Rhode Island Suicide Fatality Review Team

2025 Annual Report

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Introduction

The Rhode Island Suicide Fatality Review Team (SFRT) is a multidisciplinary group established in 2025 (RI Gen. Laws § 23-4-3) to reduce the prevalence of suicide deaths in Rhode Island by identifying areas for potential systems change. To accomplish this goal, there are five objectives:

1. Identify and review cases representative of suicides within Rhode Island.
2. Make recommendations aimed at improving suicide prevention and treatment infrastructure based on case review.
3. Communicate and promote recommendations to state and community agencies, and the public.
4. Ensure diverse and representative SFRT membership.
5. Foster multi-disciplinary and interagency collaboration for the advancement of the SFRT and their recommendations.

The SFRT is made up of emergency medicine practitioners, behavioral healthcare professionals (e.g., psychiatrists, psychologists, clinical social workers, substance use professionals), emergency medical services, law enforcement, public health professionals, individuals with lived and living experience, and representatives from organizations serving specialized populations (e.g., older adults, low income, Veterans). This group meets quarterly to review approximately 3-4 suicide death cases per meeting and identify potential opportunities for systems change that could decrease future suicide deaths amongst Rhode Island residents.

Once opportunities for change are identified, the SFRT puts forth an annual report containing a set of prevention recommendations for the Suicide Prevention Advisory Committee and all state agencies working on suicide prevention. The SFRT recognizes that some of these recommendations may already be partially or fully implemented but includes them in the report to underscore their importance in creating and maintaining a high-quality system of care and support for individuals who may be at risk for suicide.

The SFRT will continually review cases and update recommendations annually based on their findings.

Membership

The following organizations were represented on the SFRT in 2025. Members were selected based on statutory suggestion (RI Gen. Laws § 23-4-3), professional experience, and subject matter expertise. We thank all members for their time, energy, and efforts in our inaugural year.

- Bradley Hospital
- Brown University
- Brown University Health
- Burrillville Police Department
- Butler Behavioral Health
- CODAC Behavioral Health
- Commuity Care Alliance
- Crisis Intervention Teams of Rhode Island
- Elevated Results Consulting
- JSI Research & Training Institute
- The Providence Center
- Providence VA Medical Center
- PTR Ministries
- Rhode Island Department of Behavioral Health, Developmental Disabilities, and Hospitals
- Rhode Island Department of Health
- Rhode Island Geriatric Education Center
- Rhode Island Overdose Fatality Review team
- Rhode Island State Police
- South Kingstown Fire Department

In addition to members listed above, each meeting we consult with non-member subject matter experts to ensure our recommendations are data informed, appropriate, and aligned with existing best practices and guidance. We thank all of the countless individuals and organizations who helped to shape the recommendations in this report.

Confidentiality and Privacy

SFRT meetings are closed to the public, and all members of the team are required to sign confidentiality agreements before participating in meetings or receiving case documents. Members are not allowed to discuss cases with anyone outside of the SFRT. In addition, they are asked to securely store and/or destroy notes related cases to reduce accidental disclosure of sensitive information. While our case abstractors/meeting facilitators and epidemiologists have access to identified information, names of people and organizations are removed from narratives prior to distributing to the larger team to ensure privacy for the decedent and their family.

Case Selection and Review

1. Each quarter, using suicide death data provided by the Office of the State Medical Examiner (OSME), the team at the Rhode Island Department of Health (RIDOH) selects a topic or theme to explore (e.g. older adults, decedents with recent legal trouble, divorced individuals, etc.). Topics are chosen based on epidemiological data, anecdotal evidence from team members, and trends noted in previous case review meetings. Circumstances associated with suicide deaths are entered as part of the Rhode Island Violent Death Reporting System (RIVDRS), and these data are used to help identify themes and facilitate review.
2. Once the topic is confirmed, the epidemiologist selects a random sample of suicide fatalities from that population. Cases are screened to ensure there is enough data present to complete a thorough review and that the random sample is representative of the population.
3. Prior to the meeting a variety of records and information are requested including police and Emergency Medical Service (EMS) reports, medical and behavioral healthcare records, 988 call, text, and chat logs, toxicology and autopsy results, Prescription Drug Monitoring Program reports, Judiciary Public Portal Reports, online obituaries, and social media/internet searches.
4. The case abstractor creates a de-identified case narrative for each case based on a thorough review of available records. The case narrative includes demographic information, a summary of risk factors associated with suicide, and a detailed medical, social, and legal history of the decedent through the scene of the death.
5. Cases are sent to SFRT members via secure email one week prior to the meeting for members' advanced review.
6. Cases are summarized in the meeting and a discussion around potential areas for systems changes ensues. The team works collaboratively to create specific and actionable recommendations focused on infrastructure, processes, procedures, and best practices.
7. Recommendations are then reviewed monthly by a small team at RIDOH for feasibility, accuracy, and alignment with the Rhode Island Suicide Prevention Strategic Plan. Once approved, recommendations are then presented back to the larger SFRT to ensure consistency with the intent of the original recommendation and for final approval by the team. During this review and editing process, recommendations are tracked to observe trends in areas for improvement, as well as risk and protective factors which may help to inform future recommendations.

