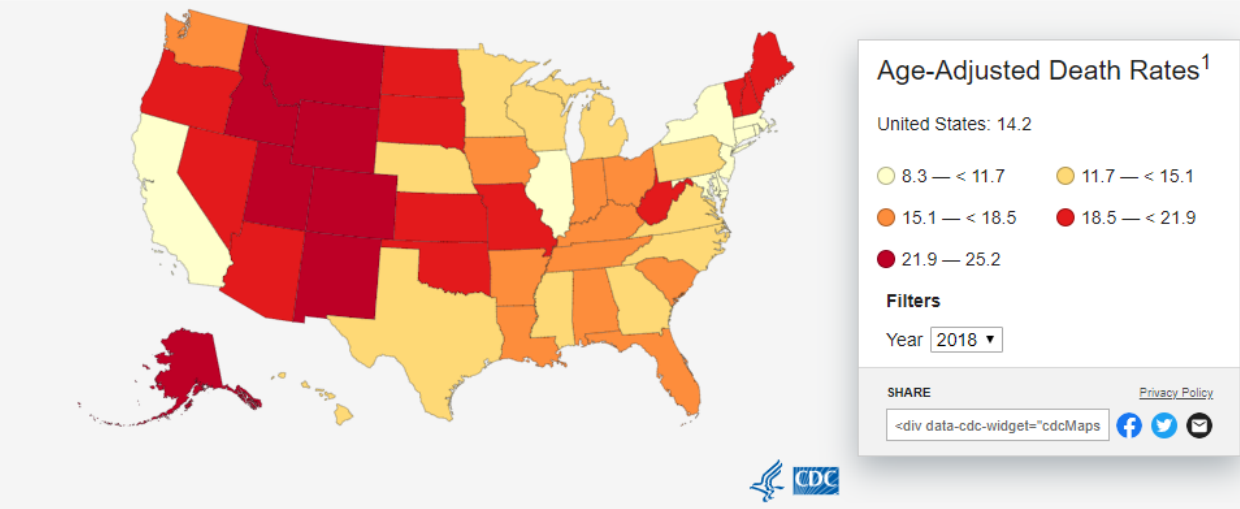
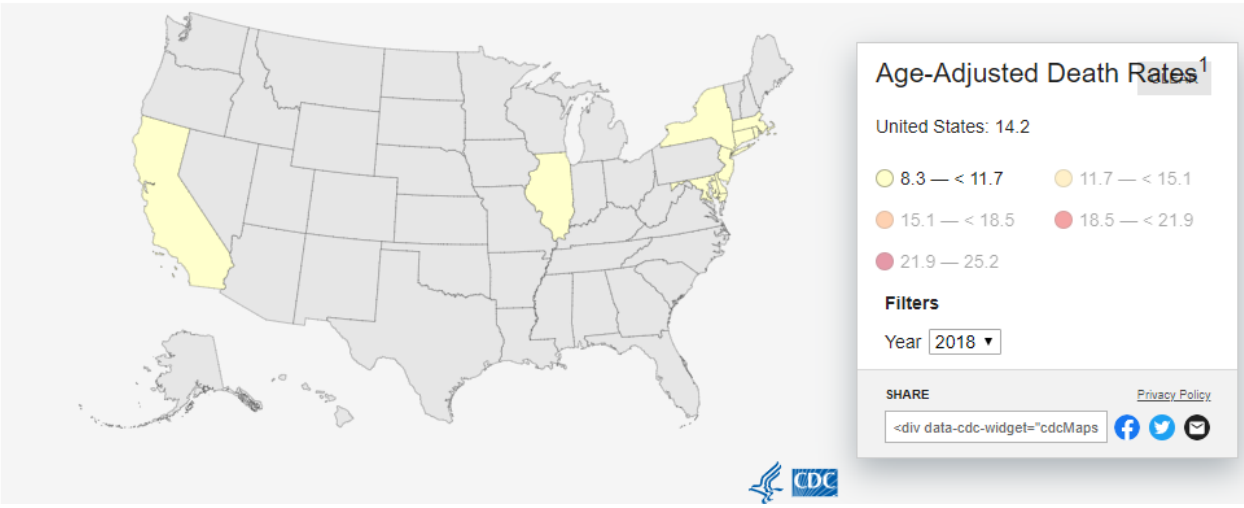
Suicide Mortality by State



