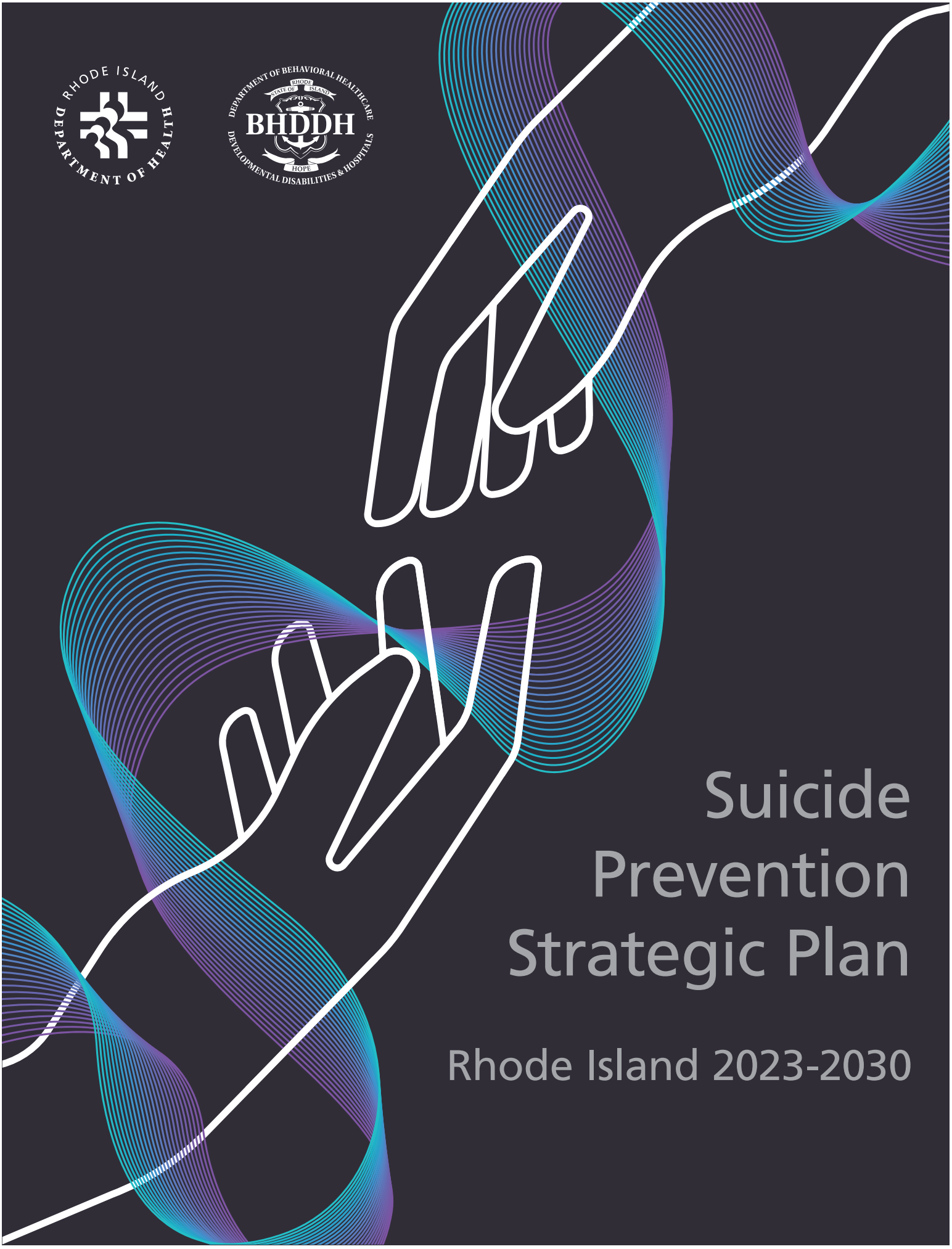

# Suicide Prevention Strategic Plan

## Rhode Island 2023-2030

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# INTRODUCTION

Each year, about 120 Rhode Islanders die by suicide. Many people in Rhode Island have experienced suicide loss. And for many of us, understanding suicide or how we can prevent it can be difficult.

Suicide is a complex problem. Suicidal feelings and thoughts are not caused by just one thing, such as a mental health condition. A mental health condition can be a risk factor (something that increases the chance that a person may attempt suicide), but most people with a mental health condition will never attempt suicide. Many things can cause someone to attempt suicide, and each person's situation is unique.

There is not one simple or easy solution to prevent suicide. But it is possible to prevent suicide — to stop suicides before they happen. To do so, we need to reduce risks and increase protective factors (things that reduce the chance that a person may attempt suicide) for everyone in our State.

Everyone can help prevent suicide. Partnering across sectors to leverage expertise and implementing multiple strategies and approaches 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.

The strategies in the Rhode Island Suicide Prevention Plan 2023-2030 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.  It was shaped by the voices of people on the front lines of our mental health and crisis systems and providers serving people at higher risk for suicide. Approximately 50 professionals with direct experience participated in interviews or focus groups that explored their ideas of how the state can improve its suicide prevention efforts. Their recommendations have been aligned with the Centers for Disease Control and Prevention (CDC) Suicide Prevention Framework, a group of overarching 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. We have contextualized these strategies with local experience to prioritize prevention activities.

The development of the Rhode Island 2023-2030 Suicide Prevention Strategic Plan was supported by the Substance Abuse and Mental Health Services Administration Community Mental Health Services COVID-19 Block Grant Supplemental funding. The grant was awarded to the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals, and the work was completed through a memorandum of understanding with the Rhode Island Department of Health. Activities implemented under this plan will be coordinated with related statewide and community-based efforts to support behavioral health.

Thank you to all of the stakeholders that made time to talk with us and also all of the community partners who are doing valuable work to improve mental well-being and reduce suicides in Rhode Island.

# RHODE ISLAND SUICIDE DATA

Rhode Island has one of the lowest rates of suicide deaths per 100,000 population in the country. The state is ranked 43rd of 50 in the nation in suicide deaths per 100,000 population and ranked second lowest in New England.[1] Overall, suicide was the 11th leading cause of death among Rhode Island residents during 2011-2020 and a leading (top 10) cause of death for those between 10-64 years old (Table 1). Specifically, suicide was the second leading cause of death for those aged 10-34 years and the fourth leading cause of death for those 35-44 years old.[2]

The Rhode Island 2023-2030 Suicide Prevention Plan was written using the most up-to-date data available at the time of writing. Please visit PreventSuicideRI.org to view any data that have become available since the publication of this document.

**TABLE 1:**
**10 Leading Causes of Death, Rhode Island, 2011-2020**

| Ranking | 10-34 years | 35-44 years | 45-54 years | 55-64 years |
|---|---|---|---|---|
| 1 | Accidents (unintentional injuries) | Accidents (unintentional injuries) | Cancerous tumors | Cancerous tumors |
| 2 | Intentional self-harm (Suicide) | Cancerous tumors | Accidents (unintentional injuries) | Heart diseases |
| 3 | Assault (Homicide) | Heart diseases | Heart diseases | Accidents (unintentional injuries) |
| 4 | Cancerous tumors | Intentional self-harm (Suicide) | Chronic liver disease and cirrhosis | Chronic lower respiratory diseases |
| 5 | Heart diseases | Chronic liver disease and cirrhosis | Intentional self-harm (Suicide) | Chronic liver disease and cirrhosis |
| 6 | Congenital malformations (diseases present at birth) | Assault (Homicide) | Diabetes | Diabetes |
| 7 | Chronic liver disease and cirrhosis | Cerebrovascular diseases (such as stroke and brain bleeding) | Cerebrovascular diseases (such as stroke and brain bleeding) | Cerebrovascular diseases (such as stroke and brain bleeding) |
| 8 | Diabetes | Diabetes | Chronic lower respiratory diseases | Intentional self-harm (Suicide) |
| 9 | Cerebrovascular diseases (such as stroke and brain bleeding) | Influenza and pneumonia | Septicemia | Septicemia |
| 10 | Influenza and pneumonia | Septicemia | Viral hepatitis | Influenza and pneumonia |

**Data Source:** Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999-2020.

**Note:** Some categories have been edited for plain language.

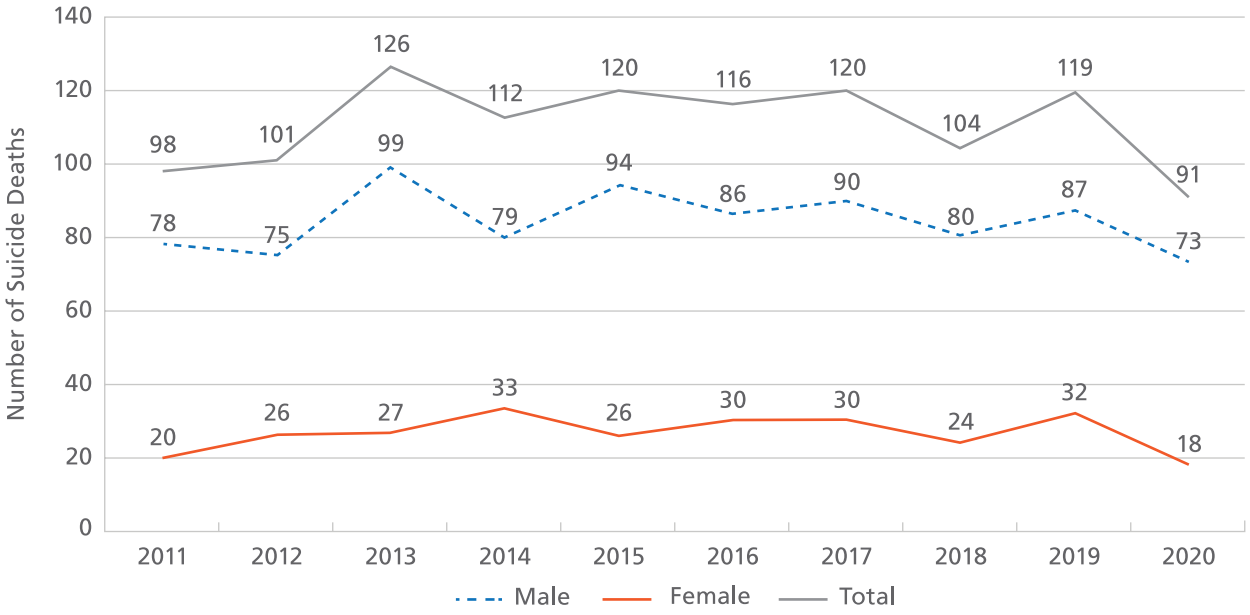
## Deaths by suicide

From 2011 through 2020, suicide accounted for the deaths of 1,107 residents[3] and cost the state over $169 million in lifetime medical and work loss costs, or $1.3 million per death by suicide.[4] During this period, the rate of deaths by suicide has remained relatively stable at 10.5 deaths per 100,000 population, rising slightly to 11.3 in 2019 and dropping to 8.7 in 2020 (18% fewer compared to the 2011-2020 average) during the pandemic. However, 2021 data show that counts have returned to similar levels observed pre-pandemic.[5]

Suicide rates vary by age, race/ethnicity, and other sociodemographic characteristics. Adults who died by suicide were more likely to be 35–64 years old, male, and non-Hispanic White:

- Overall, more males die by suicide than females in Rhode Island (Figure 1). The rate of suicide deaths among males in Rhode Island for 2011-2020 was about 3.38 times higher than for females. Males comprise more than 75% of suicide deaths and represent 50% of the population.
- Suicide deaths also disproportionately occur among individuals ages 25-64, and less frequently among individuals older than 65 and younger than 25. Among people ages 25-64, the rate of suicide death is highest among people ages 45-54 (18.36 per 100,000) and 55-64 (16.39 per 100,000).
- Among people aged 65+, males are more likely to die by suicide than females, while among people 45-54, females have a greater proportion of suicide deaths.
- White, non-Hispanic males represent 74% of the Rhode Island population older than ten years old and 88% of suicide deaths. In 2020, this same trend was observed; however, the percentage of deaths among White, non-Hispanic males was slightly lower at 82%.

**FIGURE 1:**
**Suicide Deaths in Rhode Island by Sex, 2011-2020**




**Data Source:** Rhode Island Violent Death Reporting System (RIVDRS), 2011-2020, Suicide deaths that occurred in Rhode Island among Rhode Island residents.

In addition, national data show that some other population groups disproportionately impacted by higher-than-average suicide rates include Veterans, workers in certain industries and occupations,[6] tribal populations, people who identify as LGBTQ+, people with prior incarcerations, and people experiencing certain risk factors, such as but not limited to:

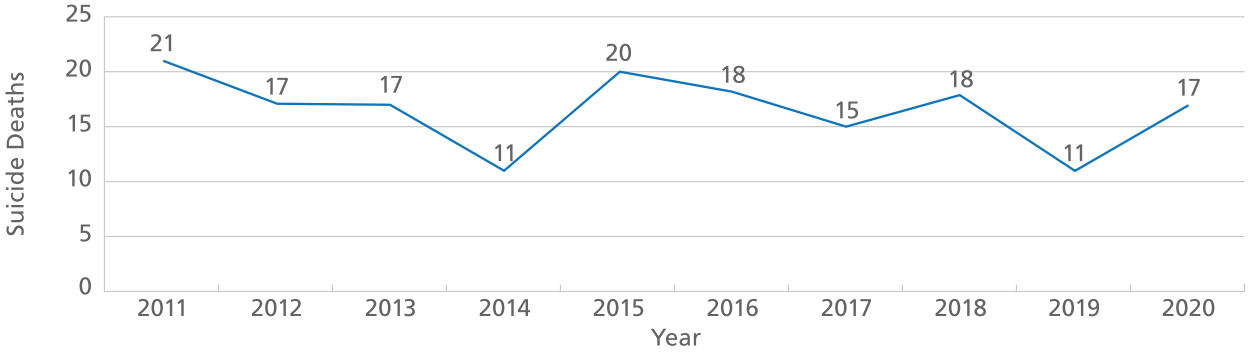
- **Individual risk factors:** Previous suicide attempt, history of depression and/or other mental illnesses, serious illness such as chronic pain, criminal/legal problems, job/financial problems or loss, gambling addiction, impulsive or aggressive tendencies, substance misuse, current or prior history 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, the stress of assimilating to a new culture, 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.[7]

Transition periods are also associated with a higher risk of suicide. This includes transitions from work into retirement, from active-duty military to civilian status, from high school to college, and between levels of healthcare, such as from an inpatient psychiatric hospitalization to outpatient care. Due to the small number of deaths by suicide in Rhode Island, it is difficult to analyze and interpret mortality data for some of these groups and risk factors in a reliable way.

## Veterans, military members,[8] and first responders

From 2011 through 2020, 15% (165) of deaths by suicide were among Veteran/military members (approximately 11-21 deaths each year). Compared to the Rhode Island population who died by suicide, Veterans/miliary personnel who died by suicide were more likely to be male (98% compared to 76%), older (67% 55 years and older compared to 37%) and die by firearm (49% compared to 25%). For the same time period, suicide accounted for 16 deaths (1%) among law enforcement and firefighters.

