research-based, adequately funded, multi-component approach that focuses on both treating those who are experiencing addiction and preventing others from starting to misuse drugs.[26] By broadening perspectives about substance misuse and who can be affected, the national response has helped decrease prejudice toward individuals who experience addiction. The response has shown that substance use treatment—including care provided from a distance—is necessary, feasible, and effective.[27, 28] In addition, programs that have widely distributed naloxone to prevent opioid overdoses have brought attention to the role that communities can play in supporting individuals in distress and connecting them to sources of treatment and recovery.

Similarly, the COVID-19 pandemic has made it clear that high levels of stress can affect anyone's mental health and emotional well-being, thus spurring a public dialogue regarding the importance of sustaining wellness and seeking mental health supports when needed. The crisis has increased the acceptance and use of technology—particularly videoconferencing—to provide services and supports to individuals who may be struggling.[29] It has also highlighted the critical role that social connections and social support can play in promoting mental health and resilience. Finally, the pandemic has increased awareness that societal-level factors—such as lack of access to well-paying jobs, safe housing, enough food, high-quality education, and effective health care services—can strongly impact mental and physical health. More research is needed on these societal factors and how programs addressing them can play a role in preventing suicide.

The Call to Action

The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention (Call to Action) seeks to advance progress toward full implementation of the *National Strategy*, while taking into account the unique challenges and opportunities of our times. Like the *National Strategy*[8] (p. 8), this *Call to Action* is dedicated to the following:

> *To those who have lost their lives by suicide,*
> *To those who struggle with thoughts of suicide,*
> *To those who have made an attempt on their lives,*
> *To those caring for someone who struggles,*
> *To those left behind after a death by suicide,*
> *To those in recovery, and*
> *To all those who work tirelessly to prevent suicide and suicide attempts in our nation.*

The *Call to Action* emphasizes that the 13 goals and 60 objectives of the *National Strategy* remain as relevant today as they were when the strategy was last updated. However, to truly make a difference in reducing suicide rates, these goals and objectives need to be fully implemented. In particular, the *Call to Action* zeroes in on six key actions that must be implemented if we are to reverse the current upward trend in suicide deaths in the U.S.

Developed in consultation with many partners (see Appendix 1), the *Call to Action* has three key objectives:

- Activate a broad-based response to suicide (Actions 1 and 2)
- Implement evidence-based approaches that must be adopted more widely:
    - Lethal means safety (Action 3)
    - Safe and effective care for suicide risk (Action 4)
    - Enhanced crisis care systems (Action 5)
- Present priorities for improving the quality, timeliness, and use of data to guide suicide prevention (Action 6)

The six actions fall broadly into the four Strategic Directions of the *National Strategy* (see sidebar), and several relate to multiple goals and objectives across the four directions.

We know that reversing the upward trend in suicide rates will not be easy, particularly given the significant challenges ahead of us in the wake of the current pandemic, but we are better prepared than ever before. Guided by scientific evidence, collaboration across public and private sectors, and insights from people with lived experience, we know what we need to do—and, as a nation, we are ready to act.

Strategic Directions and Actions

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

- Action 1: Activate a broad-based public health response to suicide
- Action 2: Address upstream factors that impact suicide

Strategic Direction 2: Clinical and Community Preventive Services

- Action 3: Ensure lethal means safety

Strategic Direction 3: Treatment and Support Services

- Action 4: Support adoption of evidence-based care for suicide risk
- Action 5: Enhance crisis care and care transitions

Strategic Direction 4: Surveillance, Research, and Evaluation

- Action 6: Improve the quality, timeliness, and use of suicide-related data

Broadening the Vision

Broadening the Vision

In the past, suicide was often viewed as a mental health problem that affected a few individuals and could only be addressed by mental health specialists. Today we recognize that suicide is both a mental health and a public health concern. Like other public health problems, such as obesity and heart disease, suicide is affected by many influences—related to individual characteristics, interpersonal relationships, the community, and the larger society. Mental illness, substance misuse, social isolation, physical health problems, relationship issues, the loss of a loved one, a family history of suicide, access to lethal means, and legal or financial problems can all increase suicide risk or precipitate a suicidal crisis.[30, 31] Other factors—such as a sense of purpose, social connectedness and support, cultural identity, life skills, and access to effective health care—can play a protective role, moderating or "buffering" the impact of existing risk factors.

The *National Strategy* emphasizes that suicide prevention efforts are more likely to succeed if they are comprehensive, combining multiple strategies that work together to prevent suicide[8]—for example, teaching coping and problem-solving skills, promoting connectedness, identifying individuals at risk and connecting them to effective care, and providing support to those who have lost a loved one to suicide.[32]

Moving upstream.

This term comes from a classic story in which rescuers saving people from drowning in a rushing river are becoming exhausted. Finally, some of the rescuers wonder why all these people are falling in the river, and they decide to move upstream to see if there is a way to stop this from happening. Like the rescuers in this story, public health works to help those already at risk but also to address factors that can prevent others from becoming at risk in the first place.

Traditionally, suicide prevention efforts have more often focused on identifying and supporting individuals and groups at risk than on modifying "upstream" risk and protective factors that affect the whole population.[33] Recognizing the need to better understand and address these upstream factors, Strategic Direction 1 of the 2012 *National Strategy* calls for efforts focused on healthy and empowered individuals, families, and communities.[8]

The *National Strategy* recognizes that while we must continue to focus on individuals and groups at risk, we must also seek to modify the upstream societal factors that influence suicide risk and mental health,[33] including adverse childhood experiences,[34] unemployment,[35] a lack of safe and affordable housing,[36] and financial hardship.[37] More recent studies are exploring the potential role of other factors (e.g., exposure to air pollution) in increasing suicide risk.[38, 39]

In addition, we need to identify ways to strengthen the protective factors that promote strength and resilience (the ability to endure, respond to, and recover from stress and adversity[40]), thereby reducing suicide risk. Research suggests that efforts aimed at increasing protective factors can have long-lasting effects. For example, the Good Behavior Game, a school-based behavior management program that has been extensively studied, has been found to have long-term effects in preventing suicidal behaviors and related problems, such as substance misuse and violence, among youth.[41, 42] Other school-based prevention programs that build life skills and resilience have also been found to have long-term positive effects in supporting various health outcomes.[33, 43, 44] In addition, family-based prevention programs, conducted with diverse groups, have been found to have long-term effects on decreasing suicide risk and providing other related benefits (e.g., prevention of mental health problems).[45–47]

Suicide prevention theory and research have long identified the social context as crucial to protecting individuals and populations from suicide.[48, 49] Theories of suicide suggest that social factors, such as isolation and the feeling of being a burden to others, may increase suicide risk.[50–52] Opportunities to contribute—through gainful employment that pays a living wage, or by volunteering or mentoring—may help reduce suicide risk by fostering supportive relationships and a sense of meaning and purpose. These theories suggest that at our core, human beings need to be connected to one another and need to believe that they are making a meaningful contribution to society. Schools, workplaces, places of worship, and many other organizations in the community help provide opportunities for individuals to develop these positive connections and be of service in meaningful ways.

As some experts have noted, suicide prevention must go beyond identifying and addressing risk factors to charting a course toward building a purposeful, engaged life.[53] While we need to continue to increase understanding of why some people experience suicidal thoughts and behaviors, we also need to better understand the factors that help individuals overcome a crisis and recover, including key supports and reasons for living.

The six actions that follow are intended to continue the progress toward full implementation of the *National Strategy*. These actions include suicide prevention strategies that are appropriate for the general population, as well as for groups at risk and for individuals in crisis. The actions are intended to bring to scale approaches that have been found to be effective, and to expand our vision of suicide prevention to include both risk and protective factors—not only to reduce injury and death, but also to help all Americans lead purposeful and connected lives.

ACTION 1
Activate a Broad-Based Public Health Response to Suicide

Inspire and empower everyone to play a role in suicide prevention.

Action 1. Activate a Broad-Based Public Health Response to Suicide

Inspire and empower everyone to play a role in suicide prevention.

The *National Strategy* calls for the implementation of a broad-based public health response to suicide that engages all societal sectors—including government, health care systems and providers, businesses, educational institutions, community-based organizations, family members, and friends—in suicide prevention.[8] Suicide prevention should be infused into schools, workplaces, faith-based organizations, corrections, senior living communities, and other diverse settings and systems. Integrating suicide prevention into the work of all sectors will help create a network of community-wide supports to reduce risk, enhance protection, and support the implementation of culturally appropriate prevention efforts that are tailored to each group's unique needs and strengths.

Communication efforts can help activate a broad-based response to suicide by changing knowledge, attitudes, and behaviors related to mental illness and suicide. As a society, we need to be comfortable talking about suicide openly and without judgment. Research suggests that we have made tremendous headway in reducing the silence around mental illness and suicide that prevents so many from seeking help. In a recent nationally representative survey, the vast majority of Americans (93 percent) believed that suicide was preventable, at least sometimes, and three in four were comfortable being there for a loved one who might be struggling or having thoughts of suicide.[54] We must build on this progress and continue to change the conversation around suicide to engage all Americans in suicide prevention.

I was an inaugural appointee

of the Workplace Task Force when the Action Alliance was started in 2010. At that time, we suspected that the culture, jobs, and lifestyles of our workers in the construction industry might place them at an increased risk for suicide. One particular concern was substance misuse, including the use of prescribed opioid pain relievers to cope with chronic pain from years of hard work.

At that time, we didn't know the extent of the problem because national data on suicide among different occupations was not readily available. When CDC analyzed occupational data from 17 states in NVDRS several years later, they found that the construction and extraction industries had the highest suicide rates and the highest number of suicides among all industries. This finding persists in the most recent occupational data collected among 32 states in 2016.

In response, our industry mobilized to actively embed suicide prevention into its safety culture. Our Construction Industry Alliance for Suicide Prevention provides access to information, resources, and training on how to make mental health and suicide prevention part of a company's culture. Construction culture has shifted from getting workers home safely at the end of the shift to getting our people back to work safely from home.

Cal Beyer, MPA
Vice President
Workforce Risk & Mental Wellbeing
CSDZ, A Holmes Murphy Company
Action Alliance Executive Committee Member

We also need to do better at translating what diverse systems, sectors, professionals, and individuals can do to reduce risk and build strengths. Every individual and organization must understand how they can support those who may be at risk for suicide and help everyone achieve a healthier and more connected, productive, and satisfying life.

People with lived experience have an important role to play in guiding and informing the implementation of a broad-based, inclusive, and effective response to suicide.[55] These individuals, who include program planners, health care providers, business leaders, teachers, and family members, have long contributed to improving supports for persons at risk for suicide by taking a lead role in the delivery of effective and compassionate care to prevent suicide. Their involvement has been key to emphasizing safety, dignity, and respect for individuals who may be experiencing a suicidal crisis. Stories and insights from those with lived experience can illustrate how we all can play a part in supporting others during a time of crisis.

Finally, we need to track our outreach efforts against established metrics and industry standard benchmarks to measure outcomes and inform continuous process improvement as messages are developed and tested, including segmented messaging to key subpopulations and the populations and communities at high suicide risk.

1.1 Broaden perceptions of suicide, who is affected, and the many factors that can affect suicide risk.

Although mental health conditions are often seen as the causes of suicide, suicide is rarely caused by any single factor. Many influences at the individual, relationship, community, and societal levels can increase suicide risk or precipitate a crisis, including social isolation, relationship problems, the loss of a loved one, and legal or financial issues.[30, 31] Other factors, such as a sense of purpose, social connectedness and support, opportunities to contribute, and access to effective care, can play protective roles.[30, 31]

The *National Strategy* identifies several groups as being at a higher risk for suicidal behaviors than the general population:[8]

- Certain demographic groups, for example:
  - Working-age men
  - Military service members and Veterans
  - American Indians and Alaska Natives
  - Sexual and gender minority populations
  - Older adults
  - Individuals in child welfare and justice settings
- Individuals experiencing risk factors linked with suicide, for example:
  - A history of suicidal behaviors
  - A loss of someone to suicide
  - Mental illness, substance misuse, and/or certain medical conditions

Studies have also found that suicide rates are higher in rural areas[3, 56] and in some occupations, such as construction.[57, 58]

Suicidal behaviors—as well as risk and protective factors for suicide—can vary among subgroups and change over time. For example, although suicide rates have been historically lower among Black people than among white people, recent studies have identified an alarming increase in suicidal behaviors and deaths among Black children and adolescents.[59–61] In some cases, the prevalence of suicidal behaviors and risk factors among some groups may not be known because data collection tools and systems do not yet collect this information or make it easily accessible. Access to timely and accurate data on deaths by suicide, suicide attempts, and related circumstances is critical in order to ensure that prevention efforts are reaching those most at risk. (For more on needed improvements to the quality and timeliness of suicide-related data, see Action 6.)

Research is shattering myths

about who dies by suicide and who engages in suicidal behaviors. The rate of self-reported suicide attempts by Black high school students rose over the past generation, even as attempt rates in students from other groups declined, according to research I led at the New York University (NYU) McSilver Institute that was published in the journal *Pediatrics* in 2019. These rising rates of suicide behavior engagement among Black youth become particularly salient to monitor given the current climate of racial unrest, the COVID-19 pandemic, and the rising rates of income inequality, all of which impinge on these youth's emotional and psychological well-being. We must focus attention and resources to get to the bottom of why this is happening, and mobilize protective factors like family education on the signs and indications of suicide risk to ensure that Black youth receive requisite support.