The CDC identifies suicide as the 10th leading cause of death in the United States with age-adjusted death rates in states ranging from 8.3 per 100,000 in New Jersey and New York to 25.2 in Wyoming. In Arizona, suicide is the 8th leading cause of death with a 2018 age-adjusted death rate of 19.2.

Suicide Mortality by State



The 9 states with the lowest 2018 age-adjusted suicide death rates include: New Jersey (8.3), New York (8.3), Rhode Island (9.5), Massachusetts (9.9), Maryland (10.2), Connecticut (10.6), California (10.9), Illinois (11.3), and Delaware (11.4).

In 2017, the CDC published Preventing Suicide: A Technical Package of Policy, Programs, and Practices. This compilation of a core set of strategies to suicide prevention assists states in prioritizing prevention activities on best available evidence. The Technical Package identifies 7 main strategies supported by approaches or specific ways to advance the strategy. The CDC notes the Technical Package includes strategies to address this public health issue where states may serve as the leaders and collaborators but leadership and commitment from a variety of sectors are vital to the implementation of initiatives.

Preventing Suicide

Strategy	Approach
Strengthen economic supports	• Strengthen household financial security • Housing stabilization policies
Strengthen access and delivery of suicide care	• Coverage of mental health conditions in health insurance policies • Reduce provider shortages in underserved areas • Safer suicide care through systems change
Create protective environments	• Reduce access to lethal means among persons at risk of suicide • Organizational policies and culture • Community-based policies to reduce excessive alcohol use
Promote connectedness	• Peer norm programs • Community engagement activities
Teach coping and problem-solving skills	• Social-emotional learning programs • Parenting skill and family relationship programs
Identify and support people at risk	• Gatekeeper training • Crisis intervention • Treatment for people at risk of suicide • Treatment to prevent re-attempts
Lessen harms and prevent future risk	• Postvention • Safe reporting and messaging about suicide

Various factors may increase an individual's risk for suicide or may indirectly increase risk by exacerbating related physical and mental health problems. Evidence suggests strengthening economic supports as an opportunity to reduce suicide risk. The CDC identifies a focus on household financial security and stability in housing as an economic support for individuals and families and includes home improvement loans and grants as a Health Impact in 5 Years (HI-5) strategy. Public health programs can be leveraged to help promote financial opportunities to help lessen financial stressors for individuals and family units.

Also related to economic supports, the CDC identifies the Earned Income Tax Credit (EITC) as a HI-5 strategy to improve the health of working people by increasing their income.

Practices from Other States:

Illinois' Housing Development Authority led the Illinois Housing Task Force, which recommended the development of an action plan to improve permanent supportive housing in the 2017 Supportive Housing Working Group report on activities and recommendations. Recommended strategies were developed after completing a current inventory of permanent supportive housing for the entire state and defining unmet need.

Maryland's Department of Housing and Community Development administers the EmPOWER Low Income Energy Efficiency Program. This program assists eligible low-income households with installation of materials and equipment at no charge. The program may provide home improvements including insulation, hot water system improvements, lighting retrofits, furnace cleaning and repairs, and health and safety items.

Minnesota's Housing Finance Agency administers a Rehabilitation Loan/Emergency and Accessibility Loan Program. The program assists low-income homeowners with financing of basic home improvements specifically affecting safety, habitability, energy efficiency or accessibility. Eligible individuals may seek assistance to address lead paint hazards, electrical wiring, plumbing repairs, and other improvements with a maximum loan amount of $27,000.