**FIGURE 2:**
**Rhode Island Veteran/Military Suicide Deaths by Year, 2011-2020**




**Data Source:** Rhode Island Violent Death Reporting System (RIVDRS), 2011-2020, Suicide deaths that occurred in Rhode Island among Rhode Island residents.

## Suburban residents

From 2011 through 2020, 55.5% (614) of deaths by suicide were among Providence County residents (Table 2). However, suburban regions (Bristol, Kent, Newport, and Washington County) had higher rates of deaths by suicide compared to other areas of the state.

**TABLE 2:**
**Rates of Suicide Death by County, 2011-2020 Combined**

| County | Rate per 100,000 |
|---|---|
| Bristol County | 12.2 |
| Washington County | 11.8 |
| Kent County | 11.4 |
| Newport County | 11.0 |
| Providence County | 9.8 |

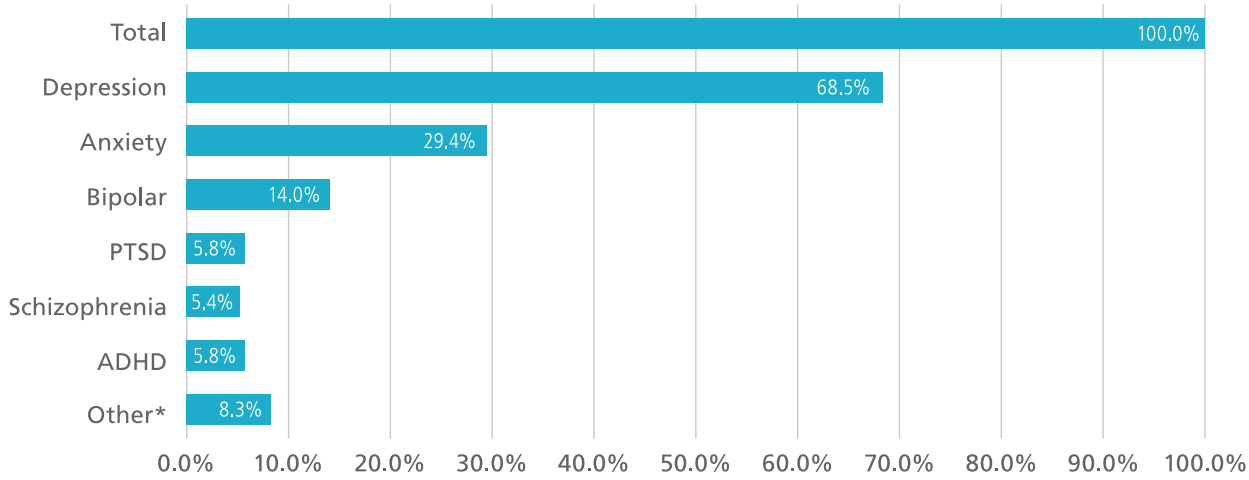
Data Source: Rhode Island Violent Death Reporting System (RIVDRS), 2011-2020, Suicide deaths that occurred in Rhode Island among Rhode Island residents.

## Precipitating events and risk factors

Twenty-two percent (239) of Rhode Islanders who died by suicide had a known alcohol problem, and 175 had another (non-alcohol) substance use disorder (16.4%). One percent (12) had a known addiction other than alcohol or another substance misuse. Nearly 60% of Rhode Islanders who died by suicide had a current known mental health problem, and 51.4% were known to be receiving current treatment.[9] Of those with known mental health problems, 435 were diagnosed with depression (68.5%), 187 were diagnosed with anxiety (29.4%), 89 were diagnosed with bipolar disorder (14.0%), 5.8% were diagnosed with post-traumatic stress disorder (PTSD), 5.8% were diagnosed with attention-deficit/hyperactivity disorder (ADHD), and 5.4% were diagnosed with schizophrenia.

**FIGURE 3:**

**Mental Health Diagnoses Among 635 Rhode Island Suicide Deaths with a Known Mental Health Problem, 2011-2020**




**Data Source:** Rhode Island Violent Death Reporting System (RIVDRS), 2011-2020, Suicide deaths that occurred in Rhode Island among Rhode Island residents.

The most common precipitating events were a current known behavioral health problem, a past suicide attempt, a known intimate partner problem, a crisis reported within two weeks before death, a medical problem, a family relationship problem, a job problem, a recent criminal legal problem, and a financial problem, including known recent eviction or loss of income.

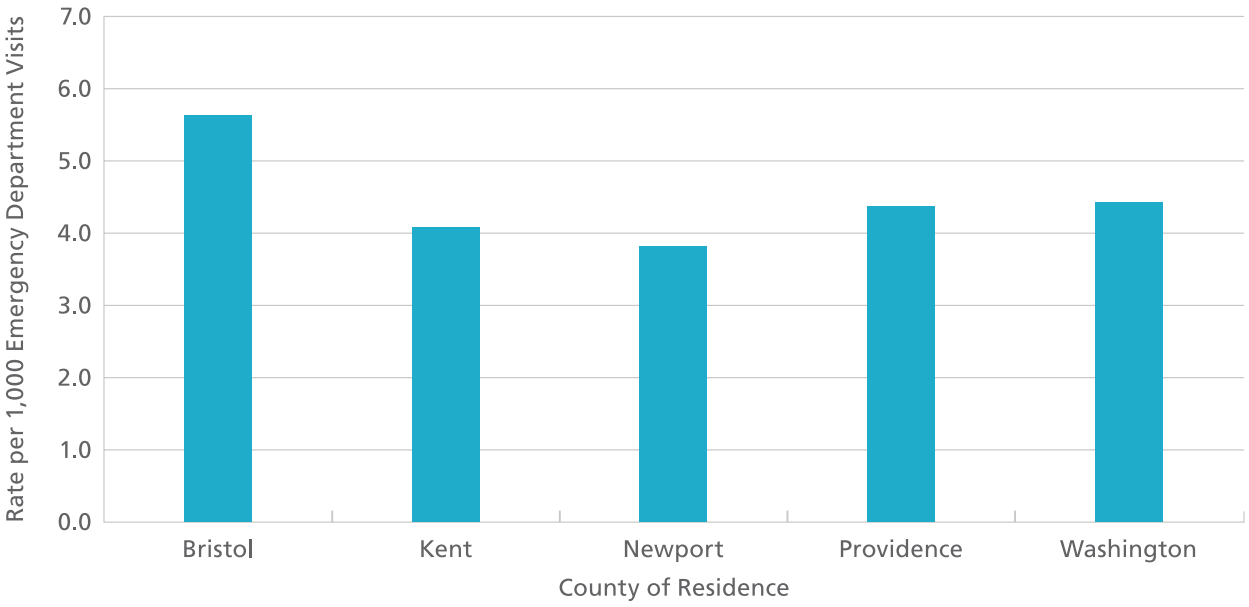
In addition, access to lethal means is associated with increased suicide risk.[10] Firearms are Rhode Island's second most common injury mechanism, followed by poisoning. In addition, mortality data show that 48 suicide deaths were bridge-related between 2011-2020. Most of these deaths occurred in Newport County (n=27), followed by Bristol County (n=10).[11]

## Suicide attempts

Suicide deaths reflect only a portion of the problem. In Rhode Island, the percentage of adults reporting serious thoughts of suicide is 4.59 (38,000 people). The number of adults in Rhode Island experiencing suicidal ideation has slightly increased each year since 2015.[12] This increase is not reflected in hospital admissions related to suicide attempts/intentional self-harm, which remained relatively constant from 2017-2021 with one exception: 10-34-year-old females. Specifically for females, the rate of visits related to suicide attempts/intentional self-harm increased by 32%, from 7.8 per 1,000 in 2017 to 10.3 per 1,000 in 2021 (a statistically significant increase). Overall, during this period, a total of 7,817 emergency department (ED) visits and 4,888 hospital admissions related to intentional self-harm/suicide attempts were identified.[13] While most suicide deaths are among males between the ages of 45 and 64, 60% of ED visits and hospitalizations relating to intentional self-harm/suicide attempts are among females, and are more likely to occur among younger age groups (10-34). Also, while most deaths and ED visits/hospitalizations occur among White, non-Hispanic individuals, Hispanic and Black individuals and individuals with a race/ethnicity recorded as "other, non-Hispanic" had higher rates of hospital admissions.[14] Among counties, Bristol County had the highest rates of emergency department visits related to intentional self-harm from 2017-2021.

**FIGURE 4:**

**Rate of Emergency Department Visits Related to Intentional Self-Harm/Suicide Attempts among Rhode Islanders Ages 10+, by County, 2017-2021**




**Data Source:** Rhode Island Hospital Discharge Data, RIDOH, 2017-2021.

**Notes:** Data include emergency department visits and hospitalizations among Rhode Island residents ages 10 years and older. Includes all acute care hospitals in Rhode Island; excludes specialty hospitals/rehabilitation centers. Visits and hospitalizations relating to intentional self-harm/suicide attempts were identified based on the presence of ICD-10 codes in any diagnosis field. Totals for emergency department visits include visits where the patient was subsequently admitted to the hospital.

The number of youth experiencing suicidal ideation has also increased. Data from the 2021 Rhode Island Youth Risk Behavior Survey (YRBS) show that there has been a significant increase in serious thoughts about suicide and suicidal attempts among young Rhode Islanders since 2011. For example, during that period:

- The percentage of high school students seriously considering attempting suicide increased from 12.3% to 17.1%.
- The percentage of high school students who made plans to attempt suicide increased from 10.7% to 14.5%.

This was exacerbated during the COVID-19 pandemic when ED visits for suspected suicide attempts began to increase among teens ages 12 to 17. By February-March 2021, ED visits for suspected suicide attempts were 50.6% higher among females age 12-17 than during the same period in 2019. Among males in this age group, suspected suicide attempt ED visits increased by 3.7%.[15]

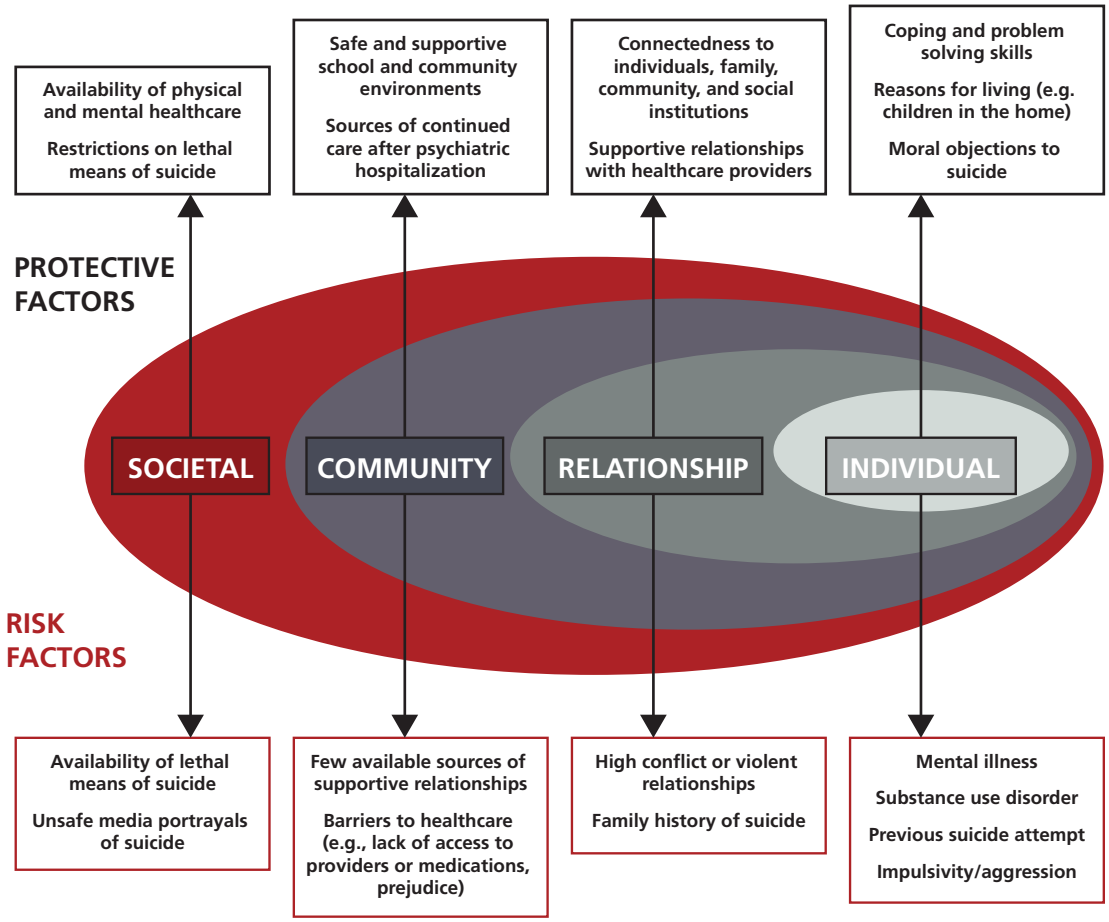
# RESEARCH-VALIDATED SUICIDE FACTORS

Many things can contribute to someone's risk of suicide. It can occur in response to a complex interplay between individual, relationship, community, and societal risk factors. These include Adverse Childhood Experiences (ACEs), substance use, poverty, untreated mental illness, and unmet basic needs. The presence of risk factors does not predict suicide or suicide attempts for any given person. Most individuals who experience risk factors or attempt suicide do not die by suicide. However, the cumulative effect of several risk factors may increase an individual's vulnerability to suicidal behaviors.

It is also important to remember that risk factors can vary by age group, culture, sex, and other characteristics.[7] For example:

- Stress resulting from prejudice and discrimination (family rejection, bullying, violence) is a known risk factor for suicide attempts among lesbian, gay, bisexual, and transgender (LGBT) youth.
- The historical trauma suffered by American Indians and Alaska Natives (resettlement, destruction of cultures and economies) contributes to the high suicide rate in this population.
- For men in their middle years, stressors that challenge traditional male roles, such as unemployment and divorce, have been identified as important risk factors.

**FIGURE 5:**
**Protective Factors and Risk Factors for Suicide**




**Source:** 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention.

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.

The visual above shows the risk and protective factors that must be considered.

# HELP IS AVAILABLE

988 SUICIDE & CRISIS LIFELINE

Suicide & Crisis Lifeline
**988**

CRISIS TEXT LINE

**Crisis Text Line**
Text HOME to **741741** from anywhere in the USA, anytime, about any type of crisis.

CALL 911

If you or someone you know is in immediate danger, **call 911.**

# STRATEGIC PLAN CORE ASSUMPTIONS, GUIDING FRAMEWORK, AND PROCESS

Rhode Island's Suicide Prevention Plan is comprehensive and data driven. The strategies in the Suicide Prevention Plan for Rhode Island 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.

