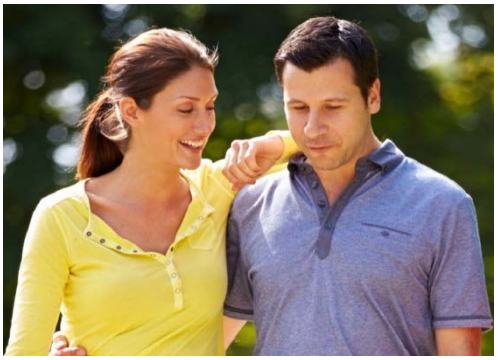
Preventing Suicide in Wyoming

2017-2021 State Suicide Prevention Plan

January 2017



Wyoming Department of Health

Commit to your health.

Prepared by

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Commit to your health.

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Source: U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012

State Suicide Prevention Goals

Overarching Goal: Reduce the annual suicide rate 20 percent by 2025

Goal 1: Develop broad-based support for suicide prevention (National Goal 1)

Goal 2: Develop and implement community-based suicide prevention programs and activities (National Goal 5)

Goal 3: Promote awareness that suicide is a public health problem that is preventable (National Goal 2)

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Introduction and Overview

Introduction

Suicide is a leading cause of preventable death in Wyoming with negative impacts that are felt by individuals, families, and communities throughout the state. Over the past three decades Wyoming has consistently had one of the highest per-capita suicide rates in the nation, currently ranking fourth with a suicide rate of 21.6 suicide deaths per a population of 100,000 people in 2014, compared to the national average of 12.93 (Wyoming Vital Statistics, 2016). Between 2011 and 2015, 705 Wyoming citizens have died by suicide (Wyoming Vital Statistics, 2016), meaning, on average, one person dies by suicide every three days in Wyoming. For every individual who dies by suicide, several others attempt suicide. Suicide takes both an emotional and financial toll across the state. Suicide costs Wyoming a total of $155,148,000 of combined lifetime medical and work loss cost, or an average of $1,184,336 per suicide death in 2010 dollars (American Foundation for Suicide Prevention, 2016). Together we can work to change the current picture of suicide in Wyoming.

The following report provides an overview of suicide deaths in Wyoming, a historical perspective of suicide prevention efforts within the state, and current and planned goals and objectives for suicide prevention initiatives to be implemented over the course of the next two years. The goals and objectives have been closely aligned with the *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*, a report from the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention.

Suicide as a Public Health Issue

Summary from the Centers for Disease Control and Prevention: "Suicide Prevention: A Public Health Issue"

Wyoming's public health and mental health services systems can best be understood in the context of the state's unique demographics. Wyoming has been aptly characterized as "a small town with very long streets." Geographically the tenth largest state in the country, Wyoming is the least populous, with an estimated 586,107 people in 2015. The state has a population density of 5.8 persons per square mile, and the entire state is considered rural or frontier with the exception of Laramie and Natrona Counties (U.S. Census Bureau, 2016).

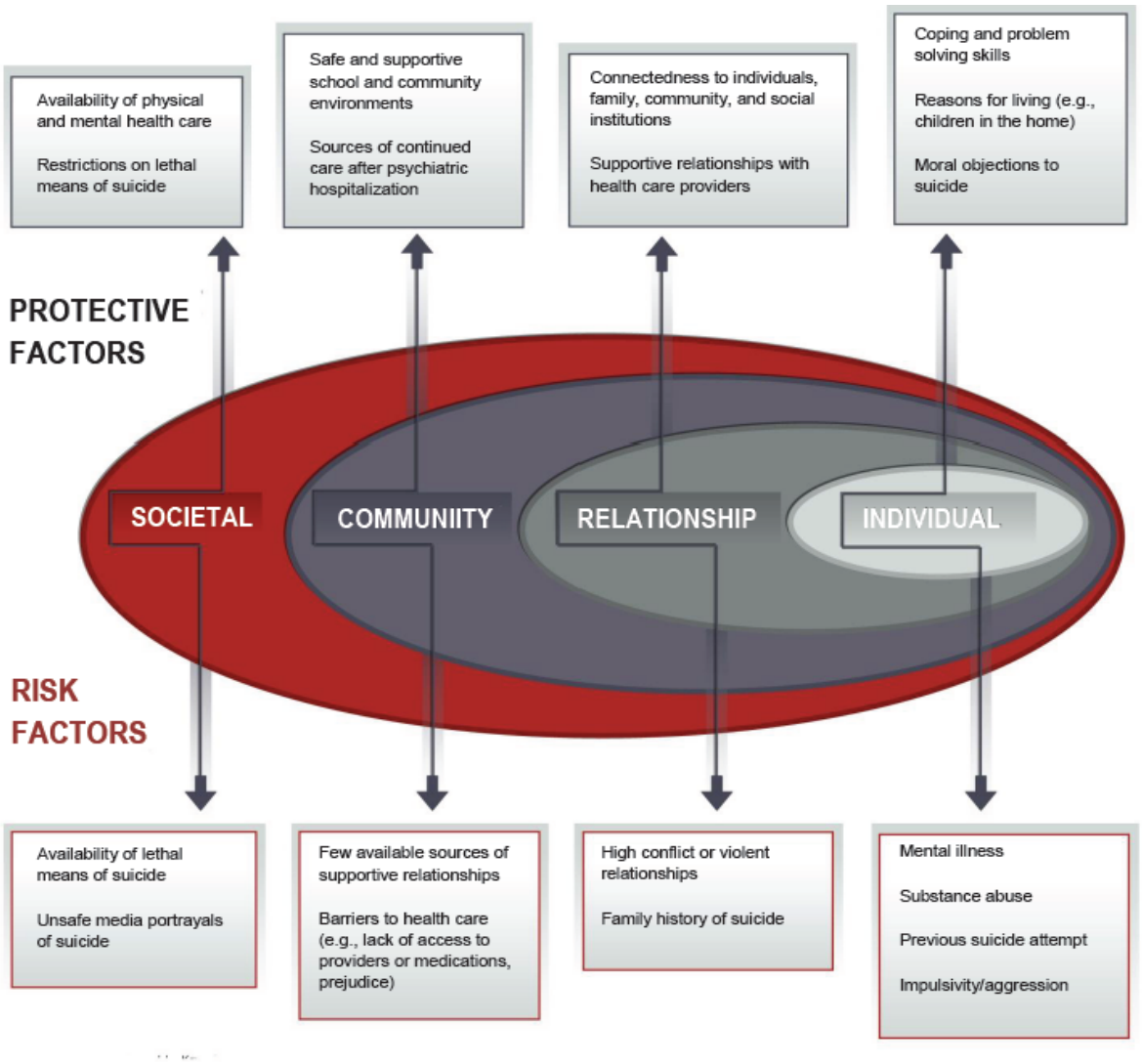
Historically, suicide has been addressed by providing mental health services to individuals who were already experiencing or showing signs of suicidal thoughts or behavior. While therapy and hospitalization are extremely important for those who may be thinking about suicide or who have made a suicide attempt, these services do not prevent suicidal thoughts or behaviors from happening in the first place. There are many additional factors which place people at risk for suicide. A public health approach to suicide prevention can address the wide range of factors that contribute to suicide in several ways.