Federal programs may also assist homeowners with housing improvements. The U.S. Department of Agriculture's Single Family Housing Repair Loans & Grants program, also known as Section 504 Home Repair program, provides loans for repairs, improvements, and modernization of homes or removal of health and safety hazards or grants for removal of health and safety hazards. Eligible individuals may receive loans up to $20,000 or grants up to $7,500. The U.S. Department of Housing and Urban Development's Rehabilitation Mortgage Insurance program, or 203(K) Mortgage, provides homeowners financing up to $35,000 into their mortgage to repair, improve, or upgrade their home.

Impact:

Improvements to housing conditions and homes addressing warmth and energy efficiency are strongly associated with health benefits, particularly in general, mental, and respiratory health[i]. Housing improvements may also lead to reductions in school and work absenteeism.

Arizona Current State & Recommendations:

The Arizona Department of Housing (ADOH) provides the Weatherization Program for eligible families to make improvements for energy efficiency while improving the health and safety of the home's occupants. Since the program initiated in 1977, more than 26,000 of Arizona's

households have received weatherization assistance. ADOH has also been piloting a program focusing on eviction prevention in certain zip codes with high numbers of evictions.

The Suicide Prevention Action Plan includes increased awareness and messaging to individuals who may be eligible for the Earned Income Tax Credit (EITC) as a means to strengthen economic supports. For Arizona, the IRS estimated 559,000 EITC claims for a total of $1.4B in 2018 for an average amount of $2,593. An estimated 23.3% of eligible individuals did not claim the benefit in Arizona in tax year 2016.

Strengthening access and delivery of care can be critical to individuals experiencing a need for mental health services. Addressing lack of access to mental health care includes support for health and behavioral health care systems. Approaches identified by the Technical Package include coverage of mental health conditions in health insurance policies, reducing provider shortages in underserved areas, and safer suicide care through systems change.

Insurance Parity

The Community Preventive Services Task Force (CPSTF) recommends comprehensive mental health parity legislation with evidence in improving financial protection and increasing appropriate utilization of mental health services for individuals at need. The CPSTF identifies evidence that this legislation is associated with increased access to care, increased diagnosis of mental health conditions, reduced prevalence of poor mental health and reduced suicide rates. At the federal level, the 1996 Mental Health Parity Act, the 2008 Mental Health Parity and the Affordable Care Act include parity requirements.

Practices from Other States:

State and federal parity laws include cover a continuum of benefits ranging from specific mental health conditions to comprehensive parity covering a broad range of mental health conditions. During the CPSTF's review, 49 states and the District of Columbia had enacted some type of mandate legislation.

A 2018 report by The Kennedy Forum titled "Evaluating State Mental Health and Addiction Parity Statutes: A Technical Report" completed a review to examine how states enact strong parity statutes to fulfill the intent of the Federal Parity Law. The report developed a Statutory Coding Instrument (SCI) to provide a quantitative, comparative assessment of state parity statutes. States with the highest grades included Illinois, Tennessee, Main, Alabama, Virginia, and New Hampshire.

The report highlighted states for their promising practices including California's Department of Managed Health Care's in-depth prospective compliance review with specific worksheets for plans to complete. Montana's Commissioner of Securities and Insurance provided state plans additional guidance detailing potential violations as example "red flags." New York Attorney General's Office leveraged regulatory enforcement through fines and reached settlements with numerous insurers after conducting investigations into their behavioral health claims practices. These investigations found nearly half of denials to be overturned on appeal. Oregon's Department of Consumer and Business Services issued regulations with greater specificity than the federal rule. Pennsylvania's Insurance Department published a comprehensive consumer guide to behavioral health with resources for individuals seeking further assistance. The Texas Department of Insurance published a report comparing data on how plans covered mental health and substance use disorder versus medical and surgical care to increase transparency on metrics related to parity.