It was shaped by the voices of practitioners in the field and providers serving people at higher risk for suicide, who are valuable resources for assessing needs and strengths and making recommendations. Approximately 50 professionals with direct experience participated in interviews or focus groups that explored their ideas of how the state can improve its suicide prevention efforts.

Their recommendations have been aligned with the CDC Suicide Prevention Framework, a group of overarching 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. We have contextualized these strategies with local experience to prioritize prevention activities.

The CDC Suicide Prevention Framework is based on the following core assumptions:

- Suicide is a public health issue.
- Any single factor does not cause suicide, and any single strategy or approach will not achieve suicide prevention.
- Suicide occurs in response to multiple biological, psychological, interpersonal, environmental, and societal influences that interact, often over time.
- Belonging, safety, dignity, and hope can support resilience and healing for individuals and communities and protect against suicide.
- Suicide, adverse childhood experiences (ACEs), and substance use are connected. ACEs refer to three specific kinds of adversity children can face in the home environment—various forms of physical and emotional abuse, neglect, and household dysfunction.
- Suicide can contribute to lasting impacts on individuals, families, and communities.

It focuses on the following priorities and goals[7] to achieve and sustain substantial reductions in suicide.

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

# RHODE ISLAND'S SUICIDE PREVENTION PLAN 2023-2030

Our goal is to reduce suicide mortality by 10% by 2026 and 15% by 2030.

## Priority 1: Strengthen economic supports

Historical trends in the US 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. Economic and financial strain may increase an individual's risk for suicide or indirectly increase risk by exacerbating existing physical and/or mental illnesses. 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. Eviction and homelessness are also related to suicide. Reducing these stressors can potentially buffer suicide risk.[7]

## Goal 1: Strengthen household financial security

According to the 2022 Rhode Island Standard of Need Report (RISN),[16] many Rhode Island households do not earn enough to make ends meet, a circumstance more commonly experienced by Latino and Black households than White households. Across racial and ethnic groups, women without children are much less likely to be able to make ends meet than men without children. Overall, Rhode Island households earning less than what is necessary to meet the RISN include:

- 61% of single adults without children.
- 70% of families with one caregiver and two children.
- 25% of families with two caregivers and two children.

Work support programs can help narrow the gap between earnings and expenses. Since Black and Latino Rhode Islanders are overrepresented as a share of Rhode Island's low-wage workers, enhancing such programs and paying all workers a living wage would decrease disparities and increase economic security and opportunity. Also, families receiving and relying upon Rhode Island Works cash assistance (including the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)) have incomes on average 26% below the Federal Poverty Level. Without subsidies from the Child Care Assistance Program (CCAP) and through HealthSource RI (Rhode Island's official marketplace for health insurance coverage), working families — including frontline and essential workers — have a large gap between income and expenses for basic needs.[16]

## Strategies

- Support efforts to increase the Rhode Island minimum wage to a fair living wage, narrow the gap between earnings and basic expenses, and expand and strengthen cash assistance and tax credits.
- Expand eligibility and benefits for CCAP.
- Expand eligibility and benefits for SNAP and cash benefits.
- Ensure automatic enrollment in public benefits when someone enters the shelter system.
- Support efforts to limit loan interest rates (APR) to 36% and establish guardrails around loan structure to protect consumers.
- Promote screening for basic needs and referrals to community-based services via UniteUs, Rhode Island's Community Resource and Referral platform.
- Enact equitable utility regulations/policies that limit the proportion of income required to maintain basic electric service, ensure equitable access to on-site energy generation, storage, and energy efficiency technologies—and the savings and resilience benefits they can provide—and ensure uninterrupted and affordable access to a basic level of electricity service.
- Make changes to medical debt laws so that residents with medical debt cannot be pursued by debt collectors or sent to court.
- Support community-driven efforts to destigmatize and provide for basic needs in naturally occurring settings such as churches, libraries, community centers, and schools.

## Goal 2: Continue to invest in housing stabilization

Housing affordability is a statewide challenge across all income, racial, and age groups, but especially for low- and moderate-income households, underscoring the need to build more affordable housing and provide rental assistance. More than 139,000 Rhode Island households, or nearly 34%, are cost burdened, paying more than 30% of their income toward housing.[16] Rent has increased by 24% in the past year. Low- and moderate-income families, including older adults on a fixed income, struggle to find affordable housing and prevent eviction.[2] It is also important to note that access to housing in Rhode Island is not an equal playing field. Black Rhode Islanders and other people of color face greater housing unaffordability and insecurity. Historical race and class discrimination have produced deep-rooted gaps in generational wealth and patterns of segregated neighborhoods, and a continued lack of access to credit and affordable housing.[17] For Rhode Islanders experiencing homelessness, there is an approximately 30-day wait for a shelter bed in Rhode Island.[18] Those who shelter in tents or cars are vulnerable to violence. As a result, they lose their shelter, personal items like pictures, and often important documents that enable them to enroll in benefits and work.

Rhode Island has several programs and initiatives that address housing challenges in the state, including eviction assistance, affordable housing support, permanent supportive housing, and more. This includes deploying more than $11.6 million in rental assistance through Safe Harbor and Housing Help RI and more than $53 million through Rent Relief RI to thousands of Rhode Island families throughout the pandemic. However, key informants noted there is still a three- to ten-year wait[19] for subsidies, depending on the funding source, exposing many to homelessness, overcrowding, eviction, and other hardships while they wait. In addition, the State of Rhode Island does not have a State-funded rental assistance program available to residents to reduce the unmet need for assistance.

The State has also implemented a five-year Pay for Success permanent supportive housing pilot. It has increased funding to eliminate health hazards (lead, asbestos, etc.) and improve housing stock. It has also allocated American Rescue Prevention Act (ARPA) funds to expand housing stabilization and diversion services.[20] However, ARPA funding is temporary, and implemented initiatives must be sustained.

The State and Rhode Island Housing are also investing more than $250 million to create and preserve more affordable homes across the state through a combination of State and federal resources. However, the expansion of affordable housing depends partly on the provisions laid out in the local zoning ordinance or code. For example, some zoning policies specify that there may be only one dwelling unit per parcel of land (restricting the development of accessory dwelling units) or prohibit the use of manufactured housing in particular residential districts. To expand affordable housing units within communities, many local jurisdictions need to revise their zoning policies to allow the market to develop these units in some or all parts of town.

In addition, more can be done to control rent increases, prohibit discrimination based on arrest or conviction records, support people taken to Eviction Court, sustain housing stabilization services, and protect people experiencing homelessness.

## Strategies

- Increase affordable and supportive housing funding to proportionately equal or exceed Rhode Island's neighboring states.
- Expand the total number of public and supportive housing units available in Rhode Island.
- Expand federal rental subsidies and create a State rental subsidy program.
- Work with cities and towns to create a more favorable planning, zoning, and development environment (e.g., facilitate community-level partnerships to identify buildings or properties that can be turned into affordable or supportive housing).
- Support efforts to establish rent control and eliminate rental application fees so landlords cannot increase rent by more than 10% within a ten-month period. Include private landlords, public housing managers, and tenants in decision-making.
- Expand funding for housing stabilization and diversion services.
- Increase the number of providers of home stabilization services (e.g., support public housing authorities to become certified providers of home stabilization services).
- Support efforts to increase staffing capacity to deliver housing stabilization services. For example, amend certification standards to remove requirements for an associate or bachelor's degree and one year of experience. (Note: a request for this is pending with the Centers for Medicare & Medicaid Services.)
- Support efforts to provide free legal counsel to people taken to Eviction Court.

- Support efforts to establish Fair Chance Housing to prohibit discrimination based on arrest or conviction record.
- Enforce the homeless bill of rights.
- Support efforts to allow emergency shelters to be opened anywhere they are needed.
- Include home stabilization services in pre-release supports for justice-involved populations through the 1115 waiver.

## Priority 2: Create protective environments

A person's environment can significantly influence the accessibility of lethal suicide means. Creating environments that reduce risk factors and increase protective factors where individuals live, work, and play can help prevent suicide. In particular, modifying physical environment characteristics, 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.[7]

### Goal 1: 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 result in high case-fatality rates. Almost 90% of people who use a firearm in a suicide attempt die from their injury. Research also indicates that the interval between deciding to act and attempting suicide can be as short as 5 to 10 minutes. People tend not to substitute a different method when a highly lethal method is unavailable or difficult to access. 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.[7]

### Safe storage

Safe storage of medications, firearms, and other harmful household products can reduce the risk of 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, unloading and separating ammunition from the firearm, and keeping medicines and hazardous household products in a locked box or another secure location. Providing a safe storage device may also be combined with education and counseling about access to lethal means to enhance adherence to safe storage practices. Approaches that effectively limit access to firearms within the home by enhancing safe storage practices help prevent adult and youth suicide alike.[7]

#### *Firearms*

In Rhode Island, firearms are the second most common injury mechanism across all deaths by suicide, followed by poisoning.[3] There are two laws stipulating the safe storage of firearms: (1) R.I. Gen. Laws § 11-47-60.3 provides that any retail sale of a pistol must include a trigger lock or other safety device designed to prevent an unauthorized user from operating the pistol, and (2) R.I. Gen. Laws § 11-47-60.1 imposes criminal liability on any person who leaves a loaded firearm on their premises and who reasonably should know that a child could obtain access to the firearm, if an injury results. In contrast, Massachusetts law requires that all guns be stored in a locked container or be equipped with a locking device whenever not in active use and provides for higher penalties if the firearm involved is an assault weapon or if a minor can access the weapon. It also provides that violation of the law may be used as evidence of reckless conduct in a criminal or civil legal proceeding. There is early evidence that this clear law helps to incentivize extra precaution when safely storing guns and may help reduce the risk of youth suicide: Guns are used in just 9% of youth suicides in Massachusetts, compared to 39% of youth suicides nationally, and the overall suicide death rate among youth in Massachusetts is 35% below the national average.

### *Medication*

The regional Rhode Island Prevention Coalitions provide medication lock bags to anyone who requests one free of charge. In addition, there are 39 permanent prescription drug disposal sites at pharmacies, health centers, police departments, and methadone clinics throughout the state, where anyone can anonymously drop off prescription drugs without questions. The state also holds two "Drug Take Back" events each year.

## Bridge access

Efforts to prevent suicide at bridge locations, such as erecting barriers and installing signs and telephones to encourage individuals who are considering suicide to seek help, can also help to prevent death by suicide.[7]

Parts of Rhode Island are connected by several large overwater bridges. Three of these bridges (Mount Hope Bridge, the Newport Pell Bridge, and the Jamestown Verrazzano Bridge) have been used more than others to end one's life. All three bridges are owned and operated by the Rhode Island Turnpike and Bridge Authority (RITBA), a quasi-public agency whose operating revenues come primarily from tolls paid by motorists crossing the Pell Bridge.[21] Mortality data show that 48 suicide deaths were bridge-related between 2011-2020. Most of these deaths occurred in Newport County (27), followed by Bristol County (10).[3]

Some interventions are already in place to reduce suicides using these bridges. For example, signs are posted near the bridge entrances on both the Jamestown and Mount Hope bridges, installed in 2013 and 2019, respectively. These signs provide the numbers for emergency services (911) and the Samaritans of Rhode Island. Additionally, there are traffic cameras installed on some of the bridges, which could be used to detect potential suicidal activity. However, these cameras are owned and operated by several different non-emergency response organizations (e.g., RITBA, Rhode Island Department of Transportation (RIDOT), and Rhode Island Emergency Management Agency (RIEMA)). Live camera access must be requested by rescue responders, restricting the timeliness of the information the videos could provide. While the RIDOT cameras are viewable, live, and directly accessible to 911, these cameras are fixed on the approaches to the bridges (not on the span where suicides are more likely to occur) and do not offer first responders the ability to zoom in to see events as they unfold.[21]

In addition, new interactive pan-tilt-zoom (PTZ) cameras[22] and communications systems have been installed on the Newport Pell and Mount Hope Bridges. While not yet fully operational, the new surveillance systems will alert a RITBA staff member if an unauthorized person or car is stopped on the bridge. If the staff member believes the person intends to harm themselves, they will notify the authorities and trigger an automated, pre-recorded message over loudspeakers, saying, "You are not alone; trained professional help is on the way." The system also has sophisticated audio and video analytic capabilities for pinpointing rescue locations in the water without delay. According to RITBA, these cameras will be monitored 24/7 by a RITBA staff member.[23]

However, cameras are not enough. While there is limited data, one study that examined camera effectiveness found that cameras and signs worked best in conjunction with other means, including operator monitoring/engagement and means restriction via bridge suicide barriers.[24] Research on structural bridge barriers has demonstrated strong evidence that physical barriers significantly decreased suicide rates on the bridges where they were installed.[23] Based on this evidence, local advocacy groups and the Bristol Health Equity Zone have introduced legislation for the past four legislative sessions that, if passed, would direct RIDOT, in conjunction with the RITBA, to erect the barriers on the Mount Hope Bridge, the Newport Pell Bridge, and the Jamestown Verrazzano Bridge. While these bills did not pass in 2022, the legislature appropriated $1 million in ARPA funding in the State Fiscal 2023 budget to support a design study for some of the bridges. (Note: the cost to study all four bridges is $1.5 million.) The studies for the Jamestown Verrazzano and Mount Hope bridges began in January 2023.

## Strategies

- Distribute medication lock bags, timer caps, and gun locks through partnerships with emergency departments, prevention coalitions, and the Rhode Island Office of Veterans Services.
- Include medication lock boxes as a value-add service in Medicaid managed care contracts.
- Utilize national and local technical assistance to bring safe firearm storage sites to Rhode Island.
- Continue to promote safe medication disposal at pharmacies, health centers, police departments, and methadone clinics.
- Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership. Encourage firearm dealers and firearm ranges to display 988 information and suicide prevention resources.
- Support efforts to amend Rhode Island's current safe storage law to more closely mirror Massachusetts' safe storage law, which requires that all firearms be stored in a locked container or with an approved locking device when not in use. Implement graduated criminal penalties for violations of the law.
- Support efforts to expand the current law to require approved locking devices to be provided with every gun sale, not just handgun sales at federally licensed firearms dealers. Such legislation could be modeled on laws in California, New York, and Michigan, which all have more expansive laws regarding the sale of locking devices.
- Encourage all gun dealers to display and make available information regarding the safe storage of firearms. Include this information in a revamped safety course and test required to obtain a Blue Card.[24]
- Implement strategies to reduce lethal means access in high-risk locations: bridges, train stations/tracks, public parking garages, and public parks. For example:
  - Support efforts to require restrictions barriers to be integrated into future bridge repair and reconstruction plans.
  - Support efforts to erect the barriers on the Mount Hope Bridge, the Newport Pell Bridge, and the Jamestown Verrazzano Bridge.

