2020

Tennessee Department of Health: Suicide Prevention Report

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Acknowledgements

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Executive Summary

The Suicide Prevention Act of 2018 (T.C.A. § 68-3-703) recognizes suicide as a serious public health issue in Tennessee and provided authorization for a suicide prevention program to be created within the Department of Health. The goal of the suicide prevention program is to review existing data and resources to identify promising practices and gaps in services for preventing suicide. This report describes deaths by suicide in Tennessee, along with the demographic characteristics of those deaths. The report also describes emergency department and hospitalization visits for suicide attempt and ideation. Through a comprehensive review of data and resources, along with input from key stakeholders, this report identifies specific opportunities for prevention of deaths by suicide. Below are key findings and recommendations:

Key Findings: Suicide Fatalities in Tennessee

- The total number of deaths by suicide increased by 23% from 2014 to 2018 (945 vs. 1,159 deaths). The rate of deaths by suicide increased by 19% from 2014 to 2018 and remains 16% higher than the national rate in 2018.
- In 2018, the suicide death rates were highest among adults aged 25-64 (22.5 per 100,000) and lowest in children/youth aged 10-24 (10.7 per 100,000).
- Seventy-six percent of suicide decedents in 2018 were males (26.8 per 100,000) and 24% were females (7.9 per 100,000).
- Ninety-one percent of suicide deaths in 2018 were among white individuals and the rate for Whites (19.8 per 100,000) was over twice that of Blacks (8.0 per 100,000).
- Firearms accounted for 60% of all 2018 suicide deaths in Tennessee.
- The burden of suicide varied across Tennessee regions with Shelby County having the lowest rate and Upper Cumberland having the highest (9.6 vs. 21.4 per 100,000 population) for 2014-2018 combined.

Key Findings: Suicidal Ideation and Suicide Attempts in Tennessee

- In 2018, there were 7,854 emergency department (ED) visits and 2,648 inpatient hospitalizations for nonfatal intentional self-harm injuries. In addition, there were 28,104 ED visits and 12,187 inpatient hospitalizations with suicidal ideation but no accompanying self-harm injury.
- For 2016-2018, females accounted for 61% of all ED visits for nonfatal intentional self-harm injuries in Tennessee with poisoning as the most common method of injury.
- From 2016 to 2018, white individuals experienced higher rates of nonfatal intentional self-harm injury and suicidal ideation than black individuals, though this gap was narrower than that seen for suicide deaths.

- The total cost associated with ED visits and hospitalizations for nonfatal intentional self-harm injury in 2018 was over $150 million, and the total cost for suicidal ideation-related ED visits and hospitalizations was over $500 million.

Key Findings: 2019 Suicide Prevention Needs Assessment Stakeholder Survey

- Sixty-two percent of survey respondents reported that individuals served by their organization face barriers in receiving suicide prevention services.

- Only 55% of respondents said they have screening/assessment policies in place in their affiliated organizations.

- Key themes for prevention from survey respondents included a need for better mental health insurance coverage, increased awareness of suicide prevention training, implementation of standardized screening in primary care and pediatric offices, increased need for treatment services specifically for children and young adults, increased access to mental health services, including crisis and treatment, particularly in rural areas, and increased efforts to reduce the impact of adverse childhood experiences.

Summary of 2020 Recommendations

Legislative Policies

- Hospitals in Tennessee should be required to report into the ESSENCE database
- Mental health facilities across the state should comply with legislation that allows mental health records of patients who have died by suicide to be shared with medical examiners and state fatality review programs
- Health insurers in Tennessee should comply with the rules and requirements of the Mental Health Parity and Addiction Equity Act

State and Community Agencies

- Increase access to adequate mental health care for all Tennesseans
- Expand awareness of suicide and encourage help-seeking behavior
- Support the widespread use of standardized behavioral health assessment protocols and tools
- Increase funding to strengthen the crisis response infrastructure within Tennessee, with particular emphasis on children and rural communities across the state
- Develop a centralized Tennessee Suicide Prevention Resource directory
- Support suicide prevention programs and training

Clinics and Hospital Systems

- Maintain “suicide safe” facilities
- Increase the use of certified peer recovery specialists or other paraprofessionals in appropriate crisis, treatment, and recovery support settings
- Promote the integration of primary care and behavioral health care to increase access to behavioral health services in primary care settings

Healthcare Providers

- Provide education to all patients on the signs of suicide
- Obtain training on depression and anxiety screening, suicide risk assessment, safety planning, and lethal means counseling
- Collaborate with mental health centers to ensure patients receive appropriate mental health referrals, follow-up, treatment, and care
- Counsel gun owners on safe firearm storage practices

Public Safety and Emergency Response Agencies

- Increase collaboration between law enforcement and other emergency response agencies in responding to a suicidal event or mental health crisis
- Promote partnerships between behavioral healthcare facilities, local law enforcement, local transportation agencies, and local emergency medical services to expand the Crisis Assessment and Response to Emergencies Program
- Encourage local law enforcement agencies, local fire departments, and local EMS agencies to create work environments that are safe, protective, and supportive of their staff members

Educational Institutions

- Incorporate suicide prevention education into school curricula
- Increase the availability of mental health screening and services provided in schools
- Provide training opportunities for mental health and suicide prevention to students, school teachers, school support staff, and other adults that interact with children and youth
- Implement mental health and suicide prevention programs within elementary school classrooms and peer-to-peer suicide prevention support programs within middle and high schools

Individuals, Families, and Friends

- Seek care with the earliest symptoms of depression or signs of suicide
- Complete suicide prevention gatekeeper trainings to learn the risk factors, how to reach out for help and how to respond appropriately to someone at risk for suicide
- Encourage conversations of suicide prevention awareness within the community

Key Definitions

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

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

Introduction

Suicide is a leading cause of death across the United States and continues to be a growing public health problem in Tennessee. The effect of suicide on individuals, families, friends, and communities is long-lasting and profound. In 2018, there were 48,344 suicide deaths in the United States, at a rate of 14.8 per 100,000 person population[1]. While suicide can affect persons of any age, race, gender, or socioeconomic background, the rate of suicide death across the nation is higher among certain groups than others. Across the U.S., there is a higher rate of suicide deaths among men, non-Hispanic Whites, non-Hispanic Alaska Native/American Indians, and veterans and other military personnel[1]. There are also significantly higher rates of suicide for those who work in certain occupations such as, but not limited to, doctors, nurses, veterinarians, dentists, and those that work in construction or production[2]. In 2018, suicide was the second leading cause of death among Americans aged 10 to 34 years [1].

Unfortunately, suicide death data only highlights a small fraction of individuals across the nation impacted by suicide or suicide-related behavior. In fact, for every suicide death in the United States, there are approximately twenty-five more individuals across the nation who will attempt suicide, and an even larger number of people who suffer with suicidal ideations. In 2018, 10.7 million Americans seriously considered suicide, 3.3 million Americans had a suicide plan, and 1.4 million Americans made a non-fatal suicide attempt[3]. Suicide and suicide-related behavior are responses to multiple internal risk factors (e.g. depression, family history of mental illness or suicide, or substance abuse) and external risk factors (e.g. lack of social support, financial stress, or lack of access to behavioral health care.). To reduce the number of people across the nation and across Tennessee who attempt or die by suicide, we must offer support, protection, and care throughout the community, rather than leaving it to be the responsibility of healthcare systems alone.

Through continued data collection and analysis, Tennessee Department of Health (TDH) aims to improve suicide prevention efforts across the state by; continuing to work collaboratively with multiple state and local agencies; supporting the expansion of current suicide prevention programs and policies offered throughout the state; and utilizing data-driven approaches to develop and implement innovative initiatives targeting those most at risk for suicide.

The purpose of the 2020 Suicide Prevention Report is to:

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

[1] CDC. Suicide Deaths. Available from https://www.cdc.gov/injury/wisqars/index.html

[2] CDC, Morbidity and Mortality Weekly Report, Vol. 67, No. 45, Available from https://www.cdc.gov/mmwr/volumes/67/wr/mm6745a1.htm?s_cid=mm6745a1_w

[3] SAMHSA. 2018 National Survey of Drug Use and Health (NSDUH). Key Substance Use and Mental health Indicators in the U.S. Available from http://www.samhsa.gov/data/release/2018-national-survey- drug-use-and-health-nsduh-releases

Background

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

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

- Providing data on suicide attempts and death to inform prevention efforts utilizing multiple data sources
- Coordinating and participating in collaborative meetings in a variety of settings across sectors
- Providing QPR trainings to internal staff in TDH and members of the community
- Promoting available suicide prevention resources, programs, and services

In 2018, in response to increasing rates of suicide across the state, the Tennessee General Assembly enacted the "Suicide Prevention Act of 2018". This Act provided TDH an opportunity to create a suicide prevention program to increase the department's capacity to provide data-driven recommendations and support the implementation of statewide suicide prevention strategies and programs.

Suicide Prevention Act of 2018

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

1. Compile existing data on suicide deaths
2. Review existing resources and programs related to suicide prevention
3. Identify evidence-based or promising practices related to the prevention of suicide
4. Convene relevant stakeholders to review existing data and existing programs and resources and identify opportunities to improve data collection, analysis and programming
5. Submit a report to the general assembly no later than June 30, 2020, and by June 30th every two years thereafter, recommending any necessary programs or policies to prevent suicide deaths in Tennessee

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

Suicide Prevention Program Overview

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

- Formed the Suicide Prevention Stakeholder Task Force Team, a diverse group of professionals with broad representation across all state and local sectors in Tennessee. Task force members are comprised of individuals who work in healthcare organizations, behavioral health care organizations, law enforcement, community-based organizations, emergency response, faith-based organizations, higher education institutions, substance abuse treatment facilities, crisis services, military and veteran affairs, and local schools. Multiple statewide agencies represented in the task force include TSPN, TDMHSAS, Tennessee Department of Education (TDE), the Tennessee Department of Agriculture (TDA), and the Tennessee Commission on Aging and Disability (TCAD). From January 2019 to March 2020, the Team convened five times to discuss suicide ideation, attempts, and death, at-risk populations, suicide prevention practices in healthcare organizations, and suicide response protocols. The task force also advised on recommendations put forth in this report.

- Developed a needs assessment survey for stakeholders in suicide prevention. One of the first requests of the Task Force was the development of a statewide survey to gain insight to: identify gaps in mental health and suicide prevention programs; determine the type of support needed for individuals at-risk for suicide; and assess statewide collaborations among suicide prevention agencies. The 25-minute survey was distributed throughout the entire month of September 2019 to mental health professionals, health professionals, school personnel, higher education representatives and others with an interest in suicide prevention. Data from 281 respondents are reflected in this report.

- Conducted weekly surveillance of suicide-related emergency department visits in children aged 18 and under. The visits were monitored using the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) software, a database with data on emergency department visits for a suicide attempt, intentional self-harm, or thoughts of suicide.

- Developed a model for rapid prevention response using surveillance data from ESSENCE. The rapid prevention response plan assists state and local partners to target areas in the state showing increased emergency department visits for suicide-related behavior in children 18 and under. The plan includes increasing awareness and offer suicide prevention resources, services, and programs within a county seeing increases in near real time.

- Participated in a National Child Safety Learning Collaborative (CSLC) through the Children's Safety Network. This collaborative aimed to spread Question, Persuade, and Refer (QPR) suicide prevention gatekeeper trainings to youth impactors across the state. Through our work in the CSLC and in partnership with TSPN, 142 gatekeeper trainings have been provided to 4,666 youth impactors across the state since January 2019.

- Partnered with the TDH Rape Education Program to provide QPR trainings to staff members in organizations that provide services to survivors of sexual assault and intimate partner violence.

- Partnered with TCAD to provide Question, Persuade, Refer (QPR) trainings to Family Caregiver Support Coordinators across the state.

- Coordinated a *Be the One Suicide Prevention Workforce Campaign* Train the Trainer session for selected TDH employees in both central and regional health offices in an effort to create a supportive and protective workplace culture for all TDH employees.

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

- Leading the Suicide Prevention Stakeholder Task Force team to review data and services on suicide-related behavior and provide opportunities for improving suicide prevention strategies in Tennessee.

- Identifying populations (e.g. occupational groups) who are most at-risk for suicide and identifying prevention strategies to be implemented for those vulnerable populations.

- Analyzing suicide-related data from various sources, including child death review, maternal mortality review, national violence death reporting system (NVDRS) and vital records, to inform data-driven suicide prevention policies, programs, and services.

- Performing weekly surveillance of suicide-related emergency department visits in children aged 18 and under, and expanding ESSENCE surveillance to other age groups across the lifespan.

- Developing and implementing rapid prevention response plans for all Tennesseans using ESSENCE surveillance to help state and local partners target high-risk populations and areas in the state more effectively.

- Participating in the CLSC's Suicide and Self-Harm Collaborative team to train youth impactors across the state in QPR.

- Partnering with state and local agencies to implement data-driven suicide prevention strategies.

- Implementing the Be the One Suicide Prevention Workforce Campaign in TDH by providing trainings to employees.