Lessons Learned

In the first year of implementation, the SFRT leadership team learned several lessons. First, while the goal is for SFRT membership to be consistent throughout an entire year, the reality is that employment changes, requiring rolling onboarding protocols and policies. As this was realized, time was dedicated to creating standardized onboarding materials and processes to ensure all members get the same welcoming experience regardless of when they join the team. Next, it was discovered that while all members of the team are participating in a professional capacity, many have lived/living experience with suicide themselves, or with someone close to them. Many times in this field, the concept of including people with lived experience can feel "othering" because professionals working in this field are often overlooked as potential individuals who have also navigated the suicide care system. When leadership stepped back and surveyed the group anonymously, we found that several members had the type of experience we thought we might be missing in our dynamic. Reflecting on this, a conscious effort is being made to encourage members to bring their whole selves to the meetings, not just their professional expertise. Finally, members expressed a desire to have a better understanding of how the recommendations are moved forward after the meetings. To ensure this is addressed, SFRT leadership has scheduled two meetings per year dedicated solely to providing updates on the current status of recommendations.

Rhode Island Suicide Overview

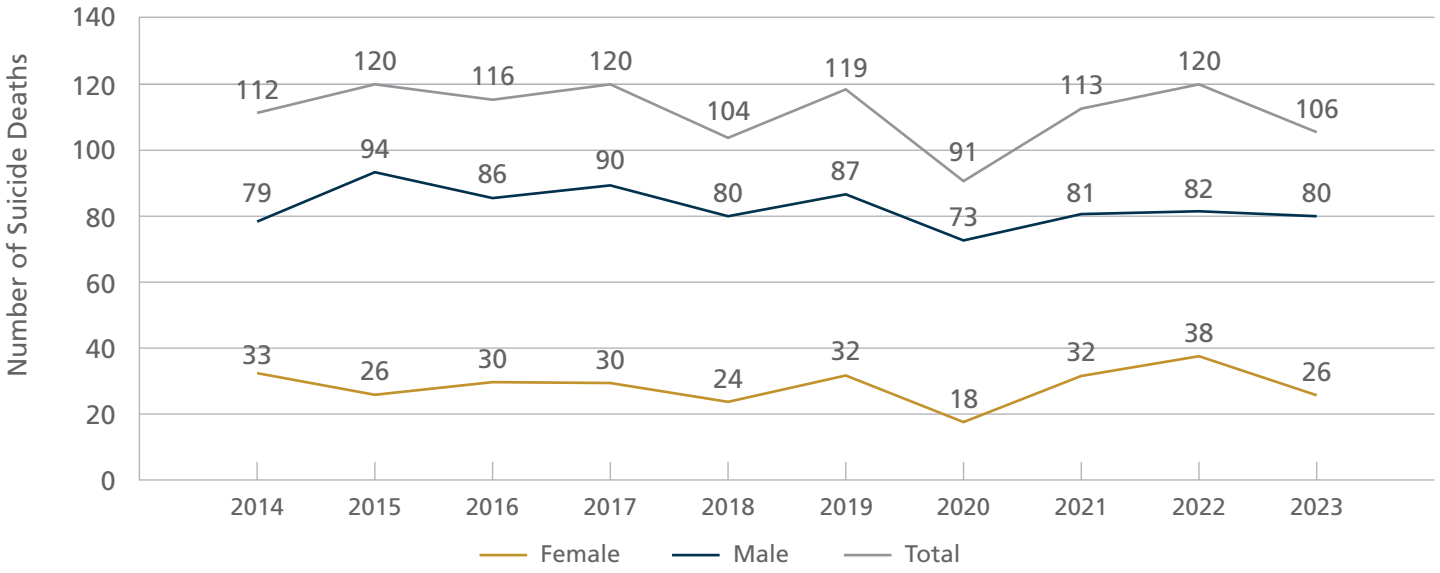
Based on 2019-2023 combined data from the Centers for Disease Control and Prevention's National Vital Statistics System, suicide (classified as intentional self-harm) was a leading cause of death amongst all ages of Rhode Islanders 10-64 years old. For 10-24 year olds it was number two, for 35-44 year olds it was number four, for 45-54 year olds it was number five, and for 55-64 year olds it was number nine.