## Goal 2: Reduce substance use through community-based policies and practices

There is a strong relationship between substance use disorders and suicide-related outcomes, including suicidal ideation, attempts, and deaths. Research studies in the US have found that greater alcohol availability is positively associated with alcohol-involved suicides. A literature review found that acute alcohol use was associated with more than one-third of suicides and approximately 40% of suicide attempts. Studies have also revealed a connection between suicide attempts and other substance misuse, such as opioids. One analysis revealed a dose-response relationship between suicide and opioids prescribed for pain, depicting higher suicide rates among those with higher-dose prescriptions.[7]

Rhode Island has seven Regional Prevention Task Force coalitions responsible for overseeing the planning and delivery of substance-use prevention activities within the region's municipalities. Each Task Force includes city and town representation, which ensures that individual communities continue to play an active role in planning and service delivery. The regional Task Forces provide administrative oversight, funding, and other needed resources to support the smaller municipal coalition contributions as part of the larger regional prevention plan.

The Regional Prevention Task Force coalitions work to prevent substance use among children, including information dissemination, peer education, alternative events, evidence-based education curriculums, and environmental strategies, including changing local laws and policies and high-visibility youth access law enforcement efforts. Figure 6 shows examples of some of the programs and campaigns the coalitions have provided to the community. Items in bold are evidence-based practices. Other items are locally developed or national strategies that do not meet criteria for an evidence-based practice.

**FIGURE 6:**
**Rhode Island Regional Prevention Task Force Programs and Campaigns**


**Source:** Rhode Island Regional Prevention Task Force coalitions

**Notes:** Items in bold are evidence-based practices. Other items are locally developed or national strategies that do not meet criteria for an evidence-based practice.

Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) is a multi-component, evidence-based intervention that has been shown to prevent and reduce substance use and promote mental wellness among youth ages 12-18. The project includes a universal prevention education curriculum as well as the utilization of student assistance counselors to provide problem identification and referral services. It is the primary problem identification and referral strategy utilized by the State and is implemented by Rhode Island Student Assistance Services (RISAS), which provides evidence-based programs in schools and communities to prevent substance use and promote mental health. By the beginning of the September 2023 school year, Project SUCCESS will be in 82 middle and high schools throughout Rhode Island.

Project SUCCESS utilizes a multi-pronged strategy:

- **Prevention Education Series (PES):** The PES is a four-topic alcohol, tobacco, and drug classroom-based program that targets seventh and ninth graders. It aims to help students identify and resist pressures to use substances, correct misperceptions about the prevalence and acceptability of substance use, and understand the consequences of substance use. In addition to teaching information designed to increase the perception of harm and improve coping strategies, PES aims to generate self, peer, and faculty referrals to the school's student assistance counselor (SAC). When students see the counselor present in the classroom, it encourages help-seeking behavior in a non-stigmatizing setting.
- **Assessment and Brief Intervention:** SACs utilize the Project SUCCESS assessment protocol described in the Program Manual, which includes a comprehensive assessment of current psychological functioning and the CRAFFT Screening Questions[25]. SACs conduct time-limited individual and group sessions utilizing motivational interviewing strategies. The sessions are designed to prevent and reduce substance use and other high-risk behaviors. All SACs have been trained in Screening, Brief Intervention, and Referral to Treatment (SBIRT), Motivational Interviewing, and Brief Challenges approaches.
- **Universal Prevention:** SACs conduct monthly school-wide activities to coincide with the calendar of awareness weeks/months in the Project SUCCESS calendar. These activities influence attitudes and norms about substance use and related high-risk behaviors in school and the community. They are sometimes done in collaboration with the Rhode Island Regional Prevention Task Force coalitions.
- **Parent Program/Outreach:** SACs implement parent outreach and education based on the school's individual needs, often in coordination with the Rhode Island Regional Prevention Task Force coalitions. These are designed to provide information concerning Project SUCCESS and its services, as well as current substance use trends within the school or community. They also provide resources to parents to increase their knowledge or that of their child regarding the consequences of substance use, risk, and protective factors for substance use.

### Strategies

- Continue to invest in efforts to increase awareness and prevent substance use by youth, such as Project SUCCESS.
- Support and reinforce the comprehensive community prevention strategies being implemented by the Regional Prevention Task Force coalitions.

## Priority 3: Improve access to and delivery of care

Most people with mental health conditions never attempt or die by suicide, but these disorders are important risk factors for suicide. According to Mental Health America,[26] less than half (49%) of adults in Rhode Island with mental health disorders receive treatment for these conditions. Lack of access to mental healthcare contributes to underusing mental health services. This may be particularly pertinent for people with serious mental illness, people from racial and ethnic minority groups, underserved communities, rural communities, and uninsured people. Poverty, combined with factors such as social stigma, mistrust of the behavioral health system, and lack of cultural adaptation of interventions, is associated with underusing mental health services. Identifying ways to improve access to timely, affordable, culturally appropriate, and quality care for people at risk for suicide is critical to prevention.[7]

## Goal 1: Cover mental health conditions in health insurance policies

In 2008, Congress passed the Mental Health Parity and Addiction Equity Act, which requires that insurers cover mental health, including addiction treatment, no more restrictively than medical and surgical treatment. However, our key informants and a report issued by the Mental Health Association of Rhode Island (MHARI) in 2020[27] reveal that insurers in Rhode Island continue to restrict access to mental health and substance use disorder treatment services and have insufficient networks of mental health providers covered by health insurance plans. In addition, key informants report that Medicaid-eligible patients in Rhode Island have greater access to mental and behavioral health services than those covered by private insurance. However, the Medicaid provider reimbursement rates are significantly lower than commercial reimbursement rates. As a result, the salary levels in agencies that predominantly serve Medicaid-eligible patients with complex needs are so low that they must rely heavily on inexperienced, unlicensed clinicians to provide services. Once those clinicians complete the hours required for licensing, they typically leave for other settings, where they are paid 80-100% more. This results in high clinician turnover, limiting access to quality care and contributing to poor health outcomes for Medicaid beneficiaries, who are disproportionately people of color.

### Strategies

- Ensure that mental health and addiction treatment is covered at the same level as care for other health conditions.
- Prioritize reimbursement rate increases for behavioral health services to help incentivize the availability of needed behavioral health services. (See Goal 2 below.)
- Increase enforcement of parity of behavioral health coverage and reimbursement rates between private and public insurance.
- Support case management services for all Medicaid-eligible individuals being discharged from incarceration.

## Goal 2: Increase provider availability

Access to effective and state-of-the-art mental healthcare largely depends upon quality training and an adequate mental healthcare workforce. In Rhode Island, there are several areas where access to quality mental healthcare needs is limited due to an inadequate number of providers. Specifically, Rhode Island needs:

**More community-based licensed mental and behavioral health clinicians[28] with expertise serving populations at higher risk of suicide:** There are long wait times for outpatient services, with many providers not participating in the insurance system due to low reimbursement rates and lack of parity between rates for behavioral health services and those for medical services. In addition, there are a very limited number of clinicians with important expertise or lived experience, including but not limited to:

- Clinicians trained to provide care to survivors of intimate partner violence.
- Clinicians trained in geriatric behavioral healthcare.
- Clinicians trained to provide gender- or LGBTQ-affirming care and/or with related lived experience.
- Clinicians equipped to provide trauma-informed services.
- Clinicians trained to provide suicide prevention-focused psychotherapy, such as Cognitive Behavioral Therapy (CBT), Collaborative Assessment and Management of Suicidality (CAMS), Safety Planning (using the Stanley Brown instrument), and Dialectical Behavior Therapy (DBT). (See Priority 6, Goal 4 for more detail.)

Interviewees also report difficulties in finding therapists who are Black, Indigenous, or people of color and note that many clinicians will not work with adults or children who have attempted suicide or experienced suicidal ideation, even if they do have the capacity, due to fears of legal and liability issues.

There are also significant workforce shortages of case managers, nurses, peer recovery specialists, and primary care and family physicians who can support mild to moderate mental and behavioral health needs.

The lack of community-based outpatient services is felt by other populations as well. The Department of Veterans Affairs (VA) Medical Center and Warwick Veterans Center report that Veterans' need for behavioral health services has outgrown their treatment capacity. To address this, they are increasingly referring Veterans to services in the community and are having trouble finding the services that their Veterans need.

**More in-house behavioral health and psychiatric services for people with cognitive decline:** CareLink has recently been funded to deliver in-home behavioral health services and psychiatric home supports to people with cognitive decline. However, more is needed across the State.

**Sustain mental health providers in school settings:** Beyond promoting mental wellness for all students, trained mental health professionals employed by schools, such as school psychologists, school counselors, and school social workers can provide intervention services and treatment for students with additional mental healthcare needs and refer youth to more intensive resources in the community when needed. Providing mental health services in schools removes many barriers to mental healthcare access for students (e.g., transportation, scheduling conflicts, and stigma). With recent grant investments, Rhode Island meets recommended ratios of students to psychologists, social workers, and counselors to provide these services at a statewide level. For example, in 2020 and 2022, the Rhode Island Department of Education (RIDE) received two five-year School-Based Mental Health Services grants to increase the number of qualified (i.e., licensed, certified, well-trained, or credentialed) mental health service providers that provide school-based mental health services to students in local education agencies (LEAs) with demonstrated need. Seven LEAs are participating in this project. However, once these grants end, the increased number of qualified mental health service providers must be maintained. Rhode Island passed legislation in 2023 that requires services provided by school social workers and certified school psychologists to be included as healthcare-related services eligible for federal Medicaid reimbursement, but this is not enough. Finally, although Rhode Island is meeting ratios set by professional associations, it is imperative to use the available data to determine if there are enough school-based mental health providers to meet the current needs of youth and families within each LEA.

**More intensive home and community-based treatment programs:** Interviewees noted that there are not enough home and community-based treatment, intensive outpatient treatment, partial hospitalization, and day treatment programs. This increases the demand for inpatient services and reduces the continuity of care post-discharge.

**More residential and inpatient substance use treatment facilities:** Interviewees noted insufficient residential and inpatient substance use treatment beds in Rhode Island, especially for pregnant or parenting people.

**More long-term psychiatric residential beds:** Stakeholders report that Rhode Island has an insufficient continuum of long-term, community-based residential psychiatric and substance use treatment beds and group homes, especially for people with serious and persistent mental illness, developmental disabilities, or comorbid behavioral health and medical concerns requiring skilled nursing facilities. In addition, the state lacks a secure, community-based residential facility for patients with self-harming tendencies and violent behavior. This gap in the current continuum impacts movement and flow throughout the system of care, preventing people from "stepping down" or "stepping up" to the most appropriate, least restrictive setting. It also often results in patients waiting for care in inappropriate settings, such as inpatient psychiatric beds. In turn, there are fewer beds for patients who need inpatient psychiatric care, so those patients wait for an inpatient psychiatric bed in a medical unit, resulting in fewer beds available in the medical unit for those needing medical care. As a result, there is tremendous pressure on inpatient units to free up beds, which can result in people being discharged inappropriately.

**Increased staffing for inpatient psychiatric beds:** A significant number of inpatient psychiatric beds are unavailable due to persistent staffing shortages across a range of occupations, including but not limited to psychiatrists, nurse psychiatrists, nurses, and support roles.

## Strategies

- Prioritize rate increases for behavioral health services to increase the availability of community-based licensed clinicians and psychiatrists participating in the insurance system.
- Increase the availability of community-based licensed clinicians and psychiatrists with expertise in caring for higher-risk populations, such as Veterans, survivors of domestic violence, and the LGBTQ+ population.
- Promote the integration of health/behavioral health in primary care settings by exploring sub-capitated Medicaid payment models for primary care practices to provide behavioral health services and address social determinants of health (SDOH) on an at-risk basis.
- Explore the feasibility of Medicaid authority and authorization to reimburse for group visits in medical settings to support cohort-based prevention services.
- Ensure the sustainability of the Pediatric Psychiatry Resource Network (PediPRN), which supports primary care providers in treating children and adolescents by offering same-day, specialized clinical consultations and resource/referral services related to mental health. This service enables providers to promptly, comprehensively care for their patients and avoid long wait times for specialized care.
- Advocate for expanding Medicaid reimbursement for mental health services provided in schools.
- Explore models for making behavioral health services available through comprehensive, school-based health centers and school-based tele-behavioral health services.
- Increase the availability of in-home behavioral health and psychiatric services for people with cognitive decline.
- Ensure that Rhode Island's long-term, community-based residential care services have the capacity and specialization to treat populations with needs for co-occurring behavioral health treatment and other medically intense services.
- Increase the number of residential and inpatient substance use treatment beds in Rhode Island, especially for youth and pregnant people/parents.
- Address inpatient psychiatric staffing shortages across several occupations, including but not limited to psychiatrists, psychiatric clinical nurse specialists, nurses, and support roles.
- Increase the number of skilled nursing facilities caring for patients with behavioral health co-morbidities.

## Goal 3: Provide rapid and remote access to help

Suicide hotlines play an important role in suicide prevention, counseling, and connecting patients to much-needed interventions and services. The recent implementation of the national 988 Suicide & Crisis Lifeline (988) is intended to:

- Provide enhanced access for people in behavioral health crisis through the use of an easy-to-remember three-digit number.
- Reduce reliance on the police by linking 988 centers with mobile crisis teams (for when the person in crisis requires services beyond what the call center itself provides).
- Reduce gaps in the existing fragmented behavioral health crisis care system by enabling 988 centers to stay in contact and follow up with those in crisis.
- Relieve emergency room boarding by providing needed evaluation and crisis intervention in the community whenever possible.
- Better meet the behavioral health needs of all people experiencing crises in a way that reduces stigma and encourages people at risk and their family members to seek help in the future.

988 was launched in Rhode Island in July 2022 and is staffed by BH Link. Both adults and children can call this line. Staff assess the caller for safety, identify the reason for the person's call, and then triage the caller. In a non-acute situation, this could include connecting the caller to resources and/or, if they are adults, getting them to a physical BH Link location for services such as a full clinical evaluation. If the staff are worried about the caller's imminent safety, they call a mobile crisis clinician and local police for a wellness check.

Key informants raised several concerns about the nationally established structure of the 988 lines. Specifically, 988 is not integrated with 911, so 988 cannot transfer calls to 911 in an emergency. Also, 988 does not have location services, so unlike 911, they cannot identify the caller's location in an emergency. In addition, Rhode Island callers who do not have a 401 area code (for example, an out-of-state college student) are rerouted to the area code in their phone number.

Key informants were also very concerned that 988 protocols in Rhode Island do not differentiate between adult and child callers. Pediatric clinicians noted that they would continue to refer their patients to Kids' Link RI until there were protocols for children calling 988, and they had a better sense of how 988 staff were trained to handle calls from people younger than age 18.

They also recommended that the State increase its promotion of the line. In addition to 988, The Samaritans of Rhode Island offers a listening line for adults. The line is staffed by volunteers and is open depending on the availability of volunteers to answer lines. The COVID-19 pandemic has made it difficult to consistently staff the line 24/7.

### Strategies

- Work to integrate 911 and 988 call centers and responses, and advocate for geolocation of 988 calls to enable mobile response if needed.
- Ensure financial sustainability for 988 and support for crisis centers.
- Promote use of youth and adult peer recovery specialists as part of the mobile crisis response teams.
- Educate the public and increase the visibility of the 988 hotline, mobile crisis, and warm line resources in all communities statewide through posters and social media.
- Clarify protocols for callers to 988 who are younger than age eighteen, and ensure that staff are trained to take calls from children.

