Promising Practices for Suicide Mortality Review Committees **Toolkit**

Photo by: Airman 1st Class Kathryn Reaves* on DoD*

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Technical Assistance and Training

The material in this document provides communities and coalitions with guidance and resources for developing suicide mortality review committees. For questions about materials, you can reach SAMHSA's SMVF TA Center at smvftacenter@prainc.com.

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Preface

Suicide prevention is the top clinical priority of the U.S. Department of Veterans Affairs (VA). Through the combined efforts of individuals and organizations inside and outside of VA, significant steps are being taken to apply a public health approach to suicide prevention, not just in the Veteran population, but across all populations in all communities.

A critical component of the public health approach is to define the problem that we are trying to solve. For suicide prevention, that means gaining a better understanding of the contributing risk factors and warning signs for an individual and population for suicide risk, taking steps to mitigate malleable risks, and shoring up protective factors.

A community can gather critical data to inform life-saving policy decisions and suicide prevention interventions through a collaborative, multi-disciplinary analysis of suicide deaths. For example, the Washington County, Oregon's Suicide Fatality Review Team found that a number of pet owners surrendered their healthy pets to the county animal shelter before dying by suicide. Within two months of receiving that information, the Washington County Suicide Prevention Council trained all staff and volunteers at every animal shelter in the county in suicide awareness and prevention, training them to understand the warning signs of someone in crisis, ask if they are considering taking their own life, and referring them to the national crisis line if so. Within three months of this training, the staff conducted interventions with seven people who were surrendering their pets who acknowledged that they were going to kill themselves after being asked by staff. (Repp et al., 2019)

The Washington County Suicide Mortality Review Team identified an additional risk factor of recent evictions that were taking place prior to deaths by suicide in their community. Such identification of community-specific risk factors can allow teams to develop enhanced risk mitigation strategies. However, suicide is complex and what may be a risk factor in one community may not be the same in another community. For example, a community-based suicide mortality review process in Humboldt County, California, found that recent evictions was one of the least frequent risk factors in their community suicide deaths. (Repp et al., 2019) Due to variations in access to resources and structures of death investigation systems across the nation, a national single method of suicide mortality has not been developed, emphasizing the importance of community-specific mortality review processes.

Communities can use this toolkit to explore how they may utilize mortality review and the development of a suicide mortality review committee to enhance suicide risk mitigation efforts in their community. Suicide is preventable, and efforts are strengthened through public health

approaches where Veterans live and connect. We hope that these resources are helpful to you and your community's efforts to save lives, and we thank you for your continued efforts in this extremely important work.

Sincerely,

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Introduction

Suicide deaths in the United States continue to be a significant concern. According to the Centers for Disease Control and Prevention, 45,979 Americans died by suicide and there were an estimated 1.2 million suicide attempts in 2020 (CDC, 2021). The numbers and rates of suicide deaths have been consistently high across every age group (such as youth, young adult, working-age adults and older adults) and among specific occupations, such as farmers, service members and Veterans, first responders and construction workers. Suicide also affects many in the community; every death by suicide impacts up to 135 people in some way (Cerel et al., 2019).

The reasons for any individual death by suicide are numerous and complex. Psychological health and wellness play a significant part, as do physical health and social connectedness (Fassberg et al., 2016; Gunn, Goldstein & Gager, 2018; Bachynski et al., 2012). Other factors must also be considered, such as social determinants of health like housing stability, economic stability, access to health care and educational opportunities and the resources available in one's community (Blosnich et al., 2020). The presence of treatable mental health conditions and substance use disorders often play a role in death by suicide, and access to lethal means and a propensity to use them is a critical risk factor (Brenner et al., 2008). Communities around the country have invested time, money and expertise in tackling these conditions individually and collectively.

It has become increasingly clear that communities, states, territories, and the nation as a whole must take a public health approach to suicide, as has been done with other public health concerns that impact communities at large, such as substance-impaired and reckless driving behaviors, obesity and weight-related conditions, smoking, vaping and infectious disease. In order to implement a public health approach, communities and organizations working to address suicide should follow these steps of the public health approach (Mercy et. al., 1993):

1. *Define the Problem*
2. *Identify Risk and Protective Factors*
3. *Develop and Test Strategies*
4. *Ensure Widespread Adoption*

Many communities are engaged in Step 3, ***Develop and Test Strategies***, in order to impact Step 2, ***Identify Risk and Protective Factors***. What is often missing, however, is a clear definition of the problem: What are the suicide numbers and rates in specific communities and in the populations

within those communities? What are the common risk factors among those deaths, and what are some protective factors within that community or population that could prevent deaths by suicide?

This toolkit is designed to help communities develop one approach to answer such questions by establishing a ***suicide mortality review committee (SMRC)*** that will conduct case study analyses of identified deaths within a community; collect data that can help identify common trends among cases; report findings in a clear, accessible and consistent manner; and make recommendations to key decision-makers within a community. A community-based SMRC will be able to identify risk and protective factors that are unique to a particular location or population and then apply interventions that studies have shown to make a difference in decreasing risk factors and improving protective factors.

The following toolkit has been developed with the input of subject-matter experts from communities that have established successful review processes to help communities consider whether they should establish an SMRC. There is no single method of organizing these committees. Some communities have established a decentralized review process, in which the review is conducted at the city, county or parish level. Other committees conduct case study analyses at the regional or state level. Some committees focus on a particular population, such as service members and Veterans, youth or persons of color; others may focus on different factors, such as manner or location of death. Even what the group is called can be different; whether it is described as a team, group or committee, identifies the process as fatality review or mortality review or focuses on

suicide specifically or on suspicious or unexplained deaths more broadly, the goal of each group is the same. For consistency, this toolkit uses the term SMRC, although another commonly used term is suicide fatality review team (SFRT).

This toolkit should be considered a basic introduction to the development, implementation and application of an SMRC. Each section addresses communities in different stages of development. Section 1 is for communities who are exploring whether there is a need to establish an SMRC and what needs to be considered to make that determination. Section 2 is for communities that have decided they want to establish an SMRC and covers what should be considered during implementation. Section 3 is for communities that may already have a form of mortality review being conducted or have established an SMRC and are looking to expand those efforts with consideration toward sustainability. Each section includes five key concepts for consideration; insights from communities with existing SMRCs from both a centralized and decentralized committee perspective; and common barriers and practical solutions for each stage of development. Each section also includes resources, either online or included in the appendices section of this toolkit, as well as key steps to consider.

The complexity of death by suicide requires unique and flexible approaches to prevention. The urgency of the consistently high numbers and rates of suicide deaths require the immediate application of practical solutions. The magnitude of the problem nationally, within individual states and territories and in impacted communities, requires a local response using proven methods. A broad range of literature has demonstrated what works to address a number of different factors that can lead to suicidal crisis; what remains to be done is to apply the broad range of proven approaches to the unique needs of the individual in crisis. By identifying the circumstances and emerging trends in suicide deaths, decision-makers can customize actionable solutions to apply them at the local level in order to solve a national problem.