- Serving as a member on key advisory and stakeholder groups.

- Providing suicide prevention reports and fact sheets to key stakeholders throughout Tennessee.

Impact of Suicide in Tennessee: Data Overview

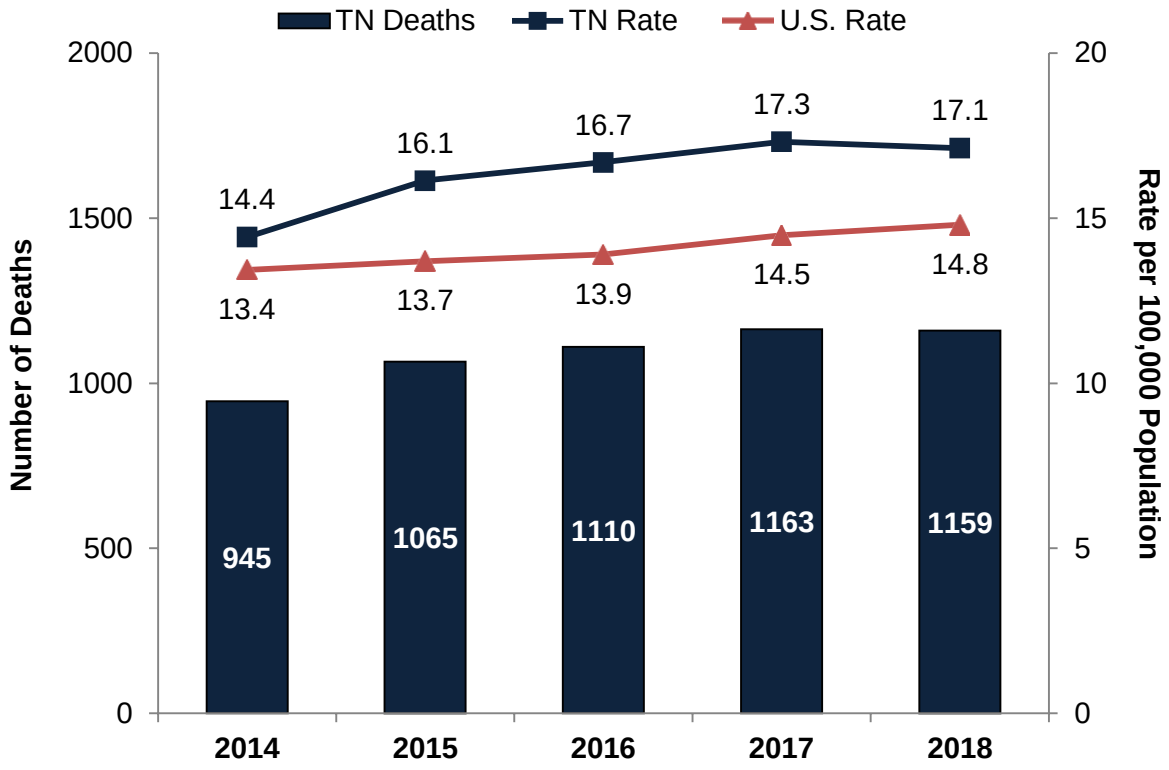
To fully understand the impact of suicide in Tennessee and improve prevention efforts, we must continually review suicide-related data to identify the groups of people most at-risk for suicide. This section includes data on suicide fatalities, suicidal ideation, suicide attempts, and suicide-risk factors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

Suicide Fatalities

Number and Rate of Suicide Deaths

In 2018, 1159 people in Tennessee died from suicide resulting in a suicide rate of 17.1 deaths per 100,000 person population. Within the past five years, Tennessee's suicide rate (deaths per 100,000 people) increased by 19%, from 14.4 deaths in 2014 to 17.1 deaths in 2018 (**Figure 1**). Over the past five years, Tennessee's suicide death rate has remained higher than the average national rate (**Figure 1**). In 2018, Tennessee's suicide rate (17.1 deaths per 100,000 person population) was 16% higher than the national average rate (14.8 deaths per 100,000 person population).

Figure 1: Number and rate of suicide deaths per 100,000 person population, Tennessee and United States, 2014-2018

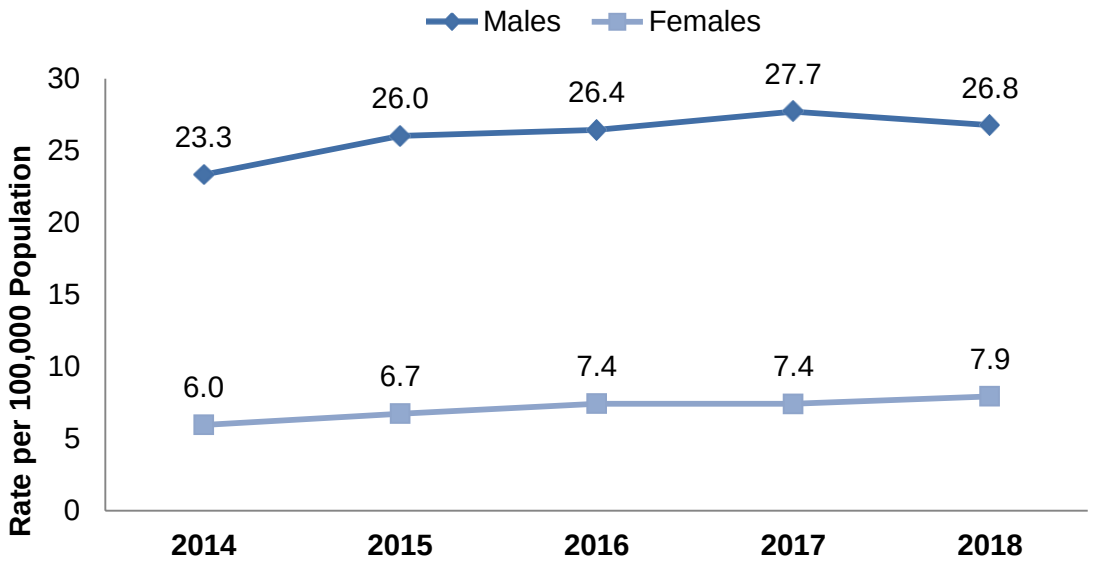


Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File, 2014-2018.

Sex/Gender

Males have over three times the rate of suicide death compared to females. In 2018, the suicide death rate for males in Tennessee was 26.8 deaths per 100,000 males compared to 7.9 deaths per 100,000 females (**Figure 2).** Although the burden of suicide death is higher among Tennessee males, over the five-year span (2014 through 2018) shown here, suicide death rate increased more among Tennessee females (32%) than males (15%).

Figure 2: Gender-specific suicide rate, Tennessee, 2014-2018

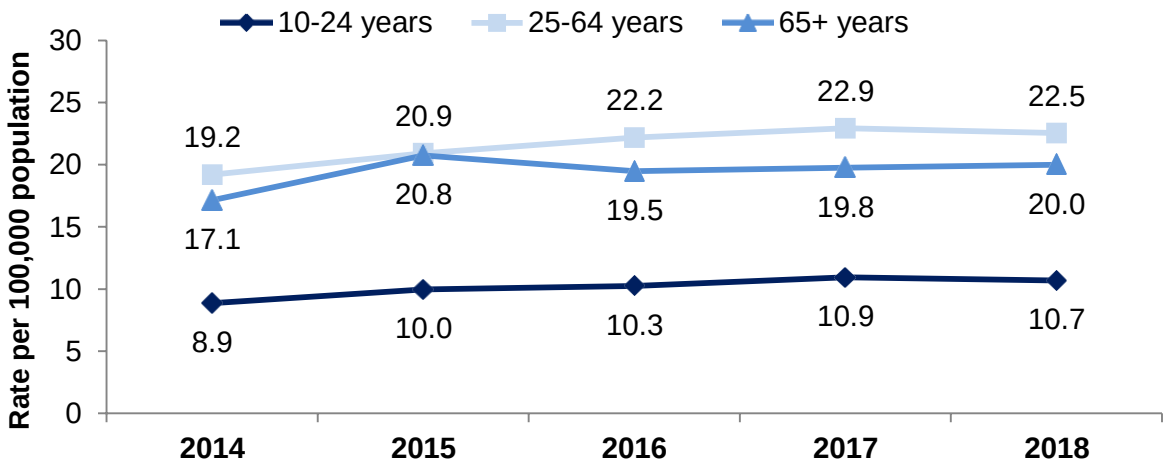


Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File, 2014-2018.

Age

he burden of suicide death varied across age groups and gender. Suicide has increased across all age groups over the last five years. Individuals aged 25-64 had the highest rate of suicide death in 2018 (22.5 deaths per 100,000 person population); (**Figure 3**). Also, as the population ages, the gender gap in suicide also widens. Males aged 65 years and older had at least six times higher suicide death rates than females of the same age group. Among adults aged 25 to 64 years, however, males had a three-fold higher rate of suicide death than females.

Figure 3: Rate of suicide deaths by age group, Tennessee, 2014-2018

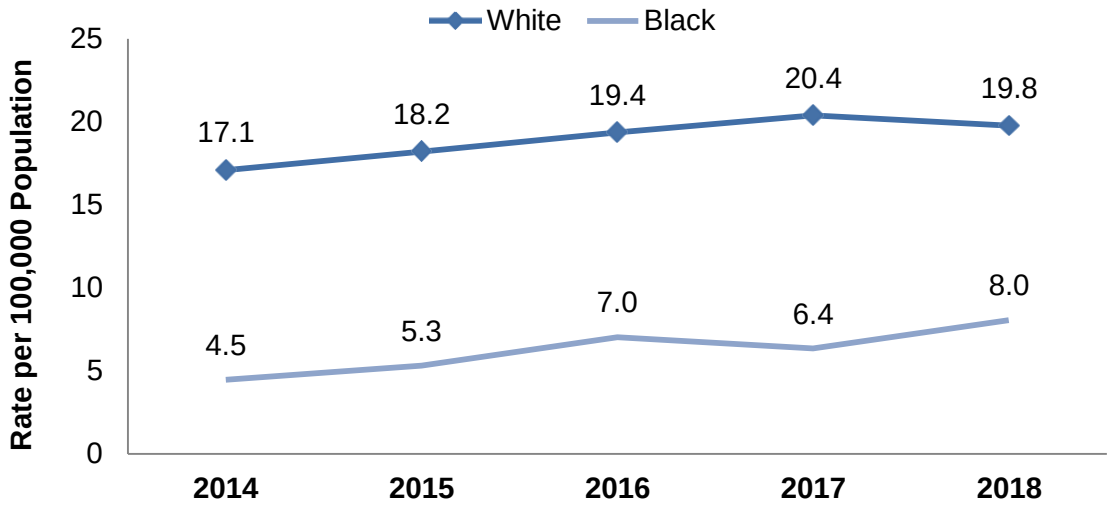


Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File, 2014-2018.

Race

The rate of suicide death is higher among Whites than Blacks in Tennessee. In 2018, the suicide rate (deaths per 100,000 person population) among Whites was 19.8 compared to 8.0 among Blacks (**Figure 4**). Compared to 2014, the suicide death rate in 2018 increased more among Blacks (78%) than Whites (16%) in Tennessee.

Figure 4: Race-specific suicide rate, Tennessee, 2014-2018

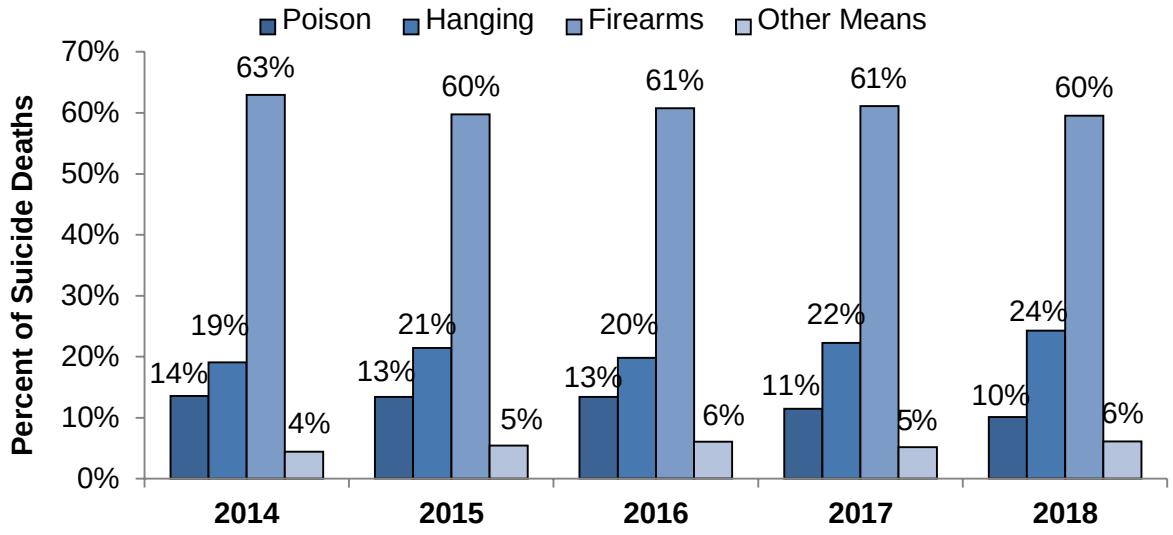


Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File, 2014-2018.

