2024 Update

Report on

Suicide and Suicide Prevention in Texas

As required by the 2024-25 General Appropriations Act, House Bill 1, 88th Legislature, Regular Session, 2023 (Article IX, Section 10.04 (f))

September 2024

22D0320C

Table of Contents

Disclaimer

The recommendations within this report were not authored by and do not reflect the views and opinions of the Texas Health and Human Services system, its component agencies, or staff.

Executive Summary

The *Report on Suicide and Suicide Prevention in Texas* was prepared by the Statewide Behavioral Health Coordinating Council (SBHCC) and is submitted in compliance with the 2024-25 General Appropriations Act, House Bill (H.B.) 1, 88th Legislature, Regular Session, 2023 (Article IX, Section 10.04 (f)). Section 10.04(f) requires the SBHCC to provide an update to the report on suicide and suicide prevention in Texas required by H.B. 3980, 86th Legislature, Regular Session, 2019, including data and recommendations specific to suicides among the veteran and youth in foster care populations.

The primary goal of suicide prevention policies, programs, and services in this state is to prevent all suicide deaths and connect individuals with appropriate behavioral health services at the right time and place. As a first step toward achieving this goal, it is critical to understand prevalence rates of suicide-related events, including suicidal thoughts, suicide attempts, and deaths by suicide. Since the year 2000:

- Texas has seen an overall increase in suicide mortality with the death rate rising 48 percent;
- Individuals ages 30-34 saw the greatest increase of any age group with an 84.5 percent increase in suicide mortality rate, closely followed by individuals ages 55-59 with an increase of 74.5 percent;
- The rate of suicide mortality for youth in the foster care system was more than twice the rate for youth in Texas for two years in 2020 and 2021, but most recently decreased to zero suicide deaths in 2022 and in 2023;
- The rate of calls to the poison control network concerning suspected suicide attempts in girls ages 6-12 increased seven-fold between 2005 and 2021, while the rate for young women 13-19 years old more than doubled; and
- The suicide mortality rate for veterans aged 18-34 rose 134.2 percent between 2001 and 2021, making it the highest rate for the veteran population.

Active military status is not collected on the Texas death certificate, therefore, suicide rates for active military members could not be calculated.

With Texas' large size and varied geography, it is important to analyze suicide mortality prevalence rates with respect to location, showing since the year 2000:

- The West Texas Centers local service area (LSA) (Andrews, Borden, Crane, Dawson, Fisher, Gaines, Garza, Glasscock, Howard, Kent, Loving, Martin,

Mitchell, Nolan, Reeves, Runnels, Scurry, Terrell, Terry, Upton, Ward, Winkler, and Yoakum counties) experienced the largest increase in the suicide death rate with an increase of 229.9 percent;
- The Camino Real Community Services LSA (Atascosa, Dimmit, Frio, Karnes, La Salle, Maverick, McMullen, Wilson, and Zavala counties) experienced the lowest increase in the suicide death rate with a decrease of 8.6 percent;
- The suicide mortality rate in non-metro areas is about 35-50 percent higher than the rate in metro areas; and
- The suicide mortality rate is increasing faster in non-metro areas than in metro areas.

For a comprehensive understanding of suicide prevention work in Texas, it is vital to recognize the existing state statutes, agency rules, and policies relating to suicide prevention, intervention, and postvention.

The Texas Education Code, Texas Family Code, Texas Health and Safety Code, Texas Civil Practice and Remedies Code, Texas Occupations Code, Texas Human Resources Code, Texas Penal Code, Texas Code of Criminal Procedure, Texas Government Code, and Texas Property Code all contain guidance relating to suicide prevention that affects the work of school personnel, mental health professionals, individuals working with veterans, in the criminal and juvenile justice systems, and child welfare employees, among many others. These state statutes are included in Appendix B of this report, along with state agency initiatives since 2000 addressing suicide and suicide prevention.

Introduction

As H.B. 3980 stated, suicide is a public health crisis affecting residents of all ages in every region of the state. Developing a shared understanding of suicide in Texas will help determine the appropriate state and regional efforts necessary to decrease state suicide rates and address the disparities in state laws, policies, programs, and efforts currently being used to address suicide. The SBHCC is required to write an update to the H.B. 3980 *Report on Suicide and Suicide Prevention in Texas* gathering available data on suicide, suicide attempts, and suicidal thoughts beginning in the year 2000, with special attention to the veteran and youth in foster care populations.

The report highlights data related to deaths by suicide in Texas, including suicide mortality data, available as of May 10, 2024. Availability of data for applicable years can vary depending on source. The Centers for Disease Control and Prevention (CDC) had 2022 data available. The U.S. Veteran's Administration only had data available from 2001 through 2021.

The report also includes suicide attempt data, referenced as suicide morbidity data. One way to capture suicide morbidity data is by examining hospital discharges reported in Texas, specifically looking at hospitalizations due to suicide attempt. Hospital discharge data was available to 2022. Since hospital discharge data does not capture all suicide attempts, emergency department visits for suicide attempts and calls to the poison control network for suspected suicide attempts are also examined in this report. Emergency department data was available through 2022. Poison Control Network data was available through 2023. Emergency department data collection began in 2016, while Poison Control Network data collection began in 2004.

The data section of the report includes data from the Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System, including suicide attempts and suicidal thoughts among the adult population and high school students in Texas, respectively.

The report lists statutes and rules passed by the Texas Legislature concerning suicide from the 78th to the 88th Texas Legislative Sessions. This information is followed by a list of suicide prevention, intervention and postvention programs implemented by state agencies since 2000. This includes the agencies' policies regarding suicide.

Lastly, the report contains seven recommendations to improve suicide prevention, intervention, and postvention in the state.

Background

Each death by suicide is tragic and has ripple effects that extend far beyond the individual whose life is lost. According to the American Association of Suicidology, an estimated 135 people are affected in some way by each suicide death, including approximately 18 survivors of suicide loss who will experience short- or long-term grief from the death.[1] In 2021 and 2022, 8,561 Texans died by suicide causing over a million people impacted by suicide and approximately 150,000 bereaved by suicide in two years.

The effects of suicide are most profound for those close to the individual who died. These survivors of suicide loss can experience long-lasting emotional, psychological, and social consequences that place their own health and well-being at risk. Those left behind after a suicide are often plagued with complicated grief reactions and major life disruptions and are at a greater risk of attempting and dying by suicide themselves. Suicides can shake the sense of safety and trust within schools and social networks, affect productivity within a workplace, and strain healthcare and mental health systems.[2]

Suicide has broader social and economic costs, too, including impacts on children and families, healthcare systems, schools, workplaces, communities, and society. According to the American Foundation of Suicide Prevention, Texas lost an estimated $3.5 billion in lifetime medical and work loss costs related to suicide in 2010. The cost averages to $1.2 million in financial loss per suicide death.[3]

Suicide is a complex problem influenced by interactions between multiple biological, psychological, social, environmental, and situational factors. Risk factors include: previous suicide attempts; history of trauma; feeling disconnected from other people; experiencing stigma; and losing a loved one to suicide, among other factors. Protective factors can mitigate suicide risk and include having healthy coping skills; feeling connected to one's family, peers, school, and community; having access to quality physical and behavioral health care; and having time and

[1] Cerel, J., Brown, M. M., Maple, M., Singleton, M., van der Venne, J., Moore, M., & Flaherty, C. (2018, March 7). How Many People Are Exposed to Suicide? Not Six. Suicide and Life Threatening Behavior, 49(2), 529–534. Retrieved from https://doi.org/10.1111/sltb.12450
[2] U.S. Department of Health and Human Services (HHS), National Strategy for Suicide Prevention. Washington, DC: HHS, April 2024
[3] American Foundation for Suicide Prevention, 2019

distance between a person who is having thoughts of suicide and their method of suicide.[4]

Anyone can experience thoughts of suicide. However, research has identified different groups that have elevated risk factors and higher suicide rates than the general population such as the following:

- **Individuals with Mental Health and Substance Use Disorders**
  Certain mental health conditions are associated with an increased risk of suicide, including major depressive disorder, bipolar disorder, anxiety disorders, personality disorders, and substance use disorders.[5]
- **Veterans**
  Veterans, particularly those who have served in combat or experienced trauma, have higher rates of suicide compared to the general population. Veterans are most vulnerable in the first three months following separation from military service, although suicide risk remains elevated for years after the transition.[6]
- **Youth in Foster Care and Juvenile Justice Systems**
  Youth in foster care are almost four times more likely to have thought about or attempted suicide than those who had never been in foster care.[7] Among justice-involved youth, suicide has been shown to occur at a rate two to three times than the rate among youth in the general population.[8]
- **Rural Communities**
  Suicide rates have been consistently higher in rural America than in urban America over the last two decades. Between 2000-2020, suicide rates increased 46 percent in non-metro areas compared to 27.3 percent in metro areas.[9]

Suicide is complex, but research shows that it is preventable. Preventing suicide requires a combination of data-informed efforts working together in a range of

---

[4] National Action Alliance for Suicide Prevention, Lethal Means Stakeholder Group. (2020). Lethal means & suicide prevention: A guide for community & industry leaders. Washington, DC: Education Development Center

[5] Association between level of suicide risk, characteristics of suicide attempts, and mental disorders among suicide attempters

[6] Help With Readjustment and Social Support Needed for Veterans Transitioning From Military Service

[7] Psychiatric symptoms and substance use disorders in a nationally representative sample of American adolescents involved with foster care.

[8] Suicidal Thoughts and Behaviors Among Detained Youth.

[9] CDC May 15, 2024 Suicide in Rural America as a Public Health Issue.

settings to address different aspects of the problem, including prevention, intervention, treatment, and postvention strategies.[10]

The goal of this report is to provide the legislature, state agencies, and community stakeholders with information about the nature and scope of suicide within Texas so that strategic actions can be taken to address this growing public health crisis. The report identifies groups in Texas that data shows are among the highest risk for suicide; includes statewide and regional data that describe recent trends in the prevalence of suicide deaths, suicide attempts, and suicidal thoughts; and lists state activities to prevent suicide. This information is instrumental to reversing the rising trends in suicide in Texas, but it will take data-informed policymaking and the implementation of best practice strategies to change outcomes and save lives.

[10] Suicide Prevention Resource Center

Recommendations

The following recommendations developed by the SBHCC identify ways Texas state agencies can partner with organizations to prevent suicide in underserved and high-risk populations. These recommendations reflect proposals that would advance the state's suicide prevention efforts.

Strengthen Access to Integrated Primary and Behavioral Health Care Services

Recommendation 1: Examine rates of reimbursement for behavioral health services in state and commercial insurance markets and implications for the growth and retention of the behavioral health workforce.

Behavioral health professionals report being disincentivized to accept state and commercial insurance as payment due to insufficient rates for services that are reimbursable, or non-coverage of certain services. In a 2023 workforce survey released by the Texas Behavioral Health Executive Council, 45.30 percent of respondents report not accepting or billing insurance for services.

Recommendation 2: Increase funding for crisis services to expand provider capacity to deliver crisis care.

Crisis services reduce imminent risk of harm to self or others or deterioration of mental or physical health. Examples of crisis services include crisis hotlines, mobile and youth crisis outreach teams, crisis respite units, crisis residential units, extended observation units, crisis stabilization units, and interdisciplinary rapid response teams.

Recommendation 3: Increase funding for integrated primary and behavioral health care services.

Integrated health care allows multidisciplinary teams of professionals to establish a comprehensive treatment plan for clients to address their biological, behavioral, and social needs. Examples of integrated health care models include Certified Community Behavioral Health Clinics and The Collaborative Care Model.

Recommendation 4: Continue to fund telehealth initiatives that expand access to behavioral and integrated primary and behavioral health care services.

People often wait months to see a primary or behavioral health care professional. Telehealth services can reduce that wait time while producing positive health outcomes. Examples of telehealth initiatives include The Child Psychiatry Access Network and Texas Child Health Access Through Telemedicine.

Strengthen Statewide Suicide Prevention Infrastructure and the Availability of Evidence-Based Suicide Prevention Training

Recommendation 1: Explore opportunities to fund the operation of the Texas Suicide Prevention Collaborative (TxSPC).

The Texas Suicide Prevention Collaborative is a nonprofit organization dedicated to supporting Texas communities in their efforts to build suicide prevention capacity. TxSPC does this by promoting the use of evidence-based best practices that encourage a public health approach to suicide prevention. Funding would be used to support TxSPC's organizational infrastructure and capacity to train people and organizations to deliver evidence-based suicide prevention trainings and other strategies.

Recommendation 2: Explore opportunities to fund the TxSPC to issue grants to suicide prevention coalition partners to deliver evidence-based suicide prevention.

TxSPC partners with suicide prevention coalitions to include statewide, local, and military and veteran coalition partners. These coalition partners may provide behavioral health services, evidence-based suicide prevention trainings, and/or provide suicide prevention, intervention, and postvention services. Grants would allow coalition partners to provide more localized and/or regionalized strategies for suicide prevention.

Clarify Data Sharing Allowance

Recommendation 1: Amend current statute to clarify that public or private entities that collect suicide and suicide prevention data may share it with HHSC to assist the SBHCC in implementing its duties under Government Code, Chapter 531, Section 531.477. Proposed statutory changes are as follows:

Sec. 531.477. SUICIDE PREVENTION SUBCOMMITTEE; SUICIDE DATA [~~REPORTS~~.] (a) The council shall create a suicide prevention subcommittee to focus on statewide suicide prevention efforts using information collected by the council from

available sources of suicide data and suicide data reports. The suicide prevention subcommittee shall establish guidelines for the frequent use of [~~those reports~~] suicide data in carrying out the council's purpose under this subchapter.

(b) The subcommittee created under this section shall establish a method for identifying how suicide data [~~reports~~] are used to make policy.

(c) Public or private entities that collect information regarding suicide and suicide prevention may provide suicide data [~~reports~~] to commission staff designated by the executive commissioner to receive [~~those reports~~] this data.

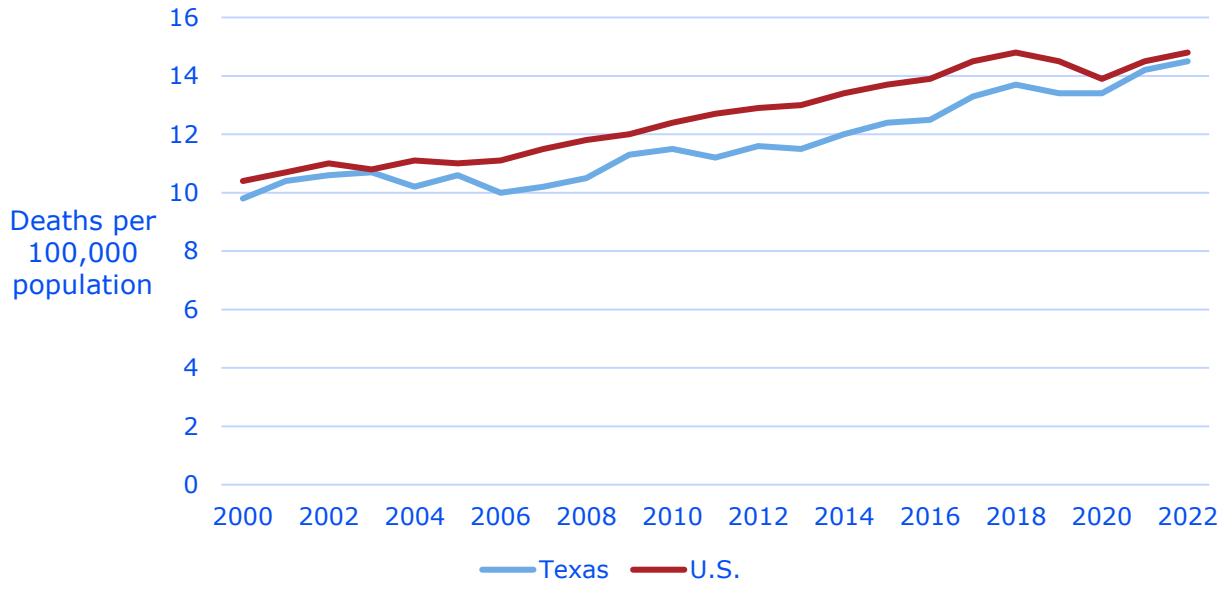
Suicide Data in Texas

Mortality Data

Mortality rates are calculated by dividing the number of deaths by the population and multiplying by 100,000. With a population of 30 million people, Texas has the second largest state population but the highest number of suicide deaths in the United States.[i] While Texas was ranked 40th in the nation for suicide mortality rates in 2022,[ii] the state has experienced an increase in suicide mortality in the years since 2000. The crude death rate[iii] rose 48 percent, from 9.8 deaths per 100,000 population in 2000 to 14.5 deaths per 100,000 population in 2022.[iv] The increase was reflected to differing degrees by different groups within the population.

Figure 1 illustrates suicide mortality rates in the U.S. and Texas between 2000 and 2022.[11]

Figure 1 Suicide Mortality in Texas and the United States, 2000-2022[12]



[11] See Table A1 in Appendix A
[12] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

Limitations of Mortality Data

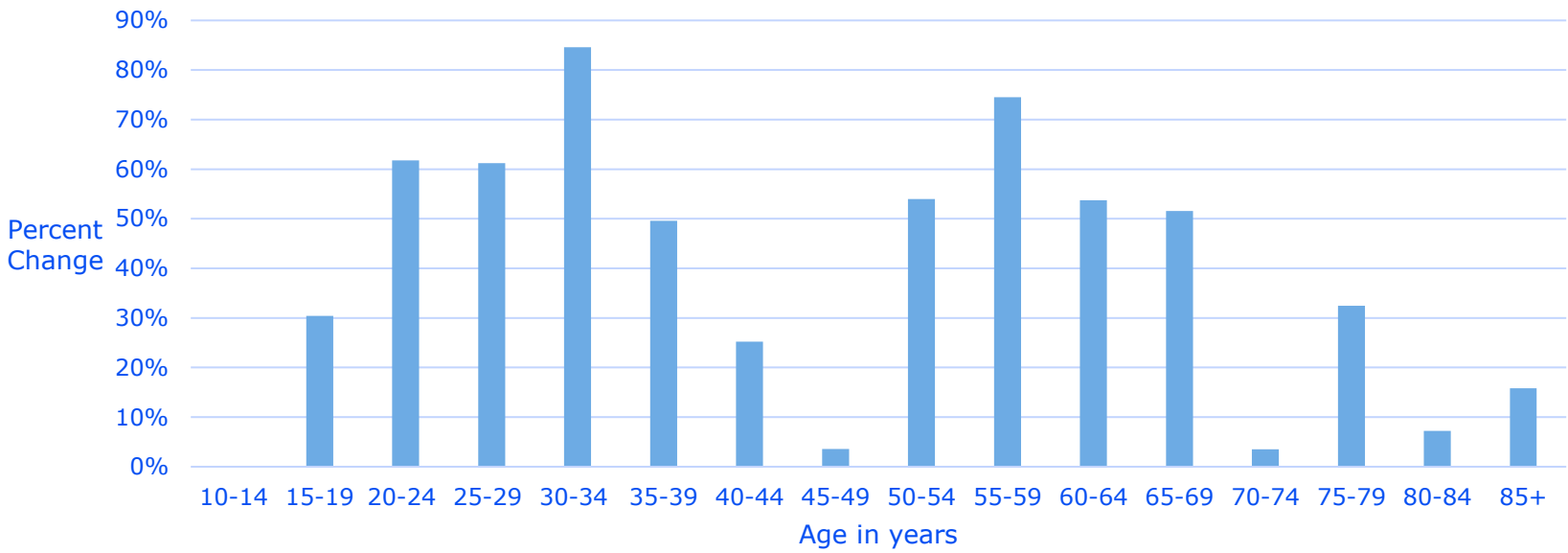
Mortality data is only as accurate as the death certificates on which it is based. Suicide is underreported on death certificates and therefore underreported in mortality data.[v] Certain information is not recorded on death certificates such as military or duty status making the denominator unable to be calculated, or unclear. As mentioned previously, any number under 10 is suppressed to protect the confidentiality of the deceased, so small numbers make it difficult to estimate rates for some areas or groups.

Age[13]

Figure 2 illustrates the changes in suicide mortality rates between 2000 and 2022 by five-year age groups.

Figure 2 Changes in Suicide Mortality by Age Group, 2000-2022[14]

[13] See Table A2, Table A3, and Table A4 in Appendix A
[14] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER


90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Percent Change
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85+
Age in years

Adults aged 30-34 saw the greatest increase in suicide mortality of any age group from 2000 to 2022. During this time, there was an 84.6 percent increase from a rate of 11.7 deaths per 100,000 population to a rate of 21.6 deaths per 100,000 population.

Adults aged 55-59 had the next highest increase at 74.5 percent, with rates rising from 11 deaths per 100,000 population to 19.2 deaths per 100,000 population.

People aged 20-24 had the next highest increase at 61.8 percent, with rates rising from 12.3 deaths per 100,000 population to 19.9 deaths per 100,000 population.

Adults aged 25-29 had the next highest increase at 61.2 percent, with rates rising from 11.6 deaths per 100,000 population to 18.7 deaths per 100,000 population.

