

2021

Tennessee Department of Health: Suicide Prevention Report



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Acknowledgments

The Tennessee Department of Health (TDH) expresses its extreme gratitude to the individuals who contributed their time to participate in the Suicide Prevention Stakeholder Task Force. The task force brought together a diverse group of stakeholders to ensure broad representation across all sectors involved in suicide prevention activities across the state.

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Executive Summary

The Suicide Prevention Act of 2018 (TCA § 68-3-703) recognized suicide as a serious public health issue in Tennessee and provided authorization for a suicide prevention program to be created within the Department of Health. The goal of the suicide prevention program is to review existing data and resources to identify promising practices and gaps in services for preventing suicide. This report describes deaths by suicide in Tennessee, along with the demographic characteristics of those deaths. The report also describes emergency department and hospitalization visits for suicide attempt and ideation. In addition, this report highlights risk factors for suicide across Tennessee through data collected from the Youth Risk Behavioral Survey, the Behavioral Risk Surveillance Survey, Electronic Surveillance Systems for the Early Notification of Community Based Epidemics (ESSENCE), and child fatality review. Through a comprehensive review of data and resources, along with input from key stakeholders, this report identifies specific opportunities for prevention of deaths by suicide. Below are key findings and recommendations:

Key Findings: Suicide Fatalities in Tennessee

- The total number of deaths by suicide increased by 13% from 2015 to 2019 (1,065 vs. 1,220 deaths). The rate of deaths by suicide (per 100,000 population) increased by 11% from 2015 to 2019 (16.1 vs 17.9 respectively). The 2019 rate of suicide in Tennessee is 29% higher than the national rate (13.9).
- In 2019, the suicide death rates were highest among adults aged 25-64 (22.8 per 100,000) and lowest in children/youth aged 10-24 (10.0 per 100,000).
- More males than females die from suicide. The rate of suicide in Tennesseean (28.3 per 100,000) males is 3.6 times higher than of females (7.9 per 100,000).
- Ninety percent of suicide deaths in 2019 were among white individuals, and the rate for Whites (20.5 per 100,000) was over twice that of Blacks (8.6 per 100,000).
- Firearms are the leading mechanism of deaths by suicide, accounting for 61% of all 2019 suicide deaths.
- The burden of suicide varied across Tennessee regions with Shelby County having the lowest rate and Upper Cumberland having the highest (10.2 vs 21.6 per 100,000 population) for 2015-2019 combined.

Key Findings: Suicidal Ideation and Suicide Attempts in Tennessee

- In 2019, there were 7,294 emergency department (ED) visits and 2,523 inpatient hospitalizations for nonfatal intentional self-harm injuries. In addition, there were 28,879 ED visits and 13,399 inpatient hospitalizations with suicidal ideation but no accompanying self-harm injury.
- The total cost of self-harm based on the median cost in 2019 was approximately \$57 million for hospitalization and \$33 million for ED visits.

- Youths and middle-aged adults have the highest rates of self-harm. Between 2016 and 2019, the rate (injuries per 100,000) of self-harm was consistently highest among TN residents aged 15-24 years and followed by those aged 25-44 years.
- Between 2016 and 2019, females represented a higher proportion of intentional self-harm for ED visits (60.5%) and hospitalizations (58.0%) compared to males.
- Between 2016 and 2019, males bore a larger burden of suicide ideation in ED visits (55.8%) than females, while the proportion of suicide ideation in ED visits (50.2%) was similar to females (49.8%).

Recommendations for Prevention

A summary of the recommendations to prevent suicide are presented on the next page. The recommendations are divided into seven categories: legislative policies, state and community agencies, clinics and hospital systems, healthcare providers, public safety/emergency response agencies, educational institutions and individuals, families, and friends. A more detailed description of the recommendations can be found on page 49.

Summary of 2021 Recommendations

Legislative Policies

- Mental health facilities should comply with legislation that allows mental health records of patients who have died by suicide to be shared with medical examiners and state fatality review programs
- Health insurers in Tennessee should comply with the Mental Health Parity and Addiction Equity Act to provide mental health benefits comparable to medical benefits.

State and Community Agencies

- Increase access to adequate mental health care for all Tennesseans
- Spread awareness of suicide and encourage help-seeking behavior
- Support the use of standardized behavioral health assessment protocols and tools
- Strengthen the crisis response infrastructure with an emphasis on children and rural communities
- Support suicide prevention trainings promoting connectedness and resiliency

Clinics and Hospital Systems

- Health and behavioral health care systems should maintain “suicide safe” facilities
- Implement policies to provide information on lethal means restriction to patients and families
- All hospitals should continue to report into the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) database to monitor ED utilization.

Healthcare Providers

- Disseminate suicide prevention educational materials to patients.
- Primary care and pediatric providers should increase screening of patients for risk of suicide and ensure appropriate referral and follow-up.
- Behavioral health providers should complete training on best practices for utilizing telehealth.
- Providers should complete the “Counseling on Access to Lethal Means” course.

Public Safety and Emergency Response Agencies

- Expand crisis intervention training to every public safety system and implement a standardized crisis response protocol across the entire state.
- Promote partnerships to implement crisis response models that support mental health diversion.
- Create safe, protective, and supportive work environments for first responder agencies.
- Develop a standardized suicide death investigation form and data collection tool.

Educational Institutions

- Increase mental health screening and referral in schools.
- Provide suicide prevention training to all school staff.
- Display the Tennessee statewide crisis number and text line information in schools.
- Implement the Good Behavior Game program within K-2 classrooms across the state.
- Implement Sources of Strength or Hope Squads in middle and high schools.
- Incorporate ESSENCE alert protocols into the school suicide prevention response plan.

Individuals, Families, and Friends

- Seek care with the earliest symptoms of depression or signs of suicide.
- Learn the risk factors for suicide, how to reach out for help, and appropriately refer a person at-risk.
- Seek training for emotion or anger control, problem solving, conflict resolution and coping skills.
- Complete suicide prevention gatekeeper trainings.
- Reduce access to lethal means within the home.
- Encourage conversations of suicide prevention awareness within the community.

Key Definitions

Definitions of terms used to describe suicide and suicide-related behavior by the Centers for Disease Control and Prevention (CDC) are outlined in the table below.

Term	Definition
Suicidal Ideation	Passive thoughts about wanting to be dead or active thoughts about killing oneself, not accompanied by preparatory behavior
Preparatory Acts and Suicidal Behavior	Acts or preparation toward making a suicide attempt, but before the potential for harm has begun. This can include anything beyond a verbalization or thought, such as assembling a method or preparing for one's death by suicide
Self-Harm (also referred to as self-injury)	Injury inflicted by a person on himself or herself deliberately, but without intent to die
Suicidal Crisis	An incident where an emotionally distraught person seriously considers or plans to attempt to take his or her own life imminently
Suicide Plan	An individual's thinking about a suicide attempt comprising elements such as timeframe, method, and place.
Suicide Attempt (also referred to as suicidal act)	Non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury
Suicide	Death caused by self-directed injurious behavior with any intent to die because of the result of the behavior
Suicidality (also referred to as suicidal behavior)	Term encompassing suicidal thoughts, ideation, plans and preparatory acts, suicide attempts, and completed suicide
Precipitating Factors for Suicide	Stressful events or experiences that can trigger a suicidal crisis in a vulnerable person
Warning Signs for Suicide	Behaviors indicate whether someone may be at immediate risk for suicide
Risk Factors for Suicide	Characteristics of a person or their environment or society that increase the likelihood of suicide death
Protective Factors for Suicide	Personal or environmental characteristics that reduce the likelihood of suicide death
Prevention	Strategy or approach that reduces the likelihood of risk of onset or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors.
Intervention	Strategy or approach intended to prevent an outcome or to alter the course of an existing condition (e.g., providing lithium for bipolar disorder or strengthening social support in a community).
Postvention	Strategy or approach implemented after a crisis or traumatic event has occurred.

Key Abbreviations

Key abbreviations for this report are listed within the table below.

Abbreviation	Full Text
TDH	Tennessee Department of Health
TDMHSAS	Tennessee Department of Mental Health and Substance Abuse Services
TSPN	Tennessee Suicide Prevention Network
TDOE	Tennessee Department of Education
CDC	Centers for Disease Control and Prevention
TNVDRS	Tennessee National Violent Death Reporting System
ESSENCE	Electronic Surveillance System for the Early Notification of Community-Based Epidemics
ED	Emergency Department
QPR	Question, Persuade, Refer
ASIST	Applied Suicide Intervention Skills Training
CSP	Comprehensive Suicide Prevention

Introduction

Suicide is a leading cause of death across the United States and continues to be a growing public health problem in Tennessee. The effect of suicide on individuals, families, friends, and communities is long-lasting and profound. In 2019, there were 47,511 suicide deaths in the United States, at a rate of 14.5 per 100,000-person population.¹ While suicide can affect persons of any age, race, gender, or socioeconomic background, certain demographics are particularly vulnerable to dying from suicide. Across the US, there is a higher rate of suicide deaths among men, non-Hispanic Whites, non-Hispanic Alaska Native/American Indians, residents of rural areas, young people who are lesbian, gay, or bisexual, and veterans/other military personnel.^{1, 2} Furthermore, deaths from suicide disproportionately affect certain age groups. From 2016 to 2019, suicide was the second annual leading cause of death among Americans aged 10 to 34 years.¹ Lastly, suicide varies by occupation or work industry, and these rates differ by sex. There are significantly higher rates of suicide for five major industry groups and six major occupational groups:

Work industries: 1) Mining, Quarrying, and Oil and Gas Extraction (males); 2) Construction (males); 3) Other Services (e.g., automotive repair) (males); 4) Agriculture, Forestry, Fishing, and Hunting (males); and 5) Transportation and Warehousing (males and females).³

Occupational groups: 1) Construction and Extraction (males and females); 2) Installation, Maintenance, and Repair (males); 3) Arts, Design, Entertainment, Sports, and Media (males); 4) Transportation and Material Moving (males and females); 5) Protective Service (females); and 6) Healthcare Support (females).³

Unfortunately, suicide death data only highlights a small fraction of individuals across the nation impacted by suicide or suicide-related behavior. For every suicide death in the United States, there are approximately twenty-five more individuals across the nation who will attempt suicide and an even more significant number of people who suffer from suicidal ideations. In 2019, 12.0 million Americans seriously considered suicide, 3.5 million Americans had a suicide plan, and 1.4 million Americans made a non-fatal suicide attempt.⁴ Suicide and suicide-related behavior are responses to multiple internal risk factors (e.g., depression, family history of mental illness or suicide, or substance abuse) and external risk factors (e.g., lack of social support, financial stress, or lack of access to behavioral health care.).



For **every** suicide death in the United States, approximately **25** more individuals attempt suicide and suffer from suicidal ideations.



To reduce the number of people who attempt or die by suicide across the nation, a healthy society could offer support, protection, and care throughout the community, rather than leaving it to be the responsibility of healthcare systems alone.

Through continued data collection and analysis, Tennessee Department of Health (TDH) aims to improve suicide prevention efforts across the state by: continuing to work collaboratively with

¹ CDC. Web-based Injury Statistics Query and Reporting System (WISQARS). (2020) Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. <https://www.cdc.gov/injury/wisqars/index.html>

² Youth Risk Behavior Survey, United States, 2019. MMWR Suppl; 69(Suppl-1): 47–55.

³ CDC. Morbidity and Mortality Weekly Report, Vol. 69, No. 3. https://www.cdc.gov/mmwr/volumes/69/su/su6901a6.htm?s_cid=su6901a6_w

⁴ SAMHSA. 2019 National Survey of Drug Use and Health (NSDUH). Key Substance Use and Mental Health Indicators in the U.S. <https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases>

multiple state and local agencies; supporting the expansion of current suicide prevention programs and policies offered throughout the state; and utilizing data-driven approaches to develop and implement innovative initiatives targeting those most at risk for suicide.

The purpose of the 2021 Suicide Prevention Report is to:

- Describe how suicide and suicidality impact Tennessee
- Provide a comprehensive overview of the current programs, resources, and services available to those individuals living in Tennessee who may be at risk for suicide
- Review evidence-based strategies and promising practices for suicide prevention
- Recommend suicide prevention programs, services, and resources to reduce deaths by suicide

Background

Throughout the nation's history, programs and practices related to the prevention of suicide have primarily been regulated within systems and organizations that support and provide mental health care and treatment. At the end of the twentieth century, there became a developing interest across the nation to address suicide as a public health issue, rather than just a mental health issue. In 2001, acknowledging the devastating impact and costs of suicide, the US Surgeon General issued the first National Strategy for Suicide Prevention. In 2012, a revised National Strategy was issued to build upon achievements and incorporate recent advances in suicide prevention.

In Tennessee, the Department of Mental Health and Substance Abuse Services (TDMHSAS) has been the primary state agency to receive both state and federal funding to implement suicide prevention services and programs across the state. In 2001, the Tennessee Suicide Prevention Network (TSPN) was established, and in alignment with the 2001 National Strategy for Suicide Prevention, the network implemented the Tennessee Strategy for Suicide Prevention. Since 2001, TSPN has made great strides in suicide prevention in Tennessee and it continues to provide education, training, and resources on suicide to local communities across the entire state. Over the last 20 years, the Tennessee Department of Health has supported suicide prevention efforts across the state by:

- Providing data on suicide attempts and death to inform prevention efforts
- Organizing and participating in collaborative meetings in a variety of settings across sectors
- Providing Question, Persuade, Refer (QPR) training to internal staff in TDH and members of the community
- Promoting available suicide prevention resources, programs, and services

Suicide Prevention Act of 2018

On May 21, 2018, Governor Bill Haslam and the Tennessee General Assembly passed the Suicide Prevention Act of 2018 (TCA § 68-3-703). This Act recognized suicide as a serious public health issue in Tennessee and provided the Commissioner of Health authorization to create a suicide prevention program within the Department of Health. The Act required the department to establish a team that would:

1. Compile existing data on suicide deaths
2. Review existing resources and programs related to suicide prevention
3. Identify evidence-based or promising practices related to the prevention of suicide
4. Convene relevant stakeholders to review existing data and existing programs and resources and identify opportunities to improve data collection, analysis, and programming

5. Submit a report to the general assembly no later than June 30, 2020 recommending any necessary programs or policies to prevent suicide deaths in Tennessee

The act took effect on January 1, 2019, and a suicide prevention program director was hired in March 2019. The law sunsets on June 30, 2021.

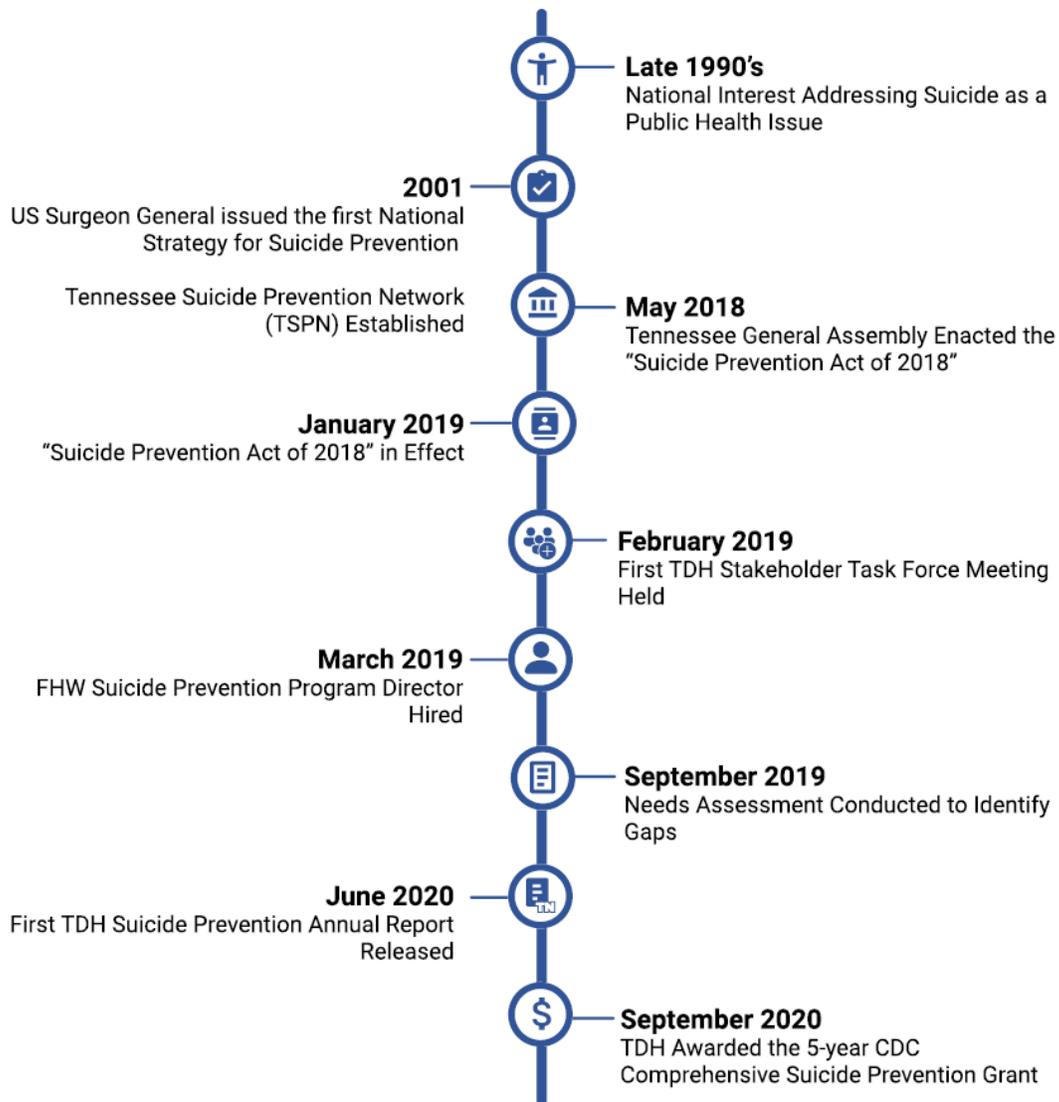
Suicide Prevention Program Overview

The TDH suicide prevention program is housed within the Division of Family Health and Wellness. Since its implementation in January 2019, the suicide prevention program has worked diligently to fulfill the requirements of the Suicide Prevention Act of 2018. From 2020 to 2021, the program assessed suicide prevention infrastructure in Tennessee, reviewed suicide prevention strategies and activities, analyzed data on trends in suicide deaths and suicide-related behaviors, and provided evidence-based recommendations for improvement. In the program's second year, the TDH suicide prevention program:

- Added 17 new members to the Suicide Prevention Stakeholder Task Force Team, a diverse group of professionals with broad representation across all state and local sectors in Tennessee. Task force members are comprised of individuals who work in healthcare organizations, behavioral health care organizations, law enforcement, community-based organizations, emergency response, higher education institutions, substance abuse treatment facilities, crisis services, military and veteran affairs, and local schools. From January 2020 to April 2021, the Team convened five times to discuss suicide-related data and statistics, state and national suicide prevention programming, the impact of COVID-19 on suicide in TN, and the expansion of suicide-related syndromic surveillance across the lifespan in Tennessee. The task force also advised on recommendations put forth in this report.
- Continued to conduct weekly syndromic surveillance of suicide-related emergency department visits in children under 18 and expanded weekly syndromic surveillance to include young adults aged 18 to 24. All visits were monitored using the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) software, a database with data on emergency department visits for a suicide attempt, intentional self-harm, or thoughts of suicide.
- Refined a model for rapid prevention response using suicide-related syndromic surveillance data from ESSENCE. The rapid prevention response plan assists state and local partners in deploying resources to areas in the state showing increased emergency department visits for suicide-related behavior in children under 18. Partners involved in the rapid prevention response plan for children under 18 include, but are not limited to, TDMHSAS, TSPN, BlueCare TN, Coordinated School Health, the Department of Education, and Youth Villages.
- Participated in a National Child Safety Learning Collaborative (CSLC) through the Children's Safety Network. This collaborative aimed to spread Question, Persuade, and Refer (QPR) suicide prevention gatekeeper training to youth impactors across the state. Working with the CSLC and TSPN, 346 gatekeeper trainings have been provided to 9,300 youth impactors across the state since January 2019. Through this work, the TDH Suicide Prevention Program is also able to share their work on a national platform while learning about programs and activities being implemented in other states across the nation.
- Presented at the Coordinated School Health (CSH) Institute about suicide-related syndromic surveillance for children under 18 and how CSH coordinators could

participate in the ESSENCE rapid prevention response plan created to help target prevention efforts within their local school districts and communities.