Section 1: Exploratory Stage: Determining the Need and Capacity for a Suicide Mortality Review Committee

> *The purpose of a suicide fatality review is: How do we prevent a death like this one from happening in the future? —Dr. Kimberly Repp*

Introduction

When states, territories or communities are considering establishing an SMRC, it can be difficult to know where to start. Perhaps your community already has some other form of mortality review or even specific case reviews for suicide deaths. The following section provides some initial steps for consideration. For some communities, it may be more beneficial to start with a broad suicide mortality review process and then focus on individual identifiable subpopulations. For other communities, it may be more beneficial to start with specific subpopulations and then broaden efforts to include other populations. This section of *Promising Practices for Suicide Mortality Review Committees* offers five key factors to consider when first considering suicide mortality review efforts. The Insights From the Field subsection highlights experiences from communities that have established a decentralized review process and from a state that has established a centralized review process. This section also identifies common barriers to establishing SMRCs and practical solutions to overcome them and provides online resources and action steps.

Any group or committee developing a process to review suicide fatalities will work in conjunction with a location's death investigation system. In the United States, death investigation systems typically consist of a coroner system or a medical examiner system, or a combination of both. An additional difference is that death investigation systems can be found at both the state and the county/parish level. A coroner is an elected

official who may or may not have medical or forensic evaluation training; a medical examiner is an appointed official with specific training in a medical profession. According to the Centers for Disease Control and Prevention (CDC), U.S. death investigation systems are as follows:

- Centralized medical examiner system: 16 states and Washington, DC
- County- or district-based medical examiner system: 6 states
- County-based system with a combination of coroner and medical examiner: 14 states
- County-, district- or parish-based coroner system: 14 states

Specific information on which states have which death investigation system can be found on the CDC's Death Investigation Systems* page.

Key Strategies

1. Identify and Analyze Local Suicide Death Data

While suicide data is often reported at the state and national level, it can be more difficult to obtain both general and specific suicide death data for a particular community. Before establishing a community-based mortality review committee, it is necessary to understand the demographics of your community as well as your community's suicide death data, both generally and for specific populations. This will help you determine whether there is a need in your community for a mortality review committee that focuses on a specific population or the method or manner of death or whether it would be more feasible to focus mortality review efforts in other areas.

The more the members of a community know about local-level suicide death data, the better you can tailor your suicide prevention efforts to the needs of your community. One resource for determining this data at the community level is the National Violent Death Reporting System (NVDRS). For community-specific data, it is recommended that you contact your state's NVDRS program manager. Certain groups have higher rates of suicide than the general U.S. population: Veterans, residents of

rural areas, sexual and gender minorities, middle-aged adults and tribal populations. In addition to understanding your community's general suicide death data, knowing your state's and community's demographics will help you better understand your more at-risk populations and allow you to better concentrate your prevention efforts where needed. If your state identifies suicide death data according to these demographics, this would be helpful information for your team to know.

2. Identify Current Suicide Prevention Efforts in Your Community

Collaboration is important to ensure that efforts are not duplicated and to identify what gaps may exist in reporting, response and prevention efforts. It would be helpful to determine what suicide prevention efforts are currently in place or being developed in your community. Most state and many local governments have established suicide prevention programs. In larger metropolitan and suburban areas, private and nonprofit agencies are also likely doing significant work in preventing suicide, both in the widespread community and with specific at-risk populations. And finally, many Veterans Service Organizations in a community have identified suicide prevention in the military-affiliated population as a particular focus of programming and support.

To identify existing state and local government suicide prevention efforts, we suggest you locate and contact your state suicide prevention office. This office is likely the best source of information for

community-based efforts, as it is a likely funding source for local programs and often provides training and educational opportunities throughout the state. An office or department of suicide prevention is also a likely point of contact to determine whether your state has a publicly available suicide prevention plan and also provides a connection to the state suicide prevention council or coalition. A state suicide prevention office could be housed in the state Department of Health, Department of Public Health or Department of Public Safety.

3. Identify Your Local Death Investigation Infrastructure

One of the first steps toward the development of an SMRC is to understand the current death investigation infrastructure in your state or territory. The staff of the local death investigation infrastructure are critical partners in the development and sustainability of an SMRC. Without the cooperation and support of the local death investigation office, the SMRC is not able to effectively conduct mortality reviews. As identified in the introduction to this section, death investigation systems vary by state, are centralized or decentralized and follow either a coroner or medical examiner model.

Most death investigation system offices and personnel are supportive of mortality reviews but do not have the capacity to conduct them on a consistent basis. It can also be helpful to work with epidemiologists, who are subject-matter experts trained in the collection, analysis and reporting of patterns of frequency, causes and effects of diseases and conditions such as suicide. If your local death investigation office has an epidemiologist on staff or is affiliated with one, engaging with this person can be instrumental in the development of your committee. Other sources of potential epidemiology partners include local universities or community or state/territory departments of health or their equivalent.

4. Identify Potential Partners to Include in Planning and Development

In addition to identifying any ongoing suicide prevention efforts in your community, it is also necessary to identify any potential stakeholders to partner with in developing a committee. Such organizations may have individuals who would be willing to join a mortality review committee, or they may offer resources or insights that are valuable in the planning and development of a committee. These can include, but are not limited to:

- public, private or nonprofit organizations

- governmental agencies at the city, county and state level
- organizations with a specific focus on mental health and well-being such as local medical centers or community mental health providers

It can also be beneficial to reach out to stakeholder organizations that represent a potential population of focus, such as local schools and parent groups if the focus of a mortality review committee is going to be youth and children. If the focus of a mortality review committee is going to be service members, Veterans and their families, then outreach to both local and chapter-based Veterans Service Organizations and VA would be beneficial. Another potential source for organizational stakeholders are community groups that represent an industry overrepresented in local suicide deaths. In many urban and suburban communities, the construction industry has a significant number of suicide deaths, and in rural communities, the agricultural and farming communities are often overrepresented in local suicide death data. Including organizations that represent these industries can be beneficial.

5. Identify an Organization With the Capacity to Lead SMRC Efforts

Finally, if research indicates that there is both a need for and a lack of general or specific suicide mortality reviews, it is necessary to identify an organization that has the capacity to develop, plan, coordinate and conduct the ongoing work. As with any community-wide collaborative effort, team members need to identify a local organization that will be the backbone organization for an ongoing mortality review committee. Based on a budget or personnel considerations, the lead agency could be the local death investigation office; part of a local governmental agency, such as the community executive branch or public health agency; or a type of stakeholder organization discussed above. Most important is that the lead agency is able and willing to manage the business of the committee for at least three to five years in order to either determine the value of the data produced by the committee to justify ongoing efforts or transition efforts to another area of focus.

The organization serving as the coordinating agency for this effort will need to ensure that it has the personnel and resources available to host planning and review meetings and conduct the ongoing business of the committee. The agency will need to ensure that it has clear and consistent communication among committee members; has developed and will adhere to the standards of review agreed upon by committee members; and has the capacity to communicate the results of the review committee to interested parties, including the community at large. This organization will also be responsible for the ongoing sustainability of the committee, to include managing and recruiting

committee participants; ensuring fidelity to the review process by conducting orientations for new committee members; and pursuing funding for ongoing or expanded review efforts.