Michael A. Lindsey, PhD
Executive Director
NYU McSilver Institute for
Poverty Policy and Research

1.2 Empower every individual and organization to play a role in suicide prevention.

Every individual and organization in the community has a role to play in promoting health and well-being, reducing risk factors, and increasing protective factors for suicide. For this to happen, we all must understand how we can help prevent suicide by supporting the implementation of effective suicide prevention strategies. For example:[32, 62]

- Help other people build life skills (e.g., coping, problem solving) and resilience
- Increase social connectedness and support
- Identify and support people at risk
- Support lethal means safety
- Support access to effective care
- Seek help, support, and care when experiencing suicidal thoughts
- Support individuals who have been affected by a suicide attempt or death

All community members should be equipped to build protective factors and to recognize the warning signs of suicide and respond appropriately to individuals in crisis by connecting them to sources of help. Two good resources are the National Suicide Prevention Lifeline (1-800-273-8255) and the new 988 number that will become operational by July 16, 2022 and will connect callers to the Lifeline. (For more on crisis care and related resources, see Action 5.)

1.3 Engage people with lived experience in all aspects of suicide prevention.

People with lived experience can play an important role in increasing understanding of how to respond effectively to suicide risk, identifying and driving needed improvements in policies and systems, and enhancing interventions for providing short- and long-term support to individuals who have experienced thoughts of suicide, made a suicide plan or attempt, or lost a loved one to suicide.

Guidance from people with lived experience can be particularly useful in implementing evidence-based prevention strategies in real-life settings. Engaging people with lived experience in the planning, design, implementation, and evaluation of suicide prevention efforts can also help reach diverse groups and meet their unique needs, thereby improving the quality and impact of suicide prevention efforts.

Sharing stories of lived experience can be a powerful way to increase understanding of what it is like to experience suicidal thoughts and behaviors. These stories may help reduce stigma by providing a personal connection to another human being's journey and promoting respect and compassion for those who may be experiencing suicidal thoughts or behaviors. In collaborating with people with lived experience to share their stories with others, it is important to ensure that the information is conveyed in a way that supports the safety of the audience and the well-being of the narrator.

1.4 Use effective communications to engage diverse sectors in suicide prevention.

Communication efforts can help activate a broad-based response to suicide by changing knowledge, attitudes, and behaviors to support prevention. For example, these efforts can increase help-seeking by publicizing available care and supports for those at suicide risk; teach families, friends, co-workers, and others how best to support people in their lives who are struggling; and strengthen suicide prevention efforts by educating decision-makers about effective policy and systems change for prevention.

Goal 2 of the *National Strategy* calls for the implementation of communication efforts that are research-based and reflect safe messaging recommendations specific to suicide.[8] Decades of research indicate that public communications efforts are most effective when they have defined goals, are designed to reach specific populations, and feature a specific "call to action."[63] Communications should be tied to an overall prevention strategy and connect to other programmatic efforts, such as education programs, available supports and services, and other resources that can help the audience take action. Credible and culturally appropriate messages should be developed and conveyed through the channels (e.g., billboards, social media, events) most likely to reach and be trusted by the intended audience. Communication planners should engage their intended audiences to co-design suicide prevention efforts from the beginning, thereby informing choice of language, channels, and platforms—and helping to ensure that the call to action is accessible and realistic for them.

All individuals and organizations communicating about suicide—including suicide prevention leaders, advocates, and programs—must also ensure that their messages reflect existing recommendations regarding safety. The Action Alliance's *Framework for Successful Messaging* is an online resource for developing safe and effective messages about suicide.[64] How news stories and entertainment depictions of suicide are framed can support prevention or lead to harmful outcomes, such as imitation of suicidal behaviors. The *Recommendations for Reporting on Suicide*[65] and *National Recommendations for Depicting Suicide*[66] (in entertainment) provide guidance on how to depict and cover suicide safely and in ways that will be helpful to someone who may be struggling. (More information on these resources is available in Appendix 2.)

Action 1: Priorities for Action

- State government and public health entities should implement the Suicide Prevention Resource Center's *Recommendations for State Suicide Prevention Infrastructure* to support comprehensive (i.e., multi-component) suicide prevention in communities.

- Prevention leaders from the public and private sectors, at all levels (national, state, tribal, and local), should align and evaluate their efforts consistent with the Centers for Disease Control and Prevention (CDC) resource *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, to expand the adoption of suicide prevention strategies that are based on the best available evidence.

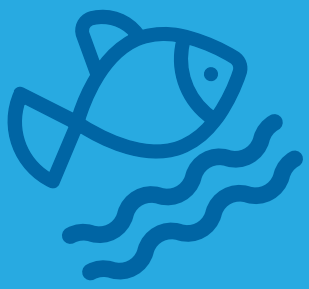
- Federal agencies and state, tribal, local, and county governments and coalitions should strengthen their prevention efforts by developing strategic suicide prevention plans based on available public health data. Mechanisms for the prompt sharing of innovations and best practices should be developed and supported.

- State and local suicide prevention coalitions and health systems should actively reach out to organizations serving populations at high risk for suicide; these systems should also reach out to individuals with lived experience in order to learn from them and engage them in designing prevention efforts.

- The public and private sectors should invest in patient-centered research and include people with lived experience in research design and implementation.

- Federal agencies, mental health and suicide prevention non-governmental organizations, and others conducting communication efforts should ensure that suicide prevention communications campaigns (1) are strategic, (2) include clear aims for behavior changes that support broader suicide prevention efforts, and (3) measure their impact.

- The federal government (Congress) should expand and sustain support for states, territories, communities, and tribes to implement comprehensive suicide prevention initiatives similar to the Comprehensive Suicide Prevention Program, funded by CDC, and the Garrett Lee Smith youth suicide prevention grants, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), which have been shown to reduce suicide in participating counties, particularly in rural areas.[12] Funding targeting substance use disorder should be broad enough in scope to allow for interventions that address suicide prevention and related workforce and infrastructure needs.



ACTION 2
Address Upstream Factors that Impact Suicide

Focus on ways to protect everyone from suicide.

Action 2. Address Upstream Factors that Impact Suicide

Focus on ways to prevent everyone from suicide.

Strategic Direction 1 of the *National Strategy* calls attention to the need to "create supportive environments that will promote the general health of the population and reduce the risk for suicidal behaviors and related problems" (p. 29).[8] Toward this end, suicide prevention efforts should include strategies aimed at reducing risk and increasing protection among all Americans. In particular, suicide prevention efforts must consider factors that influence the health of the population, including economic stability, education, social and community context, health care, and neighborhood and built environments.[67] For example, to prevent suicide among Black children and adolescents, we must address key upstream factors, such as disparities in health care and exposure to racism.[68]

As previously noted, suicide prevention theory and research suggest that two upstream strategies may be particularly effective in protecting individuals from suicide risk: increasing social connectedness, and providing opportunities for individuals to make a meaningful contribution.[32] Research also suggests that buffering the impact of economic stressors, such as unemployment and the threat of eviction, can play a protective role.[32] Diverse sectors and groups can contribute to the implementation of these strategies, including organizations that may not think of their work as contributing to suicide prevention. Addressing these types of societal-level factors that can affect suicide risk provides a critical opportunity to partner with diverse sectors, communities, and groups to impact suicide and other health issues as part of a broad-based collective effort.

A few years ago, the Yurok Tribe

declared a state of emergency due to a suicide cluster among young people ages 16–34. Six of the seven who died by suicide were male, and those who died were not engaged in the health care system.

Engaging young people can be difficult. If they are not coming into our health care system, what would be another way to reach out to them? One of the ways we thought of was through a cultural activity.

Weaving tribal culture into our suicide prevention strategy is something we do constantly and in many different ways. An example is a traditional rope-making activity conducted by leaders who hold this cultural knowledge. The activity brings young people together with others in the community to make rope from hazel sticks. The rope is then used to repair our traditional houses.

The activity brought together some of our cultural leaders, native clinicians, and other positive role models, along with young men in the community who could benefit from the training and enhanced cultural knowledge. It was very well received. When it was time to have conversations about mental health, it was a real, natural process. Some of the conversations continued throughout the afternoon and into the next day.

Participants were able to walk away from this activity with an act of generosity, of giving back to the tribal community by repairing our houses—in a traditional way.

Rob England, MA
Health Promotion Manager
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2.1 Promote and enhance social connectedness and opportunities to contribute.

Research has consistently identified social isolation as a strong risk factor for suicide and other negative health outcomes[69–71] and has identified social connectedness to family,[72] school,[73] and community as a protective factor.[74] In fact, connectedness has been a key component of theories about suicide since French sociologist Émile Durkheim first identified a link between suicide and low social integration in the late 1800s.[49, 75] Positive, meaningful, and supportive social connections can make individuals feel valued, cared for, trusted, and respected.[50] Opportunities to make a meaningful contribution to society can support the development of these positive connections and also enhance one's sense of purpose, thereby increasing reasons for living.[52]

Based on a recent review of the evidence, CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* recommends two specific approaches to increasing connectedness that have been linked to such benefits as reduced stress and improved attitudes toward help-seeking:[32]

Suicide prevention is

important to my faith community because of the increasing numbers of suicides we have experienced in our congregation and in the community. I also had a relative who died by suicide and another one who attempted suicide.

The faith community is important in the area of suicide prevention because many people seek spiritual support when life gets tough, and this is often the first place people come to for help and direction. Many faith leaders support people struggling with suicide by directing them to mental health resources, creating a safe place to share their experiences, and emphasizing suicide awareness throughout the year. In my role as a professional counselor, I am committed to providing therapeutic options to those in need and am hopeful that we can prevent these deaths by offering persons hope that includes their faith as an option for coping with their troubles.

Carla J. Debnam, DMin
First Lady, Morning Star Baptist Church
Baltimore County, Maryland

- **Peer norm programs** that support the development of positive connections with peers and encourage help-seeking and the development of connections to trusted helpers
- **Community engagement activities** that bring together members of the community, such as a walking program or a community garden

All individuals and organizations in the community, including workplaces, schools, faith-based organizations, and youth, senior, and Veteran centers, can play a role in enhancing connectedness and fostering opportunities to contribute. Examples include providing peer support to others, participating in service-learning activities, or serving as a volunteer.

Efforts to increase positive social connections and opportunities to contribute should be inclusive and tailored to the needs of specific groups (e.g., ethnic, racial, and sexual and gender minorities; adolescents; older adults). Through activities such as support groups and peer-delivered services, people with lived experience can play an important role in fostering these connections and opportunities and providing hope to individuals who may be struggling. Online and social media-based approaches, by presenting both challenges and opportunities for suicide prevention, can also be safely and effectively used to enhance feelings of connectedness among young people.[76]

2.2 Strengthen economic supports.

Economic factors are linked to suicide risk in different ways. Research has long identified financial problems as a factor that can precipitate a suicidal crisis in a person at risk.[77] Studies have also found that suicide rates increase during times of economic recession.[78, 79] For example, an analysis of suicide deaths in 16 states during the U.S. housing crisis that started in 2006 found that deaths by suicide related to evictions and foreclosures doubled from 2005 to 2010.[77] The study concluded that housing loss can precipitate a suicidal crisis and that prevention efforts should provide support to prevent home loss, particularly during times of economic crisis.

Experts note that the relationship between an economic crisis and suicidal behaviors can vary, depending on such factors as the unemployment rate, unemployment protection, the minimum wage, and access to welfare benefits.[80–82] Emotional factors, such as the fear of losing one's job or being evicted—either now or in the near future—may also increase psychological distress that could contribute to suicide risk.[83, 84]

Buffering the impact of these risk and precipitating factors by strengthening economic support systems may reduce suicide risk and also contribute to improved mental and physical health. An evidence review conducted by CDC identified two approaches that have been found to reduce suicide risk:[32]

- **Strengthening household financial security** through efforts such as unemployment benefits programs, transfer payments related to retirement and disability, medical benefits, and other forms of family assistance

- **Housing stabilization policies**, such as programs that protect homeowners from foreclosures and evictions

Although local suicide prevention programs may not be able to directly address these economic factors, they can monitor trends (e.g., increases in unemployment, evictions, or homelessness) and partner with others in the community to recognize and reduce associated distress. For example, suicide prevention coordinators and coalitions could partner with organizations in the community, such as unemployment offices, to provide training to employees on suicide prevention and to educate them about crisis lines and other resources. Similarly, suicide prevention programs could partner with workplaces that may

be downsizing to ensure that their workers are aware of options, benefits, and community services and supports. These programs should also consider ways to provide support to affected individuals and their families.

Employers have a significant opportunity to influence the mental health and well-being of their employees through workplace culture, policies, practices, and programs. By educating and engaging employers, we can ensure that they become part of the overall effort to prevent suicide.

