# Suicide Prevention Programming: Comparing Four Prominent Frameworks

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**Objective:** Suicide is a significant public health concern. About 48,000 individuals died by suicide in 2021 in the United States, and approximately one in 100 deaths globally are due to suicide. Continuing efforts in program development and evaluation are vital to preventing suicide. Multiple frameworks have been developed to reduce suicide rates, but they have not been compared to assess their comprehensiveness, nor have their components been classified.

**Methods:** In 2019, the authors conducted a narrative review of the literature and identified four major frameworks for suicide prevention: the U.S. Department of Veterans Affairs (VA) Suicide Prevention Program, the Defense Suicide Prevention Program of the U.S. Department of Defense, Zero Suicide in Health and Behavioral Health Care, and the technical package developed by the Centers for Disease Control and Prevention. Program components for these frameworks were identified and classified by using two prevention strategy classification systems: the National Academy of Medicine's (NAM's) continuum-of-care model and the Substance Abuse and Mental Health Services Administration's (SAMHSA's) prevention model.

**Results:** The cross-program comparison revealed that no single program included all components of suicide prevention programs. However, the VA program was the most comprehensive in terms of the number of components and their spread across prevention strategy classifications. The programs used few components categorized under NAM's promotion or selective prevention strategy classifications. The SAMHSA prevention strategy classifications of information dissemination, community-based processes, and positive alternatives were also used infrequently.

**Conclusions:** Organizations, health care systems, and policy makers may use these findings as they develop, improve, and implement suicide prevention programs.

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Suicide represents a significant public health crisis worldwide. More than one in 100 deaths globally were due to suicide in 2019, and an estimated 703,000 deaths are attributed to suicide each year (1). Suicide was also the fourth leading cause of death among individuals ages 15–29 years in 2019 (2). In the United States, suicide has historically been ranked as a leading cause of death (3–5). In 2021, approximately 48,000 individuals in the United States died by suicide (1). Although U.S. suicide rates declined by 5.5% from 2019 to 2020, they rose by 4% from 2020 to 2021 (1, 6). Racial-ethnic minority groups have experienced the largest increases. From 2018 to 2021, non-Hispanic White individuals had a 4% decrease, whereas American Indians and Alaska Natives had a 26% increase, Blacks and African Americans had a 19% increase, and Hispanics had a 7% increase. Suicide rates among Asians and Native Hawaiians or other Pacific Islanders remained relatively unchanged (7). In 2015, the National Action Alliance for Suicide

### HIGHLIGHTS

- The authors compared four U.S. suicide prevention programs: the U.S. Department of Veterans Affairs (VA) Suicide Prevention Program, the Defense Suicide Prevention Program of the U.S. Department of Defense, the Centers for Disease Control and Prevention suicide prevention technical package, and the Zero Suicide model.
- Of the four programs, the VA program had the most components identified as recommended practices for suicide prevention.
- Future programs could improve suicide prevention efforts by utilizing more promotion and selective prevention strategies as categorized by the National Academy of Medicine's continuum-of-care model and more prevention strategies classified by the Substance Abuse and Mental Health Services Administration as information dissemination, community-based processes, and positive alternatives.

Prevention, a partnership developed to advance the National Strategy for Suicide Prevention released by the U.S. Surgeon General, created a goal of reducing deaths by suicide in the United States by 20% by 2025 (8). Program development and implementation are important steps in addressing this issue.

Several barriers to suicide prevention have been identified, including stigma, lack of resources, lack of training, and legal responsibilities (9, 10). However, as the problem of suicide continues, more organizations, health care systems, and policy leaders are seeking to implement best practices in suicide prevention. A systematic review conducted to examine the core components of suicide prevention interventions identified four primary evidence-based prevention strategies: education and awareness, screening, treatment of mental health conditions, and restriction of lethal means access. The review advised that suicide prevention programs should be multimodal, utilizing a variety of strategies to optimize outcomes (11). Many organizations have implemented suicide prevention programs with these strategies. However, it is challenging to survey existing programs to determine how to build suicide prevention programs within other organizations. In particular, it is difficult to understand the individual components of these tailored programs and how to translate them into comprehensive suicide prevention programs within other organizations. In addition, although elements of suicide prevention programs are evidence based, to our knowledge, full suicide prevention frameworks have not been empirically tested as stand-alone programs, adding additional confusion to the process of assessing individual programs (12). One method to better understand the roots of prevention frameworks, their commonalities, and their differences is to identify the programs' core components and classify them by type of prevention strategy.

In the mid-20th century, behavioral health concerns began to be conceptualized from a public health perspective, which led to the creation of several frameworks to classify prevention strategies and to organize intervention efforts on the basis of their characteristics (13). The National Academy of Medicine (NAM), formerly the Institute of Medicine, adopted a prevention strategy classification system to reflect that distinct populations may require differing levels of intervention according to their risk for a particular behavioral health concern. This approach represented a shift from focusing on identifying the etiology of a behavioral health concern to instead concentrating on prevention efforts targeting known risk factors.

