

# **The State of State Suicide Prevention: An Environmental Scan**

OSTLTS Generic Information Collection Request  
OMB No. 0920-0879

## **Supporting Statement – Section A**

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- **Purpose of the data collection:** The purpose of this information collection is to 1) identify characteristics of suicide prevention efforts in states, territories, and selected tribes that may account for differences in suicide rates and trends, and 2) obtain current information about suicide prevention activities in states, territories and tribes.
- **Intended use of the resulting data:** Information collected will be used by the Centers for Disease Control and Prevention (CDC) Division of Violence Prevention (DVP) to improve suicide prevention technical assistance to states, territories, and tribes and design new programs, or propose modifications to existing programs, that build on knowledge acquired regarding challenges and successes experienced by states, territories, and tribes in their efforts to address suicide.
- **Methods to be used to collect data:** The primary mode of collection will be a web-based survey. Suicide Prevention Coordinators who do not respond to the email invitation will be given the option to complete the instrument via phone interview as a method to encourage response.
- **Respondent Universe:** The respondent universe includes a total of 213 respondents operating in their official capacities including:
  - 71 state, territorial, and tribal (STT) suicide prevention coordinators within health and human services departments (e.g. departments of public health, human services, mental health/substance abuse, veterans affairs) across 50 states, 5 U.S. territories (i.e., Commonwealth of Northern Mariana Islands, American Samoa, Guam, Puerto Rico, U.S. Virgin Islands), 15 Tribes, and the District of Columbia (n=71);
  - 71 STT suicide prevention grant project directors, or other STT suicide prevention leaders or their designee, within health and human services departments across 50 states, 5 U.S. territories, 15 Tribes, and the District of Columbia (n=71); and
  - 71 suicide prevention leaders working for non-profit organizations or coalitions across 50 states, 5 U.S. territories, 15 Tribes, and the District of Columbia (n=71). These individuals are considered delegates under the OSTLTS OMB Clearance Center (O2C2) – OMB No. 0920-0879 generic mechanism. Delegates are governmental or non-governmental agents (agency, function, office, or individual) acting for a principal or submitted by another to represent or act on STLT government behalf.
- **How data will be analyzed:** Quantitative data will be examined for completeness and analyzed using descriptive statistics. To the extent that the data allow, tests of association will be used to examine relationships between survey items and to examine similarities and differences among subgroups of STTs. If feasible, relationships between STT suicide prevention efforts and state suicide rates will be examined. Content analysis will be used to identify themes in qualitative responses.

## Section A – Justification

### 1. Circumstances Making the Collection of Information Necessary

#### Background

This information collection is being conducted using the Generic Information Collection mechanism of the OSTLTS OMB Clearance Center (O2C2) – OMB No. 0920-0879. The respondent universe for this information collection aligns with that of the O2C2. Data will be collected from a total of 213 respondents operating in their official capacities including:

- 71 suicide prevention coordinators within health and human services departments across 50 states, 5 U.S. territories, 15 Tribes, and the District of Columbia;
- 71 suicide prevention grant project directors, or their designee, within health and human services departments across 50 states, 5 U.S. territories, 15 Tribes, and the District of Columbia; and
- 71 delegates across 50 states, 5 U.S. territories, 15 Tribes, and the District of Columbia. These organizations are considered delegates of the state, tribal, and U.S. territory health departments for the following reasons:

- As per 0920-0879 Generic ICR language, “delegates are governmental or non-governmental agents (agency, function, office or individual) acting for a principal or submitted by another to represent or act on STLT government behalf.” The delegates include STT suicide prevention leaders working for non-profit organizations, coalitions, commissions, taskforces or advisory groups . STT health agencies task these leaders to work on their behalf to fulfill essential public health services related to suicide prevention. Delegates are either mandated by legislation to work on behalf of the STT health agency or relationships are established via grants, contracts or memorandums of understanding (MOU).
- State, tribal, and U.S. territory health departments delegate to the above listed organizations the following essential public health services:
  - Educate and inform the community about suicide and suicide prevention;
  - Mobilize community partnerships to identify suicide problems and implement solutions for suicide prevention;
  - Develop suicide prevention and response policies and plans; and
  - Link individuals to needed mental health services
- Using these delegates, STT health departments are able to implement suicide prevention strategies, facilitate communication with stakeholder groups, and engage community members throughout their respective jurisdictions.