Public health's broad view places an emphasis on population health, expanding efforts beyond the health of individuals. A population approach focuses on prevention across social systems and supports efforts that impact groups of people, versus treatment of individuals. Second, public health focuses on preventing suicidal behavior before it ever occurs, which is known as primary prevention. This approach addresses a broad range of risk and protective factors (See Figure 1).

Suicide is often thought of as an individual problem, but it also impacts families, communities, and society in general. The long-term goal of public health is to reduce suicide risk by addressing factors at the individual (e.g., substance abuse), family (e.g., poor quality parent-child relationships), community (e.g., lack of

connectedness to people or institutions), and societal levels (e.g., social norms that support suicide as an acceptable solution to problems; inequalities in access to opportunities and services).

Figure 1. Examples of Risk and Protective Factors in a Social Ecological Model



Source: 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action
Adapted from Dahlberg LL, Krug EG. Violence – a global public health problem. In: Krug E, Dahlberg LL, Mercy JA, Zwi, AB, Lozano R, eds. World report on violence and health. Geneva, Switzerland: World Health Organization; 2002.

Suicide in Wyoming

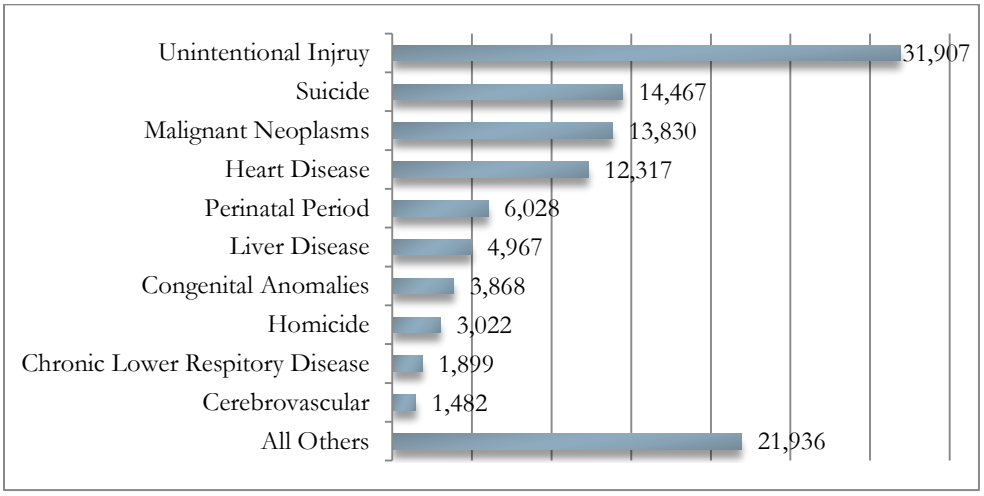
Suicide impacts all ages and races, and no group remains unaffected. In Wyoming, suicide is the second leading cause of death contributing to years of potential life lost (YPLL) (Centers for Disease Control and Prevention, 2016b). YPLL is an estimate of the average time person would have lived had he or she not died prematurely.

YPLL is used to help quantify social and economic loss due to premature death. Estimated total lifetime costs associated with suicide in Wyoming, expressed in 2010 costs, is $155,148,000 (American Foundation for Suicide Prevention, 2016). This includes both medical and work loss costs.

Table 1. Years of Potential Life Lost (YPLL) in Wyoming, 2010-2014

Cause of Death	YPLL
Unintentional Injury	31,907
Suicide	14,467
Malignant Neoplasms	13,830
Heart Disease	12,317
Perinatal Period	6,028
Liver Disease	4,967
Congenital Anomalies	3,868
Homicide	3,022
Chronic Lower Respiratory Disease	1,899
Cerebrovascular	1,482
All Others	21,936
Total	**115,723**

Figure 2. Years of Potential Life Lost in Wyoming, 2010-2014



Wyoming Suicide Rates

While significant variation can exist from year to year in suicide mortality numbers and rates, Wyoming has consistently had a higher suicide rate than the national rate. The average suicide mortality rate in Wyoming between 2011 and 2015 was 25.9 per 100,000 people; this is twice the national suicide rate of 12.93 per 100,000 people (Wyoming Vital Stastics, 2016).