According to the NAM system, interventions can be classified along a care continuum of four types of prevention strategies: promotion, universal prevention, selective prevention, and indicated prevention (14–16). These classifications have been used frequently to classify and describe interventions developed for suicide prevention (17, 18). Promotion describes interventions that target the general population to enhance the development of coping skills, self-esteem, and overall well-being (19). Universal prevention includes interventions that target a population of individuals and that aim to address specific high-risk behaviors. Selective prevention targets individuals with a higher-than-average risk for engaging in high-risk behaviors. Indicated prevention targets individuals with a significantly elevated risk for engaging in high-risk behavior because they have exhibited particular warning signs (14, 20) (Table 1). Given the recommendation that suicide prevention programs focus on multimodal, multilevel intervention strategies to increase their impact (11), use of the NAM prevention strategy classifications can help conceptualize the comprehensiveness of suicide prevention frameworks by categorizing prevention efforts by depths of their reach across different risk levels.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has defined six main prevention strategy classifications in its strategic prevention framework: information dissemination, prevention education, positive alternatives, environmental approaches, community-based processes, and identification of problems and referral to services (21) (Table 2). This prevention framework was developed to help understand substance use in the complex environmental contexts that may contribute to substance use–related behaviors (21). The prevention strategy classifications are used by communities in planning and implementing prevention programs and events. Although the SAMHSA prevention strategy classifications, to our knowledge, have not been applied to suicide, they offer actionable intervention techniques that could be helpful in the implementation of a multimodal approach to suicide prevention. Similar to substance use, suicide occurs in the context of complex environmental factors; the SAMHSA prevention strategy classifications may help to quantify the comprehensiveness of suicide prevention programs while considering the multiple factors underlying suicide.

In this narrative review, we aimed to identify prominent suicide prevention frameworks for health care systems by elucidating the components of suicide prevention programs, identifying prevention strategy classifications that current comprehensive suicide prevention frameworks rely on, and revealing shared and unique prevention strategy classifications and program components of these frameworks. We aimed to outline the core suicide prevention components of each framework and to further differentiate the frameworks through both the NAM and SAMHSA prevention strategy classifications. Framework components and prevention strategy classifications were compared and contrasted to better understand commonalities and differences among programs so that future suicide prevention frameworks could use this information to inform prevention services.

We used a narrative review instead of a more stringent systematic review of the literature because of the novelty of categorizing program components into prevention strategy classifications to examine the comprehensiveness of suicide prevention programs. In addition, the authors of this review included several researchers (B.D.B., J.M., C.J.B., J.K.B.)

**TABLE 1. National Academy of Medicine classification of suicide prevention strategies, by risk level[a]**

| Classification | Definition | Program examples |
|---|---|---|
| Promotion | Interventions that target the general population to enhance an individual's ability to develop appropriate coping skills, self-esteem, and overall well-being | Promotion of wellness programs |
| Universal prevention | Interventions that target a group of individuals (e.g., veterans) and are aimed at addressing a specific self-harm behavior (e.g., suicide) | Required regular suicide risk screening |
| Selective prevention | Interventions that target a specific population (e.g., individuals with substance use disorders) characterized by having a higher-than-average risk for engaging in a self-harm behavior (e.g., suicide) | Targeted outreach to individuals with specific risk factors for suicide |
| Indicated prevention | Interventions that target individuals considered to have an elevated risk for engaging in a self-harm behavior because they have exhibited warning signs (e.g., individuals with current suicidal thoughts or past attempts), with the goal of decreasing a self-harm behavior (e.g., suicide) | Referral to a crisis line |

[a] Source: Springer and Phillips (13).

with expertise in suicide prevention who provided knowledge about the suicide prevention programs with the greatest breadth of services. Such programs offer the greatest promise of serving as exemplars to organize, develop, and improve future suicide prevention programs. A systematic review likely would have yielded many suicide prevention programs that were developed with varying breadth and depth of reaching populations at all risk levels, which would have complicated a more thorough examination of the individual strategies implemented in each program. A notable limitation of a narrative approach is that it introduces bias due to the nonsystematic nature of program selection.

## METHODS

### Identifying Suicide Prevention Programs in Empirical Studies

In this narrative literature review, we aimed to identify and compare prominent suicide prevention programs in order to aid organizations and health care systems in building customized suicide prevention programs. Major suicide prevention frameworks were gathered via Internet searches (e.g., Google, Google Scholar, and PubMed) and from authors' expertise. We sought to identify programs that had the most program components (i.e., of the recommended practices for suicide prevention we codified from our literature review) and the widest spread of suicide prevention strategies in terms of program implementation. Moreover, the identified programs were required to have published documents describing both their frameworks and program components. Programs with overlapping scope were excluded. For example, the U.S. Air Force has a suicide prevention program, but this program is subsumed under the broader U.S. Department of Defense (DoD) suicide prevention program; therefore, the DoD program was chosen. Once these prominent programs were identified, published documents describing the frameworks were gathered for analysis and coding.