This information collection is authorized by Section 301 of the Public Health Service Act (42 U.S.C. 241). This information collection falls under the essential public health service(s) of

- 1. Monitoring health status to identify community health problems
- 2. Diagnosing and investigating health problems and health hazards in the community
- 3. Informing, educating, and empowering people about health issues
- 4. Mobilizing community partnerships to identify and solve health problems
- 5. Development of policies and plans that support individual and community health efforts
- 6. Enforcement of laws and regulations that protect health and ensure safety
- 7. Linking people to needed personal health services and assure the provision of health care when otherwise unavailable
- 8. Assuring a competent public health and personal health care workforce
- 9. Evaluating effectiveness, accessibility, and quality of personal and population-based health services
- 10. Research for new insights and innovative solutions to health problems<sup>1</sup>

Suicide is the 10th leading cause of death in the United States with rates on the rise since 1999<sup>2</sup>. In 2016, the year for which the most recent data are available, nearly 45,000 suicides occurred<sup>3</sup>. Suicide is just the tip of the iceberg, however, with millions of more people every year thinking seriously about suicide, making plans, attempts, and grieving the loss of a loved one. In 2001, the U.S. released the first National Strategy for Suicide Prevention (NSSP)<sup>4</sup>. The release of this document served as a catalyst for many states to begin their own strategic planning efforts. Since 2001, a range of other national suicide prevention activities have taken place, including funding of the National Suicide Prevention Resource Center (SPRC), an Institute of Medicine (IOM) report on reducing suicide (2002)<sup>5</sup>, the convening of the National Action Alliance for Suicide Prevention (NAASP), continuous funding of youth suicide prevention via the Garret Lee Smith Memorial Act (since 2005), enhanced efforts to prevent Veteran and Active Duty Military suicide, release of the second NSSP in 2012<sup>6</sup>, and expansion of the National Violent Death Reporting System (NVDRS), the first state-based surveillance system (created in 2002) that pools data on suicides from multiple sources from 40 states, D.C. and Puerto Rico into a usable, anonymous database. Despite these efforts, rates of suicide in the U.S. increased 25.3% between 2001 and 2016. During this time period, only Nevada saw rates decrease, while all other states reported increases. To provide an evidence-based resource to the field of suicide prevention aligned with the goals and strategies of the NSSP, CDC developed a technical package, *Preventing Suicide: A Technical Package of Policies, Programs, and Practices*, which was released in 2017<sup>7</sup>. However, little is known about state, territorial, and tribal (STTs) efforts, and their facilitators and barriers, toward implementation of suicide prevention strategies. Unanswered questions include – what is occurring at the STT level to account for increases in suicide rates and why do suicide rates vary so significantly from state to state (5.09/100,000 in D.C. to 26/100,000 in Montana in 2016<sup>2</sup>)?

In the early 2000's, CDC conducted an assessment of states to describe the key ingredients of successful state-based suicide prevention planning and implementation. The assessment's

major objectives included documenting the processes involved in developing state suicide prevention plans, compiling findings into a template for decision making based on lessons learned, and sharing findings with state groups engaged in creating suicide prevention plans and with those groups already implementing prevention activities. The assessment culminated in the 2001 publication *State Suicide Prevention Planning: A CDC Research Brief* (<https://www.cdc.gov/violenceprevention/pdf/state-suicide-prevention-planning-brief.pdf>). There has been no update to this assessment by CDC to date. With this information collection request, CDC proposes to conduct an environmental scan that will complement and build upon initial work and the work of partner agencies and groups.

The purpose of this information collection is to 1) identify characteristics of suicide prevention efforts in states, territories, and selected tribes that may account for differences in suicide rates and trends, and 2) obtain current information about suicide prevention activities in states, territories and tribes.