The RI State Mental Health Parity Law is similar to the federal law in requiring parity of benefits for behavioral health/substance use disorder (BH/SUD) and medical and surgical care. In addition, the state law also requires plans to cover BH/SUD benefits, including medication assisted therapy (MAT), prohibits annual or lifetime dollar limits for BH/SUD benefits, when reviewing SUD medical necessity, and requires plans to rely on criteria developed by the American Society for Addiction Medicine (ASAM). The State law can be found at in the RI General Laws at Title 27, Chapter 38.2.

Massachusetts: The original Massachusetts mental health parity law (MMHPL), was drafted in during the 1999–2000 legislative session and has been updated over the years. The law requires health plans to cover on a nondiscriminatory basis "biologically based mental disorders" that are described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. A health plan could not impose more stringent limits on the listed behavioral health services than it did for coverage for medical treatments. Annual or lifetime dollar or unit-of-service limitations were also prohibited. Finally, the state Mental Health Parity Law included a separate provision applying solely to children and adolescents under the age of 19, for whom carriers were directed to cover, on a nondiscriminatory basis, non-biologically based mental, behavioral or emotional disorders described in the DSM that substantially interfere with or substantially limit their functioning and social interactions.

Maryland's parity law mandates coverage for mental health/substance use disorder (MH/SUD) treatment, including outpatient treatment, partial hospitalization and inpatient treatment. In Maryland, large group health plans that are sold on the commercial market must provide MH/SUD treatment and must comply with the federal Parity Act. Individual policies and small group plans, other than self-insured small group plans and grandfathered small group plans, must comply with the Parity Act.

Enacted in 2000, Connecticut's law requires all individual and group health insurance policies covering hospital, medical-surgical, major medical and HMO coverage to provide mental health benefits.

Illinois' parity law (Public Act 99-480), was enacted in 2015 to advance parity implementation and expand on the Federal law. Illinois law goes beyond Federal parity by extending applicability to more plans and by requiring certain mental health and substance use disorder benefits for certain plans. To help consumers, health providers and health plans better understand parity and Illinois law, the law required the Illinois Department of Insurance to develop a plan for Consumer Education Campaign on mental health and addiction parity, which must include live training events, establish a consumer hotline to assist consumers in navigating the parity process, and issue a report to the General Assembly on the success of the Consumer Education Campaign. The law clarifies enforcement authority and includes an interagency workgroup to collaboratively address issues related to behavioral health treatment and access and reinforces insured appeal rights.

Delaware's law requires each health insurer offering group health insurance coverage that provides mental illness and drug and alcohol dependencies benefits to submit a report with specific reporting requirements to the Delaware Health Information Network and Commissioner.

Impact:

The CPSTF's review found in states that passed parity laws during the study period, there was a 3.2% decrease in the proportion of people with poor mental health and in state with parity laws, a 2.8% lower proportion of people with poor mental health compared to people in states without parity laws. Mental health parity is related to 4 Healthy People 2020 objectives related to access to health services and mental health and mental disorders.

Arizona Current State & Recommendations:

On March 3, 2020, Senate Bill 1523, also known as Jake's Law, was signed by Governor Ducey to require health care insurers to cover mental health without additional barriers. It additional establishes a mental health parity advisory committee and prohibits insurance companies from denying coverage for services covered by the plan delivered in an educational setting.

Zero Suicide

The Zero Suicide approach is a framework for system-wide, organizational commitment to safer suicide care in health and behavioral health care systems. Essential elements of the Zero Suicide approach include 1) Lead system-wide culture change committed to reducing suicides, 2) Train a competent, confident, and caring workforce, 3) Identify individuals with suicide risk via comprehensive screening and assessment, 4) Engage all individuals at-risk of suicide using a suicide care management plan, 5) Treat suicidal thoughts and behaviors using evidence-based treatments, 6) Transition individuals through care with warm hand-offs and supportive contacts, and 7) Improve policies and procedures through continuous quality improvement. Zero Suicide has been implemented in a variety of states and a variety of settings ranging from health care systems to private organizations.