Ranking	10-24 years	25-34 years	35-44 years	45-54 years	55-64 years
1	Accidents (Unintentional Injury)	Accidents (Unintentional Injury)	Accidents (Unintentional Injury)	Accidents (Unintentional Injury)	Cancerous Tumors
2	Intentional Self-Harm (Suicide)	Intentional Self-Harm (Suicide)	Cancerous Tumors	Cancerous Tumors	Heart Diseases
3	Assault (Homicide)	Cancerous Tumors	Heart Diseases	Heart Diseases	Accidents (Unintentional Injury)
4	Cancerous Tumors	Heart Diseases	Intentional Self-Harm (Suicide)	Liver Diseases	COVID-19
5	Heart Diseases	Assault (Homicide)	Liver Diseases	Intentional Self-Harm (Suicide)	Liver Diseases
6	*	Liver Diseases	COVID-19	COVID-19	Chronic Lower Respiratory Diseases
7	*	COVID-19	Assault (Homicide)	Diabetes	Diabetes
8	*	*	Diabetes	Cerebrovascular Diseases (such as stroke and brain bleeding)	Cerebrovascular Diseases (such as stroke and brain bleeding)
9	*	*	Cerebrovascular Diseases (such as stroke and brain bleeding)	Chronic Lower Respiratory Diseases	Intentional Self-Harm (Suicide)

*Category not reported due to small numbers

From 2014 to 2023 there were between 91 and 120 suicides in Rhode Island annually. The greatest number of total deaths by suicide occurred in 2015 followed by 2017 and 2022. Nearly three out of every four suicide deaths during this period were observed among males.

Figure 1. **Number of Suicide Deaths by Year and Sex, Rhode Island**



Data Source: Rhode Island Violent Death Reporting System (RIVDRS). Deaths among RI residents, 2014-2023.

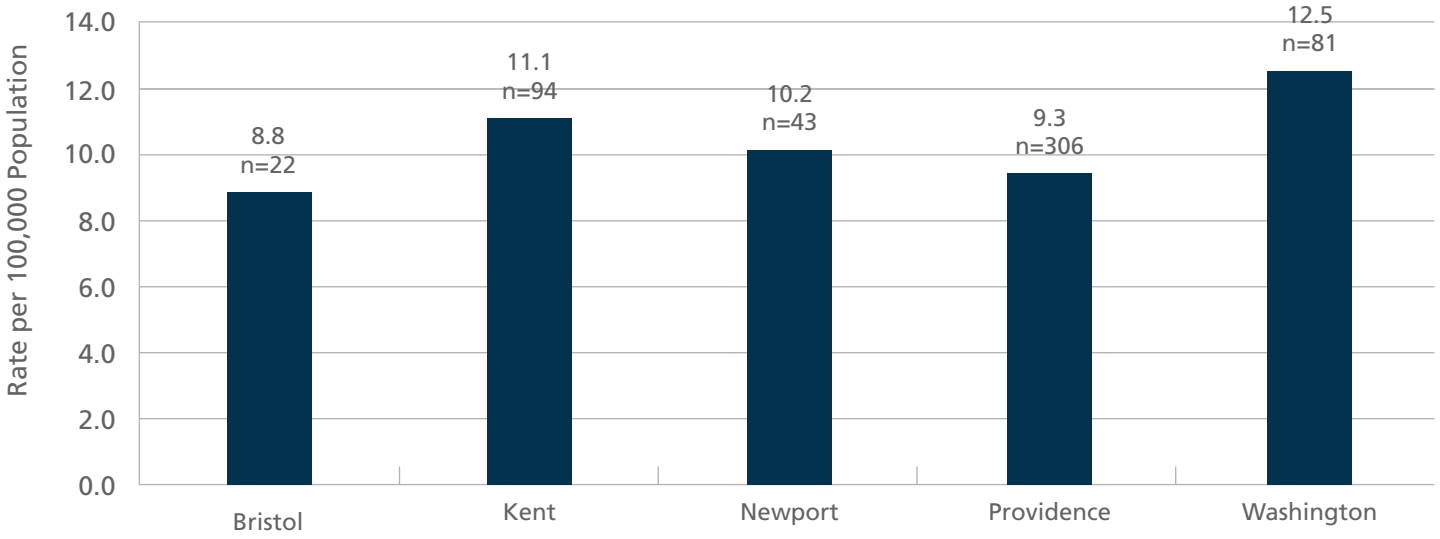
Differences are also observed by age group and sex. During 2019-2023, the median age of suicide decedents was observed to be 51 years old, with slight differences being observed among males (median=51 years) and females (median=49.5 years). The highest rates of suicide death have also been observed in middle age groups. During 2014-2023, the highest rate of suicide for males was observed among those 55-64 years old (25.7 deaths per 100,000 male population) followed by those 45-64 years old (25.3 per 1000,000 male population). For females, the highest rate of suicide was observed among those 45-54 years old (8.8 deaths per 100,000 female population) followed by those 34-44 years old (8.2 deaths per 100,000 female population).