Figure 3. Wyoming Suicide Rates Compared to National Rates, 2011-2015

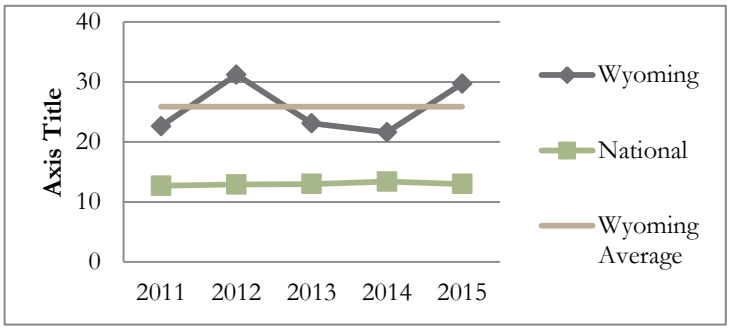


Table 2. Wyoming Suicide Rates, 2011-2015

Year	Rate	Count
2011	22.6	129
2012	31.2	170
2013	23.1	128
2014	21.6	121
2015	29.7	155
2011-2015	25.9	703

*Rates per 100,000 and age-adjusted to the 2000 US standard Population

Suicide and Age

Although there is variation from year to year, certain age groups consistently have a higher suicide rate in Wyoming. Younger groups have had consistently lower suicide rates than middle-aged and older adults.

Figure 4. Age-Adjusted Wyoming Suicide Rates by Age, 2012-2015

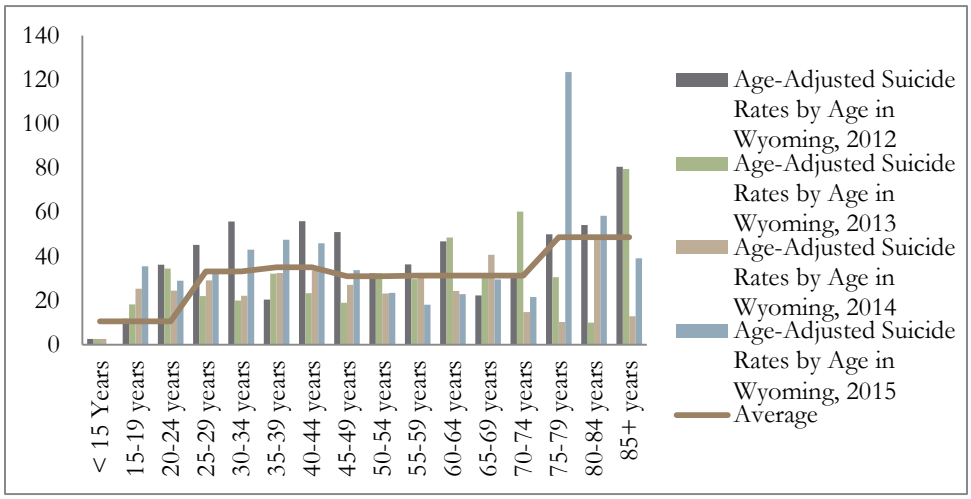


Table 3. Age-Adjusted Wyoming Suicide Rates by Age, 2011-2015

	Age-Adjusted Rate, 2011-2015
Under 24 years	10.6
25-34 years	33.2
35-44 years	35.1
45-54 years	31.1
55-64 years	31.3
65-74 years	31.3
75 + years	48.7

*Rates per 100,000 and age-adjusted to the 2000 US standard Population

Wyoming residents 75 years or older are the highest of all age groups in terms of age-adjusted suicide rates, at a rate of 48.7 persons per 100,000 between 2011 and 2015. This age group is followed by individuals 35-44 years of age, at a rate of 35.1 persons per 100,000. Among youth ages 15-24 in Wyoming, suicide is the second leading cause of death after unintentional injuries(Centers for Disease Control and Prevention, 2016a). The burden of suicide on Wyoming youth is reflected by high rates of suicidal thoughts and non-fatal suicide behaviors among high school students. While there has consistently been some annual variation

among categories, suicidal thoughts and behaviors among high school students saw an increase in 2015 in all categories.

Suicide Risk Factors in Youth

The following data are taken from the Youth Risk Behavior Surveillance System (YRBS), a survey that is given at public high schools across Wyoming, which monitors six types of health risk behaviors that contribute to the leading causes of death and disability.

Table 4. Wyoming Youth Suicidal Ideation and Behavior (Youth Risk Behavior Survey)

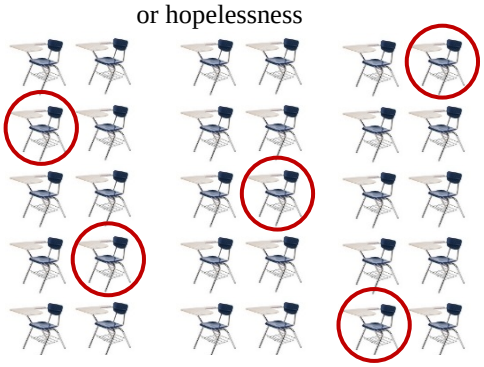
Category	2007	2009	2011	2013	2015
High School Students who **seriously considered attempting suicide** in last year	17.8%	17.3%	17.4%	16.7%	20.3%
High school students who **made a plan about how they would attempt suicide** in last year	17.8%	15.3%	14.2%	13.8%	18.2%
High school students **who attempted suicide** in last year	10.5%	9.4%	11.3%	8.6%	11.1%
High school students who **attempted suicide** in the last year that resulted in need to be **treated by a doctor**	4.2%	4%	4.9%	3.8%	4.1%
High school students with **Depression/hopelessness**	28.2%	26.9%	25.5%	27.2%	30.8%

This equates to approximately three in ten high school students who responded to the survey in 2015 have depression or hopelessness, one in five students seriously considered attempting suicide in the past year, one in six students made a suicide plan, and one in twenty students made a serious suicide attempt in the last year (Wyoming Department of Education, 2016).