Practices from Other States:

New York's prevention strategy in health and behavioral healthcare settings includes the implementation of Zero Suicide.

Figure 6- Strategy 1 Guiding Principles

Prevention in Health and Behavior Healthcare Settings–Implementation of Zero Suicide	
	1a. Start with the public mental health system, beginning with outpatient clinic care
	1b. Invest in trainings that utilize the latest clinical knowledge
	1c. Target culture change to move the system towards population-based, preventive engagement
	1d. Provide a clear definition for "suicide safer care"
	1e. Integrate lived experience into policy and planning
	1f. Capitalize on opportunities to broaden Zero Suicide beyond the public mental health system through government and private sector alliances.

Massachusetts' State Plan promotes the adoption of "zero suicide" as an aspirational goal by health care and community support systems that provide services and support the defined patient populations. The strategy includes educating the health care systems on the concept and dimensions of "zero suicide", establishing a suicide prevention task force among state agencies to address the goal of reducing suicides and suicide attempts, and working with community support systems including state agencies that serve high risk populations to adopt a "zero suicide" policy. The Massachusetts Adult Suicide Prevention Program (MASSP) has a goal to create two Community Systems of Care (CSOC) integrating health, behavioral health, and suicide crisis services for the goal of Zero Suicide.

The Connecticut Suicide Advisory Board's (CTSAB) 1 Word, 1 Voice, 1 Life campaign includes a "Zero Suicide" message including the CT Zero Suicide Initiative. In 2018, 13 health and behavioral health care organizations were selected to attend the Zero Suicide Academy, a 2-day training for senior leaders of health and behavioral health care organizations.

In Texas, Zero Suicide work is supported in health and behavioral healthcare agencies as funding allows. The state plan seeks to educate providers of health care and community support systems about adopting Zero Suicide as an aspirational goal, and promote the use of tools, resources and research on the Texas Zero Suicide Toolkit and website. The Zero Suicide in Texas (ZEST) toolkit provides guidance and support to community behavioral health centers in Texas to implement the zero suicide framework. The toolkit outlines goals for each core component and provides tools and resources to guide implementation activities.

The Chickasaw Nation Departments of Health and Family Services began Zero Suicide implementation in September 2016, first starting in the emergency department (ED) and soon after expanding to all clinical settings. It is estimated the implementation has led to, on average, 200 diversions from admission treatment per year.

Impact:

The pre-cursor to Zero Suicide, Perfect Depression Care, set a goal to eliminate suicide among HMO members of the Henry Ford Health System. Through the program, each patient was screened and assessed for suicide risk and coordinated continuous follow-up was implemented system-wide. During the time period of the program, suicide rates among members fell by 82%.

Arizona Current State & Recommendations:

Within Arizona, various entities are implementing Zero Suicide models or approaches to their organizations; however, a list of these entities does not currently exist. The AZ Suicide Prevention Action Plan sets out a recommendation to implement a Zero Suicide Task Force with the goal to identify resource needs and provide recommendations for statewide adoption.

Create Protective Environments

The Technical Package suggests three potential approaches to create environments that protect against suicide including reducing access to lethal means among persons at risk of suicide, setting organizational policies and culture to promote these environments, and implementing community-based policies to reduce excessive alcohol use.

Practices from Other States:

In Colorado, a children's hospital emergency department implemented a protocol with an aim to improve the quality of lethal means counseling for parents of pediatric patients discharged after a psychiatric assessment that addressed concerns about suicidal ideation or behavior (ED CALM)[ii]. Study results of this protocol found families were receptive to discharge counseling and free lock boxes for medication or firearms and post-tests reported improvements in use of safe storage. The Suicide Prevention Resource Center (SPRC) provides a free, online Counseling Access to Lethal Means (CALM) training which covers who needs lethal means counseling and how to work with those at risk for suicide and their families. Project ChildSafe, a program of the National Shooting Sports Foundation, promotes firearm safety and education with connections to local law enforcement agencies for safety kits.