We also have observed differences in injury mechanism by sex. During 2019-2023, males were most likely to die by hanging (43%) followed by firearm (34%) and poisoning (12%), whereas females were most likely to die by poisoning (44%), followed by hanging (31%), and all other injury mechanisms, not including firearms (14%).

Approximately 13% of Rhode Island suicide deaths during 2019-2023 were observed among military service members/Veterans. The majority of these deaths were observed among males, specifically those 65 years and older. More than half of these deaths were firearm related.

When looking at suicide deaths by race/ethnicity during 2019-2023, the highest rate was observed among individuals identified as white, non-Hispanic (12.2 deaths per 100,000 population). White, non-Hispanic individuals represent approximately 73% of the Rhode Island population 10+ years old, however they represented more than 85% of all suicide deaths in Rhode Island during this time. Compared to 2014-2018, the rate of suicide death has been observed to decrease slightly for white, non-Hispanic individuals (from 12.9 deaths per 100,000), while rates among Hispanic individuals have been observed to increase from 3.9 suicide deaths per 100,000 population during 2014-2018 to 5.6 deaths per 100,000 during 2019-2023.

Figure 2. **Rates of Suicide Deaths by County of Residence, Rhode Island, 2019-2023**



Data Source: Rhode Island Violent Death Reporting System (RIVDRS). Deaths among RI residents, 2019-2023.

In general, the proportion of suicide deaths reported by county was consistent with the distribution of the Rhode Island population that lives there (Source: 2019-2023 Rhode Island Census estimates from CDC WONDER). Most people in Rhode Island live in Providence County (60% of population 10+) and the highest percentage of suicide deaths has been observed among Providence County residents (56%). However, the rate of suicide deaths per 100,000 residents has been observed to be lower among residents of Providence County (9.3 deaths per 100,000 population) compared to all counties, except for Bristol County (8.8 per 100,000 population). The highest rate of suicide death has been observed among residents of Washington County (12.5 deaths per 100,000 population).

Overview of Reviewed Cases

A total of 12 suicide fatalities were reviewed in 2025. Each meeting had a different theme identified using epidemiological data, anecdotal evidence from our members, and trends noted in previous case review meetings.

Month	Theme	Number of Cases Reviewed
April	Men 45-64 Years Old	2
June	Veterans/History of Military Service	3
September	History of Suicide Attempt and In Mental Health Treatment at Time of Death	4
December	Intimate Partner Problem	3

As noted above, white, middle-aged men die by suicide in Rhode Island at a higher rate than any other demographic group. As such, the majority of decedents whose cases we reviewed fell into this category. However, to ensure that recommendations coming from the SFRT are relevant and appropriate for all Rhode Islanders, cases among women and other age and racial groups were also included for review. As future reviews are performed, larger sample sizes will be available across all demographic groups.

Of the 12 cases reviewed, 10 were among males and 11 were among white, non-Hispanic individuals. The age distribution of the cases was relatively evenly spread out from age 25 to 65 years and older. Seven of the 12 cases were 55 years of age and older and 5 cases were younger than 55 years old. Most of the reviewed cases were residents of Providence County (n=7). Marital status information was derived from multiple sources including death records and law enforcement reports, which at time reflected both legal and known relationship statuses. Less than 5 of the cases reviewed were married and 5 cases were either divorced, separated, or widowed.