Figure 5. Wyoming High School Students Self-Reported Rates (Youth Risk Behavior Survey)

3 in 10 high school students has depression or hopelessness

1 in 5 high school students a seriously considered attempting suicide



1 in 6 high school students has made a plan about how they would attempt suicide

1 in 20 high school students has attempted suicide

Suicide prevention efforts seek to reduce the factors that increase the risk for suicidal thoughts and behaviors and increase protective factors that help strengthen, support, and protect individuals from suicide. Risk factors are characteristic that make it more likely that a person will think about suicide or engage in suicidal behaviors (U.S. Department of Health and Human Services Office of the Surgeon General and National Alliance for Suicide Prevention, 2012). Risk factors for suicide among youth include substance abuse problems, family discord and dysfunction, sexual abuse, access to guns or prescription medication, school safety issues, and antisocial behaviors. Data on protective factors reflect that approximately one-third of high school seniors lack appropriate social skills, religiosity, or belief in a moral order, all of which can protect against suicidal behaviors (Wyoming Survey & Analysis Center, 2014). While the presence or absence of any single risk or protective factors is not predictive of suicide, these data are alarming.

Suicide Risk Factors in Adults

Suicide risk factors in adults include alcohol dependency and heavy drinking, marital status, employment and income stressors, retirement, physical illness/disability, mental health issues and military veteran status. Suicidal behaviors have drastically increased for male active-duty military personnel and veterans over the preceding decade, a problem receiving considerable attention and resources from the various military branches (Hyman, J et al., 2012). Unemployment has been show to increase risk of suicide in males by as much as 300% (Coleman, D, Kaplan, MS, Casey, JT., 2011). Wyoming's unemployment rate in 2015 averaged 4.1 which was lower than the 2015 national average of 5.2. The unemployment rate has since increased in Wyoming; the current unemployment rate (January – August 2016 average) is 5.36. This is higher than the current national average in 2016 of 4.9 (January – August 2016 average).

Table 5. Wyoming Adult Behavioral Risk Factors

Category	2011	2012	2013	2014	2015
Mental health, which includes stress, depression, and problems with emotions, **was not good** for 14 or more of the past 30 days	9.9%	10.3%	9.8%	10.4%	11.4%
Binge drinking at least once in past month	18.9%	17%	16.6%	17.2%	15.5%
Heavy drinking (60+ drinks for men; 30+ drinks for women) in past 30 days	6.6%	6%	5.8%	6.2%	5.8%
Extreme drinking (more than 10 drinks on one occasion in past 30 days)	4.9%	4.3%	5.1%	4.0%	3.4%
Driving after perhaps having **too much alcohol** at least once in past 30 days	*	2.2%	*	1.5%	*
Smoked at least 100 cigarettes in lifetime and currently smoking every day or somedays	23%	21.8%	20.6%	19.5%	19.2%
Physical health, which includes physical illness and injury, **was not good** for 14 or more days during the past 30 days	11.5%	11.1%	11.6%	10.3%	12.2%
Disability – adults limited in any way in any activities because of physical, mental, or emotional problems or they have a health problem that requires the use of special equipment such as a cane, wheelchair, special bed, or special telephone	25%	20.4%	21.7%	21.8%	24.0%

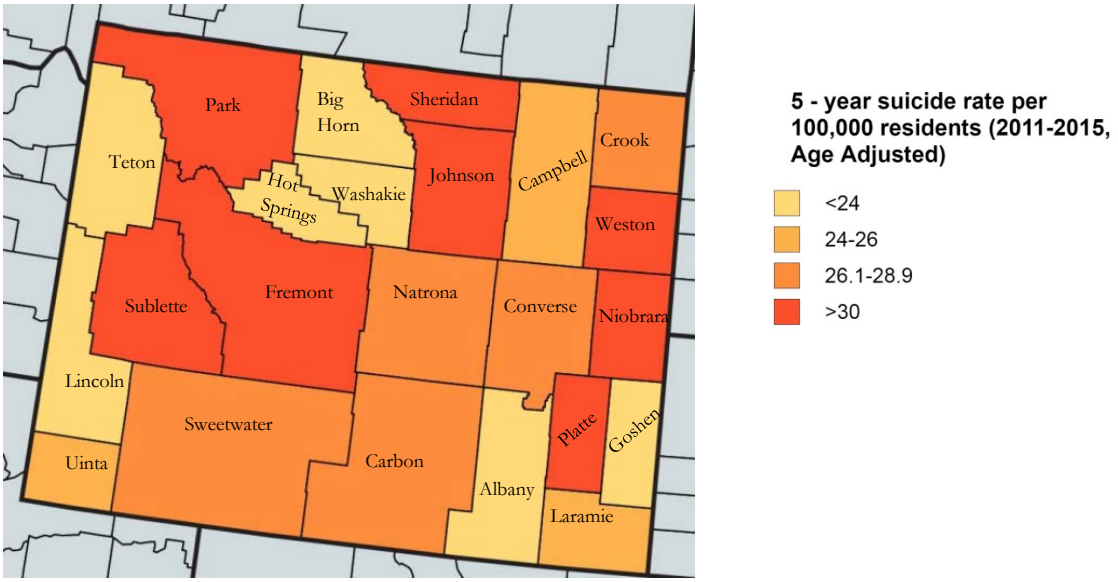
No health care coverage, which includes health insurance prepaid plans such as HMOs or government plans such as Medicare	21%	20.7%	19.5%	15.1%	14.4%
Unable to see a doctor for needed care because of the cost at least once in the past 12 months	15.1%	14.8%	14.2%	11.8%	12.1%

*Intervening years between data.

Wyoming Suicide Rates by County

Suicide rates vary by county across Wyoming. The lowest suicide rates from 2011 to 2015 in Wyoming are found in Washakie, Teton, and Goshen counties. The highest suicide rates are found in Sublette, Niobrara*, and Johnson counties (Wyoming Vital Statistics, 2016).