The CDC is partnering with Global Evaluation & Applied Research Solutions (GEARS) Inc., West Virginia University Injury Control Research Center (WVU ICRC), CSRA Inc., and consultant, Brigitte Manteuffel, Ph.D., to develop and implement this data collection. GEARS will be coordinating the overall project, including development of the data collection instrument (Word and web versions), OMB package, analysis plan, conducting data analysis and data reporting. WVU ICRC will provide suicide prevention subject matter and technical expertise. CSRA will support management of the data, including programming the web survey, managing databases, and will contribute to data analysis. Dr. Manteuffel will support development of the instrument, OMB package, analysis plan, and data analysis. The project is advised by a partner team comprised of suicide prevention leaders representing federal programs, national organizations, and universities. CDC's DVP will provide subject matter expertise and guidance throughout the project.

Information collected will be used by the Centers for Disease Control and Prevention (CDC) Division of Violence Prevention (DVP) to improve suicide prevention technical assistance to states, territories, and tribes and design new programs, or propose modifications to existing programs, that build on knowledge acquired regarding challenges and successes experienced by states, territories, and tribes in their efforts to address suicide.

### **Overview of the Information Collection System**

Data will be collected from a total of 213 respondents including 71 suicide prevention coordinators within health and human services departments across 50 states, 5 U.S. territories, 15 Tribes, and the District of Columbia; 71 suicide prevention grant project directors, or their designee, within health and human services departments across 50 states, 5 U.S. territories, 15 Tribes, and the District of Columbia; and 71 delegates such as suicide prevention coalition leaders or other suicide prevention organizations, all operating in their official capacities.

Data will be collected via a web-based survey (**see Attachment A—Instrument: Word version and see Attachment B —Instrument – Web version**). This method was chosen to reduce the overall burden on respondents. Using this data collection method will allow respondents to complete their responses electronically, answer the survey questions quickly, submit the responses to CDC with ease and complete the assessment in multiple sittings. Suicide Prevention Coordinators who do not respond to the email invitation will be given the option to complete the instrument via phone interview as a method to encourage response (**see Attachment H— Survey by Phone Script**) .

The web-based data collection instrument and survey by phone instrument were pilot tested by 4 public health professionals. Feedback from this group was used to refine questions as needed, ensure accurate programming and skip patterns and establish the estimated time required to complete the information collection instrument.

### **Items of Information to be Collected**

The web-based data collection instrument (and survey by phone instrument) consists of 54 questions of various types, including dichotomous (yes/no), multiple response, interval (rating scales), and open-ended questions. An effort was made to limit questions requiring narrative responses whenever possible. The web-based data collection instrument will collect information on the following 10 domains:

1. About your State, Territory, Tribe (8 questions)
  - Respondent jurisdiction, agency or organization, position, role, time in position and suicide prevention field
2. Suicide in your State, Territory, Tribe (5 questions)
  - Extent of problem, changes in suicide rates, data sources
3. State, Territory, Tribe Infrastructure (10 questions)
  - Office, staffing, budget, funding sources, activities supported, grants, goal achievement
4. State, Territory, Tribe Suicide Prevention Plan (5 questions)
  - Strategic plan history, development, updates, lead agency, use
5. Suicide Prevention Champions and Sectoral Engagement (4 questions)
  - Champions and sectors engaged
6. State, Territory, Tribe Legislation and Policies Promoting Suicide Prevention (2 questions)
  - Knowledge of suicide among decision makers, sources of information for legislators, types of legislation passed
7. Readiness for Suicide Prevention (2 questions)
  - Stage of readiness, capacity, community perceptions of suicide
8. Identified High Risk Populations and Risk Factors (5 questions)
  - At risk subpopulations, risk and protective factors addressed
9. Current Programs and Practices (4 questions)
  - Awareness and implementation of national strategies and goals
10. Barriers and Facilitators to Suicide Prevention (9 questions)
  - Broad range of barriers and facilitators, suicide clusters, natural disasters, opioid epidemic

## **2. Purpose and Use of the Information Collection**

The purpose of this information collection is to 1) identify characteristics of suicide prevention efforts in states, territories, and selected tribes that may account for differences in suicide rates and trends, and 2) obtain current information about suicide prevention activities in states, territories and tribes.