Method of Suicide Deaths

In Tennessee, firearms are the most prevalent means of suicide death, accounting for 3 out of 5 (60%) suicide deaths in 2018. Hanging was the next most common method, representing 24% of Tennessee's suicide deaths in 2018 (**Figure 5**). Also, the means of suicide death differed by decedent's gender. Firearms were the method used for 64% of male suicides compared to 42% of female suicides.

Figure 5: Method of suicide deaths, Tennessee, 2014-2018

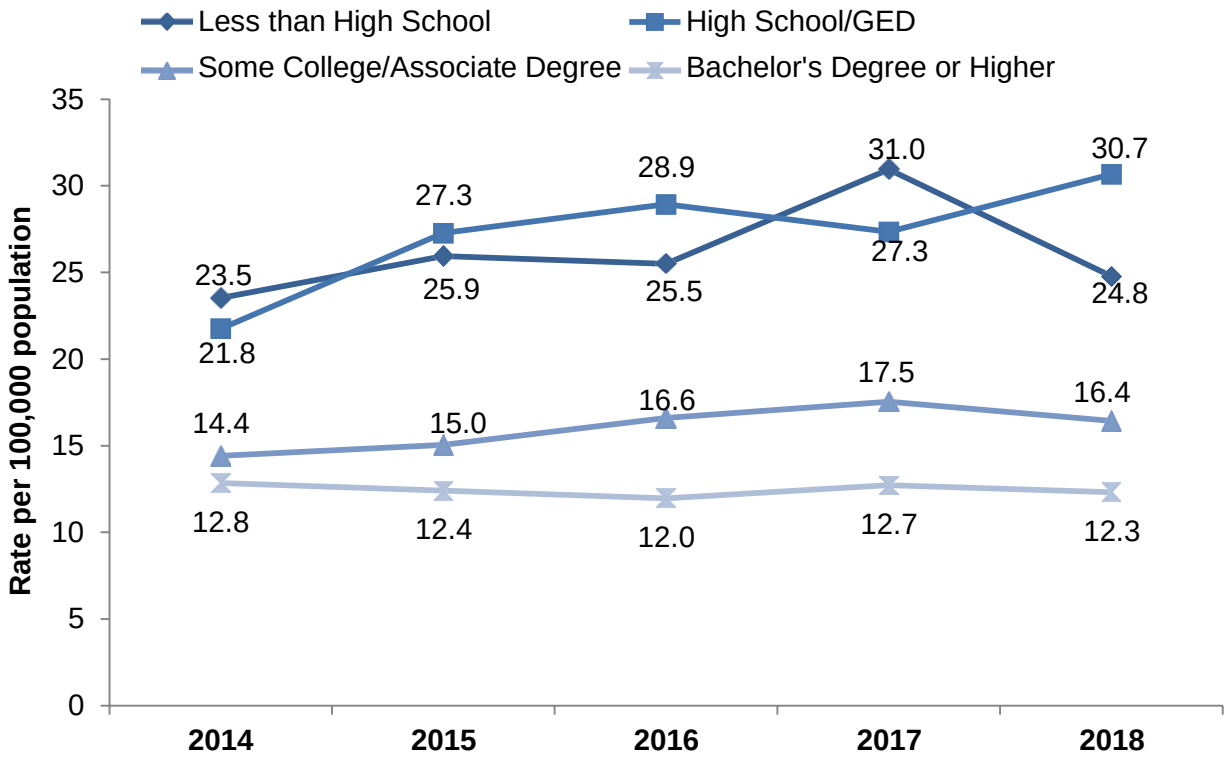


Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File, 2014-2018

Educational Status

Figure 6 shows the rate of suicide death by educational level among Tennessee residents aged 18 and older. The five-year (2014-2018) trend for the suicide death rate shows that individuals with at least a Bachelor's degree had the lowest rate of suicide death while those with lower educational achievement had higher rates of suicide.

Figure 6: Suicide rate by educational level in Tennessee residents 18 and older (2014-2018)

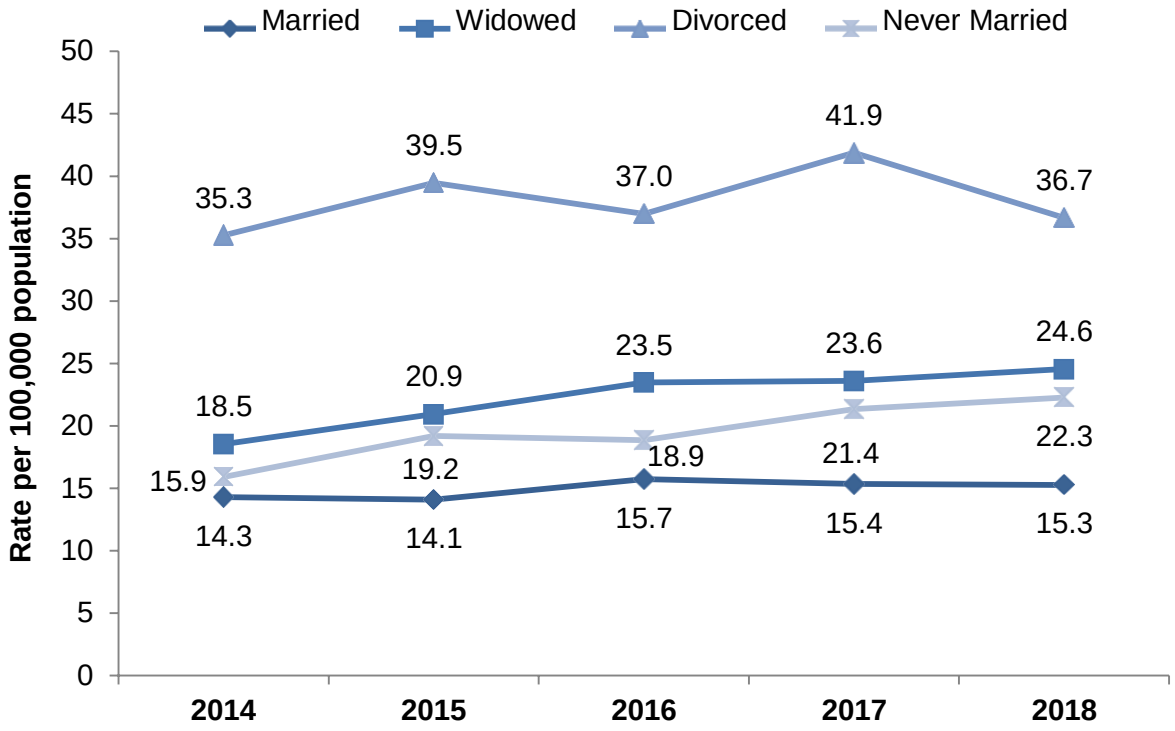


Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File, 2014-2018 and American Community Survey, United States Census Bureau.
Data displayed for suicide deaths among Tennessee residents 18 years and older.

Marital Status

The rate of suicide death by marital status among Tennessee residents aged 15 years and older is presented in **Figure 7**. In 2018, the rate of suicide death was highest among divorced individuals (36.7 per 100,000) and significantly different from other categories. In 2018, the suicide death rate was lowest among those who were currently married at time of death (15.3 per 100,000). Although, the rate of suicide deaths was higher among widowed decedents (24.6 per 100,000) than decedents who were never married (22.3 per 100,000), the difference in suicide rates between these two groups was not significant. For certain groups, however, there was a variation in suicide rate in the five-year span presented in this report. Between 2014 and 2018, the rate of suicide death among individuals who were widowed and those who were never married increased by 33% and 40% respectively.

Figure 7: Suicide rate by marital status in Tennessee residents 18 and older (2014-2018)

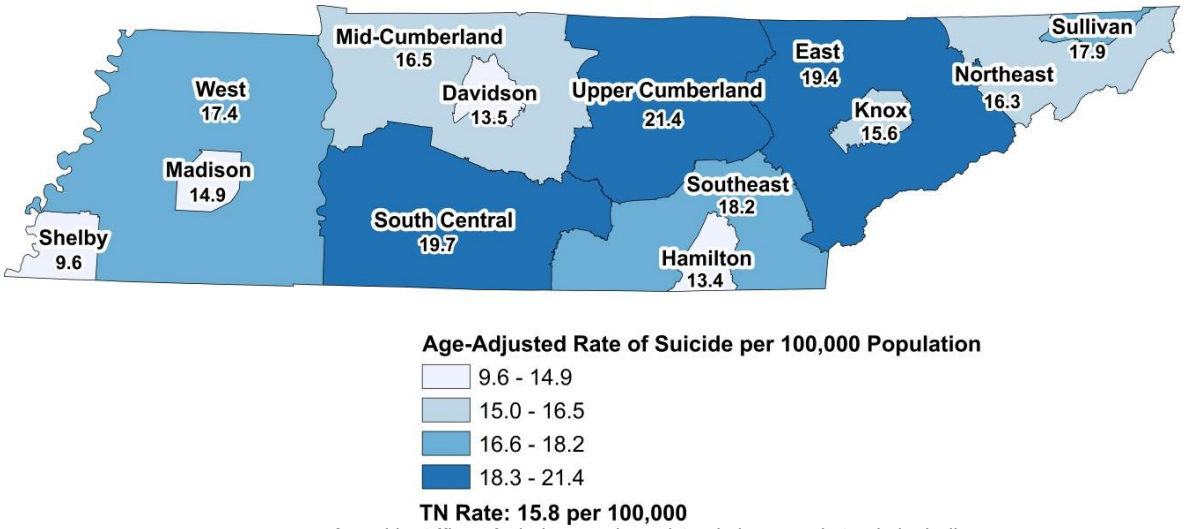


Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File, 2014-2018 and American Community Survey, United States Census Bureau. Data displayed for suicide deaths among Tennessee residents 15 years and older.

Geographic Distribution of Suicide Deaths in Tennessee

The five-year age-adjusted rate of suicide death for the thirteen regions in Tennessee is presented in **Figure 8**. From 2014-2018, the rate of suicide death was lowest in Shelby region (9.6 deaths per 100,000 population) and highest in the South Central (19.7 deaths per 100,000), Upper Cumberland (21.4 deaths per 100,000), and East (19.4 deaths per 100,000) regions of Tennessee.

Figure 8: Age-adjusted rate of suicide death by region, 2014-2018



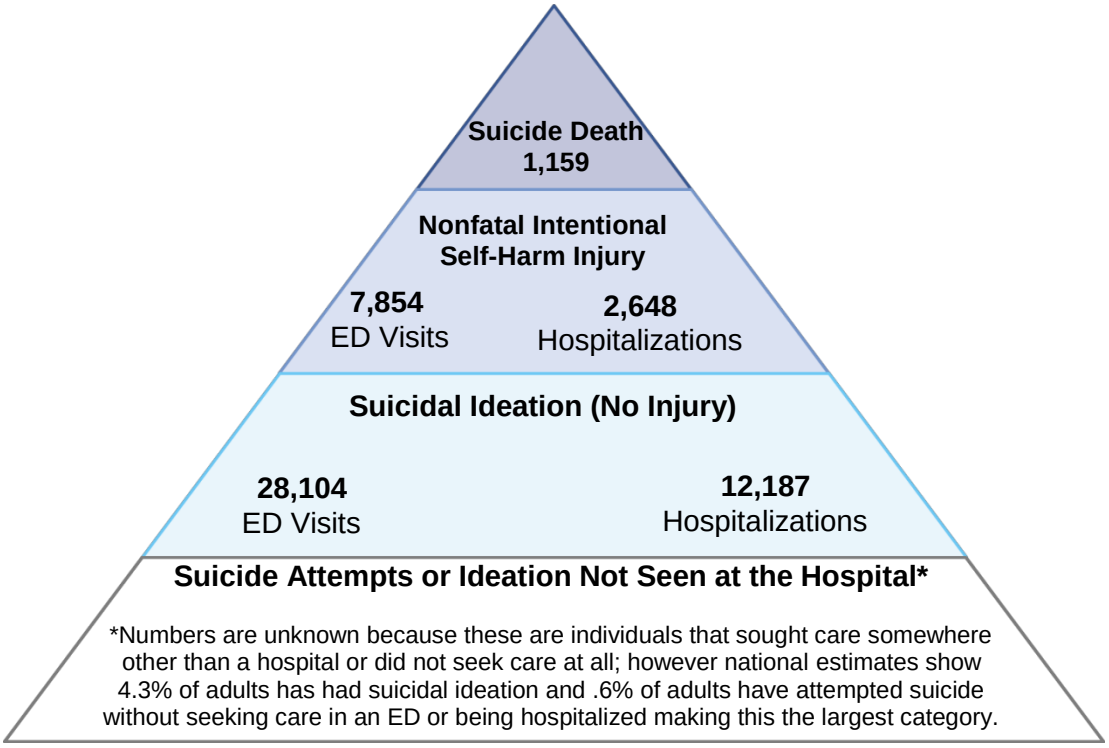
Data source: Tennessee Department of Health, Office of Vital Records and Statistics, Death Statistical File.