The next highest increase was among people aged 50-54, who had a 54 percent increase, with rates rising from 12.6 deaths per 100,000 population to 19.4 deaths per 100,000 population.

The increase for adults aged 60-64 was 53.7 percent, with rates rising from 12.1 deaths per 100,000 population to 18.6 deaths per 100,000 population.

The increase for adults aged 65-69 was 51.5 percent, with rates rising from 9.7 deaths per 100,000 population to 14.7 deaths per 100,000 population.

The increase for adults aged 35-39 was 49.6 percent, with rates rising from 12.1 deaths per 100,000 population to 18.1 deaths per 100,000 population.

The rate for adults ages 75-79 experienced an increase of 32.5 percent, rising from 15.1 deaths per 100,000 population to 20 deaths per 100,000 population.

The increase for youth aged 15-19 was 30.4 percent, with rates rising from 9.2 deaths per 100,000 population to 12 deaths per 100,000 population.

The rates for adults aged 40-44 increased 25.2 percent, rising from 14.3 deaths per 100,000 population to 17.9 deaths per 100,000 population and the rates for adults aged 85 and older increased 15.8 percent, rising from 20.2 deaths per 100,000 population to 23.4 deaths per 100,000 population.

Adults aged 80-84 saw a 7.2 percent increase from a rate of 19.4 deaths per 100,000 population to a rate of 20.8 deaths per 100,000 population.

Adults aged 45-49 saw an increase of 3.6 percent, rising from 16.9 deaths per 100,000 population to 17.5 deaths per 100,000 population and the 70-74 age

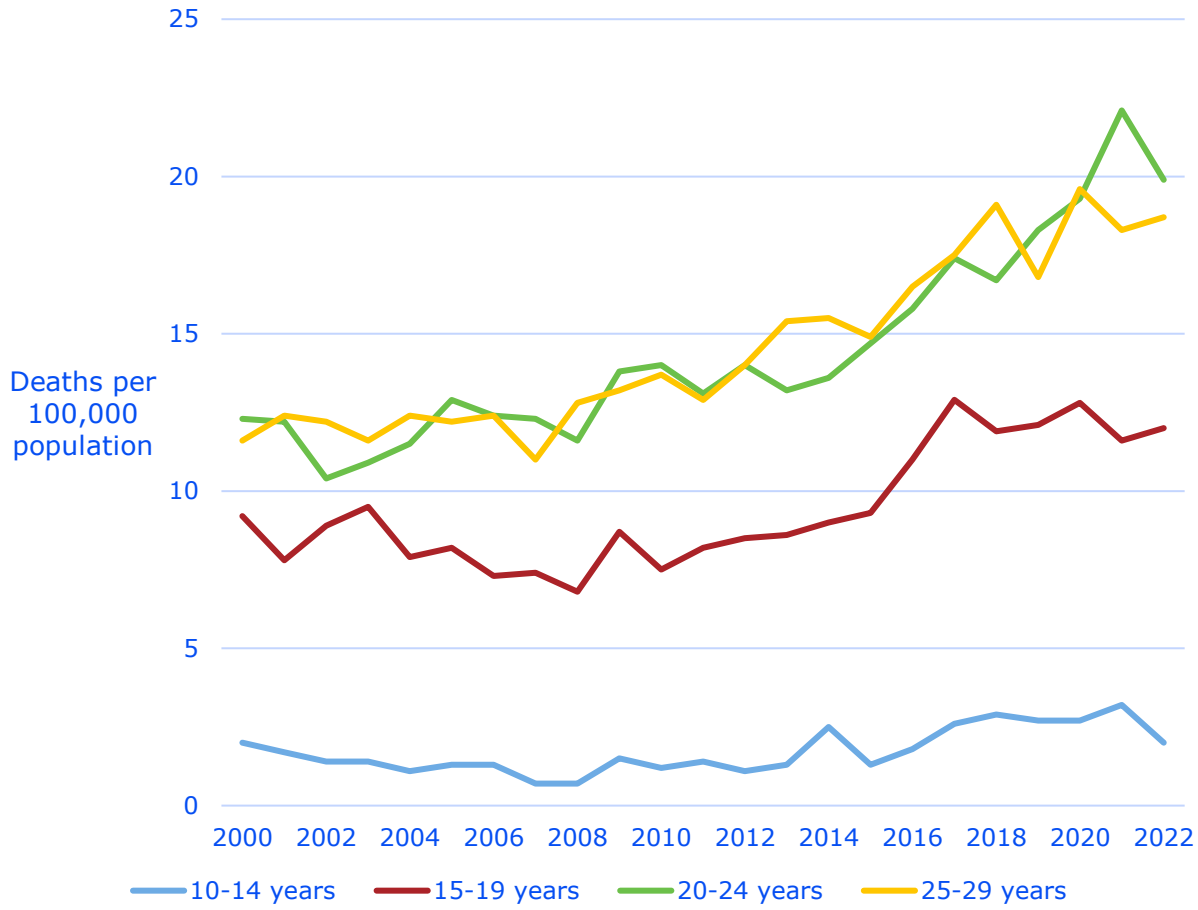
group experienced the smallest increase, rising by 3.5 percent from 14.1 deaths per 100,000 population to 14.6 deaths per 100,000 population.

The 10-14 age group stayed the same at two deaths per 100,000 population in both 2000 and 2022.

It is important to keep in mind that despite the older age groups having the highest rates, most suicides occur in middle age. Suicide rates fluctuated differently among the various groups during the years of the COVID-19 pandemic. While most older adults saw a decrease between 2019 and 2020, rates for those over 75 increased to above their 2019 levels in 2022. Adults 30-44 years old and 60-64 years old saw an increase in suicide mortality rates while those 45-59 years old saw a decrease in 2020, but both saw increases by 2022. The rate of suicide mortality for 10–19-year-olds stayed the same or decreased slightly, while the rates for 20-29-year-olds increased.

Figure 3 outlines the suicide mortality rate by youth and young adults from 2000-2022.

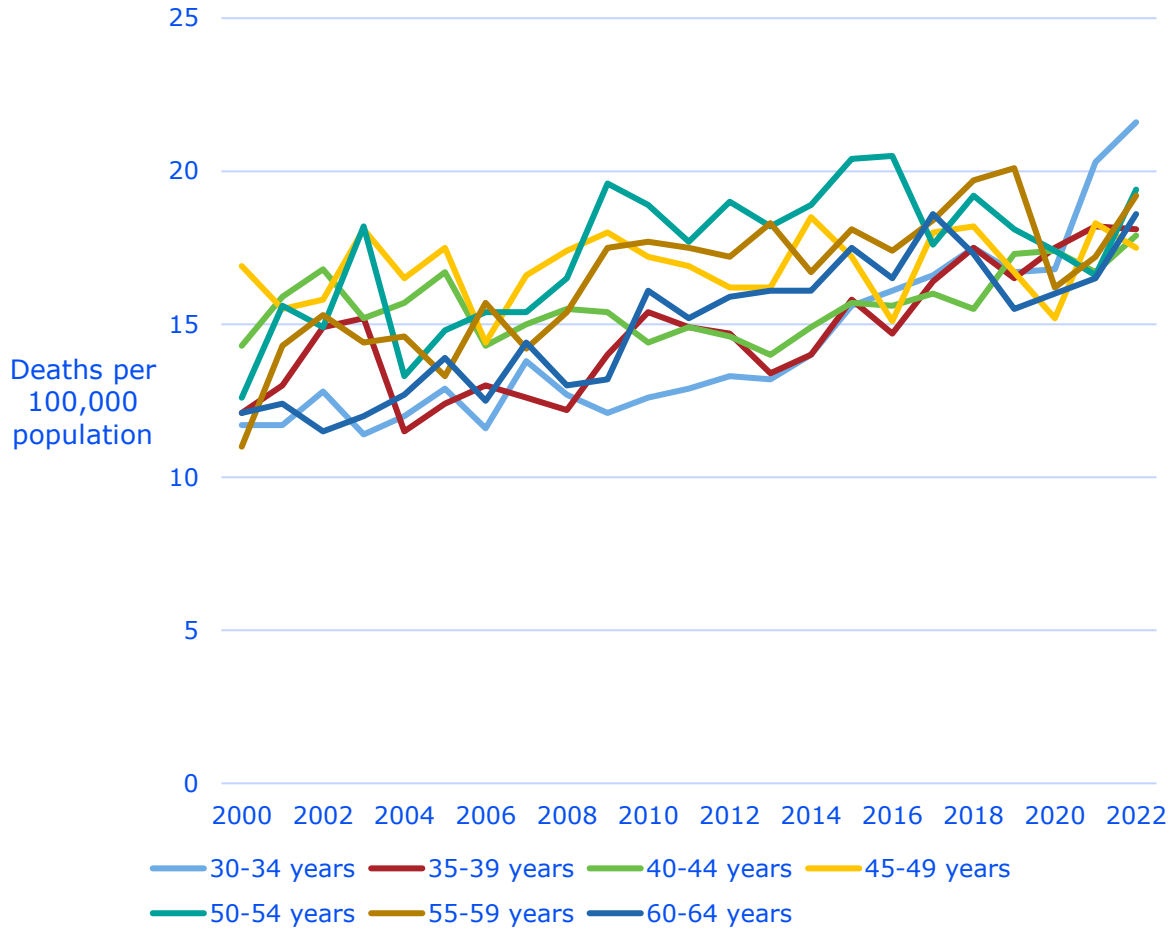
Figure 3. Youth and Young Adult Suicide Mortality, Texas 2000-2022[15]



[15] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

Figure 4 outlines the suicide mortality rate by individuals in their middle years from 2000-2022.

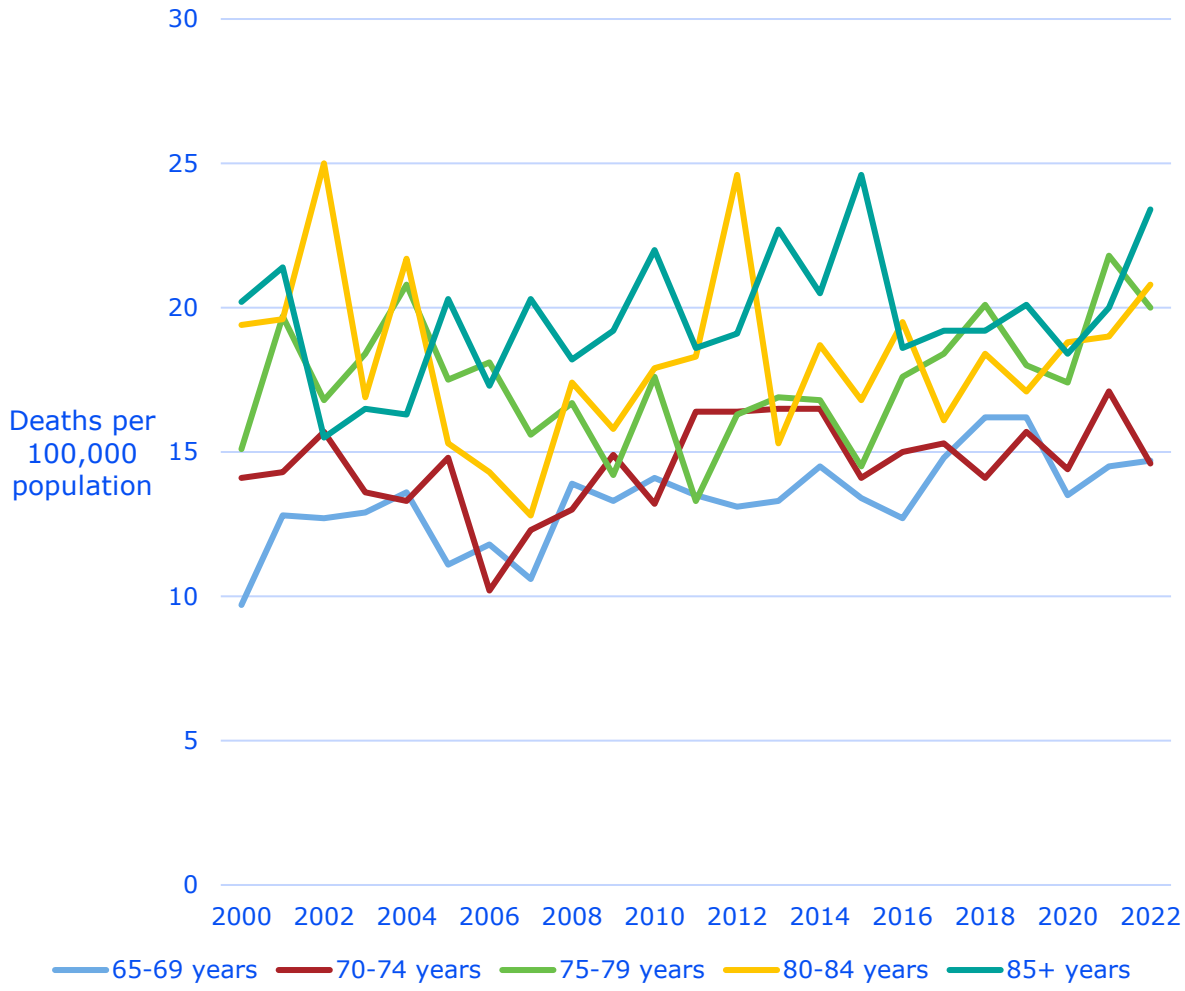
Figure 4. Suicide Mortality in the Middle Years, Texas 2000-2022[16]



[16] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

Figure 5 outlines the suicide mortality rate by older Texans from 2000-2022.

Figure 5. Suicide Mortality in Older Texas Residents, 2000-2022[17]



[17] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

Race and Ethnicity

Changes in suicide mortality rates also varied by race and ethnicity from 2000-2022. Black or African American Texas residents had the largest increase in suicide mortality rate at 78.6 percent, increasing from 5.6 deaths per 100,000 population to 10 deaths per 100,000 population between 2000 and 2022.

The next highest increase was among white, non-Hispanic Texas residents who maintained the highest rates, and saw a 71.7 percent rate increase of 13.8 deaths per 100,000 population to 23.7 deaths per 100,000 population.

Hispanic Texas residents saw a rate increase of 63.5 percent from 5.2 deaths per 100,000 population to 8.5 deaths per 100,000 population.

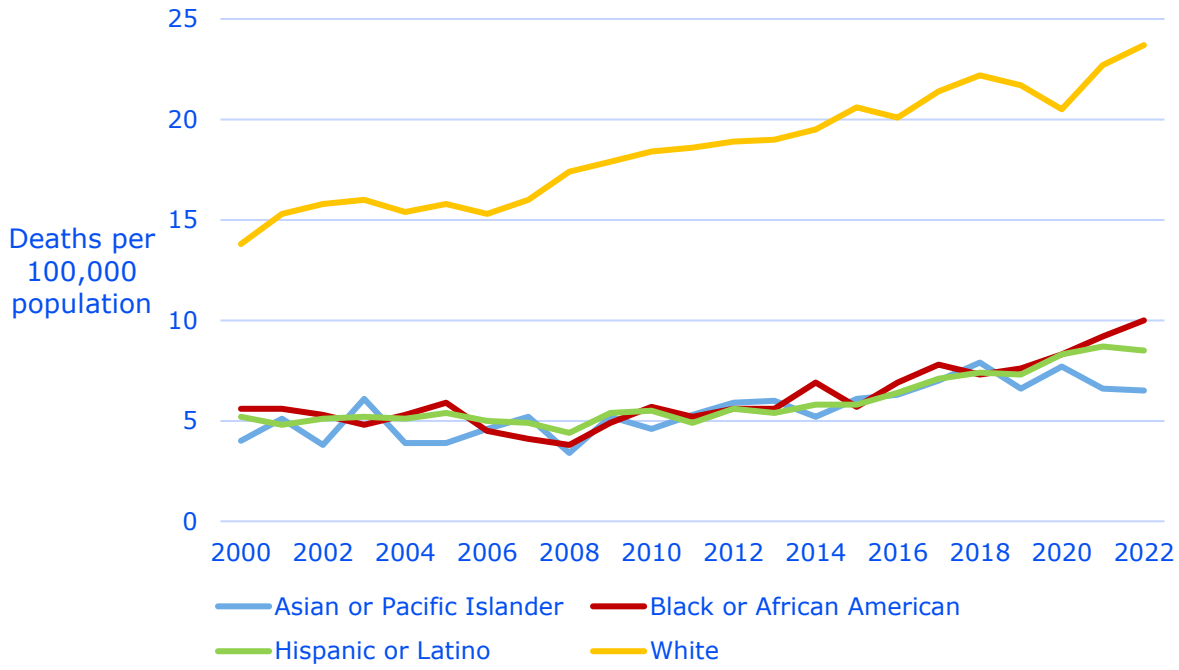
White, non-Hispanic Texan residents saw a decrease in suicide mortality in 2020, while all other groups with available data[18] saw an increase in suicide mortality. That increase continued into 2021 for Hispanic Texans and increased through 2022 for Black or African American Texans.

There were 132 suicide deaths among American Indian or Alaskan Native Texas residents during the 23 years of analysis, producing an overall mortality rate of 6.2 deaths per 100,000 population. Rates are suppressed for less than 10 deaths in order to protect confidentiality. Less than 20 deaths produce a rate which is not considered reliable. There was only one year in the 23-year period with more than nine suicide deaths in that population to produce an unreliable suicide death rate.

[18] Data on American Indian or Alaskan Native were suppressed due to small number and could not be evaluated.

Figure 6 outlines suicide mortality by race and ethnicity for 2000-2022.

Figure 6. Suicide Mortality by Race and Ethnicity, Texas 2000-2022[19]



[19] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

Sex[20]

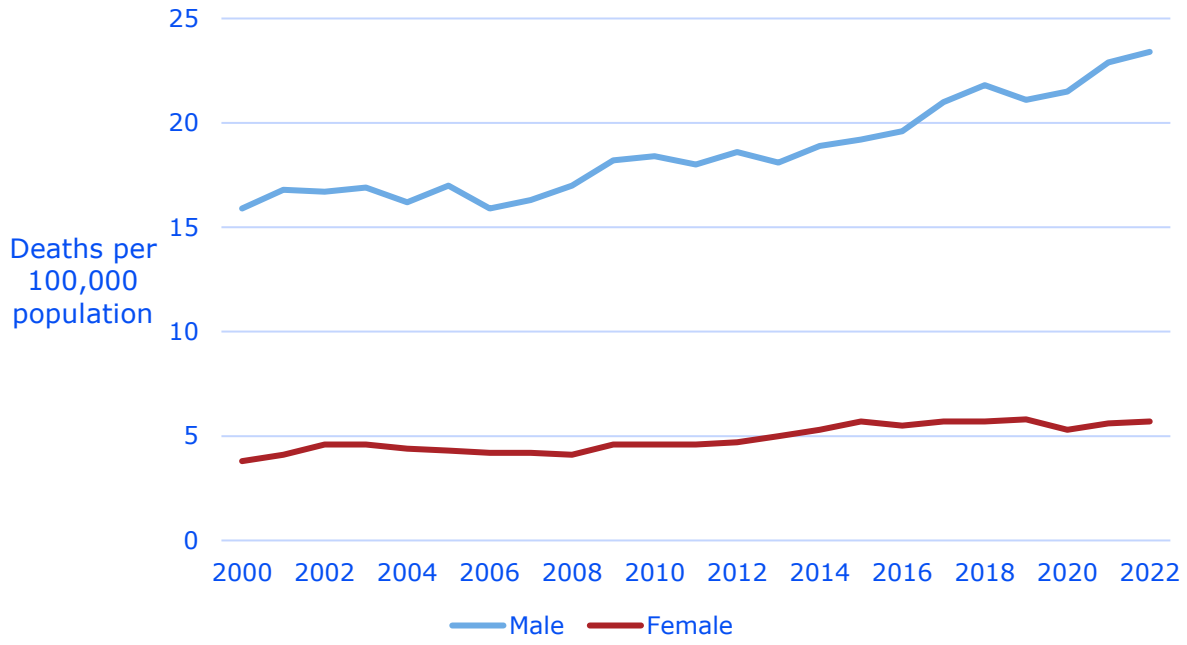
Suicide mortality rates vary greatly by sex. Males are three to four times as likely to die by suicide as females in the state of Texas; however, rates among females increased slightly more than males between 2000 and 2022.

Rates for females increased by 50 percent, from 3.8 deaths per 100,000 population to 5.7 deaths per 100,000 population.

Rates for males increased 47.2 percent, from 15.9 deaths per 100,000 population to 23.4 deaths per 100,000 population.

Figure 7 outlines the suicide mortality rate by sex for 2000-2022.