The first time I called The Trevor Project, I was a scared college student in rural Kansas, and having a trained crisis counselor on the other end of the line who was ready to listen and accept me for who I am saved my life. According to The Trevor Project's 2020 National Survey on LGBTQ Youth Mental Health, 40 percent of LGBTQ youth seriously considered attempting suicide in the past year, with more than half of transgender and nonbinary youth having seriously considered it. But these data should not be interpreted to mean that LGBTQ youth are prone to suicide because of their sexual orientation or gender identity. LGBTQ youth are at a higher risk of suicide because of increased experiences of internalized stigma, discrimination, violence, and rejection from others.

I know all too well how rejection from family, friends, and faith can compound and lead to negative mental health outcomes. But we also know that suicide is preventable and that every person can contribute to ending it. The Trevor Project's research has found that LGBTQ youth who report having at least one accepting adult were 40 percent less likely to report a suicide attempt in the past year. And you do not need to be an expert on mental health or LGBTQ identities to be that one accepting adult—you just have to listen, be affirming, and have empathy. That's what The Trevor Project does every day and why it is vital that all national suicide prevention strategies be LGBTQ inclusive and competent. Thankfully, that one counselor was there to remind me that I wasn't alone and that I did not need to be fixed, because nothing was broken.

Sam Brinton, MS
Vice President of Advocacy and Government Affairs
The Trevor Project

2.3 Engage and support high-risk and underserved groups.

As discussed in Action 1, the prevalence of suicidal behaviors—and of risk and protective factors for suicide—varies across groups and subgroups and changes over time. Suicide prevention efforts should focus on populations disproportionately impacted by suicide in different ways. Some groups may have high or increasing rates of suicidal thoughts and behaviors. Others may experience factors that can increase the risk for suicidal behaviors, such as social isolation and unemployment, or have fewer protective factors in their lives, such as access to effective mental health care. To develop and implement suicide prevention efforts tailored to each group's unique needs and strengths, program planners must review the data available from existing sources and conduct their own data-gathering efforts, as needed.

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

2.4 Dedicate resources to the development, implementation, and evaluation of interventions aimed at preventing suicidal behaviors.

Research is key to guiding action by helping us understand what works to reduce suicide risk and strengthen protective factors in different systems and with diverse populations. Goal 12 of the *National Strategy* called for the implementation of new research on suicide prevention and for the dissemination and application of findings. However, funding for suicide prevention research and for the evaluation of comprehensive suicide prevention programs continues to be very limited.[85] More resources should be dedicated to developing, implementing, and evaluating programs aimed at preventing suicide. The research must be conducted in collaboration with the affected communities, including individuals with lived experience.

As noted, much of the existing research has focused on identifying individuals at risk and assessing the effectiveness of clinical supports and care. Suicide prevention interventions and research must also focus on upstream risk and protective factors for suicide—such as social connectedness, coping skills, opportunities to contribute, and economic supports—and identify ways to best address them in partnership with other organizations in the community. In addition, suicide-related outcomes must be incorporated into existing programs and research in related fields (e.g., violence prevention, prevention of substance misuse, positive youth development, response to adverse childhood experiences and trauma) that focus on upstream factors relevant to suicide prevention.[86, 87]

Action 2: Priorities for Action

- Private companies and workplaces should leverage their health care benefits purchasing power to enhance employee mental health (e.g., invest in benefits and programs to prevent and treat behavioral health problems) and work to shape worksite values and culture to promote mental health by providing access to crisis support, support to employees following a suicide, and ongoing mental health wellness programming.

- Suicide prevention leads in federal, state, tribal, and local public health and behavioral health agencies should partner with their counterparts in labor and workforce, housing, health care, and other public assistance agencies to collaborate on strengthening economic supports for families and communities.

- Foundations and other philanthropic organizations that support early intervention programs—particularly those targeting (1) social determinants of health (e.g., reducing poverty and exposure to trauma, improving access to good education and health care, improving health equity) and/or (2) enhanced social interactions (e.g., improved parenting skills) and problem-solving and coping skills—should ensure that these programs include outcomes related to suicide (e.g., ideation, plans, attempts) and evaluation of those programs for suicide-related outcomes.

- Federal government and private sector research funders should support the analysis of existing data sets of longitudinal studies to determine the impact of various interventions (e.g., home visitation, preschool programs, substance misuse, child trauma) on suicidal ideation, plans, and attempts, and on deaths by suicide. This could include such projects as the CDC's efforts to assess and prevent adverse childhood experiences and examine their effect on suicide-related problems, and National Institutes of Health (NIH) initiatives that focus on aggregating prevention trial data sets to better understand the long-term and cross-over effects of prevention interventions on mental health outcomes, including suicide risk,[88] and to address suicide research gaps.[89, 90]

ACTION 3
Ensure Lethal Means Safety

Keep people safe while they are in crisis.

Action 3. Ensure Lethal Means Safety

Keep people safe while they are in crisis.

Although different paths can lead a person from suicidal intent to an attempt, research suggests that many suicidal crises are short-lived, with the time period between the decision to act on suicidal thoughts and a suicide attempt averaging less than 10 minutes.[91] Moreover, individuals who are thinking about suicide, even when they experience strong intent, are often ambivalent about their wish to die. Although it is commonly believed that reducing access to a lethal means of suicide will lead to substitution with another lethal means, in many cases this does not occur.[92] As a result, putting time and distance between a person at risk and lethal means of self-harm can save lives.

Firearms, which are highly lethal,[93] are the most common means of suicide in the United States, accounting for more than half (51 percent) of all suicides.[94] Among military service members, about 60 percent of suicides involve firearms,[95] and among Veterans this number reaches 70 percent.[96] Approximately 90 percent of suicide attempts involving a firearm injury result in death.[97] After firearms, the most common methods of suicide are suffocation, poisoning, and falls.[94] Although most suicide deaths are firearms-related, most suicide attempts involve poisoning.[97]

When someone is at risk for suicide, removing ready access to means that may be used in a suicide attempt (e.g., firearms, medications, illicit drugs, poisonous household chemicals, and materials that can be used for hanging or suffocation) can mean the difference between life and death when a suicidal crisis occurs. Reducing access to lethal means of suicide when individuals are in crisis is an effective strategy for preventing suicide.[43, 98] Goal 6 of the *National Strategy* promotes the implementation of diverse approaches to lethal means safety in clinical and community settings.

3.1 Empower communities to implement proven approaches.

Research has identified several proven community-based approaches to lethal means safety, each of which needs to be adopted more widely.[99] These approaches, described below, vary by type of method.

Firearms. Recommended approaches to firearms-related lethal means safety include the following:[99, 100]

- Storing firearms unloaded, with ammunition stored separately, in a gun safe or tamper-proof storage box or with external locking devices, such as cable locks
- During periods of crisis or acute suicide risk, temporarily storing firearms away from the home—for example, with a relative or friend; in a self-storage unit; at a gun shop, shooting range, or pawn shop; or with law enforcement

- Partnering with gun retailers, ranges, and clubs to promote firearms safety by recognizing the signs that a purchaser may be in distress, educating purchasers on safety, facilitating safe storage, and distributing safety devices[101]
- Considering implementation of extreme risk laws—also known as extreme risk protection orders (ERPOs) or gun violence restraining orders—enacted in some states, which set in place a legal process for temporarily removing firearms from people who may pose an extreme risk to themselves or others, as per the recommendations of the Federal Commission on School Safety[102, 103]

Partnering with people with lived experience can be critical to engaging firearm owners and building support to implement these approaches.

Poisoning. Suicides by poisoning can include the use of medicines, illegal drugs, and poisonous chemicals. Recommended approaches to reducing access to these substances among individuals at risk for suicide include the following:[99]

- Partnering with pharmacies and drug companies to modify medicine packaging (e.g., blister packaging) and to reduce package sizes
- Partnering with health care systems and providers to ensure the safe prescribing of opioids (including naloxone kits)
- Educating consumers on the safe storage and disposal of medicines, including drug lockboxes, and about medication disposal sites and drug take-back events
- Partnering with drug companies and law enforcement to implement drug buy-back programs and confidential drug return programs
- Reducing access to poisonous chemicals, such as pesticides

Talking about firearms

can feel taboo because of politics. But reducing access isn't about confiscation; it can be a friend or family member helping to lock up firearms or temporarily moving them out of the home of someone going through a rough time. Engaging firearms experts in lethal means safety education and research is critical if we want to develop and disseminate effective, respectful messages.

In the Colorado Firearm Safety Coalition, we've established creative collaborations between the firearms and suicide prevention communities. Education and outreach activities include providing suicide prevention awareness training at shooting range events and creating the first statewide map of temporary firearm storage locations in 2019. National partnerships and government programs, like those from the VA and the Department of Defense, are getting lethal means safety messages to broader communities. Although we need more research to know how these partnerships and messaging affect firearms storage and suicide rates, they clearly have already led to exciting new connections and ideas.

I dream that in 10 years, the concept of "lethal means safety" will be a cultural norm like "Friends don't let friends drive drunk." At its core, this approach is about recognizing that—regardless of gun ownership or political views—no one wants to lose a family member or friend to suicide.

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Other lethal methods. Other lethal methods of suicide include suffocation, falling from high places, and inhaling carbon monoxide from motor vehicle exhaust. Effective approaches to preventing suicide by suffocation include reducing access to ligatures (e.g., ropes, belts) and ligature points (e.g., beams, door knobs, trees). These approaches are primarily relevant to settings such as health systems, college dormitories, military barracks, prisons, detention facilities, and jails. Effective strategies to prevent suicide by falling include restricting access to sites such as bridges and rail lines, and installing physical barriers, fencing, or safety nets.[104] To prevent carbon monoxide poisoning, one strategy is to install a device that detects unsafe cabin levels of the gas, warns the driver, and—if levels rise above a determined threshold in a stationary car—turns off the engine.[99]

My husband, an active-duty U.S. Marine drill instructor, died by suicide in 1994.

My life and the lives of all those exposed to his death were irrevocably changed that day. I was very young (and pregnant) at the time, a military spouse without the tools or situational awareness to navigate a suicide intervention, let alone a discussion about lethal means safety. Twenty-six years later, having devoted my professional life and career to suicide prevention and to caring for survivors of suicide loss, I know that lethal means safety is as critically important today as it was then—particularly given the lethality and high rates of firearm-related suicide in the military and Veteran communities. Over the last decade, TAPS [Tragedy Assistance Program for Survivors] has supported more than 16,000 bereaved survivors of military or Veteran suicide loss. We know from thousands of cases how serious an issue lethal means is to addressing Veteran suicide.

Here are some of the things we've learned:

- One thing many TAPS survivors wish they had had before their loved one died is proactive counseling around lethal means safety planning for military members and their families.
- Discussions about lethal means can be challenging if firearms are a large part of the Veteran's identity, but these conversations must happen because they can save lives.
- The time for learning about these issues is right now, not in a moment of crisis.
- In the military, where safety instruction starts in basic training and continues throughout a career, lethal means training should be a permanent fixture.
- Military service members and family members transitioning out of the service—an often stressful and disorienting time—should be reacquainted with lethal means safety as a comprehensive wellness strategy.
- We must bridge the military-to-civilian transition gap by training civilian providers on lethal means safety.

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Senior Director of Suicide Postvention
Tragedy Assistance Program for Survivors

3.2 Increase the use of lethal means safety counseling

Research suggests that providing counseling on lethal means safety to patients at risk for suicide is effective in increasing the adoption of safety practices.[105, 106] Although several national organizations and professional associations have endorsed the use of lethal means safety counseling with patients at risk for suicide, health care providers often receive only minimal training in this area, and few provide this type of counseling to patients.[102, 107]

Counseling on lethal means should be routinely conducted as part of safety planning with individuals at risk. Recommended approaches include training diverse health care providers—including nurses, social workers, case managers, and certified peer workers—on lethal means safety counseling, and incorporating safety planning with lethal means counseling into suicide prevention protocols and care pathways (see also Action 5).

Asking about firearms or other lethal means should not be viewed as an abrupt shift in a clinical conversation, but rather as a type of safety assessment—similar to questions about the use of seat belts, bike helmets, and carbon monoxide alarms—that providers can routinely ask patients and their families.[102] However, several barriers prevent providers from providing this type of counseling, including discomfort in talking with patients about firearms, the misperception that suicide is inevitable, and a lack of awareness that lethal means safety works.[107] Resources and tools, such as a recently piloted Web-based decision aid,[108] are needed to help providers overcome these barriers. (Information on free online training for health care professionals is included in Appendix 2.)

3.3 Dedicate resources to the development, implementation, and evaluation of interventions aimed at addressing the role of lethal means safety in suicide and suicide prevention.

Although research on reducing access to lethal means among persons at risk has increased since the *National Strategy* was last updated, more research is needed,[91] for example:

- Foundational research to increase our understanding of factors related to lethal means use and safety, including method choice, firearm ownership and/or access to firearms in the home,[109] the role of social networks and contacts, and differences across sociodemographic groups
- Effectiveness evaluations to test the impact of different lethal means safety strategies and interventions
- Translation and dissemination research to identify effective components of each intervention and to extend and adapt these interventions to various populations and settings
- Communications research with various audiences (e.g., individuals at risk, family members and friends, health care providers, other industry and community partners) to identify and test messages regarding lethal means safety and to assess the acceptability of various approaches

- Research to determine whether lethal means safety counseling is effective in promoting firearms-related lethal means safety behaviors among adults, and whether these practices are associated with reduced suicide risk

Additional funding from private and public sources will be needed to support this research. Although federal funding of research involving firearms has been limited, with Congressional funding in FY2020, NIH[110] and CDC[111] have awarded research grants to understand and prevent firearm-related injuries, deaths, and crime, including those related to suicide. More funding is needed to support the development, implementation, and evaluation of other prevention efforts addressing the needs of diverse populations in various settings.