Intentional Self-Harm Injury and Suicidal Ideation

While prevention efforts often focus on data related to suicide death, completed suicides represent the tip of the iceberg in terms of the full spectrum of suicidal behavior. In addition to the 2018 count of suicide deaths, **Figure 9** includes data from an additional source: the hospitalization and emergency department (ED) data collected from all acute care hospitals in Tennessee. As shown in Figure 9, in addition to the 1,159 suicide deaths that occurred in 2018, there were 7,854 ED visits and 2,648 inpatient hospitalizations for nonfatal intentional self-harm injuries. Furthermore, as demonstrated in the next level of the pyramid, over 40,000 patients were hospitalized or treated in the ED with suicidal ideation, but not self-harm injury. Combined, the number of patients treated at acute care hospitals with either intentional self-harm injuries or suicidal ideation is over forty times greater than the number of completed suicides alone.

The bottom layer of the pyramid represents cases that experience suicidal ideation or intentional self-harm injury without receiving treatment at an acute care hospital. Because these individuals do not visit the hospital and may receive no care at all, they cannot be captured using the available surveillance systems and the true number is therefore unknown. According to the Youth Risk Behavior Survey, in 2017, 8.3 percent of Tennessee high school students reported attempting suicide in the prior 12 months but only 2.9 percent reported a suicide attempt resulting in an injury, poisoning, or overdose that was treated by a doctor or nurse. Adult survey data also indicate that the number of individuals who attempt or consider suicide is much greater than what can be estimated from hospitalization data alone. Data from the 2017 National Survey on Drug Use and Health indicates that 4.3 percent of U.S. adults 18 and older had thoughts of suicide in the past year and 0.6 percent attempted suicide, figures that would translate to an estimated 226,000 and 31,000 Tennessee adults respectively.

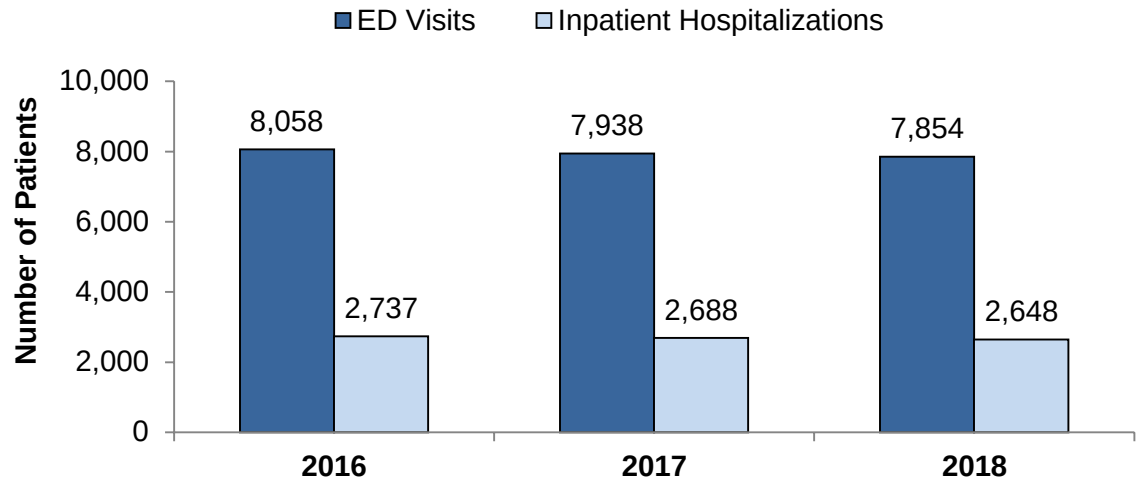
Figure 9: Number of suicide deaths, nonfatal intentional self-harm injuries, and patients with suicidal ideation but no self-harm injury, Tennessee, 2018



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

Figure 10 demonstrates the trend of ED visits and inpatient hospitalizations due to nonfatal intentional self-harm injuries for the past three years, 2016-2018. Over this time frame, the number of patients remained fairly consistent, with slight decreases each year. Data is not shown for a longer time frame because 2016 is the first full year of hospital data to utilize the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) coding system. Prior years used the Ninth Revision (ICD-9-CM) and data collected using the two coding schemes are not comparable.

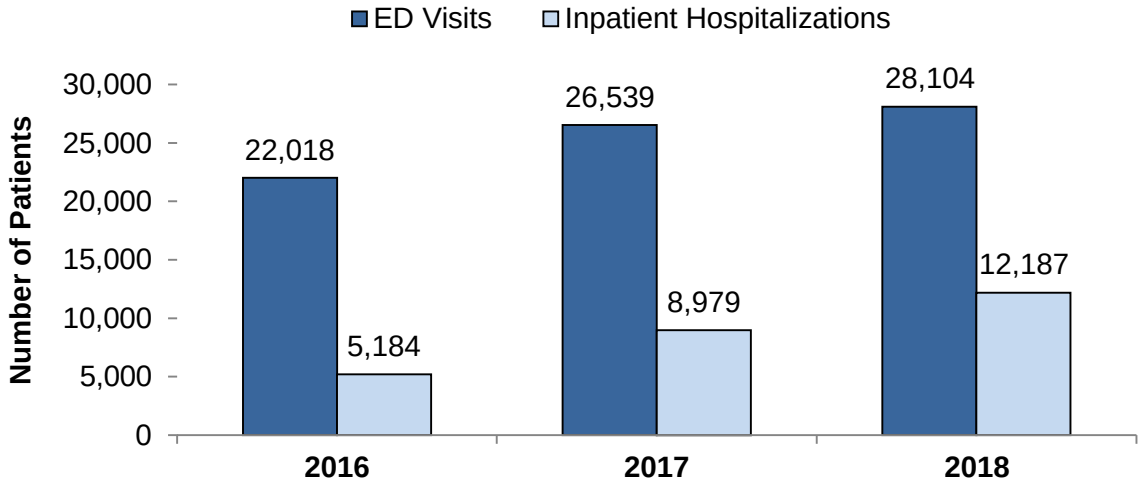
Figure 10: Number of ED visits and inpatient hospitalizations for nonfatal intentional self-harm injury, Tennessee, 2016-2018



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

Figure 11 includes data for ED visits and inpatient hospitalizations with suicidal ideation over the same time frame. In contrast to the trend seen for intentional self-harm injuries, the number of patients treated with suicidal ideation increased substantially from 2016 to 2018.

Figure 11: Number of ED visits and inpatient hospitalizations with suicidal ideation, Tennessee, 2016-2018

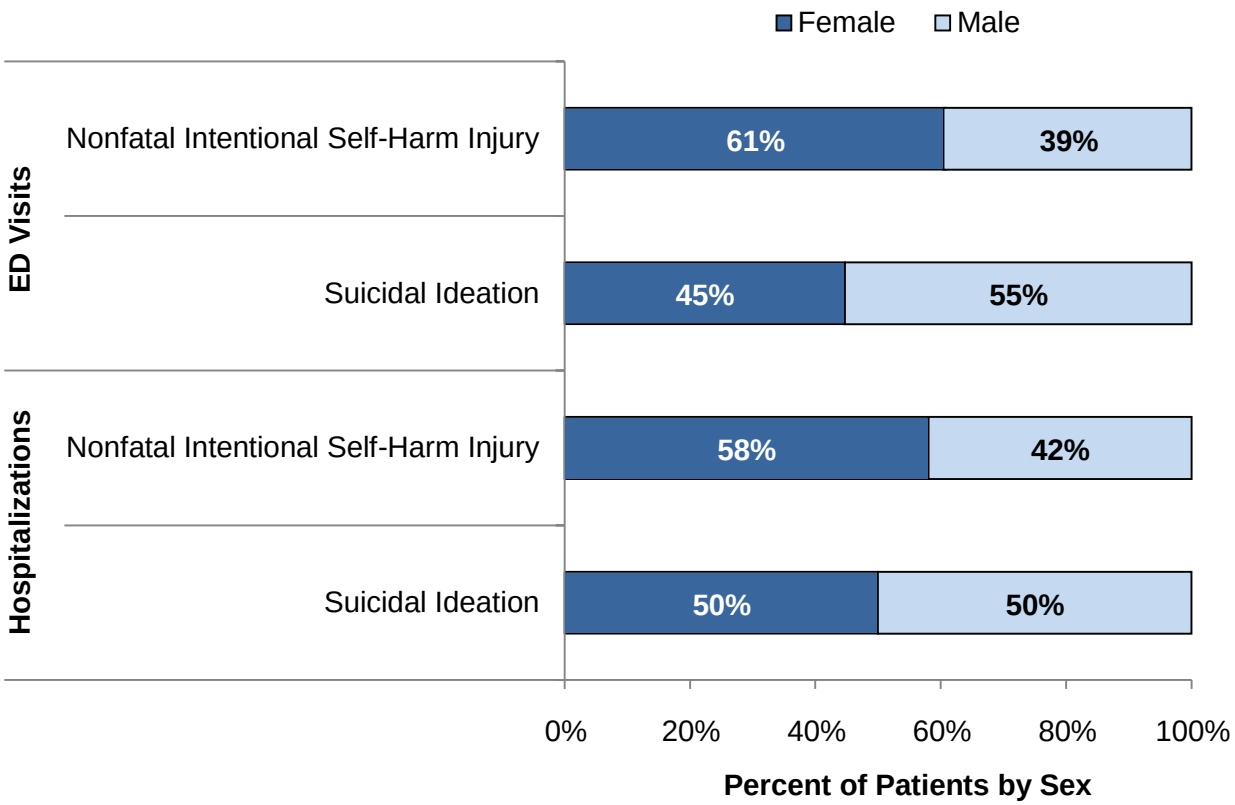


Data Source: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System.

Sex/Gender

The breakdown by sex for inpatient hospitalizations and ED visits showed a different trend compared to that seen for suicide deaths. Females made up just 24% of suicide deaths in 2018, but as shown in **Figure 12**, females made up the majority of patients treated in the ED (61%) and hospitalized (58%) for nonfatal intentional self-harm injuries. Patients treated for suicidal ideation with no accompanying intentional self-harm injury were split evenly across males and females. This difference in the gender breakdown for suicide death versus intentional self-harm injury ED visits and hospitalizations relates to choice of method: men are more likely to use firearms while females more often use less lethal methods such as poisoning.

Figure 12: Percent of patients by sex for ED visits and inpatient hospitalizations, Tennessee, 2016-2018



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

Method of Intentional Self-Harm Injury

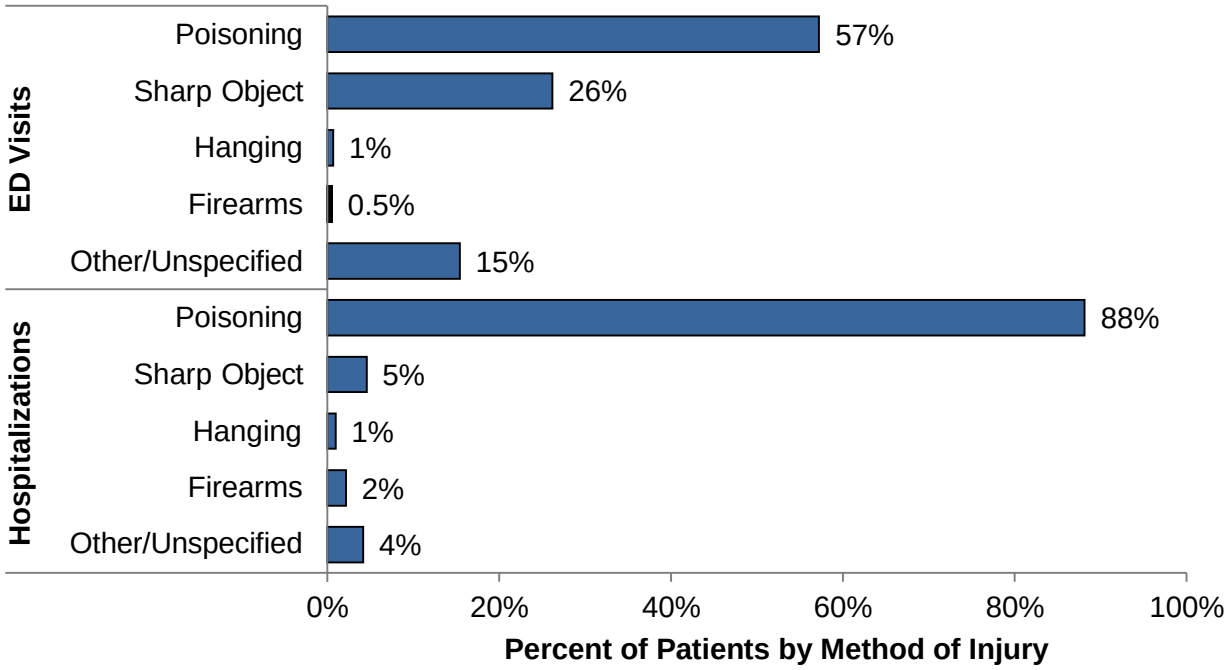
Figure 13 demonstrates the methods of injury for ED visits and hospitalizations. The most common methods of injury differed greatly for nonfatal intentional self-harm injury ED visits and hospitalizations compared to suicide deaths. Firearms consistently account for the majority of deaths by suicide in Tennessee; however, for the nonfatal ED visits and hospitalizations, firearms were the method of injury used for only a small percentage of patients (0.5% of ED visits and 2% of hospitalizations). The second most common method of suicide death, hanging, was also almost entirely absent among the nonfatal injury cases: hanging represented nearly one in four (24%) suicide deaths in 2018, but just one percent of both ED visits and hospitalizations.