Figure 7. Suicide Mortality by Sex, Texas 2000-2022[21]



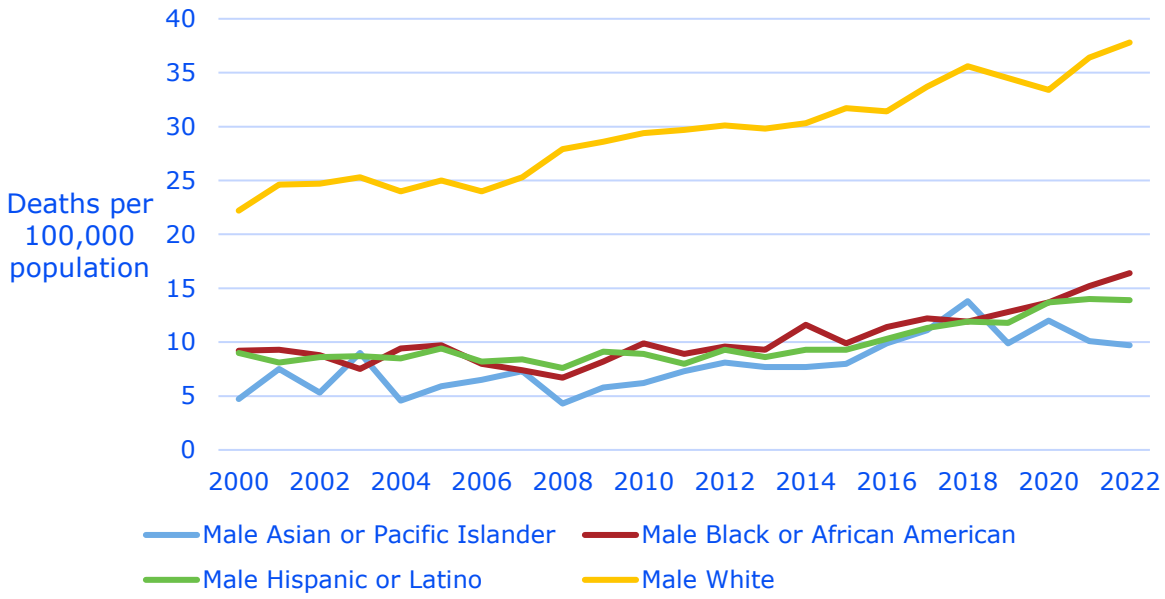
Mortality rates vary further by race, ethnicity, and sex. Among both males and females, white Texas residents have the highest suicide mortality rate. Rates are increasing among all groups, but to different degrees.

[20] See Table A6, Table A7, and Table A8 in Appendix A
[21] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

White male suicide mortality rates have increased by 70.3 percent from 22.2 deaths per 100,000 population to 37.8 deaths per 100,000 population. Black or African American male suicide mortality rates have increased by 78.3 percent from 9.2 deaths per 100,000 population to 16.4 deaths per 100,000 population. This increase mostly occurred in the years after 2014. The rates among Asian or Pacific Islander males have more than doubled with a 110.2 percent increase from 4.7 deaths per 100,000 population to 9.9 deaths per 100,000 population. The rates among Hispanic males have increased 54.4 percent from 9 deaths per 100,000 population to 13.9 deaths per 100,000 population.

Figure 8 outlines the male suicide mortality rate by race and ethnicity for 2000-2022.

Figure 8. Male Suicide Mortality by Race and Ethnicity, Texas 2000-2022[22]



Female suicide mortality rates are also increasing by race and ethnicity group. The white female suicide mortality rate increased 66.7 percent between 2000 and 2022 from 5.7 deaths per 100,000 population to 9.5 deaths per 100,000 population.

The Hispanic female suicide mortality rate increased 115.4 percent from 1.3 deaths per 100,000 population to 2.8 deaths per 100,000 population.

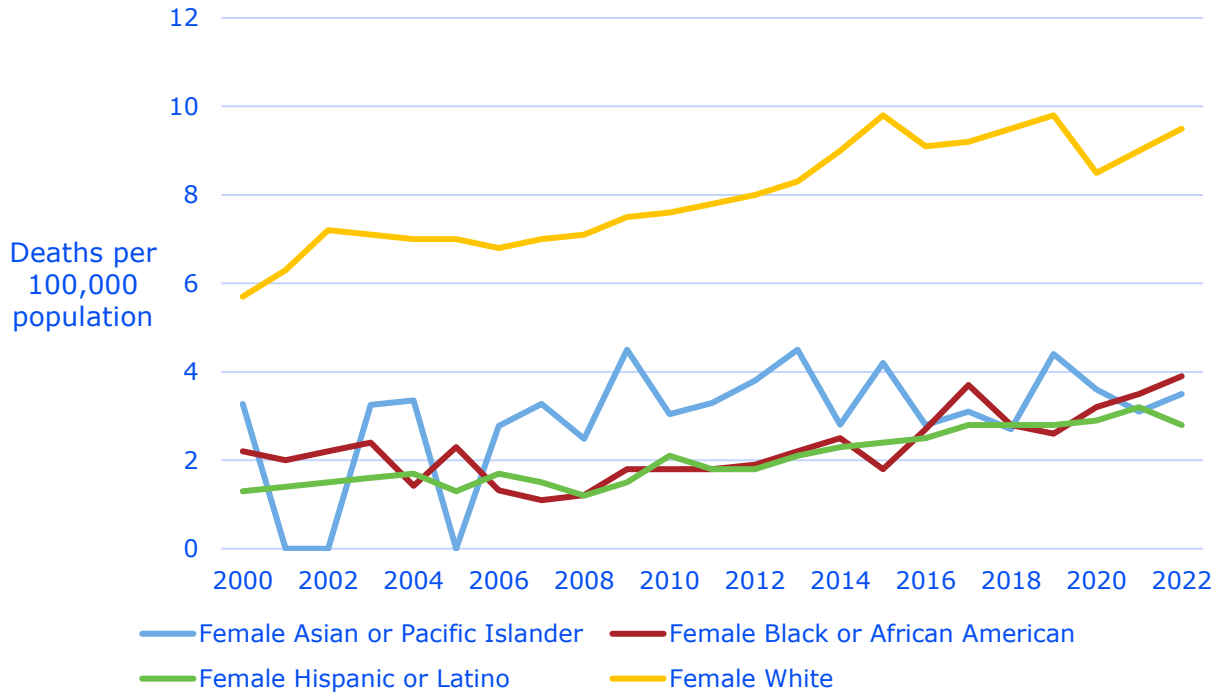
[22] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

The Black or African American female suicide mortality rate increased by 77.3 percent from 2.2 deaths per 100,000 population to 3.9 deaths per 100,000 population.

The rate for Asian or Pacific Islander females increased by 6.8 percent from 3.3 deaths per 100,000 population to 3.5 deaths per 100,000 population. While the rates may appear to be zero in 2001, 2002, and 2005, the rates are actually suppressed due to less than ten suicide deaths occurring in that year for that group. Suppression is done to protect the confidentiality of the deceased.

Figure 9 outlines the female suicide mortality rate by race and ethnicity for 2000-2022.

Figure 9. Female Suicide Mortality by Race and Ethnicity, Texas 2000-2022[23]



Industry and Occupation[24]

Emerging research indicates certain occupations and industries experience higher suicide mortality rates than others.[vi] Industry and occupation-specific suicide mortality rates were calculated for both industry sectors and occupational groups

[23] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER
[24] See tables __ and __ in Appendix A.

utilizing data from multiple sources including the Texas Department of State Health Services (DSHS) Death Certificate Data from 2020, industry and occupation coding by the National Institute for Occupational Safety and Health (NIOSH), as well as industry and occupation population estimates from the 2020 American Community Survey (ACS).

Among industries, mining, which includes oil and gas extraction, saw the highest reliable rate at 38 deaths per 100,000 population and 97 suicide deaths. Transportation and warehousing saw the second highest rate of 27.1 deaths per 100,000 population and 188 suicide deaths. The last reliable increased rate was in construction, which saw a rate of 25.4 deaths per 100,000 population and 291 suicide deaths.

The agriculture, forestry, fishing and hunting industry has a high suicide mortality rate nationally.[vii] The rate in Texas for 2020 was 47.2 deaths per 100,000 population. However, this rate had high variability (95 percent confidence interval: 35.3-62.9) due to small numbers and should be used with caution. The industry with the largest overall number of suicide deaths was construction with 291 deaths.

Among occupations, the highest reliable rate was among transportation and material moving with a rate of 58.3 deaths per 100,000 population and 578 suicide deaths. This occupation code includes truck and mass transit drivers. Construction and extraction are combined as an occupation group and saw a suicide mortality rate of 35 deaths per 100,000 population with 297 suicide deaths. The only other occupation group to have a reliable inflated suicide death was installation, maintenance, and repair, which is inclusive of all types of installation, maintenance, and repair, including automotive, utility, heating, ventilation, and air conditioning, home appliances, office machines, and aircraft, with a suicide mortality rate of 31.6 deaths per 100,000 population and 141 suicide deaths.

Other occupations known to have higher rates of suicide mortality include the farming, fishing, and forestry occupation group and the healthcare practitioners and technical occupation groups. There were 13 suicide deaths in 2020 among the farming, fishing, and forestry occupation with a rate of 38 deaths per 100,000 population with high variability (95 percent confidence interval: 22.0-65.4) and should be used with caution. There were 110 suicide deaths among the healthcare practitioner and technical occupations group with a rate of 14.6 deaths per 100,000 population which was not inflated but had high variability (95 percent confidence interval: 12.1-17.6) and should be used with caution.

Veterans[25]

According to the most recent census in 2020, the veteran population in Texas varies greatly from the general public. While the population of Texas is 51 percent female, the veteran population is only 10.9 percent female.

Figure 10 shows the proportion of the population of Texas that is male and the proportion that is female.

Figure 10 Texas General Population by Sex, 2020[26]

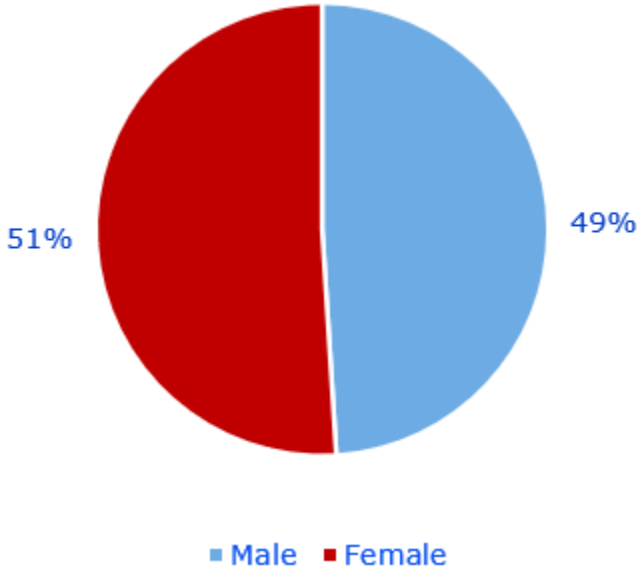
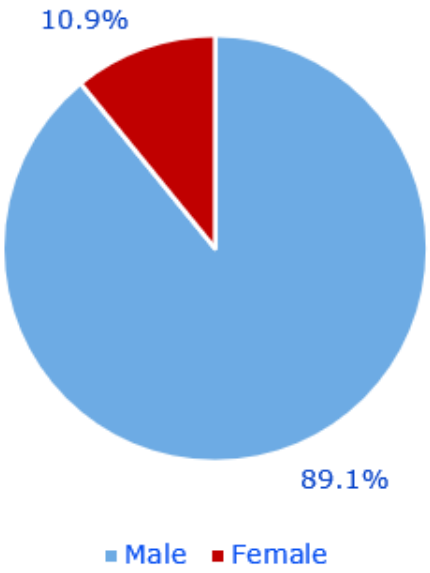


Figure 11 shows the proportion of the veteran population in Texas that is male and the proportion that is female.

[25] See Table A9, Table A10, and Table A11 in Appendix A
[26] U.S. Census

Figure 11 Texas Veteran Population by Sex, 2020[27]



Veterans in Texas also have a different age distribution than the adult general population of Texas. There is a smaller proportion of veterans in the 18–34-year-old age group and a larger proportion of veterans in the 65–74-year-old and 75 years or older age groups than the general population.

Figure 12 shows the adult general population of Texas broken out into five age groups.

[27] U.S. Census

Figure 12 Texas Adult Population by Age Group, 2020[28]

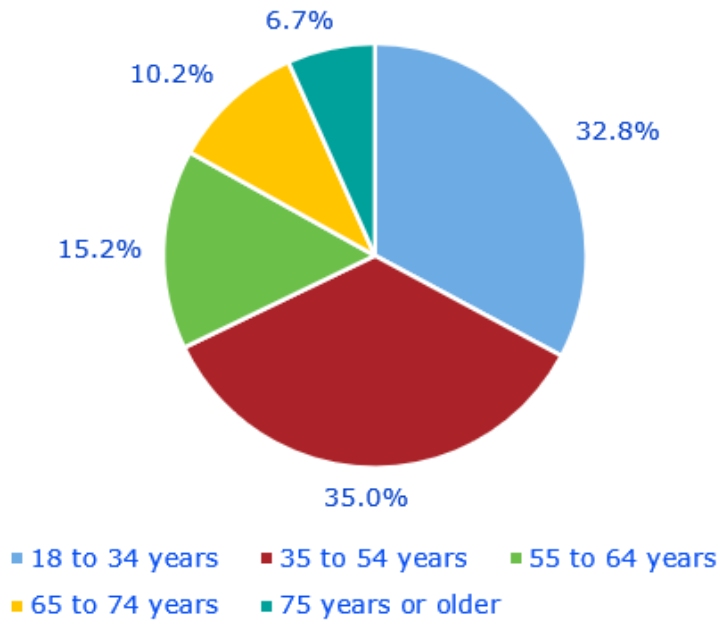
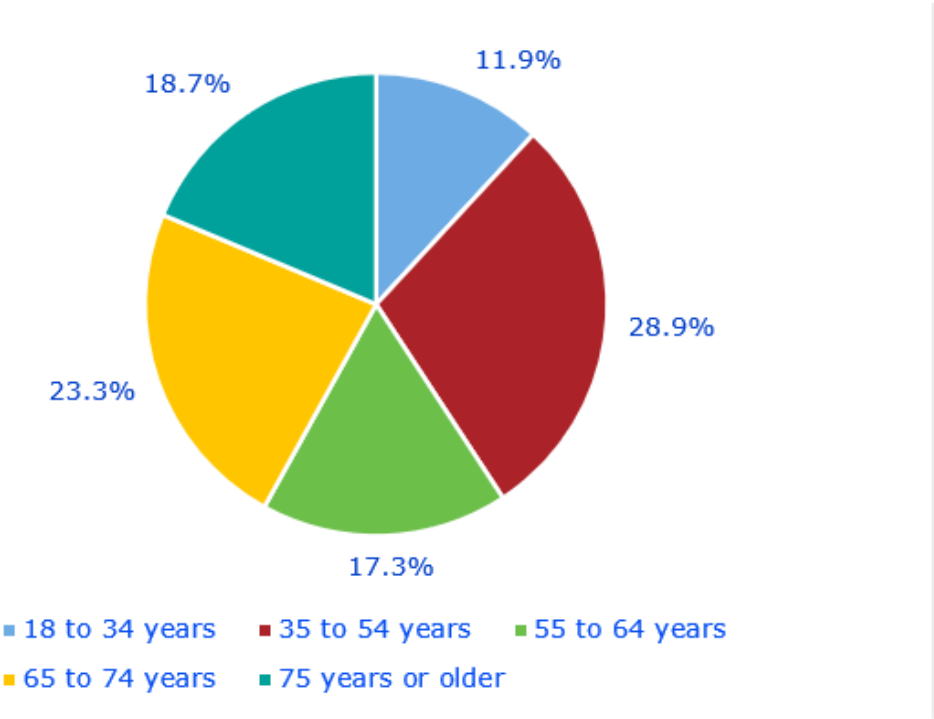


Figure 13 shows the veteran population of Texas broken out into five age groups.

[28] U.S. Census

Figure 13 Texas Veteran Population by Age Group, 2020[29]



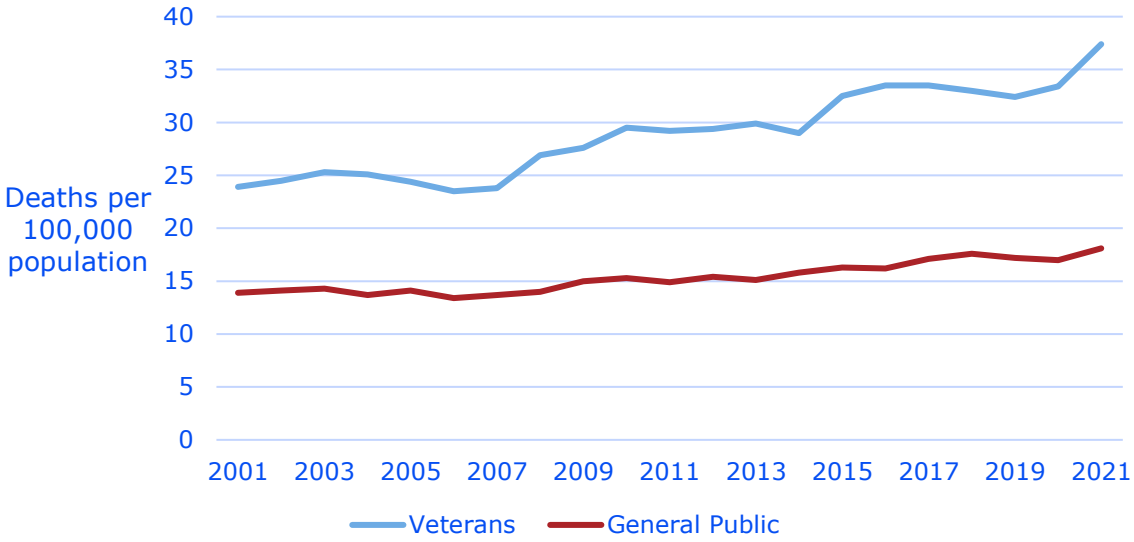
Veterans had a higher rate of death by suicide than most other categories of people examined in this report with a rate approximately two times higher than the overall Texas rate. The age-adjusted veteran suicide death rate rose 35.6 percent between 2001 and 2019, from 23.9 deaths per 100,000 veteran population to 32.4 deaths per 100,000 veteran population. The Department of Defense and Department of Veteran's Affairs Joint Mortality Data Repository has only released data through 2019. It is worthy to note that the age-adjusted rate is not sex-adjusted. The proportion of females in the veteran population is much lower than the proportion in the general population and females have lower suicide mortality rates than males. The larger proportion of females in the Texas rate would lower the overall rate for the general public.

The rate of veteran suicide mortality decreased slightly in both 2018 and 2019 creating a downward trend. The rate then increased in 2020 and 2021. Texas currently collects information about military status on the death certificate, with a single checkbox regarding involvement with the military, which could mean either active duty or veteran. As a result, it was not possible to calculate rates for active-duty service members in Texas.

[29] U.S. Census

Figure 14 outlines the age-adjusted suicide mortality rate for veterans and the general public for 2001-2021.

Figure 14. Age-Adjusted[30] Suicide Mortality, Veterans and General Public, Texas 2001-2021[31]



Looking at veteran suicide mortality by age group, the largest increase is seen in the 18–34-year-old age group where the rate increased by 134.2 percent from 22.5 deaths per 100,000 population in 2001 to 52.7 deaths per 100,000 population in 2021.

The next largest increase was among the 55–74-year-old age group which rose by 60 percent from 18.5 deaths per 100,000 population in 2001 to 29.6 deaths per 100,000 population in 2021.

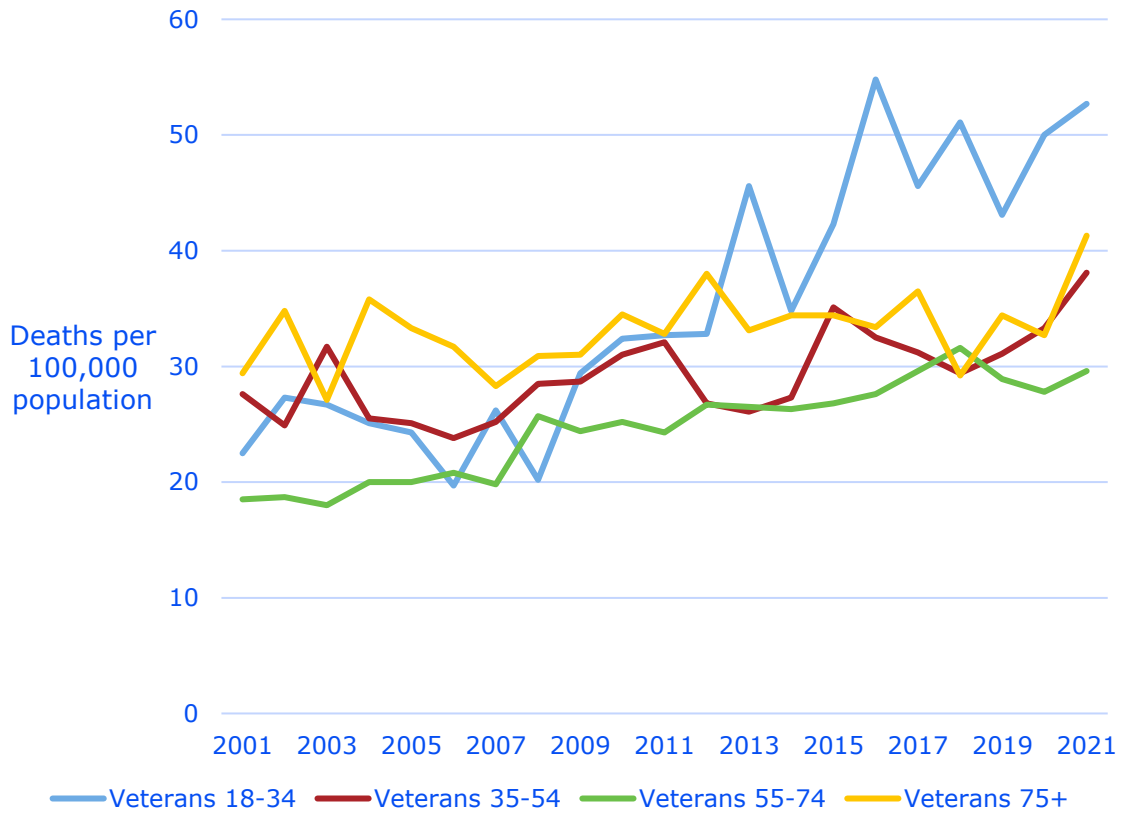
The suicide mortality rate increased 40.5 percent in the 75-year-old and older veteran population, increasing from 29.4 deaths per 100,000 population in 2001 to 41.3 deaths per 100,000 population in 2021.