In addition to demographics, risk factors and contributing circumstances were tracked. The RVDRS database was used as a guide to determine what categories should be included in this tracking, with additional categories being added as they came up in cases. There were a total of 42 risk factors/contributing circumstances identified in the 12 cases reviewed. The most common (not related to that meeting's theme, i.e. Intimate Partner Problem) were: a current mental health diagnosis/problem (8 cases), history of mental health treatment (7 cases), access to lethal means (7 cases), trauma history and PTSD (6 cases), sleep disturbances (6 cases), contributing physical health condition (6 cases), and current substance use problem (6 cases). These trends, along with the specifics of each case, helped to inform the following recommendations.

Recommendations

Due to RIDOH's Small Numbers Policy, and in alignment with agency, state, and federal confidentiality laws, in this report we are unable to link each recommendation to one or more specific cases. However, as previously noted in this report, every recommendation is based directly on the findings from the thorough review of 12 suicide death cases in Rhode Island. Findings were then compared to state and national trends to ensure that the recommendations are data informed and written to impact the largest population of people possible. Alignment with existing state and national guidelines and best practices was encouraged when feasible to further support the validity of the recommendation.

Recommendation Organization

In alignment with the Rhode Island Suicide Prevention Strategic Plan, and informed by the Centers for Disease Control and Prevention's Suicide Prevention Resource For Action, the 2025 SFRT recommendations are grouped into seven priority areas:

- **Strengthen Economic Supports:** Historical trends in the US indicate that suicide rates increase during economic recessions and decrease during economic expansions, particularly for working-age individuals 25–64 years old. Economic and financial strain may increase an individual's risk for suicide or indirectly increase risk by exacerbating existing physical and/or mental illnesses. Financial strains could include job loss, long periods of unemployment, poverty, reduced income, difficulty covering medical, food, and housing expenses, and even the anticipation of such financial stress. Eviction and homelessness are also related to suicide. Reducing these stressors can potentially buffer suicide risk.
- **Create Protective Environments:** A person's environment can significantly influence the accessibility of lethal suicide means. Creating environments that reduce risk factors and increase protective factors where individuals live, work, and play can help prevent suicide. In particular, modifying physical environment characteristics, such as access to lethal means among people at risk, can prevent harmful behavior and reduce suicide rates, particularly in times of crisis or transition.
- **Improve Access to and Delivery of Care:** Most people with mental health conditions never attempt or die by suicide, but these disorders are important risk factors for suicide. According to Mental Health America, over one quarter (27%) of adults in Rhode Island with mental health disorders report an unmet treatment need for these conditions. Poverty, combined with factors such as social stigma, mistrust of the behavioral health system, and lack of cultural adaptation of interventions, is associated with underusing mental health services. Identifying ways to improve access to timely, affordable, culturally appropriate, and quality care for people at risk for suicide is critical to prevention.
- **Promote Healthy Connections:** The literature consistently depicts social connection as a protective factor against physical and psychological disorders, all causes of mortality, and suicidal ideation and attempts. Social capital is related to connectedness and refers to a sense of trust in one's community and neighborhood, social integration, and the availability of and participation in social organizations. Together, connectedness and social capital may protect against suicidal behaviors by decreasing isolation; encouraging adaptive coping behaviors; and increasing a sense of belonging, personal value, and worth to help build resilience in the face of adversity. Connectedness and social capital can also provide individuals with better access to formal support and resources and mobilize communities to meet the needs of their members.

- **Identify and Support People at Risk:** Supporting at-risk people requires proactive case finding and effective response, crisis intervention, and evidence-based treatments. Evidence-based suicide prevention training and suicide risk screening and assessment are approaches that can identify and help people at increased suicide risk. Crisis response interventions, proactive planning and outreach interventions, and therapeutic approaches are intervention and treatment approaches to support disproportionately affected populations. Interventions and treatments should be culturally sensitive and tailored to meet the needs of populations disproportionately impacted by suicide and suicide risk.
- **Lessen Harm and Prevent Future Risk:** The risk of suicide can increase among people who have lost a friend or peer, family member, coworker, or another close contact to suicide. The potential long-term effects among survivors are not currently well understood. However, strategies can be implemented to support suicide loss survivors including improved awareness and quality of bereavement resources.
- **Build Rhode Island's Suicide Prevention Infrastructure:** State-level coordination of suicide prevention is important to ensure that prevention strategies implemented within communities address the people at highest risk for suicide and are comprehensive in scope.