Consensus on which programs to include in the present study was achieved by reviewing major U.S. suicide prevention frameworks for comprehensiveness. Programs were considered comprehensive if they used a combination of efforts to address suicide, indicating that the programs were multimodal. The frameworks included were chosen because of their comprehensiveness and applicability to suicide prevention at a national level.

### Literature Review and Program Comparisons

After key programs were identified and published documents about each program were collected, the components of the programs were identified. Specifically, the study team coded handbooks and program guides to compare unique and shared suicide prevention components across the frameworks. Materials for each program were reviewed to ascertain the basic program components and obtain a summary description (see the online supplement to this article), identify which NAM prevention strategy classification was appropriate for each program component, and determine how each program component was classified according to SAMHSA's prevention strategy classifications.

### Codebook Development

Literature on the identified suicide prevention frameworks was reviewed and used to develop a codebook containing all unique and shared components of programs with a suicide prevention framework. One master's-level team member reviewed each program's primary publication to create an initial list of program components along with their definitions. Program components were broadly defined as the framework's recommended practices for suicide prevention, and the initial review identified 41 components. Program components and definitions were then independently reviewed and compared with the original text by two master's-level team members, and definitions were refined. The codebook was reduced to 36 components after similar components were combined and descriptions were redefined. Team discussions, input from coinvestigators, and the 2019 U.S. Department of Veterans Affairs (VA)/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide (22) informed a final review and edits to the program components (see the online supplement).

**TABLE 2. Substance Abuse and Mental Health Services Administration (SAMHSA) classification of suicide prevention strategies[a]**

| Strategy | Definition | Program examples |
|---|---|---|
| Information dissemination | Using communication strategies and media to improve knowledge and change attitudes | Providing informational materials for suicide prevention |
| Prevention education | Teaching important skills in suicide prevention | Training medical center staff in core competencies of suicide prevention |
| Positive alternatives | Providing helpful and encouraging activities or treatment for co-occurring conditions | Promoting connectedness |
| Environmental strategies | Policies related to suicide prevention where people work or live to reduce risk factors and increase protective factors | Implementing high-quality improvement program focused on suicide prevention |
| Community-based processes | Strengthening the community's resources, including by improving delivery of prevention and treatment | Developing a collaborative partnership between community organizations for veteran suicide prevention |
| Identification of problems and referral to services | Evaluating individuals at high risk for suicide and determining whether further prevention or intervention services are required | Addressing co-occurring mental health conditions |

[a] Source: SAMHSA (21).

We used a deductive approach to categorize each program component in accordance with NAM's suicide prevention strategy classifications: promotion, universal prevention, selective prevention, and indicated prevention (14–16, 19). Next, program components were categorized into one of six broad prevention strategy classifications defined by SAMHSA: information dissemination, prevention education, positive alternatives, environmental strategies, community-based processes, and identification of problems and referral to services (21, 23). A portion of program components could fit into multiple prevention strategy classifications, depending on how they were implemented. Consequently, components could be classified as multiple NAM or SAMHSA prevention strategy classifications. Two masters-level coders independently coded the literature for each component, and any coding discrepancies were adjudicated by the first author. Interrater reliability was 0.95. Of note, program components were classified only if they were codified in the programs' manuals. It is possible that these programs recommended or implemented other suicide prevention strategies that were not codified.

## RESULTS

We identified four comprehensive U.S. suicide prevention frameworks in the research literature: the VA Suicide Prevention Program (VA program) (3, 23, 24), the DoD Suicide Prevention Program (DoD program) (25, 26), Zero Suicide in Health and Behavioral Health Care (Zero Suicide) (27–29), and the technical package from the Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control, Division of Violence Protection (CDC technical package) (4, 5). Each program is tailored to the goals of the organization or community it is intended to serve (Table 3); as such, each program contains different components.

The four frameworks' objectives are similar in their overarching goal of preventing suicide. However, each framework has a specific aim or focus; thus, the program components and their implementation vary. The VA program aims to prevent veteran suicide by implementing VA-wide and communitywide initiatives to mitigate suicide among all veterans, regardless of eligibility for VA care (21). This goal is accomplished through mandated programming and agencywide infrastructure. The DoD program has the overall goal of preventing suicide among service members, an aim it seeks to accomplish by setting broad standards for prevention in areas such as programming, training staff on suicide prevention, encouraging help seeking among service members, reducing stigma of mental health care, preventing access to lethal means, surveilling suicides and attempts, and honoring service members who died by suicide. The DoD program is predicated on policy enactment and oversight of individual sites rather than on specific programming requirements (26). The goal of the CDC technical package is to share strategies that help communities and states prevent suicide among residents (e.g., allotting financial resources to suicide prevention, strengthening suicide-related care, teaching coping skills, encouraging social support, and identifying at-risk individuals). The technical package aims to provide resources that can be used as desired but are not prescriptive (5). Finally, Zero Suicide has the goal of preventing death by suicide in the general population by providing a general theoretical framework based on seven core principles: lead, train, identify, engage, treat, transition, and improve (27).