[30] Age-adjusted mortality rate is the rate that would have existed if both compared populations had the same age distribution. It is frequently used when populations have disparate age distributions.
[31] Department of Defense/Department of Veteran's Affairs Joint Mortality Data Repository (MDR) and Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

The 35–54-year-old veteran age group saw the smallest increase in suicide mortality of 38 percent, rising from 27.6 deaths per 100,000 population in 2001 to 38.1 deaths per 100,000 population in 2021.

Figure 15 shows the veteran suicide mortality rate by four age groupings.

Figure 15 Veteran Suicide Mortality by Age Group, 2001-2021[32]



The veteran suicide mortality by age group differed substantially from the suicide mortality rate by age group for the state of Texas.

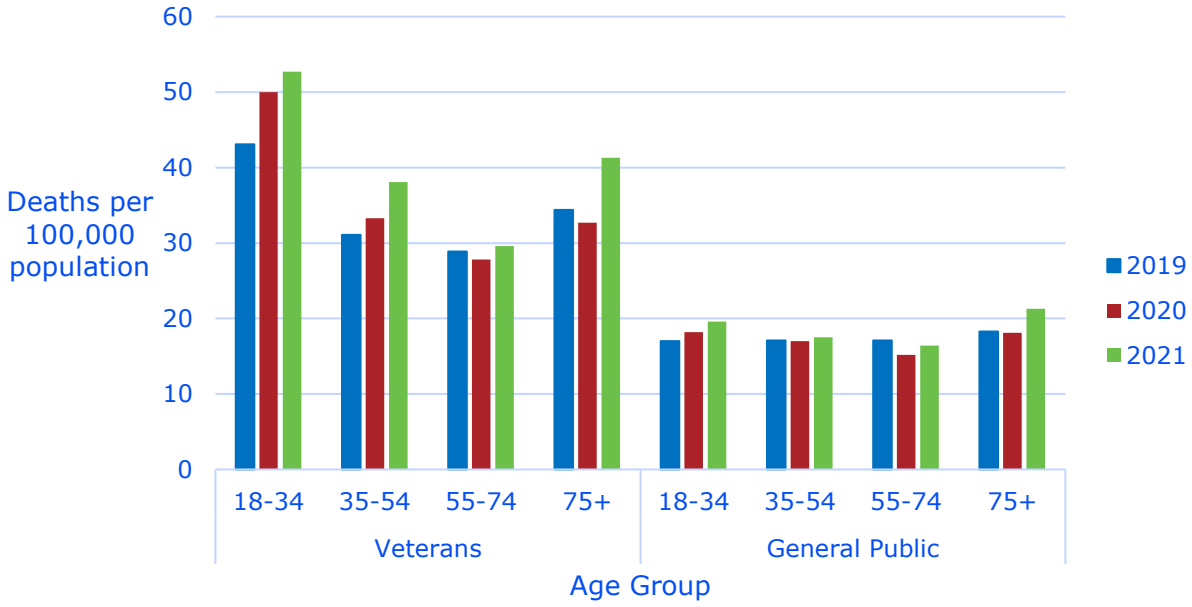
The difference was greatest in the 18–34-year-old population where the veteran rate of 52.1 deaths per 100,000 population was more than two and a half times higher than the rate for 18–34-year-old general public population of 19.6 deaths per 100,000 population.

Rates for the other veteran age groups were just less than twice as high as the age group rates for the general public.

[32] Department of Defense/Department of Veteran's Affairs Joint Mortality Data

Figure 16 shows the Texas suicide mortality rate by age for veterans and the general public.

Figure 16 Texas Suicide Mortality by Age Group for Veterans and the General Public, 2019-2021[33]



Youth in Foster Care

Records of suicide attempt and ideation are not maintained by the Department of Family and Protective Services (DFPS).

Utilizing the information gathered from DFPS, there are two methods of comparing these deaths. The first is to look at the expected and actual suicide deaths for the population in the foster care system and the second is to compare the suicide mortality death rate for children in Texas compared to children in the Texas foster care system.

The expected number is calculated by applying the statewide rate to the foster care system population. While the number of suicides in the foster care system was not more than expected in 2018 or 2019, the number of suicide deaths in 2020 and 2021 was at least twice the expected number. There are several reasons to expect a higher toll of suicide in the foster care population. One reason could be higher

[33] Joint Veterans Administration/Department of Defense Mortality Data Repository (MDR) and Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

rates of trauma and adverse childhood experiences than children outside of the Texas foster care system.[viii] [ix] These factors might contribute to the higher suicide death numbers in 2019 through 2021.

Table 1 shows the expected number of suicide deaths among youth in the foster care system and the actual number of deaths.

Table 1. Expected and Actual Number of suicide deaths among youth in the foster system.

Year	Texas Suicide Mortality rate for youth[34]	Number of youths in the foster care system	Expected Number of Suicide Deaths	Actual Number of Suicide Deaths
2018	3.1	51,974	1.6	0
2019	3.1	49,650	1.5	2
2020	3.2	46,979	1.5	3
2021	3.1	42,828	1.3	3
2022	2.9	35,319	0.7	0

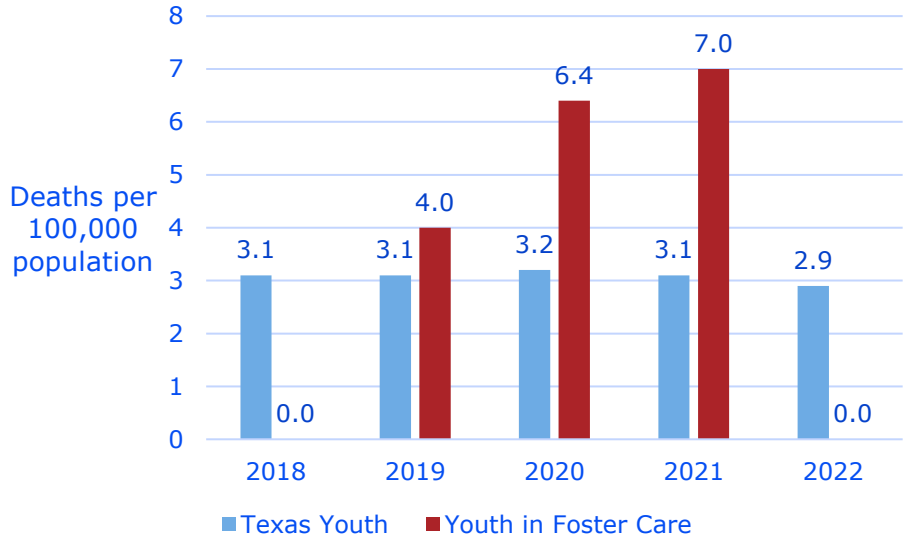
Looking at the suicide mortality rate for youth in Texas and comparing it to the suicide mortality rate for youth in the Texas foster care system, the rate for youth overall has decreased by 6.5 percent from 3.1 deaths per 100,000 population to 2.9 deaths per 100,000 population over a five-year period from 2018 through 2022. The suicide mortality rate for youth in the Texas foster care system started and ended at zero deaths per 100,000 population in the same five-year period. However, in 2021, the youth in the Texas foster care system had a suicide mortality rate of 7 deaths per 100,000 population compared to 3.1 deaths per 100,000 population for Texas youth.

Due to the population size in the foster care system of around 50,000 youth, the rate can change significantly by just one or two additional deaths, as seen in 2020 and 2021.

Figure 17 shows the Texas suicide mortality rate youth in the foster care system and youth overall in 2018–2022.

[34] Suicide mortality rate for Texas youth ages 0-18 years of age from Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER.

Figure 17 Texas Suicide Mortality Rates for Youth and Youth in the Foster Care System, Years 2018 – 2022[35]



Local Mental Health Authorities, Local Behavioral Health Authorities, and the Suicide Care Initiative[36]

For this report, data is highlighted by local mental health authority and local behavioral health authority (LMHAs and LBHAs) LSA as a convenient way to localize the data.

The data in this section of the report is not based on the client population served by the LMHAs and LBHAs, but rather the total population in the geographical regions of each LMHA and LBHA. Providing suicide mortality rates by LMHA and LBHA catchment area is not meant to provide an evaluation of the performance of these agencies. These breakouts of the 254 counties in Texas were familiar subsections for those working in public mental health.

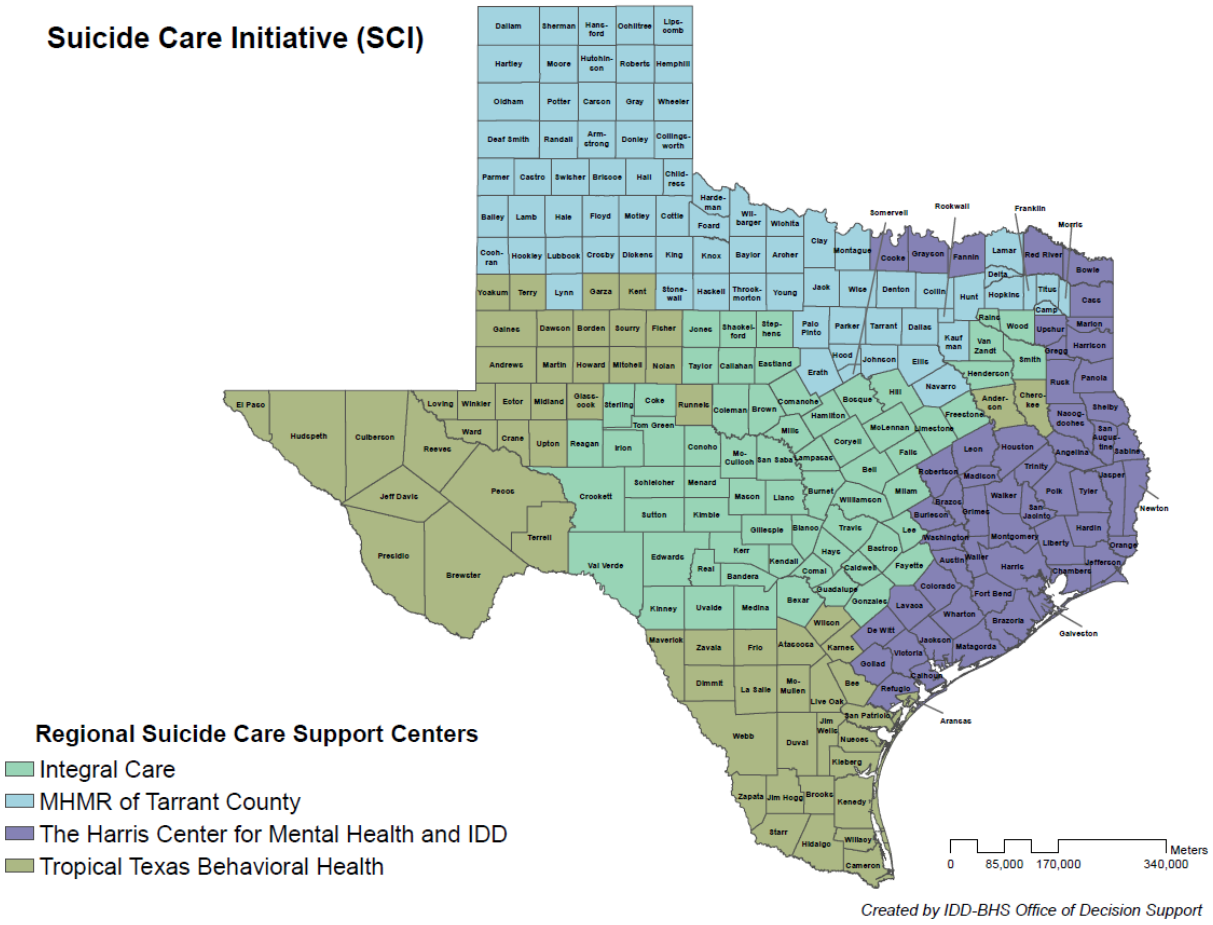
HHSC implements the Suicide Care Initiative (SCI) through contracts with four LMHAs: Integral Care, My Health My Resources of Tarrant County, The Harris Center for Mental Health and IDD, and Tropical Texas Behavioral Health. Two primary goals of the SCI initiative include the following:

[35] Texas Department of Family and Protective Services and Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER
[36] See Table A12, Table A13, Table A14, Table A15, Table A16, Table A17, Table A18, and Table A19 in Appendix A

1. Establish four Regional Suicide Care Support Centers (RSCSCs) at LMHAs that provide regional training and technical assistance on Zero Suicide best-practices for eight or nine other LMHAs or LBHAs in their region; and

2. Support RSCSCs in the implementation of the Zero Suicide framework to fidelity within their LMHA.

For this report, the SCI regions have been used to categorize the LMHA and LBHA LSAs into smaller groups of nine or ten. Within each of these groups, LSAs with similar rates are graphed in groups of five.



SCI Region One

Counties in the Gulf Coast Center LSA saw the smallest increase of 16.9 percent from 14.2 deaths per 100,000 population in 2000 to 16.6 deaths per 100,000 population in 2022.

Counties in the Texana Center LSA saw a large increase of 31.1 percent, from 7.4 deaths per 100,000 population in 2000 to 9.7 deaths per 100,000 population in 2022.

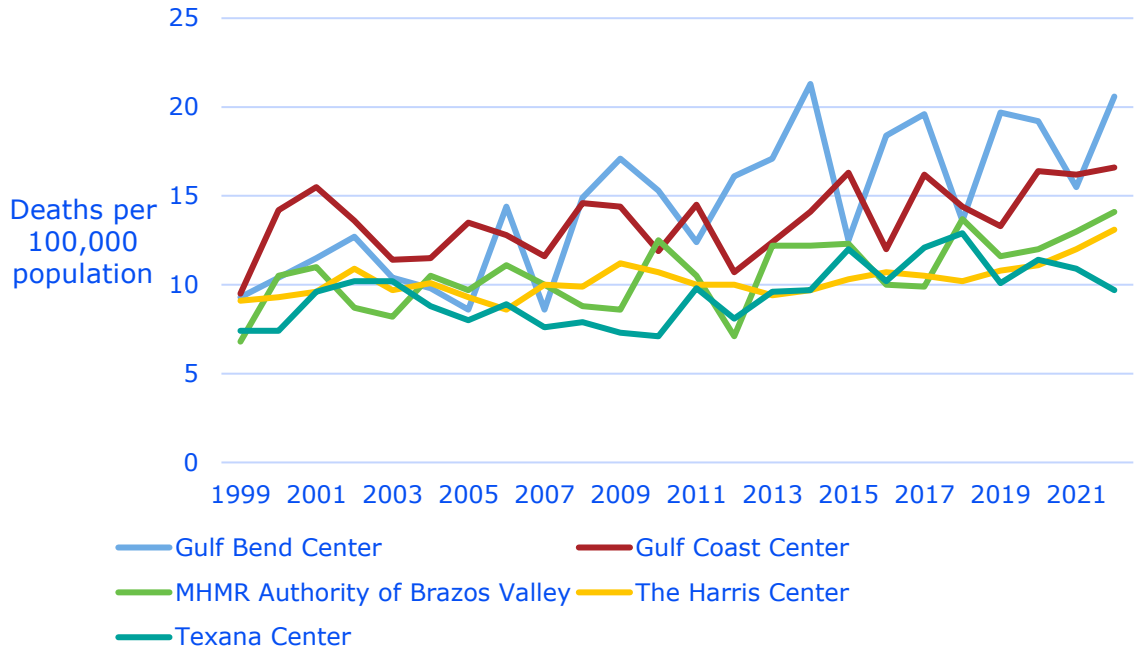
Counties in the MHMR Authority of Brazos Valley LSA saw a similar increase of 34.3 percent from 10.5 deaths per 100,000 population in 2000 to 14.1 deaths per 100,000 population in 2022.

Harris County in the Harris Center for Mental Health and IDD LSA saw a 40.9 percent increase, from 9.3 deaths per 100,000 population in 2000 to 13.1 deaths per 100,000 population in 2022.

Counties in the Gulf Bend Center LSA saw the largest increase over the 23-year period with an increase of 98.1 percent, from 10.4 deaths per 100,000 population in 2000 to 20.6 deaths per 100,000 population in 2022.

Figure 18 outlines the suicide mortality rate by SCI Region One per 100,000 population for 1999-2022.

Figure 18. Suicide Mortality Rates by SCI Region One, 1999-2022[37]



The counties in the Spindletop Center LSA saw an increase of 29 percent from 13.1 deaths per 100,000 population in 2000 to 16.9 deaths per 100,000 population in 2022.

The counties in the Burke Center LSA saw an increase of 36.3 percent, from 14.6 deaths per 100,000 population in 2000 to 19.9 deaths per 100,000 population in 2022.

The counties in the Tri-County Behavioral Healthcare LSA saw an increase of 53 percent, from 11.7 deaths per 100,000 population in 2000 to 17.9 deaths per 100,000 population in 2022.

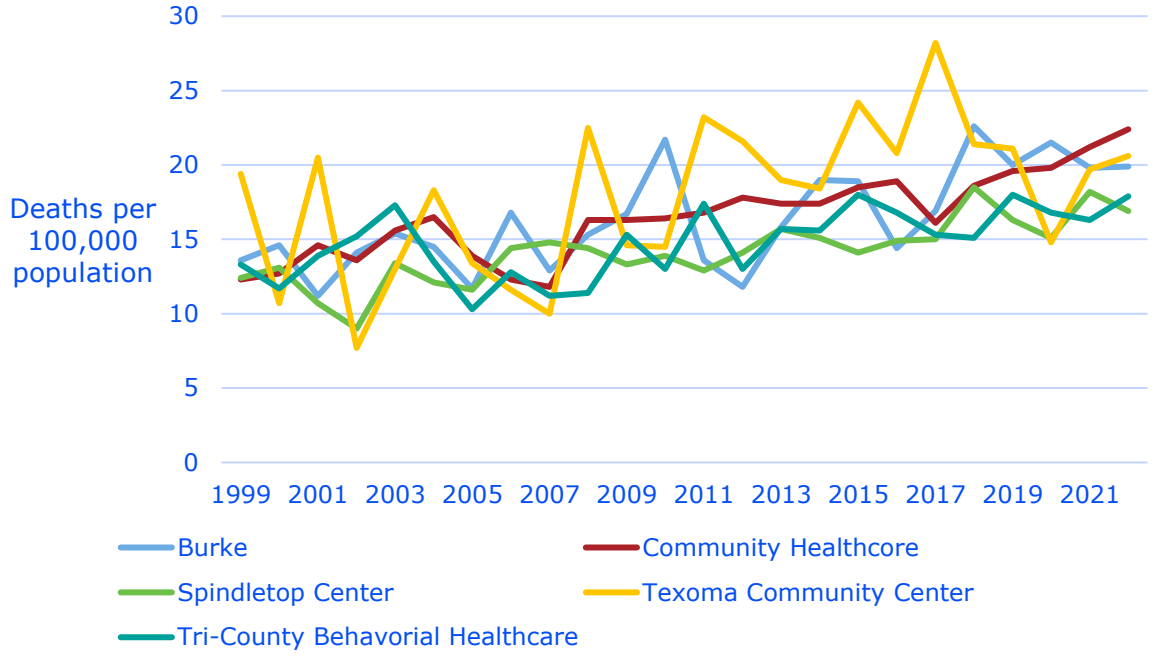
The counties in the Community Healthcore LSA saw the third largest increase with an increase of 76.4 percent, from 12.7 deaths per 100,000 population in 2000 to 22.4 deaths per 100,000 population in 2022.

The counties in the Texoma Community Center LSA saw an increase of 92.5 percent, from 10.7 deaths per 100,000 population in 2000 to 20.6 deaths per 100,000 population in 2022.

Figure 19 outlines suicide mortality rates by SCI Region One for 1999-2022.