Action 3: Priorities for Action

- The federal government and private sector entities can support efforts to ensure that updated information on lethal means safety policies, programs, and practices (e.g., ERPOs, firearm owner and retailer education, bridge barriers, medication packaging, carbon monoxide shut-off sensors in vehicles) is incorporated into existing national clearinghouses and resource centers so that local municipalities, states, and tribes can adopt and evaluate them for their prevention benefits.
- States, communities, and tribes should collaborate with the private sector to increase awareness of and take action to reduce access to firearms and other lethal means of suicide, including opioids and other medications, alcohol and other substances or poisons, and community locations (e.g., railways, bridges, parking garages) where suicidal behaviors have occurred. This urgent multi-sector effort is key to saving lives by reducing access to lethal means for individuals in crisis.
- Health systems and payers should leverage their existing training and resources and collaborate on a national initiative to train general and specialty health care providers and care teams on safety planning and lethal means counseling.
- SAMHSA and the VA should coordinate to ensure that lethal means safety assessment and counseling are incorporated into the assessment and intervention procedures of the National Suicide Prevention Lifeline and Veterans Crisis Line call centers, particularly in preparation for the national launch of 988.
- The federal government can prioritize and fund research and program evaluation analyzing community and clinical lethal means safety interventions (e.g., ERPOs, firearm owner and retailer education, bridge barriers, medication packaging, carbon monoxide shut-off sensors in vehicles) at the population level.
- State and federal governments should collaborate with the private sector on a synchronized public health communication campaign addressing lethal means safety in the context of suicide prevention, which should then be evaluated to determine prevention benefits and inform future communication efforts.

ACTION 4
Support Adoption of Evidence-Based Care for Suicide Risk

Ensure safe and effective suicide care for all.

Action 4. Support Adoption of Evidence-Based Care for Suicide Risk

Ensure safe and effective care for all.

Goals 8 and 9 of the *National Strategy* call attention to the need to include suicide prevention as a core component of all health care services, rather than limit it to services provided by mental health specialists, and to improve professional and clinical training and practice.[8] To support the adoption of safe and effective care for suicide risk, an Action Alliance work group drew on findings from successful suicide prevention efforts, such the U.S. Air Force Suicide Prevention Program[112] and the Perfect Depression Care program conducted by the Henry Ford Health System,[113] to develop recommendations for a gold standard of care for people with suicide risk.[114]

These practices have been incorporated into the comprehensive Zero Suicide framework for providing effective care for suicide risk in health systems.[115, 116] Zero Suicide provides a model of integrated practices and transformative culture and systems change. Now implemented in numerous health care organizations, including behavioral health programs, general and psychiatric hospitals, primary care settings, and health plans, Zero Suicide is showing effectiveness in decreasing suicidal thoughts and behaviors among patients in care and in lowering the number of hospitalizations and the related costs.[115] To encourage bringing Zero Suicide to scale across the nation, SAMHSA provides grants to implement Zero Suicide in health care systems, and a Zero Suicide toolkit can be accessed on the SAMHSA website.

While Zero Suicide is the gold standard for evidence-based care for suicide risk, comprehensive systems change for safer suicide care is a lengthy and challenging endeavor. In response to the need for a minimum standard of care for individuals at risk for suicide, in 2018 the Action Alliance developed *Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe*. This report identifies individual recommended practices—such as screening and assessment for suicide risk, collaborative safety planning, treatment of suicidality, and the use of caring contacts—that can be adopted in outpatient mental health and substance misuse settings, emergency departments (EDs), and primary care.

Safe and effective practices for suicide care should be embedded into diverse clinical care settings, including primary care offices and clinics, EDs, inpatient and outpatient mental health practices and facilities, and other health systems. Like other established practices for addressing the risk for health problems such as heart disease or diabetes, best practices for preventing, identifying, and treating suicide risk should be incorporated into providers' everyday practice. There is also a need to increase the use of the Collaborative Care Model (CoCM), a team-based approach that allows a primary care provider to treat symptoms of mental illness in coordination with a care manager and a mental health specialist. This model of primary care integration has been shown to improve a range of patient outcomes, including suicide risk and health disparities. The CoCM approach is now covered by Medicare, many commercial health plans, and a growing number of state Medicaid programs.[117]

Access to treatment has long been a challenge for those in rural or remote settings, who often must drive for hours to access medical and behavioral health services. During the COVID-19 pandemic, federal restrictions on practicing across state lines have been eased and reimbursement has expanded, with a resulting rise in telehealth visits.[29] These expansions should be retained even after the pandemic has passed in order to improve access for those with distance, transportation, childcare, or other barriers to physically accessing services. Although more research on the use and efficacy of telehealth for suicide prevention is needed, existing evidence suggests that virtually delivered psychiatric services can have benefits similar to in-person therapy.[118] Remaining barriers that need to be addressed include the fear of adverse events and lawsuits, and disparities in access to computers and high-speed Internet.[18] Strengthening suicide prevention resources in critical access hospitals and rural health clinics can provide rural communities with the flexibility needed to determine the best approach to addressing suicide care challenges.[119]

Some of the evidence-based practices presented under Action 4 may also be appropriate for other settings that provide services to individuals at risk for suicide, including the justice system, university health services, school health clinics, and organizations that provide social services. Public and private stakeholders—including policymakers, payers, and accreditors—must take the steps needed to make these practices the standard of care for individuals at risk for suicide.

4.1 Increase clinical training in evidence-based care for suicide risk.

Objective 7.2 of the *National Strategy* recognizes the need to "provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk" (p. 77).[8] In a study conducted in England and Wales, training clinical staff in the management of suicide prevention at least every three years was among the key elements associated with lower rates of suicide among mental health patients.[120] Although several states have enacted legislation requiring training in the assessment and treatment of suicidality,[121] many behavioral health providers still receive only minimal training on how to care for patients at risk for suicide.[122–124]

Providing regular training to health care providers on how to recognize and address suicide risk is increasingly being recognized as an essential element of effective care.[115] Education in this area should be started early in clinical training and then updated on a regular basis. Different levels of providers and staff in diverse health systems, including primary care providers, should all receive at least basic training on how to identify suicide risk and provide appropriate support to diverse groups, including sexual and gender minorities.

Behavioral health providers are assumed to be equipped with skills to address patient suicide risk and therefore should have adequate training in evidence-based suicide prevention. Although suicide risk is often associated with mental illness, such as depression or an anxiety disorder, it also includes a distinct combination of symptoms that must be treated independently. If someone is suicidal and has a serious

mental illness, it is not enough to treat the illness and hope that the suicidality will resolve.[125] To be effective, care for the mental illness should be combined with specific treatment for suicidality.[126]

Evidence-based psychotherapies for addressing suicide risk include the following:[127]

- Cognitive-Behavioral Therapy for Suicide Prevention (CBT-SP)[128, 129]
- Dialectical behavior therapy (DBT)[130]
- Collaborative Assessment and Management of Suicidality (CAMS)[131, 132]
- Brief cognitive-behavioral therapy (BCBT)[133]
- Suicide-specific brief interventions, such as the Attempted Suicide Short Intervention Program (ASSIP)[134]

More work is needed to ensure that all behavioral health providers are prepared to assess suicide risk and to intervene, using evidence-based practices. Training on evidence-based suicide care practices should be incorporated into medical education programs and behavioral health graduate programs and should be included as criteria for professional licensure and license renewal. Professional associations and accrediting bodies should be encouraged to work together to advance training in suicide prevention. For example, for clinicians to maintain licensure or certification, state behavioral health licensing boards should add a continuing education requirement for suicide prevention. There is also a need to identify and address barriers to training, such as time, financing, and turnover of clinical staff.

4.2 Improve suicide risk identification in health care settings.

Studies have found that many individuals who die by suicide are seen by a health care provider in the weeks or months before their death.[135] These visits are opportunities to detect suicide risk, address safety, and connect persons at risk to appropriate sources for care and support.

Research suggests that asking patients about thoughts of suicide or self-harm is a simple and effective way to uncover most suicide risk[136] and does not increase a person's risk of suicidal behavior.[137, 138] This brief intervention can be done safely in many settings, including behavioral health care, primary care, and the ED. Universal screening in EDs has been found to nearly double the identification of suicidal patients.[139] Research on youth has also found that children age 10 or older can be safely and effectively screened for suicide risk in the pediatric ED.[140] More research is needed regarding younger children's understanding of and ability to report suicidal thoughts.[141]

The United States Preventive Services Task Force (USPSTF) has endorsed depression screening for adults and adolescents ages 12–18. The USPSTF notes that "screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up." The USPSTF

is in the process of updating its recommendations for suicide screening in primary care for youth[142] and adults.[143]

Identifying suicide risk through screening is a key component of recommended standard care.[114] For individuals screening positive for suicide risk, the next step is a more thorough assessment that collects detailed information about the person's risk, evaluates their immediate danger, and informs treatment decisions. Although the comprehensive suicide risk assessment is typically done by a behavioral health professional using a standardized suicide risk assessment tool, tools that do not require specialized mental health training are also available.[144]

The goal of suicide screening and assessment is not to predict suicide but rather to identify and address suicide risk, much as health care providers do in regard to other medical problems, such as heart disease or diabetes. For example, health care providers routinely assess patients for heart disease in order to identify and address relevant risk factors (e.g., unhealthy diet, lack of physical activity, smoking, high blood pressure) that can be addressed to prevent a heart attack or related problems, rather than to predict when a heart attack might take place. Similarly, identifying suicide risk and providing targeted, effective interventions is a key strategy for preventing suicide.

Screening and assessment for suicide risk should be conducted using workflows and electronic health record (EHR) fields that clearly indicate the need for suicide care. Training should also be provided to ensure that the interventions are done accurately and consistently and include appropriate follow-up and referrals.

The emergency department is

an essential location for suicide risk screening. A considerable literature collected over the past 25 years shows that emergency department patient populations have a higher proportion of patients with suicide risk than other medical settings or the general community. And, importantly, these patients don't always present with a psychiatric condition—they present with other medical problems, and their suicide risk is often missed. If universal screening is not being done, after their presenting problem is treated, the person is often discharged, with nothing about their mental health or suicide risk being assessed.

We once had a woman in her thirties present to the emergency department for severe abdominal pain. As it turned out, she had pretty serious liver problems. She's a good example of a person presenting at the emergency department with a medical complaint who would ordinarily not be asked any questions related to mental health or suicide risk. But because we had implemented universal screening in our emergency department, the nurse at triage used a quick screener to detect suicide risk. The physician who conducted a follow-up evaluation found that the woman was severely depressed and hopeless, and requested a psychiatric consult. The psychiatrist then came and did an evaluation. The patient was very sick, so she was first admitted to the hospital to treat her medical problem, then transferred to a psychiatric hospital to treat her depression. It is likely that none of the mental health care she received would have happened if we hadn't been asking those screening questions of everyone.

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4.3 Conduct safety planning with all patients who screen positive for suicide risk.

Safety planning is a brief intervention, conducted after a comprehensive suicide risk assessment, that has been shown to be effective in supporting safety among persons at risk for suicide.[145, 146] In this brief intervention, the health care provider works collaboratively with the person at risk to develop a plan for recognizing suicidal thoughts and managing them safely. The patient safety plan—also referred to as a *crisis response plan*[147]—identifies prioritized coping strategies that the person will use when such thoughts arise, including both actions that the person can take alone and actions to obtain social support from family members and friends and by contacting a health care provider or crisis call center. Safety planning should not be confused with no-suicide contracts, which have not been shown to be effective and can provide a false sense of security.[145]

In 2010, when I was the Executive Director of a crisis center,

I experienced the most acute suicidal crisis of my life, and spent seven days in a psychiatric hospital. At my discharge appointment with my family, more time was spent discussing my payment plan than my plan to keep myself safe. I went home wanting desperately to be okay, but I didn't know how, as my family and I were not told that I would be at an increased risk for suicide in the next few months or given a safety plan to serve as my roadmap for recovery. After all, if I had been recovering from a heart procedure, my family would have been given detailed instructions on how to care for my wounds, what to look for in case I needed to return to the hospital, and how to support my recovery. Instead, I ended up feeling embarrassed and like a complete failure when the thoughts of suicide returned. I was ashamed and mad at myself for not being magically "cured," and felt like a disappointment to my friends and family. No matter how badly I wanted to no longer have thoughts of suicide, they weren't going away. I loved my family, but I was hopeless and struggling to find the will to live. That only intensified my despair, pain, and sense that I was a burden. Within 90 days of discharge, I made an attempt to end my life.