Figure 6. Age-Adjusted Suicide Rates by County in Wyoming, 2011-2015



*Caution should be used in the interpretation of vital statistic rates which are based on small population or a small number of events. For example, Niobrara rates have seen great fluctuations from year to year, but the numbers are very small.

Suicide and Race

The highest rate of suicides occurring in 2015 in Wyoming was among white residents. The second highest suicide rate was among blacks, which is unusual given the low rates in previous years. American Indian and Alaska Natives followed closely behind (Wyoming Vital Stastics, 2016).

Table 6. Age-Adjusted Suicide Rates by Race in Wyoming, 2015

Race	2011 Rate	2012 Rate	2013 Rate	2014 Rate	2015 Rate
All races	22.6	31.2	23.1	21.6	29.7
White	24.8	31.8	24.2	22.0	30.9
Black	9.5	0.0	0.0	0	16.1
American Indian/Alaska Native	0.0	65.6	12.5	19.7	12.3
Asian/Pacific Islander	0.0	0.0	0.0	0.0	7.4

*Rates per 100,000 and age-adjusted to the 2000 US standard Population

Suicide and Gender

Nationally, males die by suicide 3.5 times more often than women. In Wyoming that number is a little bit higher with the age-adjusted suicide rate in Wyoming being almost four times higher among the male population as compared to female population.

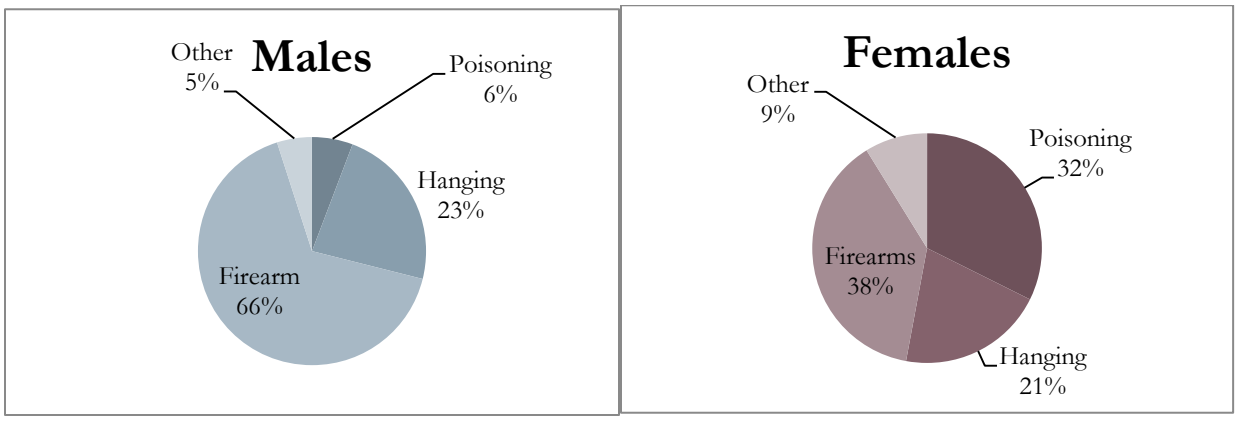
There are many factors that may play into the higher rate of males who die by suicide. One such factor may be that men are more likely than women to use a method that is likely to result in death.

Table 7. Age-Adjusted Suicide Rates by Gender in Wyoming, 2015

Gender	Rate
Male	47.0
Female	12.7
Total	29.7

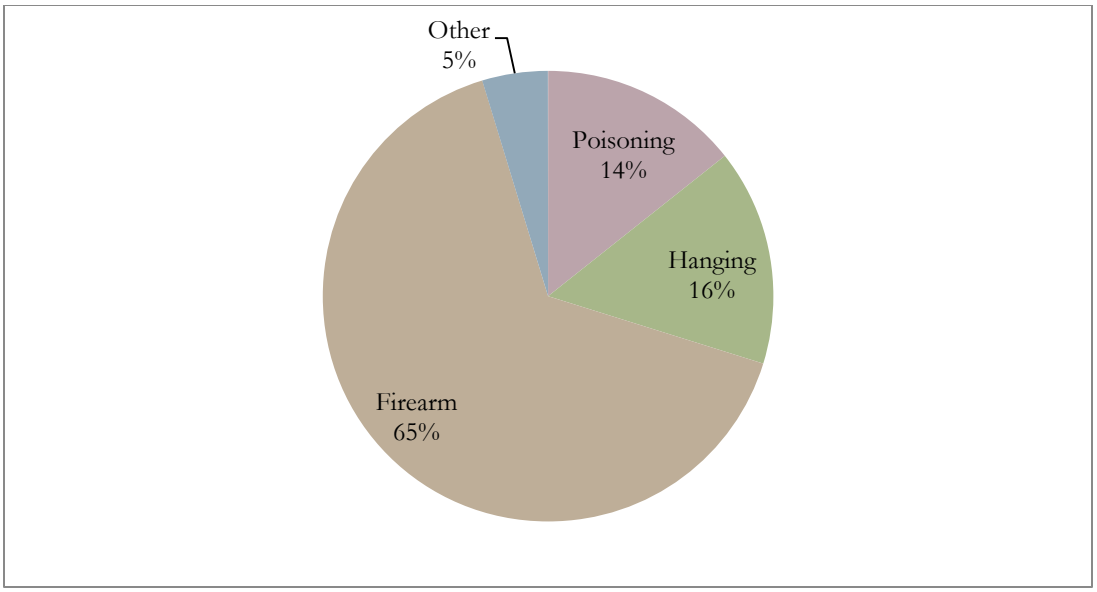
Of all Wyoming suicide deaths occurring in 2015, male suicide victims died by firearm in 66% of reported cases, woman suicide victims died by firearm in 38% of reported cases (Wyoming Vital Stastics, 2016).