[37] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

Figure 19. Suicide Mortality Rates by SCI Region One, 1999-2022[38]



SCI Region Two

The counties in the MHMR Services for the Concho Valley LSA saw the smallest increase of deaths in this region with a 17.3 percent increase, from 13.9 deaths per 100,000 population in 2000 to 16.3 deaths per 100,000 population in 2022.

Bexar County in the Center for Health Care Services LSA saw an increase of 23.3 percent, from 10.3 deaths per 100,000 population in 2000 to 12.7 deaths per 100,000 population in 2022.

Travis County in the Integral Care LSA saw a similar increase of 25.9 percent, from 10.8 deaths per 100,000 population in 2000 to 13.6 deaths per 100,000 population in 2022.

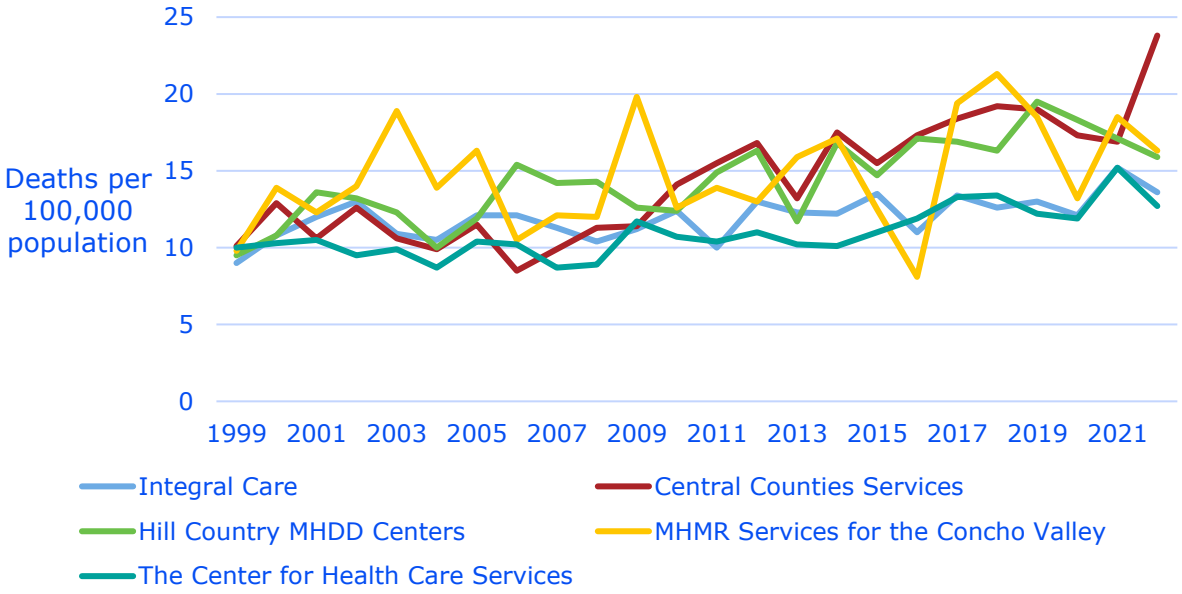
The counties in the Hill Country Mental Health and Developmental Disabilities Centers LSA saw an increase of 47.2 percent, from 10.8 deaths per 100,000 population in 2000 to 15.9 deaths per 100,000 population in 2022.

[38] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

The counties in the Central Counties Services LSA saw an 84.5 percent increase, from 12.9 deaths per 100,000 population in 2000 to 23.8 deaths per 100,000 population in 2022.

Figure 20 outlines the suicide mortality rate by SCI Region Two per 100,000 population for 1999-2022.

Figure 20. Suicide Mortality Rates by SCI Region Two, 1999-2022[39]



The counties in the Bluebonnet Trails Community Services LSA saw the smallest increase in this grouping with an increase of 61 percent, from 10 deaths per 100,000 population in 2000 to 16.1 deaths per 100,000 population in 2022.

The counties in the Heart of Texas Behavioral Health Network LSA saw an increase of 80.4 percent, from 8.7 deaths per 100,000 population in 2000 to 15.7 deaths per 100,000 population in 2022.

The counties in the Andrews Center LSA saw an 84.7 percent increase, from 11.1 deaths per 100,000 population in 2000 to 20.5 deaths per 100,000 population in 2022.

[39] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

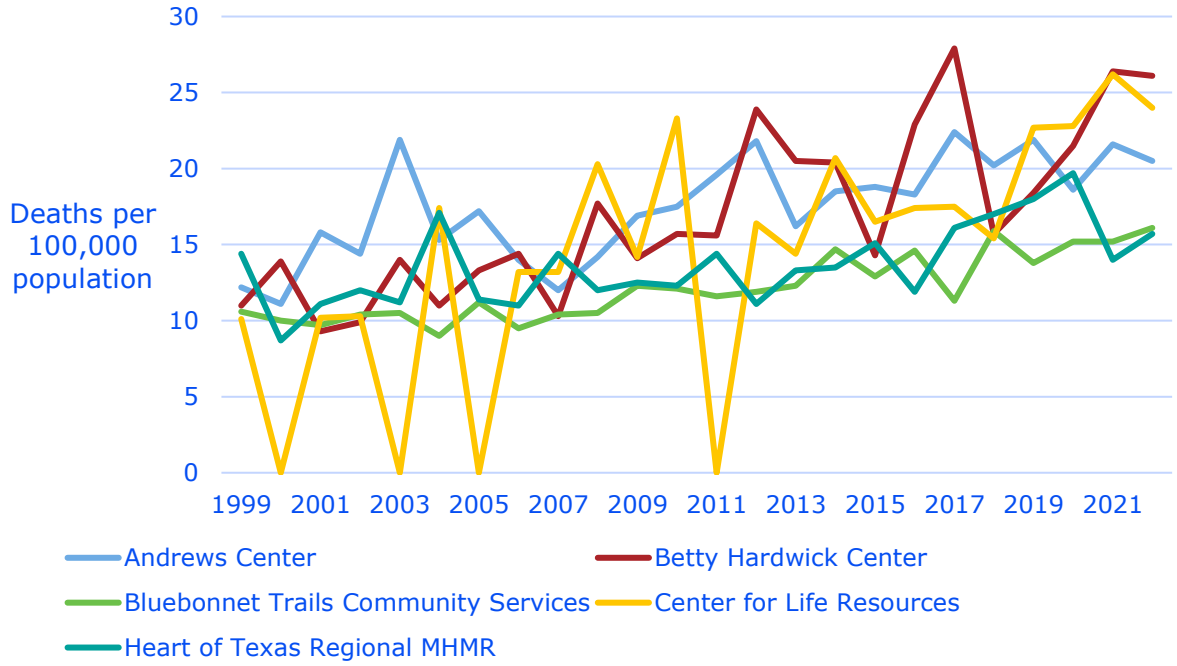
The counties in the Betty Hardwick Center LSA saw a similar 87.8 percent increase, from 13.9 deaths per 100,000 population in 2000 to 26.1 deaths per 100,000 population in 2022.

The counties in the Center for Life Resources LSA saw the largest increase of 135.3 percent, from 10.2 deaths per 100,000 population in 2001 to 24 deaths per 100,000 population in 2022.

In Figure 21, below, there are several declines to what appears to be zero deaths. In those years, there were not enough suicides in the county for data to be released. Any time there are fewer than ten deaths from a particular cause in an area, the number is suppressed to protect the decedents.

Figure 21 outlines suicide mortality rates by SCI Region Two for 1999-2022.

Figure 21. Suicide Mortality Rates by SCI Region Two, 1999-2022[40]



SCI Region Three

The counties in the LifePath Systems LSA saw the smallest increase of 45.8 percent increase, from 8.3 deaths per 100,000 population in 2000 to 12.1 deaths per 100,000 population in 2022.

The counties in the North Texas Behavioral Health Authority LSA saw an increase of 51.8 percent, from 8.5 deaths per 100,000 population in 2000 to 12.9 deaths per 100,000 population in 2022.

Tarrant County in the My Health My Resources of Tarrant County LSA saw a similar increase of 53.3 percent, from 9 deaths per 100,000 population in 2000 to 13.8 deaths per 100,000 population in 2022.

The counties in the Central Plains Center LSA saw an increase of 61 percent, from 10.5 deaths per 100,000 population in 2000 to 16.9 deaths per 100,000 population in 2022. As with the Center for Life Resources LSA above, the Central Plains Center

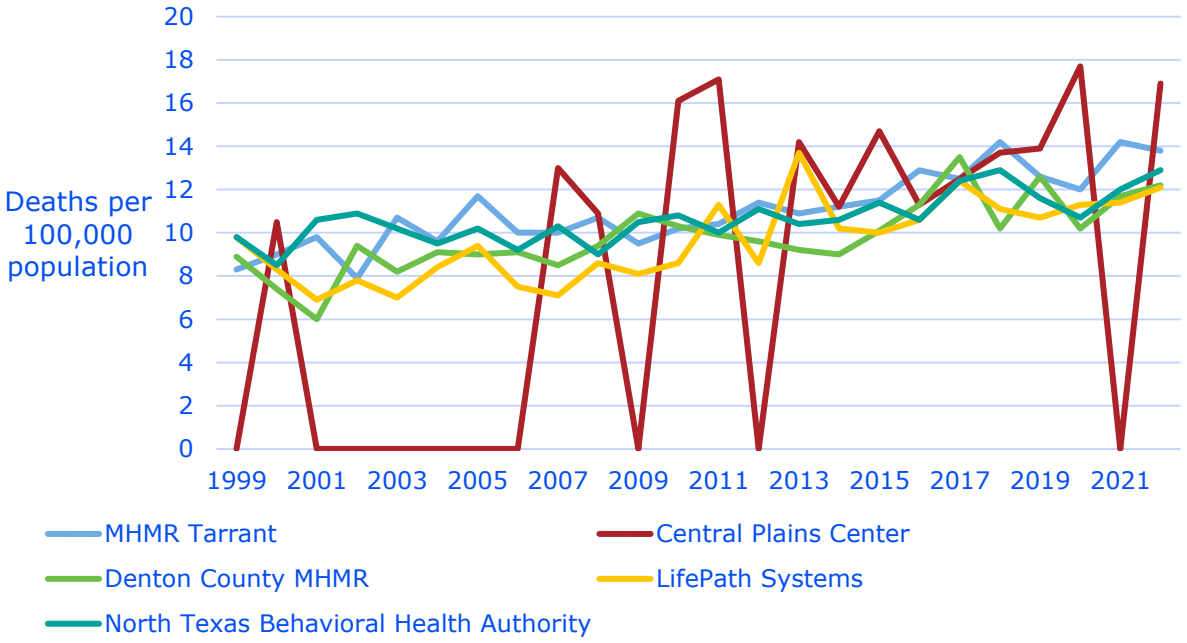
[40] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

LSA had several years of suppressed data to protect the decedents. The actual number of suicides is unknown for those years but is less than 10.

Denton County in the Denton County MHMR LSA saw a similar 64.9 percent increase, from 7.4 deaths per 100,000 population in 2000 to 12.2 deaths per 100,000 population in 2022.

Figure 22 outlines the suicide mortality rate by SCI Region Three per 100,000 population for 1999-2022.

Figure 22. Suicide Mortality Rates by SCI Region Three, 1999-2022[41]



The counties in the Lakes Regional Community Center LSA saw the smallest increase of this grouping, increasing 46.3 percent, from 16.2 deaths per 100,000 population 2000 to 23.7 deaths per 100,000 population in 2022.

The counties in the Pecan Valley Centers for Behavioral & Developmental Healthcare LSA saw a similar increase of 46.5 percent, from 9.9 deaths per 100,000 population in 2000 to 14.5 deaths per 100,000 population in 2022.

The counties in the StarCare Specialty Health System LSA saw an increase of 60.7 percent, from 11.7 deaths per 100,000 population in 2000 to 18.8 deaths per 100,000 population in 2022.

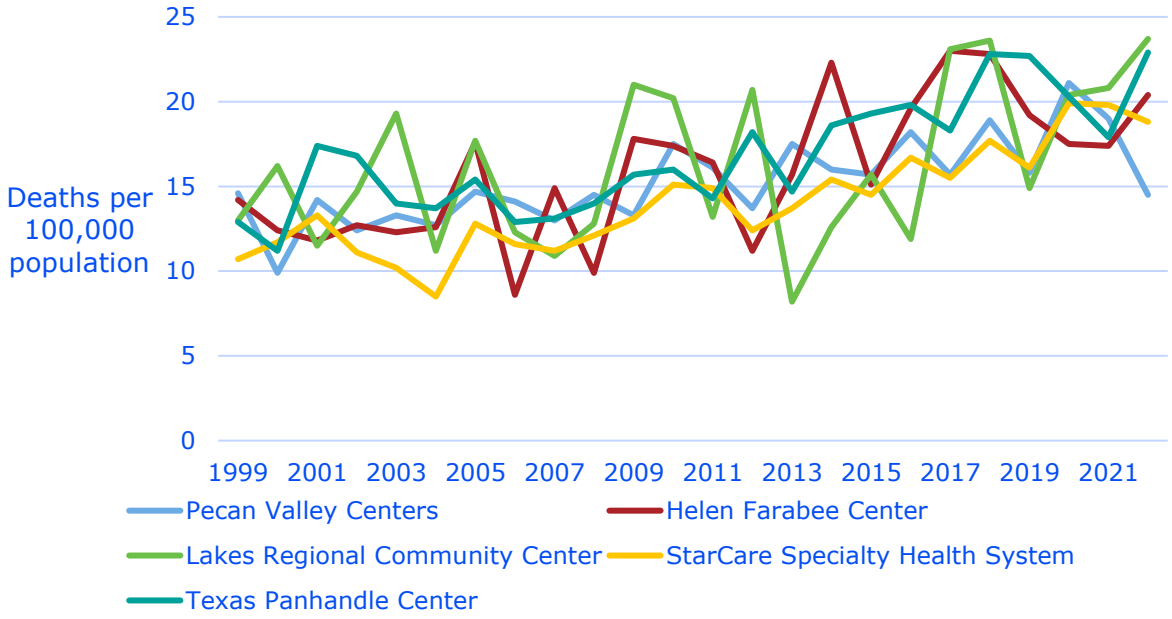
[41] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

The counties in the Helen Farabee Center LSA saw an increase of 64.5 percent, from 12.4 deaths per 100,000 population in 2000 to 20.4 deaths per 100,000 population in 2022.

The counties in the Texas Panhandle Center LSA saw a 104.5 percent increase, from 11.2 deaths per 100,000 population in 2000 to 22.9 deaths per 100,000 population in 2022.

Figure 23 outlines suicide mortality rates by SCI Region Three for 1999-2022.

Figure 23. Suicide Mortality Rates by SCI Region Three, 1999-2022[42]



SCI Region Four

The counties in the Tropical Texas Behavioral Health LSA saw a 49 percent increase of deaths, from 4.9 deaths per 100,000 population in 2000 to 7.3 deaths per 100,000 population in 2022.

Nueces County in the Nueces Center for Mental Health and Intellectual Disabilities LSA saw a 57.1 percent increase, from 10.5 deaths per 100,000 population in 2000 to 16.5 deaths per 100,000 population in 2022.

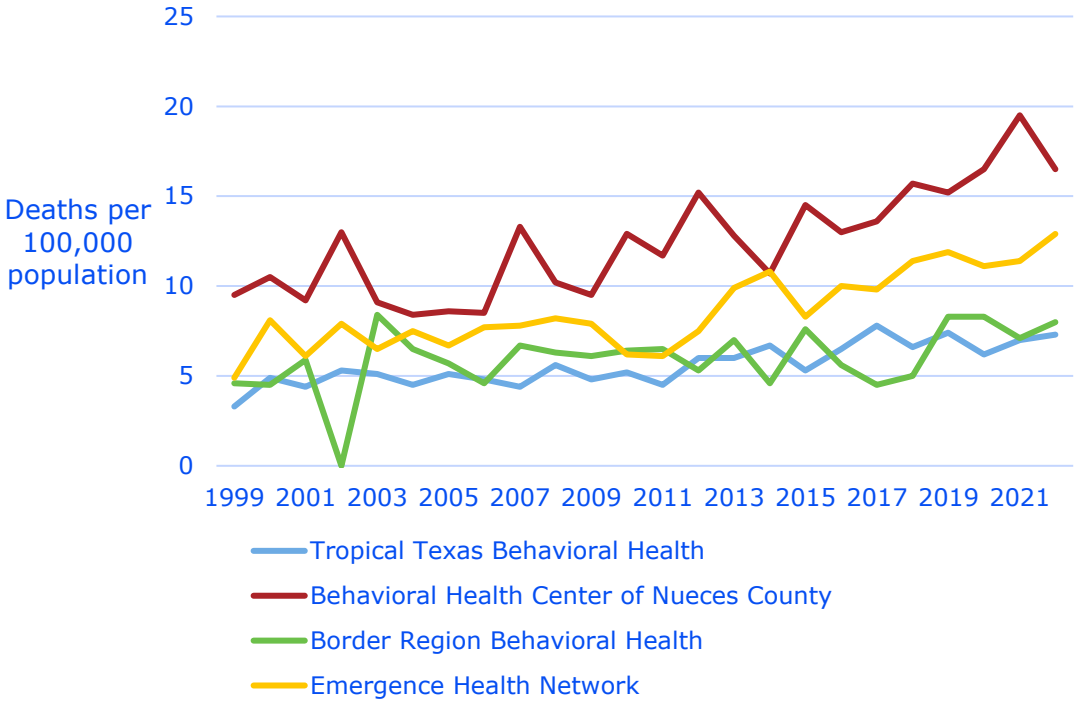
[42] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

El Paso County in the Emergence Health Network LSA saw a similar 59.3 percent increase, from 8.1 deaths per 100,000 population in 2000 to 12.9 deaths per 100,000 in 2022.

The counties in the Border Region Behavioral Health Center LSA saw a 77.8 percent increase, from 4.5 deaths per 100,000 population in 2000 to 8 deaths per 100,000 population in 2022.

Figure 24 outlines the suicide mortality rate by SCI Region Four per 100,000 population for 1999-2022.

Figure 24. Suicide Mortality Rates by SCI Region Four, 1999-2022[43]



The counties in the Camino Real Community Services LSA saw the only decrease, of 8.6 percent, from 14 deaths per 100,000 population in 2000 to 12.8 deaths per 100,000 population in 2022.

The counties in the ACCESS LSA saw a 15.7 percent increase, from 19.7 deaths per 100,000 population in 2000 to 22.8 deaths per 100,000 population in 2022.

[43] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

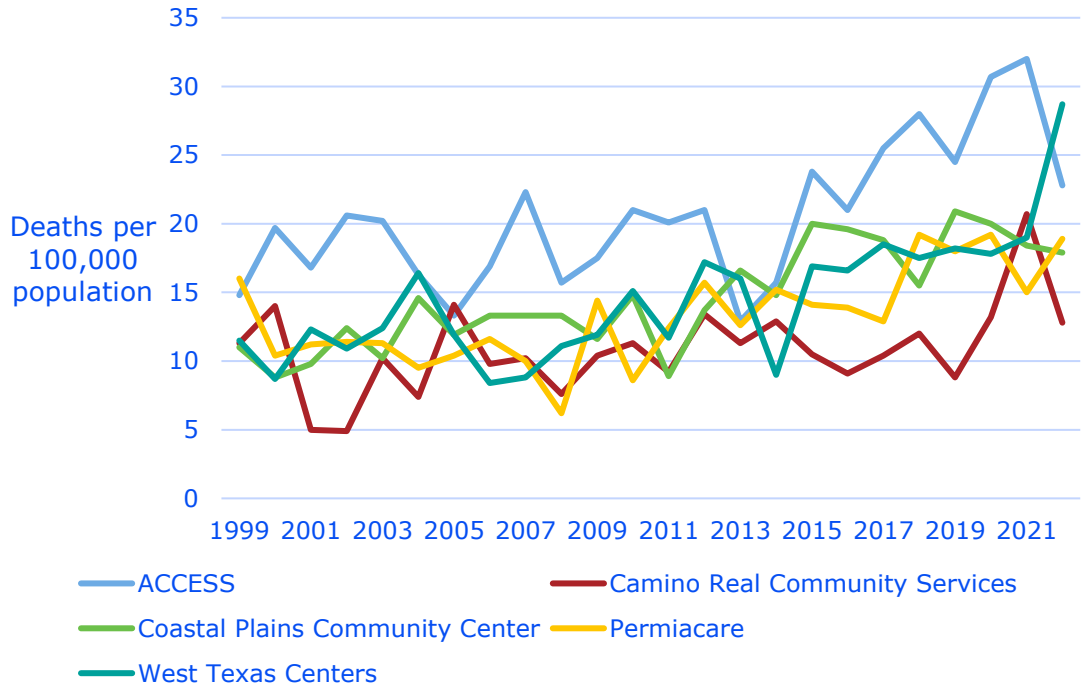
The counties in the Permiacare LSA saw an 81.7 percent increase, from 10.4 deaths per 100,000 population in 2000 to 18.7 deaths per 100,000 population in 2022.

The counties in the Coastal Plains Community Center LSA saw a 103.4 percent increase, from 8.8 deaths per 100,000 population in 2000 to 17.9 deaths per 100,000 population in 2022.