### Comparing Program Components

The programs and guidelines strikingly differed in their components because of differences in implementation type for each framework. For example, VA leadership directly develops implementation plans for VA suicide prevention policies (22). The DoD develops suicide prevention framework standards but delegates decisions regarding how policies are implemented to individual military departments (22). The CDC technical package provides broad recommendations to health care systems and communities regarding best practices for suicide prevention, without

**TABLE 3. Characteristics of the reviewed suicide prevention frameworks**

| Framework | Approach | Population | Notable framework components | Goals |
|---|---|---|---|---|
| U.S. Department of Veterans Affairs (VA) Suicide Prevention Program | Comprehensive approach to suicide prevention in the VA system with best practices and treatment strategies | Veterans, regardless of VA enrollment or eligibility | Mental health services, extended operating hours, suicide screening, high-risk flags in medical records, Veterans Crisis Line, chaplain services, educational materials, partnerships with organizations, training sessions, assessment and safety planning, root-cause analyses, inpatient safety guidelines, postvention, lethal means counseling, and suicide prevention coordinator | Decrease veteran suicide rates |
| Defense Suicide Prevention Program of the U.S. Department of Defense | Establishment of policy, general oversight, and suicide reporting systems for branches of the U.S. military | Active duty military service members and reservists | Mental health services, promotion of gun locks and firearm storage, firearm storage at facilities, suicide reporting, memorial services for those who died by suicide, promotion of coping skills, chaplain services, educational materials, partnerships in community, training sessions, education on media reporting, postvention, suicide prevention crisis line, root-cause analysis, and suicide prevention coordinator | Reduce service member suicide rates, encourage resilience, and improve access to mental health care |
| Centers for Disease Control and Prevention technical package | Provision of a technical package for community use with suicide prevention strategies, approaches, and evidence | Community and state entities concerned with suicide prevention | Unemployment benefits programs, neighborhood stabilization programs, insurance coverage of mental health care, telehealth offerings, suicide-focused health care, encouragement of safe storage and decreasing access to lethal means, community partnerships, parenting programs, suicide prevention training, suicide prevention hotline, treatments, postvention, and media guidelines for safe suicide messaging | Disseminate tools to target risks for suicide and decrease suicide rates within communities |
| Zero Suicide in Health and Behavioral Health Care | Framework for suicide care with seven core aspects: lead, train, identify, engage, treat, transition, and improve | State-level entities involved in suicide prevention | Identification of seven elements that serve as core components for safe suicide care, coaching, collection of data, assessment tools to screen for suicide risk, safety planning, collection of suicide data, and follow-up on missed appointments for individuals at risk | Elevate suicide care as a core component of health care to prevent death by suicide |

specific implementation strategies (5). Similarly, Zero Suicide provides an aspirational model for health care systems to improve suicide care and, as such, does not include implementation strategies (27). Consequently, the VA contained the most program components, and Zero Suicide had the least (Tables 4 and 5).

*Shared components.* The four frameworks shared several similarities; however, no program contained all components included in the codebook of this review (see the online supplement). Of the 36 program components identified, only 14 were shared across all frameworks. Shared program components included organizational culture promoting a protective environment, collaborative partnerships, lethal means education, integration of suicide prevention into policy decisions, training opportunities for staff, core and continuing education, surveillance systems, educating family members, lethal means counseling, inpatient mental health treatment, screening for suicide risk, contact, assessment of suicide, and addressing co-occurring mental health conditions (see the online supplement).

*Least used components.* Selective prevention was the NAM prevention strategy classification with the fewest program components among the four examined frameworks (Table 4). Selective prevention components are those tailored to a population with a higher-than-average risk for suicide, such as individuals with substance use or other psychiatric disorders. It is possible that components in the selective prevention classification were less often identified because such strategies would be clinic specific and, therefore, may not have been included in the

suicide prevention program documents. Additionally, few program components were classified as promotion. This finding is of interest given that promotion is the highest upstream prevention strategy classification possible because promotion strategies reach all individuals regardless of risk level. It is possible that program components were least often classified as promotion because they were developed for use in health care systems. Thus, these frameworks were likely to be used for individuals with a higher suicide risk than in the general population, and, consequently, the frameworks were likely to be classified as preventing suicide rather than promoting mental health. Compared with other SAMHSA prevention strategy classifications, information dissemination, community-based processes, and positive alternatives were used infrequently to classify program components (Table 5). Again, these are upstream strategies and may not be used as often as other SAMHSA prevention strategy classifications because of the greater need for prevention strategies over promotion strategies in many health care settings.