Information collected will be used by the Centers for Disease Control and Prevention (CDC) Division of Violence Prevention (DVP) to improve suicide prevention technical assistance to states, territories, and tribes and design new programs, or propose modifications to existing programs, that build on knowledge acquired regarding challenges and successes experienced by states, territories, and tribes in their efforts to address suicide.

## **3. Use of Improved Information Technology and Burden Reduction**

Data will be collected via web-based data collection instrument. This method was chosen to reduce the overall burden on respondents by allowing them to complete and submit their responses electronically. The data collection instrument was designed with particular focus on streamlining questions to allow for skipping based on respondent group and to collect the minimum information necessary for the purposes of this project (i.e., limited to 54 questions).

## **4. Efforts to Identify Duplication and Use of Similar Information**

Since the early 2000's when CDC conducted an assessment of states to describe the key ingredients of successful state-based suicide prevention planning and implementation, no new assessments have been done to collect information from states about their suicide prevention activities. Although one assessment on the use of the 2012 NSSP goals and strategies, was conducted by the National Action Alliance for Suicide Prevention in 2014, it did not collect the same information and did not collect information directly from states, or from territories or tribes<sup>8</sup>. The information that will be gathered through this information collection is not available from other data sources or through other means. A review of the literature and consultation with CDC staff and the project's partner advisory group (state, national agency, foundation, and academic leaders in suicide prevention) confirmed that this information collection is not duplicative.

## **5. Impact on Small Businesses or Other Small Entities**

No small businesses will be involved in this information collection.

## **6. Consequences of Collecting the Information Less Frequently**

This request is for a one-time data collection. There are no legal obstacles to reduce the burden. If no data are collected, CDC will be unable to:

1. Identify characteristics of suicide prevention efforts in states, territories, and selected tribes that may account for differences in suicide rates and trends.
2. Obtain current information about suicide prevention activities in states, territories and tribes
3. Improve CDC suicide prevention technical assistance to states, territories, and tribes with efforts to reduce suicide rates
4. Design new programs, or propose modifications to existing programs, that build on knowledge of the challenges and successes experienced by states, territories, and tribes in their efforts to address suicide prevention

## **7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5**

There are no special circumstances with this data collection package. This request fully complies with the regulation 5 CFR 1320.5 and will be voluntary.

## **8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency**

This data collection is being conducted using the Generic Information Collection mechanism of the OSTLTS OMB Clearance Center (O2C2) – OMB No. 0920-0879. A 60-day Federal Register Notice was published in the Federal Register on April 27, 2017, Vol. 82, No. 80, pp 19371-19373. One non-substantive comment was received. CDC sent forward the standard CDC response.

CDC partners with professional STLT organizations, such as the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the National Association of Local Boards of Health (NALBOH) along with the National Center for Health Statistics (NCHS) to ensure that the collection requests under individual ICs are not in conflict with collections they have or will have in the field within the same timeframe.

## **9. Explanation of Any Payment or Gift to Respondents**

CDC will not provide payments or gifts to respondents.

## **10. Protection of the Privacy and Confidentiality of Information Provided by Respondents**

The Privacy Act does not apply to this data collection. STLT governmental staff and / or delegates will be speaking from their official roles.

All information will be kept on secure, password protected CDC servers accessible only to project team members. Data collected during the assessment will be shared only in aggregate form.

This data collection is not research involving human subjects.

## **11. Institutional Review Board (IRB) and Justification for Sensitive Questions**

No information will be collected that are of personal or sensitive nature.

## **12. Estimates of Annualized Burden Hours and Costs**

The estimate for burden hours is based on pilot tests by 4 public health professionals. As the instrument will be offered to different respondent groups and via different modes, the details of each pilot test by group and instrument are detailed below:

### **Web-based Survey**

*Pilot Test 1: STT Suicide Prevention Coordinators (Questions 1-54)*

The average time to complete the instrument including time for reviewing instructions, gathering needed information and completing the instrument, was approximately 25 minutes (range: 20–30 minutes). For the purposes of estimating burden hours, the upper limit of this range (i.e., 30 minutes) is used.