The counties in the West Texas Centers LSA saw a 229.9 percent increase, from 8.7 deaths per 100,000 population in 2000 to 28.7 deaths per 100,000 population in 2022.

Figure 25 outlines suicide mortality rates by SCI Region Four for 1999-2022.

Figure 25. Suicide Mortality Rates by SCI Region Four, 1999-2022[44]



Snapshot of Local Mental Health Authority and Local Behavioral Health Authority Local Service Areas

The following section provides maps of the mortality rate (per 100,000 population) for LMHA and LBHA LSA providing a snapshot in time to compare the rates across

[44] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

regions. The first map (Figure 26) shows the year 2002; the second map (Figure 27) shows 2012; and the third map (Figure 28) shows 2022, the most recent available data.

ID Number	LMHA and LBHA LSAs
1	ACCESS
2	Andrews Center Behavioral Healthcare System
3	Betty Hardwick Center
4	Bluebonnet Trails Community Services
5	Border Region Behavioral Health Center
6	MHMR of Brazos Valley
7	Burke Center
8	Camino Real Community Services
9	The Center of Health Care Service
10	Center for Life Resources
11	Central Counties Services
12	Central Plains Services
13	Coastal Plains Community Center
14	Community Healthcore
15	MHMR of Concho Valley
16	Denton County
17	Emergence Health Network
18	Gulf Bend Center
19	Gulf Coast Center
20	The Harris Center for Mental Health and IDD
21	Heart of Texas
22	Helen Farabee
23	Hill Country Centers
24	Integral Care
25	Lakes Regional
26	Lifepath Systems
27	North Texas Behavioral Health Authority
28	Nueces Center
29	Pecan Valley Centers
30	PermiaCare
31	Spindletop Center
32	StarCare
33	Tarrant County
34	Texana Center
35	Texas Panhandle Centers
36	Texoma Community Center

ID Number	LMHA and LBHA LSAs
37	Tri-County Behavioral Healthcare
38	Tropical Texas Behavioral Health
39	West Texas Centers

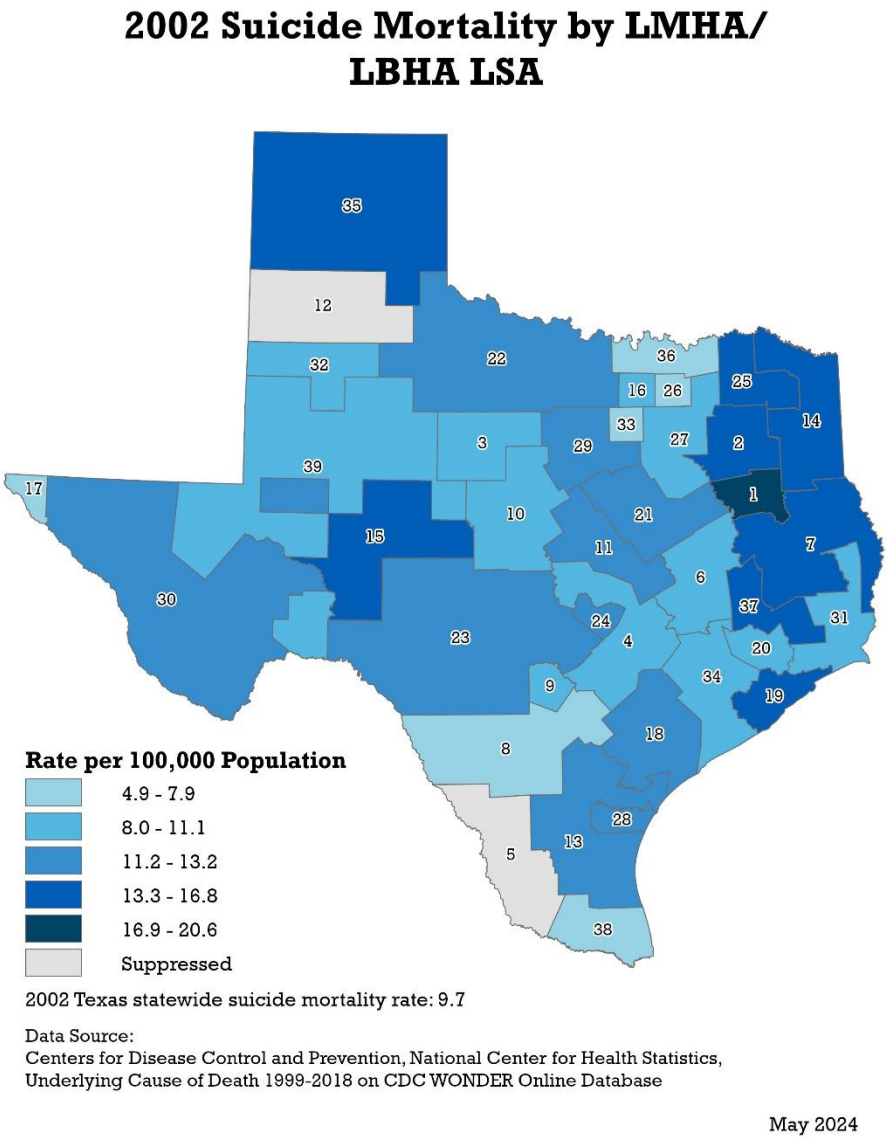
In 2002, the highest rate of suicide mortality was in the ACCESS LSA, with a rate of 20.6 deaths per 100,000 population. Texas Panhandle Centers LSA had the second highest rate of 16.8 deaths per 100,000 population. The lowest rates were in Camino Real Community Services LSA with a rate of 4.9 deaths per 100,000 population and Tropical Texas Behavioral Health LSA with a rate of 5.3 deaths per 100,000 population. The state rate was 9.7 deaths per 100,000 population.

Figure 26 outlines the suicide mortality rates per 100,000 by LMHA and LBHA LSA in 2002.

Figure 26. Suicide Mortality Rates per 100,000 Population by LMHA and LBHA LSA, Texas 2002[45] [46]

[45] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

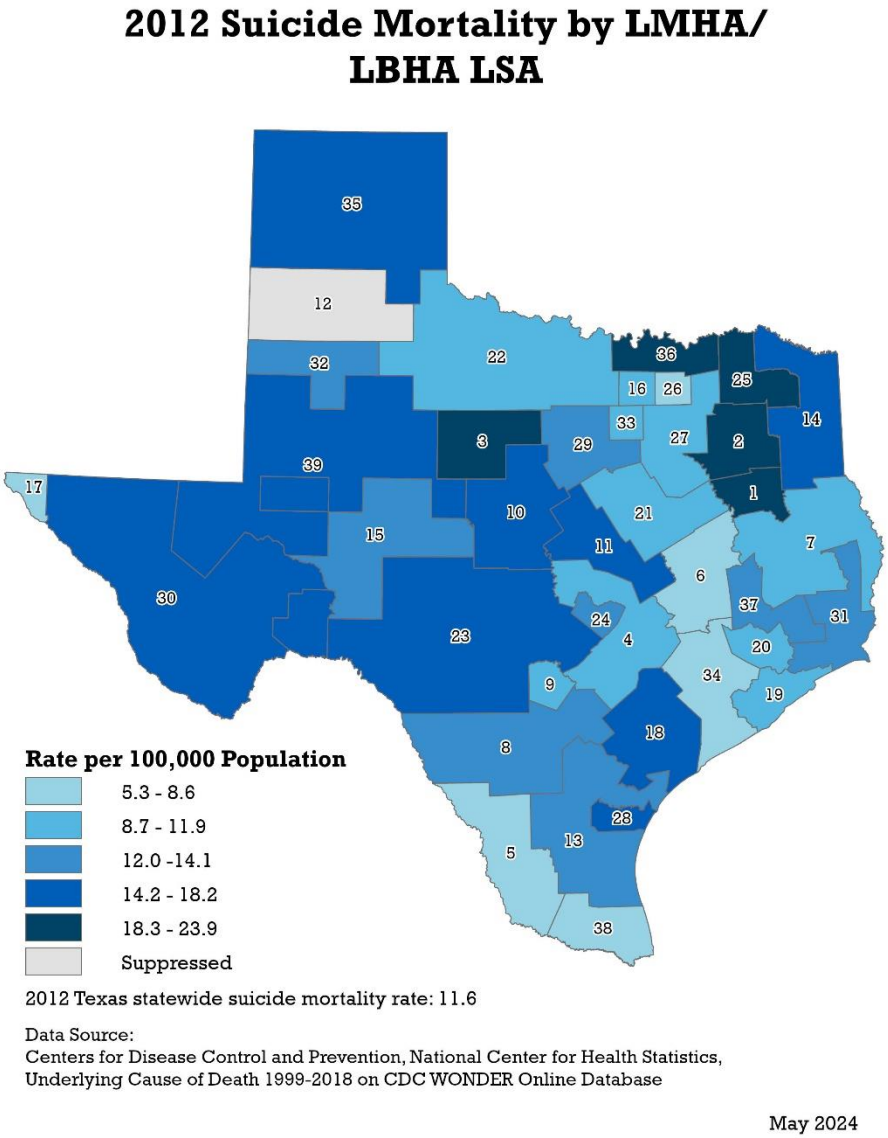
[46] The data reflects persons residing in the geographic LSAs of the LMHA AND LBHA.



In 2012, the counties in the Betty Hardwick Center LSA had the highest rate of deaths, 23.9 per 100,000 population. The counties in the Andrews Center Behavioral Healthcare System and Texoma Community Center LSAs had similar rates of 21.8 deaths per 100,000 population and 21.6 deaths per 100,000 population. The lowest rates were in counties in the Border Region Behavioral Health Center LSA with 5.3 deaths per 100,000 population and Tropical Texas Behavioral Health LSA with 6 deaths per 100,000 population. The state rate was 11.6 deaths per 100,000 population.

Figure 27 outlines the suicide mortality rates per 100,000 population by LMHA and LBHA LSA in 2012.

Figure 27. Suicide Mortality Rates per 100,000 Population by LMHA and LBHA LSA, Texas 2012[47] [48]



[47] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

[48] The data reflects persons residing in the geographic LSAs of the LMHA AND LBHA.

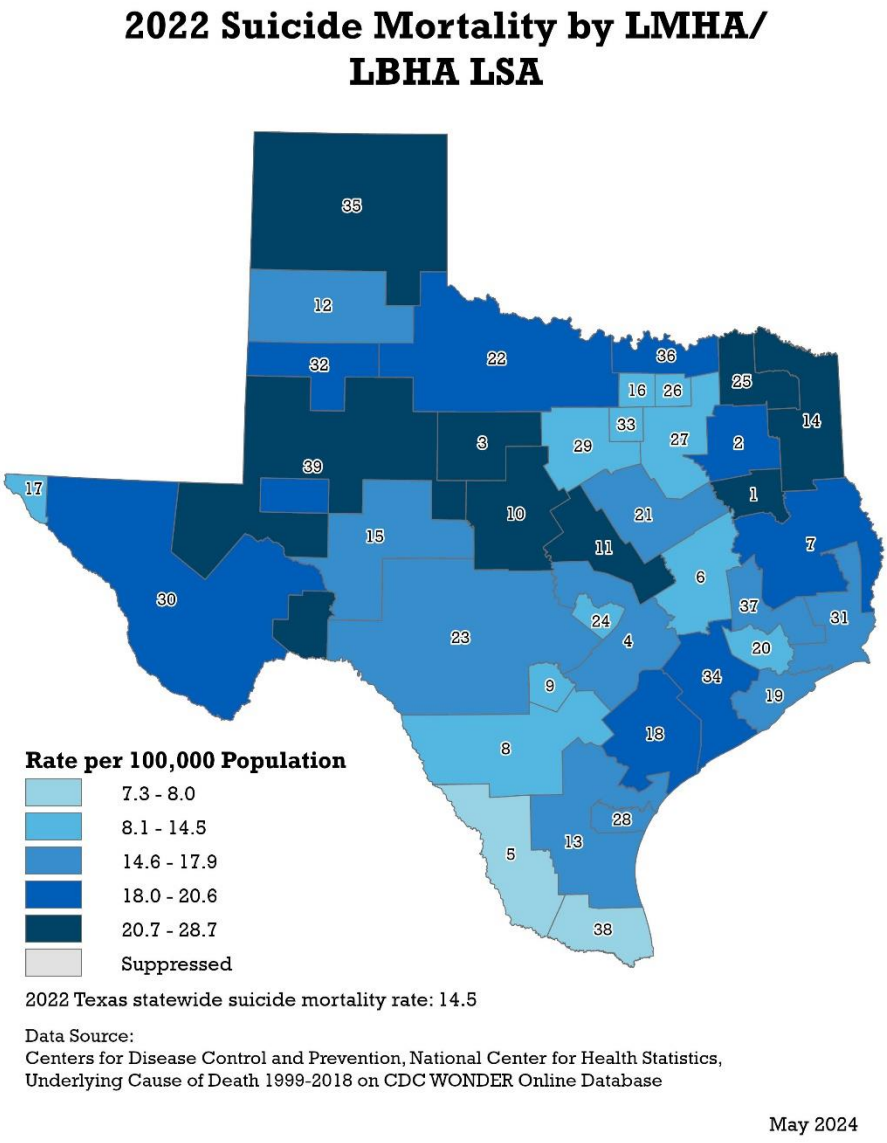
In 2022, the highest suicide mortality rate was in West Texas Centers LSA with a rate of 28.7 deaths per 100,000 population. The counties in the Betty Hardwick Center LSA had the second highest rate of 26.1 deaths per 100,000 population. The lowest rates were in counties in the Tropical Texas Behavioral Health and Border Region Behavioral Health Center LSAs with rates of 7.3 deaths per 100,000 population, and 8 deaths per 100,000 population, respectively. The state rate was 14.5 deaths per 100,000 population.

Figure 28 outlines the suicide mortality rates per 100,000 population by LMHA and LBHA LSA in 2022.

Figure 28. Suicide Mortality Rates per 100,000 Population by LMHA and LBHA LSA, Texas 2022[49] [50]

[49] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER

[50] The data reflects persons residing in the geographic LSAs of the LMHA AND LBHA.



Metro and Non-Metro Areas[51]

While most suicide deaths in Texas occur in metro areas, the suicide mortality rate is higher in non-metro areas. The mortality rate has also increased by a higher percentage in non-metro areas over the 23 years of data examined in this report. Suicide mortality in metro areas increased by 46.8 percent from 9.4 deaths per 100,000 population to 13.8 deaths per 100,000 population.

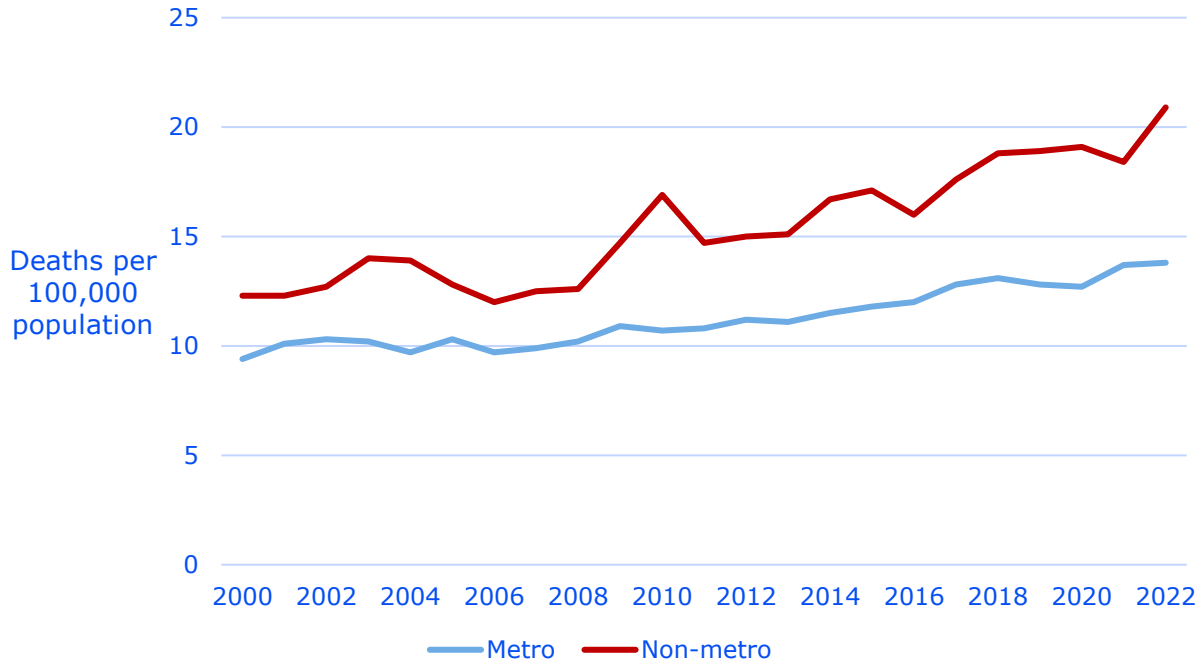
[51] See Table A20 in 0

Metro area is defined as being a county in a Metropolitan Statistical Area (MSA)[x]. There are 25 MSAs in Texas. They are Dallas-Fort Worth-Arlington, Houston-The Woodlands-Sugarland, San Antonio-New Braunfels, Austin-Round Rock-San Marcos, McAllen-Edinburg-Mission, El Paso, Corpus Christi, Brownsville-Harlingen, Killeen-Temple, Beaumont-Port Arthur, Lubbock, Laredo, Amarillo, Waco, College Station-Bryan, Tyler, Longview, Abilene, Wichita Falls, Texarkana, Odessa, Midland, Sherman-Denison, Victoria, and San Angelo.

Suicide mortality in non-metro areas increased by 69.9 percent from 12.3 deaths per 100,000 population in 2000 to 20.9 deaths per 100,000 population in 2022. 82 of Texas' 254 counties are considered metro counties. They account for about 88 percent of the population of Texas. The other 12 percent or about 3 million residents are spread across 172 counties.

Figure 29 outlines the suicide mortality rate by metro and non-metro areas for 2000-2022.

Figure 29. Suicide Mortality Rate by Metro and Non-Metro Areas, Texas 2000-2022[52]



Complex Urbanization[53]

Metro and non-metro areas can be further broken down into six categories by population size. Within metro areas there are large central metro, large fringe metro, medium metro, and small metro areas. Within non-metro there are micropolitan cities and noncore areas.[xi]

Large central metro areas consist of MSA counties with greater than one million residents in the central city of the MSA. These areas saw the second smallest increase in suicide mortality, with a 41.8 percent increase from 9.1 deaths per 100,000 population in 2000 to 12.9 deaths per 100,000 population in 2022.

Large fringe metro areas consist of the other counties in the large central metro MSAs that do not contain the central city. The smallest increase was seen in these

[52] National Center for Health Statistics, Centers for Disease Control and Prevention, WONDER
[53] See Table A21 in Appendix A

counties with mortality rates increasing by 34.9 percent from 10.6 deaths per 100,000 population in 2000 to 14.3 deaths per 100,000 population in 2022.

Medium metro, which consists of counties with populations between 250,000 and 999,999 residents, experienced a larger increase of 64 percent with suicide mortality rates increasing from 8.6 deaths per 100,000 population in 2000 to 14.1 deaths per 100,000 population in 2022.

The highest increase among the metro areas occurred in the small metro areas. These are counties with populations between 50,000 and 249,999 residents. Small metro areas had a 71.3 percent increase in suicide mortality rates, rising from 10.8 deaths per 100,000 population in 2000 to 18.5 deaths per 100,000 population in 2022.

Micropolitan areas, counties with 20,000 to 49,999 residents, experienced a similar increase of 70.2 percent. Their rates rose from 11.4 deaths per 100,000 population in 2000 to 19.4 deaths per 100,000 population in 2022.

The highest rates overall were found in the noncore counties which have populations under 20,000 residents. There the suicide mortality rate increased by 68.7 percent from 13.4 deaths per 100,000 population in 2000 to 22.6 deaths per 100,000 population in 2020.

Figure 30 shows the percentage change in suicide mortality rates between 2000 and 2022 by complex urbanization.