Figure 7. Suicide Means in Wyoming by Gender, 2015



Firearms have consistently been the number one means of suicide deaths in Wyoming, making up 65% of all suicide deaths between 2007 and 2015 (Wyoming Vital Stastics, 2016).

Figure 8. Suicide Means in Wyoming, 2007-2015

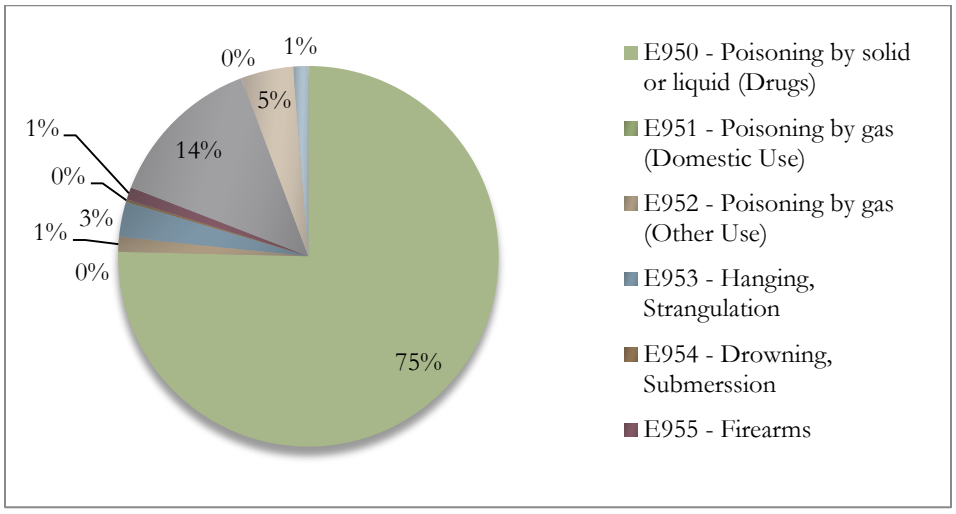


Wyoming residents are 10 times more likely to die by firearm from suicide than they are from homicide. Of all firearm deaths in Wyoming between 2010 and 2014, 86% were suicides, 8% were homicides, and 6% were unintentional injuries.

Hospitalizations for Self-Harm

Inpatient hospitalizations for self-harm were associated with costs of $6.4 million in Wyoming in 2014. Over 60% of inpatient hospitalization for self-harm occurred among women (Wyoming Discharge Data, 2014).

Figure 9. Inpatient Hospitalizations for self-harm, 2007-2015



A History of Suicide Prevention in Wyoming

The landscape of suicide prevention has changed significantly over the last two decades. Historically, suicide generally was considered exclusively a mental health issue. Beginning in the latter part of the twentieth century, there was a growing interest across the United States in addressing suicide as an important public health issue.

Late 1990s	• Wyoming Suicide Prevention Task Force was formed. The task force conducted gatekeeper trainings, convened suicide prevention meetings and conferences, and supported coalitions in some Wyoming counties. Informal suicide prevention efforts continued.
2005	• The Wyoming State Legislature created a dedicated suicide prevention program within the WDH through the adoption of Wyoming Statute §9-2-102. Efforts focused on raising awareness about the problem of suicide in Wyoming through various public outreach efforts and by providing annual community-based grants for local suicide prevention coalitions.
2006	• Wyoming received two successive rounds of competitive funding for youth suicide prevention from the Substance Abuse and Mental Health Services Administration (SAMHSA). Youth became the focus of much of the suicide prevention efforts. Prevention efforts included radio, newspaper, and television interviews, distributing brochures and other information relating to recognition of suicide warning signs, conducting suicide prevention and intervention skills trainings, maintaing a suicide prevention webpage, promoting responsible reporting of suicide death by the media. The task force became the Wyoming Suicide Prevention Advisory Council (WySPAC).
2009	• Department of Health began funding the Brief Intensive Treatment for Suicidal Individuals (BIT) pilot project in Park County, now known as the Family-Centered Brief Intensive Treatment (FC-BIT), which constitutes a treatment practice designed to help suicidal individuals in the least-restrictive community setting possible, thereby avoiding institutional placement and increased risk of suicide re-attempts.
2010	• WDH integrated suicide prevention with substance abuse prevention for community-based prevention services, which included all substance abuse prevention efforts other than tobacco prevention and control. Some funding for suicide prevention was included in the prevention portfolio provided to communities, but that funding was not sufficient to support the hiring of local staff for suicide prevention. Though in the beginning stages, the integration process engaged community prevention program managers to incorporate suicide as a priority problem to consider as part of their larger strategic planning.
2012	• WDH contracted with the Prevention Management Organization of Wyoming (PMO) to serve as a statewide, coordinated prevention system, with local program staff dedicating a portion of their time to suicide prevention. As a result, suicide prevention has been integrated into community level efforts taking place in all 23 counties, significantly improving community suicide prevention initiatives.
2013-Present	• The addition of a state director of suicide prevention and three full-time suicide prevention regional coordinators to work directly with communities has increased suicide prevention efforts. Each community has completed a comprehensive needs assessments, including collecting data on local suicide rates, risk and protective factors, and community readiness.

Current suicide prevention efforts in Wyoming reflect an overall philosophical shift across the country concerning the most effective model for prevention. Whereas prevention used to consist primarily of coordinating booths at health fairs, hanging posters in high schools, and providing individualized programs for selected groups of at-risk individuals, it now focuses on community-level (environmental) change. Prevailing prevention best practices seek to reduce dangerous and undesirable behaviors through the development of protocols and policies, and to reduce stigma by changing community norms around the issues of suicidality and mental health. Wyoming's substance abuse and suicide prevention practices are modeled after this public health approach to prevention, which emphasizes data-driven decision making for

strategic planning and program implementation, reliance on evidence-based programs and practices, and continuous evaluation.