## Goal 4: Create safer suicide care through systems change

#### Zero Suicide

The Zero Suicide model seeks to eliminate suicide among patients engaged with health systems. Zero Suicide was designed to improve suicide care, incorporating seven components (i.e., lead, train, identify, engage, treat, transition, improve) of a quality improvement model to transform how health systems care for people with suicidal thoughts and behaviors. Studies in Australia and the US have shown the effectiveness of the Zero Suicide model in reducing suicide attempts and ideation.[31]

There are several organizations and collaborations in Rhode Island using the Zero Suicide framework, including but not limited to the Washington County Healthy Bodies, Healthy Minds Health Equity Zone, which has had a Zero Suicide initiative funded through a Substance Abuse and Mental Health Services Administration (SAMHSA) grant. In addition, Certified Community Behavioral Health Centers are required to adopt this framework.

**Systems-level triage protocols for Veterans**

There is also an opportunity to improve protocols for identifying Veterans and referring them to VA services. While not all Veterans are eligible for VA medical services, RIDOH and the Rhode Island Office of Veterans Services (RIVETS) are developing identification and screening protocols through an initiative called "Ask the Question" to identify persons who served in the armed services, screen for suicide risk, and connect them with services (either with the Vet Center or, if they prefer, community-based services). The goal is to improve access to care for service members, Veterans, and their families. The initiative asks providers in civilian health-care settings and community programs to ask patients, "Have you or a family member ever served in the military?". Asking this question can build rapport and connection with patients, help identify health concerns and exposures specific to military service, and present an opportunity to refer to VA services. 988 has also implemented a triage protocol in its phone system, where callers can press a button indicating they are a Veteran and be redirected to the Veterans Crisis Line.

**System changes to prevent suicide among law enforcement**

Studies suggest that suicide rates are particularly high among law enforcement occupations. Existing research suggests that officers may be more likely to die by suicide than in the line of duty.[32] Law enforcement officers are vulnerable to the same risk and precipitating factors for suicide as others in the general population, such as mental illness, substance misuse, social isolation, relationship problems, and legal and financial issues. Additional factors more specific to the law enforcement profession include exposure to suicide and other traumatic events (e.g., child abuse, violence, death of a colleague), easy access to firearms and skills in their use, and organizational stressors (e.g., shift work, administrative burden). Protective factors that appear particularly relevant to preventing suicide among police officers include access to culturally appropriate mental health and wellness services, resilience (particularly skills for coping with work-related stressors), and social support.

Law enforcement and rescue departments in Rhode Island are increasingly adopting practices to promote mental health and wellness and prevent suicide and related problems (e.g., employee assistance program services, traumatic incident response, and mental health policies). However, these practices vary dramatically across cities and towns. Municipalities would welcome technical assistance to create model policies and establish effective peer support models.

## Strategies

- Build capacity to implement the Zero Suicide approach within all medical and behavioral healthcare settings and ensure the sustainability of existing Zero Suicide initiatives. Specifically:
  - Work with the Hospital Association of Rhode Island, the Rhode Island Health Center Association, and the Substance Use and Mental Health Leadership Council to commit to implementing Zero Suicide across their healthcare/behavioral healthcare organizations.
  - Organize statewide Zero Suicide Academies for healthcare leaders/teams to learn how to implement Zero Suicide with fidelity.
  - Develop a training and support infrastructure similar to Connecticut to support the adoption of Zero Suicide statewide.
  - Require universal, standardized screening for depression and suicidal ideation at every health/behavioral healthcare appointment.
  - Ensure the Certified Community Behavioral Health Centers implement the Zero Suicide approach.
- Improve communication and care coordination protocols between the VA Medical Center and other hospital systems in Rhode Island. Specifically, continue to explore the feasibility of implementing the "Ask the Question" initiative at hospitals and behavioral health centers.
- Develop and share a model mental health policy for law enforcement and first responders.
- Require municipalities to have a mental health policy for law enforcement and first responders in place.
- Ensure linkages to outpatient behavioral health services in pre-release supports for justice-involved populations through the 1115 waiver.

## Priority 4: Promote healthy connections

The 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. Social capital is related to connectedness and refers to a sense of trust in one's community and neighborhood, social integration, and the availability of and participation in social organizations. Together, connectedness and social capital may protect against suicidal behaviors by decreasing isolation; encouraging adaptive coping behaviors; and increasing a sense of belonging, 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 support and resources and mobilize communities to meet the needs of their members.[7]

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-reported suicidal ideation or suicide attempt. Increased school connectedness is associated with reduced reports of suicidal thoughts and behaviors among adolescents, including adolescents who identify as sexual minorities and others, such as those residing in communities with an increased risk of suicide. Physical connectedness and social capital may protect against suicidal behaviors by decreasing isolation and encouraging adaptive coping. The research also suggests that school psychologists, school counselors, school social workers, and other student support personnel have an important role to play in facilitating school connectedness.[7]

## Goal 1: Promote healthy peer norms

Promoting healthy connections among individuals and within communities through modeling healthy peer norms and enhancing community engagement may protect against suicide by normalizing protective factors for suicide, such as help-seeking and adaptive coping. Healthy peer norms can shift group-level beliefs and promote positive social and behavioral change. These approaches are often focused on youth, but they have also been implemented in community and military settings with demonstrated success.[7] In fact, peer support is a powerful resource for police in addressing stress management, mental health concerns, suicide prevention, and overall officer safety and wellness. It is important to note that the continued stigma around 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.[7]

In Rhode Island, key informants spoke about the importance of integrating and expanding peer models in a variety of settings, including law enforcement and rescue, recovery centers, behavioral health treatment, inpatient settings, and community programs working with higher-risk populations, including but not limited to Veterans, LGBTQ+ populations, survivors of intimate partner violence, and people with prior incarcerations.

## Strategies

- Disseminate best practices and support the implementation of peer models in the following settings:
  - Law enforcement and rescue settings (like the Connecticut Alliance to Benefit Law Enforcement peer support program)
  - Recovery centers
  - Behavioral health treatment settings
  - Inpatient settings
  - Youth settings and schools (e.g., the Peer2Peer model for middle and high schools)
  - Community programs working with higher-risk populations, including but not limited to Veterans, LGTBQI+ populations, survivors of intimate partner violence, and people with prior incarcerations
- Include peer support and community health worker services in pre-release supports for justice-involved populations through the 1115 waiver.

## Goal 2: Engage community members in shared activities

Key informants stressed the importance of continuing to invest in ways that children and adults can engage in their communities. Community engagement builds social capital. Older populations, in particular, are at higher risk for isolation. Investing in opportunities for adults and children to become more involved in their communities and connect with other community members, organizations, and resources is important. Participation results in enhanced overall physical health, reduced stress, and decreased depressive symptoms, reducing the risk of suicide.

### Strategies

- Support and promote community wellness initiatives, prevention education, and positive youth development activities.
- Broaden the scope of suicide prevention to include the promotion of wellness, and identify community-based organizations, faith leaders, and agencies that might be well positioned to develop programs that promote emotional well-being and connectedness.
- Support and promote activities that build a community for older adults.
- Promote, in partnership with the Department of Environmental Management, all of Rhode Island's outdoor parks (greenways) and public water access (blueways) connecting people to places of natural beauty.
- Continue public health campaigns to reduce the stigma that surrounds mental health.

## Priority 5: Teach coping and problem-solving skills

Life skills are important in protecting individuals from suicidal behaviors and reaching key developmental milestones that impact psychological health, such as success at school and work. Teaching and providing youth with education and skills to manage everyday challenges and stressors is an important developmental component of suicide prevention. It can help prevent and/or mitigate suicide risk factors such as adverse childhood experiences (abuse and neglect), substance use, and more. Acquiring coping and problem-solving skills also occurs in adulthood and is beneficial. Adults often face new and challenging life events requiring additional 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.[7]

### Goal 1: Support social-emotional learning programs and support resilience through education programs

Studies from the US and other countries demonstrate that social-emotional learning (SEL) programs are associated with positive outcomes, including reduced emotional distress, improved well-being, and better social and academic adjustment. SEL components related to suicide prevention and help seeking reduce the stigma of discussing mental health and increase help-seeking behavior. SEL programs provide children and youth with skills to resolve problems in interpersonal relationships in all settings (including school) and help them address other negative influences, such as substance use associated with suicide.[7]

There are several school-based initiatives in Rhode Island aimed at promoting social-emotional learning and emotional regulation, including:

- The Rhode Island Violence and Injury Prevention Program has contracted with Rhode Island Student Assistance Services (RISAS) to provide a school-based peer-group program designed to enhance early adolescents' ability to apply emotion regulation skills and to decrease risk behaviors related to interpersonal and sexual violence. This group model was previously studied using Project Trac by a team of local researchers, including Chris Houck, PhD from Rhode Island Hospital. Dr. Houck's work has shown that early adolescents participating in his emotion regulation programs are less likely to engage in risk-taking behaviors such as increased sexual activity and physical fighting. RISAS currently conducts

school workgroups through a model called Project Success, which includes prevention goals to reduce alcohol, tobacco, and other drugs and suicide prevention goals as part of the Department's Rhode Island Youth Suicide Prevention Program. RISAS has added an emotion regulation component to prevent and reduce interpersonal and sexual violence behaviors. Students participating in the group can practice: identifying, labeling, and monitoring emotions in themselves and others; recognizing the connection between emotions, behavior, and decision-making as well as the benefits of reducing the intensity of emotion; and regulating emotion during situations that evoke emotion. Participation in the intervention is through self-referrals and referrals made by school administrators, guidance counselors, teachers, parents, and friends.

- Since 2015, RIDE has established SEL standards and indicators (Pre-K to adult). A robust Community of Practice with more than 700 educators facilitates information sharing of research-based practices, policies, and programs.
- In June 2022, the Rhode Island Department of Education (RIDE) updated the Rhode Island Health Education framework to encompass social and emotional learning (SEL) and ensure that it is an integral part of the health education curriculum through which students can acquire and practice skills to establish and maintain positive relationships with others, among other skills that contribute to healthy lifestyles.
- Since 2018, RIDE has secured seven grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) and US Department of Education (USDOE) that focus on school climate and culture. A Multi-Tiered Systems of Support Framework[33] guides the work. Mental well-being is an integrated component focused on building mental health literacy among faculty, staff, youth, and families and providing early identification and tiered interventions to those in need. Alignment and cohesion across the tiers is an essential focus of the work.
- Ten of Rhode Island's 66 local education agencies are participating in the SAMHSA-supported Project Advancing Wellness and Resiliency in Education (Project AWARE), which aims to develop a sustainable infrastructure for school-based mental health programs and services by implementing mental health-related promotion, awareness, prevention, intervention, and resilience activities to ensure that students have access to and are connected to appropriate and effective behavioral health services. The program has increased mental health literacy among the schools and communities, removed barriers to finding care, and ensured cultural relevance for all school programs. Seven local education agencies are participating in the USDOE school-based mental health grants. (See page 21 for more detail.)
- The Woonsocket Education Department fully implemented teen Mental Health First Aid (tMHFA), which teaches teens in grades 10-12 or ages 15-18 how to identify, understand, and respond to signs of mental health and substance use challenges among their friends and peers. This work could inform expansion to other districts.
- RIDE administers SurveyWorks, a statewide school culture and climate survey that collects critical feedback from students, families, and educators about what is working and what needs to be improved in Rhode Island public schools based on their perspective and experiences. This school district and state-level data can be used to inform school improvement efforts and inform the development of safe, supportive, and predictable learning environments.
- The Rhode Island Executive Office of Health and Human Services (EOHHS) is currently leading a task force charged with developing a state plan for strengthening Rhode Island's infant and early childhood mental health (IECMH) system, which focuses heavily on early social-emotional development, early relational health, and attachment.

## Strategies

- Support implementation of the Rhode Island Health Education Framework, including mandated instructional outcomes for mental health and suicide prevention.
- Expand education on healthy relationships for youth and teens.
- Continue to support the expansion of school-based mental health initiatives across additional school districts to increase the capacity of school districts to create safe and secure environments.
- Encourage all school districts to implement teen Mental Health First Aid (tMHFA).
- Continue to support implementing a Multi-Tiered Systems of Support Framework in districts and schools to increase access to the core curriculum, including social and emotional learning and mental health school-wide.
- Support recommendations made through the Rhode Island IECMH planning process.

## Goal 2: Teach parenting skills to improve family relationships

Parenting and family skills training approaches have well-established impacts in reducing common risk factors for suicide and strengthening family bonds, a protective factor against suicide. Rhode Island implements several evidence-based, voluntary parenting and family visiting programs that provide tailored services supporting parent and family skills and positive parent-child interactions. These include but are not limited to:

| Program Name | Description | Who is Served |
|---|---|---|
| Nurse-Family Partnership | Focuses on improving three key areas: pregnancy outcomes, child health and development, and parent life trajectory. | Mothers who are pregnant (70%) and first-time mothers facing adversity. |
| Healthy Families America | Aims to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors. | Expectant parents and parents/caregivers with children younger than three months of age who have one or more risk factors. Services are offered voluntarily and intensively until the child turns four. |
| Parents as Teachers | Aims to increase parent knowledge of early childhood development and improve parenting practices, detect developmental delays and health issues early, prevent child abuse and neglect, and increase children's school readiness and success. | Services begin prenatally or immediately following the birth of a baby. They are offered voluntarily to parents/ caregivers with children younger than three months of age with one or more risk factors. Services are provided intensively until the child turns four years of age (although some programs serve families with children up to age five) |
| Family Care Community Partnership (FCCP) | Assists the family in identifying supports to help them meet their needs, both short- and long-term, to help strengthen the family and build resiliency for long-term stability. | 1) Families with children and youth who are at risk for child abuse, neglect, and/or dependency and involvement with the Department of Children, Youth, and Families (DCYF); 2) children birth to age 18 who meet the criteria for having a serious emotional disturbance; and 3) youth concluding a sentence at the Rhode Island Training School (RITS) or leaving temporary community placement who agree to participate. |

| Program Name | Description | Who is Served |
|---|---|---|
| SafeCare | Parent training program that supports parents/caretakers of children, birth to age five, with known risk factors for and/or a history of child neglect and abuse. | Parents of children birth to age five with known risk factors for and/or a history of child neglect and abuse. |
| Triple P (Positive Parenting Program) | Designed to teach positive strategies and parenting skills and their application to various target behaviors and settings. | Multi-stressed caretakers of children, birth to 12 years of age, who exhibit behavioral or emotional difficulties, such as aggressive or oppositional behavior. |
| Incredible Years® (IY) | A series of group-based programs for parents, children, and teachers to prevent and treat young children's behavior problems and promote their social, emotional, and academic competence.<br>The Incredible Years Teacher Classroom Management (TCM) Program is an evidence-based prevention program designed to strengthen teacher classroom management strategies and to promote children's prosocial behavior and school readiness (reading skills). | The Regional Prevention Task Force coalitions, through funding from the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH), have implemented the TCM program for preschool and kindergarten teachers.<br>The Bradley Learning Exchange also offers early care and education providers professional development in IY.<br>The Preschool Development Block Grant funds IY programming for parents in two Health Equity Zones. |
| Strengthening Families Program (SFP) | An evidence-based family skills training program for high-risk and general population families recognized nationally and internationally. Parents and youth attend weekly SFP skills classes together, learning parenting skills and youth life and refusal skills. The program has separate class training for parents and youth in the first hour, followed by a joint family practice session in the second hour. | This program is free to Rhode Island residents through the Regional Prevention Task Force coalitions. |
| Conscious Discipline | A comprehensive emotional intelligence and classroom management system that integrates all learning domains (social, emotional, physical, cultural, and cognitive) into one seamless curriculum. | Conscious Discipline professional development is available for RIDE Pre-K staff and administrators supported by Preschool Development Block Grant funding. |

Most of these programs are available statewide but prioritized for specific cities and towns with higher concentrations of families facing significant adversity. A common pathway for accessing these programs is the Rhode Island First Connections program, a short-term family visiting program for families with children from birth to age three that provides home and health assessments, developmental screenings, and connections to other community resources, including the long-term family visiting programs listed above. Due to funding constraints, none of these programs are available universally.