Insights From the Field

Decentralized Review Committees

Local officials in Washington County, Oregon, identified death by suicide as a priority health issue and formed a county-based Suicide Prevention Council, which in turn recommended the creation of a SMRC. The key lesson learned from this community is to begin by understanding what committee members want and do not want their review committee to be. The desired outcome of the review process was to identify common factors of suicide deaths within their community to better inform prevention efforts. The committee did not want to establish a process that assigns blame or culpability for a suicide death, nor did it want to replicate a psychological autopsy process, which requires significant training, funding and time. The committee also valued the independence to establish its own goals, rules and objectives separate from a policy directive or legislative mandate.

Centralized Review Committees

The state of Montana, which established a statewide suicide mortality review process, chose to develop legislative support for its mortality review efforts. Montana House Bill 583, which can be found in the resources portion of this section, created the statewide mortality review committee and outlined membership requirements, the process for obtaining information, confidentiality protocols and penalties. The support of legislative action ensured that the Montana statewide mortality review committee had access to suicide death data and coroner reports and removed the need for consent forms. As an added benefit, legislative requirements for coroners to provide death data increased the management and timeliness of information conveyed to the committee.

Common Barriers and Practical Solutions

Barrier: Obtaining consent from the next of kin or responsible party for a suicide mortality review can be one of the most difficult parts of the initial process for a committee.

Solution: As mentioned above, if a committee structure is legislatively mandated and confidentiality is addressed in the legislation, consent for a suicide mortality review is not required. The State of Montana explicitly addressed confidentiality in the legislation listed in the resources section. If the committee is not legislatively mandated, then how the committee obtains consent, from whom and the limits of such consent will need to be established. Examples of the Washington County, Oregon, consent process and forms are provided in the resources portion of this section.

Barrier: A funding source for an SMRC is often unavailable or a fiscal agent is not clearly identified.

Solution: The initial implementation of an SMRC can be established through a cooperative agreement between stakeholder agencies. Some mortality review committees have been established using in-kind donations of staff members' time to the coordinating agency; indirect or administrative costs to cover portions of staff time; or community or state resources. Support from community groups and agencies can also help get the review committee started. Once initial work is completed, the results obtained from the systematic review can be used to pursue grants and community or state funding.

Making Use of Available Resources

- State NVDRS program managers*
- Death investigation systems by state*
- State suicide prevention coordinators*
- VA Suicide Prevent Coordinators* (enter ZIP code to find local point of contact)
- Legislative example (Montana) of establishing a statewide SMRC*
- Critical components of a suicide mortality review checklist (p. 33)
- Sample Confidentiality Statement (Oregon) (p. 35)
- Sample Confidentiality Agreement (Montana) (p. 37)
- Sample Confidentiality Request (p. 36)
- Sample Team Member Letter of Invitation (p. 39)

Your Action Steps

- Identify and analyze local suicide data
- Identify your state's, territory's or community's death investigation structure
- Conduct an analysis of the current suicide prevention and mortality review efforts in your community
- Identify and engage with potential stakeholders to engage in planning and development of a mortality review committee
- Identify a lead agency that has the capacity to coordinate SMRC efforts
- Other: _____

Section 2: Implementation Stage: Initial Steps in Establishing a Suicide Mortality Review Committee

> *We have now been doing this for 10 years. … Our recommendations are really guiding legislation at every legislative session. —Karl Rosston, Montana*

Introduction

After your community has determined that it has both the need and capacity to conduct periodic suicide mortality reviews, the next step is to plan for the development of the committee. Establishing clear goals and intentions for the committee during the development process and implementing foundational procedures in a deliberate manner can ensure that your committee is successful and sustainable. This section of *Promising Practices for Suicide Mortality Review Committees* provides five key items to consider when developing your SMRC. The Insights From the Field subsection highlights communities that have established SMRC, and the Common Barriers and Practical Solutions subsection provides practical examples of challenges that other communities have faced in developing committees and the methods they used to overcome them. This section also provides resources that can be used to help establish your committee as well as relevant action steps.

When looking at suicide death data in a particular community, it is important to make a distinction between the overall number of deaths by suicide in a community and that community's associated suicide mortality rate. As with many types of mortality data, suicide death data is often reported as a *rate*, or how many deaths occur per 100,000 members of a particular population. For the purposes of establishing an SMRC, it is more critical to consider the *incidence* of suicide, or how many suicide deaths

occur in a community in a given time period. For the data collected to be applicable to the identified population and for an SMRC to develop actionable recommendations, it is necessary for the committee to have a minimum number of cases to review.

Established SMRCs have reported the greatest success in communities that have at least 30 deaths by suicide in an identified population over the period of one year. Because of difficulties related to consent, complete documentation and other barriers to collecting documentation for a thorough review, an SMRC will often have a smaller subset of cases to review. For communities with 10 or fewer deaths by suicide, a process that examines deaths through the use of psychological autopsies may be better suited (see Section 3).

Key Strategies

1. Partner With Your Local Death Investigation System

After determining what form of death investigation system your community has, engaging with your local death investigation office is an important first step in establishing your committee. It is critical to have the support of your local death investigation office when conducting suicide mortality reviews. Without the office's support and access to the necessary records a death investigation office provides, a SMRC will not be able to conduct meaningful analysis.

Before contacting your local death investigation office, it can be helpful to prepare some questions to guide your conversation and outreach. These can include:

- What is the office's current death investigation process related to deaths in which intentional self-harm was a potential factor?
- What is its capacity to support a mortality review committee? For example, is it limited to providing documents, or would the office be willing to have its staff serve as active members of the committee?
- What are some barriers and obstacles that the office anticipates in partnering with a community-based mortality review committee?

By engaging with your local death investigation office, you are establishing a partnership that will hopefully be long-lasting and beneficial to the community. Such a partnership can also be beneficial in that the lead death investigator, whether a medical examiner or coroner, is likely to be connected to key decision-makers in your community, such as government leaders and department heads, and serve as a key influencer of public opinion and a recognized expert in your community.

2. Identify a Population of Focus for Review

After establishing a partnership with your local death investigation office, another important step in developing your SMRC is to determine what population you will choose as the focus of your case reviews. It is important to have a large enough number of a particular population to be able to draw meaningful conclusions from the reviews but also to have a manageable number of cases to review. If a community has a large number of deaths by suicide, it is advisable that the review committee initially focus on an easily identifiable population group, such as specific age groups (youth, young adult, working-age adult, older adult) or occupation-related groups (Veterans, members of the construction industry, first responders). If the members of the development committee have a desire to focus on a particular segment of the population—Veterans or youth, for example—but the numbers of suicide deaths are not enough to draw meaningful conclusions from the review, then it would be better to focus on a larger group or explore other methods of mortality review, such as conducting psychological autopsies.

Identifying the intended population focus of the review is also important as it will help determine whom you invite to the review committee. It is important for members of the review committee to have particular experience with or expertise in that population; for example, representatives of the construction industry are key members to have if your review committee will focus on working-age adults and your community has a high number of deaths in this field. This representative is possibly less beneficial if your review committee will focus on school-aged youth. It's important to remember that choosing a specific population focus does not mean that your review committee will be excluding other suicide deaths as unimportant or irrelevant. The reason to choose a specific focus is so your review committee can start with an easily identifiable population with similar traits; implement, evaluate and refine its processes; and then apply lessons learned to other populations within your community.

