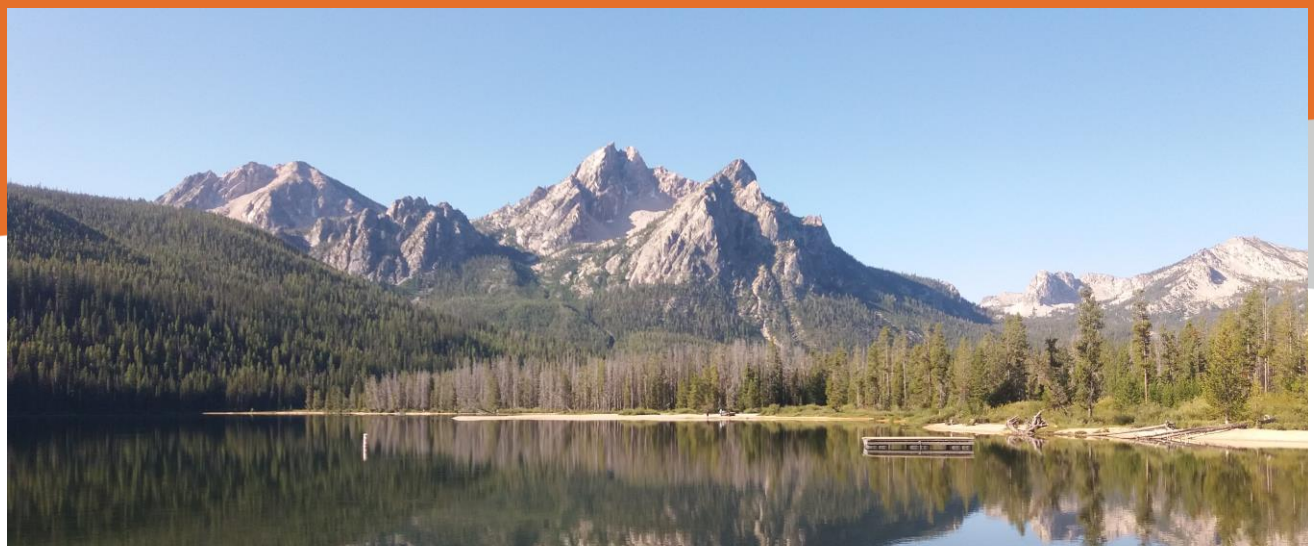
Idaho State University

IDAHO SUICIDE PREVENTION
SUMMARY OF NEEDS AND RESOURCE ASSESSMENTS

DECEMBER 2019



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Abbreviations

AAR: Age-Adjusted Rate
ACHA: American College Health Association
AFSP: American Foundation for Suicide Prevention
AI: American Indian
AMSR: Assessing and Managing Suicide Risk
AN: Alaska Native
ASIST: Applied Suicide Intervention Skills Training
ASQ: Ask Suicide-Screening Questions
BRFSS: Behavioral Risk Factor Surveillance System
BSSA: Brief Suicide Safety Assessment
CALM: Counseling on Access to Lethal Means
CAMS: Collaborative Assessment and Management of Suicidality
CHNA: Community Health Needs Assessment
CIT: Crisis Intervention Team
C-SRRS: Columbia-Suicide Severity Rating Scale
DoD: Department of Defense
GAD: General Anxiety Disorder
IDEA-NW: Improving Data and Enhancing Access - Northwest
IDHW: Idaho Department of Health and Welfare
IRH-ISU: Institute of Rural Health - Idaho State University
ISPAC: Idaho Suicide Prevention Action Collective
ISPH: Idaho Suicide Prevention Hotline
ISPP: Idaho Suicide Prevention Plan
NAMI: National Alliance on Mental Illness
Native H.O.P.E: Native Helping Our People Endure
NCHS: National Center for Health Statistics
NDI: National Death Index
NIMH: National Institute of Mental Health
NREPP: National Registry of Evidence-Based Program and Practices
OWL: Outreach Wellness Learning
PHQ: Patient Health Questionnaire
QPR: Question/Persuade/Refer (Gatekeeper Training)

RISING SUN: Reducing the Incidence of Suicide in Indigenous Groups - Strengths United through Networks

SAFE-T: Suicide Assessment Five-Step Evaluation and Triage

safeTALK: Suicide Alertness for Everyone: Tell, Ask, Listen, and KeepSafe

SAMHSA: Substance Abuse and Mental Health Services Administration

SBQ-R: Suicide Behaviors Questionnaire - Revised

SDR: Suicide Data Repository

SOS: Signs of Suicide

THRIVE - Tribal Health: Reaching out InVolves Everyone

VA: Veterans Affairs

YAM: Youth Aware of Mental Health

YRBS: Youth Risk Behavior Survey

Executive Summary

Overview

The purpose of this project is to review and analyze previously conducted needs and resource assessments related to suicide prevention in Idaho. The work of this project is commensurate with the Idaho Suicide Prevention Plan (ISPP) 2019-2023. [1] The Institute of Rural Health at Idaho State University (IRH-ISU) was contracted by the Idaho Department of Health and Welfare (IDHW), Division of Public Health in June 2019 to identify gaps in services and to analyze and report the results.

In 2018 suicide was the seventh leading cause of death in Idaho. [2] Idaho has the fifth highest suicide rate in the nation (22.9 per 100,000 people) with 393 deaths in 2017. [3] The death rate increased to 23.8 per 100,000 people with 418 deaths in 2018. [4] Idaho's suicide rate has been consistently higher than the national rate for the past decade. [3] Suicide in Idaho is a priority issue across the lifespan from children to older adults and these sobering statistics indicate a need to better understand the gaps in prevention resources.

Assessments/data sources were collected from state subject matter experts, members of the Idaho Suicide Prevention Action Collective (ISPAC), and project team personnel. Assessments/data sources were organized by publication date; the following information was extracted and reported: target population, goals, methods/activities, efforts/plans, and needs and gaps. Extracted information was self-identified from the assessment. Selected pertinent quantitative information (i.e. statistics) was also reported and organized by location, population, and source-specific data.

Results

IRH-ISU reviewed and analyzed over 40 assessments/data sources with 21 including "useful" information related to suicide prevention in Idaho and included in this report. [5-32] Other sources of data were also used to provide general statewide statistics (e.g., Bureau of Vital Records and suicide statewide fact sheets).

Included assessments/data sources spanned the state and were published between 2014-2019. There were eight community assessments and data from six surveys included. Surveys represented different populations (youth, college-aged, and adult individuals (n=1 each) and stakeholder groups (schools (n=3), suicide prevention work groups (n=1)). Five resources providing population-specific data were included: veterans (n=1), army national guard (n=1), American Indians/Alaska Natives (AI/AN) (n=2), and women and children (n=1). Lastly, a statewide assessment and data from a statewide resource were also included.

While there are limitations in Idaho's suicide data, it is known that suicide is a significant issue in Idaho; the state has an age-adjusted suicide rate that continues to be higher than that of the United States (23.2 vs. 14.0, per 100,000 people; 2017 data). [33] More Idaho suicide deaths are completed by males than females and with the use of firearms. [3] Data on specific populations indicate that suicide is especially concerning in AI/AN and military-related personnel [5,6,17,28,32]. Overall, suicide awareness, screening, training, and access to mental health services needs to be improved.

Idaho Suicide Prevention Plan (ISPP) Goals and Corresponding Gaps

To support the ISPP's current and future work, ISPP goals were linked to corresponding gaps.

Table 1. ISPP Goals and Corresponding Gaps

Goals	Corresponding Gaps
1 - Integrate and coordinate suicide prevention activities across multiple sectors and setting.	Coordinated suicide prevention activities across healthcare professionals and systems needs to be improved. There is a lack of collaboration and communication within and among public and private suicide prevention stakeholder groups.
2 - Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes and behaviors.	There is a need for increased awareness and education related to suicide.
3 - Increase knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery.	There is a need to recognize cultural differences around protective factors and to effectively transfer this information to under-represented populations.
4 - Promote responsible and accurate portrayals of suicide and mental illness in media reporting and the safety of online content related to suicide.	There is a stigma associated with a mental health diagnosis that continues to serve as a barrier.
5 - Develop, implement and monitor effective programs that promote wellness and prevent suicide and related behaviors.	There is a shortage of mental health providers based on the number of people reporting a need for care. When mental health services are available, they are difficult to access due to affordability and/or transportation and can be lacking in quality.
6 - Reduce access to lethal means of suicide among individuals with suicide risk.	Use of a firearm is the most common mechanism in suicide deaths. There is duplication around gunlock campaigns and means restriction involving firearms.
7 - Expand knowledge of community and clinical service providers on the nature, related behaviors and prevention of suicide.	There is insufficient awareness and education related to suicide. This includes the improvement of education of warning signs, risk factors, and protective factors. There is a lack of availability of training/education resources for educators related to suicide.
8 - Embed suicide prevention as a core component of health care services.	There is a lack of affordable health care for those in need.

	There are barriers to accessing care, specifically mental healthcare. The ratio of the population to mental health providers is inadequate to support the population in need.
9 - Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.	There is a lack of awareness of mental health services in Idaho.
10 - Increase knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery.	Support is needed for those affected by a suicide attempt or bereaved by suicide.
11 - Increase timeliness and usefulness of state and local surveillance systems relevant to suicide prevention and improve the ability to collect, analyze and use this information for action.	There is a lack of data related to individuals in prisons, housed in medical facilities, or who spoke a language other than English. Under-reporting of the prevalence of mental health problems and suicide may exist due to social norms. There is a lack of reliable and/or consistent data collection methods or available data related to mental health and suicide.
12 - Evaluate the impact and effectiveness of suicide prevention, intervention and systems and synthesize and disseminate findings.	A comprehensive statewide review/summary of available needs and resource assessments discussing suicide prevention is unavailable.

Introduction

IRH-ISU was awarded a six-month contract from the IDHW, effective June 15, 2019. The purpose of this work was to review and analyze previously conducted needs and resource assessments related to suicide prevention in Idaho and to summarize and report the results. IDHW agreed to provide all of the needs and resource assessments for analysis to the IRH-ISU to determine past and present statewide suicide prevention efforts in Idaho. The analysis of these prevention efforts will help key stakeholders to better understand the gaps and barriers in suicide prevention, and gain an understanding where efforts can be refined to better meet the needs of Idaho's communities.

The work of this assessment is commensurate with ISPP 2019-2023 developed in April 2019 [1]. The ISPP includes 12 goals with goal 12 to evaluate the impact and effectiveness of suicide prevention, intervention and systems, and synthesize and disseminate findings. This goal is to be achieved through objective 12.1 (evaluate the effectiveness of suicide prevention (activities, efforts, interventions, etc.) utilized in Idaho) and work with local Universities to have suicide prevention programs evaluated and to initiate performance management and continuous quality improvement activities to improve program effectiveness across the suicide prevention system statewide.

Background

Idaho's suicide rate is among the highest in the nation (23.8 per 100,000 people) [4]. Suicide is the seventh leading cause of death for all Idahoans and second leading cause of death for those 15-34 years old and for males up to 44 years old [3,7]. Suicide in Idaho is a priority issue across the lifespan from children to older adults and these sobering statistics indicate a need to better understand the gaps in prevention resources.

Methodology

IRH-ISU collected recent Idaho needs and resource assessments related to suicide prevention. Assessments were collected from state subject matter experts, including individuals at IDHW, members of the ISPAC, and project team personnel. Additional data was extracted from both statewide and national surveys, and from searching "suicide" in a previously conducted gray literature search of health-related assessments in Idaho. IRH-ISU personnel prioritized needs and resource assessments/data sources as "useful", "moderately useful", and "not useful". The term "useful" was used to identify reports that contained any data or other relevant health findings related to suicide in Idaho.

Results are summarized and reported descriptively with tables and figures used to organize and visually display relevant information. Assessments/data sources were first organized by publication date; the following information was extracted and reported: target population, goals, methods/activities, efforts/plans, and needs and gaps. Extracted information was self-identified from the assessment. If information was not applicable to the assessment, it was not reported. Selected pertinent quantitative information (i.e., statistics) was also reported and organized by location, population, and source-specific data.

Results

IRH-ISU reviewed and analyzed over 40 assessments/data sources with 21 including "useful" information related to suicide prevention in Idaho and included in this report (**Table 2**). [5-32] Other sources of data were also used to provide general statewide statistics (e.g., Bureau of Vital Records and suicide statewide fact sheets).

Included assessments/data sources spanned the state and were published between 2014-2019. There were eight community assessments and data from six surveys included. Surveys represented different populations (youth, college-aged, and adult individuals (n=1 each) and stakeholder groups (schools (n=3), suicide prevention work groups (n=1)). Five resources providing population-specific data were included: veterans (n=1), army national guard (n=1), American Indians/Alaska Natives (AI/AN) (n=2), and women and children (n=1). Lastly, a statewide assessment and data from a statewide resource were also included.