I'm so grateful that I survived and had a chance to heal. Reconnecting to hope for life came through connections to loved ones and a spiritual-cultural healing that's hard to explain. But wanting to live is only the first part—learning how to live through the pain that led to my suicidal crisis took time. There is so much more we can do to better equip families, communities, treatment providers, and attempt survivors themselves with tools to safely transition from inpatient care to life back at home. As a suicide attempt survivor and a suicide prevention professional, I know how important it is to have the highest level of care during this high-risk period, and I am encouraged by the strong focus on care transitions in this Call to Action.

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As discussed in Action 3, *lethal means safety*—identifying possible means of self-harm that are available to the person at risk, and taking specific steps to reduce access to those means during a time of crisis—is a critical component of safety planning. This approach has repeatedly been shown to be effective in community-wide suicide prevention and was also identified as an important factor in the success of suicide prevention efforts conducted at the Henry Ford Health System.[148]

As a brief intervention tied to a specific risk, safety planning is similar to other types of health interventions conducted by health care providers, such as counseling on smoking cessation or weight control, which can be done in many settings. Safety planning with lethal means safety should be embedded in the suicide care protocols and electronic medical record systems used in all health care settings.

4.4 Increase the use of suicide safe care pathways in health care systems for individuals at risk.

The use of suicide safe care pathways can help health care systems continually monitor and enhance the quality of care provided to individuals at risk for suicide, thereby improving processes and outcomes. A key component of the Zero Suicide model, the suicide safe care pathway ensures that patients at risk for suicide are identified and provided with continuing care tailored to their needs. All patients are screened on past and present suicidal behavior, and positive screens are followed by a full assessment. Individuals identified as being at increased risk are entered into a suicide safe care pathway, thus ensuring that they are provided with the attention and support they need to stay safe and recover. Components include periodic assessments of suicidality and ongoing follow-up, including contacting patients who fail to show up for an appointment or withdraw from care. The inclusion of family members and other identified support persons in pathway implementation may help support patient engagement.

Implementation of a suicide safe care pathway requires that protocols and systems be in place to collect and analyze data to track services, ensure patient safety, and assess treatment outcomes.[149] The system should collect data on process measures, such as screening rates, safety planning, and services provided; care outcomes; suicide attempts and deaths; and any other relevant factors, such as sociodemographic characteristics, clinical history, and referrals to other sources of care.

EHRs can be programmed to support pathway implementation, for example, by prompting providers to conduct suicide risk screening and further risk assessment, and by facilitating connections to outpatient treatment.[150] These systems can also be designed to "pre-screen" new patients for strong risk factors for suicide, such as a history of suicidal ideation, plans, or attempts, and to alert the provider to needed next steps. Suicide safe care pathways need to be incorporated into existing EHRs and built into new systems. A quality measure should be developed that requires systems to track the number of patients who screen positive for suicide risk, are on a suicide safe care pathway, or receive a collaborative safety plan. Health care systems must also consider ways to collaborate to ensure that patients in the suicide safe care pathway continue to be followed as they move across different settings and systems.

4.5 Increase the use of caring contacts in diverse settings.

Caring contacts are brief interventions that use encouraging notes and messages (which do not require a response from the patient) to ensure that individuals at risk receive ongoing follow-up and support, with the goal of preventing suicidal behaviors.[151, 152] First tested more than four decades ago,[153] caring contacts have been found to decrease subsequent suicide attempts by helping prevent gaps in care that can occur for different reasons. Examples include the transition from inpatient to outpatient care, the time period between a crisis line call or ED visit and seeking follow-up treatment, the interval between scheduled care sessions, and gaps in care caused by missed appointments.[154]

The contacts can be provided in many ways, including through postcards or letters with brief expressions of caring, telephone follow-up calls with patients after discharge or a missed appointment, and text messages and e-mails generated by automated systems.[154] Although the messages can be designed to support diverse goals (e.g., provide information about resources or crisis lines, remind the person of upcoming appointments), they should always communicate that the sender cares about the person's well-being. The intervention can also be used in diverse settings, including EDs, hospitals, outpatient behavioral health programs, crisis centers, community mental health, and integrated primary care. Contacts can be made by clinical or non-clinical staff, including peers who have lived experience of a suicidal crisis. The contents, media used, and delivery options should be adapted to the needs and preferences of the recipients.

Like many attempt survivors,

I have found that sharing my experiences in service to others has been an important part of my recovery. Supporting others, educating our communities, and working for change have all helped me find meaning in my experiences and allowed me to transform my past pain into something positive. In the process, I have made connections with a community of people who deeply understand my struggles and are there to offer support when I need it.

Although engaging in this work has been profoundly healing, it hasn't benefited me alone. The inclusion of people with lived experience in suicide prevention enriches the entire field. Those of us with first-hand knowledge of what it's like to live with these challenges have unique skills and insights to contribute. We apply what we've learned while navigating systems to create more effective policies. We know from experience what works and what doesn't, and we use that knowledge to design better programs and supports. We benefit from the context of our lived experiences as we interpret data, evaluate outcomes, and help build better systems. We draw strength and compassion from our own struggles as we support our peers, and we use the power of our stories to give hope to others.

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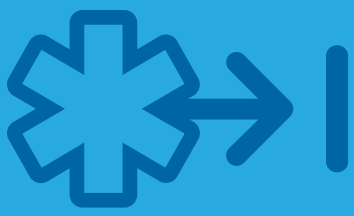
Oregon Health Authority

Caring contacts should be routinely provided to individuals at risk for suicide, similar to other standard protocols for following up with patients after other types of medical treatment, such as a surgical procedure.

Barriers to the use of this brief intervention include a lack of familiarity with the billing codes that may be used and (in some settings) a lack of reimbursement. Bundled payment options with International Classification of Disease (ICD) codes that provide payments for follow-up phone calls to patients discharged from a health care provider, such as an ED or inpatient hospital, could help address these financial barriers.

Action 4: Priorities for Action

- The federal government, professional associations, and accrediting bodies should collaborate to address barriers to adopting the Action Alliance's *Suicide Prevention and the Clinical Workforce: Guidelines for Training* to ensure increased clinical training in evidence-based care for suicide risk during graduate education and post-graduate training.
- State behavioral health licensing boards should add continuing education requirements for suicide prevention in order for clinicians to maintain licensure or certification.
- Payers from the public and private sectors should incentivize the delivery of evidence-based care via existing levers in contracting and reimbursement.
- Federal and state policymakers and commercial payers and health systems should take specific steps to improve outcomes for individuals with mental health and substance misuse conditions in primary care by using effective methods (e.g., CoCM) to integrate mental health and substance misuse treatment into primary care.
- To enhance workflows for suicide safe care, health systems should collaborate with EHR vendors to develop options for integrating screening, suicide safe care pathways, and safety planning into their EHR systems.
- Public and private health systems should adopt and/or implement the recommendations in *Recommended Standard Care for People with Suicide Risk* in all health care settings.



ACTION 5
Enhance Crisis Care and Care Transitions

Ensure that crisis services are available to anyone, anywhere, at any time.

Action 5. Enhance Crisis Care and Care Transitions

Ensure that crisis services are available to anyone, anywhere, at any time.

In many states, the only options available to an individual in suicidal crisis are a call to 911 or a crisis call line or a visit to the ED—and after this call or visit, the person loses contact with the health care system, only to resurface during the next crisis. As a result, individuals in crisis may be readmitted to a hospital multiple times and receive expensive and restrictive care that may not match their needs. This approach to crisis care is not only insufficient, it is also dangerous, as it does not ensure safety or treat suicidality. The long-term consequences of inadequate crisis care can include homelessness, involvement with the criminal justice system, and premature death.[155]

Although the police are frequently called on to respond to individuals who engage in self-harm or who exhibit suicidal ideation or suicidal behaviors, SAMHSA's recently released *National Guidelines for Behavioral Health Crisis Care* indicate that police officers and emergency medical services personnel should be involved in crisis response only if the nature of the crisis indicates that their involvement is needed (e.g., the person has a serious medical condition or poses an imminent threat of self-harm that cannot be de-escalated by phone-delivered crisis intervention). While local law enforcement has a role to play in mental health crisis response, crisis care should be provided by mental health specialists and others trained in mental health crisis response, who could include peers. This approach may contribute to more compassionate care and improved outcomes for individuals in crisis, and also reduce the burden that mental health crisis response places on law enforcement. As discussed in Action 5, strategy 5.5, the establishment of 988 as the national number for mental health crises[14] (effective by July 2022) will help address this problem by connecting callers who are experiencing a mental health crisis with appropriate responders.

Peer support is assistance and encouragement provided by individuals who share similar experiences. In the context of suicide prevention, peer support often refers to support provided to persons at risk for suicide by individuals who have experienced and overcome suicide risk themselves. Peers can provide support in many different capacities. Some peers are trained, certified by the state, and paid to assist in care. Others are trained to serve in a supportive role, such as helping individuals navigate health care. Still other individuals provide peer support on a volunteer basis, with limited or minimal training.

Individuals in crisis need immediate access to tailored services aligned with their needs, provided in the most comfortable and least restrictive setting, that will ensure their safety and connect them to continuing, effective care.[155] The Air Traffic Control (ATC) system that monitors commercial aircraft provides a useful

analogy. From takeoff to landing, each aircraft is continuously monitored by air traffic controllers, who are ready to step in when needed. Much like the ATC system never loses track of an airplane, a crisis care system should never lose track of a person at risk. Rather, the system must combine multiple approaches to stay connected, verify when a safe hand-off has occurred, and secure a "safe landing."

Ensuring that individuals at risk receive follow-up and are connected to sources of evidence-based ongoing care is best achieved through the use of a comprehensive and integrated crisis network that accepts all calls, welcomes all individuals who seek help at a health care setting, and provides real-time access to services that align with the needs of the person when and where the person needs it most. Individuals in crisis must be provided with appropriate and ongoing services regardless of their ability to pay, as intended by the Mental Health Parity and Addiction Equity Act,[156] which requires health insurers and group health plans to provide the same level of mental health and substance misuse treatment services and medical and surgical services to all individuals in need.

The experience of states that have developed effective crisis care systems, and of the individuals and families with lived experience who have relied on these supports, suggests that crisis care systems must include three key components: regional or statewide crisis service hubs that work in coordination with national crisis lines; centrally deployed 24/7 non-law enforcement mobile crisis teams; and crisis receiving and stabilization facilities with 24/7 availability.[155] All components should reflect the essential principles of crisis care, including partnering with law enforcement and emergency medical services, making significant use of peer support and peer-delivered services, and ensuring the safety and security of staff, peers, and individuals in crisis. Ongoing research and evaluation efforts addressing these services are needed to optimize individual outcomes as crisis care systems are further developed and implemented.

5.1 Increase the development and use of statewide or regional crisis service hubs.

Crisis call centers are clinically staffed statewide or regional centers that provide individuals in crisis with real-time access to a live person on a 24/7 basis—by telephone, text, chat, or other means. SAMHSA-issued guidelines indicate that, at a minimum, crisis call centers should do the following:[155]

- Operate every moment of every day
- Be staffed with clinicians overseeing clinical triage, and other trained team members to respond to all calls received
- Answer every call, or coordinate overflow coverage with a resource that also meets all minimum crisis call center expectations
- Assess the risk of suicide within each call in a manner that meets National Suicide Prevention Lifeline Risk Assessment Standards

- Coordinate connections to mobile crisis team services in the region
- Connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed

To be most effective, the crisis center should function as a hub for the effective deployment of a range of crisis services (e.g., crisis stabilization, crisis respite, psychiatric hospitalization). A crisis service hub (e.g., NYC Well, Georgia Crisis & Access Line) uses connections to service providers and technological solutions (e.g., online databases, GPS-enabled mobile crisis dispatch) to ensure that individuals at risk are provided with the least invasive and most appropriate level of care. Sample capabilities include the ability to (1) track all persons who are waiting for care, how long they've been waiting, and where they are waiting, (2) access appointment slots for outpatient scheduling, and (3) identify and deploy the closest mobile crisis team. These ATC-like capabilities also help ensure follow-up and safety for individuals in crisis as they move across services and systems.

5.2 Increase the use of mobile crisis teams.

Mobile crisis teams are crews that can be dispatched to help the person in crisis at their home, workplace, or any other location in the community where the person is experiencing a crisis. These teams provide professional intervention and peer support in real time to the person in crisis in a comfortable environment. This approach has been found to be appropriate and effective at diverting individuals in crisis from psychiatric hospitalization and connecting them to outpatient services, while also reducing unnecessary involvement with law enforcement and lowering related costs.[155]

SAMHSA-issued guidelines indicate that, at a minimum, mobile crisis team services must:[155]

- Include a licensed and/or credentialed clinician capable of assessing the needs of individuals within the region of operation
- Respond where the person is (e.g., home, work, park) and not restrict services to particular locations, days, or times
- Connect individuals to facility-based care as needed through warm hand-offs, and coordinate transportation only if or when circumstances warrant transitions to other locations

These services should incorporate best practices, such as continuity of care. Ways to support continuity of care include scheduling outpatient follow-up appointments, providing a warm hand-off that actively engages and links the person at risk to treatment and other needed services, and offering caring contacts (see Action 4, strategy 4.5) that support continued follow-up.