In addition to each being placed in one of the seven priority areas, each recommendation will also include a visual list of the group(s) best positioned to move that particular recommendation forward. The groups are:

Strengthen Economic Supports:

1. In alignment with the Rhode Island Suicide Prevention Strategic Plan, support efforts to increase the Rhode Island minimum wage to a fair living wage, narrow the gap between earnings and basic expenses, and expand and strengthen cash assistance and tax credits.

Create Protective Environments:

2. Expand access to Counseling on Access to Lethal Means (CALM) training for mental health and primary care professionals and embed it as a standard, ongoing component of suicide prevention practice. Prioritize initial and refresher trainings every two years for clinicians who serve individuals at elevated suicide risk, and emphasize the clinical importance of routinely discussing secure storage of firearms and medications as a core safety intervention.

3. Emergency Department staff to utilize an evidence-based suicide screener such as the Columbia Suicide Severity Rating Scale (C-SSRS) following alcohol-related emergency department visits after the patient reaches clinical sobriety. If suicidality is indicated, further screening related to access to lethal means should be performed. Further information related to alcohol involved suicide deaths and recommendations can be found here.

4. In alignment with US Department of Veteran Affairs recommendations, healthcare professionals working with individuals experiencing chronic pain to screen for suicide and implement prevention strategies such as limiting access to lethal means for patients at risk.

5. Rhode Island to fund research to identify effective intimate partner violence intervention strategies and develop a program that seeks to protect survivors and prevent suicides by engaging perpetrators of domestic and intimate partner violence.

Improve Access to and Delivery of Care:

6. Educate local military healthcare personnel and service members on the RI Office of Veteran Services, Department of Defense, Certified Community Behavioral Health Centers, and VA Healthcare System mental health resources, eligibility, and referral pathways to encourage engagement of military personnel who are transitioning out of active duty with treatment providers earlier in the military separation process as a strategy to better support the long-term mental health and safety of Veterans.


7. In alignment with the Rhode Island Suicide Prevention Strategic Plan, state agencies to support efforts to improve affordability of comprehensive insurance coverage, while also promoting utilization of low-cost or free mental health services through Certified Community Behavioral Health Centers by all Rhode Islanders, particularly for those who are uninsured and/or unemployed.

8. Psychiatric hospitals to make every effort possible to connect patients whose behaviors are impacting others' treatment (i.e. drinking before group sessions) to the next level of clinically appropriate care instead of simply discharging from the program. Recommended actions for the patient's primary treatment provider include working with their supervisor, the patient, and/or the patient's internal care team to determine next steps, making at least two phone calls to the patient, if needed, and/or sending a letter to the patient's last know address to communicate next steps which should include referrals, with patient consent, to other resources.

9. Statewide suicide prevention partners to continue to promote the use of 988 by the general public through awareness campaigns, community outreach, and trainings that include how to identify and respond to signs of suicide, the impact of compounding life events on suicide risk, and the importance of utilizing 988 any time a colleague, friend, or family member expresses any suicidal thoughts or makes any suicidal statements.

10. Rhode Island State Police, law enforcement/emergency medical services Crisis Intervention Teams and/or response, and/or the Rhode Island Police Chief's Association to explore the efficacy of utilizing Strategic Disengagement in RI as a best practice de-escalation response during mental health crisis calls.

Promote Healthy Connections:

11. Employers to expand and promote Peer-to-Peer recovery support programs beyond the construction sector into manufacturing and additional industries, ensuring ongoing implementation, training, and integration within workplace wellness initiatives.

12. Community-based organizations to implement and promote programs focused on healthy masculinity, created for men by men, to bring them together, improve mental health and emotional wellbeing, and increase help-seeking behaviors. Existing programs include:

a. Ten Men: https://ricadv.org/ten-men/

b. Coaching Boys Into Men: https://futureswithoutviolence.org/initiative/coaching-boys-into-men-cbim/

c. Men's support groups and peer recovery groups

13. Rhode Island Department of Health, Rhode Island Department of Behavioral Health, Developmental Disabilities, and Hospitals, and other state agencies to continue data driven communication efforts that spotlight male centered programs and initiatives such as:

a. RIDOH's *You Good, Man?*: https://preventsuicideri.org/get-help/you-good-man

b. Futures Without Violence's *Catapult*: https://catapultcampusaction.org/

c. Building Futures' *We've Got Your Back*: https://www.bfri.org/24-nspwrecap/

d. Unscripted Campaign: https://catapultcampusaction.org/unscripted-toolkit/

e. Man Therapy: https://mantherapy.org/

Identify and Support People at Risk:

14. Leverage Certified Community Behavioral Health Centers (CCBHCs) as strategic partners in a statewide outreach and education initiative targeting healthcare professionals to strengthen awareness and appropriate use of Rhode Island's full crisis service continuum—especially for patients recently treated for suicide attempts.