Table 2. Characteristics of Included Assessments/Data Sources

Name	Source/Conducted By	Publication Year
Army National Guard Suicide Data [5,6]	Army National Guard	2019
Get Healthy Idaho: Measuring and Improving Population Health [7]	Division of Public Health, IDHW	2019
Idaho Suicide Prevention Hotline Data [8]	Idaho Suicide Prevention Hotline by Jannus	2019
Idaho Suicide-Safe Schools Survey [9]	Idaho State Department of Education	2019
St. Luke's Community Health Needs Assessment 2019 - Boise/Meridian, Elmore, Jerome, Magic Valley, McCall, Nampa, Wood River [10-16]	St. Luke's Hospital System	2019
Suicide among American Indians & Alaska Natives in Idaho [17]	Northwest Portland Area Indian Health Board	2019
Idaho Health Behaviors 2016: Results from Idaho's Behavioral Risk Factor Surveillance System (BRFSS) [18]	BRFSS; Bureau of Vital Records and Health Statistics, Division of Public Health, IDHW	2018
Idaho School Health Profiles (ISHP) Data [19]	Idaho State Department of Education	2018
North Idaho Community Health Improvement Plan - Panhandle Health District [20]	Panhandle Health District	2018
American College Health Association (ACHA) - National College Health Assessment II: Idaho Consortium Reference Group Data Report [21]	ACHA	2017
Idaho North Central District Community Health Improvement Plan [22]	Public Health - Idaho North Central District	2017
Idaho Youth Risk Behavior Survey (YRBS) 2017 [23]	Idaho State Department of Education	2017
United Way of Treasure Valley 2017 Community Assessment [24]	United Way of Treasure Valley	2017

Bingham Memorial Hospital Community Health Needs Assessment 2016 [25]	Bingham Memorial Hospital; Lamprophony Enterprises, LLC	2016
Clearwater Valley Hospital 2016 Community Health Needs Assessment [26]	Clearwater Valley Hospital and Clinics	2016
Gritman Medical Center Community Health Needs Assessment and Implementation Strategy [27]	Gritman Medical Center	2016
Idaho Veteran Suicide Data Sheet [28]	U.S. Department of Veterans Affairs	2016
Suicide Prevention Program Stakeholder Survey [29]	IDHW, Suicide Prevention Program	2016
Teton Valley Healthcare Community Health Needs Assessment and Implementation Strategy [30]	Teton Valley Healthcare	2016
Multimodal Assessment of Stakeholder Perceptions of Maternal and Child Health Needs in Idaho [31]	Center for Health Policy, Boise State University	2015
Idaho American Indian & Alaska Native Community Health Profile [32]	Northwest Tribal Epidemiology Center, Northwest Portland Area Indian Health Board	2014

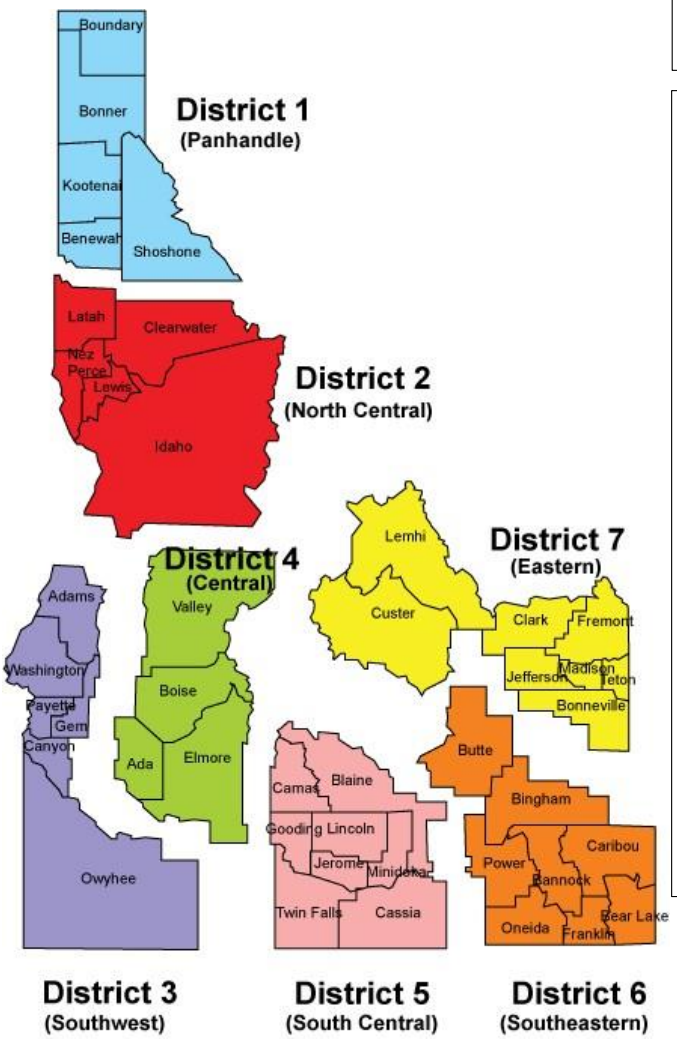
Included assessments/data sources covered all of Idaho's seven health districts (**Figure 1**).

Figure 1. Included Assessments by Health Districts

District 1:
- North Idaho Community Health Improvement Plan - Panhandle Health District

District 2:
- Idaho North Central District Community Health Improvement Plan
- Clearwater Valley Hospital 2016 Community Health Needs Assessment
- Gritman Medical Center Community Health Needs Assessment and Implementation Strategy

District 3:
- St. Luke's Community Health Needs Assessment 2019 - Nampa
- United Way of Treasure Valley 2017 Community Assessment



District 4:
- St. Luke's Community Health Needs Assessment 2019 - Boise/Meridian, Elmore, McCall
- United Way of Treasure Valley 2017 Community Assessment

District 5:
- St. Luke's Community Health Needs Assessment 2019 - Jerome, Magic Valley, Wood River

District 6:
- Bingham Memorial Hospital Community Health Needs Assessment 2016

District 7:
- Bingham Memorial Hospital Community Health Needs Assessment 2016
- Teton Valley Healthcare Community Health Needs Assessment and Implementation Strategy

Statewide:
- Army National Guard Suicide Data
- Get Healthy Idaho: Measuring and Improving Population Health
- Idaho Suicide Prevention Hotline Data
- Idaho Suicide-Safe Schools Survey
- Suicide among American Indians & Alaska Natives in Idaho
- Idaho Health Behaviors 2016: Results from Idaho's Behavioral Risk Factor Surveillance System (BRFSS)
- Idaho School Health Profiles (ISHP) Data
- American College Health Association (ACHA) - National College Health Assessment II: Idaho Consortium Reference Group Data Report Fall 2017
- Idaho Youth Risk Behavior Survey (YRBS) 2017
- Idaho Veteran Suicide Data Sheet
- Suicide Prevention Program Stakeholder Survey
- Multimodal Assessment of Stakeholder Perceptions of Maternal and Child Health Needs in Idaho
- Idaho American Indian & Alaska Native Community Health Profile

Summaries of Included Assessments and Data Sources

Army National Guard Suicide Data [5,6]

- Target Population: Idaho Army National Guard
- Goals: To prevent suicide among service members, their families, Department of Defense civilians, and veterans
- Needs and Gaps: From 2015 through May 6, 2019 the Idaho Army National Guard reported nine suicides. Most suicide deaths involve a firearm while most non-fatal suicide attempts involve medications. Safe firearm and medication storage is an effective way to help prevent suicide.

Get Healthy Idaho: Measuring and Improving Population Health [7]

- Target Population: Idaho
- Goals: 1) Provide an annual plan for improving population health and, 2) assess the health of Idahoans, resulting in improved health for Idahoans
- Methods/Activities: Oversight and approval of the *Get Healthy Idaho* Plan by the Population Health Work Group; 2015 to 2018 assessments
- Efforts/Plans: Continued focus on four health priorities: access to care, diabetes, tobacco, and obesity
- Needs and Gaps: Suicide is among the top 10 priority health issues

Idaho Suicide Prevention Hotline Data [8]

- Target Population: Persons at risk for suicide and for those concerned about them
- Goals: To provide crisis intervention, emotional support, resource referrals, linkages to local services, and follow-up for all Idahoans
- Needs and Gaps: From 2014-2019, Ada County had the highest number of calls, but county-level data was unavailable for almost half of all calls. Of ISPH callers with age collected, the majority were 55-64 years old. Sex (male, female, intersex/non-binary/other) of callers was only available from 2018-2019 with more than half of calls from females (of collected data).

Idaho Suicide-Safe Schools Survey [9]

- Target Population: Teachers, school administrators, counselors, social workers, school psychologists, nurses, school district office staff, and superintendents
- Goals: To collect information about current school and district policies, practices, and competencies related to suicide prevention, intervention, and postvention to provide support in creating safer environments for Idaho schools
- Methods/Activities: Survey
- Needs and Gaps: Sixty-eight percent of teachers and school administrators reported they have received suicide prevention/intervention training with 32% saying they have not received any training. Almost 40% of teachers and school administrators strongly disagreed/disagreed that based on their training they are capable of intervening with a suicidal student. Almost two-thirds (63.3%) of teachers and school administrators strongly disagreed/disagreed that their school staff are trained in responding to youth who have attempted suicide and to suicide deaths.

St. Luke's Community Health Needs Assessment 2019 - Boise/Meridian, Elmore, Jerome, Magic Valley, McCall, Nampa, Wood River [10-16]

- Target Population: Boise/Meridian, Elmore, Jerome, Magic Valley, McCall, Nampa, and Wood River communities
- Goals: To better understand the most significant health challenges facing communities and use the community health needs assessments to efficiently use resources and engage partners to achieve long term community health objectives
- Methods/Activities: Use of various information sources, conclusions, and health needs identified in the assessments
- Efforts/Plans: Work with communities to reduce stigma, improve mental health services, and increase access and availability of mental health providers
- Needs and Gaps: Many suicides can be prevented through awareness of warning signs, risk factors, and protective factors. The suicide death rate per 100,000 people in Idaho was 20.9 in 2016 which is about 50% higher than the national average rate of 13.9. Improving mental health and reducing suicide rank were two of their most significant priorities. The following is the suicide rate for each respective service area: Boise/Meridian 18.9, Elmore 21.5, Jerome 22.2; Magic Valley 22.2; McCall 13.9; Nampa 16.9; and Wood River 21.4.

Suicide among American Indians (AI) and Alaska Natives (AN) in Idaho [17]

- Target Population: AI and AN
- Goals: To reduce misclassification in public health data through reviewing death certificate data and provide Northwest tribes with accurate health data
- Needs/Gaps: There is inaccurate suicide race data for AI/AN; this work found that the data used for the fact sheet would have under-counted AI/AN suicides by 6 deaths and underestimated the age-adjusted rate by 16%. There were 42 suicide deaths among AI/ANs between 2013-2017, 67% male and 45% by firearm.

Idaho Health Behaviors 2016: Results from Idaho's Behavioral Risk Factor Surveillance System (BRFSS) [18]

- Target Population: Adults in Idaho
- Methods/Activities: A public health surveillance program consisting of an ongoing state-based system of telephone health surveys of individuals aged 18 and older in Idaho which includes information about health risk behaviors, preventive health practice, chronic disease prevalence, and health care access primarily related to chronic disease and injury
- Needs/Gaps: The survey includes standardized core questionnaires with the option for states to add additional questions. Suicide was included as an Idaho state added question in the 2016 BFRSS survey. The 0.8% of respondents that had attempted suicide in the past 12 months were subsequently asked if they received or sought medical care, advice, or counseling. More than a quarter of respondents (27.0%) indicated not seeking any medical care, advice, or counseling.

Idaho School Health Profiles (ISHP) Data [19]

- Target Population*:* School principals and lead health education teachers
- Goals: To monitor school health education, physical education and physical activity, practices related to bullying and sexual harassment, school health policies related to tobacco-use prevention and nutrition, school-based health services, family engagement

and community involvement; and school health coordination, allowing for policy and program development
- Methods/Activities: Two questionnaires administered in Spring 2018; questionnaires were mailed to 259 eligible secondary public, charter, alternative, and vocational schools in Idaho with 6-12 graders
- Needs and Gaps: In only 48.7% of schools did the lead health education teacher receive professional development related to suicide prevention during the past two years. However, 81.6% of lead health education teachers would like to receive professional development on this topic revealing a training need. Regardless of training, 88.7% of schools indicated that teachers tried to increase student knowledge on suicide prevention.

North Idaho Community Health Improvement Plan - Panhandle Health District [20]

- Target Population: Northern Idaho Panhandle
- Goals: To stimulate community action in impactful areas to improve the health of all North Idaho residents; the plan creates a framework for next steps in the development of strategies with measurable outcomes
- Methods/Activities: Four different assessments that assessed both qualitative and quantitative data and included both primary and secondary data, key informant interviews, and tools that measured the local public health system; results were reviewed and examined for themes
- Needs and Gaps: There are resource gaps including barriers to accessing care, as well as the lack of mental health providers and hospital bed capacity for those experiencing a mental illness.

American College Health Association (ACHA) - National College Health Assessment II: Idaho Consortium Reference Group Data Report [21]

- Target Population: Five Idaho colleges or universities
- Methods/Activities: Survey; questions pertaining to receiving information around suicide prevention, death of a family member or friend, and intentional cuts, burns, bruises and injuries to oneself were included
- Needs/Gaps: 0.4% of students reported that they ever attempted suicide in the past 30 days.

Idaho North Central District Community Health Improvement Plan [22]

- Target Population: North Idaho Central Health District
- Goals: To increase health education, develop a healthy workforce, and create health policies to bring better resources to Idaho's North Central District. However, specifically related to suicide, the goals of this project are to decrease the age adjusted suicide rate in the region from 30.8 to 29.33 by 2019
- Methods/Activities: To examine the results of the Community Health Needs Assessment for common themes and to discuss what the assessment revealed about the health of the community; several strategic issues emerged.
- Effort/Plan: To engage with the new Suicide Program at the Department of Health and Welfare Department, participate in a rural mental health symposium, and participate in mental health month and resource fairs
- Needs and Gaps: Mental health services are an area that can be improved with measurable outcomes. The ratio of population to mental health providers is identified as a key area of improvement with the goal of:

- "Improving the mental health and emotional well-being of North Idaho residents by increasing the quality, availability, and effectiveness of community-based mental health programs"

Idaho Youth Risk Behavior Survey (YRBS) 2017 [23]

- Target Population: Youth (grades 9-12) in Idaho
- Goals: To identify behaviors among youth related to leading causes of mortality and morbidity and assess how behaviors change over time; this survey measured behaviors that contribute to unintentional injuries and intentional injuries such as violence
- Methods/Activities: Two-stage cluster sample; self-administered questionnaires
- Needs and Gaps: Mortality, morbidity, and social problems which Idaho teenagers encounter are largely related to a number of negative behaviors such as drinking and driving, sexual intercourse at a young age, suicide, lack of seatbelt use, etc. These behaviors and associated health problems are largely preventable.

United Way of Treasure Valley 2017 Community Assessment [24]

- Target Population: Ada, Canyon, and Gem County
- Methods/Activities: A combination of existing local, state, and national data sources, in addition to integrating new data collected by the United Way of Treasure Valley's assessment team via in-person and telephone interviews, focus groups, and observational data
- Needs and Gaps: Mental health issues represent a crucial and unmet need for many residents of the Treasure Valley. Focus group participants described a lack of sufficient facilities to serve people who need mental health care, a prevalence of cultural stigmas preventing people from seeking treatment, and negative impacts on children when their parents are not getting the assistance they need to cope effectively with life's difficulties. Adolescent mental health and suicide prevention are significant areas of concern with an urgent need for programs to support these areas.

Bingham Memorial Hospital Community Health Needs Assessment 2016 [25]

- Target Population: Bingham, Bannock, and Bonneville counties and Fort Hall Indian Reservation
- Methods/Activities: Compilation and analysis of secondary data from a variety of sources, including state and federal agencies, as well as national foundations, in order to create a community health profile for Bingham Counties service area. Community input was gathered through key stakeholder interviews, an online survey, and regional community health needs assessments. Findings helped to identify priority health issues.
- Needs and Gaps: Population health and demographic data often lag by several years with geographic details limited (e.g., data only available at the county level). Some health issues had less robust data available, particularly on topics related to mental health and behavioral health.

