Suicide Prevention: Protecting the Future of Nurses

How to help nurses before stress leads to suicide

ABSTRACT
Nurse suicide is an alarming issue that remains largely underexplored and underaddressed. Moreover, rates of suicide among nurses, which are higher than those in the general population, may increase due to additional stressors caused by the COVID-19 pandemic. There is a decided lack of data regarding nurse suicide or the efficacy of evidence-based prevention programs. This article examines the state of nurse suicide and explores the latest statistics on nurse suicide rates; contributing factors to nurse suicide; and current suicide prevention programs, such as the Critical Incident Stress Management and Healer Education Assessment and Referral programs.

Keywords: Critical Incident Stress Management, Healer Education Assessment and Referral, nurse suicide, prevention

Nurses constitute the largest portion of the health care community, serving in a multitude of settings: hospitals, physician's offices, urgent care, home health, hospice, long-term care, and rehabilitation centers. The challenges routinely faced by nurses in their professional roles, such as chronic nurse shortages, workplace violence, and patient dissatisfaction, are inherently demanding. However, these workplace conditions can also expose nurses to psychological trauma. For instance, primary care nurses may contend with the trauma of providing care to families with seriously ill loved ones within resource-constrained environments. In acute care settings, nurses often bear witness to patients' sudden deterioration despite their unwavering efforts, while those working in long-term care facilities may endure the gradual decline of patients due to age-related ailments. These experiences can contribute to elevated levels of psychological stress among nurses.[1]

Traumatic events—those that cause mental or emotional stress beyond what's considered "normal"—can exhaust coping mechanisms. Furthermore, they can lead to *secondary traumatic stress*, a condition closely linked to providing care to individuals who have undergone trauma.[2] Moreover, being exposed to traumatic events—also referred to as *critical incidents*[3]—may engender conditions like burnout, posttraumatic stress disorder, and depression.[1] It is important to note that depression and other mental disorders are risk factors for suicide.[4]

The COVID-19 pandemic amplified existing stressors and added new concerns: shortages of personal protective equipment, fear of being infected or infecting a loved one, deaths of coworkers, financial uncertainties, being transitioned to unfamiliar units, and lacking sufficient training.[5] In a 2022 Mental Health America survey of frontline health care workers three years into the pandemic, 91% of the nearly 5,000 respondents said they regularly experienced stress, 83% reported anxiety, 81% reported exhaustion/burnout, and 77% said they felt overwhelmed.[6] Emotional exhaustion, depression, anxiety, and psychological distress can lead to burnout, and in turn to medical errors, lack of empathy, lower productivity, and higher turnover rates.[7] The burdens and pressures of working in health care can also lead to suicidality.[8]

NURSES AT RISK

Nurses have a suicide rate of 23.8 per 100,000, compared to 20.1 per 100,000 in the general population, according to an analysis of U.S. data from nearly 160,000 suicides reported between 2007 and 2018 in the National Violent Death Reporting System (NVDRS)—a state-based system that pools data from other reporting offices, such as death certificates and coroner and medical examiner reports.[9] Moreover, as more states are recording suicides within the NVDRS database, the true incidence of nurse suicide is beginning to be better understood, with an estimated 729 nurse suicides in 2017–2018.[9] A recent study of suicide risk in a nationally representative cohort of 1.8 million employed adults between 2008 and 2019 found that the risk was higher for health care workers, specifically RNs, than for non–health care workers.[10] (Regarding the lack of current data on nurse suicide, see *A Dearth of Data*.[5, 11-18])

The data regarding women are particularly startling: between 2017 and 2018, the rate of death by suicide among female nurses was nearly twice that of the general female population (17.1 versus 8.6 per 100,000).[9] It is important to review suicide in the context of gender as nursing is a female-dominated profession; in the general population, the ratio of female-to-male suicide is approximately 1:4.[9]