5.3 Increase the use of crisis receiving and stabilization facilities.

Crisis stabilization facilities are home-like environments that offer a step-down option for persons who do not need inpatient care after their crisis episode. These settings provide individuals in crisis with "a place to go," where they can stay for short-term observation (less than 24 hours) and receive crisis stabilization services.[155] The facilities should accept not only referrals, but also walk-ins and drop-offs from first responders, including ambulance services, firefighters, and the police.

The following models are most often used to provide crisis stabilization services:[155]

- **Short-term residential facilities.** Also called crisis residential facilities, these sites should include licensed and/or credential clinicians onsite on a part-time basis and on-call.
- **Peer-operated respite.** In this model, the facility is typically staffed by peers who have personal experience with mental health challenges or suicide. Although these programs usually do not have licensed staff onsite, some facilities call on licensed providers to support suicide risk assessments.

Non-peer-run facilities that offer crisis receiving and stabilization services should meet several requirements:[155]

- Be staffed at all times (24/7), with access to a multidisciplinary team (e.g., psychiatrists, psychologists, social workers, nurses, licensed or credentialed clinicians, peers) capable of meeting the needs of individuals experiencing all levels of crisis
- Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated
- Address crisis issues related to both mental health and substance use
- Be able to assess physical health needs and deliver care for most major physical health problems and to connect individuals to other providers when needed

Facility-based programs should be adequately funded to deliver on the commitment of never rejecting a first responder referral or a walk-in referral, thereby ensuring diversion from the ED and the justice system.

5.4 Ensure safe care transitions for patients at risk.

Transitions in care—such as the transition from inpatient hospitalization to outpatient care in the community—are a time of increased suicide risk. Other care transitions include the time period following discharge from an ED or from other providers of crisis care services, including crisis stabilization facilities and mobile crisis teams. Studies have found that in the month after patients leave inpatient psychiatric care, the suicide death rate for these patients is 300 times higher (in the first week) and 200 times higher (in the

At the age of 13, I was given alcohol and cocaine by adults

and was sexually assaulted. I became angry and self-destructive. I was hospitalized at 16, diagnosed with depression and anxiety, and treated for cocaine dependence. Over the next 20 years, I was homeless, incarcerated, and cycled through treatment programs and shelters, while struggling with feelings of grief, shame, a lack of self-worth, not belonging, and self-hatred, and thoughts of suicide.

The philosophy embraced by peer support was critical to my recovery. I was so unbelievably fortunate to have others take a nonjudgmental, strengths-based, and loving approach with me—to find a path where others honored my experiences and recognized them as strengths. Because of this approach, I moved from homelessness to homeowner, became a husband and father, and sit as the director of housing for the very company and opportunity that saved my life. The fact that my experiences can be used to support others struggling with similar challenges is truly a blessing. I can now inspire hope in others by walking with them, sharing space, being authentically connected, and creating the opportunity for them to come up with their own solutions.

People with lived experience add a critical and necessary perspective that doesn't replace, but rather complements and enhances, work being done by clinicians. If we do this with equal respect for each other's work, our work becomes harmonious as we reflect the philosophy of peer support and the value of clinical care.

Christopher Bartz
Recovery Services Administrator I
RI International

first month) than the general population's.[157] Suicide risk is highest in the first few days after discharge from inpatient mental health care[158] and can stay elevated for months,[159, 160] yet many patients never attend their first outpatient appointment.[161, 162] Ensuring a timely transition in care has been shown to reduce risk of subsequent suicide. In a recent study, suicide risk in the six months following psychiatric hospitalization was reduced among youth ages 10-18 who had an outpatient mental visit within 7 days of discharge.[163]

Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care issued by the Action Alliance notes that inpatient and outpatient providers need to accept shared responsibility for the patient's care and work together to ensure a seamless transition with no interruption in services.[164] This approach includes the following components:

- Developing relationships, protocols, and procedures that allow for rapid referrals.
- Making a follow-up phone call within 24 hours of discharge from psychiatric hospitalization, a crisis stabilization unit, or an ED to check in with the patient, and maintaining contact until the person attends the first outpatient appointment. It is also important to consider ways to support the transition in care, such as holding a videoconference with the patient and the outpatient provider.

- Involving individuals with lived experience to inform practices.
- Involving family members and natural supports, including trained peer specialists, to increase social and emotional support, solve practical problems, and promote hope and ongoing recovery.
- Providing education to family members and natural supports.
- Providing brief interventions, such as safety planning and caring contacts, to reduce suicide risk during care transitions.

All health care providers who care for individuals at risk for suicide—in both clinical and community settings—should have policies, protocols, and pathways for ensuring continuity of care during transitions. For this to happen, financing related to care transitions needs to be improved. In particular, the case rate reimbursement structures need to be modified to support delivery of these services.

5.5 Ensure adequate crisis infrastructure to support implementation of the national 988 number.

The FCC has authorized the creation of a new three-digit number, 988, that will be used to connect callers to mental health crisis assistance. The new number will direct callers to the National Suicide Prevention Lifeline, as will the current 10-digit number 800-273-8255 (TALK).[165] Similar to 911, which connects people in need to first responders for other emergencies, 988 will connect callers to Lifeline crisis centers that will deliver intervention services by phone, triage the call to assess for additional needs, and coordinate connections to additional support, based on the team's assessment and the caller's preferences. All carriers are required to implement the new number nationwide by July 16, 2022.[165]

As noted in SAMHSA's report to the FCC as part of the National Suicide Hotline Improvement Act, the establishment of 911 gradually transformed the U.S. emergency medical system.[166] The 988 number has the potential to play a similar role in behavioral health emergency and crisis services, with 988 being used to access a coordinated crisis system with call centers at the hub, connecting to mobile outreach, crisis stabilization units, and emergency rooms, with ATC-type monitoring to prevent persons at acute risk from falling through gaps in care.

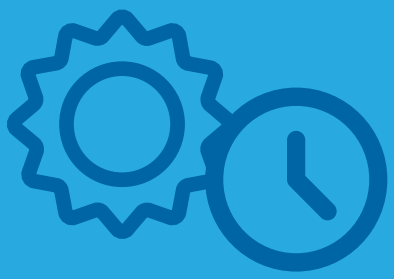
However, this national mental health crisis line will only work if there are sufficient personnel and infrastructure to keep up with the calls and provide an effective response. Crisis centers that respond to calls from state-run helplines and the National Suicide Prevention Lifeline will see an increased volume of calls and will need to increase their capacity to respond, which will require additional personnel and funding. The system will also need to include contingency plans for meeting periods of increased demand, such as following the death by suicide of a celebrity.[167]

Legislation for building a framework to run 988, called the National Suicide Hotline Designation Act of 2020,[14] was signed into law in October 2020 to allow states to add a fee to phone bills, much like 911. These

funds would go toward running 988, ensuring that the call line has the personnel, resources, and training necessary to support any increased call volume, including specialized resources for high-risk populations. Another potential funding source is a proposed new 5 percent set aside in the SAMHSA Mental Health Block Grant to support evidence-based crisis care programs.[168] Partnerships that combine federal and state funding, such as SAMHSA's state capacity grants administered through the National Suicide Prevention Lifeline, will be needed for the new 988 crisis line to achieve its full potential.

Action 5: Priorities for Action

- The federal government and the private sector should address gaps, opportunities, and resource needs to achieve standardization among crisis centers in interventional approaches and quality assurance in preparation for the launch of 988.
- The federal government, states, and the private sector should work together to optimize system design, system operations, and system financing for 988 as the hub of an enhanced, coordinated crisis system, and enhance coordination between Lifeline 988 centers and 911 centers to reduce overreliance on 911 services and ED boarding (the practice of keeping admitted patients on stretchers in hallways due to crowding).
- The federal government should fund the necessary infrastructure to support crisis care (e.g., Congressional support for the 5 percent SAMHSA Mental Health Block Grant set-aside; core services identified in SAMHSA's *National Guidelines for Behavioral Health Crisis Care*) and should provide technical assistance to states looking to evolve crisis systems of care.
- The federal government and foundations should support research to identify effective models of mental health crisis response (e.g., coordinated efforts among mental health specialists, peers, and law enforcement) to improve short- and long-term effects on communities of color and other marginalized populations.
- The federal government and private sector payers should support the use of follow-up phone calls or texts within 24 hours of discharge from psychiatric hospitalization or emergency room discharge to check in with the patient, provide support, and maintain contact until the person's first outpatient appointment.
- The federal government should establish universally recognized coding for behavioral health crisis services, and public and private sector partners should collaborate with payers and health systems to increase adoption of the new coding.
- The federal government should support the development of an essential benefits designation that will encourage health care insurers to provide reimbursement for crisis services, thus reducing the financial burden on state and local governments to pay for those services, delivered within a structure that supports the justice system and ED diversion.



ACTION 6
Improve the Quality, Timeliness, and Use of Suicide-Related Data

Know who is impacted and how to best respond.

Action 6. Improve the Quality, Timeliness, and Use of Suicide-Related Data

Know who is impacted and how to best respond.

Suicide prevention efforts must be guided by timely and reliable data on the extent of suicide in a specific community or setting, the groups most affected, and relevant risk and protective factors that prevention strategies can address. Data collection at the national, state, and local levels is critical to monitoring trends, guiding suicide prevention efforts, informing public policy, and assessing the effects of programs and policies.[169] The various systems currently being used to track the pandemic (e.g., daily reports of new cases, hospitalizations, and deaths) clearly demonstrate the importance of capturing and sharing near real-time data to guide an informed public health response.

Goal 11 of the *National Strategy* calls for improvements in the quality and timeliness of suicide data and in the use of these data to inform prevention.[8] The need for timely data related to suicide has become more pronounced with the COVID-19 crisis, which is increasing various stressors that can affect mental health and suicide risk, including social isolation, traumatic losses of family members and friends, and economic hardship—particularly among communities of color.[170] Although the impact of these risk factors on mental health and suicide is still being explored, the pandemic has added urgency to an existing need to improve the timeliness and quality of suicide-related data to implement an effective response at the federal, state, tribal, and local levels.

The Minnesota Department of Health

(MDH) is dedicated to protecting, maintaining, and improving the health of all Minnesotans. Using a data-driven approach can help us understand how frequently violent deaths are occurring, and identify areas where we can improve our systems and intervene to prevent these deaths.

In 2014, the MDH was first funded by CDC to begin setting up the Minnesota Violent Death Reporting System. At that time, 80 percent of violent deaths in Minnesota were suicides—compared with 65 percent nationwide. Having more details about the characteristics of people who die by suicide and the circumstances leading up to their deaths helps our prevention program understand the complexity of suicide, populations at increased risk, and gaps in our social services, criminal justice, health, and behavioral health systems that we should address. With this improved understanding, we are better able to target interventions and prevention initiatives to have a greater impact. For example, if the data indicate that many young adults who die by suicide do not have a behavioral health diagnosis, we can rethink which systems these individuals are interacting with and find ways to better connect them with behavioral health services that can adequately identify and treat mental illness.

Minnesota Department of Health
Suicide Prevention Team

6.1 Increase access to near real-time data related to suicide.

Access to near real-time data on suicide is critical to detecting and responding to increases in suicide attempts and deaths by suicide, identifying emerging populations at risk, and assessing the effectiveness of suicide prevention efforts over time. Since the *National Strategy* was updated in 2012, the quality and timeliness of national suicide data have somewhat improved, and the gap between the close of the calendar year and when the national data for that year become available has narrowed. However, more work is needed to achieve near real-time access to this information.

Key Sources of National Data on Suicide Deaths

- CDC's National Vital Statistics System (NVSS), a nationwide surveillance system, collects and disseminates data on births and deaths. Information on suicide deaths includes demographic, geographic, and cause-of-death data obtained from death certificates. The National Death Index, a centralized database of death record information compiled from state vital statistics offices, is a component of NVSS.

- CDC's National Violent Death Reporting System (NVDRS), a state-based surveillance system, combines data from various sources (e.g., death certificates, law enforcement, coroner and medical examiner reports) to provide information on the circumstances surrounding violent deaths. Started in six states in 2003, NVDRS now includes all 50 states, the District of Columbia, and Puerto Rico.

- The annual Department of Defense Suicide Event Report presents data collected through a Web-based system on suicide attempts and deaths among active duty military service members.

- The U.S. Department of Veterans Affairs' *National Veteran Suicide Prevention Annual Report* presents data on suicide deaths among U.S. Veterans.

While some states are able to contribute mortality data to the National Vital Statistics System (NVSS) on a fairly rapid basis, others continue to experience delays in certifying and reporting these deaths, thereby delaying the release of national statistics. These states, and the local death investigation system within each state that provides the data, need additional support and resources to collect and report their data more efficiently, consistently, and quickly. States should also ensure that mortality and attempt data are shared in real time with their state and local suicide prevention leaders and other key stakeholders. In addition,

states should facilitate wider linkages to mortality data, especially by health systems and health plans, to enable better public health surveillance regarding patterns and correlates of mortality, and should support implementation of clinical quality improvement programs that will increase survival.