3. Consider Existing Suicide or Death Review Processes to Develop Your SMRC

After partnering with the staff of your local death investigation office and identifying the population the SMRC intends to focus on, it is also necessary to determine whether your community or groups in your community are already conducting suicide mortality reviews. Specifically for the military-affiliated population, death investigations are often conducted after a service member death, including death by suicide. While these investigations and the resulting data may not be publicly available, service member death investigation efforts could serve as a source for planning and collaboration. Additionally, a community's coroner's or medical examiner's office would be aware of any groups in the community conducting mortality reviews, either generally or specifically related to suicide. Local institutions of higher education may also have periodic or ongoing studies looking at suicide deaths in a particular community, and some communities may have already established mortality review committees for certain groups or at-risk populations.

Many communities already have general or suicide-specific mortality review committees. These committees are most frequently focused on youth suicide deaths and are likely housed in or supported by community public health agencies. These existing committees can be considered collaborative partners, models for suicide mortality review in your community and sources of information. Another likely source for existing mortality investigations are local colleges or universities,

especially if they have a public health program or department. Academic research identifying the cause, manner and characteristics of local deaths can be a source of data for decision-making, and the research process itself can also be a core inspiration for the committee's own investigation procedures. Academic mortality review efforts are also supported by students conducting the research, and partnership with a local educational institution can be an ongoing source of committee members conducting mortality reviews.

4. Establish Group Structure, Including Goals, Policies and Procedures

After evaluating the capacity to form the group as discussed in Section 1, the next step in establishing your review committee is to agree upon the structure for the group. Guided by the coordinating agency previously identified, the group will need to agree upon the goals of the review committee as well as other process-oriented topics. Will the group meet virtually or in person and with what frequency? What establishing documents will be necessary, such as a committee charter or memoranda of agreement/understanding? Who will be responsible for meeting logistics such as sending invitations and reminders and disseminating materials? It might be beneficial for a core team of committee members to serve as a development group to establish the processes that will then be shared with the larger group for discussion and adoption.

Another important aspect of establishing the committee is determining its participants. Many communities have a limited number of committee members when the committee starts out, but as the effort grows, so does the number of committee members. Some committee members who join in the beginning may not continue as members of the group and the committee will realize that additional group members are needed. It can also be helpful to identify both "core" committee members and "ad hoc" committee members, who are brought in to review specific deaths. For example, it can be beneficial to have a member of the faith community as a standing committee member but also to establish connections with faith leaders in different groups or denominations who can consult on the cases of members of that denomination. Ad hoc committee members would need to receive the same level of training and meet the same standards of confidentiality but would be engaged on an as-needed rather than ongoing basis.

5. Develop Policies and Procedures to Ensure Committee Member Safety and Wellness

Finally, an important factor in establishing your community is ensuring the safety and wellness of committee members. The nature of the work of reviewing suicide fatalities requires reflection

on and awareness of the difficulty of the task. As part of the development of meeting standards and protocols, it can be helpful to begin each meeting with a moment of grounding, reflection or appreciation about the difficulty of the work. It can also be beneficial to ensure that you have committee members who are trained in supportive care and ensure the process is reviewed by someone trained in trauma-informed care. The frequency, workload and location of the meeting is also important; uninterrupted privacy in an enclosed meeting location can be beneficial to reduce distractions but also to ensure confidentiality and privacy.

In selecting committee members, it's important to establish an interview process that will allow group leadership to explain the goals of the committee as well as the level of exposure to traumatic and distressing events that committee members will experience. As identified in the introduction to this guide, it is likely that many members of a community will have been impacted by suicide death of a friend, colleague, family member, or associate at some point in their lives. However, Washington County Oregon's suicide fatality review team has reported that suicide attempt survivors, specifically, have experienced significant traumatization in conducting mortality review work, as have recent suicide loss survivors. While a public health approach to suicide prevention values the voice of those with lived experience, it is important to understand that the insights that attempt survivors and recent loss survivors may bring must be balanced with the level of traumatic cost to the individual and those who support them.

Insights From the Field

Decentralized Review Committees

Not only is it important for local death investigators to support and be involved with review committee efforts at some level, but it can also be beneficial for key members of the committee to better understand the death investigation process. In Washington County, Oregon, a key member of the review committee obtained the required certifications and permissions to be able to accompany death investigators to the scenes of fatalities in the community. The committee then determined that everything its members want to know about risk and protective factors related to suicide was already being asked by death investigators; however, the death investigation process is focused on determining manner and cause of death, not on identifying trends to prevent future

deaths. By becoming more familiar with the death investigation process, the mortality review committee can understand how the information being reviewed is gathered and reported and identify potential gaps that additional investigation could fill.

Centralized Review Committees

The centralized suicide mortality review process in the State of Utah found both short- and long-term benefits to the review process but found it important to note that the long-term benefits were of the greatest value. Short-term benefits stemmed from identifying processes or situations in particular deaths or groups of deaths that may benefit from immediate response. It is important to understand that the goal of an SMRC is not to assign blame or hold individuals or agencies accountable in a punitive way but rather to prevent future deaths. The true value is seen after long-term analysis, in which the committee can understand the characteristics that deaths have in common. This can cause a sense of futility in the short term, in which committee members may feel as though their efforts are not immediately impactful. Remind the team that their role in suicide prevention is not immediate intervention—identifying someone in crisis and preventing their death in the present—but gathering data that could lead to future identification and prevention efforts. When committee members in Utah were surveyed about what support they would find beneficial to help them continue their work, the overwhelming responses were related to a desire to see the results of the conducted analyses. Take the time to reassure committee members that their work is an important part of the state's or community's suicide prevention efforts; help them focus on the long-term goals of the committee; and communicate and celebrate any changes or improvements that have been made as a result of the team's work.

Common Barriers and Practical Solutions

Barrier: Vicarious trauma, a stress or distress response to traumatic event exposure, can significantly impact the wellness of review committee members.

Solution: Vicarious trauma is one of the most difficult and predictable problems for members of an SMRC. Regardless of the population being studied, the members who volunteer to conduct suicide mortality reviews have a measure of affinity for and empathy with the decedents; that is likely what caused them to volunteer. When developing a mortality review committee, it is important to clearly identify the potential traumatic impacts of participation; avoid traumatization in volunteers with known risk factors; and implement stress mitigation or reduction efforts during every step of the process. By being very clear in the recruitment process about the potential difficulties and potential benefits, you will ensure that potential members are fully aware and informed. However, some committee members, even prepared with this information and awareness, may find that the exposure to trauma is too significant; these members should be supported in every way possible and allowed to disengage from the process whenever they desire. As previously stated, the potential risks of traumatization for suicide attempt survivors and recent lost survivors is significant, and this risk does not outweigh the value of having their voice as part of the committee. Finally, collaborating with your committee to mitigate or reduce the impact of trauma can be beneficial in sustaining group membership. Whether this means always having a team member available during review meetings who can address immediate stress responses, limiting the number and types of cases reviewed during any particular session or implementing group norms around stress reduction, any and all measures to mitigate the exposure to stress to the greatest extent possible can be beneficial.

Barrier: It can be counterproductive to the goals of the review committee to not have key decision-makers involved in the process or willing to act on recommendations developed by the committee.