Clearwater Valley Hospital 2016 Community Health Needs Assessment [26]

- Target Population: Lewis, Clearwater, and Idaho counties
- Goals: 1) Assess the health needs, disparities, assets, and influences in Clearwater Valley Hospital's service area, 2) prioritize health needs based on community input, 3) design an implementation strategy to reflect the optimal usage of resources in the community, and 4) engage community partners and stakeholders in all aspects of the process

- Methods/Activities: County-level data was used for all three counties served by Clearwater Valley Hospital and Clinics; public comments related to mental health topics were used to identify gaps in resources and suicide
- Needs and Gaps:
    - "Accessibility and transportation are issues given the rural nature of the area, there is need for translators with an understanding of cultural differences, and mental health diagnosis and treatment are under-represented in the community"

Gritman Medical Center Community Health Needs Assessment and Implementation Strategy [27]

- Target Population: Latah County
- Methods/Activities: Data was gathered from multiple secondary sources in order to build an accurate picture of the community and its health needs. A survey of a select group of local experts was administered to review prior community health needs assessment methods, provide feedback, and ascertain whether previously identified needs were still a priority. A second survey was distributed to the same group who determined that significant health needs still exist in the community.
- Needs and Gaps: There is limited accessibility and transportation in rural areas. There is a need for translators who understand cultural differences. Mental health diagnosis and treatment are under-represented in the community.

Idaho Veteran Suicide Data Sheet [28]

- Target Population*: Western Region - Idaho*
- Methods/Activities: Suicide deaths are identified based on the underlying cause of death on the state death certificate. This information comes from the NCHS National death index (NDI) and was obtained from the joint VA/DoD suicide data repository (SDR)
- Needs and Gaps: After accounting for age differences, the Veteran suicide rate in Idaho was significantly higher than both the national and national veteran suicide rate.

Suicide Prevention Program Stakeholder Survey [29]

- Target Population: Twenty-six stakeholder organizations involved in suicide prevention
- Methods/Activities: A twelve question suicide prevention survey conducted in October 2016 to identify involvement in suicide prevention activities, and to identify duplication and gaps in services
- Needs and Gaps: Public awareness, gatekeeper training, and advocacy were the top three suicide prevention activities that respondents reported. Duplications in activities included gatekeeper trainings, gunlock campaigns, legislation, and public awareness events. Gaps consisted of ASIST trainings, AMSR, data collection, follow-up, means restriction, provider education and public awareness.
- Efforts/Plans: Discussion to prevent duplication centered around offering joint trainings, collaboration with gun lock campaigns, and the gun shop program as well as sharing in responsibility for public awareness events with more than one organization.

Teton Valley Healthcare Community Health Needs Assessment and Implementation Strategy [30]

- Target Population: Teton County
- Methods/Activities: Data from multiple secondary sources to build an accurate picture of the current community and its health needs. A survey of a select group of local experts was conducted to review a prioritized community health needs assessment and provide

feedback. A second survey was distributed to the same group, who reviewed the data from the secondary sources to determine significant health needs.

- Needs and Gaps: Mental health/suicide is an area of significant health need with improvement of awareness and access to mental health services as a gap in resources related to suicide prevention.
    - "Suicide rates are shamefully high and the obstacles to adequate, high-quality mental healthcare in our community are huge"

Multimodal Assessment of Stakeholder Perceptions of Maternal and Child Health Needs in Idaho [31]

- Target Population: Mothers and children
- Goals: To guide the state in identifying maternal and child populations most in need; and to identify resources to improve health and well-being. The assessment was designed to select state performance measures for the target populations.
- Methods/Activities: 1) Retrieval of secondary/archival data sources, 2) surveys of Idaho, consumers and providers of maternal and child health services, and 3) interviews of key informants and stakeholders
- Needs and Gaps: The assessment identified limitations of the study, rather than gaps in suicide prevention resources. These consisted of 1) out-of-date information in the review of secondary/archival data, 2) a low response rate (and consequently large confidence interval or margin of error to the general population survey), 3) survey respondents differed from the general population in several ways, 4) there was a discrepancy between the definitions of "rural" and "frontier" in the general population and consumer surveys, and 5) there was a lack of diversity among survey respondents.

Idaho American Indian & Alaska Native Community Health Profile [32]

- Target Population: AI and AN
- Methods/Activities: Available data was chosen for review of each health indicator. If statistically sound data was not available for a specific indicator, it was not reported. Due to a lack of data, several years of data was combined for analysis and comparison.
- Efforts/Plans: 1) Increase knowledge and awareness about suicide among Tribal community members, 2) improve intertribal and interagency communication about suicide and prevention treatment, and 3) increase the capacity of Tribal health programs to track, prevent, and treat suicide
- Needs and Gaps: Identified that without reliable health information, tribal information is limited in its ability to identify priorities and actions that will improve the health of their communities. Members of federally-recognized tribes who utilize Health Indian Services, Tribal, and Urban (I/T/U) clinics for primary care often have limited access to specialty, dental, and behavioral health care. This is due to chronic underfunding of the Indian health system which limits referral care and having to travel long distances for services.

Suicide Data

Idaho

In 2018 suicide was the 7th leading cause of death in Idaho. [2] Idaho has the 5th highest crude suicide rate in the nation (22.9 per 100,000 people) with 393 deaths in 2017; the death rate increased to 23.8 per 100,000 people with 418 deaths in 2018. [3,4] Idaho's crude suicide rate has been consistently higher than the national rate for the past decade (**Figure 2**). [3] When

age-adjusted, Idaho's suicide rate continues to be higher than that of the United States (23.2 vs. 14.0, per 100,000 people; 2017 data). [33]

Figure 2. Idaho and U.S. Crude Suicide Rates by Year

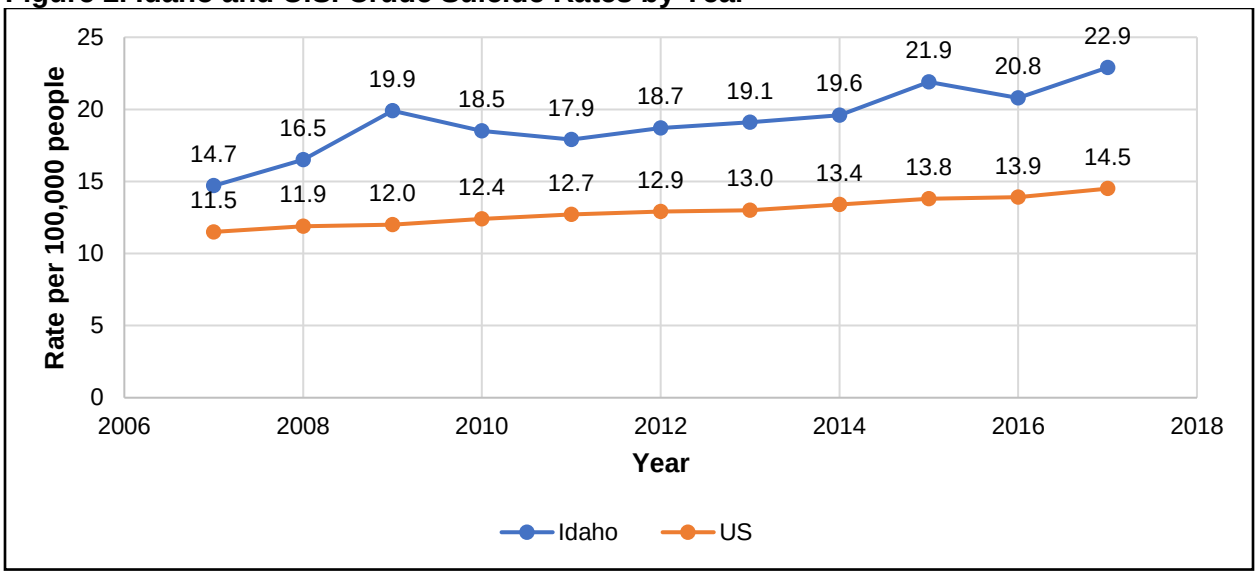


Figure recreated from Suicide in Idaho: Fact Sheet, January 2019 [3]

Suicide ranks higher as a leading cause of death in Idahoan males (5th) than females (9th). [7] Of the state's 1,734 suicide deaths from 2013-2017, 78% of these were males. [3] The 2017 age-adjusted death rates for males and females was 78.8 and 28.1 per 100,000 people, respectively. [7]

From 2013-2017, suicides were completed most by firearms (61%), suffocation (19%), and poisoning (16%). [3]

Data from 2014-2018 continues to indicate a higher number of deaths in males vs. females (**Table 3**). Non-Hispanic AI/ANs have the highest age-adjusted rate (AAR) of death per 100,000 people. Hispanics have a significantly lower AAR vs. non-Hispanics (10.0 vs. 23.7 per 100,000 people).

Table 3. Number and Age-Adjusted Rate of Suicides by Race, Ethnicity, and Sex from 2014-2018

Race and Ethnicity	Total		Male		Female	
	# of Deaths	ARR	# of Deaths	ARR	# of Deaths	ARR
Total	1,844	22.2	1,439	34.7	405	10.0
Non-Hispanic	1,746	23.7	1,358	36.9	388	10.8
White	1,682	23.8	1,312	37.3	370	10.7
Black	9	-	6	-	3	-
American Indian/Alaska Native	47	44.6	36	66.6	11	-
Asian/Pacific Islander	7	-	4	-	3	-
Hispanic	97	10.0	80	15.9	17	-

Table recreated from Idaho Suicide 2018 Data [2]
AAR=Age-adjusted rate (# of deaths per 100,000 people, age-adjusted to 2000 U.S. standard population; not calculated if <20 deaths)

Health District and County-Level Data

The most populated health district (#4) also had the highest number of suicides in 2018 (n=120), but ranked in the middle versus other districts when comparing suicide rates (**Table 4**). [4] Health district #6 had the highest rate of suicides (33.1 per 100,000 people) while district 3 had the lowest rate (18.2 per 100,000 people). [4]

Table 4. Number and Rate of Suicides by Health District in 2018

District	# of Suicides	Rate*	Rank
1	67	27.9	2
2	27	24.6	3
3	53	18.2	7
4	120	23.3	4
5	45	22.6	5
6	58	33.1	1
7	48	21.5	6
Idaho	418	23.8	-

Table recreated from Idaho Resident Suicide Deaths, Death Rate by District and County of Residence, 2013-2018 [4]
*Rate per 100,000 people

By county, Ada had the highest number of suicides (n=109), but Lincoln county had the highest suicide rate (56.0 per 100,000 people) with 3 deaths in 2018 (**Table 5**). [4]

Table 5. Number and Rate of Suicides by County in 2018

County	# of Suicides	Rate*
Ada	109	23.2
Adams	-	-
Bannock	34	39.0
Bear Lake	2	33.1
Benewah	3	32.5
Bingham	11	23.8
Blaine	2	8.8
Boise	-	-
Bonner	12	26.8
Bonneville	33	28.2
Boundary	4	33.5
Butte	1	38.3
Camas	-	-
Canyon	40	17.9
Caribou	3	42.5
Cassia	6	25.1
Clark	-	-
Clearwater	2	22.8
Custer	1	23.4
Elmore	8	29.3
Franklin	3	21.9
Fremont	-	-
Gem	5	28.4

Gooding	5	32.9
Idaho	6	36.3
Jefferson	4	13.6
Jerome	1	4.2
Kootenai	43	26.6
Latah	8	19.9
Lemhi	4	50.2
Lewis	1	25.9
Lincoln	3	56.0
Madison	3	7.6
Minidoka	6	28.8
Nez Perce	10	24.7
Oneida	1	22.3
Owyhee	2	17.1
Payette	5	21.2
Power	3	38.6
Shoshone	5	39.1
Teton	3	25.8
Twin Falls	22	25.6
Valley	3	27.2
Washington	1	9.8

Table recreated from Idaho Resident Suicide Deaths, Death Rate by District and County of Residence, 2013-2018 [4]
*Rate per 100,000 people

Five-year (2013-2017) county-level data shows that most counties have a suicide rate between 40-59.9 per 100,000 people (**Figure 3**).

Figure 3. Rate of Suicides by County from 2013-2017

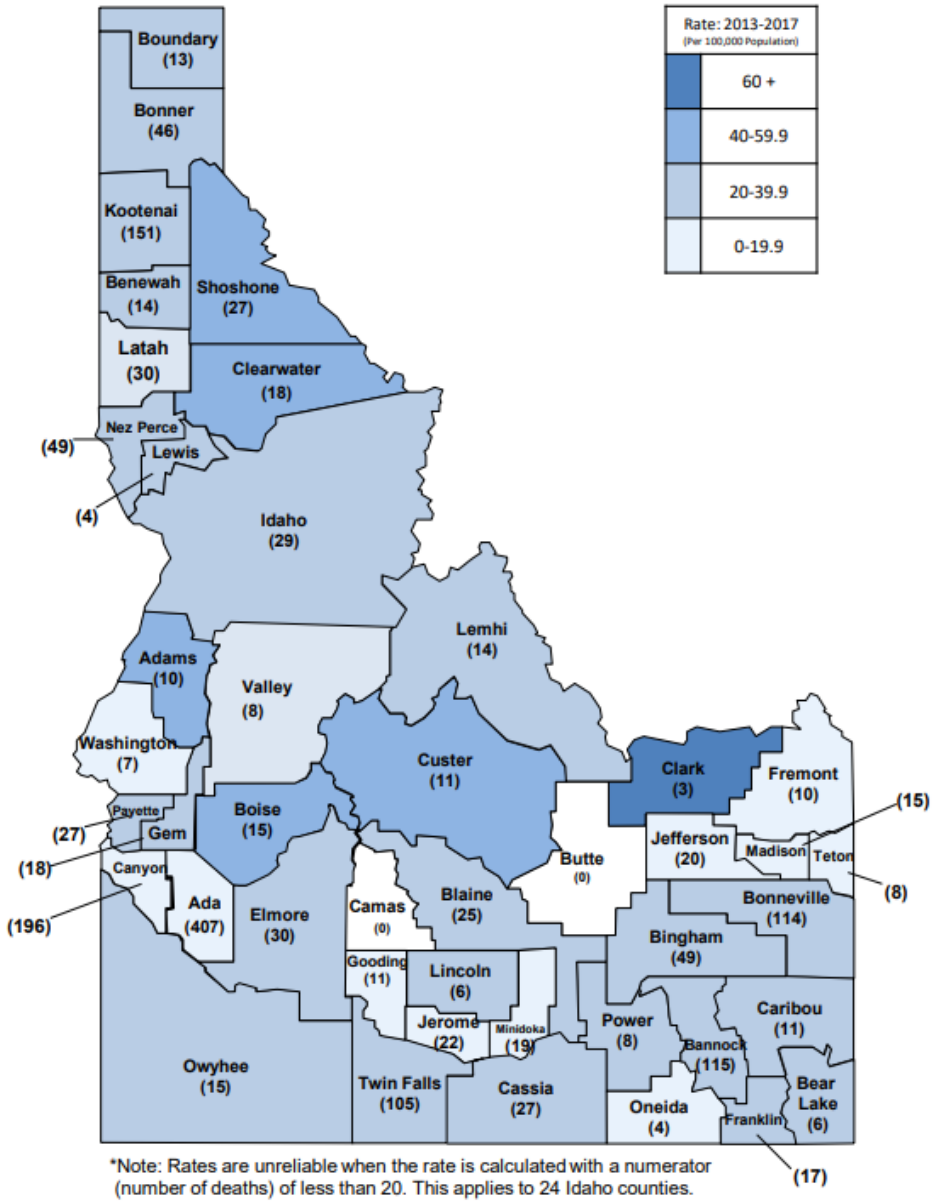


Figure retrieved from Suicide in Idaho: Fact Sheet, January 2019 [3]

Special Populations

Veterans [28]

In 2016, the Idaho veteran suicide rate was higher than the national veteran suicide rate and Idaho suicide rate (47.2 vs. 30.1 vs. 26.9, respectively). Veterans made up 17.3% (n=58) of the 335 Idaho suicides. By sex, most (n=50-60) suicides occurred in males vs. females (n=<10). By age categories, most (n=24) suicides occurred in veterans 55-74 years old, followed by those 75+ (n=10-20), 35-54 (n=18), and 18-34 (n=<10) years old. Suicides were completed by most by firearms (72.4%, n=42).