Data on the circumstances surrounding each suicide are collected through CDC's National Violent Death Reporting System (NVDRS). Although NVDRS has recently been expanded to all states, several states are still working to fully build their statewide data collection systems. A lack of centralized data systems and various logistical challenges associated with the collection of vital statistics; reports from law enforcement, coroners, and medical examiners; and other records continue to impact many states' capacity to rapidly collect information for the NVDRS. Thus, even when all state systems are up and running, the compiling of national data will encounter delays. These systems need to be improved so that the data can be reviewed annually to guide suicide prevention efforts at the state and federal levels.

6.2 Improve the quality of data on causes of death.

Studies suggest that suicide rates may be underestimated by as much as 30 percent. Suicides may be misclassified as homicides, accidents (unintentional deaths), or undetermined deaths (primarily deaths by drug overdose).[171] Many factors may contribute to the misclassification problem, including family reluctance to report the death as a suicide; legal, religious, and political pressure; and a lack of resources and training to adequately investigate the manner of death.

Moreover, each state has its own system, requirements, infrastructure, and resources related to death scene investigations and the preparation of death certificates. Challenges include a lack of consistency in definitions, burden of proof standards, and procedures across jurisdictions, and poor implementation of existing guidelines and best practices. Potential solutions include better standardizing of terms and definitions, procedures, and death certificate completion practices within and across states; improving and expanding training; improving communication across jurisdictions and disciplines; developing job aids to enhance consistency; and conducting additional research to better understand and address variations in practices across counties and states.[171] Death certificates and death investigation reports also need to be improved to better identify the characteristics of the person who died by suicide (e.g., sexual orientation, gender identity,[172] Veteran status,[173] and race or ethnicity, including Hispanic[174] and American Indian or Alaska Native[175]).

6.3 Expand the accessibility and use of existing federal data systems that include data on suicide attempts and ideation.

Data related to suicidal thoughts, plans, and attempts; risk factors; health care use; and other relevant outcomes are critical to identifying emerging trends, planning suicide prevention efforts, and assessing progress. These suicide-related data are currently available from a number of sources (see the following box on page 60 for examples). However, in many cases the data may not be available in formats that can be easily accessed and used by state and local suicide prevention programs.

Existing systems must continue to be strengthened and improved. For example, EDs should routinely use the external cause of injury code to identify suicide attempts (as opposed to self-harm with unspecified intent). Although a field to code cause of injury exists, it often is not completed uniformly across states. CDC's Youth Risk Behavior Surveillance System (YRBSS) survey should be expanded to more middle schools and should seek additional data, such as information on protective factors for suicide (e.g., school connectedness). New questions related to suicide—including questions that better identify specific groups, such as sexual and gender minority populations—should be added to existing data collection tools, such as state-level health surveys. Other variables of interest, such as risk and protective factors for suicide, should also be added to existing data collection instruments. States should make a concentrated effort to improve participation in these surveys; for example, in some states, schools in the largest metropolitan areas do not participate in the YRBSS or similar state surveys.

Access to and use of existing suicide-related data must also be improved. Existing data should be made openly available to state and local programs in formats that can be easily used to inform suicide prevention efforts. Although some sources may make raw data available to researchers, the data must be analyzed by epidemiologists and presented in formats (e.g., reports, tables, dashboards) that allow the information to be easily reviewed and applied. State and local suicide prevention programs need better access to usable data, or to experts who analyze these data, so that the information can be used to guide prevention actions.

Key Sources of Other Data Related to Suicide

- SAMHSA's annual National Survey on Drug Use and Health provides national and state-level estimates of suicide-related data (ideation, plans, and self-reported attempts) among adults, as well as data on substance misuse, mental health, and service use. Data on adults who report having seriously considered or attempted suicide are available online by state.

- CDC's nationally representative Youth Risk Behavior Surveillance System (YRBSS) survey of high school students, conducted every two years, includes questions on suicidal thoughts and behaviors. A middle school survey is also conducted by interested states, territories, tribal governments, and large urban school districts.

- CDC's cloud-based National Syndromic Surveillance Program provides near real-time electronic patient encounter data received from EDs and other health care settings in 47 states and the District of Columbia regarding visits where patients report suicidal thoughts or suicide attempts. Syndromic surveillance can serve as an early warning system for spikes in nonfatal suicide-related outcomes.

- CDC's National Electronic Injury Surveillance System—All Injury Program monitors nonfatal injuries and poisonings treated in a nationally representative sample of hospital EDs.

- The Department of Transportation's National Emergency Medical Services Information System is a national database that provides standardized data from states and territories on the provision of emergency medical services, including suicide-related activations of the 911 system that can be tracked over time to identify emerging trends.

- The Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project maintains databases on inpatient stays and ED visits that include data from many states on suicide ideation and attempts.

6.4 Improve coordination and sharing of suicide-related data across the federal, state, and local levels.

Although national data provide an overall view of the suicide problem, state and local data are key to planning effective prevention efforts. Suicide rates and risk groups at the regional, state, territorial, tribal, and local levels often vary considerably from national estimates. Now that NVDRS funds all 50 states, the information on circumstances associated with suicide deaths needed to guide state and local suicide prevention efforts will become increasingly available. However, there is still a need to create systems and to dedicate resources to improve coordination and near real-time availability between the local, state, and federal levels regarding the reporting of data related to suicide.[176] It is also critical to increase the capacity of all systems to provide near real-time data that are easily accessible and routinely used to guide decision-making at every level.

Improved access to information on suicide attempts is also needed. CDC is currently funding 10 states to conduct Emergency Department Surveillance of Nonfatal Suicide-Related Outcomes (ED SNSRO) and is using the National Syndromic Surveillance Program to monitor suicide attempts during the COVID-19 pandemic.

States should consider ways to disseminate suicide-related data in useful formats so that these data may be more widely applied. For example, the state of Colorado makes suicide data from the Colorado Violent Death Reporting System available online, in a data dashboard format, so that every county can access the information and apply this knowledge to guide their suicide prevention efforts. In Connecticut, the state purchases hospital claims data to pinpoint localities and populations with elevated risk for suicide attempts. Other states should consider similar ways to support the dissemination and use of data on suicide attempts and deaths.

6.5 Use multiple data sources to identify groups at risk and to inform action.

Diverse data sources can help suicide prevention planners identify groups most at risk and allocate resources appropriately. For example, state data on suicide death and attempt rates can help decision-makers identify populations or geographic areas where rates are particularly high and formulate solutions. A study that used NVDRS data to map county-level distribution of suicides among members of the military and Veterans found that suicides were concentrated in a small number of counties.[177] By triangulating multiple sources of data, researchers were able to better understand the circumstances surrounding these deaths and identify potential intervention sites in the affected counties. To expand these types of analyses, CDC is linking NVDRS data to the Department of Defense Suicide Event Report to better understand the circumstances of suicide among active duty military, Veterans, and civilians.

Linking data available from local, state, and national data systems (e.g., those used for medical service billing) to existing data from suicide prevention efforts could facilitate program planning and outcome assessment. For example, research on youth suicide prevention has identified many existing data systems that could be potentially linked to suicide prevention efforts.[178, 179] Programs should also establish links to existing data on societal-level factors that impact suicide prevention, including unemployment and food insecurity, available from external sources, such as the U.S. Census.

Medical records are another source of data that can be used to guide prevention efforts. The VA uses risk algorithms that examine medical record data (also referred to as predictive modeling) to identify patients at high suicide risk and inform decisions about care.[180, 181] Its Veterans Health Administration, the largest integrated health care system in the United States, has started a program that uses predictive modeling to identify patients who can benefit the most from interventions aimed at preventing suicide.

Objective 8.1 of the *National Strategy* indicates that health care systems should conduct root cause analyses (a structured process to determine the causes of suicide attempts and deaths among patients served) to continually improve service quality by identifying and addressing system-related factors that affect patient safety. The VA has successfully used this approach following discharge from not only inpatient hospitalization,[158, 182] but also nursing home care units and long-term care facilities.[183] VA research also suggests that combining information obtained through root cause analyses with data available from other sources, such as the National Death Index, may help improve the classification of deaths by suicide.[184]

The Internet and social media sites can also provide data that can be useful to suicide prevention. For example, metrics on the volume of Internet searches related to suicide can help identify increases in information- or help-seeking related to suicide. A recent study found that these searches increased following the release of a popular TV series about a young person's suicide.[185] These data can be useful in identifying times when increased capacity to provide information and crisis support may be needed.

Other sources of data needed to inform prevention efforts include qualitative studies (e.g., focus groups, key informant interviews), which can increase understanding of risk and protective factors for suicide among particular groups and inform the development of culturally tailored prevention programs. The first-hand experience of people with lived experience is another type of information that must guide the implementation of suicide prevention efforts.

Action 6: Priorities for Action

- The federal government should support near real-time collection of data on deaths by suicide and nonfatal suicide attempts in a group of sentinel states to develop the framework for a national early warning system for suicidal behavior in the U.S. The system would create a central database that links multiple data sources and would build state and local capacity to translate data trends into prevention efforts in a timely manner. In addition, the federal government should expand ED SNSRO to monitor nonfatal suicide-related outcomes, track spikes and potential clusters in suicide attempts, and identify patterns, all of which can then inform prevention activities.

- The public and private sectors should collaborate on a near real-time suicide dashboard that pulls data from existing national, state, tribal, and community databases to make data on deaths by suicide and suicide attempts timelier and more accessible, thus linking the dashboard to prevention actions on the ground.

- The federal government should implement Recommendation 1.8 of the Interagency Serious Mental Illness Coordinating Committee, which calls on public and private health care systems to routinely link mortality data for serious mental illness (SMI) and serious emotional disturbance (SED) populations, and supports the standardization of similar data gathering across state and local systems for SMI and SED populations within the justice system.

- Professional organizations connected to coroners and medical examiners at the state and national levels should release guidance on and support wide-scale implementation of coding sexual orientation and gender identity in death investigations.

- The federal government should implement the PREVENTS Executive Order recommendation for the U.S. Department of Health and Human Services and the VA to propose legislative changes that mandate a standardized process for uniform ED data reporting across the United States specific to the external cause of injury (e.g., suicide attempt).

- Health care systems should work with public sector agencies to support the linkage of mortality data with health record, social, geographic, education, and criminal justice data systems to strengthen data quality and increase accountability for patient outcomes across key systems.

- State suicide prevention coordinators and community suicide prevention leaders should routinely monitor available data to identify trends and evaluate their own efforts.

CONCLUSION

Conclusion

Since Dr. Satcher issued the first *Surgeon General's Call to Action to Prevent Suicide* more than 20 years ago, the United States has made tremendous progress in launching a broad-based coordinated response to suicide. For the last 10 years, the Action Alliance has worked to strategically advance implementation of the *National Strategy's* high-priority objectives, in collaboration with federal agencies, health systems, non-governmental organizations, business and community leaders, and many others. Today, suicide prevention efforts in the United States are more widespread than ever before,[15] and research suggests that the vast majority of Americans recognize that suicide can be prevented and want to be there for someone who is struggling or having suicidal thoughts.[54]

The time for action is now. To truly make a difference in reducing suicide, we need to move closer to fully implementing the goals and objectives in the *National Strategy*, thereby increasing the reach, breadth, and impact of our suicide prevention efforts. The six priority actions and related strategies presented in this *Call to Action* are intended to do just that.

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APPENDIX A
Acknowledgments

Appendix A: Acknowledgments

CORE PLANNING GROUP

- Rafael Campos, MPS, Strategic Partnerships Lead, Office of the Surgeon General
- Colleen Carr, MPH, Director, National Action Alliance for Suicide Prevention
- David Covington, MBA, CEO & President, RI International
- Alex Crosby, MD, MPH, Chief Medical Officer, U.S. Public Health Service, Division of Injury Prevention, Centers for Disease Control and Prevention
- Richard McKeon, PhD, Chief, Suicide Prevention Branch, Substance Abuse and Mental Health Services Administration
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APPENDIX B
Resources

Appendix B: Resources

The following selected resources can support the implementation of the six actions presented in this report.

Action 1. Activate a Broad-Based Public Health Response to Suicide

Suicide Prevention Planning

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf?s_cid=cs_293

This CDC technical package presents a select group of strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to prevent suicide.

Suicide Prevention Resource Center (SPRC) Effective Prevention Model
http://www.sprc.org/effective-suicide-prevention

Designed to help develop and implement suicide prevention efforts in any setting, SPRC's Effective Suicide Prevention Model includes three elements—strategic planning, keys to success, and a comprehensive approach—that work together to make suicide prevention efforts successful in achieving desired outcomes and using limited resources most efficiently.

Communication

Framework for Successful Messaging
http://suicidepreventionmessaging.org/

Developed by the Action Alliance, this website can help individuals and organizations who communicate about suicide develop messages that are strategic, safe, and focused on solutions.

Healthy People 2030
https://health.gov/healthypeople/about/workgroups/mental-health-and-mental-disorders-workgroup

Developed by the U.S. Department of Health and Human Services, the Healthy People initiative (or Healthy People 2030) provides national objectives and targets related to mental health and mental disorders and substance misuse, and provides evidence-based resources and data to track progress toward achieving these objectives throughout the decade.