Solution: It is very important for key decision-makers in a state or community to be fully on board with the development of the committee; agree with the strategies and goals identified by committee leadership; and be committed to considering and acting upon recommendations from the committee. Some community-based committees that made recommendations to community leaders who were not receptive to them or willing to implement them found the process to be more harmful than beneficial. Community leadership commitment can be developed in several ways. In Montana, legislation requires an annual report of the data and recommendations based on the data observed, and this has been beneficial in gaining policymaker commitment. Other committees have found success in recruiting key decision-makers or their representatives to be part of the committee development and review process.

Making Use of Available Resources

- Behavioral Risk Factor Surveillance System*
- CDC's Wide-ranging Online Data for Epidemiologic Research (WONDER)*
- VA's Suicide Prevention Annual Reports*
- Youth Risk Behavior Surveillance System*
- Web-based Injury Statistics Query and Reporting System*
- National Health and Nutrition Examination Survey*

Your Action Steps

- Engage with death investigation office officials
- Identify the population of focus for SMRC reviews
- Pattern your mortality review committee on other similar efforts
- Establish a group structure and procedural format
- Ensure procedures safeguarding team member safety and wellness are always a consideration
- Other: _____

Section 3: Sustainability Stage: Expanding and Improving Upon Existing Suicide Mortality Review Efforts

We took the suicide surveillance data ... concerning lethal means and combined them to inform a policy recommendation to leadership to extend lethal means safety training to providers serving older Veterans and female Veterans specifically. —Dr. Stephanie Gamble

Introduction

As community members start to develop and implement suicide mortality reviews, you may find that similar activities already exist in your community. These activities may be narrow in scope, have limited resources, or have explicitly defined parameters. It can also be beneficial to know, as a committee is established and developed, what possible changes the committee may expect as the effort grows. This section of *Promising Practices for Suicide Mortality Review Committees* provides five items for consideration when either expanding similar efforts within your community or implementing process improvements for a committee that has been established. The Insights From the Field section provides examples of both centralized and decentralized efforts to expand similar or existing efforts to improve community-based data, and the Common Barriers and Practical Solutions section show how particular communities have overcome obstacles to expansion. Example resources for committee expansion and next steps are included.

Establishing a multiorganizational collaborative group to conduct suicide mortality reviews is necessary, but it can also be extremely challenging. Identifying, recruiting and retaining committee members is important and must be considered when developing your committee.

Organizations in a community may have organizational goals related to supporting a particular population in a specific way or may have expertise in addressing a specific need within the community. Gaps in support may exist, but they may also not be obvious to organizations providing support within a community.

For a community to establish an effective SMRC, it is necessary from the beginning to establish a true collaborative partnership where all parties agree on mutual goals and intended outcomes. Overcoming "silo" mentalities that may exist, identifying and resolving the duplication of efforts by multiple individuals and organizations and ensuring that individual organizational goals are met as well as the goals of the SMRC are all critical elements of building a group that will be able to effectively review and recommend actionable strategies to reduce suicide.

Key Strategies

1. Review Goals, Documentation and Procedures

Some communities may have already implemented mortality reviews for other methods or manner of deaths. It can be beneficial, if mortality review efforts already exist, to consider how their processes may be applied to a suicide mortality review process and what other documentation or procedures could be put in place. For example, other mortality review procedures may or may not require consent from surviving family members or next of kin. It can also be important to understand how existing mortality review committees are structured—either as part of a governmental agency or as an independent review committee coordinated by a nongovernmental agency—and how that could apply to your committee.

Other documentation considerations could be applied to the structure of your committee specifically, such as templates for meeting agendas and minutes or documents used for preparation work prior to a meeting. Does your committee have documentation outlining roles and responsibilities for all members as well as key leadership positions? How are leadership positions determined, and are these procedures outlined in a committee charter? The goal for updating documentation is to ensure that efforts are indefinitely sustainable and not reliant upon individual committee members.

2. Review Committee Membership

One common experience among the communities that have established SMRCs is that committee membership grows and shifts over time. It is important to periodically review committee membership to ensure that the organizations and population groups represented are still relevant and to determine whether other organizations or groups should be represented that are not currently involved in the review process. It is also important to explore how committee members experience the review process. Are meetings being held too frequently or not frequently enough? Is the workload for each committee member manageable, or do new committee members need to be brought on to reduce the burden?

One reason to expand committee membership is that trends emerge over time. For example, a community may notice an increase in suicide deaths in individuals whose primary residence is in another location but who temporarily reside within their jurisdiction; this may indicate that it would be beneficial to have a representative from RV parks or a long-term rental property management company as a committee member. Trends in other factors such as race, ethnicity, gender, gender expression or sexual orientation may emerge. As trends emerge, it is extremely important to have committee members with lived experience in those communities or demographics.

3. Consider Using Additional Analysis Methods to Improve Data Collection and Recommendations

Additional fatality analysis methods such as psychological autopsies or in-depth mortality reviews can be extremely informative and provide a wealth of information not normally found in a standard case review. It could be beneficial, after identifying emergent trends in a particular group or location, to set aside a small number of cases that could be referred for more in-depth analysis through a psychological autopsy. This could be applied in more specific situations, such as combining a manner of death with a particular demographic. For example, if there is an emerging trend of young adults who die from intentional overdose in a particular area of your community, conducting psychological autopsies on a limited number of cases may inform future committee work and identify emerging trends sooner than standard reviews.

It is important to understand that death investigations, suicide mortality reviews and psychological autopsies exist on a continuum and require different levels of expertise and certification. All can be critical to understanding suicide in a particular community and can be applied in different ways at different times. If your community does not have someone who is certified to conduct psychological autopsies, or lacks the resources to contract with certified professionals, it can be beneficial to have a certified forensic analyst take part in your review committee process, either as an adviser and referral source or as a standing member of the team.

4. Consider Expanding Review Efforts to Different Populations or Fatality Types

After conducting suicide mortality reviews, another response to emerging trends is to expand review efforts to different populations or other types of death. Some communities have expanded their review scope beyond clearly identified deaths by suicide to include other types of unexplained sudden deaths. These can include single-vehicle accidents where no immediate cause is apparent, overdose deaths, drownings or other ambiguous deaths that may or may not have been intentional. Circumstances of these deaths could also indicate intentional self-harm, and data interpreted as a result could be used to further inform recommendations to community members and leaders.

Another possible expansion is to pursue a deeper focus on intersectional trends that have emerged. For example, an SMRC that specifically looks at suicide in young adults may see a large number of Veterans in the reviewed cases, which could lead to a subcommittee that specifically looks at Veteran deaths in the region. Or if a committee looking at Veteran deaths sees a significant number of deaths among those who were involved in the criminal justice system, expanding review efforts to all suicide

deaths that include recent incarceration or justice involvement could identify critical information that could lead to recommendations for additional support for individuals in these populations. It is important to remember when considering other populations to review, that a suggested minimum of 30 suicide deaths in a population in a given year provides the most effective results. If no single community meets the suggested minimum number of deaths, it might be beneficial to take a regional approach to establishing an SMRC. Rural and extremely rural counties, for example, share a similar population base within their geographic region and combined aggregate data could be considered using a decentralized approach with a larger group of stakeholders. If you identify trends but the population has fewer than 30 suicide deaths, consider an alternate review method such as psychological autopsies. More information regarding psychological autopsies is available through links in the resources portion of this section.