*Pilot Test 2: STT Suicide Prevention Grant Project Directors Delegates: (Questions 1-8 and questions 24-54)*

The average time to complete the instrument including time for reviewing instructions, gathering needed information and completing the instrument, was approximately 20 minutes (range: 15–25 minutes). For the purposes of estimating burden hours, the upper limit of this range (i.e., 25 minutes) is used.

### **Telephone-based Survey**

*Pilot Test 3: STT Suicide Prevention Coordinators (Questions 1-54)*

When completing the survey by phone, the average time to complete the instrument was approximately 25 minutes (range: 20–30 minutes), For the purposes of estimating burden hours, the upper limit of this range (i.e., 30 minutes) is used.

Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) Bureau of Labor Statistics for occupational employment for Administrative Service Managers (11-3011) and Social and Community Service Managers (11-9151) [http://www.bls.gov/oes/current/oes\\_nat.htm](http://www.bls.gov/oes/current/oes_nat.htm). Based on DOL data, an average hourly wage of \$47.56 is estimated for STT suicide prevention coordinators, and \$34.07 for STT suicide prevention grant project directors, or their designee, and delegates. Table A-12 shows estimated burden and cost information.

**Table A-12:** Estimated Annualized Burden Hours and Costs to Respondents

<b>Data collection Instrument : Form Name</b>	<b>Type of Respondent</b>	<b>No. of Respondents</b>	<b>No. of Responses per Respondent</b>	<b>Average Burden per Response (in hours)</b>	<b>Total Burden Hours</b>	<b>Hourly Wage Rate</b>	<b>Total Respondent Costs</b>
Suicide Prevention Web-based Survey	STT Suicide Prevention Coordinators	63	1	30/60	32	\$47.56	\$ 1,522
	STT Suicide Prevention Grant Project Directors	71	1	25/60	30	\$34.07	\$1,022
	Delegates	71	1	25/60	30	\$34.07	\$1,022
Suicide Prevention Telephone-based Survey	STT Suicide Prevention Coordinators	8	1	30/60	4	\$47.56	\$190
	<b>TOTALS</b>	<b>213</b>	<b>1</b>		<b>96</b>		<b>\$3,756</b>

### 13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers

There will be no direct costs to the respondents other than their time to participate in each data collection.

### 14. Annualized Cost to the Government

There are no equipment or overhead costs. Contractors (GEARS, WVU ICRC, CSRA, & consultant) are being used to support the following tasks: to develop the data collection instrument and OMB package, plan and implement the data collection, and perform data analysis. The only cost to the federal government would be the salary of CDC staff and contractors. The total estimated cost to the federal government is \$601,545.00. Table A-14 describes how this cost estimate was calculated.

**Table A-14:** Estimated Annualized Cost to the Federal Government

Staff (FTE)	Average Hours per Collection	Average Hourly Rate	Total Average Cost
<b>CDC Staff</b>			
Health Scientist (GS-13-1): Support the development of the instrument, pilot testing, review and oversee OMB package preparation, data analysis, and report preparation	360	\$42.31/hour	\$15,231.60
Behavioral Scientist / Science Officer (GS-13-7): Support the development of the instrument, pilot testing, review and oversee OMB package preparation, data analysis, and report preparation	360	\$52.69/hour	\$18,968.40
<b>Contractors</b>			
GEARS, Inc.	736	Contractor Sub-total: \$331,408	
West Virginia University Injury Control Research Center (WVU ICRC)	360	Contractor Sub-total: \$77,269	
CSRA Inc.	250	Contractor Sub-total: \$67,377	
Brigitte Manteuffel, PhD	383	Contractor Sub-total: \$91,291	
<b>Estimated Total Cost of Information Collection</b>			<b>\$601,545.00</b>

**15. Explanation for Program Changes or Adjustments**

This is a new data collection.