### Strategies

- Expand access to voluntary short-term family visiting services for all Rhode Island families.
- Continue to invest in long-term family visiting programs, including Nurse-Family Partnership, Healthy Families America, and Parents as Teachers.

## Priority 6: Identify and support people at risk

Gatekeeper training[34] and suicide risk screening and assessment are 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. Supporting at-risk people 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 risk may face social and economic issues that can adversely affect their ability to access supportive services. Interventions and treatments should be culturally sensitive and tailored to meet the needs of populations disproportionately impacted by suicide and suicide risk. Key priorities are to develop optimal ways of identifying individuals at risk, customize services to make them more accessible (such as leveraging telehealth services when appropriate), and engage people in evidence-based care.[7]

### Goal 1: Strengthen universal screening and train gatekeepers

Gatekeepers can come from all sectors of the community. They can help prevent suicide by being trained to identify people 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, and primary and urgent care providers. This training may be implemented in various settings to identify and support at-risk people.

In Rhode Island, there are efforts in healthcare settings and schools to train staff to identify people at risk for suicide. However, there is an opportunity to more comprehensively train healthcare providers and staff at natural touchpoints[35] to screen for suicide universally.

### Screening in healthcare settings

As of the writing of this plan, the Rhode Island Department of Health (RIDOH) and the Rhode Island Office of Veterans Services are exploring the implementation of an initiative called "Ask the Question." Through this initiative, healthcare providers ask patients, "Have you or a family member ever served in the military?" The broad language in the question purposefully casts a large net to include anyone with a military connection. It employs the "any, any, any" definition of a Veteran: any person who served for any length of time in any military service branch (The Army, Marine Corps, Navy, Air Force, Space Force, and Coast Guard). The goal is to improve access to care for service members, Veterans, and their families. Asking this question can build rapport and connection with patients, help identify health concerns and exposures specific to military service, and present an opportunity to refer individuals to VA services.

## Screening in School settings

Currently, the approach and scope of behavioral health and/or suicide screening vary by the school district. The Nathan Bruno and Jason Flatt Act (2021-H 5353, 2021-S 0031), effective July 2, 2021, requires that districts implement professional development for staff and curricula for students in grades 6-12. The Rhode Island Department of Education (RIDE) developed a list of professional development and curricula that schools must choose to implement to meet the requirements of the law. Each district must develop their own policy based on the model guidance. RIDE partnered with RIDOH, the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH), Rhode Island Student Assistance Services (RISAS), and the school districts to support the implementation of these requirements. It should be noted that the requirements of the Nathan Bruno and Jason Flatt Act are an unfunded mandate. School districts are trying to use existing resources to support the implementation of all of the requirements and grapple with growing mental health needs among their students.[36]

Ten districts are participating in the SAMHSA-supported Project AWARE, which aims to develop a sustainable infrastructure for school-based mental health programs and services by implementing mental health-related promotion, awareness, prevention, intervention, and resilience activities to ensure that students have access and are connected to appropriate and effective behavioral health services. SAMHSA expects this program to promote the healthy social and emotional development of school-aged youth and prevent youth violence in school settings.

In addition, there are several youth suicide prevention initiatives available to Rhode Island public schools. In 2015, Bradley Hospital Access Center, in partnership with RIDOH and RISAS, developed a coordinated youth suicide prevention referral system called the Suicide Prevention Initiative (SPI). SPI is a diversion protocol. Student support staff at participating schools receive training on the protocol, including screening using the Columbia Suicide Severity Rating Scale (C-SSRS) and referring students to Kids' Link RI (Kids' Link). Kids' Link evaluates the child and connects them with appropriate services. The goal is to divert at-risk students experiencing a mental health crisis from unneeded emergency room visits and inpatient services by connecting them to local mental health services with follow-up support. This system has grown every year. It began with five school districts and now has been adopted in fifteen districts (some of the same districts that are also doing Project AWARE). The capacity of Kids' Link constrains the ability to grow the SPI program. School districts report having difficulty getting slots for evaluation or beds when they use the SPI process because Kids' Link's evaluation capacity is limited, and available inpatient beds are also limited. However, when it works, schools report it is a positive experience. Forty percent (15 out of 36) of municipal school districts participate in SPI. Fifty-two percent of the school districts participate in either SPI or Project AWARE.

The level of need varies by school, and even districts participating in SPI or other grant-funded efforts may struggle to meet their students' growing mental health needs. The table on the next page shows the various programs implemented in each district. Additional detail on Project SUCCESS, School-Based Mental Health Services grants, and Mobile Crisis Response can be found on pages 18, 21, and 37 respectively.

**TABLE 3:**

**Participation in Behavioral Health and Suicide Prevention Programs by School District**

| School District | Suicide Prevention Initiative (SPI) | Project AWARE | Project SUCCESS | School-Based Mental Health Services grant | Mobile Crisis Response[37] |
|---|---|---|---|---|---|
| Barrington | | | x | | |
| Bristol Warren | x | | x | | |
| Burrillville | | | x | | |
| Central Falls | x | | x | x | x |
| Chariho | | x | x | | |
| Coventry | | | x | x | |
| Cranston | | x | x | | x |
| Cumberland | | | x | | |
| East Greenwich | | | | | |
| East Providence | x | x | x | | x |
| Exeter-West Greenwich | x | | x | x | |
| Foster-Glocester | | | x | x | |
| Jamestown | | | | | |
| Johnston | x | | x | x | |
| Lincoln | | | x | | |
| Little Compton | | | | | |
| Middletown | | | x | | x |
| Narragansett | x | | x | | x |
| New Shoreham | | | x | | |
| Newport | x | x | x | | x |
| North Kingstown | x | | x | | x |
| North Providence | | | x | | |
| North Smithfield | | | x | | |
| Pawtucket | x | x | | | x |
| Portsmouth | x | | x | | |
| Providence | x | x | x | | x |
| Scituate | x | | x | x | |
| Smithfield | | | x | | |
| South Kingstown | x | | x | | x |
| Tiverton | | | x | | |
| Warwick | x | x | x | | |
| West Warwick | | x | x | | x |
| Westerly | | x | x | | |
| Woonsocket | x | x | x | | x |

**Data Source:** Rhode Island Department of Education, Rhode Island Executive Office of Health and Human Services, and Rhode Island Student Assistance Services, 2023.

Finally, RISAS offers training to the community in QPR (Question, Persuade, Refer), an evidence-based training on the warning signs of suicide and how to refer a youth for help. This free training is available to community-based organizations, parents, and other groups. It is a one-hour training focused on "gatekeepers"—people in a position to recognize a crisis and do something about it. A gatekeeper can be a friend, coworker, teacher, boss, or parent. Please note that QPR is not a RIDE-approved professional development program to meet the needs of the Nathan Bruno Act.

## Strategies

- Ensure that all districts implement RIDE's Learning, Equity, and Accelerated Pathways (LEAP) Task Force recommendations[38] to screen all students for social-emotional health universally.
- Promote universal suicide screening at natural touchpoints where individuals may be experiencing unanticipated or stressful transitions (e.g., domestic violence crisis centers, faith-based organizations, legal services for immigrant populations, unemployment offices, employee assistance programs, banks, casinos, justice systems, offices of providers who work with the bereaved, such as funeral directors, locations where individuals sell firearms and provide training in their use), and via targeted outreach to individuals experiencing heightened stress (e.g., youth transitioning out of foster care, via providers working with individuals newly diagnosed with serious and/or chronic health problems).
- Increase suicide prevention awareness campaigns at natural touchpoints where people may be experiencing unanticipated or stressful transitions (see list above).
- Integrate suicide prevention into training for staff and volunteers who may encounter individuals at natural touchpoints where people may be experiencing unanticipated or stressful transitions (see list above).
- Expand the capacity of student assistance within districts or use mobile screening teams to expand the school's capacity to screen for behavioral health issues and suicide.
- Advocate for expanding Medicaid reimbursement for mental health services provided in schools.
- Continue to promote the use of evidence-based youth suicide prevention curricula.
- Sustain and expand the SPI program to all districts in the state and expand the capacity of Kids' Link to scale the program.
- Ensure that all justice-involved populations are regularly screened using evidence-based mental and behavioral health screening.

## Goal 2: Respond to crises

When a crisis occurs, it is important to provide real-time 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 a telephone hotline, online chat, text messaging, or in person. 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. Crisis response interventions can put space or time between an individual who may be considering suicide and harmful behavior.[7]

Like most states, rescue services and/or law enforcement are often the first responders to most crises in Rhode Island. Crisis Intervention Teams (CIT) is a program that brings together mental health service providers and law enforcement officers to assist persons with behavioral health disorders (e.g., mental illness, developmental disabilities, Alzheimer's disease, and substance use disorders). The most important aspect of the CIT Program is the 40-hour training provided to law enforcement officers. The effort aims to improve safety, reduce arrests, improve the use of emergency psychiatric assessment, and avoid over-reliance on emergency room visits. Every district (county) within Rhode Island has at least one police department with at least one employee who has received CIT training. However, more training is needed, not just for law enforcement officers but also for rescue personnel. While the training is grant-funded, municipalities must pay personnel to fill in for the person in training. This is costly (approx $2,200 per person).

Another component of Rhode Island's crisis response system is a triage facility for adults called BH Link. BH Link is located in East Providence and intended to connect people to immediate, stabilizing emergency behavioral health services and long-term care and recovery supports. Interviewees stressed the importance of triage facilities to provide stabilizing services and divert patients, where appropriate, from the emergency room. They also made several recommendations for improvement:

- **Locate the facility in a more central location or open multiple locations in different areas of the state:** A main concern is that the current location deters law enforcement and rescue services from bringing people to the facility. Its location in East Providence is difficult to get to from many areas of the state and especially during rush hour, even from adjacent cities like Providence. It can take three hours round trip from Westerly to take someone there and at least two hours during rush hour from parts of Providence. When municipalities dispatch a law enforcement or rescue team to bring a resident to BH Link, they must pay for backfill coverage in their town while their staff is deployed to BH Link. Law enforcement is not equipped to handle crises arising during the trip (e.g., blackouts, seizures, self-harm, etc.), so they are reluctant to transport people long distances. As a result, law enforcement and rescue from most areas of the state avoid bringing people to BH Link (even those located in Providence).
- **Shorten the assessment time and eligibility requirements:** Another reason that law enforcement and rescue are reluctant to bring people to BH Link is the screening and assessment requirements. They must call ahead and report waiting for 30+ minutes to find out if BH Link will accept the patient. There is also a perception that BH Link has very rigid rules for who they will take— another deterrent for law enforcement. Finally, BH Link often does not come up as an option unless the patient knows about it or the rescue provider is knowledgeable enough to suggest it to the patient (or wants to suggest it). This significantly limits the utilization of BH Link by people who require rescue services or law enforcement involvement.
- **Increase capacity:** There is a perception that BH Link frequently discharges people back to emergency rooms because they cannot provide the appropriate level of care or are at capacity.

**Strengthen post-discharge follow-up and care coordination:** Some interviewees shared that people who have used the BH Link service report that there is little to no follow-up after discharge from BH Link.

Rhode Island also recently implemented mobile response and stabilization services (MRSS) for children and youth. In May and June 2022, Rhode Island used funding from the Rhode Island Department of Education (RIDE) to create a small MRSS project with two contracted organizations, Family Services of Rhode Island (FSRI) and Tides Family Services. MRSS aims to provide immediate, appropriate, in-person care and follow-up to children and families in crisis to prevent as many children as possible from seeking institutional care. Referrals are accepted and responded to 24/7, 365 days per year. The response team includes at least two people: a masters-level clinician and a paraprofessional. Follow-up interventions, coordination, and case management are provided up to 30 days after the initial assessment. The services can go beyond 30 days if there is nowhere more permanent to care for the patient. Transitional discharge planning and involvement with the family remain in place until there is a secure connection to the services within the children's behavioral health system of care.

For the initial building block program, the Executive Office of Health and Human Services (EOHHS), RIDE, and the participating organizations partnered with the Providence Public School District to ensure wraparound support for children receiving mobile response support services at home and school. In November 2022, EOHHS expanded this program with $5 million in Home and Community-Based Services (HCBS) funding. EOHHS reached out to 12 high-need districts across the state, working with RIDE to identify which districts should be prioritized given limited funding. EOHHS will work closely with the 988 Sucide and Crisis Lifeline, RIDE, and the Department of Children, Youth, and Families (DCYF) to ensure that referral and triage protocols are aligned and connected. Additional Substance Abuse and Mental Health Services Administration (SAMHSA) funding will allow the State to continue to expand MRSS for children until the State's Certified Community Behavioral Health Clinic (CCBHC) program starts in February 2024 (if approved by the legislature). At that time, MRSS will transition to become a required service for Certified Community Behavioral Health Clinics funded through Medicaid reimbursement.

In addition, Newport Mental Health has started a new program called Rhode Island Outreach, based on the CAHOOTS (Crisis Assistance Helping Out On The Streets) model. The CAHOOTS response team includes a crisis intervention worker skilled in counseling and de-escalation techniques and a medic who is either an EMT or a nurse. This pairing allows CAHOOTS teams to respond to a broad range of situations.

## Strategies

- Continue to find ways to expand investment in Crisis Intervention Training (CIT) for both law enforcement and rescue, and make the training affordable and accessible to municipalities.
- Continue to expand investments in diversion strategies (e.g., mobile crisis services and BH Link), and address areas for improvement.
- Ensure that mobile crisis referral and triage protocols are aligned with existing programs and systems like the Suicide Prevention Initiative (SPI), Project AWARE, law enforcement, rescue services, and BH Link.