Army [5,6]

From 2015-2019, the Army National Guard Data reported 9 suicides with 3, 3, 2, and 1 suicide occurring in 2015, 2017, 2018, and 2019, respectively.

Military [2]

Individuals with military status typically comprise ~20% of suicide deaths in Idaho.

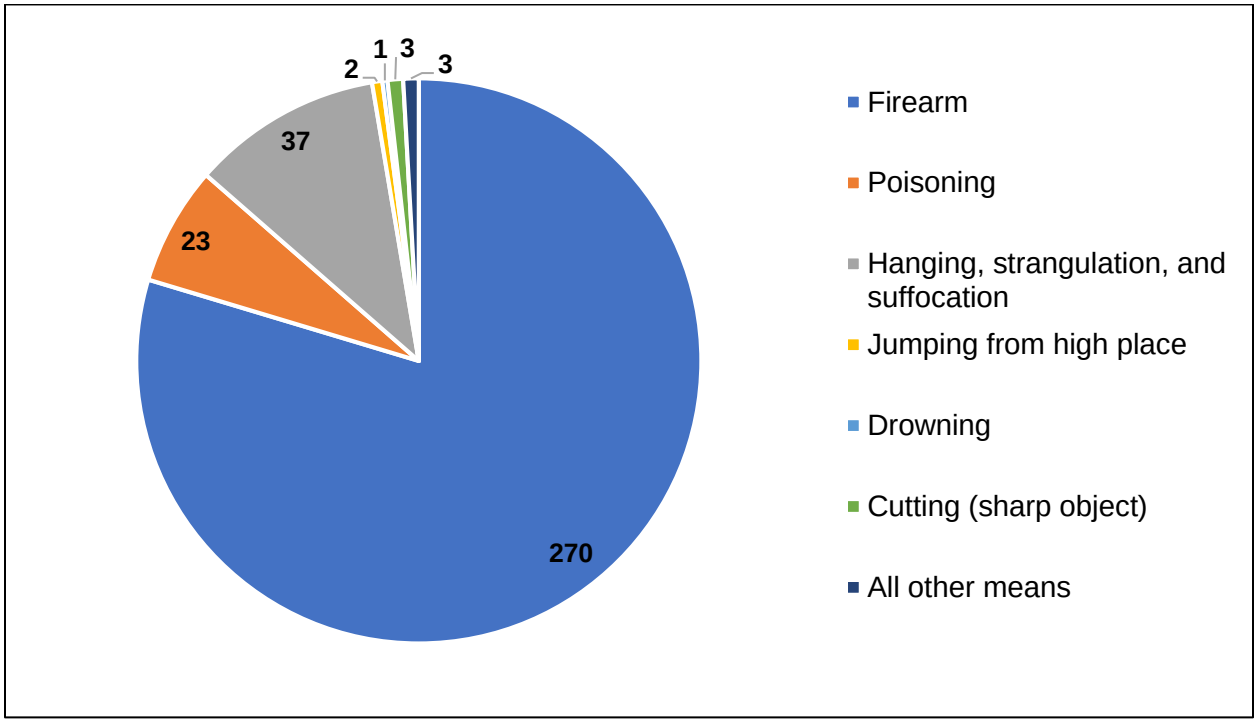
Table 6. Number of Suicides by Military Status and Year from 2014-2018

Year	Yes (%)	No (%)	Unknown (%)	Total
2014	56 (18.5)	243 (80.5)	3 (1.0)	302
2015	74 (21.5)	270 (78.5)	-	344
2016	68 (20.3)	265 (79.1)	2 (0.6)	335
2017	74 (19.8)	297 (79.6)	2 (0.5)	373
2018	67 (17.1)	322 (82.1)	3 (0.8)	392
TOTAL	339 (19.4)	1,397 (80.0)	10 (0.6)	1,746

Table recreated from Idaho Suicide 2018 Data [2]

Of these suicide deaths, use of a firearm was the most common mechanism (79.6%) (**Figure 4**). In individuals who did not serve in the military, 55.8% of suicide deaths was by firearm.

Figure 4. Number of Suicide Deaths in those Who Served in the U.S. Armed Forces by Mechanism from 2014-2018



Women and Children [31]

In a general population survey (random sampling) of Idaho residents (n=102), mental health problems and suicide were considered most important in the community by 27% and 9% of

respondents. Mental health was also identified as an important health issue for pregnant women and youth; intentional self-harm was also identified as an important issue for youth.

In a “consumer” survey including individuals or those with children that used maternal and child health-related services had child and with organizations affiliated with families with children or youth with special health care needs (n=265), access to mental health services was identified as an issue of most importance for the health of women (aged 18-44 years), pregnant women and infants, and teens.

Providers of maternal and child health-related services also noted mental health as an issue considered to be a common challenge for pediatrics, pregnant patients, and women (aged 18-44 years).

American Indians (AI) and Alaska Natives (AN) [17,32]

Suicide among AI and AN in Idaho is a concern with suicide representing the second leading cause of death for individuals 10-24 years of age in this population; it is the seventh leading cause of death overall for AI/ANs and the age-adjusted suicide rate has increased since 2014 to 34.7 per 100,000 people. There is a disparity in suicides between AI/AN compared to non-AI/AN in Idaho with AI/ANs having a 1.3X higher age-adjusted suicide rate (**Figure 5**). Although suicide rates for females are lower, there is a larger disparity.

Figure 5. AI/AN and Non-AI/AN Age-Adjusted Suicide Rates from 2013-2017

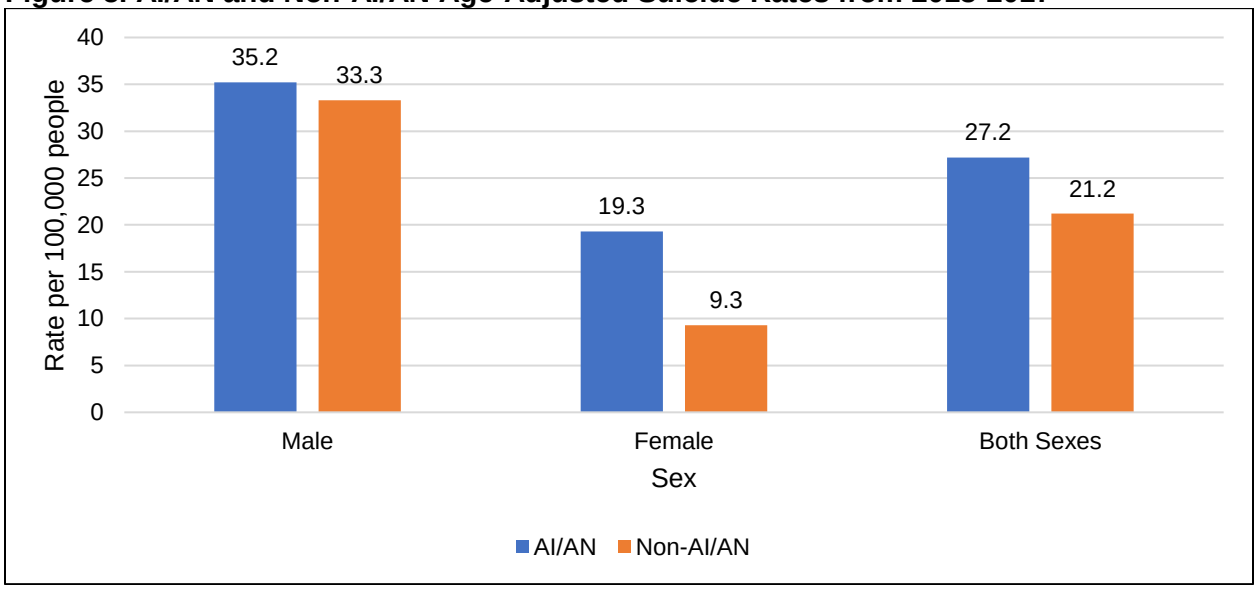


Figure recreated from Suicide among American Indians & Alaska Natives in Idaho [17]

From 2013-2017, there were 42 AI/AN suicide deaths; 67% male, 45% completed by firearm and 38% by hanging/strangulation. Most deaths (45.2%) occur in individuals 0-34 years of age, followed by those 35-49 years old (33.3%) and 50+ years old (21.4%).

Source-Specific Data

Idaho Suicide Prevention Hotline (ISPH) [8]

ISPH is the state's nationally accredited crisis hotline. Data on county, age, and sex from the past five years (2014-2019) was gathered. However, reported data is not comprehensive over this time period due to changes in data collection techniques.

County-Level Data

The comprehensive list of all counties analyzed during the 2014-2019 time period includes: Ada, Adams, Bannock, Bear Lake, Benewah, Bingham, Blaine, Boise, Bonner, Bonneville, Boundary, Butte, Camas, Canyon, Caribou, Cassia, Clark, Clearwater, Custer, Elmore, Franklin, Fremont, Gem, Gooding, Idaho, Jefferson, Jerome, Kootenai, Latah, Lemhi, Lewis, Lincoln, Madison, Minidoka, Nez Perce, Oneida, Owyhee, Payette, Power, Shoshone, Teton, Twin Falls, Valley, and Washington. Some counties were not included. If data were not collected for a specific county, it was categorized as one of the following: refused/not collected, unknown, other/outside of Idaho, or non-specified/not collected.

From available data, Ada County had the highest number of calls during the five-year time period (n=9,331) (**Table 7**). However, county-level data was unavailable for 45.7% (n=20,125) of calls.

Table 7. Number of ISPH Calls by County from 2014-2019

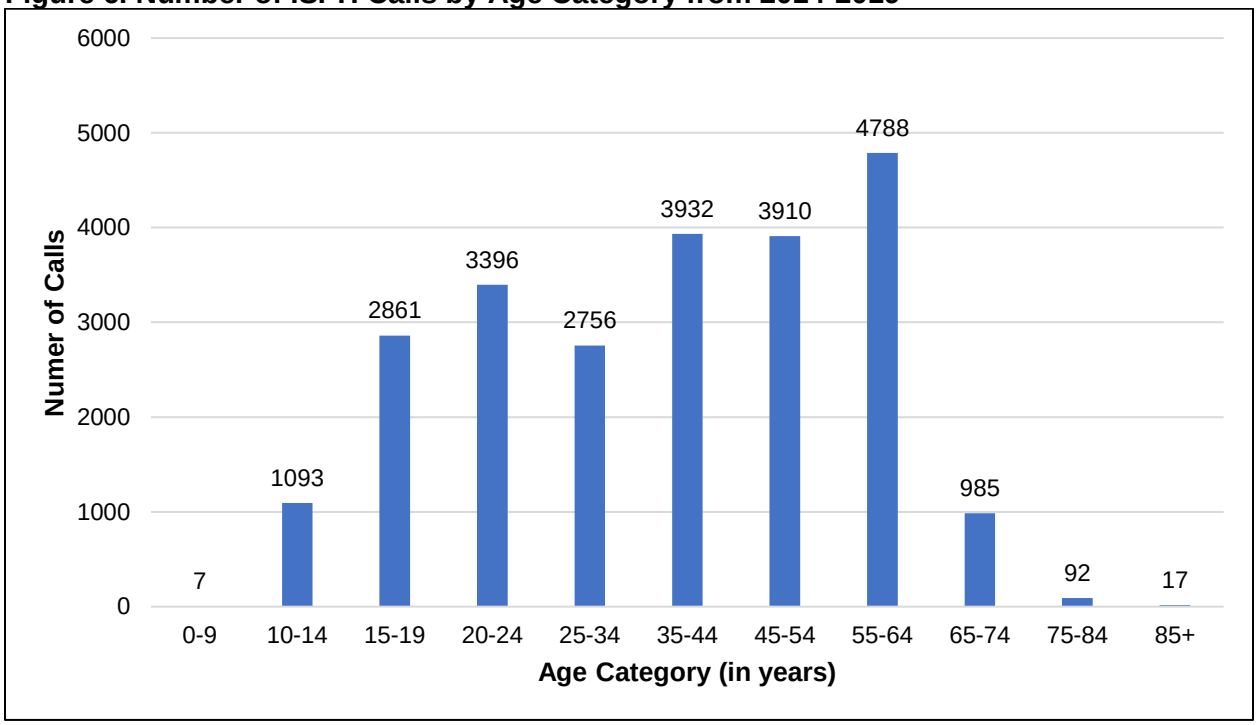
County	# of Calls
Ada	9,331
Adams	47
Bannock	1,219
Bear Lake	17
Benewah	60
Bingham	1,434
Blaine	235
Boise	112
Bonner	519
Bonneville	1,173
Boundary	33
Butte	23
Camas	6
Canyon	3,521
Caribou	21
Cassia	212
Clark	7
Clearwater	48
Custer	30
Elmore	202
Franklin	63
Fremont	128
Gem	171
Gooding	196

Idaho	63
Jefferson	63
Jerome	241
Kootenai	1,715
Latah	649
Lemhi	47
Lewis	22
Lincoln	13
Madison	246
Minidoka	78
Nez Perce	478
Oneida	9
Owyhee	67
Payette	129
Power	57
Shoshone	186
Teton	37
Twin Falls	872
Valley	72
Washington	57
Unknown	1
Refused/Not collected	6,778
Other	689
Outside Idaho	5,368
Non-specified/Not collected	7,289
TOTAL	44,034

Age

Of ISPH callers with age collected, the majority were 55-64 years old (**Figure 6**), with declining rates especially in those 65 years of age and older. It is important to note that not all age categories were accounted for during all years of data collection; the 0-9 age group was not utilized until the second quarter of 2018. There were 10,550 calls with age information unavailable.