In addition to the effects of job-related stress, nurses are at risk for suicide because they have access to lethal medications and the knowledge to complete a suicide attempt by pharmacological poisoning. Davis and colleagues found that posthumous toxicology reports of nurses who died by suicide were more likely than those of the general population to contain certain medications.[9] Compared with the general population, nurses who died by suicide had higher levels of antidepressants (44% versus 36%), benzodiazepines (42% versus 32.7%), and opiates (33.7% versus 27.4%).[9]

NURSES WHO DON'T SEEK CARE

A 2017 survey sent to 86,858 nurses and a sample of 5,198 U.S. workers found that nurses are more likely than other U.S. workers to contemplate suicide, yet they are less likely to seek professional help.[19]

There has long been a stigma in the nursing community attached to seeking help for mental health issues. The reticence is often due to fear of that stigma and what seeking help might entail. "Among the barriers to self-reporting," write Shah and colleagues, "is the perception of being devalued, dismissed, and dehumanized, in addition to actual or perceived discouragement from disclosing psychological challenges."[5] When Davidson and colleagues conducted interviews with colleagues regarding nurse suicide, they found that "no one, at any level, was comfortable talking about suicide when it occurred."[11]

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Personal barriers can pose significant challenges for nurses when it comes to seeking mental health care. One prominent reason is that nurses frequently prioritize patient care over self-care.[20] Additionally, nurses may neglect personal relationships because they have a heavy workload, which often includes work-related stressors. This combination of job-related stressors and the challenge of maintaining a healthy work–life balance can lead to role strain—an experience where the demands of work interfere with personal life—and contribute to issues in personal relationships.[8]

Furthermore, job-related demands on nurses can significantly affect their mental health, leading to, for instance, anxiety, depression, and sleep disturbances.[8] This struggle becomes even more pronounced as nurses attempt to juggle long and irregular work hours with their nonwork responsibilities at home.[5, 11] These multifaceted personal barriers collectively contribute to the challenges nurses face in accessing the care and support they need.

Although these challenges preceded COVID-19, during a pandemic concerns about infecting others, combined with a heavy workload, may lead nurses

A Dearth of Data

Various researchers have documented the lack of current data on nurses who are at risk for suicide.[11,15] In fact, Davidson and colleagues found that their 2016 research into nurse suicide prevention was the first of its kind.[12] Available prevention programs have minimal outcomes data or studies quantifying efficacy.

The paucity of data not only hampers efforts to comprehend the extent of the problem but also impedes the development of effective preventive measures. Few health care facilities track nurse suicide, and if a nurse separates from a facility, then dies by suicide, it is not recorded.

In an analysis of 2015 data, the National Violent Death Reporting System (NVDRS) concluded that nurses may have elevated suicide rates compared to the general population.[16] However, it was only in 2018 that the NVDRS included all 50 states, Puerto Rico, and the District of Columbia.[17] Although participation has increased, the data are only robust enough at this time to use 30 out of 50 states for analysis.

Complicating research is the COVID-19 pandemic. Although we have minimal data on the effects of COVID-19 on nurses' mental health, studies have shown that the increased stressors on nurses during the pandemic negatively affected rates of burnout, moral injury, posttraumatic stress disorder, and suicide.[5,13] In a qualitative study from the early phase of the pandemic, nurses were found to have new issues associated with suicide: posttraumatic stress and grief, in addition to stressors previously reported in the literature.[18] As Dzau and colleagues predicted in their *New England Journal of Medicine* editorial, "We have a brief window of opportunity to get ahead of two pandemics, the spread of the virus today and the harm to clinician well-being tomorrow. If we fail, we will pay the price for years to come."[14]

to neglect relationships that might buffer stress.[20] This is congruent with Davidson and colleagues' reporting that work and home stress—which can be compounded by undertreated depression or lifestyle behaviors such as risky substance use—are associated with a high risk of suicide.[11]

While organizations may promote self-care, they often fail to provide the support nurses need in order to engage in such care and to establish healthy habits. This lack of support is evident in the continuation of increasing workloads, nurse-to-patient ratios, and time demands. For instance, researchers who initiated a nurse suicide prevention program in California found that clinical nurses frequently needed help finding time to attend informational meetings such as grand rounds on burnout, depression, and suicide.[12]

Another study involved interviews with three nurses who had experienced coworker suicides.[11] These nurses reported that they were expected to navigate the grieving process for their lost coworkers while simultaneously maintaining their patient care responsibilities. Essentially, nurses may be expected to negate their feelings in times of personal turmoil, crisis, and mourning to prioritize safe and effective patient care with no concession to their emotional well-being and mental health. This is an unsustainable and unsafe practice.