Figure 30. Percentage Change in Suicide Mortality rates between 2000 and 2022 by Complex Urbanization

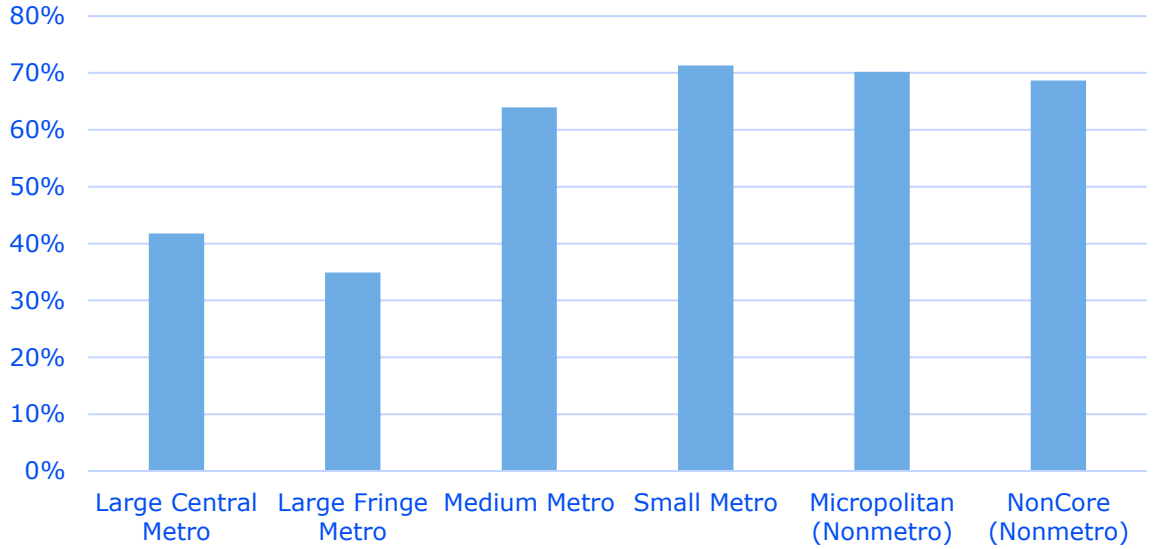
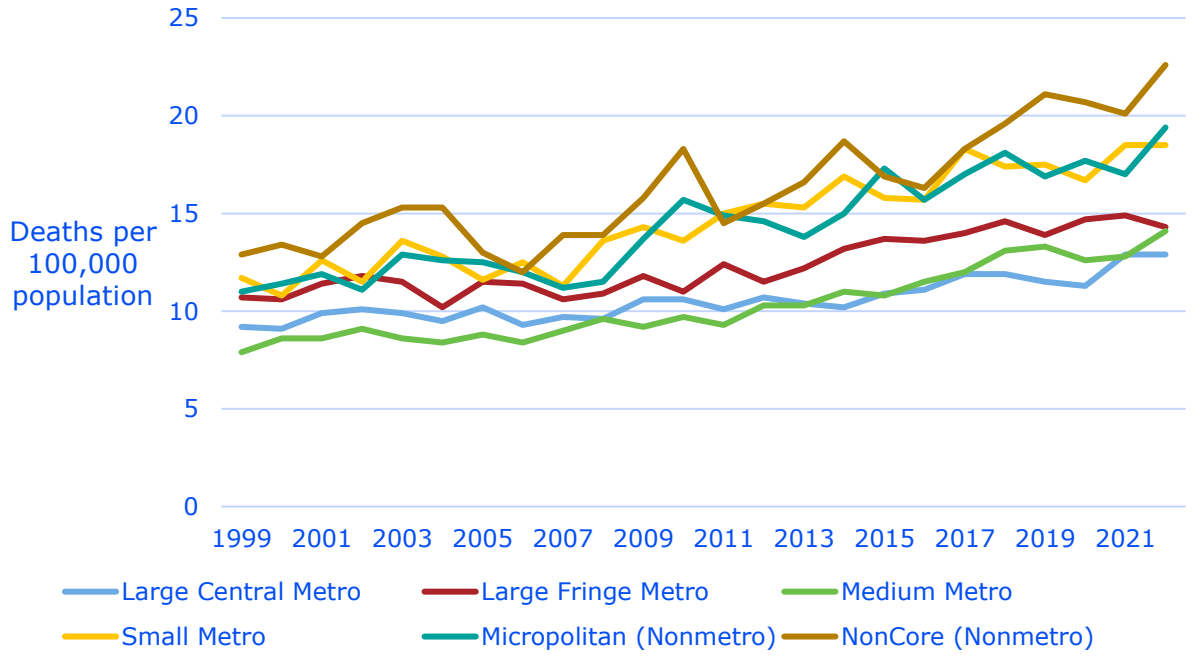


Figure 31 outlines the suicide mortality rate by complex urbanization for 2000-2020.

Figure 31. Suicide Mortality in Texas by Complex Urbanization, 2000-2022



Various changes in suicide mortality were seen in these sectors during the COVID-19 pandemic. Suicide mortality rates decreased in 2020 and 2021 in medium metro, small metro and noncore, while increasing in micropolitan and large fringe

metro between 2019 and 2020. All rates then increased in 2022, with the exception of large central metro and medium metro which stayed the same.

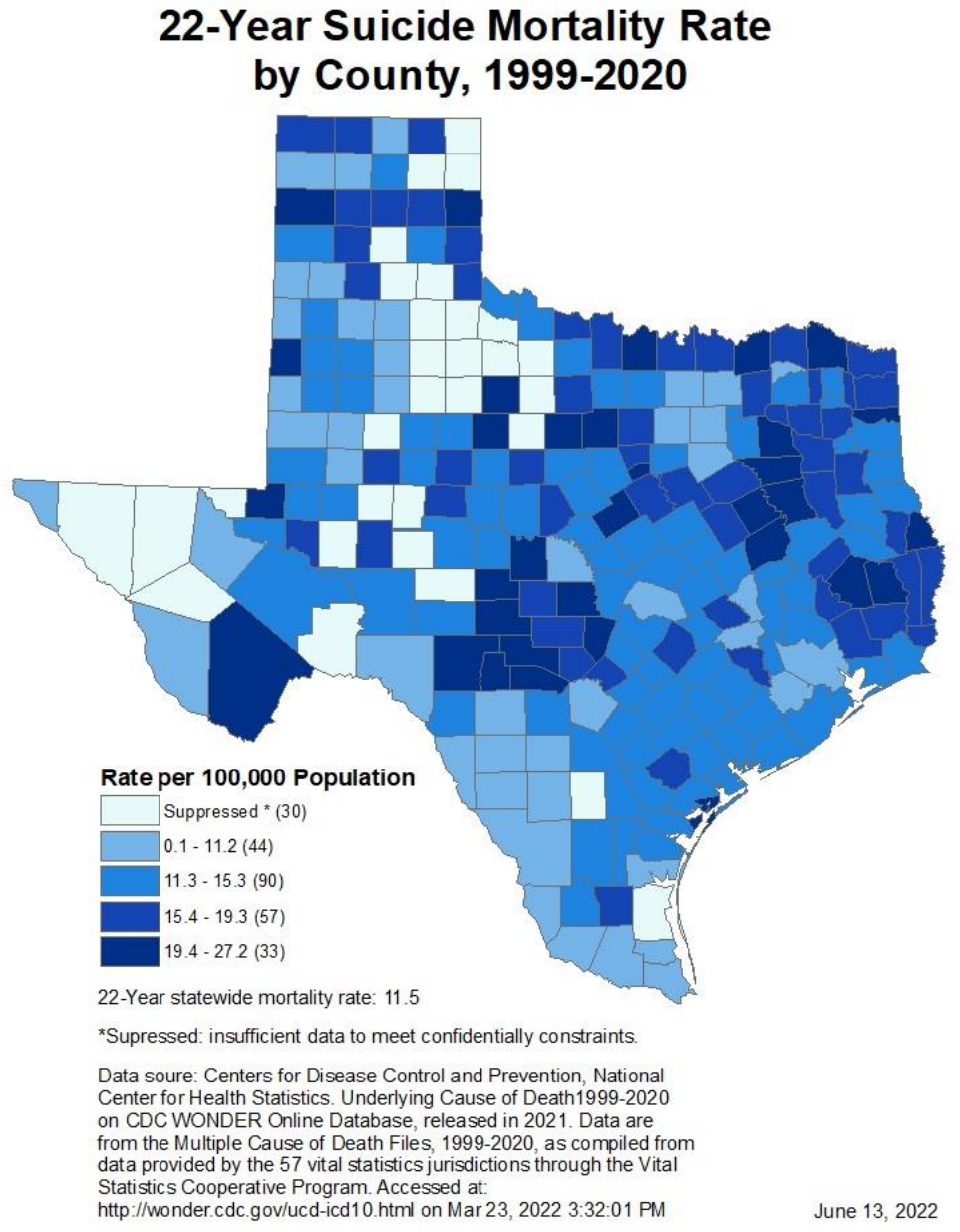
Counties[54]

To calculate rates for the greatest proportion of all counties in Texas, 22-year rates were calculated to compare among counties. Changes in the CDC query system did not allow for the years 2021 and 2022 to be added to rates. Any time there are fewer than ten deaths from a particular cause in an area, the number is suppressed to protect the deceased. Many counties did not have enough suicide deaths over the 22-year period to calculate a stable rate. The highest rates were in Aransas (26.4), Haskell (23.3), Anderson (22.9), Montague (22.6), Jones (22.1), Stephens (22.0), Brewster (21.5), Llano (21.5), Marion (21.5), Kerr (21.5), Bandera (21.4), Polk (21.3), Hamilton (21.3), Winkler (21.2), Somervell (21.2), Blanco (20.4), Sabine (20.3), Red River (20.3), Tyler (20.3), and Kimble (20.2). The lowest rates were in Hidalgo (5.2), Maverick (5.4), Webb (5.6), Willacy (6.2), Cameron (6.2), Zapata (6.7), Starr (6.7), Frio (7.2), Kleberg (7.9), Brazos (8.0), Val Verde (8.0), El Paso (8.4), Fort Bend (8.4), Hale (8.7), Zavala (9.3), Gaines (9.6), Collin (9.7), Denton (9.9), Dallas (10.0), and Harris (10.1). See table A22 in Appendix A for more details.

[54] See Table A22 in Appendix A

Figure 32 outlines the 22-year suicide mortality rates per 100,000 population in Texas counties for 1999-2020.

Figure 32. 22-Year Suicide Mortality Rates per 100,000 population in Texas Counties, 1999-2020[55]



[55] National Center for Health Statistics, Center for Disease Control and Prevention, CDC WONDER

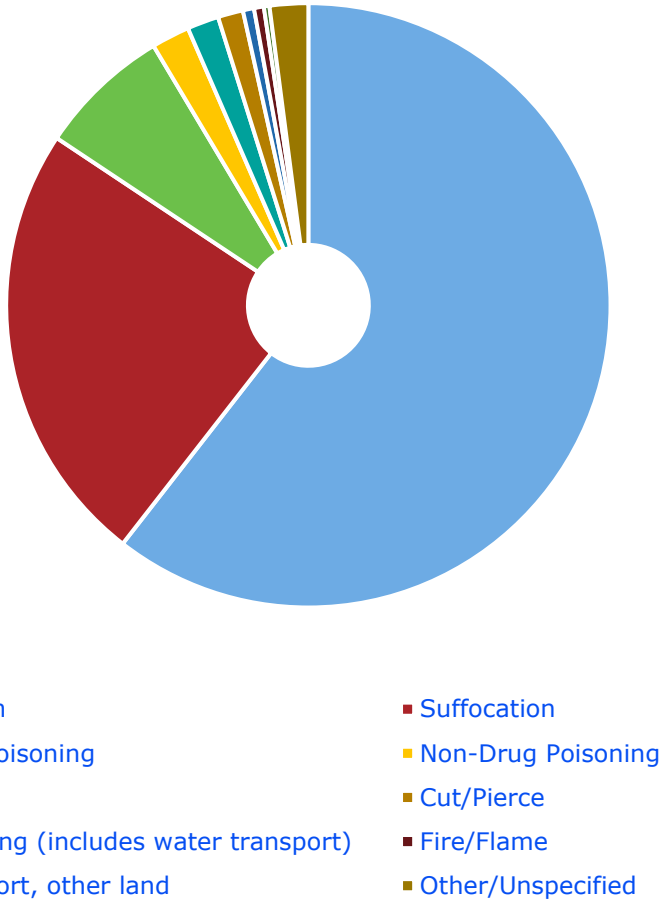
Suicide Method

Method is an important consideration in suicide. It can be the difference between an attempt and a death. Women attempt suicide more often than men, but more men die by suicide than women. This is because of method. Men tend to use firearms or hanging while women tend to use medications or sharps.

In 2022, 60.5 percent of suicide deaths in Texas were by firearm. This compares to 54.6 percent of suicide deaths in the United States that same year. The next most common method in both Texas and the United States was suffocation due to hanging which accounted for 23.8 percent of suicide deaths in Texas. Drug poisoning accounted for 7.1 percent of suicide deaths. Non-drug poisoning (like carbon monoxide) accounted for 2.1 percent of suicide deaths. Falls accounted for 1.7 percent of deaths. And cutting or piercing accounted for 1.3 percent.

Figure 33 outlines the percentage of suicide deaths by method in Texas in 2022.

Figure 33. Suicide Deaths by Method in Texas, 2022



Hospitalization Data[56]

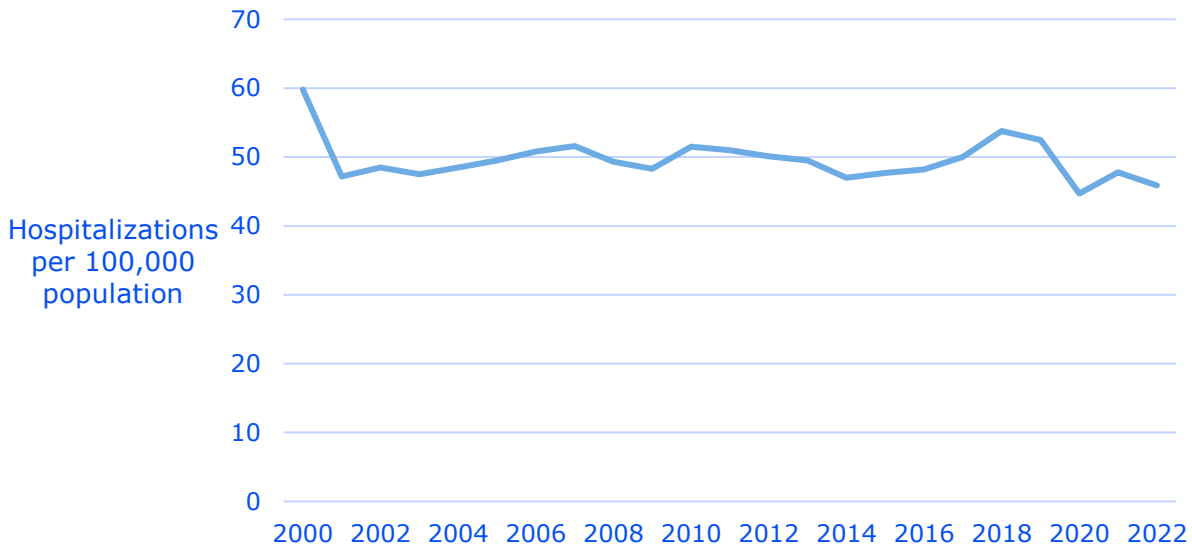
There are about 15,000 hospitalizations each year for suicide attempts in the state of Texas. The number of hospitalizations has been steadily increasing since 2001 until 2019 and 2020 which saw modest decreases. In 2001, the rate was 47.2 hospitalizations per 100,000 population and in 2022, the rate was 44.7

[56] See Table A23 in Appendix A

hospitalizations per 100,000 population representing a 5.2 percent decrease overall.

Figure 34 outlines the hospitalization rate for suicide attempts in Texas from 2000-2020.

Figure 34. Hospitalization Rate for Suicide Attempt, Texas 2000-2022[57]



There was a noticeable spike in hospitalizations for suicide attempts in 2000 that is unexplainable. HHSC examined social, weather, and economic events in Texas to try to explain the spike, but no cause was concluded. Future data analysis will examine hospitalization for suicide attempts which occurred in the late 1990s to determine if the 2000 rate is a decrease from a previously higher rate. Because of this anomaly, all analysis of hospital discharge data begins with 2001.

Limitations of Hospitalization Data

The International Classification of Diseases (ICD)-9 and ICD-10 codes used to identify hospitalizations for suicide attempts can also be used to code non-suicidal self-injury (NSSI), so there is a chance that the incidents coded in this analysis are not actually suicide attempts. The injuries in this analysis were serious enough to require inpatient hospitalization and therefore were very serious injuries and most likely a suicide attempt and not NSSI.

The other major limitation of hospital discharge data is it being discharge-based and not individual-based. There is the possibility, although unlikely, that one group

[57] Texas Health Care Information Collection (THCIC), Department of State Health Services

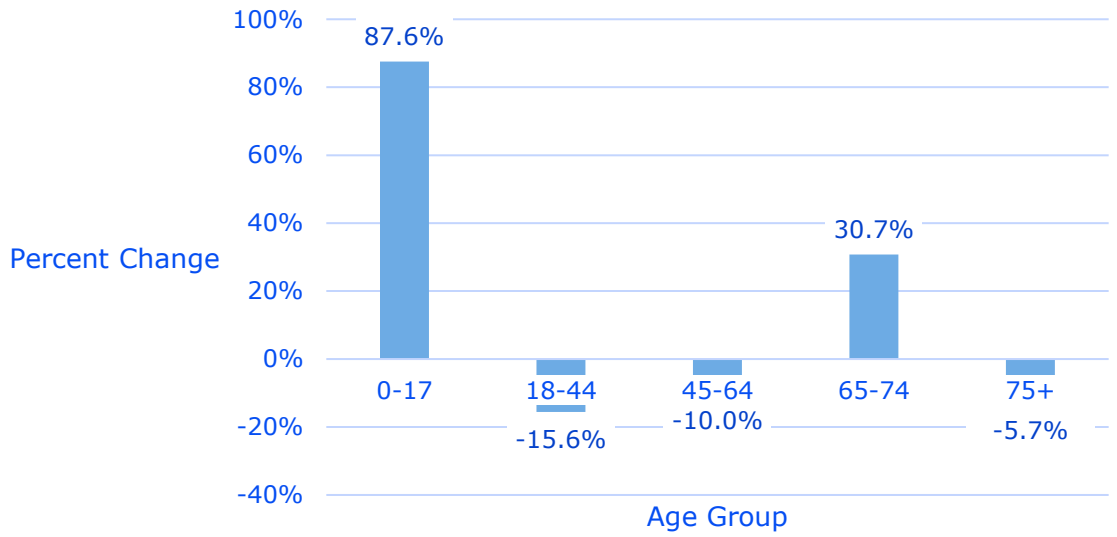
of individuals is repeatedly hospitalized for suicide attempts and accounting for the high number of hospital discharges as opposed to many people being hospitalized for suicide attempts.

Other limitations to hospitalization data are due to suppression of data elements to protect confidentiality of those hospitalized. Any case with an alcohol, drug, or Human Immunodeficiency Virus (HIV) diagnosis is automatically suppressed in several different ways. This includes suppressing sex and using broader age categorizations which were used in this report. For this reason, it is not possible to provide data analysis based on the sex of the person admitted. Data by sex was suppressed in approximately half of hospital admissions for suicide. There is no way of knowing if these individuals had similar sex breakdowns to the individuals identified by sex in the dataset and thus if this suppression would bias the analysis.

Age[58]

Figure 35 illustrates the changes in hospitalization rates for suicide attempt since 2001 by age group.

Figure 35. Percentage Change in Hospitalization Rate for Suicide Attempt from 2001 to 2022 by Age Group.



The highest rates of inpatient hospitalization for suicide attempt were seen in the 18–44-year-old age group. That group, however, saw a 15.6 percent decrease in hospitalizations for suicide attempt with a rate of 74.8 hospitalizations per 100,000

[58] See Table A24 in Appendix A

population in 2001 and a rate of 63.2 hospitalizations per 100,000 population in 2022.

The next highest rates of inpatient hospitalization for suicide attempt were seen in the 45–64-year-old age group which also saw a 10 percent decrease in hospitalizations for suicide attempt with a rate of 38.5 hospitalizations per 100,000 population in 2001 and a rate of 34.6 hospitalizations per 100,000 population in 2022.