- Partnered with TDH's Early Childhood Section within the Division of Family Health Wellness to provide QPR training across the state to evidence-based home visitors and staff from the Community Health Access and Navigation in Tennessee program.
- Presented about the intersectionality of suicide and sexual violence and strategies to prevent suicide in survivors of sexual violence and intimate partner violence at the Rape Education and Prevention (RPE) Institute hosted by the TN Coalition to End Domestic and Sexual Violence
- Partnered with TDH's Traumatic Brain Injury (TBI) Program within the Division of Family Health and Wellness to provide QPR training to TBI Service Coordinators across Tennessee.
- Partnered with TDMHSAS and TDH's Office of Informatics and Analytics on the ResilienTN Campaign, which focused on building resilience and strengthening community connections to prevent the tragic loss of life to overdose and suicide during the winter months.
- Received award funding through a 5-year grant from the Centers for Disease Control and Prevention (CDC) to implement a comprehensive public health approach to suicide prevention across Tennessee. Through this grant, TDH will receive \$750,000 in award funding per year, with the grant beginning on September 1, 2020 and ending on August 31, 2025. This grant provides TDH the ability to hire an epidemiologist to expand suicide-related syndromic surveillance and data collection; to hire a communication specialist who will expand and improve suicide-related communications and the dissemination of suicide-related data and other material; to contract with TSPN to support CSP strategies and activities; to contract with Centerstone Research Institute for program evaluation; to contract with Centerstone to offer telehealth training to behavioral health providers across the state; and to contract with American Institute for Research to provide training to implement the Good Behavior Game in elementary school classrooms across the state.
- Developed a weekly report, in partnership with TSPN and TDMHSAS, to monitor suicide-related behavior occurring across Tennessee during the Covid-19 pandemic. As of April 23, 2021, 54 weekly suicide data reports were generated and shared with TDH senior leadership, TDMHSAS and the Covid-19 Unified Command Group.



While the program made significant strides and met numerous benchmarks in its second year, more effort is needed to continue to improve suicide prevention programming and services across the state. Therefore, TDH's suicide prevention program will persist in:

- Leading the Suicide Prevention Stakeholder Task Force team to review data and services on suicide-related behavior and provide opportunities for improving suicide prevention strategies in Tennessee.
- Identifying populations (e.g., occupational groups) who are most at-risk for suicide and identifying prevention strategies to be implemented for those vulnerable populations.
- Analyzing suicide-related data from various sources, including child death review, maternal mortality review, national violent death reporting system (NVDRS), and vital records, to inform data-driven suicide prevention policies, programs, and services.
- Performing weekly syndromic surveillance of suicide-related emergency department visits in children under 18 and young adults aged 18 to 24 using the ESSENCE database and expanding suicide-related syndromic surveillance to include all age groups across the lifespan.

- Developing and implementing rapid prevention response plans for all Tennesseans using ESSENCE surveillance to help state and local partners target high-risk populations and areas in the state more effectively. Plans will be developed and implemented in partnership with TSPN.
- Maintaining a contract with TSPN to help support implementation of CSP grant strategies and activities such as expanding the number of people trained to identify and support those at risk for suicide through gatekeeper trainings such as QPR and ASIST; expanding suicide-related syndromic surveillance response plans to include individuals across the lifespan; strengthening delivery and access to suicide care within health and behavioral healthcare agencies through implementation of the Zero Suicide Initiative; and reducing gaps in accessing behavioral healthcare by increasing the understanding of mental health parity laws in Tennessee through education to providers and the general public.
- Working with TSPN to develop a statewide suicide prevention resource guide that will include all suicide prevention, intervention and postvention resources available throughout the state, including, but not limited to, available training, available resources and services for help, available support groups, fact sheets, infographics and data, articles, etc.
- Contracting with Centerstone Research Institute to evaluate individual suicide prevention strategies and activities being implemented across the state and to evaluate the comprehensive public health approach to suicide prevention.
- Contracting with Centerstone to provide telemental health training to behavioral health providers across the state, with a specific focus on providers who serve within rural communities across the state.
- Contracting with American Institutes for Research to help implement the Good Behavior Game (GBG) program within K-2 elementary school classrooms across the state by providing teacher and coach implementation trainings and train-the-trainer sessions for trained coaches in selected rural counties across the state.
- Participating in the CSLC's Suicide and Self-Harm National Collaborative team to train youth impactors across the state in QPR.
- Partnering with state and local agencies to implement data-driven suicide prevention Strategies and activities.
- Implementing the Be the One Suicide Prevention Workforce Initiative in TDH by providing trainings to employees.
- Serving as a member of key advisory and stakeholder groups.

Impact of Suicide in Tennessee Death and Hospitalization Data: 2015-2019

Impact of Suicide in Tennessee: Data Overview

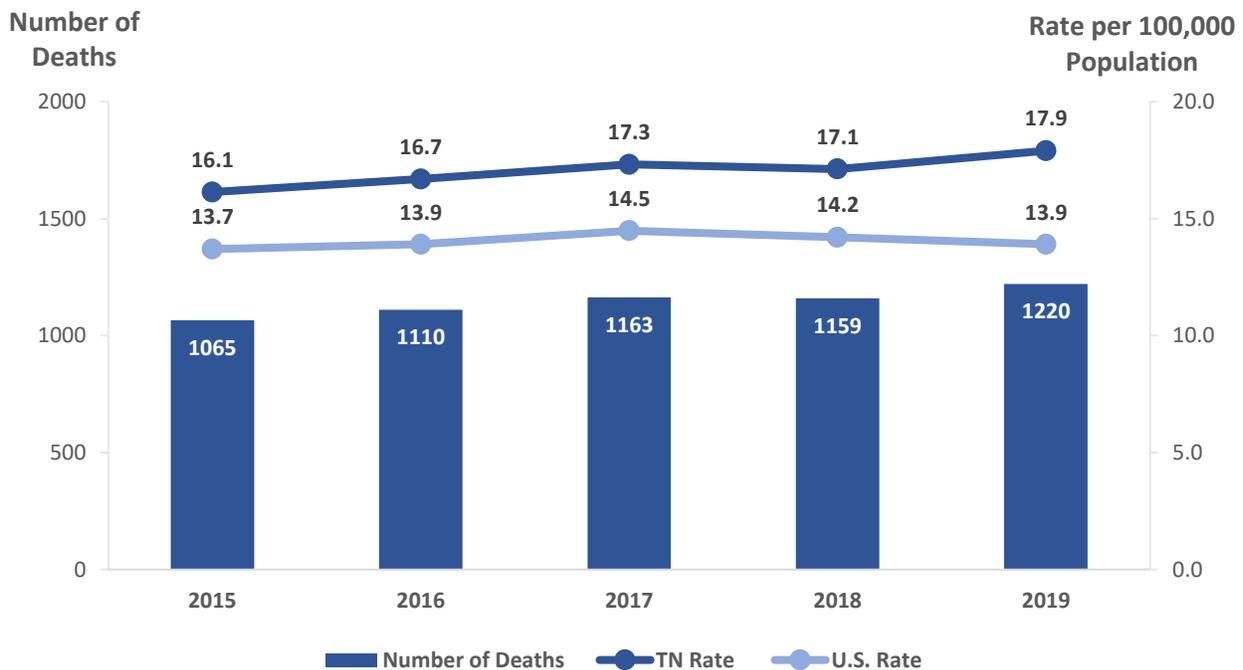
To fully understand the impact of suicide in Tennessee and improve prevention efforts, we must continually review suicide-related data to identify the groups of people most at-risk for suicide. This section includes data on suicide fatalities, suicidal ideation, suicide attempts, and suicide-risk factors from the Youth Risk Behavioral Surveillance System, Behavioral Risk Surveillance Survey, and the Child Fatality Review Program.

Suicide Fatalities

Number and Rate of Suicide Deaths

In 2019, 1,220 people in Tennessee died from suicide resulting in a suicide rate of 17.9 deaths per 100,000-person population. Within the past five years, Tennessee's suicide rate (deaths per 100,000 people) increased by 13%, from 16.1 deaths in 2015 to 17.9 deaths in 2019 (**Figure 1**). Over the past five years, Tennessee's suicide death rate has remained higher than the average national rate (**Figure 1**). In 2019, Tennessee's suicide rate (17.9 deaths per 100,000-person population) was 29% higher than the national average rate (13.9 deaths per 100,000-person population).

Figure 1: Number and rate of suicide deaths per 100,000-person population, Tennessee, and United States, 2015-2019



Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File, 2015-2019.

Sex/Gender

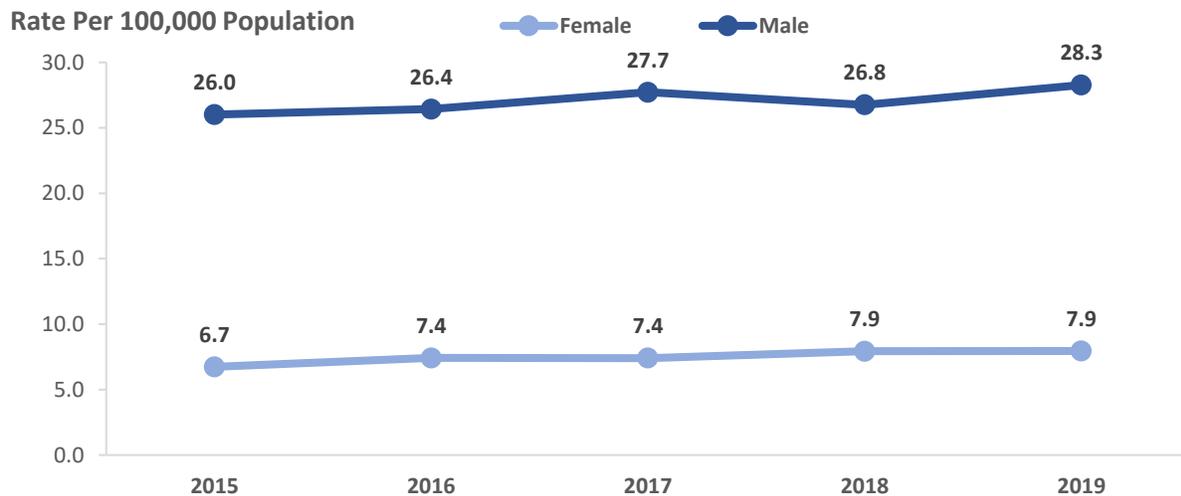
Males have over three times the rate of suicide death compared to females. In 2019, the suicide death rate for males in Tennessee was 28.3 deaths per 100,000 males compared to 7.9 deaths per 100,000 females (**Figure 2**). Although the burden of suicide death is higher among Tennessee males, over the five years (2015 through 2019) shown here, the suicide death rate increased more among Tennessee females (18%) than males (9%).



Males have over **3X** the rate of suicide death compared to females.



Figure 2: Gender-specific suicide rate, Tennessee, 2015-2019

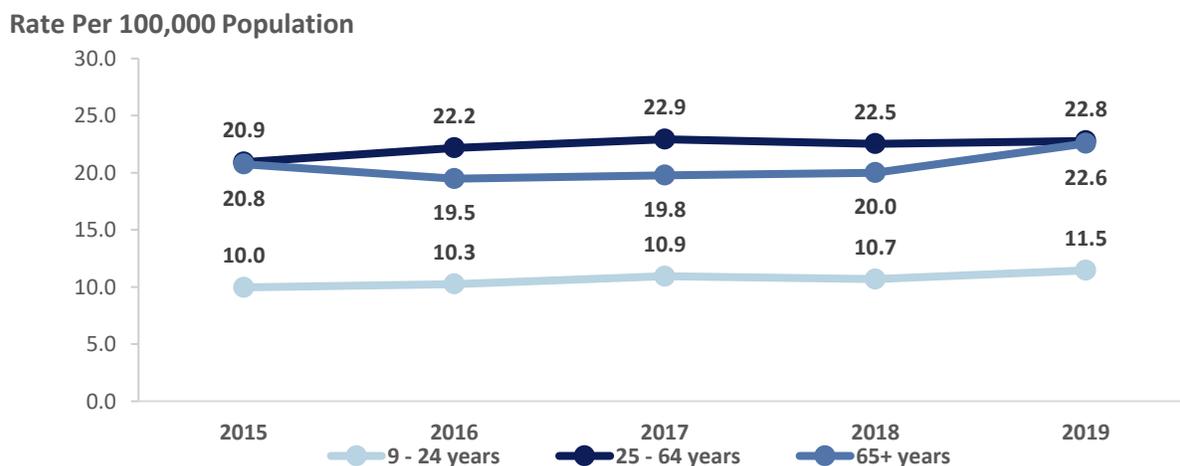


Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File, 2015-2019.

Age

The burden of suicide death varied across age groups and gender. Suicide has increased across all age groups over the last five years (**Figure 3**). Also, as the population ages, the gender gap in suicide widens. Males aged 65 years and older had at least five times higher suicide death rates than females of the same age group. However, among adults aged 25 to 64 years, males had a three-fold higher rate of suicide death than females.

Figure 3: Rate of suicide deaths by age group, Tennessee, 2015-2019



Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File, 2015-2019.

Race

The rate of suicide death is higher among Whites than Blacks in Tennessee. In 2019, the suicide rate (deaths per 100,000-person population) among Whites was 20.5 compared to 8.6 among Blacks (**Figure 4**). Compared to 2015, the suicide death rate in 2019 increased more among Blacks (62%) than Whites (13%) in Tennessee.

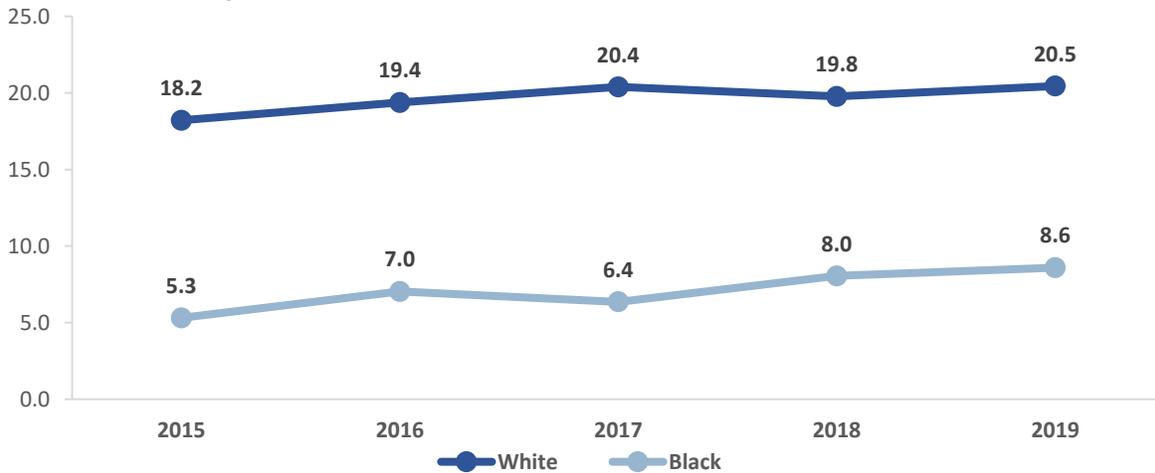


White people have over 2X the rate of suicide death compared to Black people.



Figure 4: Race-specific suicide rate, Tennessee, 2015-2019

Rate Per 100,000 Population



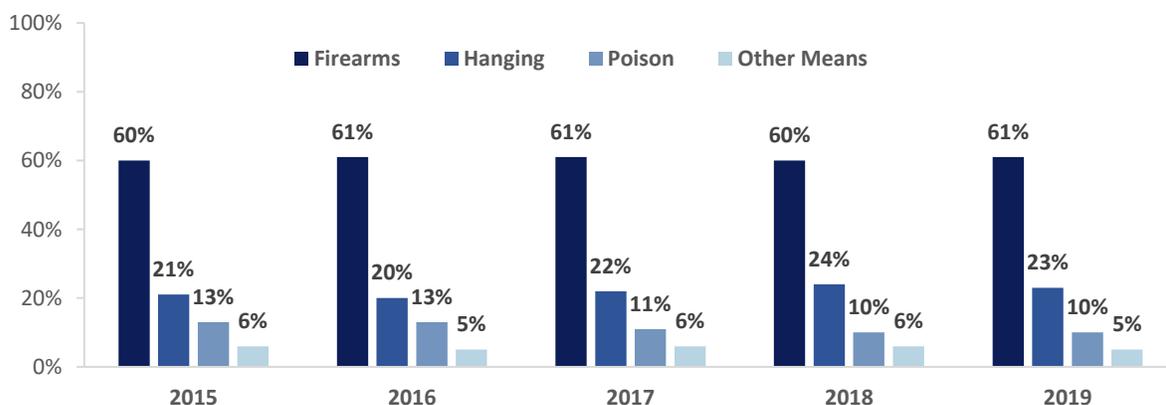
Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File, 2015-2019.