5. Deliberately Focus on Reporting Conclusions and Making Actionable Recommendations

As important as it can be to identify and gather the data related to suicide in your community, it is equally important to develop recommendations based on the analysis of that data. This requires an ability to communicate the findings of the committee concisely and to establish connections with decision-makers willing to act on these findings. Although defining the problem is an important step in the public health approach to suicide prevention, it is not the only step. Identifying the

contributing factors to suicide death in your community can help identify both risk and protective factors related to suicide deaths, and both are critical for developing programs or activities designed to promote protective factors or reduce risk factors.

Data can also be used to report information in a way that educates the community on the scope of the problem and to provide a basis for expanding the current work. By producing an annual report specifically for your community on the conclusions of the committee, you can ensure that both the general public and community leaders are aware of the suicide mortality review efforts as well as of changes that can be made to reduce suicide deaths. An annual report by the committee can also be used to effect policy changes, which results in increased budgets for the local death investigation office to support committee work, or to apply for grants that would allow the committee to sustain its efforts over the long term.

Insights From the Field

Decentralized Review Committees

If a community has an established SMRC, the process will naturally develop and expand over time. Committee leadership will need to understand how and when to add new members to the committee. When considering whether to expand committee membership, it can be beneficial to determine whether certain criteria are being met:

- Are actionable recommendations being developed?
- Is there evidence of recommendations being used?
- Is attendance consistent and are committee members involved in the process?

If the above criteria are met, then committee leadership could invite additional organizational representatives to the review process. It is recommended that a committee add no more than three new committee members a year and that all new committee members start at the same time. It could also be beneficial to develop and institute an onboarding process for new members and to include an objectives overview, training modules and a mentorship program where new committee members are connected with existing members for guidance and support.

Centralized Review Committees

While a committee may initially focus on one particular population or type of death, expanding the types of suicide deaths the committee reviews can lead to more data and more comprehensive conclusions obtained from the analysis of that data. The State of Utah, which reviews suicide fatalities collectively at the state level, expanded its suicide mortality review to include overdose deaths. Its system, the Sudden and Unexpected Death Surveillance System (SUDSS), reviews fatalities that may or may not be suicides but is likely to include all suicide deaths in the state. Given such an expanded scope of cases to review, the SUDSS narrowed the population focus of the committee's reviews to teens and youth.

Other circumstances in a state or community can lead to expansions or modifications of the focus for suicide mortality review. Utah also specifically reviews patient deaths in hospitals using the Zero Suicide prevention framework. As previously stated, such review is not meant to assign blame or find fault but instead to identify opportunities for intervention. The conclusions and recommendations of the review committee can then be provided to all hospital systems using the Zero Suicide framework, leading to increased support for all patients experiencing a suicidal crisis in such systems.

Common Barriers and Practical Solutions

Barrier: A narrow focus on policy recommendations to create or replace procedures may overlook the opportunity to make small but impactful changes.

Solution: Identifying the goals of your SMRC during development and both keeping a focus on those goals and evaluating them periodically can ensure that your committee is as effective as possible. It is necessary for both committee leaders and members to be flexible and open-minded regarding the recommendations developed from the analysis. Consider recommendations from a "repair or replace" perspective. If a recommendation is a "repair," then it focuses on a particular procedure or intervention within a community that may not lead to effective prevention or intervention. If the recommendation is a "replace," then it identifies procedures or interventions that do not exist or are not effective. Small changes to existing procedures are quickly applied and may not lead to observable changes, but the accumulative effect on prevention in the community is one of improvement. Replace recommendations, such as legislative recommendations or program

development, typically take longer to implement but can lead to obvious change. If a committee's goals are narrowly focused on either one or the other type of recommendation, then the advantages of both recommendations may not be realized.

Enhancing Protective Factors

Barrier: When developing SMRCs with a narrow goal to identify risk factors for suicide, groups often overlook opportunities to identify and increase protective factors that will prevent suicide.

Solution: A key component of the public health model is to identify both risk-reduction and protective factors that influence suicide deaths. Risk-reduction factors are those that, in the event of a suicidal crisis, decrease the likelihood that the crisis will be fatal. Protective factors are those that can keep someone from experiencing a suicidal crisis in the first place or can lessen the experienced distress so it does not lead to attempts or deaths. If an SMRC is focused solely on identifying and reducing risk factors—such as limiting access to lethal means or providing appropriate mental health care to those in crisis—then the opportunity to increase protective factors might be overlooked. The Washington County, Oregon, SFRT uses a matrix that helps the team identify both risk and protective factors for each case reviewed; for example, the team identified a trend that people who died by suicide had been keeping their eye doctor appointments, which indicated health-seeking and -improving behaviors. This led to a recommendation to provide education, awareness and prevention

training to optometrists in their community. Identifying and influencing both risk-reduction and protective factors as part of the SMRC process can make significant differences in suicide prevention.

Making Use of Available Resources

- VA Behavioral Health Autopsy Program*
- VA annual reports*
- Legislative report on the Utah Youth Suicide Research Project*
- Service Members, Veterans, and their Families Technical Assistance Center webinar: Using Psychological Autopsies & Mortality Review to Inform Suicide*
- Model Commitment Letter for Coalition Partners (p. 38)
- Skills Inventory Worksheet for Coalition Partners (p. 41)
- Stages of Coalition Team Building (p. 40)

Your Action Steps

- Review existing committee documentation to ensure fidelity to goals or possible modifications
- Periodically review committee membership and modify or change as necessary
- Consider the use of additional forms of analysis to obtain more data
- Consider expanding the types and manners of suicide deaths being reviewed
- Identify the most effective way to report ongoing progress and make effective recommendations
- Other: _____

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Appendix I: Critical Foundational Conditions: A Checklist

The elements below are important foundational conditions that should exist or be in development prior to the establishment of a suicide mortality review committee. Review each element and discuss how to implement it in your state, territory or community.

Engagement with Death Investigation Office

- ☐ Death Investigation Office is voluntarily engaged and willing to participate in SFR
- ☐ Death Investigation Office performs robust death investigations with American Board of Medicolegal Death Investigators-certified investigators whose narrative reports for suicides are a page or more
- ☐ Death Investigation Office has capacity to fill out an online 5-minute form after each suicide
- ☐ Death Investigation Office is able to/can delegate the sending of the next of kin letters on their letterhead/envelopes and follow up with one phone call if there is no response

Organizational Capacity

- ☐ There is a project coordinator for SFR (suicide prevention coordinator)
- ☐ There is an existing coalition consisting of an active and broad representation of community organizations who can implement SFR recommendations
- ☐ County counsel is willing to consult on what the NOK release form allows in terms of sharing information

Key Personnel

- ☐ There is an epidemiologist or public health professional to collect data during SFR
- ☐ There is an epidemiologist or public health professional with qualitative data analysis experience to synthesize findings from SFR
- ☐ Key decision makers are voluntarily engaged and willing to receive and implement actionable recommendations based on findings

Adapted from "SFR Setting Up for Success Checklist" provided by Dr. Kimberly Repp

Appendix II: Resource List

Confidentiality Examples

Coalition Development Resources

Confidentiality Statement (Montana Example)

The purpose of the Suicide Mortality Review Team is to conduct a thorough review of all suicide deaths in Montana in order to better understand how and why people complete suicide and to take action to prevent future suicides.