Progress

As the rate of suicide nationwide continues to steadily climb, the suicide rate in Wyoming has remained relatively steady, a sign that the prevention efforts in Wyoming are working. Thousands of Wyoming residents have been trained using evidence-based suicide risk assessment and intervention models such as Applied Suicide Intervention Skills Training (ASIST); Question, Persuade, Refer (QPR); and SafeTALK. Additionally, Assessing and Managing Suicide Risk (AMSR) workshops for clinicians have been held across the state. In State Fiscal Year 2016 along, 11,569 Wyoming residents were trained. Not only do these trainings provide residents with the knowledge to help an individual at risk, we expect that they reduce the stigma surrounding suicidal thoughts and behaviors.

Make a Difference

There are so many ways that you can get involved to prevent suicide. Together we can reduce the annual suicide rate 20 percent by 2025.

1. Join suicide prevention efforts in your community. Anything from joining the local coalition to participating in suicide prevention events.
2. Raise awareness for suicide prevention. Be an advocate!
3. Attend suicide prevention training and encourage others to do the same.
4. Reduce stigma by talking about suicide. Be a safe person for someone to reach out to for help.
5. Become familiar with the warning signs and risk factors. Be on alert for anyone who exhibits signs of depression or warning signs for suicide, and get that person help.

Conclusion

For three decades, Wyoming's per capita suicide rates have been among the highest in the country. Despite the progress made over the last several years in building statewide capacity and enhancing suicide prevention and early intervention efforts in Wyoming, the data continues to indicate that suicide poses a significant public health challenge in the state. There is a profound need to continue to capitalize on and expand suicide prevention efforts.

The 2011-2017 Wyoming Suicide Prevention Plan provides the needed framework to enhance suicide prevention efforts and build new partnerships within the state while aligning Wyoming's initiatives with the broad-based strategies identified by experts and leaders across the county through the *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. Through existing and new collaborations, efforts to significantly reduce the rate of suicide and the subsequent toll on communities and families will be an important priority for leaders throughout the state.

Wyoming Suicide Prevention Plan

Suicide prevention requires a comprehensive and coordinated strategy across organizations throughout Wyoming. The Wyoming Department of Health, in collaboration with the Prevention Management Organization of Wyoming and the Wyoming Suicide Prevention Advisory Council, completed a coordinated statewide suicide prevention plan with specific state and regional benchmarks.

Wyoming's capacity for suicide prevention within each of the 23 counties in the state has continued to grow. The state plan was written with goals and objectives that align closely with the *2012 National Strategy for Suicide Prevention* and build upon the momentum for suicide prevention efforts at both the state and local levels to reduce the annual suicide rate 20% by 2025.

Strategy 1: Community Support and Involvement

Goal 1: Develop broad-based support for suicide prevention (National Goal 1).

Objective 1: Increase support for suicide prevention efforts by lawmakers, including state and local policy makers, business leaders, and public and private foundations.

Commitment 1.1: Hold a Wyoming Suicide Prevention event for state and other political leaders to unveil the 2017-21 state plan and garner support for suicide prevention efforts.

Commitment 1.2: Increase organizations that integrate suicide prevention into their ongoing programs and activities from 15 to 22.

Commitment 1.3: Increase and maintain strategic capacity by recruiting a broad range of engaged stakeholders to participate in the Wyoming Suicide Prevention Advisory Council (WySPAC).

Goal 2: Develop and implement community-based suicide prevention programs and activities (National Goal 5).

Objective 2: Support and develop community-based coalitions for suicide prevention intervention.

Commitment 2.1: Maintain and support local coalitions to increase capacity/readiness and sustainability.

Objective 3: Promote expertise and increased capacity for suicide prevention within school districts.

Commitment 3.1: Increase the number of school districts with accredited school Suicide Prevention Specialists on staff from 2 to 12.

Commitment 3.2: Increase the number of schools that provide evidence-based suicide prevention programs as part of their curricula from 4 to 14.

Commitment 3.3: Provide technical assistance and support for training and education of school personnel in suicide risk recognition and response.

Strategy 2: Increase Awareness

Goal 3: Promote awareness that suicide is a public health problem that is preventable (National Goal 2).

Objective 4: Develop media campaigns to raise awareness about suicide prevention.

Commitment 4.1: Develop and maintain statewide media campaign(s) with approval from WHD Director (including social media and websites) utilizing safe and positive messages to increase public and political support for suicide prevention activities.

Objective 5: Coordinate with other suicide prevention organizations in Wyoming to maximize efforts.

Commitment 5.1: Develop standard talking points and presentation slides for public awareness presentations on suicide prevention to identified community-based groups.
Commitment 5.2: Collaborate with other suicide prevention organizations to coordinate efforts and maximize the impact of suicide prevention awareness efforts statewide.
Commitment 5.3: Develop standard talking points and presentation slides for policy makers with a focus on developing industry resources.
Commitment 5.4: Provide targeted suicide prevention education and outreach via the internet.

Assessment: Assessment will be a key part of any media campaign to determine the effectiveness in raising awareness.

Strategy 3: Reduce Stigma

Goal 4: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services (National Goal 3).

Objective 6: Promote understanding that recovery is possible.

Commitment 6.1: Develop multi-media campaign(s) with approval from the WHD Director and/or awareness activities (to include social media) utilizing safe and positive messages to increase: a) help-seeking by at-risk individuals and family members, b) social acceptance of depression as a medical illness, c) public awareness that recovery is possible.

Goal 5: Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illness, and the safety of online content related to suicide (National Goal 4).

Objective 7: Maintain current level of media education around suicide, and provide resources as deaths occur.

Commitment 7.1: Educate media on appropriate reporting.

Assessment: Evaluate the effectiveness of campaign(s) on stigma via an established stigma survey.