Method of Suicide Deaths

In Tennessee, firearms are the most prevalent means of suicide death, accounting for 3 out of 5 (61%) suicide deaths in 2019. Hanging was the next most common method, representing 23% of Tennessee's suicide deaths in 2019 (**Figure 5**). Also, the means of suicide death differed by decedent's gender. Firearms were the method used for 65% of male suicides compared to 43% of female suicides.

Figure 5: Method of suicide deaths, Tennessee, 2015-2019

Percent of Suicide Deaths

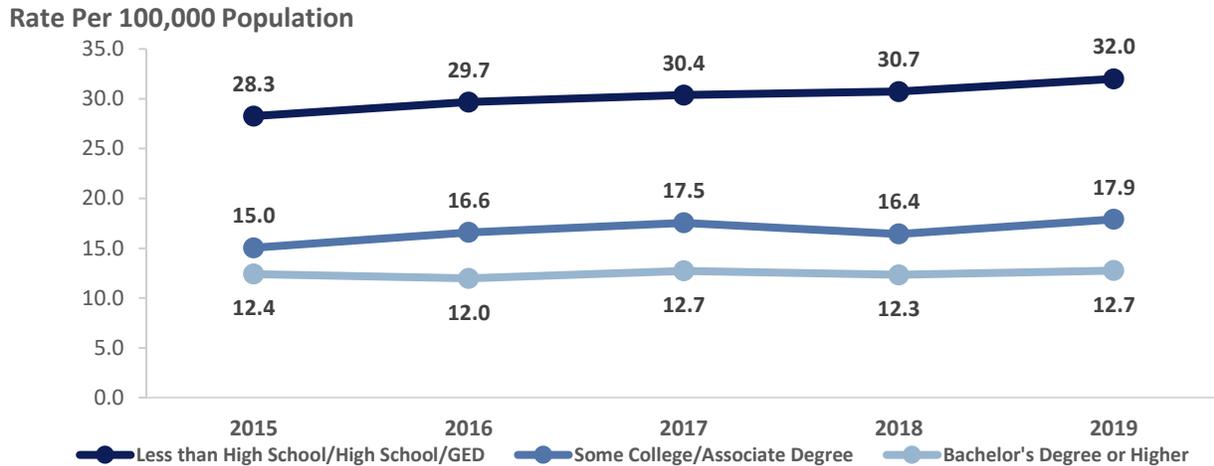


Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File, 2015-2019.

Educational Status

Suicide death by educational level among Tennessee residents aged 18 and older shows that individuals with at least a Bachelor’s degree had the lowest rate of suicide death (**Figure 6**). The five-year (2015-2019) trend for the suicide death rate shows those with lower educational achievement had higher rates of suicide.

Figure 6: Suicide rate by educational level in Tennessee residents 18 and older (2015-2019)

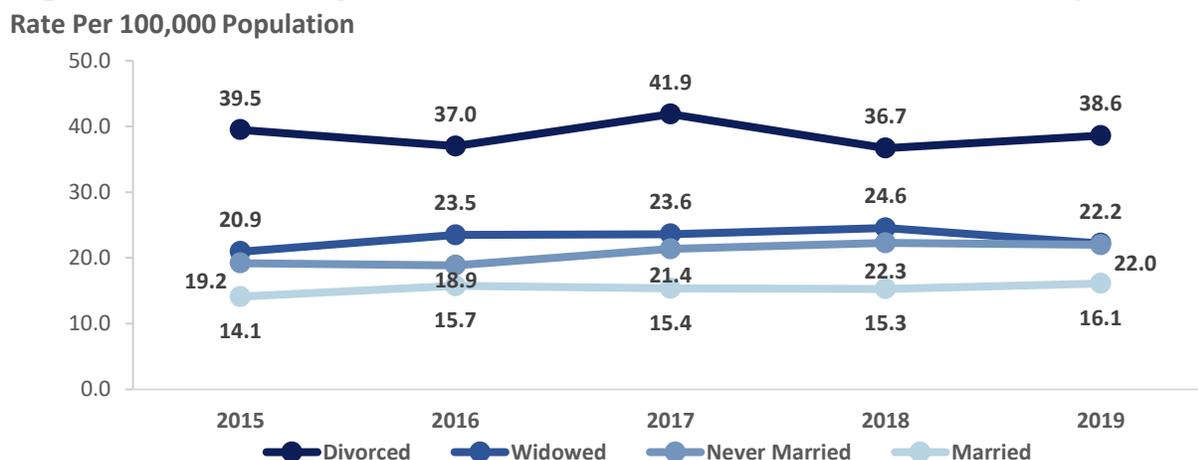


Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File, 2015-2019 and American Community Survey, United States Census Bureau. Data displayed for suicide deaths among Tennessee residents 18 years and older.

Marital Status

The rate of suicide death by marital status among Tennessee residents aged 15 years and older are presented in **Figure 7**. In 2019, the rate of suicide death was highest among divorced individuals (38.6 per 100,000) and significantly different from other categories. In 2019, the suicide death rate was lowest among those who were currently married at the time of death (16.1 per 100,000). Although the rate of suicide deaths was higher among widowed decedents (24.6 per 100,000) than decedents who were never married (22.3 per 100,000), the difference in suicide rates between these two groups was not significant. However, there was a variation in the suicide rate in the five years presented in this report for certain groups. Between 2015 and 2019, the rate of suicide death among widowed individuals and those who were never married increased by 6% and 15%, respectively.

Figure 7: Suicide rate by marital status in Tennessee residents 18 and older (2015-2019)

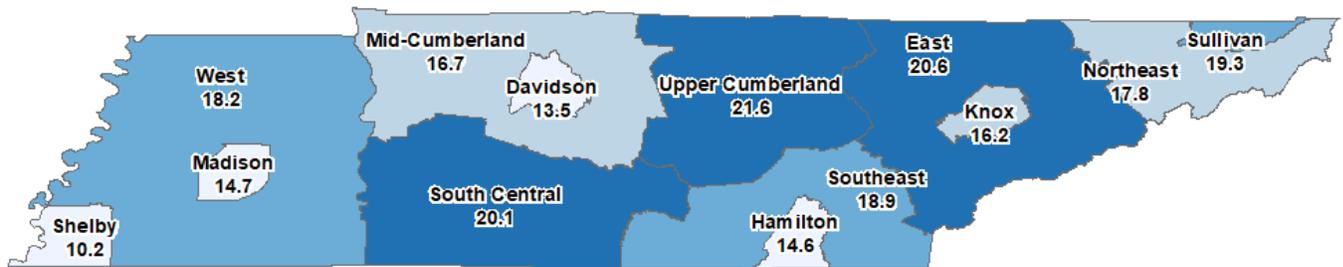


Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File, 2015-2019 and American Community Survey, United States Census Bureau. Data displayed for suicide deaths among Tennessee residents 15 years and older.

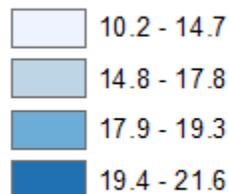
Geographic Distribution of Suicide Deaths in Tennessee

The five-year age-adjusted rate of suicide death for the thirteen regions in Tennessee is presented in **Figure 8**. From 2015-2019, the rate of suicide death was lowest in the Shelby region (10.2 deaths per 100,000 population) and highest in the Upper Cumberland (21.6 deaths per 100,000), East (20.6 deaths per 100,000), and South Central (20.1 deaths per 100,000) regions of Tennessee.

Figure 8: Age-adjusted rate of suicide death by region, 2015-2019



Age-Adjusted Rate of Suicide Death per 100,000 Population



Tennessee Total Rate: 16.5 per 100,000 Population

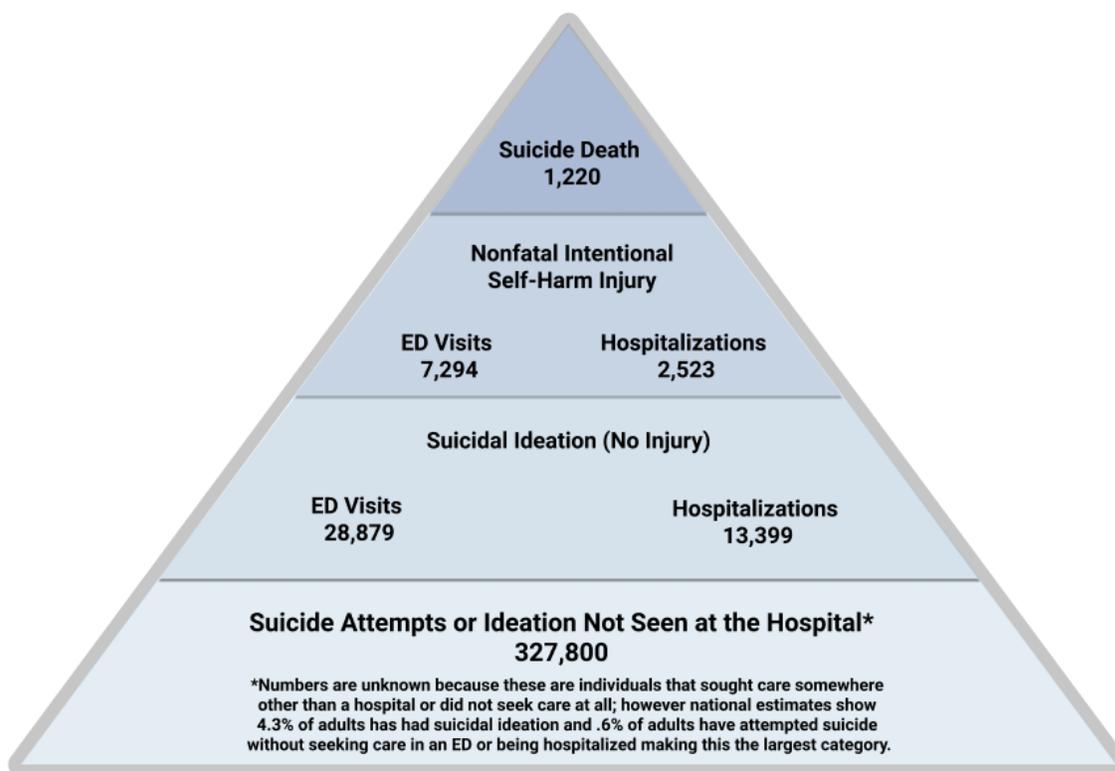
Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File.

Intentional Self-Harm Injury and Suicidal Ideation

While prevention efforts often focus on data related to suicide death, completed suicides represent the tip of the iceberg in terms of the full spectrum of suicidal behavior. In addition to the 2019 count of suicide deaths, **Figure 9** includes suicide ideation and non-fatal intentional self-harm injuries data from an additional source: the hospitalization and emergency department (ED) data collected from all acute care hospitals in Tennessee. Non-fatal intentional self-harm includes intentional injuries from poisoning, firearms, toxic substances, hanging, and sharp objects. It is difficult to prove suicidality intent for all the non-fatal intentional self-harm injuries in this report. For the purposes of this report, we refer to all incidents of non-fatal intentional self-harm—regardless of their suicidality—as intentional self-harm.

As shown in **Figure 9**, in addition to the 1,220 suicide deaths that occurred in 2019, there were 7,294 ED visits and 2,523 inpatient hospitalizations for intentional self-harm. Furthermore, as demonstrated in the next level of the pyramid, over 40,000 patients were hospitalized or treated in the ED with suicidal ideation, but not self-harm injury. Combined, the number of patients treated at acute care hospitals with either intentional self-harm injuries or suicidal ideation is over forty times greater than the number of completed suicides alone. The bottom layer of the pyramid represents cases that experience suicidal ideation or intentional self-harm injury without receiving treatment at an acute care hospital. Because these individuals do not visit the hospital and may receive no care at all, they cannot be captured using the available surveillance systems, and the actual number is therefore unknown. According to the Youth Risk Behavior Survey, in 2019, 8.9% of Tennessee high school students reported attempting suicide in the prior 12 months. Still, only 2.5% reported a suicide attempt resulting in an injury, poisoning, or overdose that a doctor or nurse treated. Adult survey data also indicate that the number of individuals who attempt or consider suicide is much greater than what can be estimated from hospitalization data alone. Data from the 2017 National Survey on Drug Use and Health indicates that 4.8% of US adults 18 and older had thoughts of suicide in the past year, and 0.6% attempted suicide. These figures would translate to an estimated 327,800 and 40,975 Tennessee adults, respectively.

Figure 9: Number of suicide deaths, non-fatal intentional self-harm injuries, and patients with suicidal ideation but no self-harm injury, Tennessee, 2019



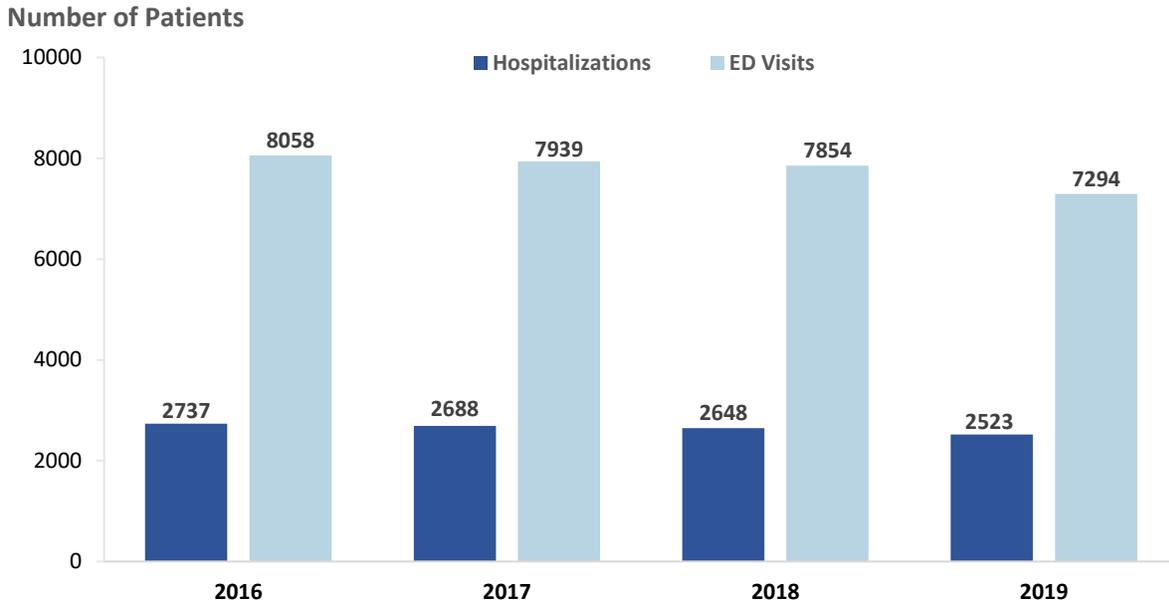
Data Sources: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System; Office of Vital Records and Statistics, Death Statistical File.

Figure 10 demonstrates the trend of ED visits and inpatient hospitalizations due to nonfatal intentional self-harm injuries for the past four years, 2016-2019. Over this time frame, the number of patients remained fairly consistent, with slight decreases each year. Data is not shown for a longer time frame because 2016 is the first full year of hospital data to utilize the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) coding system. Prior years used the Ninth Revision (ICD-9-CM) and data collected using the two coding schemes are not comparable.



ED and hospitalization visits for self-harm have remained consistent since 2016, while suicidal ideation has increased since.

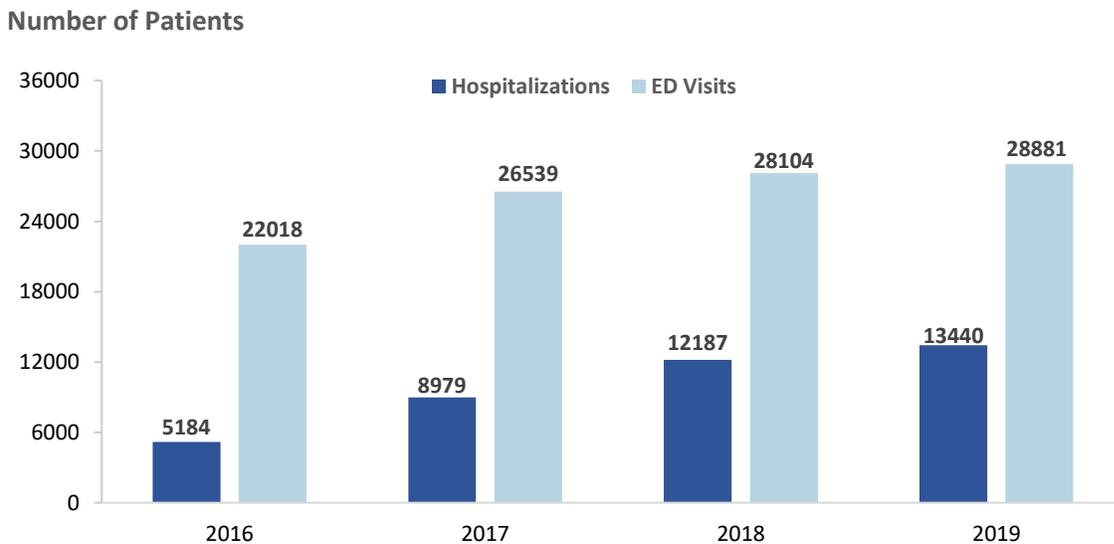
Figure 10: Number of ED visits and inpatient hospitalizations for intentional self-harm injury, Tennessee, 2016-2019



Data Source: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System.