## Goal 3: Plan for safety and follow-up after an attempt

Preventing suicide reattempts includes safety and crisis response planning, follow-up contact, and brief contact interventions leveraging diverse modalities such as home visits and phone outreach. These strategies are designed to help individuals get treatment after attempting suicide. They can also increase adherence to treatment and promote continuity of care.[7] Interventions that support engagement and safety during care transitions are critical to suicide prevention. 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. 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 individuals and typically invite individuals to reconnect with their providers.

The efficacy of transitions and discharge planning for suicide care varies widely in Rhode Island. Often discharged individuals wait six or more weeks for an appointment with an outpatient clinician. In the meantime, during that period (the highest-risk period), they may get little to no support or caring contacts unless they have access to a Zero Suicide peer. Having peer support while an individual is waiting for outpatient services is critical. In addition, the absence of clinical support during this time puts an enormous burden on the peer to help the individual get through the transition. Also, very few discharged individuals receive support from community health workers to address social determinants of health. More needs to be done to support individuals post-discharge after a suicide attempt.

### Strategies

- Develop clear plans and hand-off protocols between all levels of intervention to support coordinated and continuous care and ensure the safety and well-being of all individuals assessed and treated for suicide risk.
- Ensure adequate and responsive after-care, especially post-discharge from acute care:
  - Encourage health and behavioral healthcare providers to utilize caring contacts (e.g., follow-up calls, texts, and cards) to support connections to care and prevent future suicide attempts.
  - Explore models for intensive care transitions that connect people to services and supports in their home communities upon discharge from a psychiatric inpatient setting.
- Create strong partnerships between community providers and hospitals to assist with continuity of care.
- Use data on Emergency Medical Services (EMS) runs and emergency department visits for attempted suicides to deploy outreach workers for follow-up.

### Goal 4: Provide therapeutic approaches

Therapeutic approaches include various forms of suicide prevention-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.[7]

In addition to clinician shortages and long wait times for outpatient services, Rhode Island does not have enough clinicians trained in suicide prevention-focused psychotherapy. According to key informants, of those who are trained, very few currently participate in the insurance system, meaning their services must be fully paid out of pocket. Examples of evidence-based therapies include but are not limited to Cognitive Behavioral Therapy (CBT), Collaborative Assessment and Management of Suicidality (CAMS), Safety Planning (using the Stanley Brown instrument), and Dialectical Behavior Therapy (DBT).

### Strategies

- Increase the number of available Rhode Island clinicians able to provide suicide prevention-focused psychotherapy, such as Cognitive Behavioral Therapy (CBT), Collaborative Assessment and Management of Suicidality (CAMS), Safety Planning (using the Stanley Brown instrument), and Dialectical Behavior Therapy (DBT).

## Priority 7: Lessen harms and prevent future risks

Many people are bereaved by suicide yearly. The risk of suicide can increase among people who have lost a friend or peer, family member, coworker, or another close contact to suicide. The potential long-term effects among survivors are not currently well understood. However, public messaging and media reporting are important in preventing and reducing future suicide risks. For example, targeted media campaigns can increase exposure to protective factors by promoting resiliency and encouraging help-seeking behaviors. Research also suggests that media can play a role in increasing exposure to risk factors (e.g., reports of suicide that include sensational or otherwise uninformed reporting can inadvertently contribute to what is known as suicide contagion).[7]

### Goal 1: Intervene after a suicide (postvention)

One approach that can lessen harm and prevent future risk of suicide is postvention. 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, faith leaders, local community 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.

Rhode Island has limited postvention services, especially in the area of bereavement support groups for surviving friends, family members, or other close contacts. Currently, there are three available services, and they do not appear to be widely known:

- Wood River Health, as part of the Washington County Zero Suicide program, sponsors the state's only support group for survivors of suicide attempts (SOSA). This initiative is grant funded. The funding ends in September 2023.
- Friendsway offers specialized bereavement groups for children and teens affected by suicide. Volunteer clinicians facilitate these groups, but several factors limit their capacity: the number of volunteers available; physical space (as of the writing of this report they were at capacity); the location of their building, which is in Warwick and not easily accessible to many parts of the state; and the lack of bilingual volunteer clinicians to facilitate groups in languages other than English.
- The Samaritans of Rhode Island offers the Safe Place program, Rhode Island's only adult bereavement support group for people grieving the loss of a loved one to suicide. The meetings are held in Providence.

### Strategies

- Sustain financial support for the Survivors of Suicide Attempts (SOSA) support group.
- Establish more geographically accessible bereavement support groups in Rhode Island. Ensure services are multilingual, culturally sensitive, and meet the needs of different age groups.
- Help to integrate suicide prevention efforts across sectors and settings, like faith- and community-based organizations, by providing a postvention toolkit for faith leaders and local community leaders to support them in providing comfort to those affected by suicide.
- Support implementation of trauma response teams of trained volunteers who provide supportive services to agencies, businesses, and/or informal groups who have experienced a recent death by suicide, sudden traumatic loss, or other traumatic incidents. Volunteers should receive training in healthy processing, Mental Health First Aid, and/or have other related skills.

## Goal 2: Report and message about suicide safely

A second approach that can lessen harms and prevent future risk of suicide is safe messaging and reporting about suicide. Public messaging about suicide prevention is a key communication strategy for educating individuals about warning signs and resources available to help individuals at risk for suicide before a crisis occurs. Safe messaging emphasizes that suicide is 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 information about a suicide is shared (like during school assemblies), can heighten the risk of suicide among at-risk individuals and can inadvertently contribute to suicide contagion.

There is no central coordination of safe reporting following a suicide in Rhode Island. Several key informants shared anecdotal stories of poor messaging and communication in their communities after a death by suicide.

### Strategies

- Provide a postvention toolkit to schools, communities, and the media that offers comprehensive, practice-informed, and evidence-based guidance when responding to a death by suicide.

## Priority 8: Build Rhode Island's suicide prevention infrastructure

State-level coordination of suicide prevention is important to ensure that prevention strategies implemented within communities address the people at highest risk for suicide and are comprehensive in scope.[39]

### Goal 1: Establish multi-sectoral partnerships to plan and implement suicide prevention efforts

Suicide prevention cannot be a one-person or single-agency effort. While public health and behavioral health agencies are well primed to take on a leadership role and convene stakeholders, build capacity (e.g., support coalitions, develop training resources), and expand suicide prevention efforts, partnerships across a broad set of community partners such as prevention coalitions, task forces, or multi-agency work groups is essential to build commitment and ownership.

Ultimately, agencies working in clinical health, mental health, substance use, education, justice, Veterans services, healthcare, healthy aging, school systems, and private sector groups need to be involved and play a role in developing and implementing the plan. Engagement from groups at the highest risk for suicide (e.g., representatives from LGBTQ+ communities, suicide attempt survivors, and survivors of suicide loss) are essential participants in any planning effort. Ideally, a convening agency with at least one position to support suicide prevention in the State should serve as the lead author and manage the State's suicide prevention plan to ensure a coordinated effort. Without sustained leadership and infrastructure, well-intentioned suicide prevention activities can be fragmented and non-strategic, and thus unable to achieve sufficient range, depth, or focus to have a measurable impact on reducing suicides or suicide attempts.

Currently, Rhode Island has a group of stakeholders who convene in support of the Governor's Challenge to Prevent Suicide among Service Members, Veterans, and their Families, but does not have a dedicated group of stakeholders focused on suicide prevention for all populations in the state.

It should also be noted that Rhode Island has a number of renowned suicide prevention researchers working at Brown University. Their expertise can be utilized to train Rhode Island's workforce and provide consultation.

### Strategies

- Convene a coalition of stakeholders focused on suicide prevention, and meet regularly to engage in strategic discussions and facilitate partnerships and information sharing.
- Leverage the outreach capacity of the Regional Prevention Task Force coalitions to facilitate suicide prevention efforts.
- Foster partnerships with suicide prevention researchers and faculty at Brown University and other institutions of higher education to provide training and foster the adoption of best practices in Rhode Island.
- Explore the possibility of partnering with Brown University to host an annual conference focused on suicide prevention.

## Goal 2: Enhance the state's capacity to use data to inform suicide prevention efforts

State suicide prevention plans should be data-driven, living documents. Data on suicide and suicide attempts, including suicidal behavior among people receiving care in behavioral healthcare systems, should be monitored and analyzed regularly. Rhode Island has several sources of data to help inform suicide prevention planning and conduct surveillance, including:

- Mortality data from the Rhode Island Violent Death Reporting System (RIVDRS)
- Morbidity data from quarterly hospital discharge data and real-time (every 24 hours) emergency room visit data
- Self-reported data from the Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH) Rhode Island Student Survey
- Self-reported data from the BHDDH Rhode Island Young Adult Survey (RIYAS)
- Self-reported data from the Rhode Island Department of Health (RIDOH) high school and middle school Youth Risk Behavior Survey (YRBS)

Each source has its strengths and limitations. For a more comprehensive description of each data source, its strengths, and its limitations, please see the Appendix.

As a small state, Rhode Island is limited in how it can report data related to suicide mortality and morbidity due to its small numbers policy. Counts under five must be suppressed due to privacy and reliability concerns. With approximately 100 deaths by suicide per year, this makes it difficult to report on or analyze mortality data for disparately affected populations, such as individuals identifying as LGBTQ+, experiencing intimate partner violence or homelessness, or with prior involvement in the criminal justice system. It is also difficult to understand patterns in deaths by suicide on bridges unless multiple years of data are aggregated.

Another challenge is understanding patterns in morbidity data for numerically small but disparately affected populations and priority populations such as Veterans, because the information is not routinely captured in hospital records or included in the hospital discharge data sets shared with RIDOH. Expanding what is captured in morbidity data and required for hospital reporting would provide Rhode Island with the data that are needed for a deeper understanding of patterns among disparately affected and priority populations.

### Strategies

- Strengthen data collection and sharing to enable a better understanding of patterns among priority populations and numerically small but disparately affected populations, including but not limited to:
  - Veterans
  - Individuals experiencing housing instability
  - Individuals identifying as LGBTQ+
  - Survivors of intimate partner violence
  - Individuals with involvement in the criminal justice system

# APPENDIX A: DESCRIPTION OF DATA SOURCES

**Mortality Data:** The Rhode Island Violent Death Reporting System (RIVDRS) provides data on all violent deaths in Rhode Island. Data reflect violent deaths (suicides, homicides, undetermined deaths) occurring in Rhode Island. The city or town where the death occurred may differ from the city or town where the individual was pronounced dead. If the location of the incident was not in Rhode Island or is unknown, the death is not usually included in a geographical count. Variations in unknown city/town of the incident may impact trends. Rhode Island residents who died of a violent death outside of Rhode Island are omitted.

Compared with available morbidity data, mortality data are generally more completely reported. Legally, all deaths have to be recorded and a death certificate issued. These data are also more comprehensive. Deaths resulting from suicide are usually investigated and more information is collected compared to nonfatal attempts. Information from all death certificates becomes part of the National Vital Statistics Records System. This system produces public information that can be easily accessed online and is also used as the basis of many reports and analyses. Even so, mortality data provide an incomplete picture of the problem of suicidal behavior, because most suicide attempts do not result in death and, by definition, are not included in mortality data.

In addition, despite better reporting than morbidity data, not all suicides are reported. Sometimes there is not enough information to determine intent. Without conclusive evidence, potential suicides may be recorded as unintentional or undetermined on death certificates. Even if the subsequent investigation determines that the death was a suicide, the death certificate may not be updated to reflect this finding. Medical examiners, coroners, physicians, and public safety professionals may not record a death as a suicide to spare the victim and their family the social stigma sometimes associated with a death by suicide (or to avoid other consequences, such as voiding the victim's life insurance and thereby denying benefits to the victim's family). Inconsistent case definitions about what determines a suicide create difficulty in coding mortality data.

**Morbidity Data:** Rhode Island has two data sources on medically treated, nonfatal suicide attempts. All hospital systems in Rhode Island report discharge data on hospital visits every quarter. Hospital visits that are self-harm- or suicide-related are identified using specific criteria. However, interpreting these data is challenging because it is hard to determine intent. Rhode Island also has syndromic surveillance data. All acute-care hospitals send emergency department visit data every 24 hours to the Rhode Island Department of Health (RIDOH) through a system called ESSENCE. Epidemiologists at RIDOH monitor these data using a syndrome algorithm developed by the Centers for Disease Control and Prevention (CDC) based on the chief complaint when presenting to the emergency department and discharge diagnosis. Visits that meet the criteria are flagged, and the data are used to monitor patterns. While these data potentially provide a complete picture of the problem of suicidal behavior, because most suicide attempts do not result in death, they are still less completely reported. While psychologically serious, many suicide attempts are not medically serious enough to require medical attention and do not get reported/coded. Some attempts that do require medical attention are also not coded as suicide attempts. Also, while hospital datasets are more accessible for public health surveillance than data from private physicians, clinics, and health maintenance organizations, hospital data may under- or over-represent certain subgroups. For example, lower-income people are more likely than higher-income people to use emergency departments to care for lower-severity medical problems. As a result, hospital data may over-represent suicide attempts among lower-income people. People who are treated for a suicide attempt at a psychiatric facility or a US Department of Veterans Affairs medical facility will also not be captured by hospital discharge data, as these facilities do not participate in the Uniform Hospital Discharge Data System.

**Self-Reported Data:** Rhode Island also has self-reported data on suicidal behavior. These data provide a more complete picture of individuals suffering from suicidal feelings or behaviors and can be useful for evaluating trends over time. Because suicide is a relatively rare event, it is difficult to measure the impact of a suicide prevention program on mortality data, particularly at the local level. Nonfatal attempts and suicidal ideation are far more frequent and, therefore, more sensitive to changes over time. However, it is more difficult to collect data accurately about how people feel or think versus how they behave, and self-reported data are subject to reporting biases. For example, high school students are asked on the Youth Risk Behavior Survey if they ever seriously considered suicide. This question is subject to recall bias (not all people will remember), social desirability bias (not all will want to admit suicidal feelings, even on an anonymous survey), and definition issues. After all, what is meant by "seriously" considered suicide? Mental Health America also conducts an annual survey and publishes state rankings on several mental health variables.