### Multiple Classifications

Several program components were classified under multiple NAM and SAMHSA prevention strategy classifications (Tables 4 and 5). Across all programs, eight components were categorized under both NAM and SAMHSA prevention strategy classifications. Program components such as having peer support specialists, promoting connectedness, and addressing co-occurring mental health conditions were each assigned only a single NAM prevention strategy classification; however, they may meet multiple SAMHSA prevention strategy classifications, depending on how they are implemented. For example, employing peer support specialists falls under the strategy of promotion because peer support aims to increase positive health behaviors such as seeking social support. However, such a support can be categorized under the SAMHSA classifications of positive alternatives, environmental strategies, or identification of problems and referral to services, depending on the role of the peer support specialists within a particular setting.

### VA Program

The VA developed a broad-spectrum suicide prevention program (23), which takes a public health approach to suicide prevention, including implementation of a wide array of best practices in prevention strategies. The VA program includes a large range of components across various NAM and SAMHSA prevention strategy classifications and aims to reach all veterans, regardless of their enrollment or eligibility for VA health care, by equipping communities to help connect veterans to care. In this endeavor, the VA collaborates with national, state, and local stakeholders (30, 31).

The VA program was the most comprehensive of the surveyed programs in the number of included program components and in the spread of program components across NAM and SAMHSA prevention strategy classifications. Specifically, it contained 35 (97%) of the 36 unique program components we identified. The VA program spanned all NAM and SAMHSA prevention strategy classifications. Components of the VA program that were not in other frameworks included offering nontraditional operating hours, flagging suicide risk in the medical record, and providing a suicide prevention consultation hotline. The VA likely has the most comprehensive framework because the organization developed comprehensive and standardized nationwide plans for implementation across medical centers, whereas the DoD, Zero Suicide, and CDC programs have not.

**TABLE 4. Program components categorized under the suicide prevention strategy classifications of the National Academy of Medicine[a]**

| | N of program components | | | | |
|---|---|---|---|---|---|
| Classification | Total | VA | DoD | ZS | CDC |
| Promotion | 5 | 4 | 4 | 4 | 3 |
| Universal prevention | 10 | 10 | 9 | 8 | 8 |
| Selective prevention | 3 | 3 | 2 | 1 | 2 |
| Indicated prevention | 10 | 10 | 5 | 6 | 6 |
| Multiple strategies[b] | 8 | 8 | 7 | 5 | 6 |
| Total | 36 | 35 | 27 | 24 | 25 |

[a] CDC, Centers for Disease Control and Prevention technical package; DoD, U.S. Department of Defense; VA, U.S. Department of Veterans Affairs; ZS, Zero Suicide.

[b] Components with more than one National Academy of Medicine classification are counted only in the multiple strategies classification.

### DoD Program

The DoD's Defense Suicide Prevention Program establishes policy, general oversight, and reporting of suicidal ideation and death for all branches of active military service and reserves to strengthen the resilience of DoD employees and their dependents (26). The DoD program centers around a climate of suicide prevention education and resilience awareness and encourages military personnel to seek behavioral health care. The DoD takes a proactive stance on access to lethal means by promoting use of gun locks and providing opportunities for service members and their families to voluntarily store privately owned firearms at their nearest military installation (26). The DoD also establishes policies for mental health referral, assessment, evaluation, and treatment of service members who may pose a risk for danger to themselves or others, with emphasis on reducing the stigma associated with receiving mental health care (25). Notably, the VA and DoD programs both focus on providing clinical services for patients at risk for suicide.

The DoD program was the second most comprehensive of the programs and guidelines, containing 27 (75%) of the 36 unique program components. Similar to the VA program, the DoD program likely includes many of the components because the DoD had to implement comprehensive programming to address challenges related to suicide among service members as a result of congressional mandates, creating a more robust framework. However, unlike the VA,

**TABLE 5. Program components categorized under SAMHSA's suicide prevention strategy classifications[a]**

| Classification | N of program components | | | | |
|---|---|---|---|---|---|
| | Total | VA | DoD | ZS | CDC |
| Information dissemination | 1 | 1 | 1 | 0 | 1 |
| Community-based process | 1 | 1 | 1 | 1 | 1 |
| Prevention education | 7 | 7 | 6 | 4 | 6 |
| Environmental strategies | 6 | 6 | 4 | 4 | 2 |
| Identification of problems and referral to services | 8 | 8 | 4 | 6 | 6 |
| Positive alternatives[b] | 0 | 0 | 0 | 0 | 0 |
| Multiple strategies[c] | 8 | 8 | 7 | 5 | 6 |
| Total | 31 | 31 | 23 | 20 | 22 |

[a] CDC, Centers for Disease Control and Prevention technical package; DoD, U.S. Department of Defense; SAMHSA, Substance Abuse and Mental Health Services Administration; VA, U.S. Department of Veterans Affairs; ZS, Zero Suicide.
[b] Positive alternatives were classified only under "multiple strategies."
[c] Components with more than one classification are counted only in the multiple strategies classification.

the DoD delegates enactment of specific policies to each service branch, which may explain why the DoD program contained fewer of the identified components than the VA program. The DoD program did not have any components that were unique to its program. Furthermore, compared with the VA program, the DoD program had fewer components categorized under NAM's universal, selective, and indicated prevention strategy classifications and fewer program components categorized under SAMHSA's prevention education, environmental strategies, and identification of problems and referral to services classifications. This difference likely also reflects the DoD's approach of delegating the specific implementation of most suicide prevention programming to individual military services, which may make the framework more general.