Figure 6. Number of ISPH Calls by Age Category from 2014-2019



Sex

Sex (male, female, intersex/non-binary/other) of callers was only available from 2018-2019. Of collected data, more than half (54.8%, n=7,454) of calls were female. Males and individuals identifying as intersex/non-binary/other comprised 6,143 and 17 calls, respectively. There were 1,488 calls with sex information not collected.

Idaho Youth Risk Behavior Survey (YRBS) [23]

Idaho's YRBS is a weighted, representative sample of public school students in ninth through twelfth grade. Student responses (n=1,818) were self-recorded during a regular class period in spring 2017. Data from 53 public schools is represented with a school response rate of 92%, student response rate of 85%, and overall response rate of 79%. Weighted characteristics of the respondent sample include a fairly even distribution of sex (male=51.0%) and grades (9^{th}=27.6%, 10^{th}=26.1%, 11^{th}=24.1%, 12^{th}=22.1%). Weighted data most represents Whites/Non-Hispanic (77.2%), followed by Hispanic/Latino (16.5%).

Of survey respondents, there was a higher percentage of females than males who, during the past 12 months: ever felt so sad or hopeless almost every day for two or more weeks in a row that they stopped doing some usual activities (**Figure 7**), seriously considered attempting suicide (**Figure 8**), made a plan about how they would attempt suicide (**Figure 9**), actually attempted suicide one or more times (**Figure 10**), and attempted suicide which resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (**Figure 11**). When comparing percentages of overall Idaho rates (2017 survey) to 2015 U.S. data, Idaho is always higher.

Figure 7. Percentage of Students Who Ever Felt Sad or Hopeless Almost Every Day for Two or More Weeks in a Row that they Stopped Doing Some Usual Activities in the Past 12 Months by Grade and Sex

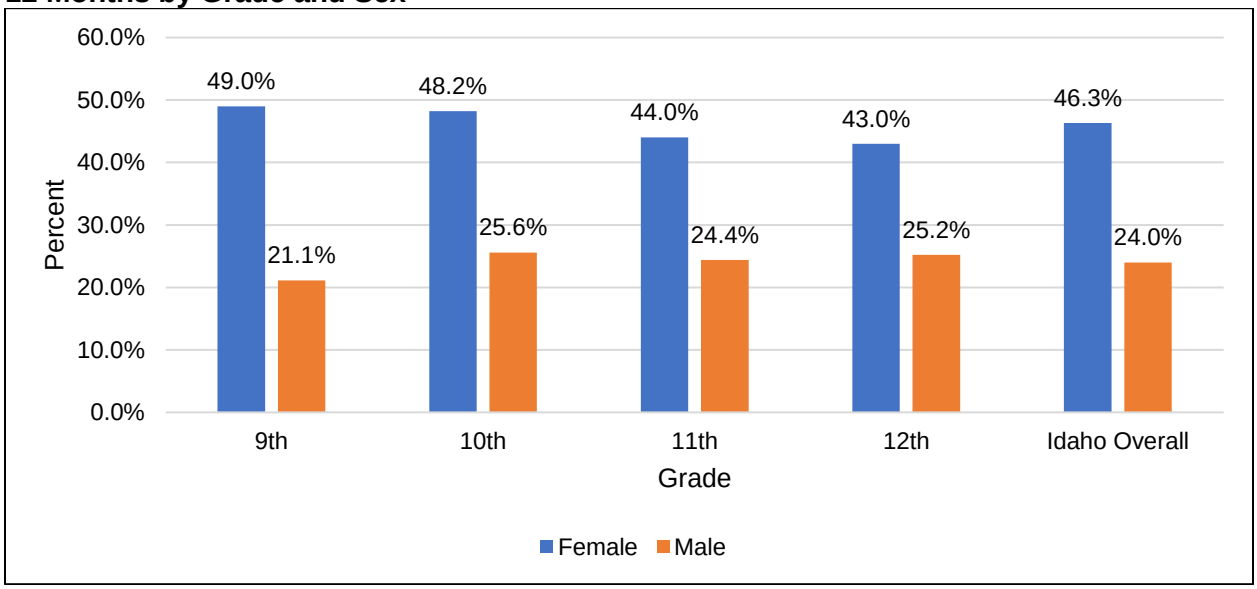


Figure 8. Percentage of Students Who Seriously Considered Attempting Suicide During the Past 12 Months by Grade and Sex

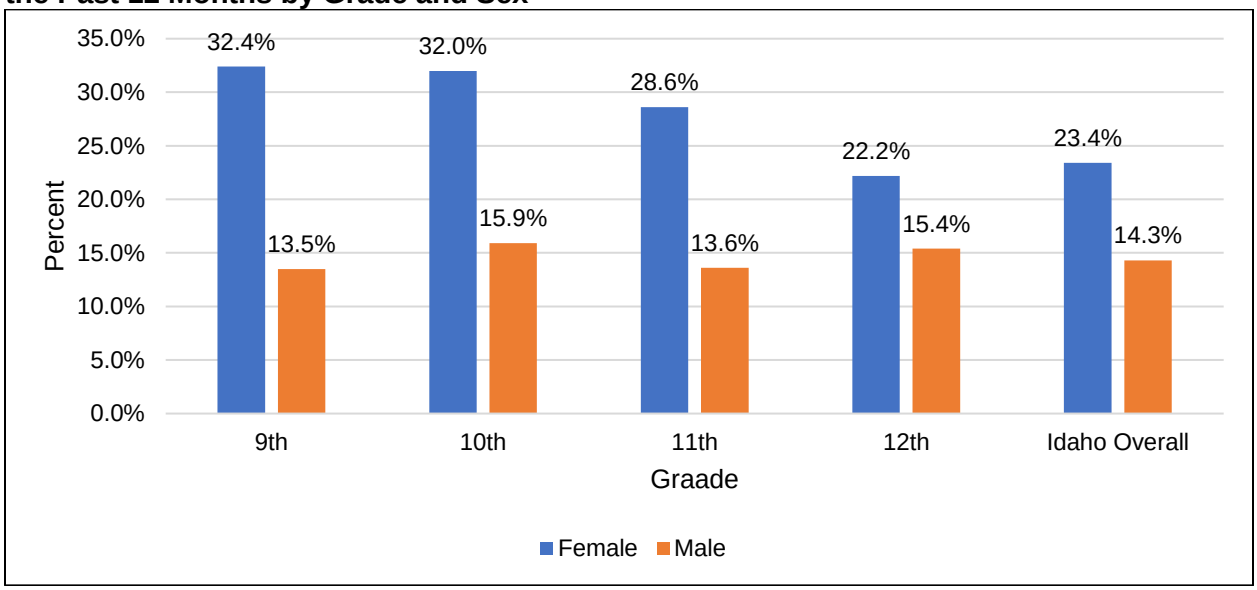


Figure 9. Percentage of Students Who Made a Plan about How They Would Attempt Suicide During the Past 12 Months by Grade and Sex

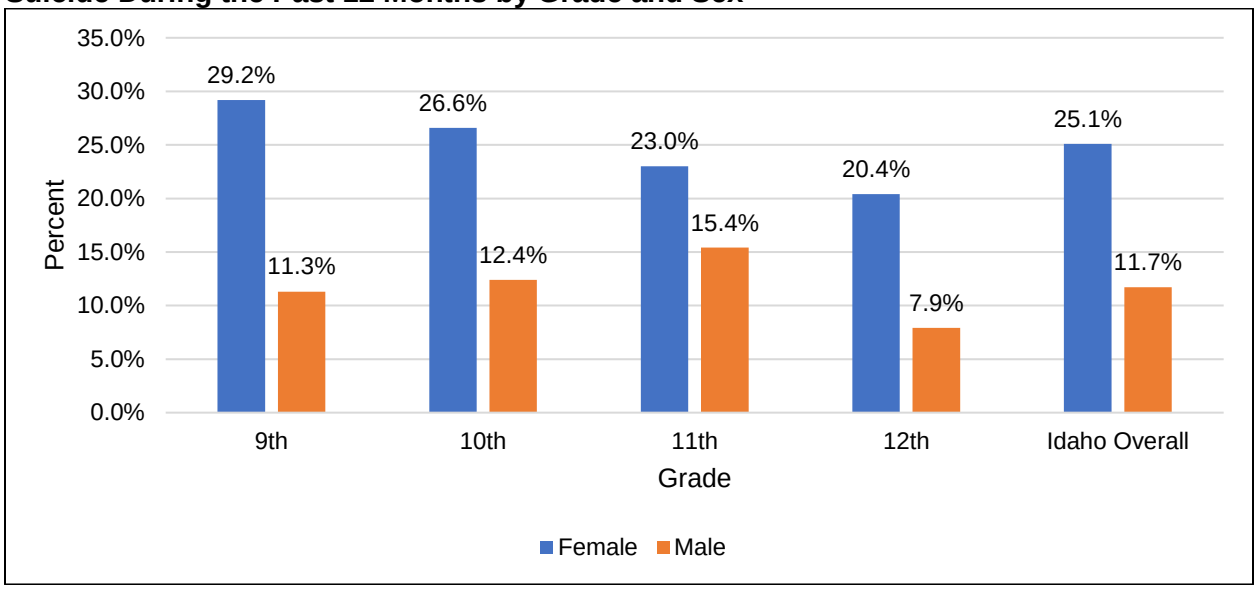


Figure 10. Percentage of Students Who Actually Attempted Suicide One or More Times During the Past 12 Months by Grade and Sex

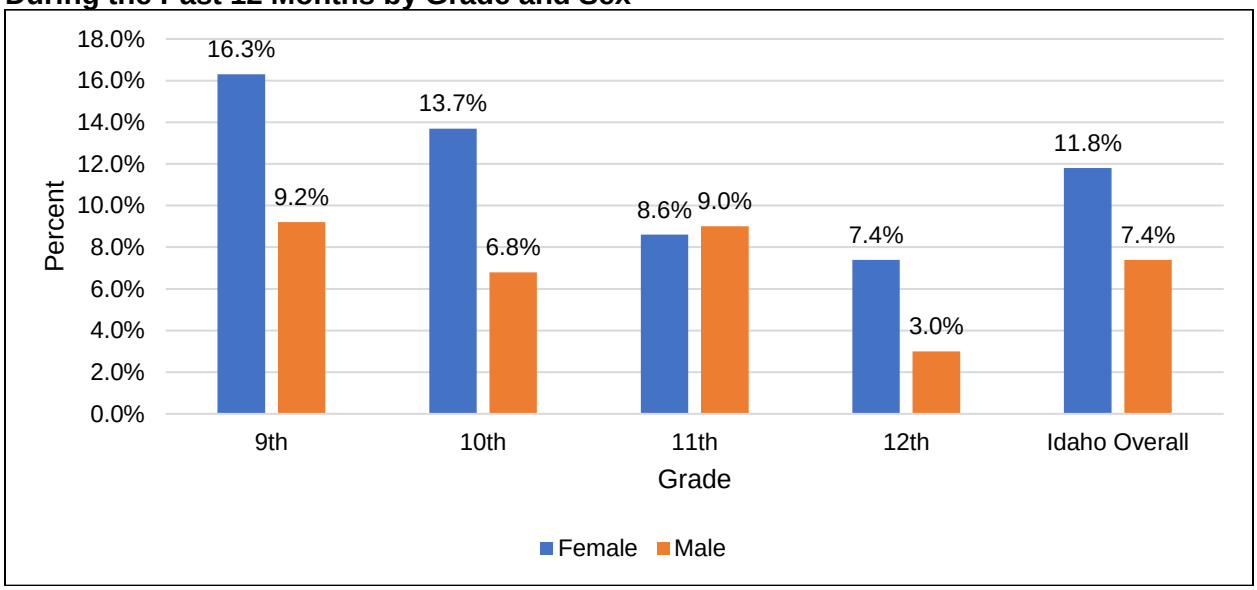
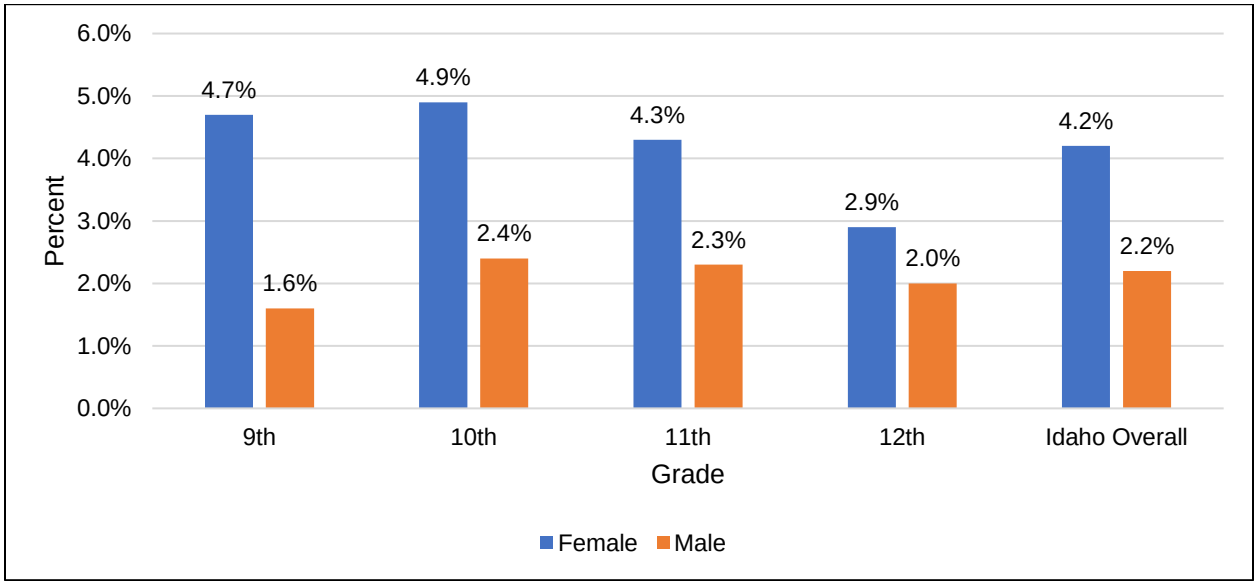