It is worth noting that while many organizations offer sponsored gym memberships, incentives for lower health insurance costs for nonsmokers, and smoking cessation programs, the need for mental health resources extends beyond these incentives. Nurses often find it challenging to incorporate self-care into their daily routines, including taking breaks and eating healthfully, not only because they lack access to such incentives but also because of the nature of their shifts, the lack of staffing, and time constraints. These issues underscore the need for organizations to address systemic challenges and establish clear procedures for nurse managers to guide their teams and promote work–life balance while ensuring continued patient care. In the specific case of mourning the loss of a colleague, processes need to be enculturated to include time off for mourning and group opportunities to process the grief.[21,22]

Another significant challenge nurses often encounter is "presenteeism," which is characterized by diminished on-the-job effectiveness due to factors such as fatigue or illness.[23] Nurses grappling with conditions like depression, burnout, and moral injury may discover themselves lacking the vital mental and emotional resources necessary to deliver the high-quality care expected in critical patient situations—as well as the care they should be giving themselves.[13] *Moral injury* stems from actions taken contrary to one's moral or ethical convictions or from failing to take action in accordance with those principles. Nurses experience moral injury when they act in conflict with their deeply held moral values or when they witness violations of these moral principles.[13] This narrative must be changed, and nurses must embrace that they are valued members of the medical community who need to prioritize their own mental health to effectively care for their patients.

MANAGING STRESS TO PREVENT SUICIDE

Many organizations are putting programs in place to address the issue of provider suicide, through both suicide prevention and stress mitigation and management (see Table 1[3,12,24-26]).

The Critical Incident Stress Management (CISM) program is a comprehensive approach to crisis inter-

Table 1. Suicide Prevention and Stress Mitigation Programs[3, 12, 24-26]

	CISM	HEAR	HEAR for Nurses
Description	Multicomponent crisis prevention, intervention, and mitigation system (for individuals, small and large groups, organizations, and communities)	Suicide risk screening program for physicians	Suicide risk screening program adapted for nurses
Components	• Precrisis education: o stress management o stress resistance o crisis mitigation • Community support programs • Defusing: 3-phase small group intervention that takes place within hours of event • Critical Incident Stress Debriefing: 7-phase structured group discussion 1-10 days after event • One-on-one crisis intervention/support • Family crisis intervention • Ongoing care to prevent mental health effects of acute stress	Multipronged approach: • Series of didactic presentations to destigmatize depression and educate on burnout and suicide • An ISP anonymous, encrypted mental health screen for a variety of mental health conditions • Referral into treatment with "warm handoff" (help finding an appointment)	Added an approach: • Provides critical incident and emotional process debriefings proactively and also upon request
Providers	• Peer counselors (colleagues) receive training and are supervised by mental health professionals. • Mental health professionals that employees can see (ideally culturally competent mental health professionals)	After ISP completion, physicians can receive anonymous psychiatric help, ranging from: • email or text • to one-on-one counseling • to referral to psychiatric care	Therapists, who focus on the emotions and psychological stress following troubling event(s)
Proactive?	Yes • Employees can contact a peer counselor if they self-identify a need for support. • Employees can suggest peer counselors touch base with an employee in need. • Employees can self-refer for specialized care to a mental health professional who is overseeing the program.	Yes, screening is available through an open access link on HEAR website. A screening link is proactively sent annually to all physicians and medical trainees.	Yes, screening is available through an open access link on HEAR website. A screening link is proactively sent annually to all nurses. Nurses can respond to offers for debriefings and anonymous screening.