In order to assure a coordinated response that fully addresses all systemic concerns surrounding suicide deaths, all relevant data should be shared and reviewed by the team, as permitted by law, including historical information concerning the deceased person, his or her family, and the circumstances surrounding the suicide. Much of this information is protected from public disclosure by law.

MCA 50-19-405 and MCA 50-19-406 stipulates in no case will any team member disclose any information regarding team discussion outside of the meeting other than pursuant to the mandated agency responsibilities of that individual. Failure to observe this procedure may violate various confidentiality statutes that contain penalty. Public statements about the general purpose of the suicide mortality review process may be made, as long as they are not identified with any specific case.

The undersigned agrees to abide by the terms of this confidentiality policy.

List names and signatures:

Adapted from the Montana Suicide Mortality Review Program Manual, 2013.
Used With Permission

Authorization for Release of Confidential Information

Deceased Veteran's Full Name: _____

Date of Birth (mm/dd/yyyy): _____ Date of Death (mm/dd/yyyy): _____

I, [Legal Representative/Personal Representative of Deceased Name Here], authorize the release of information to the [Add State/County] Suicide Mortality Review Committee for the purpose of conducting a quality assurance review regarding my deceased family member.

Organizations to Whom Information is to be Released: Below is a list of Suicide Mortality Review Committee organizations who may have had contact with your family member. Even if you have reason to believe your family member did not have any contact with these organizations, we will not be able to request or disclose information without your signature. By signing below, I authorize the following organizations to disclose and share information with each other during the review process. Any information obtained in this process will be confidential to the members of the committee.

- County Departments and Programs
- County District Attorney's Office
- State of [Add State/County] Department of Human Services Departments and Programs
- Law Enforcement (Federal, State, Local) Departments and Programs
- Veterans Affairs (VA)/ Veterans Health Administration (VHA)
- Healthcare Representatives (Hospitals, Providers, Coordinated Care Organizations)
- Mental Health Representatives (Hospitals, Providers, Coordinated Care Organizations, National Organizations, Including the National Alliance on Mental Illness)
- Local and National Crisis Line Representatives
- Faith Community Representatives
- Education, School District, College/University Representatives

Name and Address of Organization To Whom Information Is To Be Released

_____

_____

Information Requested: The information requested by the [Add State/County] Suicide Mortality Review Committee on the decedent is:

☐ All health information from [Add Date] to [Add Date] prior to the date of death, including drug abuse, alcoholism or alcohol abuse records, sickle cell anemia, human immunodeficiency virus (HIV) in the possession of the organizations listed below who participate on the Suicide Mortality Review Committee.

☐ Other information (Describe): _____

_____

_____

De-identified or anonymized information will be used for an annual report [which is submitted to].

Authorization: I may refuse to sign this authorization. My refusal to sign this authorization will not impact my treatment, payment, enrollment, or eligibility for benefits.

I may inspect or copy any information used and/or disclosed under this authorization. My authorization may be revoked at any time in writing; the only exception is when the action/disclosure has already occurred as instructed in the authorization. Written revocation is effective upon receipt by the Release of Information department at the organization or facility housing the records. I understand the entire health record may not be provided due to restrictions on release in other federal statues. This authorization will expire one (1) year after the date of signature. I understand that information may be released to an entity not covered by Federal privacy laws or regulations and redisclosed.

A copy of this form shall have the same validity as the original. I understand that I will receive a copy of this form after I sign it.

Legal Representative/Personal Representative Signature _____

Date (mm/dd/yyyy): _____ Relationship to Deceased: _____

Review Team Confidentiality Agreement

The purpose of a Suicide Mortality Review Team is to conduct a thorough examination of each suicide death in Montana. In order to assure a coordinated response that fully addresses all systemic concerns surrounding suicide fatalities, all relevant data, including historical information concerning the deceased person and his or her family, must be shared at team reviews. Much of this information is protected from disclosure by law, especially medical information. Therefore, team reviews are closed to the public, and confidential information cannot be lawfully discussed unless the public is excluded. In no case should any team member or designee disclose any information regarding team decisions outside the team, other than pursuant to team confidentiality guidelines. Failure to observe this procedure may violate various confidentiality statutes that contain penalties. Any agency team member may make a public statement about the general purpose or nature of the suicide mortality review process, as long as it is not identified with a specific case.

The undersigned agree to abide by the terms of this confidentiality agreement.

Name	Agency

Adapted from the Montana Suicide Mortality Review Program Manual, 2013.
Used With Permission

Model Commitment Letter: Coalition Organizations

Our organization, [name], is committed to be an active member of the [name] Coalition. We are committed to the vision, goals, objectives and strategies that have been and/or will be decided by the Coalition. We are committed to the planning and collaboration that such coalitions undertake and understand that it will take time. We acknowledge the contributions and expectations of the other members of the Coalition. Benefits of membership include: newsletters, access to coalition website and its resources, educational events, connection to other members and priority populations, _____ [specify others that apply]

As general evidence of our commitment, we agree to do the following:

- ☐ Appoint a representative(s) to attend coalition meetings and activities
- ☐ Authorize that representative to make decisions on our behalf, except for decisions regarding _____ [specify exceptions, if appropriate]
- ☐ Read minutes, reports and newsletters to keep abreast of coalition decisions/activities
- ☐ Disseminate relevant information to organizational members or employees through listservs, websites and newsletters
- ☐ Keep coalition informed of our organization's related activities

Specifically, our organization will commit the following resources to the coalition:

- ☐ Access to our volunteers for coalition tasks
- ☐ A financial commitment for $ _____ [or dues, if appropriate]
- ☐ In-kind contributions of staff time, material resources, meeting space, refreshments and/or incentive items _____ [specify]
- ☐ Connections to other key organizations/individuals _____ [specify]

Name of Organization _____

Signature of Representative to Coalition _____

Date _____

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New Team Member Letter of Invitation (Montana Example)

(Date)

Dear (Insert Name):

Suicide Mortality Review is a multidisciplinary process to help us better understand why people in our community die by suicide and to help us identify how we can prevent these deaths. The suicide mortality review program in Montana is a new program, created out of the 2013 Legislature. Our team meets 8 times per year to review suicide deaths of adults, 18 and older (youth suicides are reviewed by the Fetal, Infant Mortality Review program. Team members share case information on suicide deaths that occur in the state with the goal of preventing other deaths. In order for this process to be successful, all agencies involved in the safety, health and protection of Montanans should be part of the team. Therefore, we would like you to consider participating on the Suicide Mortality Review Team.

Included in this mailing are the team roster, a copy of the legislative bill (HB 583) and a team protocol book that covers all aspects of the review process. These materials should familiarize you with the review process in our community.

Suicide is a tragic event. Reviewing the circumstances involved in every suicide is part of our job as professionals. Only then can we truly understand how to better protect our communities and prevent future suicides from occurring. Our first meeting is scheduled for (time and location of next meeting). At this meeting, we will discuss the review process and answer any questions that you might have. Thank you for your time and interest in the suicide mortality review process.

Sincerely,

Team Coordinator's Name and Contact Information

Adapted from the Montana Suicide Mortality Review Program Manual, 2013.
Used With Permission

Stages of Team Building

Stage I: Forming—Why Are We Here?