Poisoning was the method of injury for the majority of ED visits and inpatient hospitalizations for nonfatal intentional self-harm injuries in 2018. This method, which accounted for just 10% of suicide deaths in 2018, made up 57% and 88% of ED visits and inpatient hospitalizations,

respectively. The vast majority (approximately 95%) of both the ED visits and inpatients hospitalizations due to intentional poisoning were drug overdoses, while the remaining five percent were nondrug poisonings involving substances such as ethanol, isopropyl alcohol, and carbon monoxide from motor vehicle exhaust. Among the drug overdoses, the most common substances used were benzodiazepines (which include familiar brand names such as Valium and Xanax) and acetaminophen (most common brand name is Tylenol).

Intentional self-harm by sharp object, or cutting, was the next most common method for both ED visits and hospitalizations, though it was a distant second among hospitalizations (5% of cases) and a much more sizeable proportion among ED visits. About one in four (26%) of the self-harm injuries treated in the ED were due to cutting. This again differed sharply with the methods seen for suicide deaths, where cutting represented just 1% of cases.

Figure 13: **Percent of patients by method of injury for ED visits and inpatient hospitalizations, Tennessee, 2016-2018**

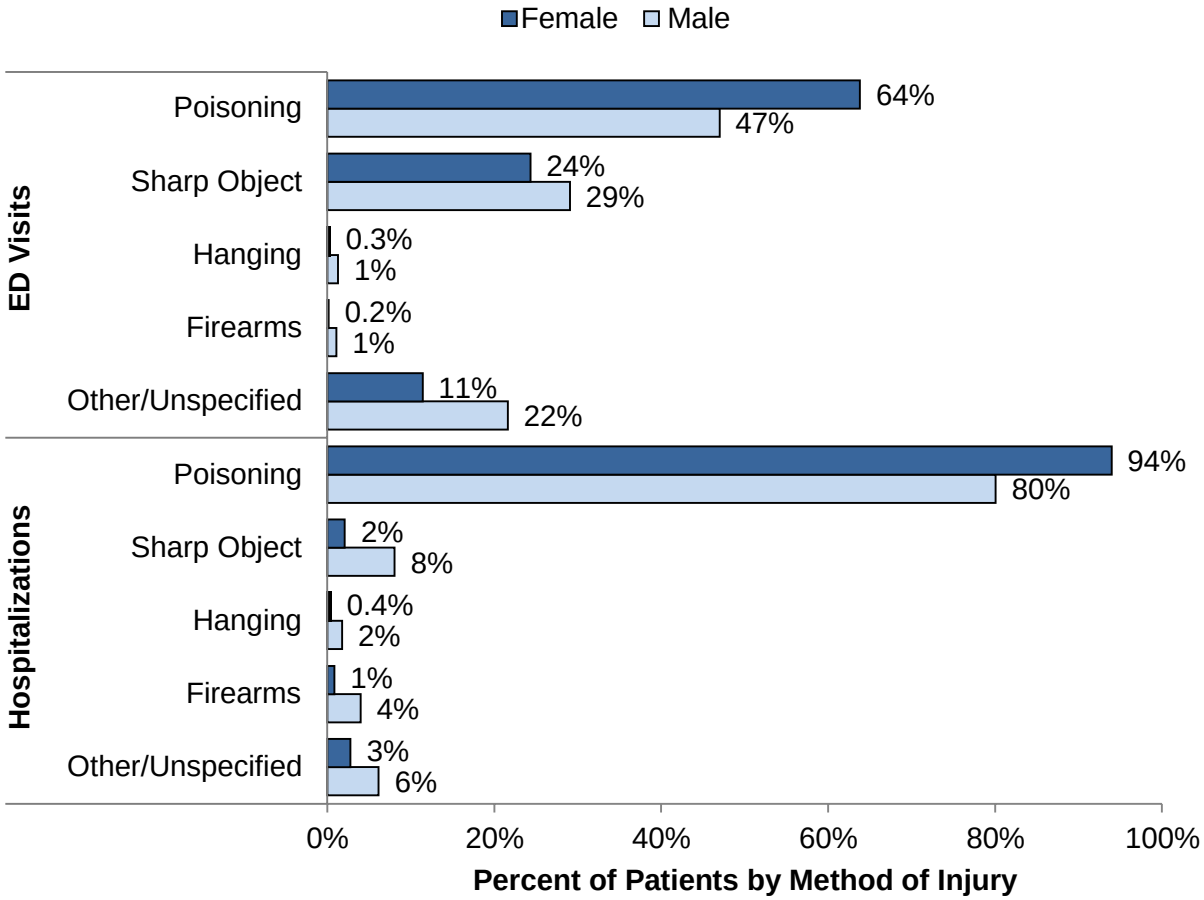


Data Source: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System.

Sex/Gender

Figure 14 demonstrates the methods of injury for nonfatal intentional self-harm injury ED visits and inpatient hospitalizations by sex. This reveals that poisoning was a particularly common method for female patients treated in the ED or hospitalized for self-harm injuries, accounting for 64% of ED visits and 94% of hospitalizations compared to 47% and 80% for men. Self-harm by sharp object, otherwise known as cutting, was the method of injury for comparatively large proportions of male patients: this was the method used for 29% of male patients seen in the ED (compared to 24% of female patients) and 8% of hospitalized male patients (compared to 2% of female patients). As previously stated, the percentage of nonfatal injuries due to firearm and hanging were extremely low for both male and female patients, but the number of patients injured using these methods was larger for men than for women.

Figure 14: **Percent of patients by sex and method of injury for ED visits and inpatient hospitalizations, Tennessee, 2016-2018**

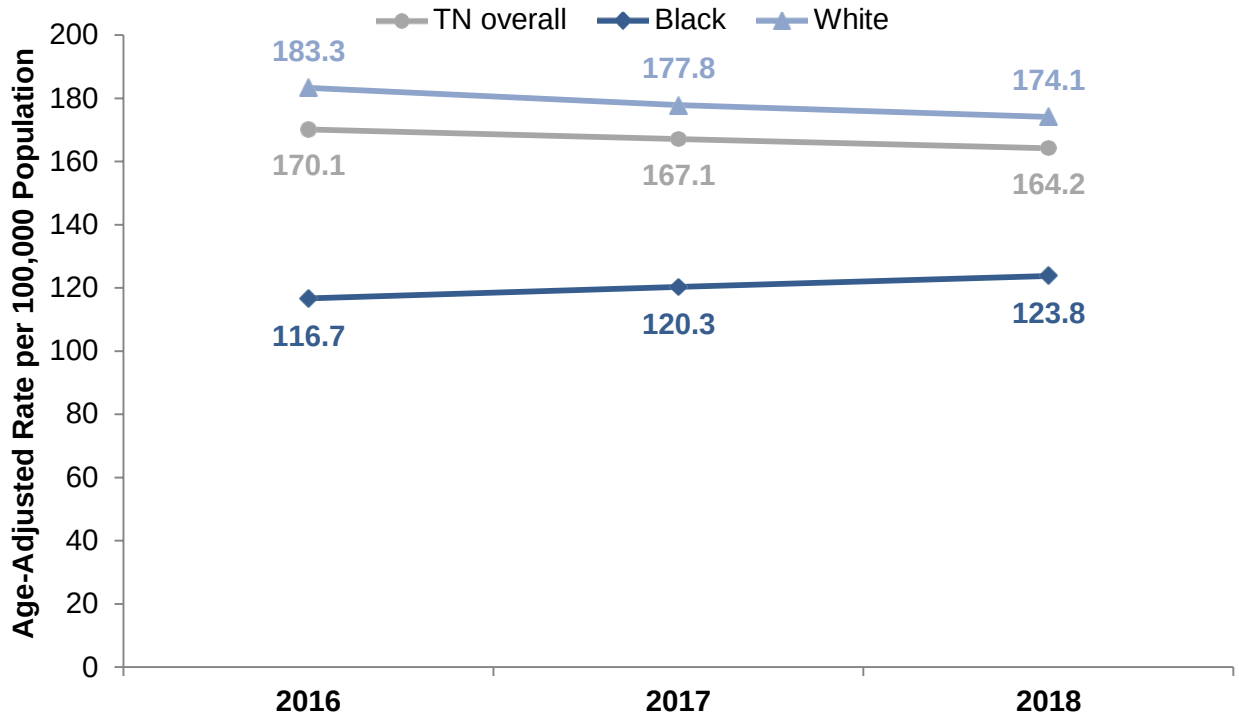


Data Source: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System.

Race

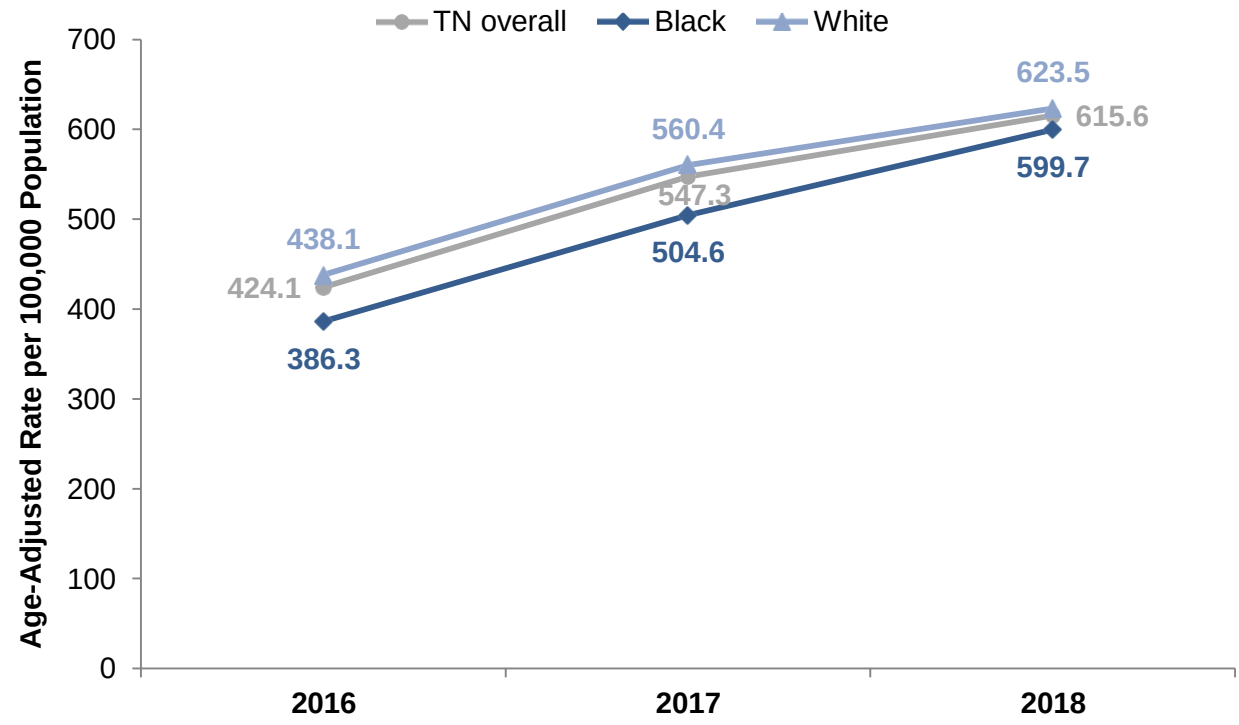
Figures 15 and **16** show the three year trend by race for nonfatal intentional self-harm injuries and suicidal ideation, with ED visits and inpatient hospitalizations combined. For both intentional self-harm injuries and suicidal ideation, the age-adjusted rates were higher for white Tennesseans each year, but the gap was narrower than that seen for suicide death. To compare, in 2018: i) the rate of suicide death was 147.5% higher for Whites than Blacks; ii) the rate of self-harm injury was 40.6% higher for Whites than Blacks; and iii) the rate of suicidal ideation was just 4.0 percent higher for Whites than Blacks. Black Tennesseans also experienced sharper increases during the three year time frame shown. For intentional self-harm injuries, the rate for whites decreased slightly while the rate for blacks marginally increased. For suicidal ideation, both groups increased significantly in 2018 compared to 2016, with a 55% increase for blacks and 42% increase for whites. This increase in the rate of hospital encounters for suicidal ideation in the black population was primarily driven by black females.