CISM = Critical Incident Stress Management; HEAR = Healer Education Assessment and Referral; ISP = Interactive Screening Program.

vention that originated in emergency services. CISM recognizes that everyday job stressors present a cumulative stress risk and works to preemptively mitigate those stressors to prevent active mental health crises.[2] CISM components focus on crisis prevention, defusing after a critical event, and ongoing care to prevent the long-term mental health effects of cumulative and acute stress.[3, 24]

The CISM program offers psychological first aid through peer counselors who receive training and are overseen by a mental health professional.[25] Employees can contact their designated peer counselors if they self-identify the need for support. Additionally, employees can convey to a peer counselor concerns regarding coworkers. This embraces proactive education regarding red flags and increased dialogue about mental health.

CISM is an adaptable, integrative, multicomponent crisis intervention system.[24] It can be applied to individuals, small groups, large groups, organizations,

and communities.[24] William Lang, EMT-P, for instance, developed a CISM program for first responders that focused on improving mental health after repeated exposures to acute traumas and resulting cumulative stress.[25] He adapted the CISM model to the complex nature of 911 private ambulance services and tailored it to the paramedics of Oregon's Multnomah and Clackamas counties, and Clark County, Washington. The program accommodates the dynamic staffing and unique challenges presented by ambulance dispatching, including teaching dispatchers to alert on-duty staff of a potential need for debriefings after high-stress events, such as pediatric codes and multiple casualty accidents.

The HEAR program adapted for nurses. In 2016, the HEAR program was adapted for nurses and the balance of hospital staff.[26] During the initial six months of its implementation, 172 nurses completed the ISP.[12] The results were staggering: 74 (43%) were deemed at high risk for suicide and 94 (55%) were at moderate risk. Twelve respondents (7%) disclosed active suicidal ideation or acts of self-harm, and 19 (11%) admitted to a history of suicide attempts. Perhaps the most concerning statistic reported is that only 28 nurses (16%) were receiving mental health therapy at the time of the survey. Forty-four nurses (26%) received counseling, and 17 (10%) were referred for continued treatment.[12] Between 2016 and 2020, the program referred nearly 300 nurses to treatment.[26] An additional element of the HEAR program was developed to provide critical incident and emotional process debriefings following an incident and upon request. These are led by therapists who focus purely on the emotion and psychological stress that may occur following a troubling event or series of events. Debriefings are multidisciplinary and include everyone in the organization who would like to attend.[26]

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There is a research gap when it comes to CISM's efficacy as a comprehensive approach to mental health care and crisis prevention.[27] A systematic review of studies published between 2008 and 2019 found limited and inconsistent results due to inconsistent application of CISM and a lack of long-term follow-up.[27] However, in a survey of 120 nurses who participated in a CISM program at a pediatric hospital, 117 (97.5%) said it had a positive effect on their ability to cope with negative events.[2]

The Healer Education Assessment and Referral (HEAR) program, a suicide risk screening program for physicians, was developed at the University of California San Diego School of Medicine in 2008 in collaboration with the American Foundation for Suicide Prevention (AFSP).[12] HEAR originally included a two-pronged approach: first, clinicians could participate in a series of didactic presentations to destigmatize depression and provide education on burnout and suicide; second, they could be given AFSP's Interactive Screening Program (ISP; https://afsp.org/interactive-screening-program)—an anonymous web-based health screening for depression, among other mental health conditions.[12] Individuals who complete this survey can receive anonymous psychiatric help ranging from an email or text exchange to one-on-one counseling and referral to psychiatric care. At least once a year staff are sent a "push" email inviting them to access the screening. After the HEAR program was implemented, physician suicides at the school dropped from one per year to none.[12] In 2016, HEAR was named an exemplar program in suicide prevention by the American Medical Association.[12]

CISM vs. HEAR. One drawback to the CISM program is that by nature peer support cannot be provided anonymously. Peer support counselors are colleagues, and someone in crisis may be uncomfortable confiding in peers about mental health stressors. However, CISM is a proactive approach when fully implemented and peer counselors throughout the workforce can recognize the warning signs of colleagues in distress. By contrast, HEAR offers anonymity; however, it relies heavily on nurses being aware of their mental health needs and on their willingness to respond to the survey. It has been found anecdotally that colleagues will contact the HEAR therapists when a colleague is in trouble psychologically or thought to be at risk for suicide. Both HEAR and CISM have easily accessible resources. These suicide prevention programs can potentially complement each other in an innovative way that has not been utilized in suicide prevention.