Strategy 4: Reduce access to lethal means

Goal 6: Promote efforts to reduce access to lethal means and methods of self-harm among individuals with identified suicide risk (National Goal 6).

Objective 8: Collaborate and provide support for local gun shop owners and stakeholders to establish a lethal means reduction coalition.

Commitment 8.1: Provide education and support for gun shop owners, gun owners, hunter safety experts, and other stakeholders to establish coalition efforts that include suicide prevention initiatives.

Commitment 8.2: Develop and promote creating a safe home campaign.

Objective 9: Support safe prescribing standards and guidelines to prevent prescription drug abuse.

Commitment 9.1: Collaborate with the Wyoming Prescription Drug Abuse Prevention Stakeholders on prescribing initiatives.

Objective 10: Maintain, support, and expand prescription drug abuse prevention efforts.

Commitment 10.1: Collaborate with the Prescription Drug Abuse Prevention Stakeholders to support and expand prescription drug abuse prevention efforts.

Strategy 5: Increase training

Goal 7: Implement training for recognition of at-risk behavior and delivery of effective treatment (National Goal 7 & Goal 8).

Objective 11: Build statewide capacity for training across multiple levels and disciplines including a focus on cultural competency in diverse populations.

Commitment 11.1: Develop public-private relationships to support comprehensive statewide education and training strategies in suicide prevention.

Commitment 11.2: Public-Level Trainers – promote and support culturally competent training in evidence-based public-level suicide recognition and response education (e.g., QPR, Operation SAVE, and SafeTALK).

Commitment 11.3: Intervention-Level Trainers – promote and support culturally competent training in evidence-based intervention-level suicide recognition, response, and management education (e.g., ASIST< CIT/MHIT).

Objective 12: Provide culturally competent training to multiple audiences, including public, private, and faith-based organizations.

Commitment 12.1: Train at least 10% of the Wyoming adult population in suicide prevention recognition and response (~43,000 people) within a 5-year period.

Objective 13: Continue funding of suicide prevention as part of broader prevention efforts.

Objective 14: Assess current knowledge, training, and gaps in clinical services (to include cultural understanding of diverse populations) for treating individuals at risk for suicide in primary care, as well as in substance abuse and mental health care.

Commitment 14.1: Conduct and assess surveys of primary care providers (including psychiatrists) and mental health providers in Wyoming.

Objective 15: Assess and support current professional practices and cultural knowledge for assessing and treating those at risk for suicidal behaviors; promote effective treatment while being culturally sensitive to diverse needs including traditional healing practices.

Commitment 15.1: Provide education on best practice guidelines to effectively engage families and concerned others, when appropriate, through entire episodes of care for individuals with suicide risk.

Commitment 15.2: Offer evidence based training, such as Recognizing and Responding to Suicide Risk – Primary Care and Emergency Department to medical staff (especially physicians, PAs, and NPs).

Commitment 15.3: Provide Zero Suicide for healthcare training and support.

Commitment 15.4: Distribute the Western Interstate Commission for Higher Education (WICHE) suicide prevention toolkit for rural primary care to providers in Wyoming.

Commitment 15.5: Encourage adoption of the FC-BIT model of outpatient treatment for individuals (and their families) who have experience suicide thoughts and/or actions.

Strategy 6: Suicide Risk and Suicide Survivor Services

Goal 8: Increase key services for individuals at risk for suicide and suicide survivors (National Goal 9 & Goal 10).

Objective 16: Establish a statewide network of suicide survivors and support group leaders.

Commitment 16.1: Develop capacity for contacting and connecting suicide survivors across the state.

Commitment 16.2: Assist in building capacity for community postvention response and readiness in all Wyoming counties.

Objective 17: Collaborate with other suicide prevention organizations to maximize suicide survivor resources across the state.

Commitment 17.1: Develop a network of skilled, trained support groups for suicide survivors.

Commitment 17.2: Provide continuing education for support group leaders.

Objective 18: Collaborate with primary care facilities to incorporate suicide prevention and appropriate responses to individuals at risk for suicide

Commitment 18.1: Primary care training – promote and support culturally competent training in evidence-based intervention-level suicide recognition, response, and management (RRSR-PC, AMSR)

Commitment 18.2: Develop, promote, and implement standard guidelines for services for individuals at risk for suicide

Strategy 7: Data and Research

Goal 9: Improve and expand surveillance systems to collect suicide-related data (National Goal 11).

Objective 19: Coordinate the implementation of psychological autopsy research in Wyoming.

Commitment 19.1: Collect and analyze psychological autopsy data.

Objective 20: Standardize the collection and reporting of suicide attempt data throughput the medical systems.

Commitment 20.1: Coordinate with the State Medicaid Office to support PHQ-9 screening among primary care providers.

Commitment 20.2: Improve the usefulness and quality of suicide-related data.

Commitment 20.3: Collaborate with coroners to establish a suicide death review team to improve consistency in investigation and reporting of suicide deaths.

Goal 10: Support focused suicide prevention research projects (National Goal 12).

Objective 21: Develop and implement a comprehensive saturation model for suicide prevention

Commitment 21.1: Implement the Systems Approach / Comprehensive Rural Community Suicide Prevention Model, as proposed, in one county.

Objective 21: Evaluate the effectiveness of innovative early intervention programs.

Commitment 22.1: Utilize existing data and a follow up evaluation to determine the effectiveness of the Family-Centered Intensive Treatment approach to early intervention.

Objected 23: Support innovative research projects in suicide prevention in Wyoming.

Commitment 23.1: Collaborate with health science programs at the university and colleges in Wyoming to stimulate three (3) research projects in suicide prevention.

Goal 11: Evaluate the impact and effectiveness of suicide prevention.

Objective 24: Utilize data to identify suicide prevention activities that have the greatest impact in Wyoming.

Commitment 24.1: Identify new opportunities to collect and evaluate data on suicide prevention activities.

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