# APPENDIX B: KEY INFORMANTS

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|---|---|---|
| Katelyn C. Affleck, PhD | Lead Psychologist | Lifespan Physician Group, Bradley Hospital |
| Sibel Algon, MD | Unit Chief, Adolescent Inpatient Units | Bradley Hospital Outpatient Services, Adolescents |
| Denise Alves | Co-Director | East Bay Regional Coalition |
| Jillian Angell | Youth and Young Adults Coordinator | Tobacco Control Program, Rhode Island Department of Health |
| Arnaldo Berges, MD | Assistant Chief of Psychiatry and Director of Adult Inpatient Psychiatry | Rhode Island Hospital |
| Adriana Briceno | Community Living Aide | Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals |
| Michelle Brophy | Associate Director, Interdepartmental Services/Vulnerable Populations | Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals |
| Lisa Carcifero | Regional Director | Blackstone Valley Prevention Coalition |
| Brittany Church | Medicaid State Plan Coordinator | Rhode Island Executive Office of Health and Human Services |
| Maria Cimini | Director | Rhode Island Office of Healthy Aging |
| Brenda Clement | Director | HousingWorks RI |
| Kerrie Constant | Area Director, Rhode Island | American Foundation for Suicide Prevention |
| Tara Cooper | Chief | Center for Health Promotion, Rhode Island Department of Health |
| Jay Cordova | Fellow | National Academy for State Health Policy |

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| Melissa Cotta, RN, MSW | Founder | RI Bridging the Gap |
| Sarah Dinklage | Chief Executive Officer | Rhode Island Student Assistance Services |
| Tricia Driscoll | Executive Director | Center for Mediation and Collaboration RI |
| Elizabeth Farrar | Associate Administrator, Office of Prevention | Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals |
| Ruth Feder | Interdepartmental Project Manager | Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals |
| Kim Ferrante, LICSW | Community Engagement and Partnership Coordinator | VA Providence Healthcare System |
| Nicolas Ferro | Social Worker | Building Futures |
| Karen Flora | Associate Administrator/Project Director | Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals |
| Rochelle Fortin | Director | Providence Vet Center (at the time of interview); now with the Providence VA Medical Center |
| Bryan Ganley | Founder | RI Bridging the Gap |
| Michele Gessman, LICSW | Clinical Director of Social Work and Counseling | Bradley Hospital |
| Melissa Goldstein | Project Director | Bristol Health Equity Zone |
| Erin Goodman | Peer Recovery Specialist | Washington County Zero Suicide Program |
| Rob Harrison | Director | Washington County Zero Suicide Program |
| Heidi Hartzell | Policy and Partnerships Specialist | Tobacco Control Program, Rhode Island Department of Health |
| Kate Hawley | Community Champion | Bristol Health Equity Zone |
| Laurie Heydon | Community Champion, School Psychologist | Bristol Health Equity Zone, Bristol-Warren School District |
| Melissa Holcomb | Administrator | Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals |
| Amy Hulberg | Medicaid Policy Director | Rhode Island Executive Office of Health and Human Services |
| Jeffrey Hunt, MD | Director of Inpatient and Intensive Services | Bradley Hospital |

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| Colleen Judge | Director, School-Based Services | Rhode Island Student Assistance Services |
| Cory King | Acting Health Insurance Commissioner | Office of the Health Insurance Commissioner |
| Jacqueline Lafontant | Senior Planning and Program Development Specialist | Office of the Child Advocate |
| Don LaLiberte, LICSW | Assistant Director, Pediatric Behavioral Health Emergency Services | Lifespan Behavioral Health Emergency Services |
| Beth Lamarre | Executive Director | National Alliance on Mental Illness Rhode Island |
| Ryan Loiselle, LICSW | Program Director | FRIENDS WAY |
| Kathleen Kemp, PhD | Director | Rhode Island Family Court Mental Health Clinic |
| Zach Kenyon | Chief of Rescue | Providence Fire Department |
| Ian Knowles | Director | RICARES |
| Marybeth MacPhee | Community Champion, Professor of Public Health | Bristol Health Equity Zone, Roger Williams University |
| Thomas Martin | Director, Division of Behavioral Healthcare | Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals |
| James McNulty | Executive Director | Oasis Wellness & Recovery Centers of Rhode Island |
| Hannah Meharg | Associate | Rhode Island Prevention Resource Center |
| Margaux Morisseau | Deputy Director | Rhode Island Coalition to End Homelessness |
| Rachel Morse, MSHS, CPS | Co-Director | Rhode Island Prevention Resource Center |
| Weayonnoh Nelson-Davies, JD | Executive Director | Rhode Island Economic Progress Institute |
| Obed Papp | Program Manager and Regional Coalition Director | Healthy Communities Office, City of Providence |
| Lynne and John Patton | Co-Founders | Matthew Patton Foundation |
| Stacy Perin | Associate Director | The Spurwink School |
| Marisa Petreccia | Deputy Director | Rhode Island Department of Human Services |
| James Rajotte, MS | Director of Strategy and Innovation | Rhode Island Executive Office of Health and Human Services |

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|---|---|---|
| Kim Rausch | Associate Director of Policy and Program · | Rhode Island Department of Human Services |
| Zachary Rega-Oliveira, MHA, MSN, PMHNP-BC, NEA-BC | Director, Psychiatric Nursing Services | Rhode Island Hospital and Hasbro Children's Hospital |
| Gary Regan, LICSW | Clinical Director | Adolescent Partial Hospital and SafeQuest Programs, Bradley Hospital |
| Rosemary C. Reilly-Chammat, EdD | Associate Director for School Health and Extended Learning | Rhode Island Department of Education |
| Leigh A. Reposa, LICSW | Rhode Island Youth Suicide Prevention Program Manager | Rhode Island Student Assistance Services |
| Ellen Reynolds, EdD | Vice President, Student Affairs | University of Rhode Island Health Services |
| Lucy Rios | Executive Director | Rhode Island Coalition Against Domestic Violence |
| Candace Rodgers | Lead Administrator of Prevention and Recovery Services | Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals |
| Alicia Rodriguez | Community Engagement and Partnership Coordinator | Providence VA Medical Center |
| Marti Rosenberg | Director of Policy, Planning, and Research | Rhode Island Executive Office of Health and Human Services |
| Corrina Roy | Associate Director, Division of Behavioral Healthcare | Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals |
| Tim Ruel | Employment and Training Case Manager | Operation Stand Down |
| Paul Santilli, LICSW | Counselor | Providence Vet Center, Warwick |
| Catherine Schultz | Director, Governor's Overdose Task Force | Rhode Island Executive Office of Health and Human Services |
| Jeanne Smith, LICSW | Suicide Prevention Coordinator | Providence VA Medical Center |
| Tyrone Smith | Director of Employment and Training | Operation Stand Down |
| Emily Spence | Suicide Prevention Work Group Champion | Bristol Health Equity Zone |
| Anthony Spirito | Director, Division of Clinical Psychology | Warren Alpert Medical School of Brown University |
| Shannon Spurlock, MA, CPS | Co-Director | Rhode Island Prevention Resource Center |
| Kathy Sullivan | Director, Coastline EAP | Kent Prevention Coalition |

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| Patricia Sweet | Director, Region 1 Prevention Coalition | Tri-County Community Action Agency |
| Andy Taubman, LCSW | Director of Youth Service | Youth Pride, Inc. |
| Jo-el Tillinghast | 988 Community Network Coordinator | Community Care Alliance (at time of interview); current position is with Horizon Healthcare Partners |
| Lisa Tse | Interdepartmental Project Manager | Rhode Island Executive Office of Health and Human Services |
| Hailey Voyer | Public Health Epidemiologist | Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals |
| Kristen Westmoreland | Co-Director | East Bay Regional Coalition |
| Jennifer Wolff, MD | Staff Psychologist, Researcher on Suicide | Lifespan Physician Group, Bradley Hospital |
| Gracie Woodcock | Community Champion | Bristol Health Equity Zone |
| Victor Woods | Health Economic Specialist | Office of the Health Insurance Commissioner |

## Endnotes

[1] Drapeau, CW, & McIntosh, JL (2021). U.S.A. suicide: 2020 Official final data. Minneapolis, MN: Suicide Awareness Voices of Education (SAVE), (December 24, 2021) https://save.org/wp-content/uploads/2022/01/2020datapgsv1a-3.pdf

[2] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999-2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999-2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html

[3] Rhode Island Violent Death Reporting System (RIVDRS) (2011-2020), Suicide deaths that occurred in Rhode Island among Rhode Island residents.

[4] American Foundation for Suicide Prevention (2020) https://afsp.org/chapter/rhode-island

[5] Rhode Island Violent Death Reporting System (RIVDRS) (2021). 113 suicide deaths in Rhode Island among Rhode Island residents were reported during 2021.

[6] For example, first responders, law enforcement, and construction workers.

[7] Centers for Disease Control and Prevention (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.

[8] Rhode Island Violent Death Reporting System (RIVDRS) collects data on Veteran/Military status; however, it does not distinguish between whether the individual was on active duty versus a Veteran.

[9] Rhode Island Violent Death Reporting System (RIVDRS). 1,066 of the 1,107 suicide deaths during this time had circumstance information available (96.3%). Percentages were calculated among deaths with known circumstances in RIVDRS.

[10] Harvard TH Chan School of Public Health. Firearm Access is a Risk Factor for Suicide. https://www.hsph.harvard.edu/means-matter/means-matter/risk/

[11] Rhode Island Violent Death Reporting System (RIVDRS). Bridge-related suicides that occurred in Rhode Island, 2011-2020.

[12] Mental Health America, Adult Data 2022, https://mhanational.org/issues/2022/mental-health-america-adult-data

[13] Data includes emergency department visits and hospitalizations among Rhode Island residents ages 10 years and older. Includes all acute care hospitals in Rhode Island; excludes specialty hospitals/rehabilitation centers. Visits and hospitalizations relating to intentional self-harm/suicide attempts were identified based on the presence of ICD-10 codes in any diagnosis field. Totals for emergency department visits include visits where the patient was subsequently admitted to the hospital.

[14] A note about "other, non-Hispanic": Rhode Island is not able to evaluate suicide rates for the many different ethnic groups contained within this category due to the Department of Health's small numbers policy. Among other groups, this category contains Asian and Pacific Islander people, and American Indian/Alaskan Native people. In particular, it is important to recognize that national evidence tells us that American Indian/Alaskan Native people are more likely than any other racial or ethnic group to die by suicide.

[15] National Syndromic Surveillance System, Centers for Disease Control and Prevention (CDC) Emergency department (ED) visit data.

[16] Rhode Island Economic Progress Institute, RI Standard of Need 2022, https://www.economicprogressri.org/rhode-island-standard-of-need-8/

[17] The Providence Journal, RI racial gap in homeownership worse than national average (June 16, 2022), https://www.providencejournal.com/story/news/local/2022/06/16/brown-university-report-ri-racial-gap-owning-house/7633908001/

[18] The wait time for a shelter changes daily. At the time of the interview, the RI Coalition for the Homeless reported a 30-day wait.

[19] The Center for Budget and Policy Priorities, Families Wait Years for Housing Vouchers Due to Inadequate Funding (July 22, 2021), https://www.cbpp.org/research/housing/families-wait-years-for-housing-vouchers-due-to-inadequate-funding

[20] Diversion is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing.

[21] Cottle, J.L., Fuller, M., & Avila, S. (May 2021). Suicide Barriers on RI Bridges.

[22] PTZ cameras are built with mechanical parts that allow them to swivel left to right, tilt up and down, and zoom in and out of a scene.

[23] Bennewith O, Nowers M, Gunnell D. (2011). Suicidal behaviour and suicide from the Clifton Suspension Bridge.

[24] Possession of a Pistol/Revolver Safety Certificate, also known as the "blue card," is a required document as part of the process to purchase a handgun and/or ammunition in Rhode Island. The blue card certifies that the applicant has successfully passed the State's requisite safety exam.

[25] The CRAFFT is a health screening tool designed to identify substance use, substance-related riding/driving risk, and substance use disorder among youth ages 12-21. https://crafft.org/about-the-crafft/

[26] Mental Health America, Ranking the States 2022. https://mhanational.org/issues/2022/ranking-states

[27] Mental Health Association of Rhode Island, Mental Health Parity in Rhode Island: Experiences of patients and professionals (2020). https://mhari.org/wp-content/uploads/2020/07/ParityReport2020Final.pdf

[28] Licensed mental and behavioral health clinicians include roles such as psychologists, masters-level counselors, clinicians, and therapists, clinical social workers, psychiatrists, and psychiatric nurse practitioners.

[29] While ratios are a reasonable benchmark of capacity, it is important that student and family need be the primary driver for determining needed staffing ratios.

[30] Rhode Island KIDS COUNT. Children's mental health in Rhode Island (October 2022). https://www.rikidscount.org/Portals/0/Uploads/Documents/Issue%20Briefs/11.22%20Mental%20Health%20Brief%20FINAL.pdf?ver=2022-11-15-121931-453

[31] ZeroSuicide, Framework, https://zerosuicide.edc.org/about/framework

[32] National Officer Safety Initiatives, Preventing Suicide Among Law Enforcement Officers: An Issue Brief (2020). https://www.theiacp.org/sites/default/files/2020-02/_NOSI_Issue_Brief_FINAL.pdf

[33] Rhode Island supports Rhode Island K-12 schools and districts in the implementation of a multi-tiered system of supports (MTSS) framework and the practices, data, and systems that lead to better outcomes for all students. https://www.mtssri.org/

[34] Gatekeeper training is one of the most widely used suicide prevention strategies. It involves training people who are not necessarily clinicians to be able to identify people experiencing suicidality and refer them to appropriate services.

[35] Natural touchpoints are places like domestic violence crisis centers, legal services for immigrant populations, unemployment offices, employee assistance programs (EAP), providers, banks, and justice systems. Natural touchpoints also include places and situations involving youth transitioning out of foster care, providers working with individuals newly diagnosed with chronic or serious mental or physical health problems, providers who work with the bereaved, such as funeral directors, individuals selling firearms and providing training in their use, and faith leaders.

[36] Data from the 2021 Rhode Island Youth Risk Behavior Survey (YRBS) show that there has been a significant increase in serious thoughts about suicide and suicidal attempts among young Rhode Islanders since 2011. For example, during that period: 1) the percentage of high school students seriously considering attempting suicide increased from 12.3% to 17.1%, and 2) the percentage of high school students who made plans to attempt suicide increased from 10.7% to 14.5%.

[37] Mobile response is delivered to children experiencing escalating emotional symptoms, behaviors, or traumatic circumstances that have compromised or impacted their ability to function within their family, living situation, school, or community. The goal of MRSS is to provide intervention and support at the earliest moment families identify that help is needed. It includes four components: 1) on-site intervention for immediate de-escalation of presenting emotional symptoms and behaviors, including observing, interrupting and shifting dynamics, providing education and skill introduction; 2) assessment, planning, skill building, psycho-education, and resource linkage to stabilize presenting needs, including understanding strengths, triggers, communication, and other key contexts (medical, mental health, trauma, development, patterns of behavior, collateral outreach, etc.); 3) assistance to the child and family in returning to baseline or routine functioning, and the prevention of further escalation, and 4) provision of prevention strategies and resources to cope with presenting emotional symptoms, behaviors, and existing circumstances, and create a plan to avoid future crises. For more detail about Rhode Island's mobile response initiative, see page 37.

[38] Rhode Island Department of Education, Learning, Equity, Accelerated Pathways (LEAP) Taskforce Report (July 2021), https://www.ride.ri.gov/Portals/0/Uploads/Documents/COVID19/LEAPTaskForceReport.pdf?ver=2021-04-28-150118-777

[39] Suicide Prevention Resource Center, State Suicide Prevention Infrastructure, https://sprc.org/state-infrastructure/

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