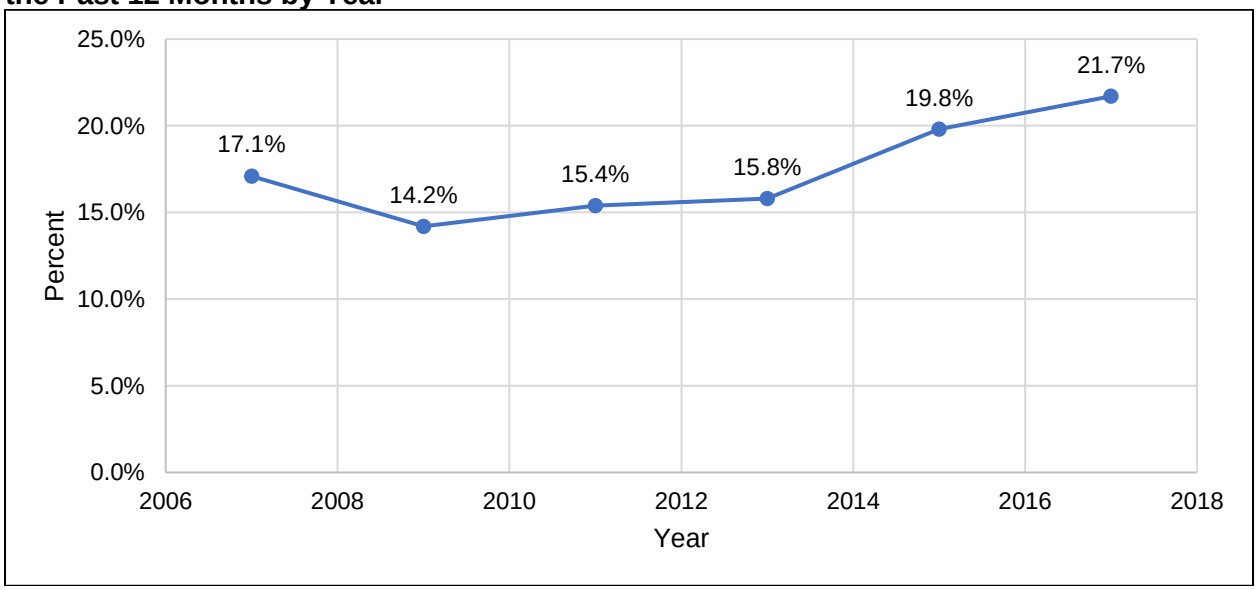
Figure 11. Percentage of Students Who Attempted Suicide which Resulted in an Injury, Poisoning, or Overdose treated by a Doctor or Nurse During the Past 12 Months by Grade and Sex



Academic achievement was significantly associated with considering suicide during the past 12 months; those receiving lower grades had a higher percentage of suicide consideration.

From 2011-2017, there was a significant increase in the percentage of students who seriously considered attempting suicide during the past 12 months (**Figure 12**).

Figure 12. Percentage of Students Who Seriously Considered Attempting Suicide During the Past 12 Months by Year



Idaho School Health Profiles [19]

In spring 2018, the Idaho State Department of Education surveyed 6th-12th grade lead health education teachers through the School Health Profile Survey. In only 48.7% of schools did the lead health education teacher receive professional development related to suicide prevention during the past two years. However, 81.6% of lead health education teachers would like to receive professional development on this topic revealing a training need. Regardless of training, 88.7% of schools indicated that teachers tried to increase student knowledge on suicide prevention.

Idaho Suicide-Safe Schools Survey [9]

The Idaho Suicide-Safe Schools Survey collected information from: 1) teachers and school administrators, 2) health/mental health staff, and 3) superintendents and school district staff to understand policies, practices and competencies related to suicide prevention, intervention (i.e., training), and postvention (i.e., aftermath of a suicide death).

1. Teachers and School Administrators: The majority of teachers (n=239) and school administrators (n=54) that completed the survey have been in their current position for 1-5 years (n=158) and worked in any education setting for over 15 years (n=123). Respondents worked in elementary (n=99), middle (n=29), high (n=46), and alternative (n=18) schools; some respondents worked in two or more settings (n=94).

Table 8. Percentage of Teachers and School Administrators to Select Yes/No Questions in the Suicide-Safe Schools Survey

Question	Yes	No	Unsure
Have you received suicide prevention/intervention training?	68.0%	32.0%	-
Does your school have a suicide prevention policy?	51.4%	5.3%	43.3%
Does your school have a suicide postvention policy?	27.5%	10.9%	61.6%
Has your school provided suicide prevention training to students (for middle and high school)?	30.1%	34.8%	N/A = 35.1%
Is suicide prevention information posted in your school, e.g., hotline number, where to get help, etc.?	51.1%	16.2%	32.7%
Has your school experienced a student or staff suicide death in the last five years?	32.0%	47.5%	20.4%
Is it common knowledge among staff, students, and parents to whom concerns about suicide should be reported at school?	72.8%	7.8%	19.4%

Sources of Strength was the most common suicide prevention training used (76.0%) and Sources of Strength + was the most common emotional learning or wellness program used (47.7%).

Table 9. Percentage of Teachers and School Administrators to Select Agreement-Scale Questions in the Suicide-Safe Schools Survey

Question	Strongly Disagree	Disagree	Agree	Strongly Agree
Based on my training, I am capable of intervening with a suicidal student	6.0%	33.9%	43.8%	16.3%
I know the warning signs of suicide	0.7%	14.4%	61.3%	23.6%
My school's staff are trained in suicide prevention and intervention	8.5%	36.5%	46.5%	8.5%
My school's staff are trained in responding to youth who have attempted suicide and to suicide deaths	11.0%	52.3%	32.7%	3.9%

Staff most often receive training annually (45.1%).

2. Health/Mental Health Staff: Seventy-four health/mental health personnel completed the survey with 36 having been in their current position for 1-5 years and 24 working in any education setting for over 15 years. Respondents worked in elementary (n=16), middle (n=5), high (n=21), and alternative (n=4) schools; some respondents worked in two or more settings (n=25).

More than 95% of health/mental health staff received suicide prevention/intervention training with Sources of Strength alone (61.1%) or with another program (8.3%) being the most common training used. Health/mental health staff agreed (30.8%) or strongly agreed (61.5%) that they have the skills and abilities to conduct depressions screenings for students; 7.7% disagreed. All respondents indicated having the knowledge and skills to respond to youth who have attempted suicide and to suicide deaths (61.5% strongly agreed, 38.5% agreed). Staff most often receive training annually (61.2%)

3. Superintendent and School District Staff: Like with the other surveys, the majority of superintendents (n=4) and school district staff (n=15) that completed the survey have been in their current position for 1-5 years (n=10) and worked in any education setting for over 15 years (n=9). Respondents worked in elementary, high, and alternative schools (n=1 each) as well as middle schools (n=4) and in two or more settings (n=12).

Table 10. Percentage of Superintendents and School District Staff to Select Yes/No Questions in the Suicide-Safe Schools Survey

Question	Yes	No	Unsure
Does your district require suicide prevention/intervention training for school staff?	38.5%	23.1%	38.5%
Does your district have a suicide prevention policy?	69.2%	7.7%	23.1%
Does your school have a suicide postvention policy?	61.5%	-	38.5%
Does your school district have a crisis team?	69.2%	7.7%	23.1%

Two-thirds of superintendents and school district staff agreed (33.3%) or strongly agreed (33.3%) that their crisis team and/or school staff are trained to respond to youth who have attempted suicide and to suicide deaths (25.0% disagreed, 8.3% strongly disagreed). Staff most often receive training annually (41.7%).

2017 ACHA National College Health Assessment [21]

Five self-selected postsecondary educational institutions participated in 2017 ACHA National College Health Assessment. The survey was administered via web and completed by 2,745 Idaho students. Of valid responses, most respondents identified as a woman (69.4%) and the mean and median age of respondents was 24 and 21 years, respectively. The assessment was completed most by undergraduates (first year=20.7%, second year=22.6%, third year=18.0%, fourth year=16.7%, fifth year=7.7%); graduate/professional students, those not seeking a degree, or other years in school made up the remaining percentage.

About half of students (51.7%) indicated *an interest* in receiving suicide prevention information from their college or university; half (51.0%) also indicated receiving information from their college or university on suicide prevention.

The majority of students never seriously considered (**Table 11**) or attempted (**Table 12**) suicide.

Table 11. Number of Students who Ever Seriously Considered Suicide

Response	# of Students	Percent
Never	1,831	67.2
Not in last 12 months	507	18.6
In the last 2 weeks	73	2.7
In the last 30 days	63	2.3
In the last 12 months	251	9.2

Table 12. Number of Students who Have Ever Attempted Suicide

Response	# of Students	Percent
Never	2,367	86.8
Not in last 12 months	303	11.1
In the last 2 weeks	9	0.3
In the last 30 days	2	0.1
In the last 12 months	45	

When drinking alcohol, the percentage of students who seriously considered suicide within the last 12 months was 3.8% (n=103).

Behavioral Risk Factor Surveillance System (BRFSS) [18]

BRFSS is a health-related, telephone survey conducted in Idaho and throughout the U.S. The survey includes standardized core questionnaires with the option for states to add additional questions; suicide was included as an Idaho state added section in the 2016 BRFSS survey.

Nearly all (99.2%) of the 4,705 respondents of Idaho's added section on suicide stated that they had not attempted suicide in the past 12 months. The 0.8% of respondents that had attempted suicide in the past 12 months were subsequently asked if they received or sought medical care, advice, or counseling. Sixteen respondents indicated receiving services from the physician office (34.8%), hospital emergency department (47.1%), urgent care facility (18.1%), mental health provider (13.0%), and other health care facility (16.6%); respondents could indicate receiving services from multiple options. More than a quarter of respondents (27.0%) indicated not seeking any medical care, advice, or counseling.

Mental Health

Mental health is an important factor in suicide prevention. Idaho 2016 BRFSS respondents (n=5,148) reported a mean of 3.5 “not good” days when asked how many days during the past 30 days was their mental health (stress, depression, and problems with emotions) not good.

Figure 13. County Comparison of Mentally Unhealthy Days Reported in the Past 30 Days

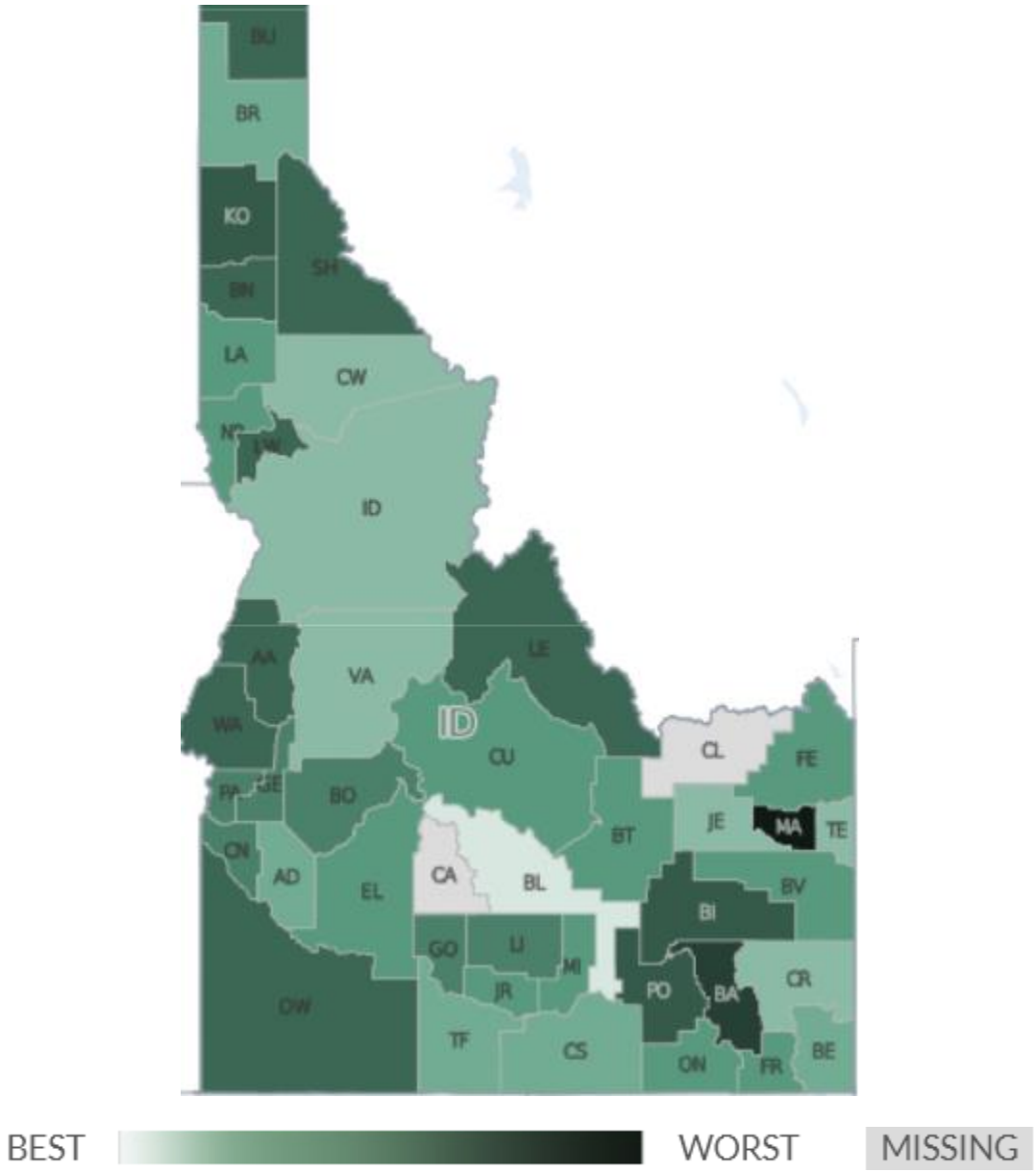


Figure retrieved from County Health Rankings & Roadmaps [34]

Related to poor mental health days is mental distress. Eleven percent of Idahoans also report frequent mental distress, defined as reporting ≥14 days of “not good” mental health days in the past 30 days [34].

Unfortunately, all of Idaho's 44 counties are designated as a geographic or population mental health professional shortage area with access to care identified as a major issue [35]. Across the state, the mental health provider to population ratio ranges from 250:1 (Bannock County) to 7,880:1 (Jerome County) indicating within and overall state disparities in mental health provision (**Table 13**) [34].