- People express differences: Check each other out; decide whether to be part of group
- Feelings: Anxiety & confusion
- Little work accomplished: Conflicts emerge, leadership, value & feasibility of task(s) challenged
- *Tasks:* Feel included & expect that opinions will be respected

Stage II: Storming—Can We Work Together?

- More conflicts emerge as members negotiate tasks
- Power plays may occur, i.e., who's in charge & what actions taken toward goal
- Feelings: Instability & polarization
- Team must bring conflict out in open, encourage good communication skills & affirm that disagreement is healthy & resolvable
- *Tasks:* Develop skills; redefine goals, roles & tasks; Learn to work together

Stage III: Norming—How Will We Work Together?

- Rules created; members learn to productively work together; team pride develops
- Norms established for how people treat each other, how meetings are conducted, who will do what work & how it will be accomplished
- *Tasks:* Deepen skills & understanding; increase productivity; share opinions & skills; evaluate critically & constructively

Stage IV: Performing—How Can We Work Smarter?

- Group becomes functional team; can diagnose, solve problems & make decisions
- Much work can occur; team may become creative & tackle new tasks
- Team works together or delegates work; shares leadership & responsibility
- *Tasks:* Achieve tasks; deal with group issues; build skills & knowledge; use time well

Stage V: Mourning/Re-forming—Should We Continue?

- Group celebrates achievements or disbands & mourns loss of group
- Most groups reform when goals achieved, new goals created or members & leaders turn over
- Once group progresses through stages, subsequent team building goes faster

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Adapted from Tuckman & Jenson, 1977; Drinka, 1991

Coalition Member/Leader Inventory

	Never Done	Needs Work	Average	Above Average	Experience(s) Where You Gained the Skill
PERSONAL ATTRIBUTES					
Competitiveness Ability/willingness to compete &be measured on performance					
Constancy Persistent, faithful					
Direction Ability to define personal goals & needs					
Deciding Finding alternatives, making best use of resources or materials					
Delegating Tasks or responsibilities					
Energy Level Demonstrates confidence & capacity to make things move ahead					
Flexibility Receptive to new ideas & situations					
Goal-Oriented Ability to identify, work toward & reach aims					
Motivating Self and others					
Patience Ability to remain calm, endurance					
Perseverance Continue course of action despite difficulties					
Self-Knowledge Ability to assess your own capabilities					
Self-Starter Identify purposeful work & take action					
PERSONAL SKILLS					
Compiling or Analyzing Situations or data					
Calculating/Estimating Costs, income, space or risk assessment					
Coaching or Counseling Guiding or tutoring					
Constructing Objects or buildings					

Adapted from SunRaye Enterprises, 1997. Accessed June 4, 2009, at http://www.sunraye.com/job_net/ws5.htm

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Appendix III: Glossary

Attempt Survivors	Individuals who have survived a prior suicide attempt (CMHS, 2001).
Centralized Death Investigation System	A death investigation system that consists of a medical examiner office that consolidates cases from across the state or territory (Mack et al., 2019).
Decentralized Death Investigation System	A death investigation system that consists of county, parish or district offices that consolidates cases from across the county, parish or district. These can led by a medical examiner, a coroner, or a mix of the two within a state (Mack et al., 2019).
Incidence of Suicide	The total number of suicides of the population with a particular characteristic, for a given unit of time (CMHS, 2001).
Loss Survivors	Family members, significant others or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is also used to mean suicide attempt survivors (CMHS, 2001).
Mortality	The relative frequency of death, or the death rate, in a community or population (CMHS, 2001).
Protective Factors	Factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment (CMHS, 2001).
Psychological Autopsy	A method of investigating suicide deaths that involves collecting all available information on the deceased through structured interviews of key individuals, review of information sources such as available health care records, psychiatric records and other documents and forensic examination (Isometsä, 2001).
Public Health Approach	The systematic approach using basic evidence-based steps, which are applicable to any health problem that threatens substantial portions of a group or population (CMHS, 2001).
Risk Factors	Those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment (CMHS, 2001).

Suicidal Behavior	A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts and completed suicide (CMHS, 2001).
Suicidal Ideation	Self-reported thoughts of engaging in suicide-related behavior.
Suicidality	A term that encompasses suicidal thoughts, ideation, plans, suicide attempts and completed suicide (CMHS, 2001).
Suicide	Death from injury, poisoning or suffocation where there is evidence that a self-inflicted act led to the person's death.
Suicide Attempt	A potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries (CMHS, 2001).
Suicide Rate	The number of suicides per unit of the population with a particular characteristic, for a given unit of time. Typically expressed as the number of deaths by suicide per 100,000 (CMHS, 2001).

Glossary Citations

Center for Mental Health Services (US, & Office of the Surgeon General (US. (2001). National strategy for suicide prevention: Goals and objectives for action.

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Appendix IV: Links

Cover

- Airman 1st Class Kathryn Reaves: https://www.defense.gov/Multimedia/Photos/igphoto/2002040015/
- DoD: https://www.defense.gov/Multimedia/Photos/

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- DoD website: https://www.dimoc.mil/resources/limitations/
- Microsoft 365 subscribers: https://support.microsoft.com/en-us/topic/what-am-i-allowed-to-use-premium-creative-content-for-0de69c76-ff2b-473e-b715-4d245e39e895

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- Death Investigation Systems: https://www.cdc.gov/phlp/publications/coroner/death.html

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- State NVDRS program managers: https://www.cdc.gov/violenceprevention/datasources/nvdrs/stateprofiles.html
- Death investigation systems by state: https://www.cdc.gov/phlp/publications/coroner/death.html
- State suicide prevention coordinators: https://sprc.org/states/
- VA Suicide Prevent Coordinators: https://www.veteranscrisisline.net/find-resources/local-resources/
- Suicide fatality review overview presentation from Washington County, Oregon
- Legislative example (Montana) of establishing a statewide SMRC: https://leg.mt.gov/bills/2013/hb0599/HB0583_3.pdf

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- Behavioral Risk Factor Surveillance System: https://www.cdc.gov/brfss/index.html
- CDC's Wide-ranging Online Data for Epidemiologic Research (WONDER): https://wonder.cdc.gov/
- VA's Suicide Prevention Annual Reports: https://www.mentalhealth.va.gov/suicide_prevention/data.asp
- Youth Risk Behavior Surveillance System: https://www.cdc.gov/healthyyouth/data/yrbs/index.htm
- Web-based Injury Statistics Query and Reporting System: https://www.cdc.gov/injury/wisqars/index.html
- National Health and Nutrition Examination Survey: https://www.cdc.gov/nchs/nhanes/index.htm

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- VA Behavioral Health Autopsy Program: https://www.data.va.gov/dataset/Behavioral-Health-Autopsy-Program-BHAP-/47vy-pcre
- VA annual reports: https://www.va.gov/vetdata/Report.asp
- Legislative report on the Utah Youth Suicide Research Project: https://health.utah.gov/wp-content/uploads/DOH_Youth-Suicide-Legislative-Report_2021.pdf
- Service Members, Veterans, and their Families Technical Assistance Center webinar: Using Psychological Autopsies & Mortality Review to Inform Suicide: https://youtu.be/qJXsy-VWxeI