Figure 15: **Age-adjusted rate of nonfatal intentional self-harm injury inpatient hospitalizations and ED visits (combined) by race, Tennessee, 2016-2018**



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

Figure 16: **Age-adjusted rate of suicidal ideation inpatient hospitalizations and ED visits (combined) by race, Tennessee, 2016-2018**

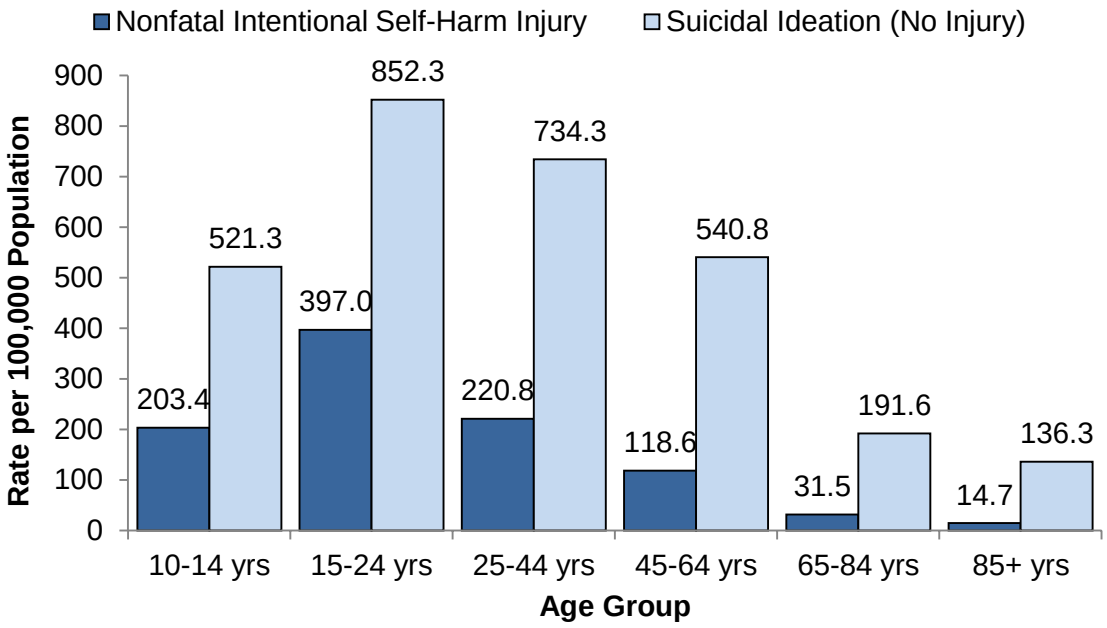


Data Source: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System.

Age

As stated in the previous section, the rate of nonfatal intentional self-harm injury and suicidal ideation differed substantially across age groups. **Figure 17** presents the age-specific rates for self-harm injury and suicidal ideation. Youths between the ages of 15 and 24 experienced the highest rates for both self-harm injury and suicidal ideation. This trend differed significantly from that seen for suicide death with the 2018 rate of suicide death highest for individuals aged 45 to 64.

Figure 17: **Rate of nonfatal intentional self-harm injury and suicidal ideation inpatient hospitalizations and ED visits (combined) by age group, Tennessee, 2016-2018**

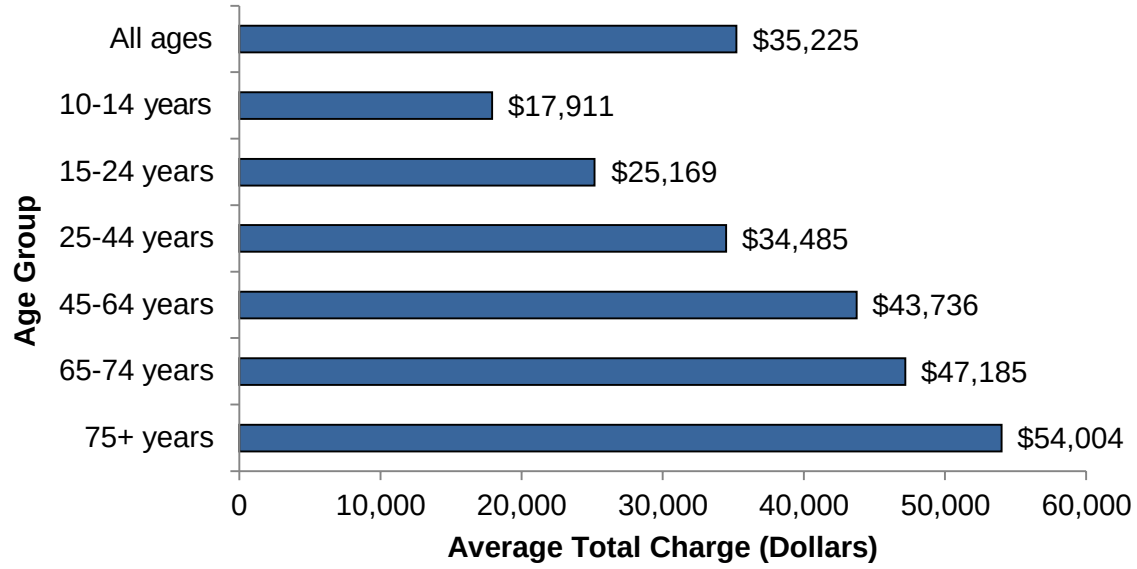


Data Source: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System.

Cost

In addition to the emotional trauma associated with receiving care for intentional self-harm injury or suicidal ideation, medical treatment for these issues incurs a significant financial cost. **Figure 18** demonstrates the average total charge for an intentional self-harm injury hospitalization by age group. For each successive age group, the average total charges climbed higher, reaching a peak of $54,004 for hospitalizations of patients 75 and older. This amount was three times the average charge associated with hospitalizations of patients in the youngest age category, which included individuals aged 10 to 14. The higher average charge for hospitalizations of older patients is related to the fact that these individuals also remained in the hospital for longer: the average length of stay for patients aged 75 and older was approximately seven days, compared to two days for patients aged 10 to 14. This increased cost and length of hospital stay is a result of medical complications associated with injuries of older individuals. Together, the total cost associated with all intentional self-harm ED visits and hospitalizations in 2018 was over $150 million, and the total cost of ED visits and hospitalizations of patients with suicidal ideation was over $500 million.

Figure 18: **Average total charge in dollars for nonfatal intentional self-harm hospitalization by age group, Tennessee, 2016-2018**

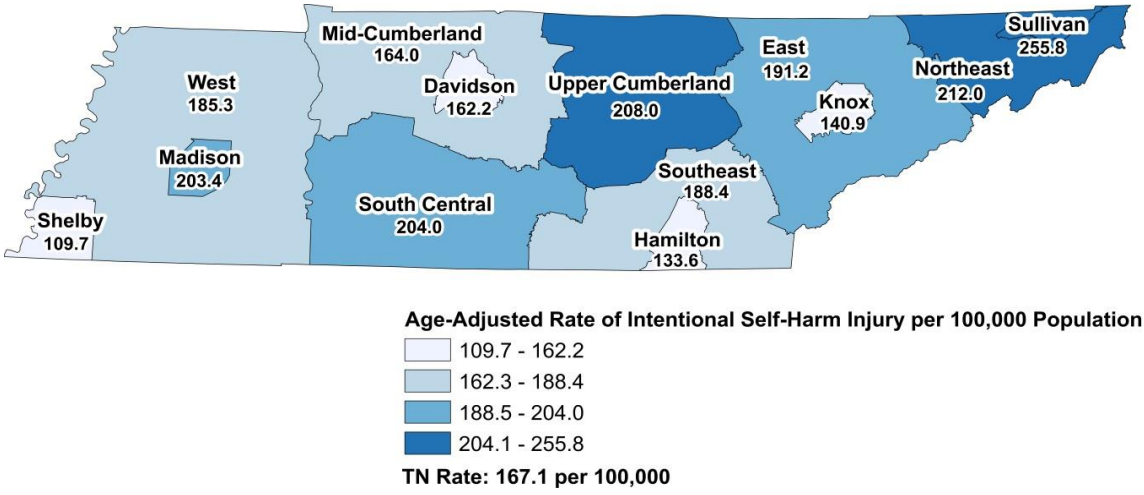


Data Source: Tennessee Department of Health, Division of Population Health Assessment, Hospital Discharge Data System.

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

Figure 19 demonstrates the geographic distribution of intentional self-harm injury inpatient hospitalizations and ED visits by region for 2016-2018. The rates presented are age-adjusted, as the age distributions within regions are different (which some regions having older populations while others are relatively young). The lowest statewide rate of intentional self-harm injury was for Shelby County. This reflected the pattern seen for suicide death, where Shelby County also had a much lower rate than any other region. The highest statewide rate was for Sullivan County, which had a rate of self-harm injury that was significantly higher than Tennessee as a whole and over twice as high as Shelby County. Notably, the four major metros of Tennessee (Shelby, Davidson, Hamilton, and Knox) all had rates of intentional self-harm injury below the statewide average.

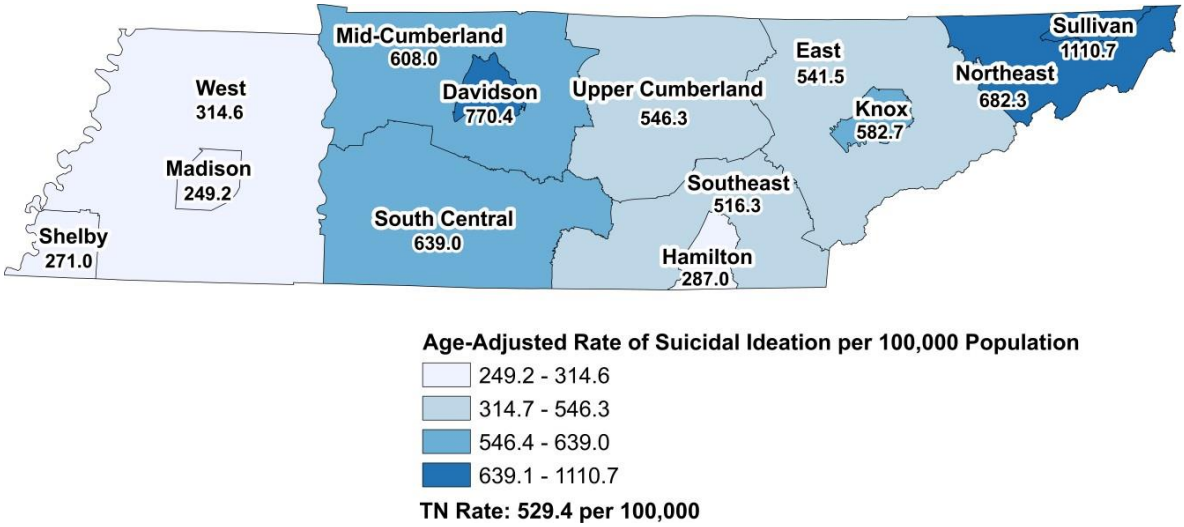
Figure 19: Age-adjusted rate of intentional self-harm injury inpatient hospitalizations and ED visits (combined) by region, 2016-2018



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

Figure 20 demonstrates a similar trend for ED visits and hospitalizations with suicidal ideation: residents of Sullivan County were again found to experience the highest rates in the state by far. The rate of suicidal ideation-related ED visits and hospitalizations was over twice as high for Sullivan County as for the state as a whole, and over four times as high as the rate for Madison County, which was the lowest in the state. Shelby County once again fell into the lowest category, as only Madison County had a lower rate of suicidal ideation-related hospital visits.

Figure 20: Age-adjusted rate of suicidal ideation-related inpatient hospitalizations and ED visits (combined) by region, 2016-2018



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

Youth Risk Behavior Survey Data[4]

The 2017 Youth Risk Behavior Surveillance System, a survey administered to high school students, provides information on risk factors for suicide deaths including suicide ideation and attempts. Results from the survey shows that about 1 in 6 (16.5%) high school students in Tennessee seriously considered taking their lives. There are gender disparities in suicide ideation. In 2017, more Tennessee female (22.7%) than male high school students (10.2%) seriously considered attempting suicide. Also, approximately 1 in 12 (8.3%) high school students attempted suicide, with more females (10.8%) than males (5.7%) reporting attempted suicide . Lastly in 2017, about one in every thirty-three (2.9%) Tennessee high school students reported attempting suicide that ended up in an injury, overdose, or poisoning that required treatment by a physician or nurse.

Behavioral Risk Factor Surveillance Survey[5]

In 2018, one in four Tennesseans (25.2%) reported to have been diagnosed with a form of depression (i.e. depression, major or minor depression, or persistent depressive disorder), a risk factor for suicidal behavior. The prevalence of depression is higher among females (32.6%) than males (17.3%). In addition, depression affects people of various race/ethnicity differently. Over a third (37.7%) of Tennesseans who identified as multiracial, non-Hispanic had the highest prevalence of depression compared to non-Hispanic Tennesseans (26.7%) and non-Hispanic Black Tennesseans (20.9%). Lastly, individuals aged 55-64 years reported the highest prevalence of depression (31.5%) while those 65 years and older reported the lowest prevalence (18.7%).