Figure 11 includes data for ED visits and inpatient hospitalizations with suicidal ideation over the same time frame. In contrast to the trend seen for intentional self-harm injuries, the number of patients treated with suicidal ideation increased substantially from 2016 to 2019.

Figure 11: Number of ED visits and inpatient hospitalizations with suicidal ideation, Tennessee, 2016-2019



Data Source: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System.

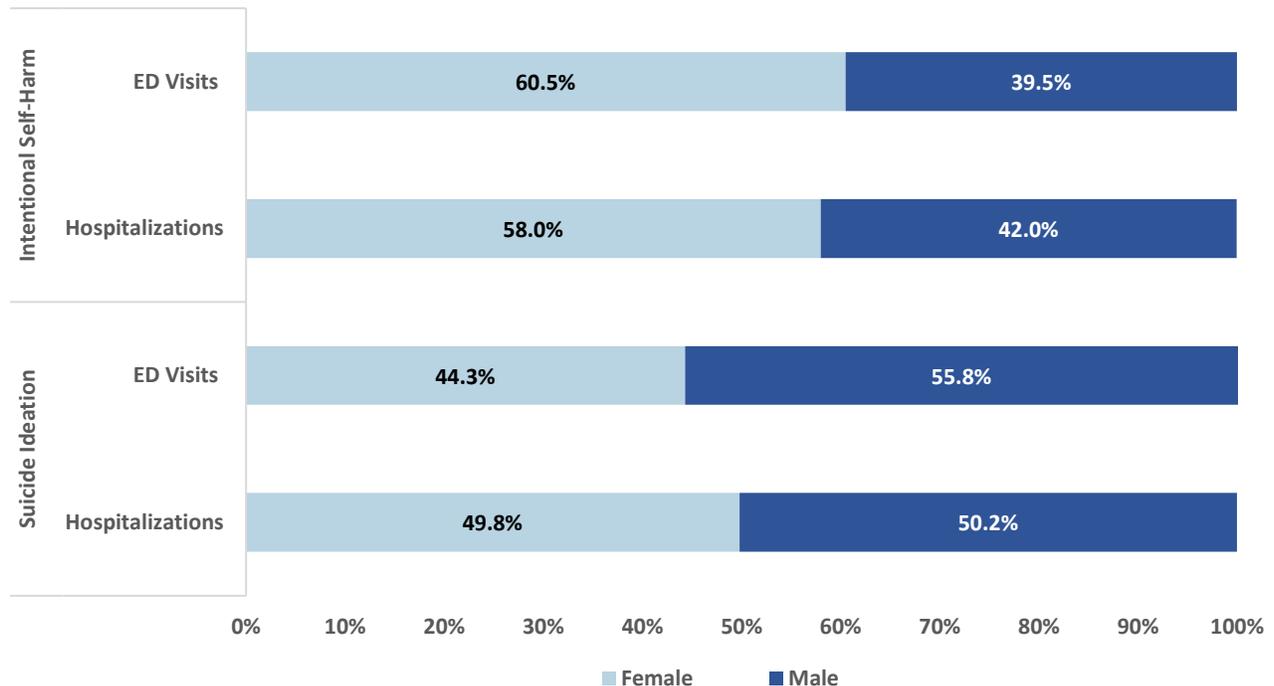
Sex/Gender

The breakdown by sex for inpatient hospitalizations and ED visits showed a different trend compared to that seen for suicide deaths. Females made up just 22% of suicide deaths in 2019, but as shown in Figure 12, Patients hospitalized for suicidal ideation with no accompanying intentional self-harm injury were split evenly across males and females. However, more males than females visited the ER for suicide ideation. This difference in the gender breakdown for suicide death versus intentional self-harm injury ED visits and hospitalizations relates to choice of method: men are more likely to use firearms while females more often use less lethal methods such as a sharp object.



Females made up the majority of patients treated in the ED and hospitalized for nonfatal intentional self-harm injuries.

Figure 12: Percent of patients by sex for ED visits and inpatient hospitalizations, Tennessee, 2016-2019



Data Source: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System.

Method of Intentional Self-Harm Injury

Figure 13 demonstrates the methods of injury for ED visits and hospitalizations. The most common methods of injury differed greatly for nonfatal intentional self-harm injury ED visits and hospitalizations compared to suicide deaths. Firearms consistently account for the majority of deaths by suicide in Tennessee; however, for the nonfatal ED visits and hospitalizations, firearms were the method of injury used for only a small percentage of patients (1% of ED visits and 2% of hospitalizations). The second most common method of suicide death, hanging, was also almost entirely absent among the nonfatal injury cases: hanging represented nearly one in four (23%) suicide deaths in 2019, but just 1% of both ED visits and hospitalizations.

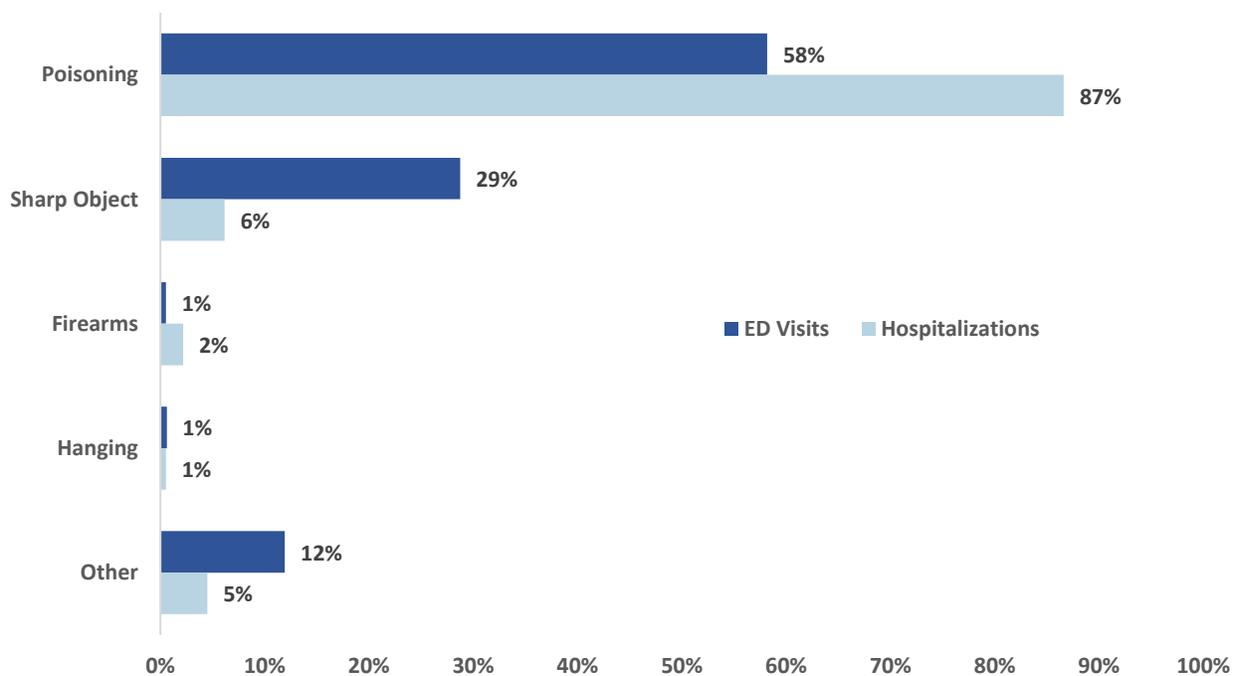
Poisoning was the method of injury for the majority of ED visits and inpatient hospitalizations for nonfatal intentional self-harm injuries in 2019. This method, which accounted for just 10% of suicide deaths in 2019, made up 58% and 87% of ED visits and inpatient hospitalizations, respectively. The vast majority (approximately 95%) of both the ED visits and inpatient hospitalizations due to intentional poisoning were drug overdoses, while the remaining 5% were nondrug poisonings involving substances such as ethanol, isopropyl alcohol, and carbon monoxide from motor vehicle exhaust. Among the drug overdoses, the most common substances used were benzodiazepines (which include familiar brand names such as Valium and Xanax) and acetaminophen (most common brand name is Tylenol).



Poisoning was the method of injury for the majority of ED visits and inpatient hospitalizations for nonfatal intentional self-harm injuries in 2019.

Intentional self-harm by a sharp object, or cutting, was the next most common method for both ED visits and hospitalizations, though it was a distant second among hospitalizations (6% of cases) and a much more sizeable proportion among ED visits. About one in four (29%) of the self-harm injuries treated in the ED were due to cutting. This again differed sharply with the methods seen for suicide deaths, where cutting represented just 1% of cases.

Figure 13: Percent of patients by method of injury for ED visits and inpatient hospitalizations, Tennessee, 2016-2019

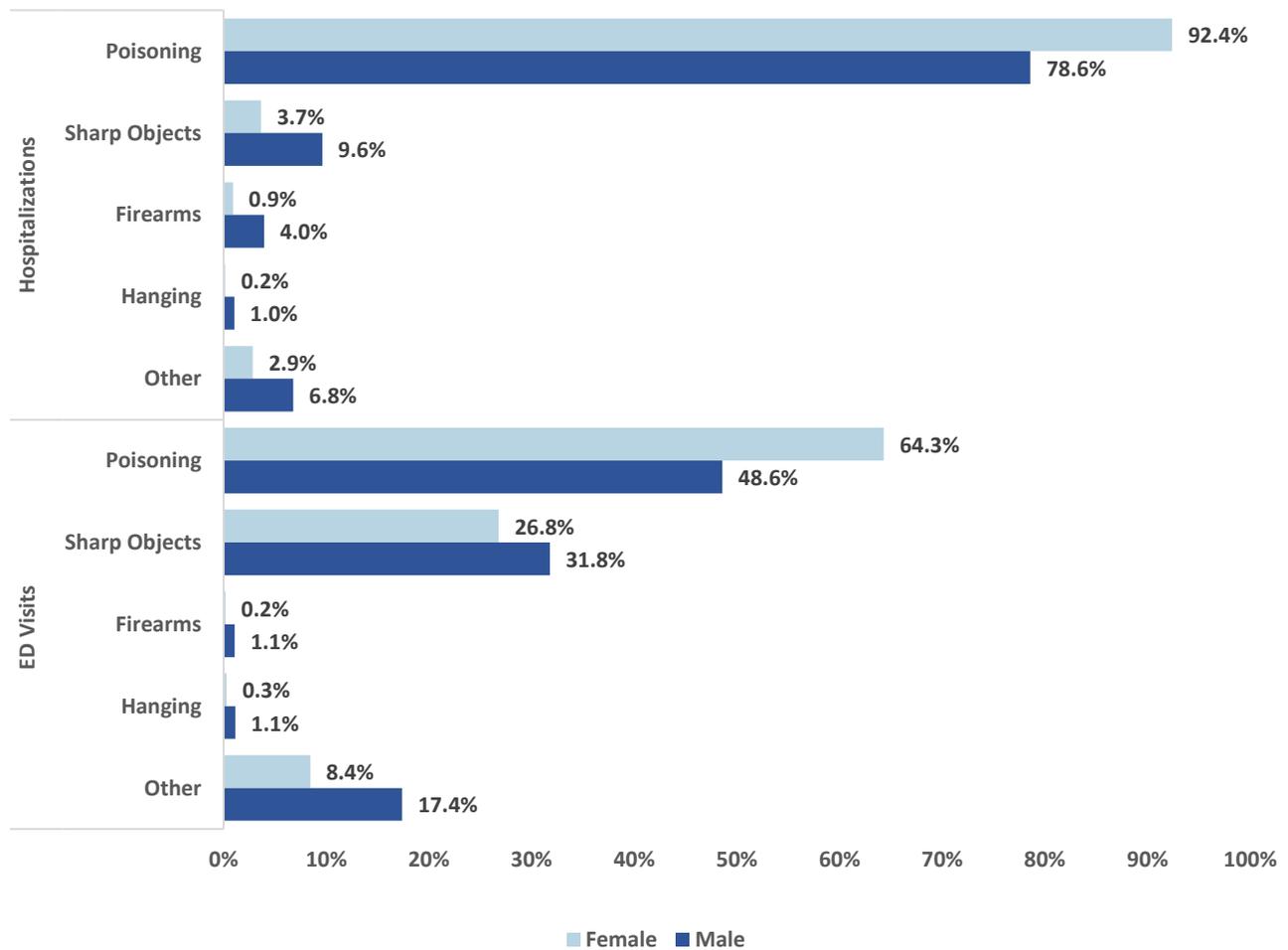


Data Source: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System.

Sex/Gender

Figure 14 demonstrates the methods of injury for nonfatal intentional self-harm injury ED visits and inpatient hospitalizations by sex. This reveals that poisoning was a particularly common method for female patients treated in the ED or hospitalized for self-harm injuries, accounting for 64% of ED visits and 93% of hospitalizations compared to 49% and 79% for men. Self-harm by sharp object, otherwise known as cutting, was the method of injury for comparatively large proportions of male patients: this was the method used for 32% of male patients seen in the ED (compared to 27% of female patients) and 10% of hospitalized male patients (compared to 4% of female patients). As previously stated, the percentage of nonfatal injuries due to firearm and hanging were extremely low for both male and female patients, but the number of patients injured using these methods was larger for men than for women.

Figure 14: Percent of patients by sex and method of injury for ED visits and inpatient hospitalizations, Tennessee, 2016-2019

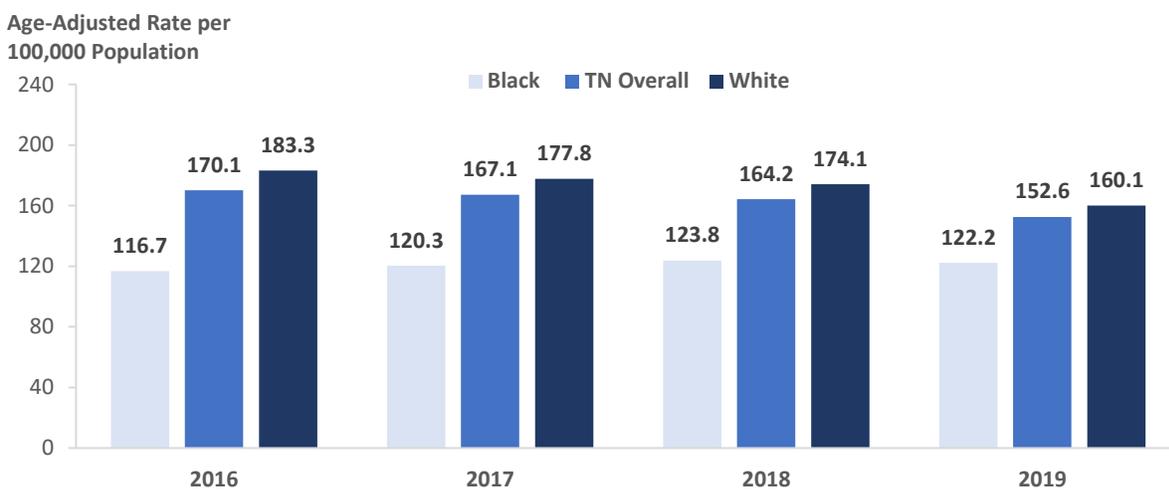


Data Source: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System.

Race

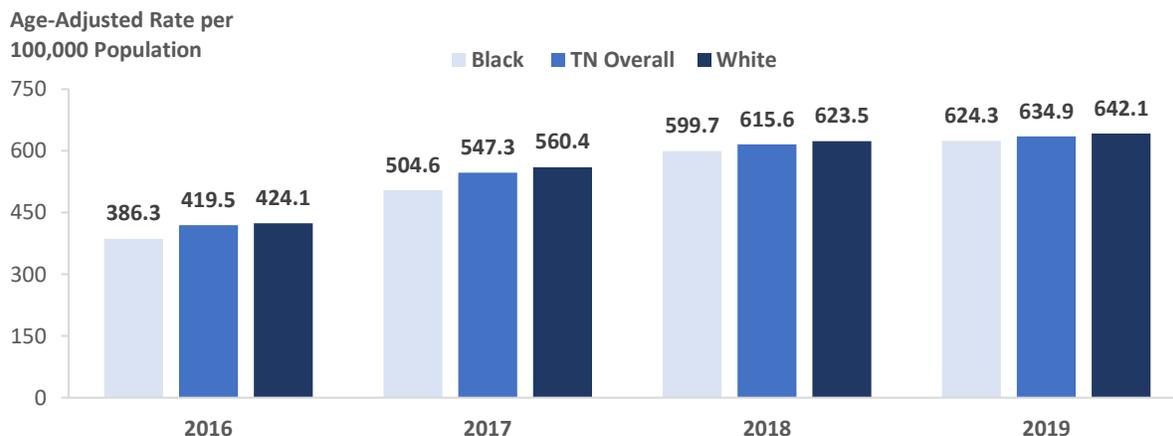
Figures 15 and 16 show the four-year trend by race for nonfatal intentional self-harm injuries and suicidal ideation, with ED visits and inpatient hospitalizations combined. For both intentional self-harm injuries and suicidal ideation, the age-adjusted rates were higher for white Tennesseans each year, but the gap was narrower than that seen for suicide death. To compare, in 2019, the rate of suicide death was 138.4% higher for Whites than Blacks; the rate of self-harm injury was 31.0% higher for Whites than Blacks; and the rate of suicidal ideation was just 2.9% higher for Whites than Blacks. Black Tennesseans also experienced sharper increases during the three-year time frame shown. For intentional self-harm injuries, the rate for whites decreased slightly while the rate for blacks marginally increased. For suicidal ideation, both groups increased significantly in 2019 compared to 2016, with a 62% increase for blacks and 51% increase for whites.

Figure 15: Age-adjusted rate of intentional self-harm injury inpatient hospitalizations and ED visits (combined) by race, Tennessee, 2016-2019



Data Source: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System.