**16. Plans for Tabulation and Publication and Project Time Schedule**

Data collection using EpiInfo will take approximately 4 weeks to complete. Once the data collection period for the web-based assessment has closed, GEARS contractor staff with CDC security clearance will manage the cleaning and analysis of the data collected via the Epi Info 7 Web Survey system (EIWS). Data analysis will be performed using one or more of the statistical components available in EpiInfo including Classic Analysis, Visual Dashboard, and StatCalc. Data will be reviewed for completeness, and simple descriptive statistics will be run to examine response frequencies for quantitative data. Depending on the response distributions, frequencies may be cross-tabulated or correlated to examine similarities and differences among responses and respondent subgroups. Frequency data will be tabulated by type of jurisdiction, or other subgroups (e.g., grouped by region, by suicide rates or changes in rates, update/not updated suicide prevention plans, high or low readiness). If feasible, statistical relationships between groups of respondents will be examined. Content analysis will be used to identify themes in qualitative responses.

All data will be stored on a CDC secure network environment. Data will not be exposed to unsecured external environments nor available to non-approved users.

Aggregated results of the scan will be documented in a formal report, translated for lay audiences, presented as a conference abstract, and written up as a peer-reviewed journal article. This information will be communicated to the public, to public and mental health professionals, and to states and communities via our CDC website, partner networks (National Action Alliance for Suicide Prevention, American Foundation for Suicide Prevention, Suicide Prevention Resource Center, social media (Twitter, Facebook), and professional meetings and publications.

The timeline is consistent with other state vital statistics report timelines.

Project Time Schedule

- ✓ Design instrument ..... (COMPLETE)
- ✓ Develop protocol, instructions, and analysis plan ..... (COMPLETE)
- ✓ Pilot test instrument ..... (COMPLETE)
- ✓ Prepare OMB package ..... (COMPLETE)
- ✓ Submit OMB package ..... (COMPLETE)
- OMB approval ..... (TBD)
- Administer web-based assessment ..... (Open 4 weeks)
- Clean and analyze web-based information..... (2 months)
- Prepare summary report(s) ..... (2.5 months)
- Disseminate results/reports ..... (3.5 months)

**17. Reason(s) Display of OMB Expiration Date is Inappropriate**

We are requesting no exemption.

**18. Exceptions to Certification for Paperwork Reduction Act Submissions**

There are no exceptions to the certification. These activities comply with the requirements in 5 CFR 1320.9.

**LIST OF ATTACHMENTS – Section A**

Note: Attachments are included as separate files as instructed.

- A. Attachment A – Instrument: Word Version**
- B. Attachment B – Instrument: Web Version**

## REFERENCE LIST

1. Centers for Disease Control and Prevention (CDC). "National Public Health Performance Standards Program (NPHPSP): 10 Essential Public Health Services." Available at <http://www.cdc.gov/nphpsp/essentialservices.html>. Accessed on 8/14/14.
2. Web-based Injury Statistics Query System. <https://www.cdc.gov/injury/wisqars/fatal.html>
3. National Drug Use and Health Report <https://www.samhsa.gov/samhsa-data-outcomes-quality/major-data-collections/reports-detailed-tables-2016-NSDUH>
4. U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and Center for Mental Health Services. National Strategy for Suicide Prevention: Goals and Objectives for Action. Rockville (MD): US Public Health Service, 2001. <https://www.ncbi.nlm.nih.gov/books/NBK44281/>
5. Institute of Medicine. 2002. Reducing Suicide: A National Imperative. Washington, DC: The National Academies Press. <https://doi.org/10.17226/10398>. <https://www.nap.edu/catalog/10398/reducing-suicide-a-national-imperative>
6. U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC: HHS, September 2012. <https://www.ncbi.nlm.nih.gov/books/NBK109917/>
7. Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., and Wilkins, N. (2017). Preventing Suicide: A Technical Package of Policies, Programs, and Practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
8. Substance Abuse and Mental Health Services Administration: National Strategy for Suicide Prevention Implementation Assessment Report. HHS Publication No. SMA17-5051. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2017.