The Suicide Prevention and Response Independent Review Committee has cited other factors for the DoD program's less comprehensive programming, including ad hoc programming after a service member's suicide without sufficient plans for long-term implementation, high turnover among leaders in suicide prevention and consequent lack of program continuation, and unstable funding that creates ill-sustained programming (32). Notably, the DoD program did not include components related to the physical environment of care, particularly on inpatient units. This characteristic contrasts with the VA's approach to such strategies, which includes monitoring of safety hazards (e.g., access to chemicals and sharp objects and the use of self-locking doors) (33, 34). The DoD likely implements this program component, but it is not explicitly included in its program guide. In addition, not all DoD installations are equipped with 24-hour emergency services, and some installation medical centers are available only during traditional hours of operation. These medical centers do not offer nontraditional appointment hours, making it more challenging for service members to seek mental health services in emergencies.

### CDC Technical Package

To aid U.S. communities in prevention, the CDC developed a comprehensive technical package, entitled *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (5), which provides information about policies, programs, and best practices for suicide prevention. The goal of the package is to improve community-based suicide prevention by implementing best practices. The best practices identified and promoted in the technical package include strengthening financial supports, building and implementing suicide-related services, encouraging environmental protections, creating opportunities for connection, teaching skills for coping and solving problems, identifying and targeting support for at-risk individuals, and preventing future risks for suicide (5). Importantly, the CDC technical package provides resources for health care systems to strengthen their suicide prevention programs, rather than providing clear and distinctive programming guidance.

The CDC technical package had fewer program components and less spread across prevention strategy classifications than the VA and DoD programs. It contained 25 (69%) of the 36 unique program components. Similar to the DoD program and Zero Suicide, the CDC technical package contained few program components categorized under the indicated prevention strategy classification of NAM and fewer components categorized under the SAMHSA classifications of environmental strategies and prevention education.

### Zero Suicide

Given its wide application as a community program, Zero Suicide was selected for inclusion in this narrative review. Zero Suicide is a model for implementation of comprehensive suicide prevention into community health care systems (29). In contrast with the VA and DoD programs, Zero Suicide is a systemwide framework. The premise of the Zero Suicide model is that all suicide deaths are preventable. A unique aspect of Zero Suicide is elevating suicide care as a core component of health care through a systemic approach (35). The view of suicide care as a core component of health care requires workforce training in assessment and treatment of suicide risk that becomes a regular part of clinical practice. Of critical importance, Zero Suicide differs from the VA and DoD programs in that it is a set of guidelines rather than a readily implementable program.

With 24 (67%) of the 36 unique program components, Zero Suicide contained the fewest components and the least spread over NAM and SAMHSA prevention strategy classifications. Specifically, compared with the VA program, Zero Suicide had fewer components categorized under the selective prevention and indicated prevention strategy classifications of NAM. In particular, Zero Suicide did not outline the program components categorized by NAM's selective and indicated prevention strategy classifications, such as offering nontraditional operating hours at mental health facilities, providing postvention support for survivors, advertising a

suicide prevention crisis line, conducting a root-cause analysis of suicides, flagging in medical records systems, and providing suicide prevention consultation. Zero Suicide also had fewer program components categorized under multiple NAM and SAMHSA prevention strategy classifications, such as utilizing predictive analytics and outreach, having suicide prevention coordinators, and having peer support specialists.

## DISCUSSION

In this narrative review and analysis, we examined the program components of four suicide prevention frameworks and categorized these components by using both NAM and SAMHSA classifications of suicide prevention strategies. Community organizations, health care systems, and policy makers may use this information to develop and build suicide prevention programs within their own organizations. When referencing these frameworks to develop new programs, clinicians and researchers need to examine several frameworks in order to understand the range of possible program components. When developing a program, program components should be chosen across a range of prevention strategy classifications to create a multimodal program with a diverse set of strategies for suicide prevention.

### Components of Suicide Prevention Programs

The classification used in this review illuminated differences among the four programs. The VA program was the most comprehensive in terms of the number of program components it included and the spread of components across the suicide prevention strategy classifications of NAM and SAMHSA. The VA has built a comprehensive, multicomponent suicide prevention program within its own health care system that is unparalleled in other private or public health care systems (36, 37). Importantly, veterans are at greater risk for suicide than are nonveterans, dying by suicide at rates 1.5 times greater than rates for civilians (24). However, from 2018 to 2020, veterans had a greater decrease (by 9.7%) in suicide rate compared with nonveterans (decrease by 5.5%) (6). This larger decrease may be due, in part, to the VA's comprehensive program. Other suicide prevention programs can learn from the program components the VA has pioneered and successfully implemented (see the online supplement).