Figure 16: Age-adjusted rate of suicidal ideation inpatient hospitalizations and ED visits (combined) by race, Tennessee, 2016-2019



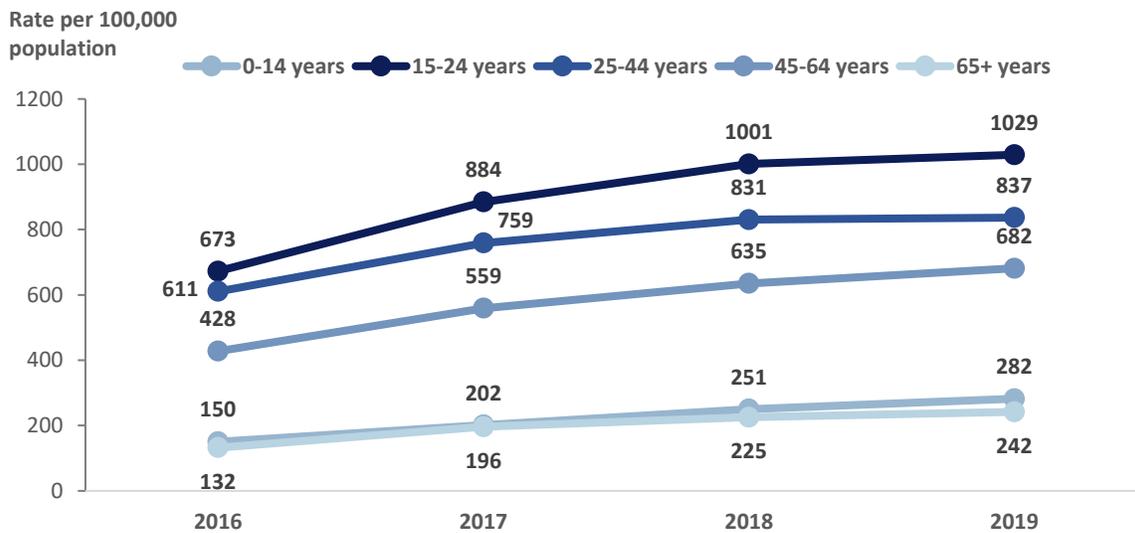
Data Source: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System.

Age

As stated in the previous section, the rate of nonfatal intentional self-harm injury and suicidal ideation differed substantially across age groups. **Figures 17 and 18** present the age-specific rates for self-harm injury and suicidal ideation. Youths between the ages of 15 and 24 experienced the highest rates for both self-harm injury and suicidal ideation. This trend differed significantly from that seen for suicide death with the 2019 rate of suicide death highest for individuals aged 25 to 64. Also, the rate of suicide ideation in youth aged 15-24 has increased every year within the past four years of data reported. For instance, the rate of suicide ideation in Tennesseans aged 15-24 increased 53% from 2016 to 2019. Nonetheless, from 2016 to 2019, the percentage increase in rates of suicide ideation was highest in individuals less than 14 years (88%) and those 65 years and older (83%).

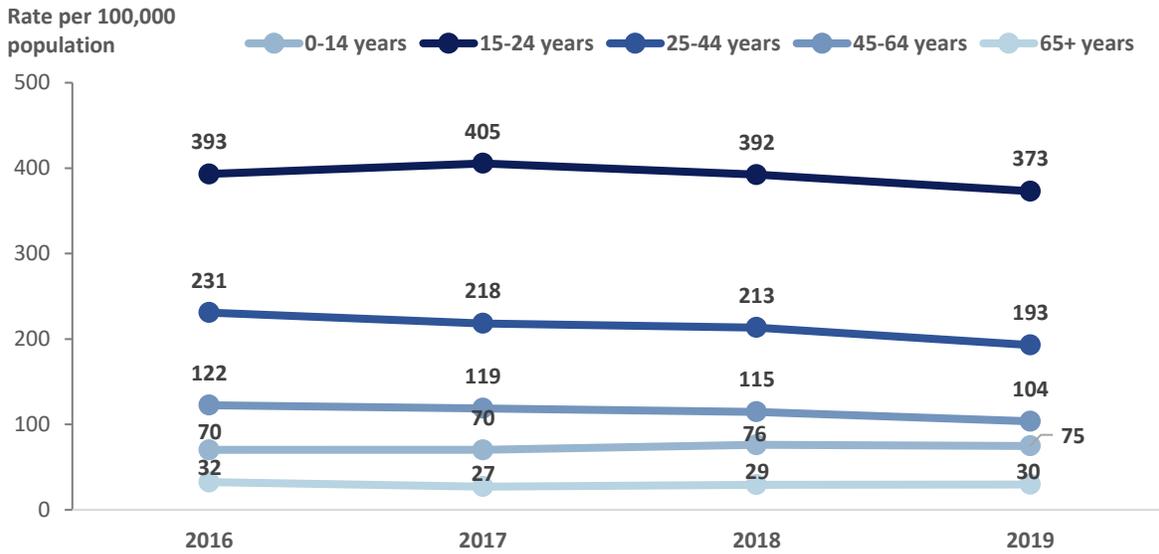
Contrary to the trend observed in suicide ideation, the age-specific rates of intentional self-harm has steadily decreased for three age groups. From 2016 to 2019, the percentage decrease in the rate of self-harm for Tennesseans aged 15-24 years, 25-44 years, and 45-64 years was 5%, 16%, and 15% respectively.

Figure 17: Rate of suicidal ideation inpatient hospitalizations and ED visits (combined) by age group, Tennessee, 2016-2019



Data Source: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System.

Figure 18: Rate of intentional self-harm injury inpatient hospitalizations and ED visits (combined) by age group, Tennessee 2016-2019



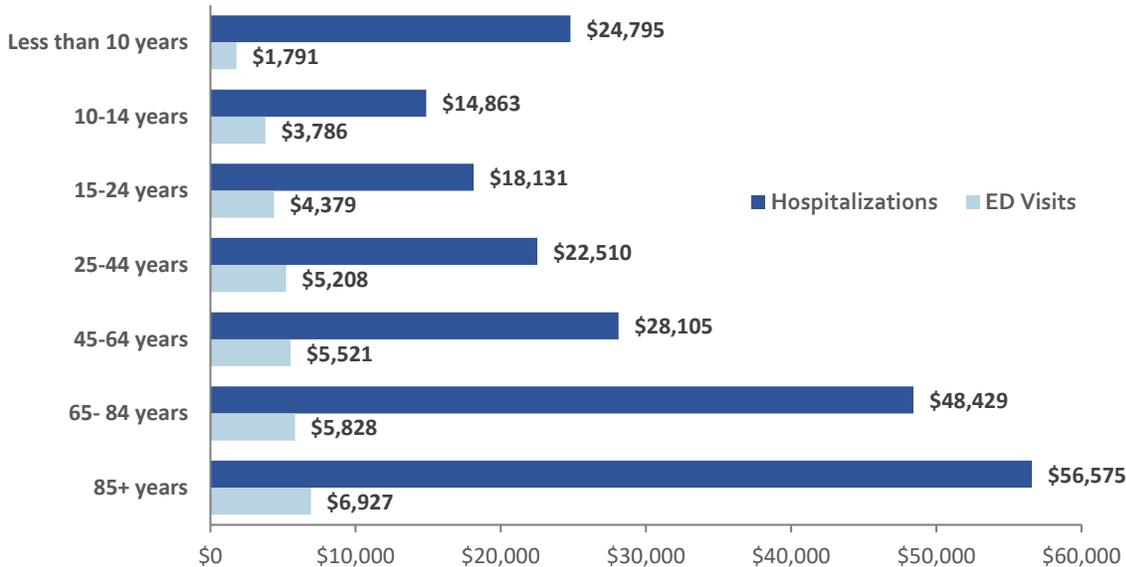
Data Source: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System.

Cost

In addition to the emotional trauma associated with receiving care for intentional self-harm injury or suicidal ideation, medical treatment for these issues incurs a significant financial cost. **Figure 19** demonstrates the median total charge for an intentional self-harm injury hospitalization and ED visits by age group in 2019 and **Figure 20** by year. The median costs of non-intentional self-harm were higher for hospitalizations than ED visits.

The median total charges climbed higher for each successive age group, reaching a peak of \$56,575 and \$6,927 for hospitalizations and ED visits, respectively, for patients 85 and older. This amount was twice the median charge associated with hospitalizations of patients in the youngest age category, including individuals aged less than ten. The higher median charge for hospitalizations of older patients is related to the fact that these individuals also remained in the hospital for longer. The average length of stay for inpatient hospitalizations was four days, although this varied by age group. The highest average length of stay for inpatient hospitalization was approximately seven days in patients aged 75 and older, while the lowest was two days for patients aged 5 to 14. This increased cost and length of hospital stay result from medical complications associated with injuries of older individuals. Together, the total cost associated with all intentional self-harm ED visits and hospitalizations in 2019 was over \$150 million. The total cost of ED visits and hospitalizations of patients with suicidal ideation was over \$500 million.

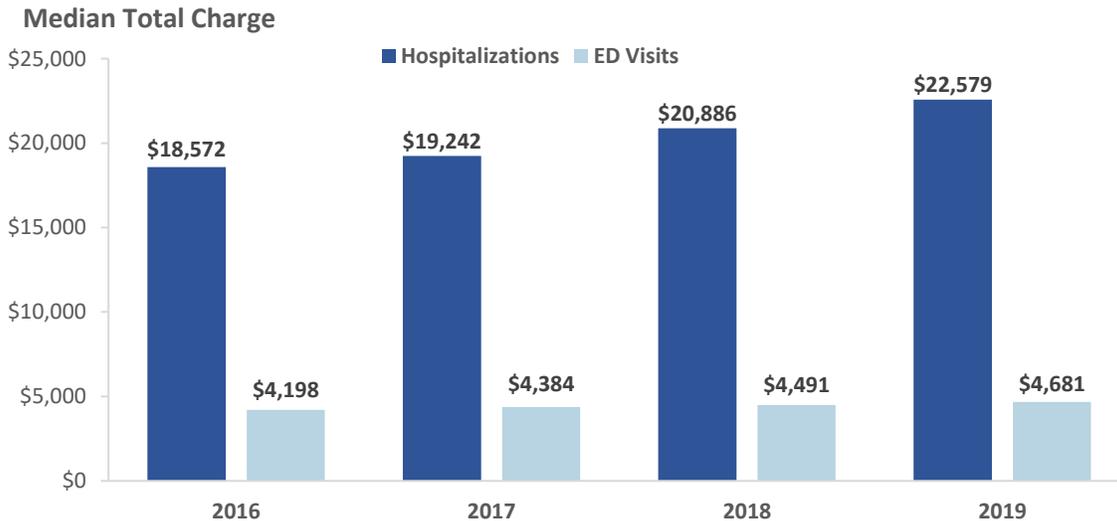
Figure 19: Median total charge in dollars for intentional self-harm hospitalization and ED visits by age group, Tennessee, 2016-2019



Data Source: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System.

Figure 20 describes the median total charge in dollars for intentional self-harm hospitalizations and ED visits from 2016 and 2019. Over the past four years, there has been a steady increase in median cost of intentional self-harm hospitalizations. The median total charge for intentional self-harm increased by 22%, from \$18,572 in 2016 to \$22,579 in 2019. Unlike hospitalizations, the median total charge of intentional self-harm from ED visits did not vary much over the years reported. Between 2016 and 2019, there was a 12% increase in the median costs of ED visits for non-intentional self-harm.

Figure 20: Median total charge in dollars for intentional self-harm hospitalization and ED visits, Tennessee, 2016-2019



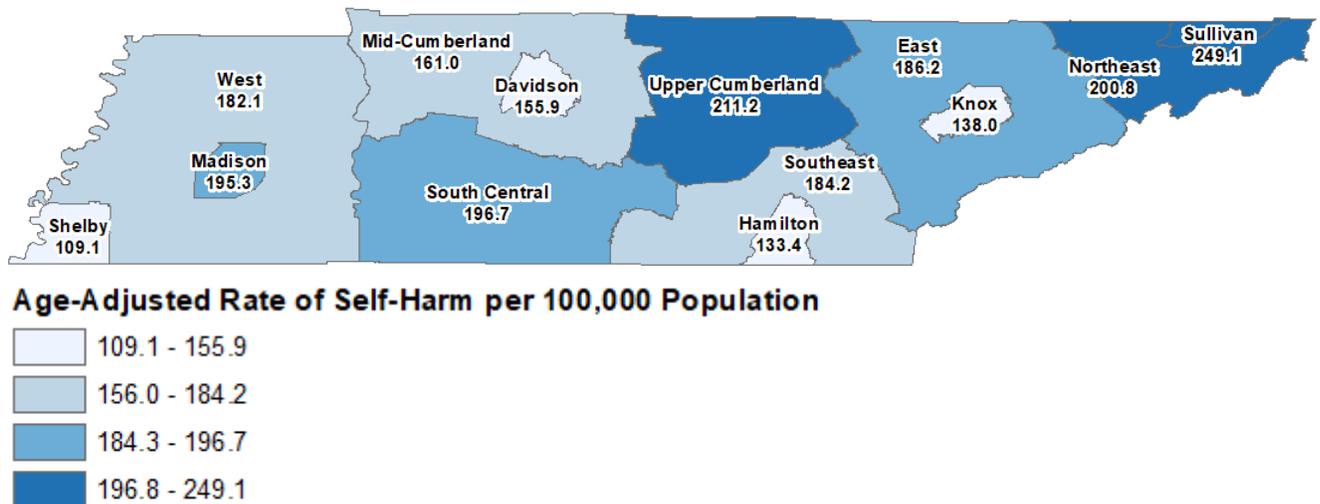
Data Source: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System.

Geographic Distribution of Intentional Self-Harm Injury and Suicidal Ideation in Tennessee

The 2016-2010 rates of intentional self-harm injury and suicidal ideation without self-harm injury for ED visits and hospitalizations are presented by region in **Figure 21** and **Figure 22**. The rates presented are age-adjusted, as the age distributions within regions are different. Thus, the age-adjusted rates of self-harm injury and suicidal ideation allow for a comparison of rates across various regions using standard age distribution.

As shown in **Figure 21**, the lowest statewide rate per 100,000 of intentional self-harm injury was for Shelby County (109.1), where the rate was significantly lower than for the state (177.1). This reflected the pattern seen for suicide death, where Shelby also had a much lower rate than any other region. The highest regional rate was for Sullivan County (249.1), which had a significantly higher rate than Tennessee (177.1) as a whole and over twice as high as Shelby (109.1). Notably, the four regions with the major metros of Tennessee (Shelby, Davidson, Hamilton, and Knox) all had rates of intentional self-harm injury below the statewide average.

Figure 21: Age-adjusted rate of intentional self-harm injury inpatient hospitalizations and ED visits (combined) by region, 2016-2019

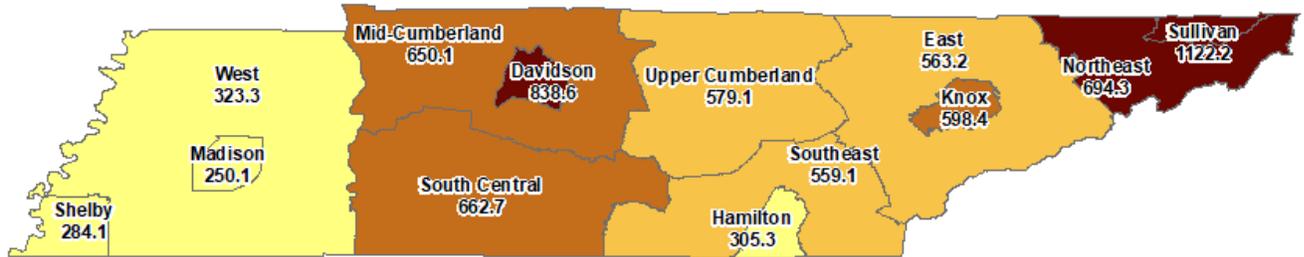


Tennessee Total Rate: 177.1 per 100,000 Population

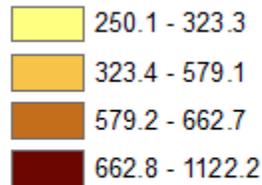
Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File.

Figure 22 displays a similar trend for ED visits and hospitalizations with suicidal ideation. Similar to the trend observed in intentional self-harm, residents of Sullivan had the highest rates of suicide ideation in Tennessee. The age-adjusted rate per 100,000 of suicidal ideation-related ED visits and hospitalizations was twice as high for Sullivan (1122.2) as for the state (571.6), and over four times as high as the rate for Madison (250.1). Shelby had the second-lowest rate (284.1 per 100,000) of suicide ideation in Tennessee, following a similar pattern as distribution in the rates of intentional self-harm across the state.

Figure 22: Age-adjusted rate of suicidal ideation-related inpatient hospitalizations and ED visits (combined) by region, 2016-2019



Age-Adjusted Rate of Suicide Ideation per 100,000 Population



Tennessee Total Rate: 571.6 per 100,000 Population

Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File.

Youth Risk Behavior Survey Data

The 2019 Youth Risk Behavior Surveillance System, a survey administered to high school students, provides information on risk factors for suicide deaths, including suicide ideation and attempts. Results from the survey show that about 1 in 5 (19.2%) high school students in Tennessee seriously considered taking their lives. There are gender disparities in suicide ideation. In 2019, more Tennessee females (24.4%) than male high school students (13.7%) seriously considered attempting suicide. In certain cases students made a plan for their suicide attempt; 15.4% of Tennessee students planned how they would attempt suicide. Also, approximately 1 in 9 (10.6%) high school students attempted suicide, with more females (11.8%) than males (9.2%) reporting attempted suicide. Lastly, in 2019, about one in every twenty-nine (3.9%) Tennessee high school students reported attempting suicide that resulted in an injury, overdose, or poisoning that required treatment by a physician or nurse.⁵

Behavioral Risk Factor Surveillance Survey Data

In 2019, one in four Tennesseans (25.0%) reported having been diagnosed with a form of depression (i.e., depression, major or minor depression, or persistent depressive disorder), a risk factor for suicidal behavior. The prevalence of depression is higher among females (30.9%) than males (18.5%). In addition, depression affects people of various races/ethnicity differently. About a third (31.9%) of Tennesseans who identified as multiracial, non-Hispanic had the highest prevalence of depression compared to White non-Hispanic Tennesseans (26.8%) and non-Hispanic Black Tennesseans (19.4%). Lastly, individuals aged 18-24 years reported the highest prevalence of depression (31.7%), while Tennesseans 65 years and older reported the lowest prevalence (18.7%).⁶

Electronic Surveillance Systems (ESSENCE)

The use of syndromic surveillance for suicide prevention by TDH includes the weekly, monthly, and annual gathering of information derived from the Electronic Surveillance Systems for the Early Notification of Community Based Epidemics (ESSENCE) available from the National Syndromic Surveillance Program (NSSP). The designated quantitative syndromic surveillance for suicide prevention includes ICD-10 code queries and discharge diagnoses directed at suicidal ideation, self-inflicted harm, and suicide attempts amongst youth and young adults. The complementary qualitative analysis includes dashboards that monitor triage notes targeted at identifying suicide risk factors.