15. Advance the adoption of warm hand-off protocols across healthcare settings, aligned with Zero Suicide and National Action Alliance best practices. Prioritize implementation for high-acuity patients, those screening positive for suicide risk using validated tools, and individuals referred to crisis services. Emphasize warm hand-offs as a critical strategy to improve engagement, ensure safety during care transitions, and strengthen continuity across the behavioral health system.

16. Primary care providers to conduct comprehensive evidence-based suicide risk screening and referrals to internal or external behavioral health clinicians for further assessment, when needed, for patients who present with key risk factors, including:

a. Alcohol use disorder and a history of suicide attempt (e.g., using Audit-C);

b. Sleep issues or disturbances;

c. A newly diagnosed chronic or life-threatening medical diagnosis;

d. A history of military service;

e. Signs of cognitive decline or early-stage dementia.

For validated tools and guidance, refer to the Zero Suicide website

17. Educate healthcare professionals on the relationship between chronic substance use, mental health diagnoses, and suicidality, and how these co-occurring conditions and potential substance interactions impact screening outcomes, clinical decision-making, treatment planning, care engagement, and response to interventions.

18. Promote the use of Community Health Workers, Care Coordinators, Social Workers, Peer Support Specialists, Case Managers, and Integrated Behavioral Health staff to increase access, engagement, and continuity of care by connecting patients to behavioral health services, providing emotional support, and conducting follow-up phone calls. Staff in these roles should prioritize engagement with patients who:

a. Have received a significant medical diagnosis (e.g., tuberculosis)

b. Are referred to mental health services by their primary care provider

c. Who have previously refused mental health referrals

19. Educate all patient-facing staff at healthcare organizations on the importance of asking patients about their and their family member's military history using resources from the VA's Ask the Question campaign.

20. Professional societies and employers of behavioral healthcare and primary care professionals to promote training and implementation around how to educate and engage patients and their support networks (with consent) in mental health care, including wrap-around services, safety planning, and education on signs, symptoms, and appropriate response to suicidal ideation. Emphasize the importance of family/support system engagement to improve adherence, reduce suicide risk, and support long-term outcomes while respecting patient autonomy and privacy.

21. Clinical Education Training Institutions and Clinical Rhode Island Academic Societies to continue to provide training and continuing education opportunities on delivering difficult news/diagnoses and the importance of offering mental health resources and supports as patients are adjusting to new diagnoses.

22. Re-educate healthcare and behavioral healthcare professionals on existing policies, protocols, and best practices for responding to a patient with an increased PHQ-9 (or other short form depression screening) score. If no existing policies exist, create and disseminate them to practice staff.

23. In accordance with National Center for PTSD research, for patients with comorbidity of intermittent/passive suicidal ideation and PTSD; mental health professionals should prioritize the treatment and management of PTSD with evidence-based exposure treatments (CPT, PE, etc.) as part of a suicide treatment plan. Mental health professionals should use clinical judgement to assess the level of severity and/or manageability of suicidal ideation in each patient prior to initiating exposure therapy, as patients experiencing significant and/or active suicidality or who are in acute crisis should not be treated with exposure therapies.

24. Mental and Behavioral Health training programs and professional societies to provide ongoing educational opportunities for mental health professionals on evidence-based PTSD interventions, including exposure based treatments. Training should be created in alignment with the American Psychological Association's recommendations for treating patients with PTSD to ensure clinicians are confident in selecting the most appropriate and effective intervention for each patient while also assessing and tracking suicidal ideation.

25. Ensure healthcare professionals review and apply current evidence-based pharmacotherapy guidelines—such as those from the American Psychiatric Association—prior to initiating treatment for major psychiatric disorders. Emphasize the importance of accurate diagnosis, guideline-concordant prescribing, and awareness of contraindications, especially in complex conditions such as bipolar disorder, where some courses of treatment can increase suicide risk.

26. Federally Qualified Health Centers (FQHCs) to prioritize the integration of community health workers (CHWs) and case managers into existing healthcare referral workflows to ensure patients experiencing economic instability are connected to these professionals who can offer comprehensive supports that address key social determinants of suicide risk. FQHC leadership to ensure that professional development opportunities for CHWs, case managers, and similar staff on these comprehensive supports is offered regularly via the Community Health Worker Association of Rhode Island, community based organizations, and state agencies that offer these resources.