Table 13. Number of Mental Health Providers and Population Ratio by County in 2018

County	# of Mental Health Providers	Mental Health Provider: Population Ratio
Ada	1,252	360:1
Adams	3	1,380:1
Bannock	338	250:1
Bear Lake	5	1,210:1
Benewah	19	480:1
Bingham	59	780:1
Blaine	32	690:1
Boise	2	3,650:1
Bonner	89	490:1
Bonneville	313	370:1
Boundary	15	790:1
Butte	1	2,600:1
Camas	-	-
Canyon	307	710:1
Caribou	3	2,340:1
Cassia	28	850:1
Clark	0	870:1
Clearwater	10	850:1
Custer	-	-
Elmore	33	810:1
Franklin	8	1,700:1
Fremont	5	2,620:1
Gem	14	1,240:1
Gooding	19	800:1
Idaho	15	1,090:1
Jefferson	6	4,740:1
Jerome	3	7,880:1
Kootenai	291	540:1
Latah	57	690:1
Lemhi	10	790:1
Lewis	2	1,940:1
Lincoln	1	5,320:1

Madison	54	720:1
Minidoka	5	4,150:1
Nez Perce	95	430:1
Oneida	6	740:1
Owyhee	3	3,880:1
Payette	21	1,110:1
Power	2	3,800:1
Shoshone	17	740:1
Teton	12	950:1
Twin Falls	214	400:1
Valley	20	530:1
Washington	4	2,530:1

Table created from County Health Rankings & Roadmaps [34]

ISPP Goals, Objectives, Identified Gaps, and Supporting Assessments

During our review of needs and resource assessments, we found that the ISPP 2019-2023 already recognized and addressed (through goals, objectives, and recommended activities and actions) many gaps in the state's suicide prevention needs. To support current and future work outlined in the ISPP, goals are linked to our identified gap(s). **Please see the ISPP for additional details on priority objectives and recommended activities and actions.**

Goal 1 - Integrate and coordinate suicide prevention activities across multiple sectors and settings.

Objective	Gap	Supporting Assessments
1.3.2 Improve and support inter-agency collaboration.	Coordinated suicide prevention activities across healthcare professionals and systems needs to be improved.	▪ Idaho Suicide Prevention Hotline Data ▪ North Idaho Community Health Improvement Plan - Panhandle Health District ▪ Clearwater Valley Hospital 2016 Community Health Needs Assessment ▪ Gritman Medical Center Community Health Needs Assessment and Implementation Strategy ▪ Teton Valley Healthcare Community Health Needs Assessment and Implementation Strategy
1.3.3 Improve and support public-private initiatives that can contribute to suicide prevention success outcomes.	There is a lack of collaboration and communication among public and private suicide prevention stakeholder groups.	▪ Suicide Prevention Program Stakeholder Survey

Notes: While this gap was not explicitly stated in any assessments, we found duplication in efforts across organizations implying a possible lack of coordination. Integration and coordination of activities may lead to more efficient use of limited resources.

Goal 2 - Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes and behaviors.

Objective	Gap	Supporting Assessments
2.4 Increase knowledge and awareness of the warning signs for suicide and how to connect individuals with assistance and care within their communities.	There is a need for increased awareness/education related to suicide.	▪ Idaho Suicide Prevention Hotline Data ▪ Idaho Health Behaviors 2016: Results from Idaho's Behavioral Risk Factor Surveillance System (BRFSS) ▪ Idaho Youth Risk Behavior (YRBS) Survey 2017 ▪ United Way of Treasure Valley 2017 Community Assessment ▪ Clearwater Valley Hospital 2016 Community Health Needs Assessment ▪ Idaho American Indian & Alaska Native Community Health Profile

Goal 3 - Increase knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery.

Objective	Gap	Supporting Assessments
3.1 Promote culturally competent, evidence-based and best practice program that increase protection from suicide risk.	There is a need to recognize cultural differences around protective factors and to effectively transfer this information to un-represented populations.	▪ Gritman Medical Center Community Health Needs Assessment and Implementation Strategy
Notes: Idahoans from racial and ethnic minority populations, as well as those from lower socioeconomic backgrounds and those who live in rural communities, are less likely to have access to mental health care and more likely to receive lower quality care. Even with the investment in community mental health centers and the expansion of Medicaid, more work is needed to eliminate these disparities by understanding the contributing factors and to study the effectiveness of programs to eliminate them.		

Goal 4 - Promote responsible and accurate portrayals of suicide and mental illness in media reporting and the safety of online content related to suicide.

Objective	Gap	Supporting Assessments
4.1. Encourage and recognize news organizations and develop and implement policies and practices addressing the safe and responsible reporting of suicide and other related behaviors.	There is a stigma associated with a mental health diagnosis that continues to serve as a barrier.	▪ Idaho Youth Risk Behavior (YRBS) Survey 2017 ▪ United Way of Treasure Valley 2017 Community Assessment
Notes: Stoicism exists in Idaho and there appears to be a reluctance for some to seek help. This cultural observation coupled with undiagnosed or untreated mental health difficulties, fallout from the opioid crisis, economic pressures, easy access to guns, and increased use of social media especially by adolescents are all contributing factors to the increase in suicide.		

Goal 5 - Develop, implement and monitor effective programs that promote wellness and prevent suicide and related behaviors.

Objective	Gap	Supporting Assessments
5.2 Encourage and empower institutions, agencies, and organizations in the community to implement effective programs and provide education that promote wellness, prevent suicide and related behaviors.	There is a shortage of mental health providers based on the number of people reporting a need for care.	▪ Idaho North Central District Community Health Improvement Plan
5.4 Increase access to effective programs and services for mental health and substance use disorders.	When mental health services are available, they are difficult to access due to affordability and/or transportation and can be lacking in quality.	▪ St. Luke's Community Health Needs Assessment 2019 ▪ North Idaho Community Health Improvement Plan - Panhandle Health District ▪ United Way of Treasure Valley 2017 Community Assessment ▪ Clearwater Valley Hospital 2016 Community Health Needs Assessment ▪ Teton Valley Healthcare Community Health Needs Assessment and Implementation Strategy

Goal 6 - Reduce access to lethal means of suicide among individuals with suicide risk.

Objective	Gap	Supporting Assessments
6.1 Encourage those who interact with individuals at risk for suicide to assess routinely for access to lethal means and mitigate means.	Use of a firearm is the most common mechanism in suicide deaths.	▪ Army National Guard Suicide Data ▪ Suicide among American Indians & Alaska Natives in Idaho ▪ Idaho Veteran Suicide Data Sheet ▪ Fig. 2. Idaho and U.S. Crude Suicide Rates by Year
Notes: Data indicate that Idahoans, including AI/ANs and veterans, complete suicide deaths by firearm more than any other mechanism.		
6.2 Collaborate with firearms dealers, shooting clubs, ranges, hunting organizations, and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible gun ownership.	There is duplication around gunlock campaigns and means restriction involving firearms.	▪ Army National Guard Suicide Data ▪ Suicide Prevention Program Stakeholder Survey

Goal 7 - Expand knowledge of community and clinical service providers on the nature, related behaviors and prevention of suicide.

Objective	Gap	Supporting Assessments
7.1. Provide suicide prevention training to community groups on their role in the prevention of suicide and related behaviors.	There is insufficient awareness and education related to suicide. This includes the improvement of education of warning signs, risk factors, and protective factors.	▪ St. Luke's Community Health Needs Assessment 2019 ▪ Clearwater Valley Hospital 2016 Community Health Needs Assessment
7.2 Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior and the delivery of effective clinical care for people with suicide risk.	There is a lack of availability of training/education resources for educators related to suicide.	▪ Idaho Suicide-Safe Schools Survey ▪ Idaho School Health Profiles (ISHP) Data
Notes: The findings suggest the state would benefit by considering using a multi-tiered approach to screening for all elementary, secondary, and post-secondary students using Substance Abuse and Mental Health Services (SAMHSA) National Registry of Evidenced-Based Program and Practices (NREPP).		

Goal 8 - Embed suicide prevention as a core component of health care services.

Objective	Gap	Supporting Assessments
8.1 Promote the adoption of the Zero Suicide model by health care and the community support systems that provide services and support to defined patient populations.	There is a lack of affordable health care for those in need.	▪ Idaho Suicide Prevention Hotline Data ▪ St. Luke's Community Health Needs Assessment 2019 ▪ United Way of Treasure Valley 2017 Community Assessment ▪ Teton Valley Healthcare Community Health Needs Assessment and Implementation Strategy
8.3 Promote timely access to assessment, intervention and effective care for individuals with a heightened risk for suicide.	There are barriers to accessing care, specifically mental healthcare.	▪ St. Luke's Community Health Needs Assessment 2019 ▪ North Idaho Community Health Improvement Plan - Panhandle Health District ▪ Idaho North Central District Community Health Improvement Plan ▪ United Way of Treasure Valley 2017 Community Assessment ▪ Clearwater Valley Hospital 2016 Community Health Needs Assessment ▪ Gritman Medical Center Community Health Needs Assessment and Implementation Strategy ▪ Teton Valley Healthcare Community Health Needs Assessment and Implementation Strategy
8.6 Establish linkages and collaboration between providers of mental health services and community-based programs such as peer support programs, crisis centers, veteran's organizations, etc.	The ratio of the population to mental health providers is inadequate to support the population in need	▪ Idaho North Central District Community Health Improvement Plan
Notes: The state would benefit through better collaborative care and planning services among health care systems and providers (primary care and behavioral health).		

Goal 9 - Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

Objective	Gap	Supporting Assessments
9.1 Facilitate the adoption, dissemination and implementation of guidelines for the assessment of suicide risk among persons receiving care in all settings, including patients receiving care for mental health and/or substance use disorders.	There is a lack of awareness of mental health services in Idaho.	▪ Teton Valley Healthcare Community Health Needs Assessment and Implementation Strategy

Goal 10 - Increase knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery.

Objective	Gap	Supporting Assessments
10.2 Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, include trauma treatment and care for complicated grief.	Support is needed for those affected by a suicide attempt or bereaved by suicide.	▪ Idaho Suicide-Safe Schools Survey

Goal 11 - Increase timeliness and usefulness of state and local surveillance systems relevant to suicide prevention and improve the ability to collect, analyze and use this information for action.

Objective	Gap	Supporting Assessments
11.2 Improve the usefulness and quality of suicide-related data.	There is a lack of data related to individuals in prisons, housed in medical facilities, or who spoke a language other than English. Under-reporting of the prevalence of mental health problems and suicide may exist due to social norms.	▪ Idaho Suicide Prevention Hotline Data ▪ Idaho Health Behaviors 2016: Results from Idaho's Behavioral Risk Factor Surveillance System (BRFSS) ▪ Idaho Youth Risk Behavior Survey (YRBS) 2017
Notes: Increase uniformity in use of electronic health record data across health systems may help to identify people at risk of suicide.		

11.3 Improve and expand state, tribal and local capacity (public health, schools, and other systems) to collect routinely, analyze, report and use suicide-related data to implement prevention efforts and inform policy decisions.	There is a lack of reliable and/or consistent data collection methods or available data related to mental health and suicide.	▪ Bingham Memorial Hospital Community Health Needs Assessment 2016

Goal 12 - Evaluate the impact and effectiveness of suicide prevention, intervention and systems and synthesize and disseminate findings.

Objective	**Gap**	**Supporting Assessments**
12.1 Evaluate the effectiveness of suicide prevention (activities, efforts, interventions, etc.) utilized in Idaho.	A comprehensive statewide review/summary of available needs and resource assessments discussing suicide prevention is unavailable.	Contract between IIDHW and IRH-ISU
Notes: This report works to remedy this.		

Appendix

Appendix A: Select Training Resources

Training materials are a necessary part of any program or activity that involves knowledge acquisition and retention. The following is a list of training resources for educating students, parents, and professionals. Many of these trainings have been utilized in Idaho.

Applied Suicide Intervention Skills Training (ASIST)
ASIST is a two-day, two-trainer, workshop designed for members of all caregiving groups. Family, friends, and other community members may be the first to talk with a person at risk, but have little or no training. ASIST can also provide those in formal helping roles with professional development to ensure that they are prepared to provide suicide first aid help as part of the care they provide. The emphasis is on teaching suicide first-aid to help a person at risk stay safe and seek further help as needed. Participants learn to use a suicide intervention model to identify persons with thoughts of suicide, seek a shared understanding of reasons for dying and living, develop a safe plan based upon a review of risk, be prepared to do follow-up, and become involved in suicide-safer community networks. The learning process is based on adult learning principles and highly participatory. Graduated skills development occurs through mini-lectures, facilitated discussions, group simulations, and role plays.

Assessing & Managing Suicide Risk (AMSR)
Assessing and Managing Risk (AMSR) is a series of one day or half day trainings designed for health and behavioral health professionals interested in the latest intersectional suicide care practices.

Behavioral Health and Substance Abuse Community Health Worker and Community Paramedic Training Module – Idaho State University, Institute of Emergency Management
The purpose of this course is to provide an understanding of behavioral health as a public health professional who promotes full and equal access to necessary health and social services by applying his or her unique understanding of the experiences, language, and culture of the communities he or she serves. Through this training module, students will be able to apply knowledge of Behavioral Health and Substance Abuse in order to successfully navigate patients throughout the healthcare system.

CALM: Counseling on Access to Lethal Means
Reducing access to lethal means, such as firearms and medication, can determine whether a person at risk for suicide lives or dies. The free online course focuses on how to reduce access to the methods people use to kill themselves. It covers how to(1.) identify people who could benefit from lethal means counseling, (2) ask about their access to lethal methods, and (3) work with them and their families to reduce stress. While this course in primarily designed for mental health professionals, others who work with people at risk for suicide, like social service professionals and health care providers, may also benefit from taking it.

CAMS Training
CAMs stands for the "Collaborative Assessment and Management of Suicidality" (CAMS). CAMs is first and foremost a clinical philosophy of care and is an effective evidence-based assessment, intervention and treatment that directly targets suicidal risk. It is a flexible approach

that can be used across theoretical orientations and disciplines for a wide range of suicidal patients across treatment settings and different treatment modalities.

Crisis Intervention Team Programs (CIT)

The lack of mental health services across the US has resulted in law enforcement officers serving as first responders to most crises. A Crisis Intervention Team (CIT) program is an innovative, community-based approach to improve the outcomes of these encounters. In over 2700 communities nationwide, CIT programs create connections between law enforcement, mental health providers, hospital emergency services and individuals with mental illness and their families. Through collaborative community partnerships and intensive training, CIT improves communication, identifies mental health resources for those in crisis and ensures officer and community safety.