Electronic Surveillance Systems for the Early Notification of Community Based Epidemics (ESSENCE)

The qualitative section focuses on suicide indicators such as poisoning (e.g., non-prescription drugs, prescription drugs, and household chemicals), self-inflicted harm, threats of suicide attempts, and hanging attempts. The analysis also identifies risk factors for suicide, including confirmed child abuse and neglect, intimate partner violence, and violence amongst youth (e.g., bullying, peer difficulties at school, and physical threats of self-harm or harm to others), major depressive disorder, history of suicide attempts/self-harm, mental health disorders, and recently the novel Coronavirus (COVID-19). Both quantitative and qualitative data vary weekly, and reports are generated and stored for data requests and monthly suicide reports sent to the Tennessee Governor's Office. Keywords help identify suicide activity/behavior within the ESSENCE database.

⁵ CDC. Youth Risk Behavior Surveillance System. <https://www.cdc.gov/healthyyouth/data/yrbs/results.htm>

⁶ Behavioral Risk Factor Surveillance System (BRFSS). BRFSS Prevalence & Trends Data. 2018. Available from <https://www.cdc.gov/brfss/brfssprevalence/index.html>

Re-evaluations/modifications and updates to queries based on expanding knowledge are integral to the division's ongoing syndromic surveillance. After identifying the regions/counties with suicide alerts among children and young adults who visit an ED, the response plan includes local and statewide action. Interventions include notifications to key stakeholders (i.e., The Department of Education, TDMHSAS, and TSPN). Additional actions include recommended training such as QPR training, participation in Be the One, ASIST training, and implementing the Good Behavior Game in schools.

Suicide among Tennessee Children: Child Fatality Review Data

Tennessee, through its [Child Fatality Review](#) efforts, examines all manners of child death, including suicide. The CFR documents method of suicide, circumstances associated with suicide, and its preventability. In 2019, 32 children in Tennessee died by suicide. Many suicide decedents displayed certain warning signs, such as talking about suicide (n=8), displaying severe emotional pain and distress (n=5), and expressing hopelessness (n=4). Children who died by suicide also experienced death. In four cases, the child had a history of the death of a peer, family, or friend.

In addition, many life stressors were noted among many suicide decedents including, experiencing racism (n=9), being victims of bullying (n=9), poverty (n=14), pregnancy (n=3), housing instability (n=3), parents' divorce/separation (n=9), family discord (n=10) communicating suicidal thoughts or intents, and having divorced parents.

Also, mental health issues were noted among suicide decedents; four children had anxiety spectrum disorder diagnosis, and five children had depression. Finally, among children who completed suicide, six of them were noted to have had suicidal behavior/attempts prior to death.

Suicide Prevention Programs & Services in Tennessee

Suicide Prevention Programs and Services in Tennessee

Effective suicide prevention is a comprehensive, multifaceted effort. Best practices in suicide prevention focus on suicide prevention strategies and activities such as:

- Promoting connectedness and resilience within communities
- Providing social support in communities to ensure individuals and families have necessities, such as food and shelter
- Reducing the stigma surrounding mental health and suicide by changing community norms through outreach and education
- Teaching community members how to identify persons at-risk for suicide and connecting them with appropriate referrals
- Increasing help-seeking behavior in individuals struggling with suicidal behavior or other mental health issues
- Ensuring availability of adequate crisis care and mental health care at the community level
- Ensuring appropriate care transitions are in place for those individuals who have attempted suicide or considered suicide
- Discussing means reduction strategies and access to lethal means with suicidal individuals and their families.

Suicide prevention programs and services in Tennessee implement many of the strategies listed above across diverse settings and agencies. This section highlights several suicide prevention programs and services currently offered in Tennessee.

Suicide Prevention Gatekeeper Trainings

Everyone has a role to play in reducing suicide attempts and suicide deaths in Tennessee. Therefore, everyone should be trained on how to identify individuals at-risk for suicide and ensure that they receive appropriate assistance. Gatekeeper training help in identifying people at risk for suicide by teaching participants the warning signs and symptoms of a person experiencing a suicidal crisis. The training also teaches participants how to engage with suicidal individuals and offers hope to those individuals. Gatekeeper training is delivered at no cost to participants, and they are designed for the general population. The three primary gatekeeper training currently offered in Tennessee are Question, Persuade, Refer (QPR), safeTALK, and Applied Suicide Intervention Skills Training (ASIST). In 2020, TSPN delivered suicide prevention gatekeeper training to 22,731 people across the state.⁷ All three gatekeeper trainings are evidence-based or evidence-informed programs, with QPR being the most provided training in Tennessee. QPR training delivers a concise message. The training can be tailored to discuss the risk of specific high-risk populations such as the LGBTQI+ population or individuals who suffer from a substance use disorder.

To help increase identification and support for those at-risk for suicide across Tennessee and to support CSP grant activities, TDH will contract with TSPN to help expand the number of suicide prevention gatekeeper trainings provided across Tennessee, especially within rural communities across the state. Over the first two years of the CSP grant, TSPN will provide QPR and ASIST

⁷ TSPN 2020 Training Outcome and Measures

trainings to members of drug and alcohol coalitions; to individuals that work with survivors of sexual and intimate partner violence; and to those that work with or care for individuals with disabilities. In addition to this, TSPN will also work to recruit businesses or organizations from rural areas in Tennessee to participate in the Be the One Suicide Prevention Workforce Initiative to help expand the number of people trained in suicide prevention within the Tennessee workforce.

Suicide Prevention Programs and Trainings that Protect Children and Youth

To reduce the number of children and youth impacted by suicide in Tennessee, there are several statewide programs and trainings that address the specific needs of this population.

School principals, teachers, and other support staff in schools play a vital role in identifying children at-risk for suicide. In 2007, the Tennessee General Assembly passed the Jason Flatt Act (HB 0101/SB 0057), making annual suicide awareness and prevention training mandatory for all individuals who work in a school setting. To meet the two-hour continuing education requirement for suicide awareness and prevention, schoolteachers and support staff must take all the development modules created by and offered through the Jason Foundation. These modules are free and include information on:

- The scope and magnitude of youth suicide
- The signs, symptoms, and risk factors for youth suicide
- How to recognize young people who may be struggling with suicidal thoughts or intention
- How to approach and help at-risk youths find resources to mitigate suicidal behavior

Children and youth face numerous challenges in their daily lives that increase their risk for suicide, and many do not feel comfortable revealing suicidal ideation to those around them. Identifying children at-risk for suicide and ensuring they receive the assistance they need is imperative to reduce the number of children who die by suicide in Tennessee. There are several programs in Tennessee aimed to raise awareness on suicide among children and youth and identify those most at-risk for suicide in Tennessee. These programs include:

- The Tennessee Lives Count-Connect 2 (TLC-Connect2) is a program that seeks to reduce suicidal ideation, suicide attempts, and suicide deaths among children and youth aged 10-24. TLC-Connect2 develops and implements statewide suicide prevention and early intervention strategies, risk screening/assessment, and enhanced follow-up practices through collaborations with schools, healthcare organizations, behavioral health organizations, foster care, and other agencies that work with youth and young adults.
- The Youth and Young Adult Suicide Prevention and Mental Health Awareness, a program that seeks to prevent suicide and promote better mental health among Tennesseans up to 25 years of age. This program partners with pediatric offices to establish processes that provide suicide risk screening and referral to treatment and services for all patients. This program also works with higher education institutions to conduct suicide prevention activities that raise awareness of suicide among students and staff.

- Project AWARE (Advancing Wellness and Resiliency in Education), a program that aims to promote resilience and positive behavioral functioning among school-age youth and expand youth access to mental health resources. The program has three specific goals:
 - Build state capacity to increase mental health awareness and access in schools and communities. This goal is accomplished through the development of state and local policy and resource integration
 - Promote competency among child-serving adults to detect and respond to youth mental health concerns by providing Youth Mental Health First Aid (YMHFA) trainings
 - Expand the continuum of school- and community-based behavioral health supports and interventions, respond to youth mental health needs, and keep youth in school and out of the juvenile justice system.

The TLC-Connect2 program is funded through the Substance Abuse and Mental Health Services Administration (SAMSHA). The TLC-Connect2 program was initially piloted as part of a federal grant from 2014-2019 and was re-established with a subsequent federal grant in 2020. The second five-year grant period began January 15, 2020 and will end January 14, 2025. Through the first year of TLC-Connect2, 1,246 individuals have been provided suicide prevention gatekeeper trainings, and 17,813 individuals have received suicide prevention educational materials through outreach efforts. Through the work of Project AWARE, 5,819 individuals who work with children and youth across the state have received training in YMHFA.⁸

Suicide Prevention Programs for Healthcare Professionals

Another way to effectively reduce deaths by suicide is by providing training on suicide to healthcare professionals within primary care clinics and hospital settings. According to national research, 45% of individuals who die by suicide have visited their primary care physician within a month of their death and 67% of those who attempt suicide receive medical attention as a result of their attempt.⁹ Suicide is a public health issue, and healthcare professionals have a vital role to play in the field of suicide prevention. Teaching healthcare professionals how to identify and screen at-risk patients and how to create appropriate care transitions for those individuals who are identified as being at-risk for suicide is essential in reducing attempts and deaths by suicide. There are several other suicide prevention programs and initiatives being implemented across Tennessee which target healthcare professionals, including:

- The Suicide Prevention in the Emergency Department training program is an interactive online training that is free to participants and reviews:
 - The prevalence of suicide on the national level and within the state of Tennessee
 - Suicide risk factors and warning signs
 - Evidence-based suicide risk assessment tools
 - Recommendations on what can be done to prevent suicide attempts in the emergency department

⁸ Tennessee Department of Education, Project AWARE Outcome and Measures

⁹ Substance Abuse and Mental Health Services Administration, Primary Care: A Crucial Setting for Suicide Prevention, Available from <https://www.integration.samhsa.gov/about-us/esolutions-newsletter/suicide-prevention-in-primary-care>

- Counseling on Access to Lethal Means (CALM) is a free, online training program designed to help providers implement counseling strategies which can help clients at risk for suicide and their families reduce access to lethal means within their homes.
- Columbia-Suicide Severity Rating Scale(C-SSRS) is a free online training that teaches clinicians how to identify whether someone is at risk for suicide, assess the severity and immediacy of a risk, and gauge the level of support the person needs.

Suicide Prevention for Healthcare Systems

The Zero Suicide Initiative creates a framework for systematic, clinical suicide prevention in behavioral health and healthcare systems and it relies on a system-wide approach to improve outcomes and close gaps in services provided to patients who may be at risk for suicide. Many people are seen within a healthcare facility prior to dying by suicide, but often these patients are not identified or assessed for suicide risk. The Zero Suicide Initiative uses specific tools and strategies to achieve a reduction in suicide for all patients who receive care within the organizations implementing the approach. These tools and strategies include:

- Creating a leadership driven, safety-oriented workforce culture that commits to dramatically reducing suicide
- Developing a competent, confident, caring workforce by ensuring all employees receive suicide prevention training
- Identifying and assessing all patients for suicide risk
- Engaging patients at risk for suicide in a safety care plan, which includes protocols for referrals and follow-up
- Treating suicidal thoughts and behaviors directly, which includes collaborative safety planning and means restriction conversations with patients and their family members
- Following patients through every transition in care, including any treatment they receive within outside organizations
- Applying a data-driven quality improvement plan

Adopting the Zero Suicide Approach to increase help-seeking behavior along with identifying and assisting those at risk for suicide are top strategies healthcare organizations across the state can implement to reduce suicide deaths. In an effort to help strengthen access and delivery of suicide care across Tennessee and to support CSP grant strategies, TDH will also contract with TSPN to implement the Zero Suicide Initiative within healthcare and behavioral healthcare agencies which serve high-risk populations across the state. Through this partnership over the first two years of the CSP grant, TSPN will work to recruit agencies that work with survivors of sexual or intimate partner violence and agencies that work with individuals with disabilities to implement the Zero Suicide Initiative.

Crisis Services

An effective way to reduce suicide death and suicidal behavior is to provide a full range of crisis services for individuals experiencing mental health emergencies, which includes referrals to mental health treatment services and appropriate follow-up care. Tennessee has a wide range of crisis services available for those experiencing a mental health emergency. These services include:

- The Tennessee Statewide Crisis Line

- Mobile Crisis Services and Response
- Crisis Walk-In Centers
- Crisis Stabilization Units
- Crisis Respite Services
- Mobile Crisis Services for Children and Youth

From 2016 to 2020, face-to-face crisis assessments provided by mobile crisis teams or through crisis-walk in centers decreased by 2% across the state. In 2020, a total of 75,344 face-to-face assessments were provided to Tennesseans experiencing a mental health crisis. Of those assessments, 56,131 people were assessed through mobile crisis and 19,213 people were assessed through crisis walk-in centers.¹⁰ All crisis services within Tennessee are offered 24 hours a day, 7 days a week, and 365 days of the year. There are 13 mobile crisis teams and 8 crisis walk-in centers available across the state. Unfortunately, only one crisis walk-in center, and no crisis stabilization unit, exists for children under 18 in Tennessee. While we have a strong crisis infrastructure within the state, crisis services could be improved for children under 18 and individuals who live within rural areas across the state.

Upstream Prevention Activities

Another effective way to reduce suicide across Tennessee is by expanding more upstream prevention activities to teach children how to appropriately respond and cope through difficult situations which may arise within their lives. One evidence-based program shown to have long-term positive outcomes in reducing an individual's risk of suicide is The Good Behavior Game (GBG). The GBG is a classroom based behavioral management program which aims to promote positive behavior choices within children. The GBG is grounded by the Life Course/Social Field Theory and the Behavioral Theory. The Life Course/Social Field Theory states that individuals can act as "natural raters" in order to identify what tasks and behaviors are expected of us and to help determine how well we are performing these tasks within environments such as schools or the workplace. The Behavioral Theory states that a group of individuals cannot succeed without the cooperation and support of everyone, which means that every individual within a group, or community, must meet a certain standard for the group to succeed. Through the GBG, teachers help implement these two theories in order to teach children how to work together to create a positive learning environment for all by monitoring their own behavior, as well as that of their classmates, and holding one another accountable for poor or alarming behavior choices. This program was tested in 41 classrooms within 19 elementary schools and researchers followed up periodically with students all the way into early adulthood to study the immediate, mid-, and long-term effects of the game. Through this follow-up, the GBG has been proven to:

- Reduce aggressive, disruptive, and off-task behavior within students
- Reduce the need of mental health services
- Reduce illicit drug use and alcohol use
- Reduce tobacco use
- Reduce antisocial disorder

¹⁰ TN Crisis Management System, Crisis Services Fast Facts, Available from <https://www.tn.gov/behavioral-health/research/tmhsas-fast-facts-test-3/fast-facts--crisis-services.html>

By teaching children how to be supportive of one another and by promoting connectedness, resiliency, and responsibility within the classroom at an early age, the GBG is an excellent way to help reduce the number of individuals who attempt or die by suicide at later stages within their life. To help increase coping and problem-solving skills in young students across Tennessee and to support CSP grant activities, TDH will contract with the American Institute for Research (AIR) to help implement the GBG in elementary school classrooms across the state, with a specific focus on schools located within rural communities. Over the first two years of the CSP grant, AIR will provide GBG teacher implementation training to 140 K-2 elementary school teachers located within rural counties across Tennessee. AIR will also provide GBG coach training to 40 school-based partners within those districts to help provide support and technical assistance to teachers who choose to implement the GBG within the classroom. In addition to these trainings, AIR will provide GBG Train-the-Trainer sessions to all 40 GBG coaches to ensure long-term sustainability of the program within those schools. Lastly, AIR will also provide technical assistance to GBG coaches as they provide GBG teacher implementation training to an additional 140 K-2 elementary school teachers. Through this work, by the end of August 2022, 280 K-2 elementary school teachers in Tennessee will be trained to implement the GBG within their classroom.

Adjustments Made to Suicide Prevention Programming in Tennessee

Due to COVID-19

In 2020, the COVID-19 pandemic presented physical, mental, and emotional complications for everyone, especially for individuals who are already at-risk (i.e. those suffering from depression, anxiety, mental illness, substance misuse, or thoughts of suicide). Many communities across Tennessee have experienced a dramatic loss of human life and risk factors for suicide such as unemployment, homelessness, physical health problems, and access to lethal means within those communities have increased as well. In addition to this, the COVID-19 pandemic has presented unprecedented challenges to public health. Now more than ever, it's crucial to continue to raise awareness about suicide prevention and how we can all take steps to promote resiliency, healing, and hope. Over the last year, TDH made several adaptations to suicide prevention programming to adhere to COVID-19 social distancing measures:

- Hosting all suicide prevention stakeholder task force team meetings in a virtual setting, rather than in-person since February 2020.
- Collaborating more with internal and external partners through email, phone calls, and virtual meetings.
- Providing Question, Persuade, Refer (QPR) suicide prevention gatekeeper trainings in a virtual format, rather than in an in-person setting.
- Providing Be the One Suicide Prevention Workforce trainings to TDH employees in a virtual format, rather than in an in-person setting.
- Developing weekly suicide reports to track and monitor statewide suicide deaths, emergency department visits for suicide-related behavior, crisis calls, and texts through the crisis text line.

Through these adaptations, the TDH Suicide Prevention Program was able to:

- Increase the number of stakeholders attending and participating during suicide prevention task force meetings by 65%.
- Train 132 individuals across the state in QPR including evidence-based visitors, senior center staff, Care through Conversation volunteers, Community and Health Access Navigation staff, Traumatic Brain Injury Coordinators, and staff who work with survivors of sexual or intimate partner violence.
- Train 114 TDH employees in the Be the One Suicide Prevention Workforce Initiative.
- Develop 54 weekly reports tracking suicide-related behavior across Tennessee.