[4]CDC. Youth Risk Behavior Surveillance System. https://nccd.cdc.gov/youthonline/App/Default.as
[5]Data Source: Behavioral Risk Factor Surveillance System (BRFSS). BRFSS Prevalence & Trends Data. 2018. Available from https://www.cdc.gov/brfss/brfssprevalence/index.html

Suicide Prevention Needs Assessment Survey Results

A statewide survey was conducted to gain insight to: identify gaps in mental health and suicide prevention programs; determine the type of support needed for individuals at-risk for suicide; and assess statewide collaborations among suicide prevention agencies. The survey was distributed to mental health professionals, health professionals, school personnel, higher education representatives and others with an interest in suicide prevention. Data from 281 respondents are reflected in the suggestions below. Respondents of the needs assessment survey were asked what opportunities exist for improvement to suicide prevention in Tennessee. The most common improvement opportunities reported by respondents included:

- Increasing public awareness of suicide (67%)
- Providing additional funding for suicide prevention (66%)
- Increasing access to affordable mental health care (63%)
- Promoting effective help-seeking behavior (62%)

Other reoccurring themes seen within survey responses on ways suicide prevention resources and services could be improved across Tennessee included:

- Better mental health coverage for the underserved and uninsured populations living in Tennessee
- Increased awareness of mental health and suicide prevention in the general population
- Increased awareness about the suicide prevention trainings, programs, and services available across the state
- Increased access to mental health services in rural areas
- Increased access to crisis and treatment services in rural areas
- Crisis and treatment services tailored specifically for children and young adults
- Implementation and use of a standardized statewide screening tool, such as the C-SSRS, especially in primary care and pediatric offices
- More thorough and increased suicide prevention trainings are needed in school systems on both the faculty and peer level
- A need for increased upstream prevention strategies to support families and reduce the impact of adverse childhood experiences

Suicide Prevention Programs and Services in Tennessee

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

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

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

Suicide Prevention Gatekeeper Trainings

Everyone has a role to play in reducing suicide attempts and suicides deaths in Tennessee. Therefore, everyone should be trained on how to identify individuals at-risk for suicide and ensure that they receive appropriate assistance. Gatekeeper trainings help in identifying people at risk for suicide by teaching participants the warning signs and symptoms of a person experiencing a suicidal crisis. The trainings also teach participants how to engage with suicidal individuals and offer hope to those individuals. Gatekeeper trainings are delivered at no cost to participants and they are designed for the general population. The three main gatekeeper trainings currently offered in Tennessee are Question, Persuade, Refer (QPR), Suicide Alertness for Everyone (safeTALK), and Applied Suicide Intervention Skills Training (ASIST). In 2018, TSPN delivered suicide prevention gatekeeper trainings to 16,666 people across the state.[6] All three gatekeeper trainings are evidence-based or evidence-informed programs, with QPR being the most commonly provided training in Tennessee. QPR trainings deliver a concise message, and the training can be tailored to discuss the risk of specific populations such as the LGBTQI+ population or individuals who suffer from a substance use disorder.

[6] TSPN 2018 Training Outcome and Measures

Suicide Prevention Programs and Trainings that Protect Children and Youth

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

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

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

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

- The Tennessee Lives Count-Connect (TLC-C) a program that seeks to reduce suicidal ideation, suicide attempts, and suicide deaths among children and youth ages 10-24. TLC-C develops and implements statewide suicide prevention and early intervention strategies, risk screening/assessment, and enhanced follow-up practices through collaborations with schools, healthcare organizations, behavioral health organizations, foster care, and other agencies that work with youth and young adults.

- The Youth and Young Adult Suicide Prevention and Mental Health Awareness, a program that seeks to prevent suicide and promote better mental health among Tennesseans up to 25 years of age. This program partners with pediatric offices to establish processes that provide suicide risk screening and referral to treatment and services for all patients. This program also works with higher education institutions to conduct suicide prevention activities that raise awareness of suicide among students and staff.

- Project AWARE (Advancing Wellness and Resiliency in Education). The aim of this program which aims to promote resilience and positive behavioral functioning among school-age youth and expand youth access to mental health resources. The program has three specific goals:

- Build state capacity to increase mental health awareness and access in schools and communities. This goal is accomplished through the development of state and local policy and resource integration
- Promote competency among child-serving adults to detect and respond to youth mental health concerns by providing Youth Mental Health First Aid (YMHFA) trainings
- Expand the continuum of school- and community-based behavioral health supports and interventions, respond to youth mental health needs, and keep youth in school and out of the juvenile justice system.

The TLC-C program is funded through the Substance Abuse and Mental Health Services Administration (SAMSHA) and the first grant cycle occurred from September 2014 to December 2019. Over those five years, the TLC-C program reached 241,682 educators, parents, medical staff, and other youth impactors across the state through suicide prevention awareness exhibits and events. Within the same time period, the TLC-C program provided QPR gatekeeper trainings to 41,017 individuals who work with children and youth across the state, including individuals whom are associated with higher education institutions and 919 individuals across the state received ASIST trainings.[7] The TLC-C program was awarded another round of funding through SAMSHA which will allow the program to continue and be expanded upon for an additional five years. Through the work of Project AWARE, 5,264 individuals who work with children and youth across the state have received training in Youth Mental Health First Aid (YMHFA).[8]

Suicide Prevention Programs for Healthcare Professionals

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

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

[7] Tennessee Department of Mental Health and Substance Abuse Services, TLC-C Final Outcome Report

[8] Tennessee Department of Education, Project AWARE Outcome and Measures

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

    - Recommendations on what can be done to prevent suicide attempts in the emergency department
- Counseling on Access to Lethal Means (CALM) is a free, online training program designed to help providers implement counseling strategies which can help clients at risk for suicide and their families reduce access to lethal means within their homes.
- Columbia-Suicide Severity Rating Scale (C-SSRS) is a free online training that teaches clinicians how to identify whether someone is at risk for suicide, assess the severity and immediacy of a risk, and gauge the level of support the person needs.
- The Zero Suicide Initiative is a system-wide approach to improve outcomes and close gaps in services for patients who may be at risk for suicide. Many people are seen within a healthcare facility prior to dying by suicide, but often times these patients are not identified or assessed for suicide risk. Those facilities participating in the Zero Suicide Initiative ensure all staff are trained on suicide prevention, all patients are assessed for suicide risk, and implement protocols for referral and follow-up.

Crisis Services

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

- The Tennessee Statewide Crisis Line
- Mobile Crisis Services and Response
- Crisis Walk-In Centers
- Crisis Stabilization Units
- Crisis Respite Services
- Mobile Crisis Services for Children and Youth

From 2014 to 2018, face-to-face crisis assessments provided by mobile crisis teams or through crisis-walk in centers increased by 15% across the state. In 2018, a total of 80,570 face-to-face assessments were provided to Tennesseans experiencing a mental health crisis. Of those assessments, 61,985 people were assessed through mobile crisis and 18,585 people were assessed through crisis walk-in centers.[10] All crisis services within Tennessee are offered 24 hours a day, 7 days a week, and 365 days of the year. There are 13 mobile crisis teams and 8 crisis walk-in centers available across the state. Unfortunately, only one crisis walk-in center, and no crisis stabilization unit, exists for children 18 and under in Tennessee. While we have a strong crisis infrastructure within the state, respondents of the Suicide Prevention Needs Assessment Survey stated that crisis services could be improved for children 18 and under and individuals who live within rural areas across the state.

Upstream Prevention Activities

Despite all of these activities being implemented in Tennessee, there is a lack of upstream prevention activities to teach children how to appropriately respond and cope through difficult

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

situations which may arise within their lives. Three upstream programs that have shown positive outcomes in other states are the Good Behavior Game (GBG), Sources of Strength and Hope Squads.

The Good Behavior Game is a classroom based behavioral management program which aims to promote positive behavior choices within children. Through the GBG, children are taught how to work together to create a positive learning environment for all by monitoring their own behavior, as well as that of their classmates, and holding one another accountable for poor or alarming behavior choices.

Sources of Strength (SOS), is a program that aims to prevent suicide in children by increasing help-seeking behaviors and promoting connections between young people and caring adults. Program activities aim to reduce the acceptability of suicide as a response to distress, increase the acceptability of seeking help, improve communication between youth and adults, and develop healthy coping attitudes among youth.

Hope Squads is a program that teaches students how to recognize the warning signs of suicide and intervene with students who are at-risk. Hope Squad members are taught how to identify peers who may be struggling with undetected or untreated mental health disorders. Hope Squads rely on peer-to-peer exchanges in order to spot students most at-risk for suicide within schools and ensure they get the help that they need.

Implementing upstream programs such as these could make a big impact on suicide in Tennessee. These programs teach children coping skills that last them throughout their lifetime.

The next section discusses recommendations for prevention of suicide in Tennessee. The recommendations include expansion of many existing programs in Tennessee along with implementation of programs that have been successful in other states.

Suicide Prevention Recommendations for Tennessee

Legislative Policies

1. All hospitals within Tennessee should be required to report into the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) database to assist with real time surveillance of populations experiencing increased incidents of suicide-related behavior.

2. All mental health facilities should comply with legislation that allows mental health records of suicide decedents to be shared with medical examiners across state (T.C.A. 38-7-117) and those individuals who request records for and state fatality review programs such as the Tennessee National Violent Death Reporting System, the Maternal Mortality Review Program(T.C.A. § 63-3-2), and the Child Fatality Review Program (T.C.A. § 68-142-108)

3. All health insurers within the state of Tennessee should comply with the rules and requirements of the Mental Health Parity and Addiction Equity Act. The Parity Act requires a health plan's standards for substance use and mental health benefits to be comparable to the standards for other medical benefits.

State and Community Agencies

1. Increase access to adequate mental health care for all Tennesseans by:
    - Increasing funding to expand inpatient and outpatient facilities throughout the state that can provide treatment for mental health conditions and crisis care, especially for children and individuals residing in rural parts of Tennessee
    - Increasing the number of licensed behavioral health professionals practicing in Tennessee, especially those who work with children/youth
    - Expanding behavioral health safety net coverage for individuals without health insurance, including children under the age of 18
    - Encouraging the use of telehealth for mental health services

2. Spread awareness of suicide and encourage help-seeking behavior by:
    - Developing and disseminating a statewide and culturally-competent awareness campaigns on suicide prevention, stigma reduction, and lethal means restriction
    - Collaborating with the media to ensure that any reporting related to mental health and suicide follows research-based and effective suicide prevention messaging guidelines

3. Support the widespread use of standardized behavioral health assessment protocols and tools such as the Columbia-Suicide Severity Rating Scale in:
    - All healthcare and behavioral health care agencies
    - Agencies serving high-risk population such as, but not limited to, home health agencies which can target both patients and their caregivers/family members, juvenile and adult corrections, active military and veterans affairs, LGBTQI+ outreach groups, adult and child protective services, adult and juvenile correction facilities, faith- based organizations, before and after-care programs, senior centers, senior transportation services, older adult meal

services, licensed adult day centers, assisted-living centers, community centers, and licensed childcare providers.

4. Increase funding to strengthen the crisis response infrastructure in Tennessee, with particular emphasis on children and rural communities across the state by:
    - Expanding the use of crisis response teams
    - Expanding the number of walk-in crisis centers and crisis stabilization units
    - Ensuring appropriate follow-up practices are implemented to all Tennesseans who receive crisis response services
    - Adapting policies and procedures that address and allow for crisis care and treatment to be provided for medically complicated patients
    - Providing postvention support and resources to survivors of suicide loss as soon after a suicide death as possible

5. Develop a centralized Tennessee Suicide Prevention Resource directory includes a location based list of all services, programs, trainings, and resources available throughout the state.

6. Support suicide prevention programs and trainings promoting connectedness and resiliency in all Tennessee communities. This recommendation can be achieved by:
    - Providing ongoing support for programs and trainings that address Adverse Childhood Experience and foster resiliency and social emotional learning
    - Encouraging employers to create work environments that are safe, protective, and supportive of all employees, by implementing initiatives such as *the Be the One Suicide Prevention Workforce Campaign*
    - Expanding the use of peer support services in mental health, substance use, and crisis response systems across the state, especially within at risk populations including rural communities, children/youth, and older adults
    - Increasing the capacity and availability of evidence-based gatekeeper trainings in suicide prevention and intervention, such as Question, Persuade, Refer (QPR), Applied Suicide Intervention Skills (ASIST), and Suicide Alertness for Everyone (safeTALK)

Clinics and Hospital Systems

1. Health and Behavioral Health Care Systems across the state should maintain “suicide safe” facilities by:
    - Implementing the Zero Suicide Approach to Suicide Prevention
    - Ensuring that all healthcare professionals receive core competencies in suicide prevention and provide timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.
    - Developing collaborations between emergency departments, health care providers (e.g., health and mental health centers), local emergency first responders, and crisis services to ensure rapid follow-up after discharge. This collaboration would provide alternatives to emergency department care and hospitalization when appropriate.
    - Increasing the use of certified peer recovery specialists or other paraprofessionals in appropriate crisis, treatment, and recovery support settings across the state.