27. In accordance with the National Comprehensive Cancer Network Distress Management (NCCN) and Joint Commissions Guidelines, neuro-oncologists to use validated tools to assess for distress and refer any patient considered to be a danger to themselves to neuro-psychiatry. For these patients, an evidence-based instrument should be used to conduct a suicide assessment, and increased monitoring, safety planning, and reduction of access to lethal means are warranted.

28. In alignment with United States Preventive Services Task Force (USPSTF) guidelines, Primary Care Professionals to continue alcohol and drug misuse screenings for all adults 18 years and older. For special populations such as older adults, screening tools validated for that demographic should be used (i.e. MAST-G).

29. Integrate standardized behavioral health screenings (e.g. AUDIT-C and PHQ-9) into oncology practices and establish clear referral pathways for patients who screen positive and accept further evaluation or treatment.

30. When appropriate, to enhance coping, social connection, and self-management outcomes, healthcare professionals to encourage use of evidence-based, holistic treatment options such as peer programming (e.g. Chronic Pain Self-Management Program) and non-medication pain management techniques (e.g. yoga, meditation, etc.) for chronic conditions that negatively impact quality of life (e.g., restless leg syndrome, tinnitus, etc.) in conjunction with traditional interventions including referrals to pain management clinics and/or behavioral health support.

31. In accordance with the American Academy of Family Physicians' general guidance on supporting bereaved patients, healthcare professionals to acknowledge and support patients grieving a loss using empathetic listening, strategies to manage symptoms of grief, and referrals to community-based resources.

32. Rhode Island Department of Labor and Training to continue partnering with other state agencies (Department of Health, Department of Behavioral Health, Developmental Disabilities, and Hospitals, etc.) to promote mental health and suicide prevention resources by integrating education and resources into their programs and services.

33. Provide evidence-based suicide prevention training (i.e. Mental Health First Aid, Talk Saves Lives, QPR etc.) for Housing Managers at RI Public Housing Authorities and staff involved in eviction-related processes at RI Legal Services to equip them with the skills to recognize warning signs and connect individuals to appropriate mental health resources.

34. Based on National Institute on Alcohol Abuse and Alcoholism best practices and other research, patients being seen in the Emergency Department for alcohol use disorder should be offered referrals for further detox and/or treatment at every presentation. If they decline, Emergency Department social workers, nursing and/or applicable staff should:

a. Provide a warm handoff to patients' primary care providers to actualize coordination of care including repeated referrals and brief interventions for the patient.

b. Send a follow-up communication offering resources/referrals, particularly Peer Recovery Support Services to build rapport and make additional referrals.

c. Consider use of Motivational Interviewing (MI) related to alcohol and substance use treatment options.

35. Rhode Island Division of Sheriffs to include suicide prevention information and resources (e.g. 988, PreventSuicideRI.org) in the packet when serving restraining and/or protective orders to defendants.

Lessen Harm and Prevent Future Risk:

36. Rhode Island Department of Health to ensure Rhode Island funeral homes have access to updated grief resources and are encouraged to distribute them to families of deceased individuals by providing an annual presentation to the Rhode Island Funeral Directors Association, maintaining a list of resources on PreventSuicideRI.org, and sending out an annual grief resources email using the Medical Examiner's Office funeral directors list serv.

Build Rhode Island Suicide Prevention Infrastructure:

37. State of Rhode Island to allocate adequate resources to the Rhode Island Office of the Health Insurance Commissioner to provide timely, comprehensive oversight of health plan compliance with the 2023 Affordability Standards with a focus on policies and practices that increase patient access, including those with major psychiatric disorders, to comprehensive advanced team based care in primary care settings.

38. Establish sustainable funding and a statewide Crisis Intervention Team (CIT) infrastructure to support increased suicide prevention efforts in police and fire departments across the state, including use of evidence-based screenings (i.e. Columbia Screener) and other interventions during mental health related calls.

Dissemination of Recommendations

The recommendations included in this report will be shared with the Governor's Council on Behavioral Health, the Rhode Island Suicide Prevention Advisory Committee, and other state and community partners. Recommendations will be disseminated via a combination of presentations, email communication, social media posting, and inclusion on both the RIDOH and PreventSuicideRI.org websites. Hard copies of this report will be made available upon request.

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