The DoD program provides specific suicide prevention guidance but delegates implementation to individual sites, as it does for all policies. This system creates differences in implementation across military services and departments, leaving room for potential systematic errors. The CDC technical package and Zero Suicide model were found to contain fewer program components, likely because they are guidelines rather than implemented programs and do not contain specific activities related to developing programming in organizations. Zero Suicide was developed as an aspirational model rather than an implemented program, and the CDC's technical package was created as a guide from which individual organizations could pull best practices to incorporate into their own programs. Additionally, these models may have fewer program components because they focus on strategies for programming within tertiary health care settings (e.g., specialty care) that have treatment-seeking patients and may offer more individualized, patient-specific suicide prevention recommendations, rather than broader components that require treatment adherence. Despite having fewer components, these two models may highlight areas of suicide prevention that could be useful for individuals and organizations creating their own suicide prevention programs. For example, the CDC technical package provides information about how unemployment benefits programs, neighborhood stabilization programs, and insurance coverage of mental health care may help to address suicide risk in communities; therefore, the package provides strategies that can be used at the level of promotion for suicide prevention. Zero Suicide provides a helpful theoretical foundation of the seven core aspects of care for suicidal thoughts and behaviors, which may help organizations conceptualize how to frame their mission of suicide prevention.

Our results also offer the opportunity to reflect on current frameworks and guidelines in order to identify service gaps and develop new program components to increase the diversity and breadth of the suicide prevention safety net. In the NAM model, program components were least often categorized under the selective prevention strategy and promotion classifications. The promotion classification had few components directly integrated into existing suicide prevention frameworks. This finding could be due to frameworks' implementation of broader promotion and wellness initiatives that were not captured within the documents outlining the suicide prevention framework. Consequently, it may be important for agencies such as the VA and DoD to examine current promotion-focused offerings across their systems and to work to integrate them where possible within their suicide prevention frameworks. Similarly, the CDC and Zero Suicide could work to expand promotion program components within their guidelines.

Of note, suicide rates increased from 2018 to 2021 among American Indian and Alaska Native, Black and African American, and Hispanic individuals, whereas suicide rates decreased for non-Hispanic White individuals (7). Health equity in suicide prevention is of critical importance for addressing suicide rates; although these rates can be addressed at all levels of prevention, advancing suicide prevention at the universal level is particularly advantageous. Universal screening for suicide risk factors that may underlie these racial-ethnic disparities in suicide rates (e.g., experiences of racism, institutional racism, and discrimination) (38) may help to inform health and well-being promotion and later prevention efforts. In addition, addressing systemic and institutional racism at the policy level of mental health promotion may help to increase access to mental health care for individuals

from racial-ethnic minority groups and may thereby help decrease suicide rates (39). Promotion efforts may also involve collaborating with key community advocates to elicit and incorporate feedback on engaging members of racial-ethnic minority groups in care; examining organizational practices to identify problematic structural policies that perpetuate racism, contribute to mental health problems, and increase suicide risk; and developing training for staff. Such strategies may increase the accessibility of services. The goal of promotion programs is to increase the public's overall health and well-being in order to decrease the risk for negative mental health outcomes, such as suicide. Promotion program components could help to encourage health equity in suicide prevention.

Additionally, few components across the programs were categorized under the selective prevention strategy classifications. Selective prevention strategies target groups at higher risk for suicide and can include components such as offering extended operating hours at mental health facilities, providing support for suicide survivors, and educating family members on mental health stigma and treatment options. These components may be marketed in specialty settings within a health care system (e.g., education of family members within a clinic for substance use disorders) that may not be captured in documents outlining the suicide prevention frameworks. Increasing the number of program components classified as selective prevention may help reach at-risk groups before suicidal ideation and behaviors develop. For example, contagion is known to increase the risk for additional suicides within a geographical area and is commonly studied in adolescents (40). Having adequate postvention support (i.e., approaches that promote healing among, and reduce negative effects on, individuals exposed to a suicide event) within school systems, such as access to a mental health professional, survivor groups, and conversations about suicide, is hypothesized to curb suicide contagion (41) and may be a selective prevention strategy of use in other settings as well.

For SAMHSA's prevention strategy classifications, program components were least frequently classified as information dissemination, community-based processes, or positive alternatives. Each of these prevention strategy classifications has a critical role in creating and maintaining a strong suicide prevention safety net. Moreover, these prevention strategies can be used before an individual develops risk factors for suicide and, as such, offer important areas of health promotion to target suicide before specific risk factors emerge. Many individuals do not contact crisis lines or other forms of support before attempting suicide, possibly because many people are unaware of these resources, with messaging about these support systems not adequately reaching them (42). Information dissemination lets individuals know about available options and alerts organizations to consider building additional program components. Some programs have successfully implemented information dissemination tools. For example, the American Foundation for Suicide Prevention has developed a series of videos for use in schools to teach adolescents, parents, and educators to recognize signs of depression and other mental health problems that can be risk factors for suicide (43).