2. Disseminate information on means restriction to patients and families, and incorporate counseling on access to lethal means into suicide risk assessment protocols. Address means restriction in safety plans created with patients at risk for suicide.

3. Promote the integration of primary care and behavioral health care to increase access to behavioral health services in primary care settings.

Healthcare Providers

1. Healthcare providers should educate all patients on the signs of suicide, including how to reach out for help if they or someone they know is in crisis.

2. Primary Care and Pediatric Providers should obtain training on depression and anxiety screening, suicide risk assessment, safety planning, and lethal means counseling and implement these practices during their assessment of all patients. Healthcare providers should ensure that all suicidal patients are appropriately referred to mental health services.

3. Primary Care and Pediatric Providers should work with mental health centers to ensure that all suicidal patients receive appropriate mental health referrals, follow-up, treatment, and care.

4. Behavioral and Mental Health Providers should utilize evidence-based approaches to treat suicidal thoughts and behaviors directly utilizing:
    - The Stanley Brown Safety Plan
    - Counseling on Access to Lethal Means
    - The Collaborative Assessment and Management of Suicidality
    - Dialectical Behavioral Therapy, and Cognitive Behavioral Therapy for Suicide Prevention.

5. Primary Care and Pediatric Providers should counsel gun owners on safe firearm storage practices and provide strategies to reduce access to lethal means of suicide within the home

Public Safety and Emergency Response Agencies

1. Create better collaboration between law enforcement and other emergency response agencies in responding to a suicidal event or mental health crisis by:
    - Expanding crisis intervention training programs and supports across every public safety system in Tennessee including, but not limited to, law enforcement officers, EMTs, firefighters, correctional officers, parole officers, and emergency response operators
    - Implementing a standardized crisis response across the entire state.

2. Promote partnerships between behavioral healthcare facilities, local law enforcement, local transportation agencies, and local emergency medical services in order to expand the Crisis Assessment and Response to Emergencies Program

3. Encourage local law enforcement agencies, local fire departments, and local EMS agencies to create safe, protective, and supportive work for all employees. This recommendation can be achieved by:

- Implementing workplace suicide prevention programs and initiatives that spread awareness of suicide, such as the *Be the One* Workforce Campaign
- Offering mental health wellness and counseling support through their employee benefits or Employee Assistance Programs
- Providing immediate counseling and ensuring appropriate follow-up occurs for those employees who have witnessed or responded to extremely traumatic events

Educational Institutions

1. Incorporate mental health and wellness education—including components on suicide prevention—as a core part of the health curriculum for all school-aged children and youth. Integrate appropriate core suicide prevention competencies in all higher education core curricula.

2. Increase the availability of and accessibility to mental health screening, care, and referral to community-based mental health services in schools.

3. Provide training opportunities for mental health and suicide prevention, such as Question, Persuade, Refer (QPR), Applied Suicide Intervention Skills (ASIST), and Youth Mental Health First Aid (YMHFA), to students, school teachers, school support staff, and to any other adults that interact with children and youth in schools so they are able to recognize students at potential risk of suicide and refer those students to appropriate services.

4. Encourage K-12 and higher educational institutions to spread awareness of suicide by displaying the national suicide prevention hotline number, the Tennessee statewide crisis number, and crisis text line information throughout the school, and consider adding suicide resources to student ID's and in all course syllabi across the state.

5. Implement and support positive mental health and suicide prevention programs in all K-12 schools, such as The Good Behavior Game and Erasing the Stigma/I.C. Hope, in elementary school classrooms and peer-to-peer suicide prevention support programs, such as Sources of Strength and Hope Squads, in middle and high schools across the state.

Individuals, Families, and Friends

1. Seek care with the earliest symptoms of depression or other signs of suicide

2. Seek positive peer interactions and reach out to trusted individuals to improve interpersonal connectedness and to build resilience

3. Seek resources or trainings to develop skills related to emotional or anger control, problem solving, conflict resolution and coping skills

4. Learn the risk factors for suicide, reaching out for help, and responding appropriately to suicidal person through suicide prevention resources such as the National Suicide Prevention Lifeline, the Tennessee Statewide Crisis Line, and the Crisis Text Line.

5. Complete suicide prevention gatekeeper trainings such as Question, Persuade, and Refer (QPR), Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA) training.

6. Complete Applied Suicide Intervention Skills (ASIST) training.

7. Encourage conversations on suicide prevention awareness within the community settings such as local faith-based organizations, hair salons and barber shops, bars and restaurants, animal hospitals and veterinary offices, and hotels and motels.

Conclusion

The goal of this report is to provide data, resources and recommendations for suicide prevention in Tennessee. The rate of suicide in Tennessee continues to be higher than the national rate and we continue to lose too many Tennesseans each day to suicide. Several recommendations in this report warrant further attention including the need for:

- Better mental health coverage for the underserved and uninsured populations living in Tennessee, including children 18 and under
- Increased awareness of mental health and suicide prevention in the general population
- Increased awareness about the suicide prevention trainings, programs, and services available across the state
- Increased access to mental health services for children 18 and under and within rural areas
- Increased access to crisis and treatment services for children 18 and under and within rural areas

We encourage all who read this report to utilize the data and recommendations contained herein to explore opportunities for improving the health and well-being of those who may be at risk for suicide within their own communities.

Appendices

Appendix 1: Tennessee Statewide Suicide Prevention Programs and Services

Program	Children/ Youth	Adults	Seniors	Veterans	Cost for Recipients	Funding Source for Program/ Service	Approximate % of TN Counties that Offer Program/ Service Locally
Alcohol and Drug QPR(A & D) Gatekeeper Training	Yes	Yes	Yes	Yes	None	State and Federal Funding TSPN Volunteer Trainers	100%
Applied Suicide Intervention Skills(ASIST) Training	Yes	Yes	Yes	Yes	None	State and Federal Funding TSPN Volunteer Trainers	100%
Assessing and Managing Suicide Risk(AMSR)	Yes	Yes	Yes	Yes	None	None	None
"Be the One" Suicide Prevention Workforce Campaign	No	Yes	Yes	Yes	None	Federal Funding	100%
CALM: Counseling on Access to Lethal Means Training	Yes	Yes	Yes	Yes	None	N/A	100%
Columbia-Suicide Severity Rating Scale(C-SSRS)	Yes	Yes	Yes	Yes	None	N/A	100%
General Suicide Prevention	Yes	Yes	Yes	Yes	None	State and Federal Funding	100%

Training						TSPN Volunteer Trainers	
Gun Safety Project	Yes	Yes	Yes	Yes	None	Federal Funding TSPN Funding	100%
I.C. Hope (Erase the Stigma Program)	Yes	N/A	N/A	N/A	None	Federal Funding	65%
Juvenile Justice Diversion Program	Yes	N/A	N/A	N/A	None	State Funding	100%
Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex QPR(LGBTQI+) Gatekeeper Training	Yes	Yes	Yes	Yes	None	State and Federal Funding TSPN Volunteer Trainers	100%
Mental Health First Aid(MHFA) Training	Yes	Yes	Yes	Yes	None	State Funding Centerstone	100%
Mental Health 101	Yes	N/A	N/A	N/A	None	State Funding Mental Health America of East TN	100%
Postvention Training	Yes	Yes	Yes	Yes	None	State and Federal Funding	100%
Pre-Arrest Diversion Infrastructure Program	N/A	Yes	Yes	Yes	None	State Funding	21%
Project BASIC (Better Attitudes and Skills	Yes	N/A	N/A	N/A	None		

in Children)							
Question, Persuade, Refer(QPR) Gatekeeper Training	Yes	Yes	Yes	Yes	None	State and Federal Funds TSPN Volunteer Trainers	100%
Shield of Care	Yes	N/A	N/A/	N/A	None	Federal Funding	100%
Suicide Prevention in the Emergency Department	Yes	Yes	Yes	Yes	None	Federal Funding	100%
Suicide to Hope(s2H)	Yes	Yes	Yes	Yes	None	None; offered through community trainers that are not contracted or associated with any direct funding	0%
Tennessee Lives Count-Connect	Yes	N/A	N/A	N/A	None	Centerstone, Federal Funding TSPN Funds	100%
The Jason Foundation	Yes	N/A	N/A	N/A	None	State funding	100%
TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment	Yes	Yes	Yes	Yes	Yes	None	None
Violence and Bullying Prevention Program	Yes	N/A	N/A	N/A	None	State Funding	9%
Youth and Young Adult Suicide Prevention and Mental Health Awareness Program	Yes	N/A	N/A	N/A	None	State Funding	33%

Youth Mental Health First Aid(YMHFA)	Yes	Yes	Yes	Yes	None	Federal Funding	100%
Zero Suicide Initiative	Yes	Yes	Yes	Yes	None	Centerstone, Federal Funding TSPN Funds	100%
Services	**Children/ Youth**	**Adults**	**Seniors**	**Veterans**	**Cost for Recipients**	**Funding Source for Program/ Service**	**Approximat e %of TN counties who provide Program/Se rvice Locally**
Crisis Respite Services	No	Yes	Yes	Yes	None	State Funding	100%
Crisis Stabilizatio n Units(CSU)	No	Yes	Yes	Yes	None	State Funding	100%
Crisis Walk-In Centers	Yes	Yes	Yes	Yes	None	State Funding	100%
Healthy Transitions Initiative	Yes	N/A	N/A	N/A	None	Federal Funding	95%
Mobile Crisis Services	Yes	Yes	Yes	Yes	None	State Funding	100%
National Alliance on Mental Illness(NAMI) TN Support Groups	No	Yes	Yes	Yes	None	NAMI is most often funded through community contributions and sponsorships	100%
Peer Support Centers and Services	No	Yes	Yes	Yes	None		60%
Project AWARE (Advancing Wellness and	Yes	N/A	N/A	N/A	None	Federal Funding	4%

Resiliency in Education)							
STAR(Students Together Advancing Resilience)	Yes	N/A	N/A	N/A	None	Tenncare or other personal health insurance coverage	4%
TeenScreen	Yes	N/A	N/A	N/A	None	Federal Funding	100%
TN Statewide Crisis Phone Line	Yes	Yes	Yes	Yes	None	State Funding	100%

Appendix 2: Tennessee Statewide Suicide Prevention: Description of Programs

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

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

Pre-Arrest Diversion Infrastructure Program	Program that aims to reduce or eliminate the time individuals with mental health, substance abuse, or co-occurring disorders spend incarcerated by redirecting them from the criminal justice system to community-based treatment and supports	Adults involved in the criminal justice systems
Project BASIC (Better Attitudes and Skills in Children)	Award-winning school-based mental health prevention and early intervention program offering mental health education through direct classroom interaction with children and through work with teachers, coaching them on strategies to promote social emotional development of children.	Elementary aged school children
Question, Persuade, Refer (QPR) Gatekeeper Training	A 60-120 minute in-person training designed to teach participants how to recognize the warning signs of someone who may be contemplating suicide and question them about whether or not they are suicidal, how to offer hope to an individual experiencing a suicidal crisis and persuade them to get assistance, and how to refer an individual having a suicidal crisis to help in order to save their life	General Population
Shield of Care	8 hour in-person training and curriculum designed specifically for staffs working in the nation's juvenile justice facilities. The training provides participants knowledge of suicide prevention strategies, including risk and protective factors, self-efficacy to prevent suicide and specific suicide prevention skills.	Staff working in juvenile justice facilities
Suicide Prevention in the Emergency Department	Online interactive training focused on training hospital emergency department staff about mental health and suicide. The screening, assessment, and referral process of patients at risk for suicide, environmental risk factors for suicide in the hospital setting, means reduction, and referral materials to provide to patients upon discharge.	Hospital Emergency Department staff
Suicide to Hope (s2H)	One-day in-person workshop designed for clinicians and caregivers working with those recently at risk of and currently safe from suicide. It provides tools to help these caregivers and persons with experiences of suicide work together to develop achievable and significant recovery and growth goals.	Mental Health Clinicians and Professionals
Tennessee Lives Count-Connect	Program aimed to reduce suicidal ideation, suicide attempts, and deaths among youth and young adults ages 10-24 by developing and implementing statewide suicide prevention and early intervention strategies, risk screening/assessment, and enhanced follow-up. Program goals comprise providing suicide prevention and postvention trainings for gatekeepers (schools, law enforcement, foster care, etc.) and training for primary/behavioral health professionals, screening/assessment, early intervention, follow-up, outreach/education, and linkages to treatment services, using the evidence-based Applied Suicide Intervention Skills Training (ASIST) and Columbia Suicide Severity Rating Scale (C-SSRS) models, strengthening public/private collaborations and supporting higher learning institutions to	Children/Youth aged 10-24 and those that work with this population

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

	and connection to suicide attempt survivor support groups.	

Appendix 3: Tennessee Statewide Suicide Prevention Description of Services

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

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

Appendix 4: List of Figures