Promotion of help seeking behavior in the workplace has been implemented in settings such as the United States Air Force Suicide Prevention Program. The Program included policy and education initiatives and engaged leaders in culture changes. The program was associated with a 33% relative risk reduction in suicide[iii].

Connecticut collaborated with National Shooting Sports Foundation to develop CT-specific materials; Mailed all shops new materials and training resources; Working with CT Poison Control Center to expand poison prevention efforts based on their suicide attempt data; Host a Data and Surveillance Committee under the CT Suicide Advisory Board and use CTVDRS, hospital and other data sources to guide efforts; Through Zero Suicide efforts, promote to health and behavioral health care systems the use and importance of counseling access to lethal means, and the use of the Columbia Suicide Severity Rating Scale and Safety Planning tool.

Delaware started to provide training in lethal means counseling at various venues throughout the state.

Maryland's Suicide Prevention and Early Intervention Network (SPIN) created a fact sheet for messaging on means safety and suicide prevention. The resource provides information for families, peers and friends, law enforcement, and colleges and universities.

Massachusetts created posters for posting in all stores that sell guns.

In Rhode Island, the Providence VA Suicide Prevention program distributed gun locks through children's hospital emergency room. The Rhode Island American Foundation for Suicide Prevention (AFSP) chapter held Out of the Darkness Community Walks where locks are distributed to event attendees with information from the Suicideproof.org website.

Impact:

There is evidence to support safe storage of medications, firearms, and other household products to reduce the risk for suicide.

Arizona Current State & Recommendations:

In 2018, firearm (55.9%), strangulation/hanging (26.2%), and poisoning by drugs (10.6%) were the most common mechanisms of suicide in Arizona.

Suicidality, along with chronic pain and substance use, involve an underlying theme as diseases of despair. The previous Surgeon General has a platform discussing the Loneliness Epidemic and its impact to one's health. Evidence suggests there is a significant increased risk for premature mortality associated with social isolation and loneliness. Strong social connections and relationships are identified as protective factors and an important public health strategy. The Technical Package includes two approaches for the promotion of connectedness including peer norm programs and community engagement activities.

Practices from Other States:

California passed legislation in 2018 to establish the first voluntary mental health standards for the workplace in the U.S. to help combat stigma and encourage discussion of mental health in the workplace.

Illinois' Suicide Prevention Strategic Plan includes a goal to increase awareness of policies and programs to foster social connectedness, especially those focused on reaching groups that may be the most isolated or marginalized by 2020. The state identifies the potential strategies of promoting connectedness between individuals and recognizing the importance of received or perceived social support, close and supportive interpersonal relationships, and the benefit of social integration.

Sources of Strength, a strength-based comprehensive wellness program that focuses on suicide prevention but impacts other issues such as substance abuse and violence, uses teams of peer leaders mentored by adult supervisors to change peer social norms about help seeking. The program has been implemented in a variety of urban, rural, and tribal settings nationwide.

CareMore Health's Togetherness Program aims to combat the epidemic of loneliness among seniors through weekly phone calls, home visits, and community programs for Medicare patients.

Impact:

There is evidence to suggest benefits of peer norm and community engagement activities to protect against suicidal behavior; however, it has been evaluated if this also translates into reduced suicide attempts and deaths.

Arizona Current State & Recommendations:

Stress on social connection and interpersonal relationships to better one's health is alluded to in several current public health campaigns and initiatives, including the ASHLine, The Arizona Pain and Addiction Curriculum, the youth opioid prevention campaign and the chronic pain campaign.

Teaching Coping & Problem-Solving Skills

The Technical Package identifies social-emotional learning programs as well as parenting skill and family relationship programs as approaches to teach coping and problem-solving skills. These skills are an important developmental component to suicide prevention to help individuals adapt to stressors in life.