Moving forward, TDH will continue to adjust suicide prevention programming as necessary to meet the current needs of stakeholders and communities across Tennessee. Over the next year, TDH will continue: to collaborate with stakeholders and hold task force meetings in a virtual setting; provide virtual QPR and Be the One suicide prevention gatekeeper trainings; and develop monthly suicide reports to track and monitor statewide suicide deaths, emergency department visits for suicide-related behavior, crisis calls, and texts through the crisis text line. To support CSP grant work over the next five years, TDH will also work to improve suicide prevention programming across the state by contracting with Centerstone Research Institute to provide extensive program evaluation. Lastly, TDH will continue to provide local Tennessee partners and communities timely data and information about suicide, including information about how the COVID-19 pandemic may have impacted mental health and suicide-related behavior across Tennessee, through future communications such as reports, infographics, or fact sheets.

Suicide Prevention Recommendations for Tennessee

Suicide Prevention Recommendations for Tennessee

Legislative Policies

1. All mental health facilities should comply with legislation that allows mental health records of suicide decedents to be shared with medical examiners across the state (T.C.A. 38-7-117) and those individuals who request records for fatality review programs such as the Tennessee National Violent Death Reporting System, the Maternal Mortality Review Program (TCA § 63-3-2), and the Child Fatality Review Program (TCA § 68-142-108).
2. All health insurers within the state of Tennessee should comply with the rules and requirements of the Mental Health Parity and Addiction Equity Act. The Parity Act requires a health plan's standards for substance use and mental health benefits to be comparable to the standards for other medical benefits.

State and Community Agencies

1. Increase access to adequate mental health care for all Tennesseans by:
 - Increasing funding to expand inpatient and outpatient facilities throughout the state that can provide treatment for mental health conditions and crisis care, especially for children and individuals residing in rural parts of Tennessee
 - Increasing the number of licensed behavioral health professionals practicing in Tennessee, especially those who work with children/youth
 - Expanding behavioral health safety net coverage for individuals without health insurance, including children under the age of 18
 - Encouraging the use of telehealth for mental health services.
2. Spread awareness of suicide and encourage help-seeking behavior by:
 - Posting existing suicide prevention PSAs on social media accounts, websites, and other means of dissemination.
 - Educating the media to ensure that any reporting related to mental health and suicide follows suicide prevention safe messaging guidelines.
 - Utilizing ESSENCE alerts to increase awareness of the helpline in identified high-risk areas
3. Support the widespread use of standardized behavioral health assessment protocols and tools such as the Columbia-Suicide Severity Rating Scale in agencies serving high-risk population such as, but not limited to, home health agencies, juvenile and adult corrections facilities, active military and veterans affairs agencies, LGBTQI+ outreach groups, adult and child protective services, before and after school care programs, senior centers, licensed adult day centers, assisted-living centers, agencies serving sexual assault survivors and agencies serving those at risk for substance use.
4. Strengthen the crisis response infrastructure in Tennessee, with particular emphasis on children and rural communities across the state by:
 - Expanding the use of crisis response teams
 - Expanding the number of walk-in crisis centers and crisis stabilization units
 - Ensuring appropriate follow-up practices are implemented to all Tennesseans who receive crisis response services
 - Adapting policies and procedures that address and allow for crisis care and treatment to be provided for medically complicated patients

- Providing postvention support and resources to survivors of suicide loss as soon after a suicide death as possible
5. Support suicide prevention programs and trainings promoting connectedness and resiliency in all Tennessee communities by:
 - Requiring employees to complete Adverse Childhood Experiences training.
 - Providing all local and state government employees education and training on suicide prevention through agency implementation of the Be the One Suicide Prevention Workforce Initiative provided by the Tennessee Department of Mental Health and Substance Abuse Services.
 - Requiring employees to complete evidence-based gatekeeper trainings in suicide prevention and intervention, such as Question, Persuade, Refer (QPR), Applied Suicide Intervention Skills (ASIST), and Suicide Alertness for Everyone (safeTALK).

Clinics and Hospital Systems

1. Health and Behavioral Health Care Systems across the state should maintain “suicide safe” facilities by:
 - Implementing the Zero Suicide Approach to suicide prevention
 - Ensuring that all healthcare professionals receive core competencies in suicide prevention and provide timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.
 - Developing collaborations between emergency departments, health care providers (e.g., health and mental health centers), local emergency first responders, and crisis services to ensure rapid follow-up after discharge. This collaboration would provide alternatives to emergency department care and hospitalization when appropriate.
 - Increasing the use of certified peer recovery specialists or other paraprofessionals in appropriate crisis, treatment, and recovery support settings across the state.
2. Implement policies to provide information on means restriction to patients and families and incorporate counseling on access to lethal means into suicide risk assessment protocols.
3. All hospitals should continue to report into the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) database to assist with real time surveillance of populations experiencing incidents of suicide-related behavior.

Healthcare Providers

1. Healthcare providers should disseminate educational materials to patients on the signs of suicide, including how to reach out for help if they or someone they know is in crisis.
2. Primary care and pediatric providers should utilize screening tools such as the Columbia-Suicide Severity Rating Scale to screen all patients for risk of suicide and refer those at risk to mental health services.
3. Primary care and pediatric providers should work with mental health centers to ensure that all suicidal patients receive appropriate mental health referrals, follow-up, treatment, and care.

4. Behavioral health providers should complete training on best practices for utilizing telehealth.
5. Primary care and pediatric providers should complete the “Counseling on Access to Lethal Means” course to better counsel gun owners on safe firearm storage practices and provide strategies to reduce access to lethal means of suicide within the home.

Public Safety and Emergency Response Agencies

1. Expand crisis intervention training to every public safety system in Tennessee including law enforcement officers, EMTs, firefighters, correctional officers, parole officers, and emergency response operators. Implement a standardized crisis response protocol across the entire state.
2. Promote partnerships between behavioral healthcare facilities, local law enforcement, local transportation agencies, and local emergency medical services to expand the Crisis Assessment and Response to Emergencies Program or to implement other community responder models that support mental health diversion.
3. Create safe, protective, and supportive work environments for all employees within law enforcement agencies, fire departments and EMS by:
 - Implementing workplace suicide prevention programs and initiatives that spread awareness of suicide, such as the *Be the One* Workforce Initiative
 - Offering mental health wellness and counseling support through employee benefits or Employee Assistance Programs
 - Providing immediate counseling and ensuring appropriate follow-up occurs for those employees who have witnessed or responded to a traumatic event
4. Develop a standardized suicide death investigation form for medical examiners, law enforcement officers, and first responders to use during suicide death scene investigations to improve data collection for the Tennessee National Violent Death Reporting System (TNVDRS) and increase understanding of the circumstances involved in deaths by suicide.

Educational Institutions

1. Increase the availability and accessibility of mental health screening, care, and referral to community-based mental health services in schools.
2. Provide training opportunities for suicide prevention, such as Question, Persuade, Refer (QPR), Applied Suicide Intervention Skills (ASIST), and Youth Mental Health First Aid (YMHFA), to students, school teachers, school support staff, and to any other adults that interact with children and youth in schools so they are able to recognize students at potential risk of suicide and refer those students to appropriate services.
3. Display the Tennessee statewide crisis number and text line information throughout all schools including higher educational institutions. Schools should add suicide prevention resources to student ID’s and in all course syllabi.
4. Implement the Good Behavior Game program within K-2 classrooms across the state. Implement peer-to-peer programs such as Sources of Strength and Hope Squads in middle and high schools.
5. Incorporate a protocol for responding to ESSENCE alerts into the school suicide prevention response plan.

Individuals, Families, and Friends

1. Seek care with the earliest symptoms of depression or other signs of suicide.
2. Seek resources or trainings to develop skills related to emotion or anger control, problem solving, conflict resolution and coping skills.
3. Learn the risk factors for suicide, how to reach out for help, and appropriately refer a person at-risk for suicide to the Suicide Prevention Lifeline, the Tennessee Statewide Crisis Line, or the Crisis Text Line.
4. Reduce access to lethal means within the home by:
 - safely storing firearms and prescription medications
 - utilizing prescription drop boxes located throughout the state to dispose of any unused or out-of-date prescription medications
5. Complete suicide prevention trainings such as Question, Persuade, and Refer (QPR), Mental Health First Aid (MHFA), Youth Mental Health First Aid (YMHFA) training and Applied Suicide Intervention Skills (ASIST) training.
6. Encourage conversations on suicide prevention awareness within the community settings such as local faith-based organizations, hair salons and barber shops, bars and restaurants, animal hospitals and veterinary offices, and hotels and motels.

Success Stories: Suicide Prevention in Tennessee

Tennessee Suicide Prevention Success Stories

Increased Funding to Improve Suicide Prevention across Tennessee

The Tennessee Department of Health (TDH) received a five-year, \$750,000 per year, funding award from the Centers for Disease Control and Prevention (CDC) to improve suicide prevention efforts across the state over the next five years. TDH was one of nine organizations across the nation which received this funding from the CDC's new Comprehensive Suicide Prevention (CSP) program. The overall purpose of the CSP grant is to enhance, support, and strengthen suicide prevention infrastructure across Tennessee by implementing data-driven approaches to achieve a 10% reduction in suicide morbidity and mortality by 2025. This new funding began on September 1, 2020, and provides TDH the ability to improve suicide prevention efforts across the state, with a specific focus on rural communities, by supporting the implementation and evaluation of a comprehensive public health approach to suicide prevention across Tennessee. According to the CDC, a comprehensive public health approach to suicide prevention includes: strong leadership that convenes multi-sectoral partnerships; prioritization of data to help identify vulnerable populations and to better characterize risk and protective factors impacting suicide; leveraging existing suicide prevention programs and services; selection of multiple evidence-based strategies listed within the CDC's Preventing Suicide: A Technical Package of Policy, Programs, and Practices; effective plans for communication and data dissemination; and rigorous evaluation of the individual selected strategies and activities and the overall comprehensive public health approach to suicide prevention to ensure quality program improvement and sustainability.

Over the next five years, TDH will implement a comprehensive public health approach to suicide prevention across Tennessee by expanding existing suicide prevention efforts within the state and implementing new activities. Plans include increasing the number of partners engaged with the stakeholder task force team, especially partners who serve rural communities; expanding the number of people trained to identify and support those at risk for suicide through gatekeeper trainings such as QPR and ASIST; increasing coping and problem solving skills in young students by training K-2 elementary school teachers to implement the Good Behavior Game program within the classroom; expanding suicide-related syndromic surveillance efforts and associated response plans to include individuals across the lifespan; strengthening delivery and access to suicide care within health and behavioral healthcare agencies through implementation of the Zero Suicide Initiative; reducing gaps in accessing behavioral healthcare by increasing the understanding of mental health parity laws in Tennessee through education to providers and the general public; and by providing telehealth training to mental health care providers across the state. To support CSP grant work, TDH hired a full-time contract epidemiologist in December 2020. TDH will also hire a contract suicide prevention communication specialist to be responsible for increasing communications of suicide prevention across Tennessee through multiple channels and stakeholders. To ensure CSP grant requirements are met, TDH will also contract with several state and national agencies to support this work including TSPN, Centerstone Research Institute, American Institute for Research, and Centerstone.

Increasing Suicide Prevention Gatekeeper Trainings across Tennessee

Tennessee Suicide Prevention Network (TSPN) and The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) are two partners who participate on the TDH Suicide Prevention Stakeholder Task Force Team who have successfully increased the number of suicide prevention gatekeeper trainings being provided within local Tennessee communities. Suicide prevention gatekeeper trainings are an excellent way for both professionals and the public to learn how to identify and support those who may be at-risk for suicide across Tennessee.

TSPN is the only statewide organization which offers suicide prevention training, support, and resources within all 95 counties of Tennessee. TSPN has regional directors, covering all 95 counties, who can provide free, evidence-based suicide prevention programs such as ASIST, QPR, and Zero Suicide. TSPN works across the state to eliminate the stigma of suicide and educate communities about the warning signs of suicide to help reduce the number of people who die by suicide each year within Tennessee. In 2020, TSPN delivered 471 QPR trainings to 9,950 individuals and 9 ASIST trainings to 160 individuals across Tennessee. In total, in 2020, TSPN provided 633 suicide prevention trainings to 22,731 individuals across Tennessee. To learn more about TSPN, please go to www.tspn.org. To schedule a suicide prevention training with TSPN, please [click here](#).

TDMHSAS offers the Be the One Suicide Prevention Workforce Initiative to businesses and organizations across Tennessee. The initiative's focus is suicide prevention for co-workers, and it is based on the idea that colleagues can help build a supportive workforce which values and affirms life. The training associated with the Be the One Suicide Prevention Workforce Initiative teaches participants how to recognize when a coworker may be thinking about suicide, how to question a coworker about being suicidal, and how to help a coworker through a suicidal crisis. Since September 2019, 252 Be the One trainings have been provided to 2,828 individuals within workforces across Tennessee. There are currently 16 state departments and 13 private agencies across Tennessee participating in the Be the One Suicide Prevention Workforce Initiative. To learn more about "Be the One" or to sign up to participate, please [click here](#).

Broaden Communication about Suicide Prevention across Tennessee

Given that misconceptions about suicide are abundant and beliefs about mental wellness, suicide, and help-seeking behavior often vary widely, it is essential that the Tennessee Department of Health (TDH) provide local Tennessee partners and communities, including individuals and families, timely data and information about suicide which aligns with national safe and effective messaging guidelines for reporting on suicide. Over the last year, the TDH Suicide Prevention Program developed several new informational products to help broaden communications about suicide and suicide-related behavior in Tennessee and to help encourage help-seeking behavior for at-risk individuals across the state. Informational products developed by TDH in 2020 included two 30-second public service announcements (PSAs) which highlight suicide as a problem in Tennessee and promote suicide prevention trainings available across the state, and an infographic which provides an overview of 2019 suicide deaths in Tennessee. In addition, TDH also developed a data dissemination and communication plan which aligns with CSP grant goals and the statewide implementation of a comprehensive public health approach to suicide prevention across Tennessee. The plan lists the goals, objectives, tactics/channels, frequency, desired outcomes, and evaluation metrics for all TDH communications efforts regarding the prevention of suicide in Tennessee.

Suicide Prevention PSAs:

TDH developed two 30-second PSAs to help increase the number of people across the state who sign up for and receive suicide prevention gatekeeper trainings provided by TSPN. One commercial was tailored for professionals, and the other commercial was tailored for the public. The commercials aired on television from December 2020 to February 2021 in the South Central, Southeast, East, and Northeast regions of the state. During this same period, traffic to the TDH Suicide Prevention Program website increased. The PSAs were also shared with the suicide prevention stakeholder task force team and on TDH social media sites garnering hundreds of additional shares and views. As of April 2021, the PSAs tailored for professionals had been viewed 362 times, and the PSAs tailored for the public had been viewed 887 times on TDH's YouTube page. To watch and share these PSAs, please go to:

TDH Suicide Prevention Training PSA for [Professionals](#)

TDH Suicide Prevention Training PSA for [General Public](#)

TDH 2020 Suicide Deaths in Tennessee Infographic:

An infographic highlighting the key findings of 2019 suicide deaths in Tennessee was developed and disseminated to partners engaged in suicide prevention across the state. An electronic version of the infographic was distributed widely to partners on many platforms and printed copies of the infographic were made available to partners upon request. Key findings highlighted within the infographic include: 1,220 Tennessee residents died by suicide in 2019; suicide is the third leading cause of death for children and youth aged 10-24; suicide is highest among individuals aged 45 to 64; 90% of deaths by suicide in 2019 were of white individuals; individuals living in rural communities died by suicide at a rate 1.4x higher than those in metro areas; firearms was the mechanism used in 61% of all suicide deaths in 2019; 18% of all 2019 suicide deaths were individuals affiliated with the U.S. Armed Forces; and males died by suicide at more than 3x the rate of females in 2019. The infographic also listed the number for the Tennessee Statewide Crisis Line and the Crisis Text Line.

Conclusion

The goal of this report is to provide data, resources, and recommendations for suicide prevention in Tennessee. The rate of suicide in Tennessee continues to be much higher than the national rate and we continue to lose too many Tennesseans each day to suicide. We encourage all who read this report to utilize the data and recommendations contained herein to explore opportunities for improving the health and well-being of those who may be at risk for suicide within their own communities.