Community-based processes offer another area for expansion and include strategies that focus on coalition building and community organization. Only a few specific strategies related to community-based processes were identified within the programs. Of note, the VA has pioneered community-based methods and programming to address the need for community-based programs, including the Together With Veterans Program, Governor's Challenge, and use of community engagement partnership coordinators (44–47). Together With Veterans focuses on suicide prevention among rural veterans by disseminating best practices for suicide prevention among mental health professionals and leaders in rural communities (48).

Additionally, only a few program components were categorized under the SAMHSA prevention strategy classification of positive alternatives. It seems particularly important to provide individuals at increased risk for suicide with alternative activities they can engage in to reduce distress, such as speaking with peers and social supports. The National Endowment for the Arts has created the Military Healing Arts Network to connect veterans to art, with the goal of improving mental health and social connection (49). The Military Healing Arts Network was successfully implemented through a music therapy program in which active duty service members wrote songs in music therapy sessions to process distressing events and memories. A major theme in the content of songs was appreciation for the connections service members had with their loved ones—in other words, they reflected on the benefits of their relationships (50). As these programs continue to evolve, and as other suicide prevention programs develop, positive alternatives may be a prevention strategy classification to incorporate into programming.

### Implementing a Suicide Prevention Program

This review provides information about how suicide prevention programs can be implemented. Each of the analyzed programs offers components that can be beneficial in developing different types of suicide prevention programs. For example, a stand-alone, outpatient community mental health clinic may be more likely to use program components that can be implemented in individual outpatient psychotherapy sessions, such as screening for suicide risk factors, providing lethal means safety education, training staff in suicide prevention, educating family members on stigma and mental health treatment options, initiating a safety plan, and providing evidence-based psychotherapy. Although inpatient mental health clinics may also implement these components, because of the higher acuity of illness in these settings, these clinics may require program components classified as selective and indicated prevention strategies, such as continued contact with at-risk patients after hospitalization; provision of enhanced interdisciplinary care involving physicians, social workers, and other professionals; root-cause

analysis of suicide-related deaths; and consultation for clinicians working with at-risk patients. Larger hospital organizations and state suicide prevention programs may seek to implement additional components at more upstream levels, such as promotion or universal prevention strategies, including flagging in record systems, offering education about suicide risk and prevention, disseminating suicide prevention materials, developing collaborative partnerships for suicide prevention, and promoting a broader organizational culture that supports general health and well-being.

Barriers to implementation of program components across NAM and SAMHSA classifications may include limited resources, lack of organizational structures to facilitate implementation, and the specific mission and scope of the organization implementing the suicide prevention program. Organizations can explore the wide variety of program components discussed in this review (see the online supplement) and choose elements that are feasible for implementation within their specific contexts. Different organizations may use different suicide prevention frameworks for inspiration in accordance with available resources, organizational structures, and scope. For example, hospital systems with larger organizational structures that could support more robust programming may use the VA and DoD programs as models. However, organizations such as community outpatient clinics and stand-alone hospitals may struggle to fully implement programs similar to those of the VA and DoD because of their smaller organizational structure. Organizations that have a strong focus on general public health, such as state programs and colleges or universities, may benefit from a more aspirational framework to guide their efforts and may therefore use Zero Suicide or the CDC technical package as resources.

### Limitations

One limitation of this narrative review was that data were collected in 2019. Since then, various tool kits and suicide prevention programs have been updated to continue to address suicide risk. These prevention frameworks may have updated their published materials to include more comprehensive programming since our initial coding. Another limitation was that direct comparisons of programs were difficult to make because each program was designed for unique purposes. Zero Suicide, for instance, was designed as a set of principles to guide suicide prevention more broadly and provides links to suicide prevention resources online that are not necessarily included in the published tool kit. As a result, some of these resources may not have been captured in this review. In contrast, the VA must take suicide prevention to full implementation and therefore details its suicide prevention components in published materials. Differences in purposes of the programs may contribute to some of the discrepancies in components that were identified in published materials.

## CONCLUSIONS

The findings of this narrative literature review reveal that the VA currently has the most comprehensive and broadest suicide prevention program. Overall strengths of the four programs we analyzed include having many components classified as universal prevention or indicated prevention. Similarly, many components were categorized under SAMHSA's prevention strategy classifications of prevention education, environmental strategies, and identification of problems and referral to services. Areas for growth included improving the number of program components categorized as selective prevention and promotion under NAM's strategy classifications. The SAMHSA prevention strategy classifications of information dissemination, community-based processes, and positive alternatives were also used infrequently. The identified gaps point to possible directions for further process improvements within these programs. This information may also be used by community organizations, health care systems, and policy leaders to establish and standardize suicide prevention program components in their own organizations.

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