Ending the Silence (NAMI)

An interactive presentation that helps teens to learn about the warning signs of mental health conditions as well as what steps they should take to find support for themselves of their friends.

Idaho Lives Project Training

The Idaho Lives Project implements and supports youth suicide prevention and wellness through the Sources of Strength program in middle/junior and senior high schools throughout the state of Idaho. The project started in schools spring of 2014, originally through a Garrett Lee Smith Federal Grant. Most recently, in 2016, the project has been supported through a collaboration with the Division of Public Health and the State Department of Education. It received additional funding this spring from the state of Idaho to increase school implementation and support for existing schools with the program. To date, the Idaho Lives Project team has trained 63 schools and will add 17 new schools during the 2018-2019 school year. Also included in the Idaho Lives Project are gatekeeper trainings, regional program/school support, community information and outreach, postvention consulting, booster trainings for all Sources schools, mini-Sources trainings, and adult advisor/peer leader trainings.

It's Real: College Students and Mental Health

The AFSP-produced film *It's Real: College Students and Mental Health* is designed to raise awareness about mental health issues commonly experienced by students, and is intended to be used as part of a school's educational program to encourage help-seeking. By featuring real stories and experiences, *It's Real* conveys that depression and other mental health conditions are real illnesses that can be managed through specific treatments and interventions. It encourages students to be mindful of the state of their mental health, to acknowledge and recognize when they are struggling, and to take steps to seek help.

Mental Health First Aid

Mental Health First Aid helps you assist someone experiencing a mental health or substance use-related crisis. In the mental health first aid course, you learn risk factors and warning signs for mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help. Mental Health First Aid teaches about recovery and resiliency - the belief that individuals experiencing these challenges can and do get better, and use their strengths to stay well.

Native H.O.P.E (Helping Our People Endure)
A peer-counseling (youth helping youth) curriculum that focuses on suicide prevention and related risk- factors such as substance abuse, violence, trauma, and depression. This school-based curriculum has been used successfully throughout Indian Country.

Outreach Wellness Learning (OWL)
OWL seminars have been designed to increase mental health literacy. Through education, communities will begin to eliminate stigma associated with mental illness and increase access to behavioral health supports and services. Examples include: Mental Health 101; Mental Health Crisis; Living with Mental Illness; Me Life is a Gift: Suicide Prevention; Maternal Mental Health Education and Screening; Building Resilience in Youth

PAX
The PAX Good Behavior Game is a powerful evidence-based practice, consisting of proven instructional and behavioral health strategies used daily by teachers and students in the classroom. This universal preventative approach not only improves the classroom behavior and academics, but also provides a lifetime of benefits for every child by improving self-regulation and co-regulation with peers.

Question/Persuade/Refer (QPR) – Gatekeeper Training
The QPR program instructs individuals on how to question a person about suicidal thoughts, persuade them to get help, and refer them to the assistance they may need.

Respond Training
This training is for any university faculty, staff, or administrator who wish to learn more about how to respond with elective support and useful referrals to students or colleagues who are in distress. The course provides a basic overview of symptoms often associated with mental health challenges and offers and action plan to help you respond effectively. Very often graduate and undergraduate students who work in student-assistance roles are also welcome to attend these trainings.

Say it Out Loud – Speaking with Teens About Mental Health
Say it Out Loud gives adults the tools they need to hold conversations about mental health including suicide with teens. The toolkit includes a short film featuring three teen's experiences; a discussion guide; a narrated presentation for the facilitator; fact sheets and information about connecting with your local NAMI

Shield of Care: A System Focused Approach to Protecting Juvenile Justice Youth from Suicide
Shield of Care is an 8 hour, research-informed curriculum that teaches juvenile justice staff strategies to prevent suicide in their correctional facility environment. Specifically the model (1) emphasizes that policy, connectedness to youth, and communication between staff are essential system level elements of suicide prevention (2) Teaches staff specific steps of effective suicide intervention (seeing, protecting, listening, assessing, networking), and provides opportunities for staff to reflect on internal policies for suicide prevention, discuss strategies for overcoming potential barriers, and plan how to take action in their facility.

Signs, Ask, Validate, Encourage and Expedite (SAVE)
The U. S. Department of Veterans Affairs (VA) in collaboration with the Psych Armor Institute recently launched (June 2018) a free 25- minute online suicide-prevention training video designed to equip anyone who interacts with Veterans to demonstrate care, support and compassion when talking with a Veteran who could be at risk for suicide.

Signs of Suicide Program (SOS)
The Signs of Suicide (SOS) program serves middle and high schools across the country. The program has shown a reduction in self-reported suicide attempts by 40-64% in randomized control studies (Shilling et al. 2015). Through a video and guided discussion, student learn to identify warning signs of suicide and depression in a single class period. At the end of the session, students are encouraged to take a survey - question screening for depression (anonymous or signed - the school can decide) which enables the school to identify students who are at risk. The curriculum raises awareness about behavioral health and encourages student to ACT (Acknowledge, Care, Tell) when worried about themselves or their peers.

Sources of Strength
A best practice evidence-based youth wellness and suicide prevention program that prepares student peer leaders to be change agents in their schools. Peer leaders are trained to apply a model of health coping to their own lives emphasizing eight protective “sources of strength”. The intervention curriculum has peer leaders meet regularly with trained adult advisors to reinforce their skills, plan and implement prevention activities Trained peer leaders use their network of friends to: have one on one conversations about sources of strength; develop hope, help, strength poster and or public service announcement programs using local faces and voices, present peer to peer presentations, develop video, internet or texting prevention messages. . This upstream model strengthens multiple sources of support (protective factors) around young individuals so that when times get hard they have strengths to rely on.

Suicide Alertness for Everyone (safeTALK)
SafeTALK is a half-day training program that teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention. SafeTALK stresses safety while challenging taboos that inhibit open talk about suicide. The program recommends that an ASSIST trained resource or other community support resource be at all trainings. The "safe" of safeTALK stands for "suicide alertness for everyone. The "TALK" letters stand for the practice actions that one does to help those with thoughts of suicide: Tell, Ask, Listen, and KeepSafe. The safeTALK learning process is highly structured, providing graduated exposure to practice actions. The program is designed to help participants monitor the effect of false societal beliefs that can cause otherwise caring and helpful people to miss, dismiss, or avoid suicide alerts and to practice the TALK step actions to move past these barriers. Six 60-90 second video scenarios, each with non-alert and alert clips, are selected from a library of scenarios and strategically used through the training to provide experiential referents for the participants.

Talk Saves Lives: An Introduction to Suicide Prevention
This training is a community-based presentation that covers the general scope of suicide, the research on prevention, and what people can do to fight suicide. Attendees learn the risk and warning signs of suicide as well as prevention methods. In this training, participants learn what suicide is, who it affects, what we know about it, and what can be done to prevent it. It is suggested that community members age 15 or older who want to learn more about suicide prevention participate.

THRIVE (Tribal Health: Reaching out InVolves Everyone)
The suicide prevention project at the Northwest Portland Area Indian Health Board. THRIVE provides suicide prevention training, media material development, and technical assistance to Tribes in the Pacific Northwest in order to increase knowledge and awareness about suicide among tribal community member, improve intertribal and interagency communication about suicide prevention and treatment, and encourage tribal health programs to track, prevent, and treat suicide. THRIVE provide ASIST and QPR trainings, and works to increase tribal capacity to prevent suicide using the Zero Suicide Model, the Healing of the Canoe curriculum, and other evidence-based interventions.

Youth Aware of Mental Health (YAM)
YAM is an interactive program for adolescents promoting increased discussion and knowledge about mental health, suicide prevention, and the development of problem-solving skills and emotional intelligence. YAM brings different learning methods together with the fundamental components of the program being as follows: five interactive sessions, role-playing, informational reading materials, and posters for display in the classroom.

Youth Suicide Prevention Programming - Idaho
Developmentally appropriate, student-centered education materials on suicide prevention will be integrated into the curriculum of all K-12 health classes. The content of these age-appropriate materials may include 1) the importance of safe and healthy choices and coping strategies, 2) how to recognize risk factors and warning signs of mental disorders and suicide in oneself and others, 3) help-seeking strategies for oneself or others, including how to engage school resources and refer friends for help. In addition, schools may provide supplemental small group suicide prevention programming for students.

Zero Suicide
The zero suicide framework is a system-wide organizational commitment to safer care in health and behavioral health care systems. The framework is based on the realization that suicidal individuals often fall through the cracks in a sometimes fragmented and distracted health care system and that a systematic approach to quality improvement in these settings is both available and necessary.

Appendix B: Select Screening Tools

Ask Suicide-Screening Questions (ASQ) Toolkit
The Ask Suicide-Screening Questions (ASQ) Toolkit is a free resource for medical settings (emergency department, inpatient medical/surgical units, outpatient clinics/primary care) that can help nurses or physicians successfully identify youth at risk for suicide. ASQ is a set of four screening questions that takes 20 seconds to administer. In an NIMH study a "yes" response to one or more of the four questions identified 97% of youth (aged 10 to 21 years) at risk for suicide. By enabling early identification and assessment of young patients at high risk for suicide, the ASQ toolkit can play a key role in suicide prevention.

Brief Suicide Safety Assessment (BSSA)
Use after a patient (10-24 years) screens positive for suicide risk on the ASQ. Assessment guide for mental health clinicians, MD's, NP's or PA's. Prompts help in determining the disposition.

Columbia – Suicide Severity Rating Scale (C-SRRS)
The C-SSRS is used extensively across primary care, clinical practice, surveillance, research, and institutional settings. It is available in over 100 country-specific languages, and is part of a national and international public health initiative involving the assessment of suicidality, including general medical and psychiatric emergency departments, hospital systems, managed care organizations, behavioral health organizations, medical homes, community mental health agencies, primary care, clergy, hospices, schools, college campuses, US Army, National Guard, VAs, Navy and Air Force settings, frontline responders (police, fire department, EMTs), substance abuse treatment centers, prisons, jails, juvenile justice systems, and judges to reduce unnecessary hospitalizations. The C-SSRS has been administered several million times and has exhibited excellent feasibility (Posner et al, 2011, Mundt et al, 2013) – no mental health training is required to administer it.

General Anxiety Disorder 2 & 7 (GAD)
GAD is diagnosed with a mental health screening that your primary care provider can perform. They will ask you questions about your symptoms and how long you've had them. They can refer you to a mental health specialist, such as a psychologist or psychiatrist. Your doctor may also do medical tests to determine whether there is an underlying illness or substance abuse problem causing your symptoms. Anxiety has been linked to: gastroesophageal reflux disease, thyroid disorders, heart disease, menopause

Patient Health Questionnaire (PHQ-2)
The purpose of the PHQ-2 is not to establish a final diagnosis or to monitor depression severity, but rather to screen for depression as a "first-step" approach.

Patient Health Questionnaire (PHQ-9)
The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression. The PHQ-9 incorporates depression diagnostic criteria with other leading major depressive symptoms into a self-report tool. The PHQ-9 is brief and useful in clinical practice. The PHQ-9 is completed by the patient in minutes and is rapidly scored by the clinician. The PHQ-9 can also be administered repeatedly, which reflect improvement or worsening of depression in response to treatment

P.E.S.T.E. R
Suicide severity assessment that involves the following criteria: plan, emotional stability, stress level and sources, thinking, environmental issues, response/treatment plan.

Reducing the Incidence of Suicide in Indigenous Groups – Strengths United through Networks (RISING SUN)
RISING SUN has produced a number of useful tools, including an online toolkit on how to measure the impact and effectiveness of suicide prevention in circumpolar Indigenous communities.

Safety Planning Guide
A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is brief, in the patient's own words, and is easy to read.

Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) for Mental Health Professionals
This resource gives a brief overview on conducting a suicide assessment using a five-step evaluation and triage plan. The five step plan involves identifying risk factors and protective factors, conducting a suicide inquiry, determining risk level and interventions, and documenting a treatment plan**.**

Suicide Behaviors Questionnaire (SBQ-R)
The SBQ-R has 4 items, each tapping a different dimension of suicidality: Ideation or attempt; frequency of ideation over past twelve months; threat of suicide; self-reported likelihood of suicidal behavior in the future.

Tribal Tool
Michigan State has developed a screening tool for adolescent American Indian/Alaska Natives that has been adopted for use by a few tribal communities in northern California.

Appendix C: Sources of Strength Assessment [36]

Sources of Strength, a school-wide wellness and suicide prevention program, trains student "peer leaders" to use healthy coping skills and model behavior school-wide. In the past five years, 81 Idaho schools have implemented Sources of Strength with 43 schools participating in a recent program evaluation (Spring 2019).

Peer Leaders (n=594) from 35 schools indicated that participation in the training increased their personal growth (**Table 14**) and ability to help suicidal peers (**Table 15**).

Table 14. Percent of Sources of Strength Peer Leaders Indicating Personal Growth

	% Agree or Strongly Agree	
Response	**Average**	**School Range**
I've learned better ways to handle tough times in my life	91.3%	66.7-100%
I've increased my own 'sources of strength'	86.0%	63.6-100%
I've made a positive difference in my school	85.1%	61.1%-100%

Table 15. Percent of Sources of Strength Peer Leaders Indicating Readiness to Access Adult Help

	% Agree or Strongly Agree	
Response	**Average**	**School Range**
I know more about how to get help for a suicidal friend	92.7%	63.6-100%
I know more adults I trust to get help for a suicidal peer	90.7%	54.5-100%

Staff (n=817) from 37 schools also indicated positive results from participation in the Sources of Strength program for themselves (**Table 16**) and students (**Table 17**).

Table 16. Percent of Sources of Strength Staff Indicating Positive Program Impact on Self

Since Peer Leaders and Adult Advisors have been trained in Sources of Strength…	% Agree or Strongly Agree	
Response	**Average**	**School Range**
I am more open to talking to students about their problems	91.7%	50.0-100%
Our school is a more positive place	92.1%	50.0-100%
I've learned more about how to get help for a suicidal student	77.4%	56.3-100%
I've shared my own Sources of Strength with students	85.6%	42.9-91.7%

Table 17. Percent of Sources of Strength Staff Indicating Positive Program Impact on Students

Since Peer Leaders and Adult Advisors have been trained in Sources of Strength, students in our school…	% Agree or Strongly Agree	
Response	**Average**	**School Range**
Are likely to find an adult they can talk to	91.7%	41.7-100%
Are encouraged to develop their own voice	92.1%	58.3-100%
Are involved in decisions about things that affect them in school	77.4%	42.9-100%
Seem more willing to talk to me and other school staff	85.6%	54.5-100%
Are supporting one another	88.9%	42.5-100%
Are having conversations about healthy friends and activities	91.5%	25.0-100%

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