Appendices

Appendix 1: Tennessee Statewide Suicide Prevention Programs and Services

Program	Children/ Youth	Adults	Seniors	Veterans	Cost for Recipients	Funding Source for Program/Service	Approximate % of TN Counties that Offer Program/Service Locally
Alcohol and Drug QPR (A & D) Gatekeeper Training	Yes	Yes	Yes	Yes	None	State and Federal Funding TSPN Volunteer Trainers	100%
Applied Suicide Intervention Skills (ASIST) Training	Yes	Yes	Yes	Yes	None	State and Federal Funding TSPN Volunteer Trainers	100%
“Be the One” Suicide Prevention Workforce Campaign	No	Yes	Yes	Yes	None	Federal Funding	100%
CALM: Counseling on Access to Lethal Means Training	Yes	Yes	Yes	Yes	None	N/A	100%
Columbia-Suicide Severity Rating Scale(C-SSRS)	Yes	Yes	Yes	Yes	None	N/A	100%
General Suicide Prevention Training	Yes	Yes	Yes	Yes	None	State and Federal Funding TSPN Volunteer Trainers	100%
Gun Safety Project	Yes	Yes	Yes	Yes	None	Federal Funding TSPN Funding	100%
I.C. Hope (Erase the Stigma Program)	Yes	N/A	N/A	N/A	None	Federal Funding	65%
Juvenile Justice Diversion Program	Yes	N/A	N/A	N/A	None	State Funding	100%
Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and	Yes	Yes	Yes	Yes	None	State and Federal Funding TSPN Volunteer Trainers	100%

Intersex QPR (LGBTQI+) Gatekeeper Training							
Mental Health First Aid (MHFA) Training	Yes	Yes	Yes	Yes	None	State Funding	100%
Mental Health 101	Yes	N/A	N/A	N/A	None	Centerstone State Funding	100%
Postvention Training	Yes	Yes	Yes	Yes	None	Mental Health America of East TN State and Federal Funding	100%
Pre-Arrest Diversion Infrastructure Program	N/A	Yes	Yes	Yes	None	State Funding	21%
Project BASIC (Better Attitudes and Skills in Children)	Yes	N/A	N/A	N/A	None		
Question, Persuade, Refer (QPR) Gatekeeper Training	Yes	Yes	Yes	Yes	None	State and Federal Funds TSPN Volunteer Trainers	100%
Shield of Care	Yes	N/A	N/A	N/A	None	Federal Funding	100%
Suicide Prevention in the Emergency Department	Yes	Yes	Yes	Yes	None	Federal Funding	100%
Tennessee Lives Count-Connect2	Yes	N/A	N/A	N/A	None	Centerstone, Federal Funding TSPN Funds	100%
The Jason Foundation	Yes	N/A	N/A	N/A	None	State funding	100%
TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment	Yes	Yes	Yes	Yes	Yes	None	None
Violence and Bullying Prevention Program	Yes	N/A	N/A	N/A	None	State Funding	9%
Youth and Young Adult Suicide Prevention and Mental Health Awareness Program	Yes	N/A	N/A	N/A	None	State Funding	33%

Youth Mental Health First Aid (YMHFA)	Yes	Yes	Yes	Yes	None	Federal Funding	100%
Zero Suicide Initiative	Yes	Yes	Yes	Yes	None	Centerstone, Federal Funding TSPN Funds	100%
Services	Children/ Youth	Adults	Seniors	Veterans	Cost for Recipients	Funding Source for Program/Service	Approximate % of TN counties who provide Program/Service Locally
Crisis Respite Services	No	Yes	Yes	Yes	None	State Funding	100%
Crisis Stabilization Units (CSU)	No	Yes	Yes	Yes	None	State Funding	100%
Crisis Walk-In Centers	Yes	Yes	Yes	Yes	None	State Funding	100%
Healthy Transitions Initiative	Yes	N/A	N/A	N/A	None	Federal Funding	95%
Mobile Crisis Services	Yes	Yes	Yes	Yes	None	State Funding	100%
National Alliance on Mental Illness (NAMI) TN Support Groups	No	Yes	Yes	Yes	None	NAMI is most often funded through community contributions and sponsorships	100%
Peer Support Centers and Services	No	Yes	Yes	Yes	None		60%
Project AWARE (Advancing Wellness and Resiliency in Education)	Yes	N/A	N/A	N/A	None	Federal Funding	4%
STAR (Students Together Advancing Resilience)	Yes	N/A	N/A	N/A	None	TennCare or other personal health insurance coverage	4%
TeenScreen	Yes	N/A	N/A	N/A	None	Federal Funding	100%
TN Statewide Crisis Phone Line	Yes	Yes	Yes	Yes	None	State Funding	100%

Appendix 2: Tennessee Statewide Suicide Prevention: Description of Programs

Program Name	Program Description	Audiences
Alcohol and Drug QPR (A & D) Gatekeeper Training	60-120 minute in-person customized version of QPR focused on the role substance abuse plays in suicide	General Population
Applied Suicide Intervention Skills (ASIST) Training	Two day in-person training that provides intensive suicide first-aid training using an evidence-based suicide intervention model that teaches participants how to identify persons with thoughts of suicide, how to seek a shared understanding of reasons for dying and living, how to develop a safety plan, and how to prepare for follow-up.	General Population
"Be the One" Suicide Prevention Workforce Campaign	2 hour in-person workplace gatekeeper training provided to employees in the workplace. Be the One teaches participants specific skills for identifying a co-worker at risk for suicide and teaches specific skills on how to intervene and save a life.	Employees in Organizations who have implemented the Be the One Campaign
CALM: Counseling on Access to Lethal Means Training	2-hour online training designed to help providers implement counseling strategies within their care practices to assist clients at risk for suicide and their families reduce access to lethal means, particularly (but not exclusively) firearms	Healthcare Providers, but also available for the general population
Columbia-Suicide Severity Rating Scale (C-SSRS)	30 minute online training that teaches participants how to use the suicide risk assessment tool in order to identify whether someone is at risk for suicide, assess the severity and immediacy of a risk, and gauge the level of support the person needs.	General Population
General Suicide Prevention Training	In-person presentation covering basic suicide prevention and warning signs of suicide.	General Population

Gun Safety Project	Project, with a 30-minute training component, designed to help gun shop and firing range owners and employees learn how to identify, address, and assist potentially suicidal customers.	Gun shop and firing range owners
I.C. Hope (Erase the Stigma Program)	Age-appropriate education and curricula provided to children and youth about mental health stigmas and the importance of mental health wellness.	Children/youth
Juvenile Justice Diversion Program	Program that focuses on diverting youth who have been referred to juvenile court for a delinquent/unruly charge, or who have already been adjudicated delinquent/unruly, and are at risk of being placed in DCS custody further penetration into the juvenile justice system through the use of community-based services, rather than commitment to state custody, where treatment through community-based services better addresses the youth's mental health needs.	Children/youth involved in the juvenile justice system and those who work with this population
Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex QPR (LGBTQI+) Gatekeeper Training	60-120 minute in-person customized version of QPR regarding suicide risk within the LGBTQI+ population.	General Population
Mental Health First Aid (MHFA) Training	One day in-person training that teaches participants how to identify, understand, and respond to signs of mental illnesses and substance use disorders. The course introduces participants to risk factors and warning signs of mental health concerns, builds understanding of their impact, and provides an overview of common treatments.	General Population
Mental Health 101	Curriculum provided to middle school and high school students which focuses on reduces the stigma of mental illness and raising awareness of suicide.	Middle school and high school aged youth
Postvention Training	In-Person training that teaches participants how to coordinate a comprehensive and safe response to a suicide affecting a business, school, or organization, with suggestions of how to talk to persons bereaved by suicide loss to promote their healing and identification of community resources. Length of training varies.	General Population
Pre-Arrest Diversion Infrastructure Program	Program that aims to reduce or eliminate the time individuals with mental health, substance abuse, or co-occurring disorders spend incarcerated by redirecting them from the criminal justice system to community-based treatment and supports	Adults involved in the criminal justice systems

Project BASIC (Better Attitudes and Skills in Children)	Award-winning school-based mental health prevention and early intervention program offering mental health education through direct classroom interaction with children and through work with teachers, coaching them on strategies to promote social emotional development of children.	Elementary aged school children
Question, Persuade, Refer (QPR) Gatekeeper Training	A 60-120 minute in-person training designed to teach participants how to recognize the warning signs of someone who may be contemplating suicide and question them about whether or not they are suicidal, how to offer hope to an individual experiencing a suicidal crisis and persuade them to get assistance, and how to refer an individual having a suicidal crisis to help in order to save their life	General Population
Shield of Care	8 hour in-person training and curriculum designed specifically for staffs working in the nation's juvenile justice facilities. The training provides participants knowledge of suicide prevention strategies, including risk and protective factors, self-efficacy to prevent suicide and specific suicide prevention skills.	Staff working in juvenile justice facilities
Suicide Prevention in the Emergency Department	Online interactive training focused on training hospital emergency department staff about mental health and suicide. The screening, assessment, and referral process of patients at risk for suicide, environmental risk factors for suicide in the hospital setting, means reduction, and referral materials to provide to patients upon discharge.	Hospital Emergency Department staff
Tennessee Lives Count-Connect2	Program aimed to reduce suicidal ideation, suicide attempts, and deaths among youth and young adults ages 10-24 by developing and implementing statewide suicide prevention and early intervention strategies, risk screening/assessment, and enhanced follow-up. Program goals comprise providing suicide prevention and postvention trainings for gatekeepers (schools, law enforcement, foster care, etc.) and training for primary/behavioral health professionals, screening/assessment, early intervention, follow-up, outreach/education, and linkages to treatment services, using the evidence-based Applied Suicide Intervention Skills Training (ASIST) and Columbia Suicide Severity Rating Scale (C-SSRS) models, strengthening public/private collaborations and supporting higher learning institutions to train students in recognizing early signs of suicide and referring individuals needing assistance.	Children/youth aged 10-24 and those that work with this population
The Jason Foundation	Series of online staff development training modules with information on the awareness and prevention of youth suicide. This series of programs introduces the scope and magnitude of the problem of youth suicide, the signs of concern, risk factors, how to recognize young people who may be struggling, how to approach the student and help an at-risk youth find resources for assistance.	Teachers, Support Staff, and Students (Required training in Tennessee as part of The Jason Flatt Act)

TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment	90 minute in-person training that presents guidelines for substance abuse treatment professionals working with clients who demonstrate suicidal ideation and behavior.	Mental Health Professionals
Violence and Bullying Prevention Program	Program assisting children ages 4-14, in grades 4-8, enhance skills in empathy building, resilience training, impulse control, decision making, and anger management.	Children aged 4-14
Youth and Young Adult Suicide Prevention and Mental Health Awareness Program	Program aimed to prevent suicide and promote better mental health among Tennesseans up to 25 years of age. This program expands outcomes based suicide prevention activities, including conducting outreach, providing mental health awareness, and suicide prevention training to Institutions of Higher Education; and assisting Middle Tennessee Pediatric Offices in establishing processes for providing suicide risk screening and referrals, as indicated to treatment and services.	Children aged 10-25
Youth Mental Health First Aid (YMHFA)	One day in-person training that teaches participants the unique risk factors and warning signs of mental health problems in adolescents (12-18), builds understanding of the importance of early intervention, and teaches individuals how to help an adolescent who is in crisis or experiencing a mental health challenge.	General population with a focus on those work directly with children and youth
Zero Suicide Initiative	Project to reduce suicide attempts/deaths by developing and implementing cross-system suicide prevention strategies, including rapid and enhanced follow-up services for individuals experiencing suicidal thoughts and/or behaviors through a series of training sessions in a best-practice suicide prevention protocol for any and all personnel who may come in contact with suicidal persons, from executives to support staff following the Suicide Care in Systems Framework. Training sessions will incorporate suicide prevention, risk assessment, and crisis intervention for all new and current staff members, with annual refresher courses provided, a customized action plan that outlines which staff members are responsible for counseling and/or referral, and an aftercare plan that involves regular follow-up and connection to suicide attempt survivor support groups.	Professionals who work in healthcare and behavioral health agencies

Appendix 3: Tennessee Statewide Suicide Prevention Description of Services

Name of Service	Description of Service	Population Served
Crisis Respite Services	Services that provide short-term relief for a person experiencing a mental health emergency. Services may include medication management, illness management and recovery services, peer support, referral to other services, and follow-up services. Crisis Respite Services can only be accessed by referral from Mobile Crisis Services or Crisis Walk-In Services and the average length of stay is 48 hours or less.	Adults aged 18 and over
Crisis Stabilization Units (CSU)	Services providing 24/7/365 intensive, short-term stabilization for someone experiencing a mental health emergency and is willing to receive services. Services may consist of individual and/or family counseling and support, medication management and administration, stress management counseling, individualized treatment plan development that empowers the consumer, mental illness/substance abuse awareness/education, and identification and development of natural support systems. Crisis Stabilization Services can only be accessed by referral from Mobile Crisis Services or Crisis Walk-In Services and the average length of stay is 3 days.	Adults aged 18 and over
Crisis Walk-In Centers	Services that provide in-person 24/7/365 evaluation for those who are experiencing a mental health emergency. Services may include mental health assessment, referral to services, and follow-up services.	Adults aged 18 and over. One walk-in center available for children/youth 17 and under in Davidson County
Healthy Transitions Initiative	Initiative that gives mental health and support services for youth and young adults aged 16-25 years old including supported employment and education and creates opportunities for informal peer support.	Youth and young adults aged 16-25
Mobile Crisis Services	Services providing 24/7/365 response for those who are experiencing a mental health emergency. Services may comprise telephone services provided by trained crisis specialists, face-to-face or telehealth assessment, referral for additional services & treatment, stabilization of symptoms, and follow-up services.	General Population (children and adults)
National Alliance on Mental Illness (NAMI) TN Support Groups	NAMI affiliates where family members, individuals with mental illness, friends, mental health service providers and other gather to offer peer-to-peer support groups, education opportunities, and advocacy at the grassroots, community level	Adults aged 18 and over
Peer Support Centers and Services	Services that provide those with a mental illness and/or substance use disorders can learn about recovery and find peer support.	Adults aged 18 and over
Project AWARE (Advancing Wellness and Resiliency in Education)	Grant-funded project that supports the development and implementation of a comprehensive plan of activities, services, and strategies to decrease youth violence and support the healthy development of school-aged youth. This project works to increase awareness of mental health issues among school-aged youth,	K-12 school aged youth

	provide training for school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues, and connect school-aged youth, who may have behavioral health issues (including serious emotional disturbance or serious mental illness), and their families to needed services.	
STAR (Students Together Advancing Resilience)	Program offering therapeutic services to students and their families in school setting. Services offered include a comprehensive mental health assessment; individual & family therapy; psychiatric evaluation & medication management; and linkage to case management services for those insured by TennCare	Elementary, middle, and high school children
TeenScreen	Free and voluntary mental health screenings to youth in qualifying communities, schools, agencies, and other service providers in Tennessee.	Children/youth across Tennessee
TN Statewide Crisis Phone Line	Statewide crisis line offering 24/7/365 help to anyone experiencing a mental health crisis. All calls are routed to a trained crisis specialist.	General Population (children and adults)

Appendix 4: Tennessee Statewide Suicide Prevention Laws and Policies

Law/Policy	Population Addressed	Description of Law/Policy
Jared's Law of Tennessee	K-12 schools	Jared's Law aims to prevent student suicide by requiring all employees of a Local Education Association (LEA) to complete two hours of training annually in suicide prevention and awareness and for each LEA to develop a policy on suicide prevention awareness.
Kenneth and Madge Tullis Act: TCA § 63-1-125 (2019)	Behavioral Health and Healthcare Professionals	The legislation requires licensed behavioral health and health professionals such as a social worker, a marriage and family therapist, professional counselor, or pastoral counselor; an alcohol and drug abuse counselor; an occupational therapist; and any other professional staff working in the field of mental health and substance abuse who has direct patient or client contact in Tennessee to complete two hours of suicide prevention training every four years.
Mental Health Parity: HB 2355/SB 2165	General population	Aligns definitions in state's parity law with the Federal Parity Act; defines conditions covered by state's parity law as any mental health or substance use disorder that falls under the diagnostic categories in the current edition of the International Classification of Disease or the Diagnostic and Statistical Manual of Mental Disorders; for substance use disorders, requires that insurers use American Society of Addiction Medicine clinical review criteria or other evidence-based clinical guidelines; requires the Department of Commerce and Insurance to implement and enforce provisions of the Federal Parity Act, and to issue a report on its parity enforcement activities to the General Assembly; requires the Department of Commerce and Insurance to request detailed analyses of plans' parity compliance, particularly with respect to non-quantitative treatment limitations whenever the department is conducting market conduct examinations; and notes that the mandate to provide coverage for mental health services shall not apply with

		respect to a group health plan if the application of the mandate to the plan results in an increase in the cost under the plan of more than 1%.
Suicide Prevention Act of 2018	General population	This Act recognized suicide as a serious public health issue in Tennessee and provided the Commissioner of Health authorization to create a suicide prevention program within the Department of Health. The Act required the department to establish a team that would (TCA § 68-3-703(b)): compile existing data on suicide deaths, review existing resources and programs related to suicide prevention, identify evidence-based or promising practices related to the prevention of suicide, convene relevant stakeholders to review existing data and existing programs and resources and identify opportunities to improve data collection, analysis and programming, and submit a report to the general assembly no later than June 30, 2020, and by June 30 every two years thereafter, recommending any necessary programs or policies to prevent suicide deaths in Tennessee
Suicide Prevention for Veterans	Veterans	The new law seeks to support and protect Tennessee veterans by requiring the state Department of Veterans Services to provide training in suicide prevention to their employees who directly interact with veterans.
Suicide Prevention in Higher Education HB 1354/ SB 1175	Higher Education Institutions	This bill requires institutions of higher education to develop and implement a suicide prevention plan for students, faculty, and staff, and to provide the suicide prevention plan to students, faculty, and staff at least one time each semester
The Jason Flatt Act of Tennessee HB 0101/ SB 0057 Public Chapter 45	K-12 schools	This legislation requires mandatory youth suicide awareness and prevention training for all school personnel including principals, teachers. Major components of the legislation include: youth suicide awareness and prevention training is mandatory for teachers and principals, in-service training must include two hours of youth suicide awareness and prevention education each school year,

		training is required in order to maintain or renew their teaching license, This education may be accomplished through self-review of suitable suicide prevention material.
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Appendix 5: Tennessee Statewide Suicide-Related Groups

Group (e.g. coalition, public-private partnership, task force)	Lead Agency/ Organization	Population Served	Description of Group (e.g. priorities, mission)
Advisory Council	Tennessee Suicide Prevention Network	All TN Residents	Independent, non-partisan, voluntary group of individuals, organizations, and agencies (public and private) who promote community awareness of the signs of suicide and intervention strategies for the prevention of suicide.
Farm and Ranch Stress Assistance Network (FRSAN)	Tennessee Suicide Prevention Network	Farmers, Ranchers, and Agricultural Workers	The network will coordinate six specific strategies designed to help rural citizens and communities. These include establishing a hotline for immediate accessibility, developing a comprehensive website with information and resources to address individual situations, and curating and creating resources for the website. The effort will also establish training for representatives working within rural communities to support individuals through direct services or support groups. Research into how to alleviate farmer and rancher stress as well as the issues endemic to rural communities is also part of the effort.
Intra-State Departmental Group	Tennessee Suicide Prevention Network	All TN Residents	Statewide state department representatives who serve on an ex-officio basis on TSPN's advisory council
Suicide Prevention in the African American Faith Communities Coalition	Tennessee Suicide Prevention Network	African American Community	This task force meets to create and carry out action items to best help the at-risk population of African Americans.
Suicide Prevention Stakeholder Task Force	Tennessee Department of Health	All TN Residents	Members of the task force team meet quarterly each year to help identify gaps in mental health and suicide prevention services that may exist across the state and then they work

			with one another to find ways to merge those gaps in order to help reduce the number of people who die by suicide each year in Tennessee
Tennessee Farmers Suicide Prevention Task Force	Tennessee Suicide Prevention Network	Farmers and Agricultural Workers	This task force meets to create and carry out action items to best help the at-risk population of Farmers.
Tennessee First Responders Task Force	Tennessee Suicide Prevention Network	First Responders	This task force meets to create and carry out action items to best help the at-risk population of law enforcement, EMS, fire personnel and other first responders
Tennessee Veterans Suicide Prevention Task Force	Tennessee Suicide Prevention Network	Veterans, Active Military, and their Families	This task force meets to create and carry out action items to best help the at-risk population of veteran/active military members and their families

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