Practices from Other States:

The PAX Good Behavior Game is a classroom-based, evidence-based preventive intervention applied by teachers as part of their daily management of their classroom. This intervention adheres to SAMHSA's key principles of trauma-informed approach and is recommended by the Institute of Medicine. PAX GBG provides opportunities for student teamwork, collaboration, and group rewards for their collective efforts. PAX GBG uses research-based strategies to arrange for both peer reinforcement for exhibiting prosocial behavior as well as peer reinforcement for inhibiting problematic behavior. PAX GBG evolved from the original Good Behavior Game developed in the 1960s.

Community-based setting programs to provide parenting and family skills training such as the Incredible Years (IY) and Strengthening Families 10 – 14 programs have shown impacts in preventing risk factors associated with suicide.

Evidence-based programs supported by the Health Resources & Services Administration (HRSA) Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) support parenting skills to encourage positive parenting and improve maternal and child health.

Impact:

Coping and problem-solving skill training has been shown to improve resilience and reduce problem behavior and risk factors for behaviors related to suicide.

Arizona Current State & Recommendations:

In 2019, the Arizona Department of Education (ADE) and the Arizona Health Care Cost Containment System (AHCCCS) announced a partnership to offer PAX GBG materials and trainings to school districts throughout the state paid for using federal opioid prevention funds. Through this initiative, Arizona estimates approximately 1,600 classrooms will implement PAX GBG in 2020 statewide.

The Technical Package identifies vulnerable populations who experience suicidal behavior at higher rates which may include individuals with lower socio-economic status, individuals living with a mental health problem, individuals who have previously attempted suicide, veterans and active duty military personnel, and members of certain racial and ethnic minority groups. Approaches to focus on vulnerable populations include identifying at risk individuals and ensuring services are tailored to their needs and easily accessible.

Practices from Other States:

Gatekeepers, defined as individuals in the community who have face-to-face contact with large numbers of community members, are a key group for prevention training to identify persons at risk of suicide and refer to treatment and support services. Some examples may include clergy, first responders, pharmacists, caregivers, and employees of schools, prisons, and the military.

Connecticut sets suicide prevention programming and training as a central focus of efforts by the CTSAB and member agencies to offer QPR Training, QPR Training of Trainers, ASIST, as well as other similar training.

Delaware set a goal to increase the number of clergy who received gatekeeper training in identifying and responding to suicide risk and behaviors using Applied Suicide Intervention Skills Training (ASIST), Question Persuade Refer (QPR) Training, and other similar trainings.

In Illinois, gatekeeper trainings where set as an objective to implement in settings where first responders are likely to be found. The state also expanded this training to include relatives, friends, neighbors, and members of the faith community.

In Massachusetts, training for gatekeepers and elder service support staff was made available for suicide prevention and education.

Crisis intervention approaches include support and referral services via telephone hotline, online, chat, text, or in-person connections.

The National Suicide Prevention Lifeline provides 24/7, free support for individuals in distress and serves as a network of local crisis centers. The network provides options of phone call, web-based chat, Spanish phone call, and options for the deaf and hard of hearing.

The Trevor Lifeline is the only national 24/7 crisis intervention and suicide prevention lifeline for LGBTQ young people under the age of 25. The Trevor Project provides lifeline number, chat, and text options.

The Crisis Text Line is a national free, 24/7 text support for individuals in crisis to text with a trained Crisis Counselor.

In California, MY3 is available for individuals who may be having thoughts of suicide, or who have a history of suicidal behavior. The service, created in partnership with the California Mental Health Services Authority and was funded by the California Mental Health Services Act, is designed to help these individuals stay safe when they are experiencing thoughts of suicide. The strategies found in the customized safety plan can be used before or during a suicidal crisis.

Maryland's Helpline was a focus of the state's plan to enhance the use and capacity of suicide prevention hotlines. The helpline is connected to Maryland's 2-1-1 resource.