A NATIONAL EMERGENCY: WHAT CAN BE DONE?

Nurse suicide should be considered a national emergency. According to Dzau and colleagues, who compare the mental health crisis to COVID-19, "We are

now facing a surge of physical and emotional harm that amounts to a parallel pandemic."[14]

Reducing nurse suicide requires a collective, multifaceted national intervention (see *Federal Funds for Mental Health*[28, 29] for steps already taken). Currently, two federal agencies, the Department of Health and Human Services (HHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA), have divisions charged with suicide prevention activities. SAMHSA funds and supports the 988 Suicide and Crisis Lifeline (https://988lifeline.org) and Suicide Prevention Resource Center (https://sprc.org). It also developed the Evidence-Based Practices Resource Center (www.samhsa.gov/resource-search/ebp), which provides information and tools to incorporate evidence-based practices into communities and clinical settings, and manages the Garrett Lee Smith Suicide Prevention Grant Program, which funds campus, state, and tribal programs to prevent suicide among youth.[30, 31] Through the Office of the Surgeon General, in 2021 the HHS introduced a blueprint for suicide prevention and called for the development of a comprehensive national strategy.[32]

A potential solution to coordinate efforts could be a unified command structure suitable for directing emergency relief efforts, fostering collaboration among organizations to achieve common goals. As outlined in the suicide prevention blueprint, *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention*, this strategy "is far from being implemented nationally or in its entirety, and suicide prevention continues to lack the breadth and depth of the coordinated response needed to truly make a difference in reducing suicide."[32] For more assistance, see *Resources: Where to Turn for Help*.

CONCLUSION

Nurse suicide is a threat to the entire populace, causing collateral suffering to families, colleagues, patients, organizations, and communities. Protecting nurses and fellow health care staff from the effects of the job has a similarly monumental ripple effect.

Federal Funds for Mental Health

The American Rescue Plan Act of 2021, signed into law on March 11, 2021, allocates $60 million to advocate for, bolster, and advance the mental health of health care professionals.[28] In addition, on March 18, 2022, the Dr. Lorna Breen Health Care Provider Protection Act was signed into law.[29] (Breen, an ED physician, committed suicide during the peak of COVID-19.) This law establishes grants and sets forth mandates for improving mental and behavioral health among health care providers, removing barriers to accessing care and treatment, and identifying strategies to promote resiliency.

Resources: Where to Turn for Help

988 Suicide and Crisis Lifeline
https://988lifeline.org
Call or text: 988
Chat: https://988lifeline.org/chat

Veterans Crisis Line
Call 988, then press 1
Text: 838255
Chat: www.veteranscrisisline.net

Disaster Distress Helpline
Call or text: (800) 985-5990

Crisis Text Line
Text HOME to 741741

For the Frontlines
Text FRONTLINE to 741741

Safe Call Now
(206) 459-3020

Change can be accomplished by using existing resources and tailoring programs to address the unique challenges of performing health care. There are programs that offer organizational structure, peer support, and complete anonymity. These programs must be accessible to both health care and ancillary personnel, including aides, janitorial staff, and security.

Nurses need organizational support and leadership as the impetus to improve mental health care. Most important, nurses must value themselves and each other by embracing support and being agents of change in nurse culture. ▼

Tiffhany Hofstetter is a community health nurse coordinator for the Portland VA Medical Center, Portland, OR. Noralynn L. Mayer is a hospice nurse at St. Barnabas Hospice Care, Gibsonia, PA. *The authors and planners have disclosed no potential conflicts of interest, financial or otherwise.*

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