National Recommendations for Depicting Suicide
https://theactionalliance.org/messaging/entertainment-messaging/national-recommendations

Developed by the Action Alliance, in collaboration with the Substance Abuse and Mental Health Services Administration and the Entertainment Industries Council, this resource provides national recommendations for depicting suicide in entertainment content.

REACH
https://www.reach.gov/

The REACH public health campaign encourages a culture of openness, support, and belonging surrounding the topic of suicide, and mental health more broadly. Through REACH, the federal government is now able to engage Americans nearly a billion times per month to REACH those who are struggling with mental health challenges, substance misuse and addiction, and self-destructive or suicidal thoughts and behaviors.

Recommendations for Reporting on Suicide
https://reportingonsuicide.org/

This brief guide to the "do's and don'ts" of responsible reporting was developed by leading experts in suicide prevention and in collaboration with several international suicide prevention and public health organizations, schools of journalism, media organizations, key journalists, and Internet safety experts.

SPRC Strategic Communication Planning Video Series
http://www.sprc.org/resources-programs/strategic-communication-planning

These brief videos feature expert advice on developing a suicide prevention communication plan, understanding your audience, and evaluating your communications efforts.

Lived Experience

Engaging People with Lived Experience: A Toolkit for Organizations
http://www.sprc.org/livedexperiencetoolkit/about

This online toolkit was developed by SPRC to assist organizations and agencies leading suicide prevention programs in their communities with recruiting and engaging individuals with lived experience.

Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines
https://theactionalliance.org/resource/responding-grief-trauma-and-distress-after-suicide-us-national-guidelines

Prepared by the Action Alliance's Survivors of Suicide Loss Task Force, this report outlines how communities can effectively respond to the devastating impact of suicide loss. The report paves the way for advances in postvention services, including support for the bereaved after a suicide.

The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experience
https://theactionalliance.org/resource/way-forward-pathways-hope-recovery-and-wellness-insights-lived-experience

Prepared by the Action Alliance's Suicide Attempt Survivors Task Force, this report summarizes eight core values and offers a lens through which suicide prevention can be envisioned to embrace safety and bring hope and meaning to those in suicidal despair.

Research and Evaluation

A Prioritized Research Agenda for Suicide Prevention: An Action Plan to Save Lives
https://theactionalliance.org/resource/prioritized-research-agenda-suicide-prevention-action-plan-save-lives

Developed by the Action Alliance's Research Prioritization Task Force and the National Institute of Mental Health, this resource outlines the research areas that show the most promise in helping to reduce the rates of suicide attempts and deaths.

RAND Suicide Prevention Evaluation Toolkit
https://www.rand.org/pubs/tools/TL111.html

This toolkit was designed to help program staff overcome common challenges to evaluating and planning improvements to their programs. The toolkit's design and content are the result of a rigorous, systematic review of the program evaluation literature to identify evaluation approaches, measures, and tools used elsewhere.

Action 2. Address Upstream Factors that Impact Suicide

Hiring Our Heroes
https://www.hiringourheroes.org/

Launched in 2011, the U.S. Chamber of Commerce's Hiring Our Heroes initiative is a nationwide effort to connect Veterans, service members, and military spouses with meaningful employment opportunities. PREVENTS, Hiring Our Heroes, and the VA partnered in November 2019 to launch Wellbeing in the Workplace, a collaborative workplace mental health effort. An initial group of 30 companies, representing 6 million employees, signed the *Pledge to Prioritize Mental Health and Emotional Wellbeing in the Workplace* at a launch ceremony in Washington, D.C. The companion Wellbeing Guidebook was created to assist companies with the basic steps in creating an emotionally healthy workforce. Through this ongoing initiative, employers are committing to prioritizing mental health and well-being in the workplace and recognizing that the health and well-being of their employees is both good for business and good for America.

A New Way to Talk About Social Determinants of Health
https://www.rwjf.org/en/library/research/2010/01/a-new-way-to-talk-about-the-social-determinants-of-health.html

Developed by the Robert Wood Johnson Foundation, this guide discusses why we need a better way to talk about the social determinants of health, and best practices to assist in conversation with different audiences around this concept.

Pain in the Nation: The Drug, Alcohol and Suicide Crises and the Need for a National Resilience Strategy
http://www.paininthenation.org/assets/pdfs/TFAH-2017-PainNationRpt.pdf

This report from the Well Being Trust and Trust for America's Health provides high-level ways to address the many factors that contribute to diseases of despair.

Projected Deaths of Despair During the Coronavirus Recession
https://wellbeingtrust.org/wp-content/uploads/2020/05/WBT_Deaths-of-Despair_COVID-19-FINAL-FINAL.pdf

This report from the Well Being Trust estimates the impact of the coronavirus pandemic in the United states on *deaths of despair*—defined as deaths to drugs, alcohol, and suicide—based on similar past situations.

Promoting Individual, Family, and Community Connectedness to Prevent Suicidal Behavior
https://www.cdc.gov/violenceprevention/pdf/suicide_strategic_direction_full_version-a.pdf

This CDC resource describes ways to prevent suicide by strengthening connectedness and social bonds within and among individuals, families, and communities.

SPRC Comprehensive Approach
http://www.sprc.org/effective-prevention/comprehensive-approach

This model presents nine strategies that form a comprehensive approach to suicide prevention. Each strategy is a broad goal that can be advanced through an array of possible activities.

Action 3. Ensure Lethal Means Safety

CDC Firearm Violence Prevention: unded Research
https://www.cdc.gov/violenceprevention/firearms/funded-research.html

This webpage provides information on funding opportunities from CDC's National Center for Injury Prevention and Control related to the prevention of firearm violence.

Lethal Means & Suicide Prevention: A Guide for Community & Industry Leaders
https://theactionalliance.org/resource/lethal-means-suicide-prevention-guide-community-industry-leaders

This Action Alliance report describes the role of reducing access to lethal means among those who may be at risk for suicide, and highlights actions by governments, organizations, and industries that have resulted in lives being saved.

Means Matter
https://www.hsph.harvard.edu/means-matter/

This website, maintained by the Harvard Injury Prevention Research Center at the Harvard School of Public Health, provides information about the connection between firearms at home and increased risk of suicide.

The President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS)
https://www.va.gov/PREVENTS/

Launched in June 2019, this nationwide roadmap aims to implement a comprehensive approach to ending the national tragedy of suicide. The roadmap includes 10 overarching recommendations to inform suicide prevention across various sectors.

SPRC Reduce Access to Means of Suicide
http://www.sprc.org/comprehensive-approach/reduce-means

This SPRC webpage provides information and the latest resources on lethal means safety.

Action 4. Support Adoption of Evidence-Based Care for Suicide Risk

Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments
https://www.sprc.org/edguide

This guide is designed to improve patient outcomes after discharge by assisting ED health care professionals with decisions about the care and discharge of patients with suicide risk.

Critical Crossroads: Pediatric Mental Health Care in the Emergency Department Care Pathway Toolkit
https://www.hrsa.gov/critical-crossroads

This toolkit is designed to assist EDs in improving the identification, management, and continuity of care for children and adolescents who present to the ED in a mental or behavioral health crisis. The toolkit walks the user through the available resources that support the creation of a customized care pathway through various stages of patient management.

Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe
https://theactionalliance.org/resource/recommended-standard-care

This Action Alliance report outlines recommended standard care aimed to help health systems better identify and support people who are at increased risk of suicide.

Suicide Prevention Toolkit for Primary Care Practices
http://www.sprc.org/settings/primary-care/toolkit

This toolkit, which can be used by all primary care providers, contains tools, information, and resources to implement state-of-the art suicide prevention practices and overcome barriers to treating suicidal patients in the primary care setting.

Zero Suicide Toolkit
http://zerosuicide.edc.org/toolkit

This SPRC website provides information and tools for developing a Zero Suicide program in health and behavioral health care systems.

Action 5. Enhance Crisis Care and Care Transitions

Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care
https://theactionalliance.org/resource/best-practices-care-transitions-individuals-suicide-risk-inpatient-care-outpatient-care

This Action Alliance report presents feasible, evidence-based practices for health systems to improve patient engagement and safety during the transition from inpatient to outpatient care.

Crisis Now
https://crisisnow.com/

Developed by the Action Alliance, the National Association of State Mental Health Program Directors, RI International, and the National Suicide Prevention Lifeline, this website provides communities with a roadmap to safe, effective crisis care that diverts people in distress from the ED and jail by developing a continuum of crisis care services that match people's clinical needs.

Crisis Now: Transforming Services Is Within Our Reach
https://theactionalliance.org/sites/default/files/inline-files/CrisisNow%5B1%5D.pdf

Developed by the Action Alliance's Crisis Services Task Force, this report identifies the core elements of effective crisis care.

National Guidelines for Behavioral Health Crisis Care: A Best Practices Toolkit
https://www.samhsa.gov/find-help/implementing-behavioral-health-crisis-care

Released in 2020, these national guidelines are intended to help states and communities develop and implement effective crisis services and systems.

Crisis Lines

988 Number

https://www.fcc.gov/document/fcc-designates-988-national-suicide-prevention-lifeline

This new telephone number will connect callers to the National Suicide Prevention Lifeline. *Note: This number will be in place by July 2022 but is not yet operational.*

Crisis Text Line

https://www.crisistextline.org/

Text-messaging support is available for those in crisis. Callers text "HOME" to 741741 from anywhere in the United States at any time to obtain support from trained crisis counselors.

Military Crisis Line and Veterans Crisis Line
https://www.veteranscrisisline.net/get-help/military-crisis-line
https://www.veteranscrisisline.net/

Phone-based text-messaging and online chat support is provided at no cost to all service members, including members of the National Guard and National Reserve, and all Veterans, even if they are not registered with the VA or enrolled in VA health care.

National Suicide Prevention Lifeline (1-800-273-8255)
https://suicidepreventionlifeline.org/

This 24-hour toll-free confidential suicide prevention hotline is available to anyone in suicidal crisis or emotional distress. Pressing "1" connects callers to the crisis lines for military service members and Veterans.

TrevorLifeline (1-866-488-7386)
https://www.thetrevorproject.org/get-help-now/

Crisis services are provided by phone, chat, and text to LGBTQ persons by The Trevor Project, the leading national organization providing crisis intervention and suicide prevention services to LGBTQ young people.

Action 6. Improve the Quality, Timeliness, and Use of Suicide-Related Data

Data Infrastructure: Recommendations for State Suicide Prevention
http://www.sprc.org/sites/default/files/StateInfrastructureDataSupplement.pdf

This detailed supplement to the Suicide Prevention Resource Center (SPRC) resource *Recommendations for State Suicide Prevention Infrastructure* can help state and local leaders understand the data resources and systems needed to effectively direct suicide prevention efforts.

Healthy People 2030
https://health.gov/healthypeople

Healthy People provides 10-year, measurable public health objectives, and tools to help track progress toward achieving them.

Locating and Understanding Data for Suicide Prevention
https://training.sprc.org/enrol/index.php?id=35

This free SPRC online course helps participants locate and apply suicide-related data to inform their prevention efforts.

Strategic Planning, Step 1: Describe the Problem and Its Context
http://www.sprc.org/strategic-planning/problem-context

This SPRC webpage provides guidance on how to describe the suicide problem and offers relevant data resources.

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Prevention Strategies

A comprehensive public health approach to suicide prevention can decrease risk.

Suicide is a serious public health problem that can have long-lasting effects on individuals, families, and communities. The good news is that suicide is preventable. Preventing suicide requires strategies at all levels of society. This includes prevention and protective strategies for individuals, families, and communities. Everyone can help prevent suicide by learning the warning signs, promoting prevention and resilience, and a committing to social change.

CDC's Suicide Prevention Resource for Action highlights strategies based on the best available evidence to help states and communities prevent suicide. The strategies and their corresponding approaches are listed in the table below. Click here to learn more about how to implement the strategies in the Prevention Resource.

Strategies to Prevent Suicide

Strengthen economic supports

- Improve household financial security
- Stabilize housing

Create protective environments

- Reduce access to lethal means among persons at risk of suicide
- Create healthy organizational policies and culture
- Reduce substance use through community-based policies and practices

Improve access and delivery of suicide care

- Cover mental health conditions in health insurance policies
- Increase provider availability in underserved areas
- Provide rapid and remote access to help
- Create safer suicide care through systems change

Promote healthy connections

- Promote healthy peer norms
- Engage community members in shared activities

Teach coping and problem-solving skills

- Support social-emotional learning programs

- Teach parenting skills to improve family relationships
- Support resilience through education programs

Identify and support people at risk

- Train gatekeepers
- Respond to crises
- Plan for safety and follow-up after an attempt
- Provide therapeutic approaches

Lessen harms and prevent future risk

- Intervene after a suicide (postvention)
- Report and message about suicide safely

See Suicide Prevention Resources for articles and publications about prevention strategies for suicide.

Need help? Know someone who does?

Contact the 988 Suicide and Crisis Lifeline if you are experiencing mental health-related distress or are worried about a loved one who may need crisis support.

- Call or text 988
- Chat at 988lifeline.org

Connect with a trained crisis counselor. 988 is confidential, free, and available 24/7/365.

Visit the 988 Suicide and Crisis Lifeline for more information at 988lifeline.org.

Last Reviewed: October 11, 2022