New Jersey supports a 24/7 Mobile Response and Stabilization Service to help children and youth experiencing emotional and behavioral crises. The NJ Hopeline is a service available to callers for confidential support, assessment, and referral, and includes web-based crisis chat and texting capabilities.

Impact:

Evidence suggests identifying people at risk of suicide and providing support can positively impact suicide. Crisis intervention may put time between an individual who may be considering suicide and harmful behavior.

Arizona Current State & Recommendations:

The Crisis Response Network (CRN) provides crisis call center services for central and northern Arizona. In addition to the 24-hour peer-run warm line, they provide serious mental illness (SMI) determinations, mobile team dispatches, crisis transportation services, emergency room-based assessments, Department of Child Safety (DCS) rapid response and crisis stabilization services.

The Be Connected program is a statewide program in Arizona with three aspects: 1) Call – a support line that anyone can call, 2) Match – help and support to navigate to the right resources, and 3) Learn – training to equip individuals with knowledge and skills to assist. Be Connected was implemented to support the military and veteran population by connecting service members, veterans and their families to support and resources.

The Technical Package identifies the need for specific care and attention to bereaved individuals who have lost a friend, peer, family member, co-worker, or other close contact to suicide. Approaches to lessen harms and prevent future risks include postvention and safe reporting and messaging about suicide.

Practices from Other States:

Postvention is an intervention that happens after a suicide to provide support for the bereaved and may include debriefing sessions, counseling, support groups. While not yet evaluated for impact on future suicide, they may reduce survivor's guilt, feelings of depression, and complicated grief.

In New York, coalitions are being encouraged to develop community postvention teams to expand their postvention response capacity with teams reflective of local circumstances and conditions while maintaining a consistent structure and set of principles.

In Texas, the approach is to inform communities and school districts about support for postvention including how to address suicide clusters and contagion through the local mental health authority suicide prevention coordinator, local suicide prevention coalitions, the state suicide prevention coordinator, and the ad hoc state postvention advisory group of The Texas Department of State Health Services. The Texas Suicide Prevention Council developed "Coming Together to Care: A Suicide Prevention and Postvention Toolkit for Texas Communities."

The Maryland Suicide Prevention Program recently made available "Postvention Resources in Maryland: Resources for after a suicide-loss" with local county resources as well as statewide resources and toolkits.

Communication to the public, specifically from the media, can inadvertently heighten the risk of suicide among vulnerable individuals and contribute to suicide contagion.

The Recommendations for Reporting on Suicide, developed in collaboration by a variety of suicide prevention partners provide the public with important points for covering suicide, language to avoid, a checklist for responsible reporting, and suggestions for media, message boards, bloggers, and citizen journalists.

Impact:

Evidence suggests postvention can impact risk and protective factors for suicide, particularly for active postvention approaches in which outreach to survivors occurs at the scene of a suicide. Active postvention is associated with intake into treatment sooner and greater attendance at support group meetings compared to passive postvention.

There is also evidence to support changes in the quality and quantity of media reporting reducing suicides through the use of the Recommendations for Reporting on Suicide.

Arizona Current State & Recommendations:

In Arizona, La Frontera / EMPACT-Suicide Prevention Center (SPC) is a leader in postvention through Survivors of Suicide (SOS) support groups and individual therapy as well as through the Local Outreach to Suicide Survivors (LOSS) program which provides immediate support to family and friends after a suicide occurs.

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[ii] Runyan CW, Becker A, Brandspigel S, Barber C, Trudeau A, Novins D, Lethal means counseling for parents of youth seeking emergency care for suicidality. *West J Emerg Med*. 2016; 17(1):8-14.
[iii] Knox KL, Litts DA, Talcott GW, Feig JC, Caine ED. Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: cohort study. *BMJ*. 2003;327(7428):1376. doi:10.1136/bmj.327.7428.1376