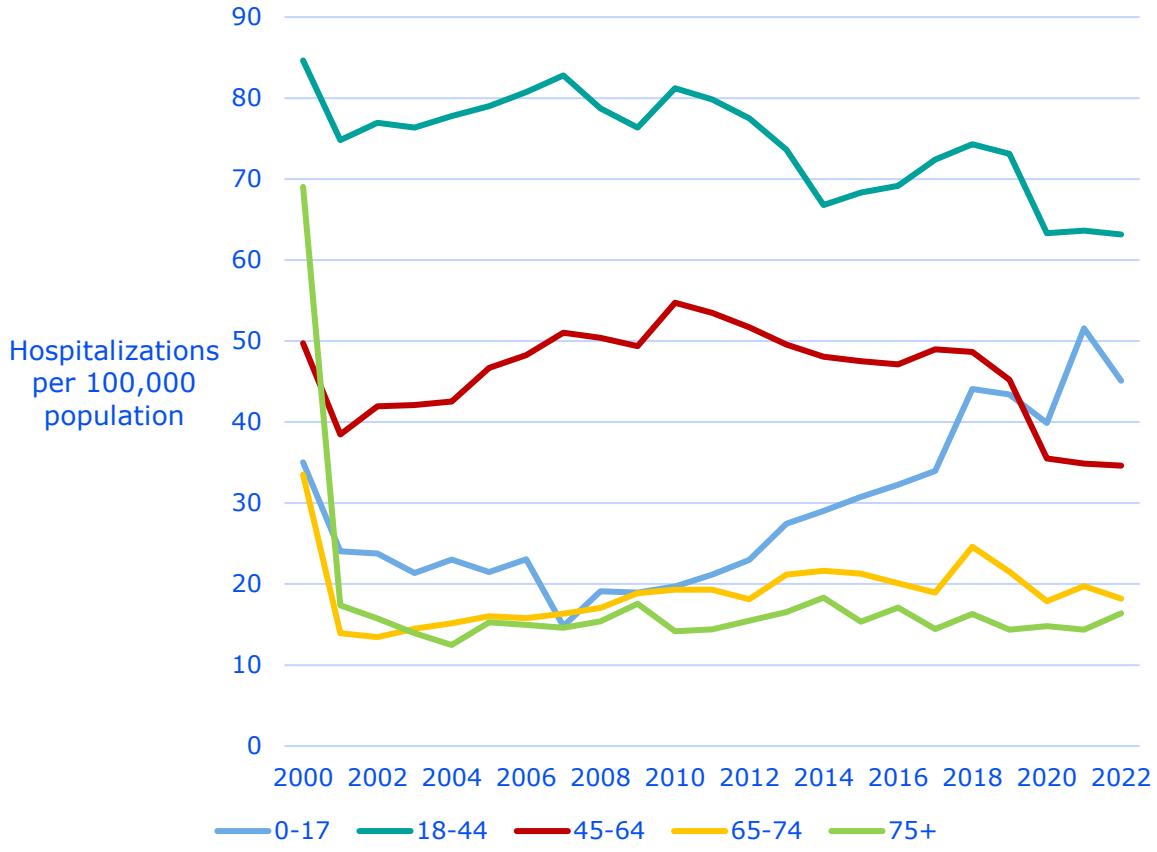
The next highest rates and the largest increase of inpatient hospitalizations for suicide attempt were seen in the 0-17-year-old age group which saw an 87.6 percent increase in hospitalizations for suicide attempt with a rate of 24 hospitalizations per 100,000 population in 2001 and a rate of 45.1 hospitalizations per 100,000 population in 2022.

The 65-74-year-old age group saw the only other increase in rate of inpatient hospitalizations for suicide attempt with their rate increasing 30.7 percent from 13.9 hospitalizations per 100,000 population in 2001 to 18.2 hospitalizations per 100,000 population in 2022.

The lowest rates of inpatient hospitalizations for suicide attempt were seen in the 75-year-old and over age group which decreased 5.7 percent from 17.4 hospitalizations per 100,000 population in 2001 to 16.4 hospitalizations per 100,000 population in 2022.

Figure 36 outlines the inpatient hospitalization rate for suicide attempt age group from 2000-2022.

Figure 36. Inpatient Hospitalization Rate for Suicide Attempt by Age Group, 2000-2022[59]



Local Mental Health Authority and Local Behavioral Health Authority Local Service Areas[60]

SCI Region One

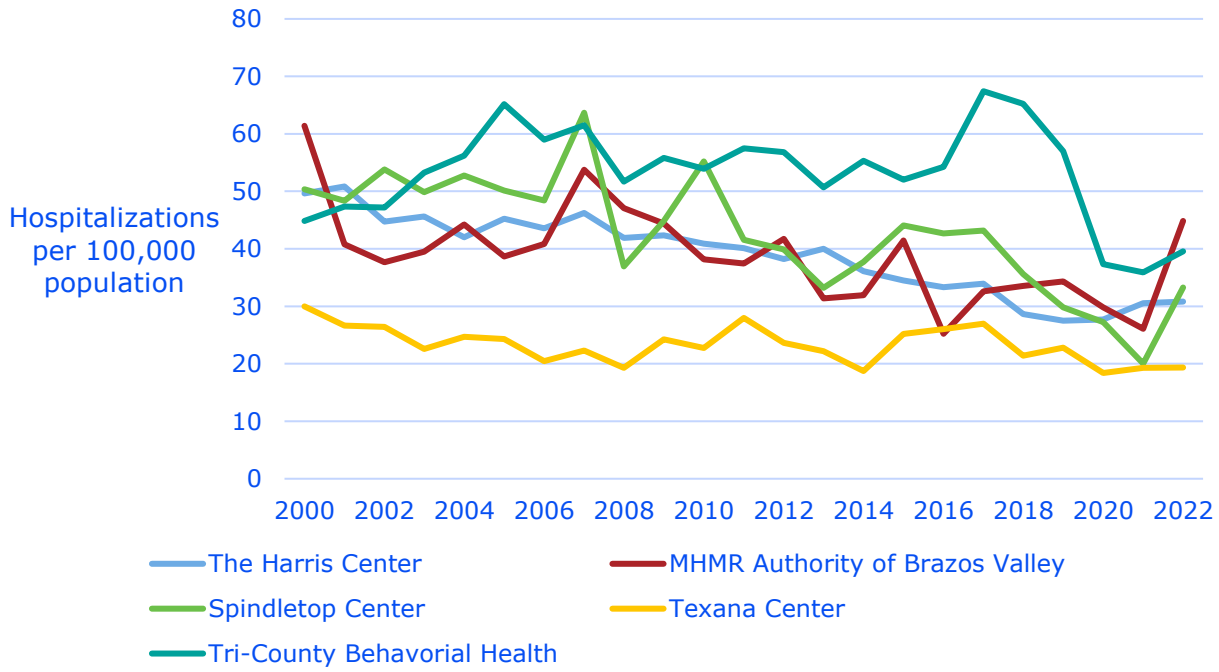
The hospitalization rate for suicide attempt decreased across most LMHA and LBHA LSAs in SCI Region One between 2000 and 2022. Harris County in the Harris Center for Mental Health and IDD LSA saw a decrease of 39.4 percent, from 50.8 hospitalizations per 100,000 population in 2001 to 30.8 hospitalizations per 100,000 population in 2022. The rate in the counties in the Spindletop Center LSA decreased by 31.2 percent, from 48.3 hospitalizations per 100,000 in 2001 population to 33.3 hospitalizations per 100,000 population in 2022. The rate in the

[59] THCIC, Department of State Health Services
[60] See Table A25, Table A26, Table A27, Table A28, Table A29, Table A30, Table A31, and Table A32 in 0

counties in the MHMR Authority of Brazos Valley LSA increased by 9.9 percent, from 40.8 hospitalizations per 100,000 population in 2001 to 44.8 hospitalizations per 100,000 population in 2022. The rate in the counties in the Texana Center LSA decreased by 27.5 percent, from 26.7 hospitalizations per 100,000 population in 2001 to 19.3 hospitalizations per 100,000 population in 2022. The rate in the counties in the Tri-County Behavioral Health LSA decreased by 16.5 percent, from 44.9 hospitalizations per 100,000 population in 2001 to 39.6 hospitalizations per 100,000 population in 2022.

Figure 37 outlines the hospitalization for suicide attempt rates in SCI Region One from 2000-2022.

Figure 37. Hospitalization for Suicide Attempt Rates in SCI Region One, 2000-2022[61]



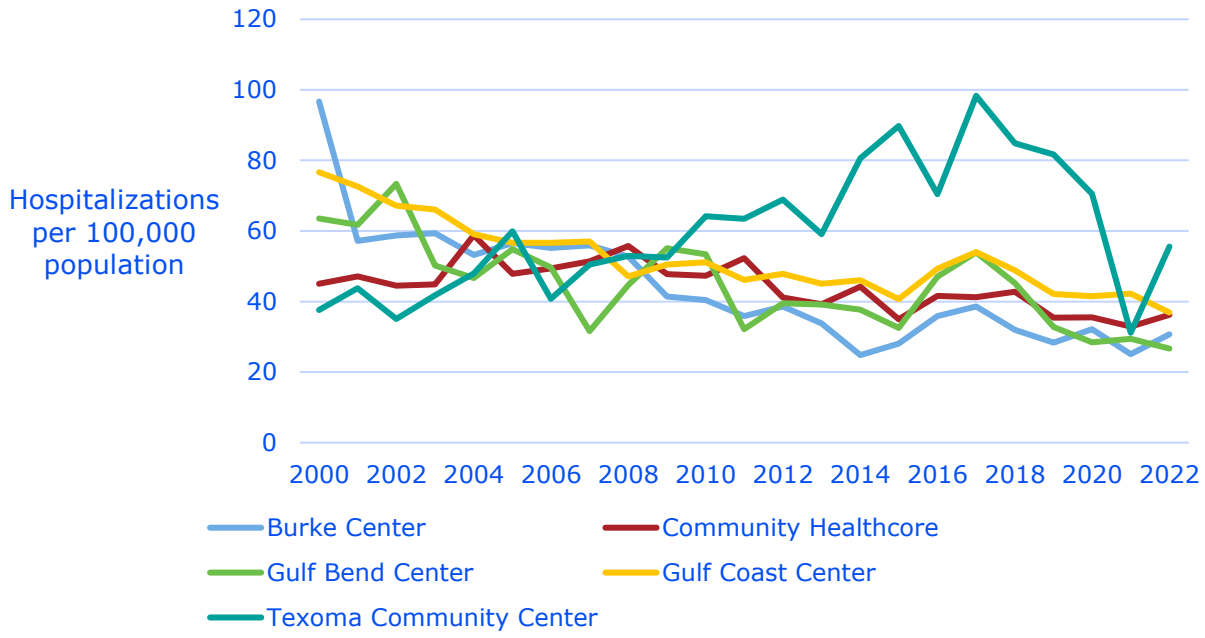
The rate in the counties in the Texoma Community Center LSA increased by 26.9 percent, from 43.7 hospitalizations per 100,000 population in 2001 to 55.5 hospitalizations per 100,000 population in 2022. The rate in the counties in the Community Healthcore LSA decreased 23.1 percent, from 47.1 hospitalizations per 100,000 population in 2001 to 36.2 hospitalizations per 100,000 population in 2022. The rate in the counties in the Gulf Coast Center LSA decreased 49.2

[61] THCIC, Department of State Health Services

percent, from 72.6 hospitalizations per 100,000 population in 2001 to 36.9 hospitalizations per 100,000 population in 2022. The rate in the counties in the Burke Center LSA decreased 46.3 percent, from 57.2 hospitalizations per 100,000 population in 2001 to 30.7 hospitalizations per 100,000 population in 2022. The rate in the counties in the Gulf Bend Center LSA decreased 56.8 percent, from 61.8 hospitalizations per 100,000 population in 2001 to 26.7 hospitalizations per 100,000 population in 2022.

Figure 38 outlines the hospitalization for suicide attempt rates in SCI Region One for 2000-2022.

Figure 38. Hospitalization for Suicide Attempt in SCI Region One, 2000-2022[62]



SCI Region Two

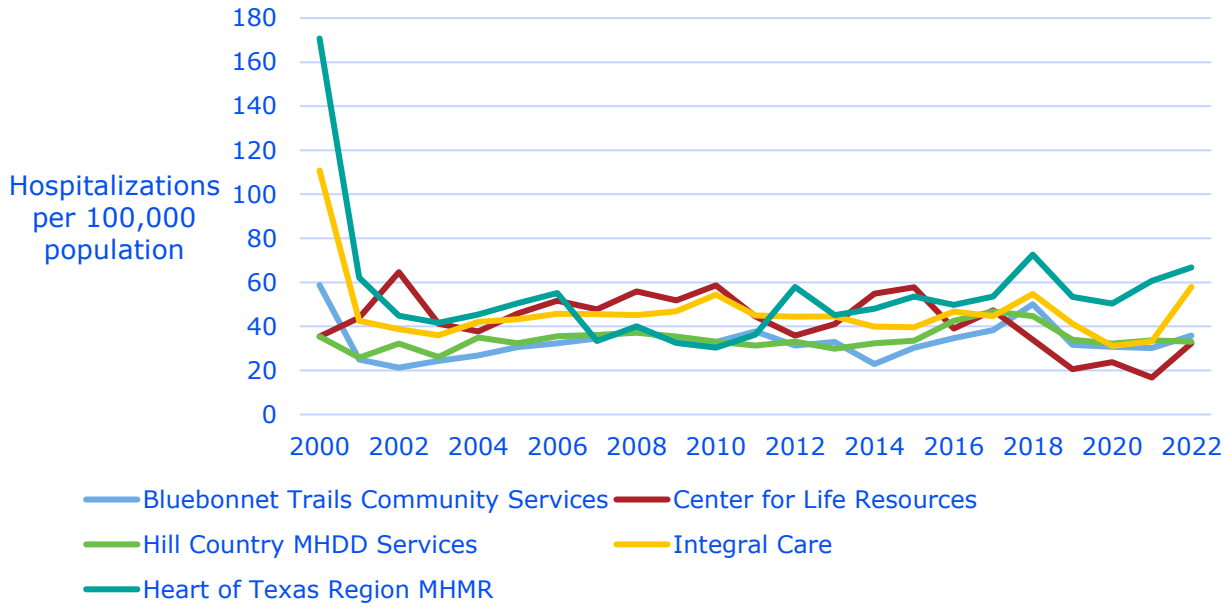
The hospitalization rate for suicide attempt decreased in about half of the LMHA and LBHA LSAs in SCI Region Two between 2001 and 2022. The counties in the Heart of Texas Behavioral Health Network LSA saw an increase of 7.5 percent, from 62.1 hospitalizations per 100,000 population in 2001 to 66.7 hospitalizations per 100,000 population in 2022. The rate in the counties in the Center for Life Resources LSA decreased by 26.5 percent, from 44 hospitalizations per 100,000 in 2001 population to 32.3 hospitalizations per 100,000 population in 2022. Travis County in the Integral Care LSA increased by 36.4 percent, from 42.5

[62] THCIC, Department of State Health Services

hospitalizations per 100,000 population in 2001 to 58 hospitalizations per 100,000 population in 2022. The rate in the counties in the Bluebonnet Trails Community Services LSA increased by 43.3 percent, from 24.9 hospitalizations per 100,000 population in 2001 to 35.8 hospitalizations per 100,000 population in 2022. And the rate in the counties in the Hill Country Mental Health and Developmental Disabilities Centers LSA increased by 28.3 percent, from 25.8 hospitalizations per 100,000 population in 2001 to 33.1 hospitalizations per 100,000 population in 2022.

Figure 39 outlines the hospitalization for suicide attempt rates in SCI Region Two from 2000-2022.

Figure 39. Hospitalization for Suicide Attempt Rates in SCI Region Two, 2000-2022[63]



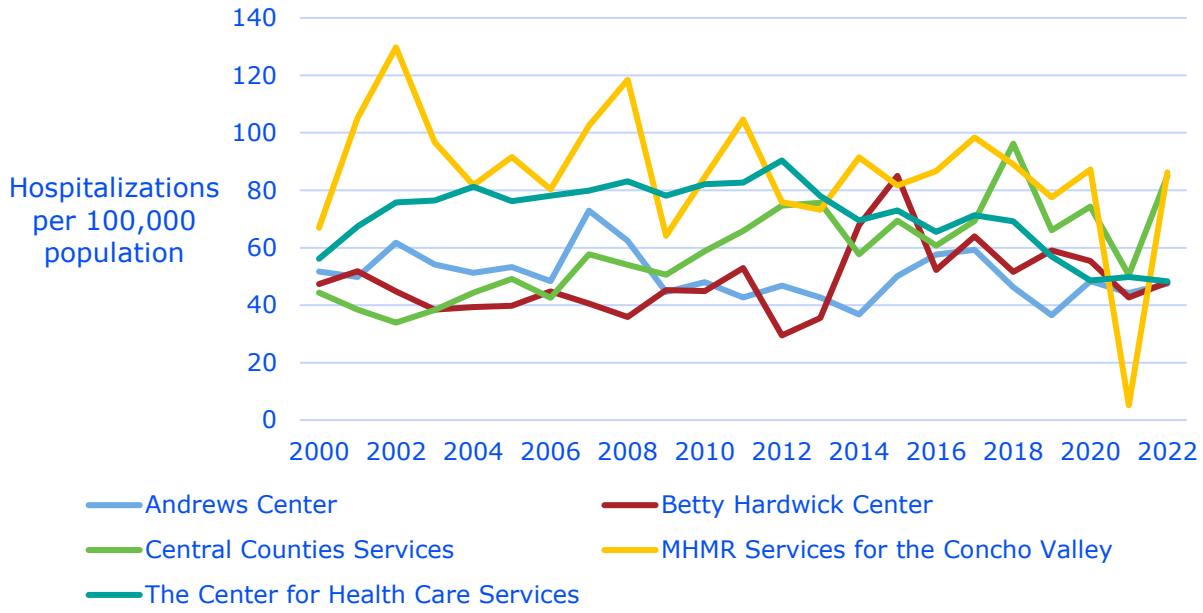
Bexar County in the Center for Health Care Services LSA saw a decrease of 28.4 percent, from 67.4 hospitalizations per 100,000 population in 2001 to 48.3 hospitalizations per 100,000 population in 2022. The rate in the counties in the MHMR Services for the Concho Valley LSA decreased by 18 percent, from 105.1 hospitalizations per 100,000 in 2001 population to 86.2 hospitalizations per 100,000 population in 2022. The rate in the counties in the Andrews Center LSA decreased by 4.7 percent, from 49.8 hospitalizations per 100,000 population in 2001 to 47.4 hospitalizations per 100,000 population in 2022. The rate in the counties in the Betty Hardwick Center LSA decreased by 7.5 percent, from 51.8

[63] THCIC, Department of State Health Services

hospitalizations per 100,000 population in 2001 to 47.9 hospitalizations per 100,000 population in 2022. The rate in the counties in the Central Counties Services LSA increased by 121.1 percent, from 38.5 hospitalizations per 100,000 population in 2001 to 85.1 hospitalizations per 100,000 population in 2022.

Figure 40 outlines the hospitalization for suicide attempt rates in SCI Region Two from 2000-2022.

Figure 40. Hospitalization for Suicide Attempt in SCI Region Two, 2000-2022[64]



SCI Region Three

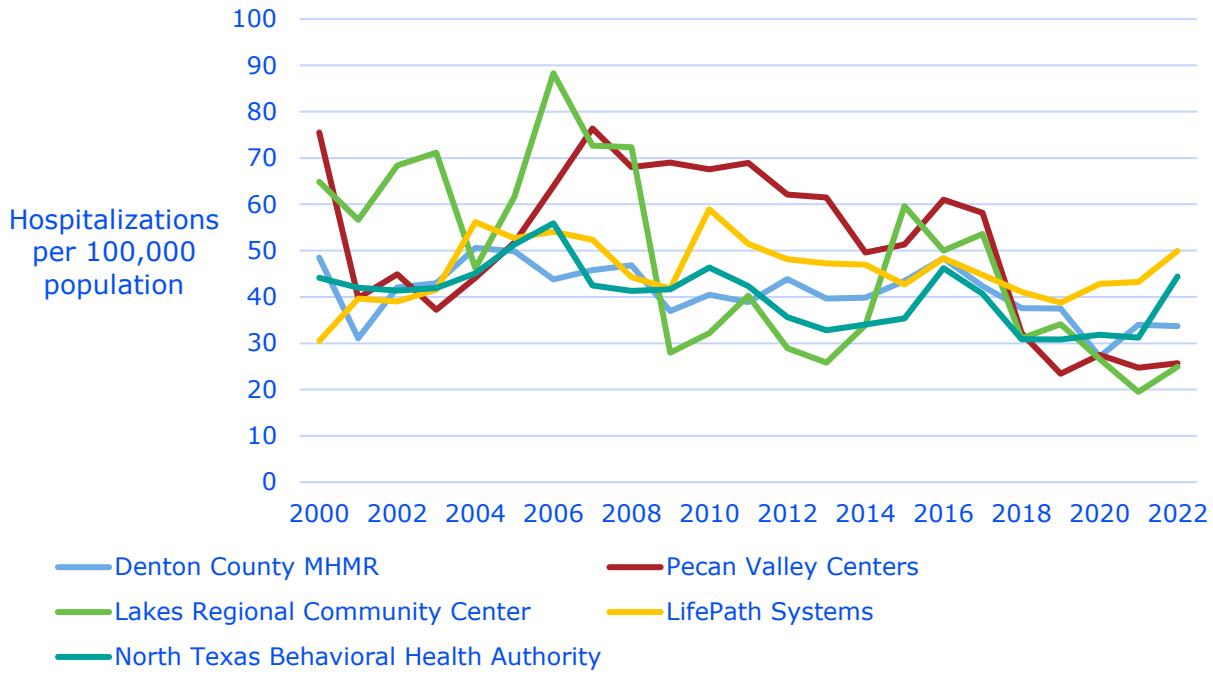
The hospitalization rate for suicide attempts decreased in more than half of LMHA and LBHA LSAs in SCI Region Three between 2001 and 2022. The counties in the Pecan Valley Centers for Behavioral and Developmental Healthcare LSA saw a decrease of 35.5 percent, from 39.8 hospitalizations per 100,000 population in 2001 to 25.7 hospitalizations per 100,000 population in 2022. The rate in the counties in the Lakes Regional Community Center LSA decreased by 56 percent, from 56.7 hospitalizations per 100,000 in 2001 population to 25 hospitalizations per 100,000 population in 2022. The rate in the counties in the North Texas Behavioral Health Authority LSA increased by 5.6 percent, from 42 hospitalizations per 100,000 population in 2001 to 44.4 hospitalizations per 100,000 population in 2022. Denton County in the Denton County MHMR LSA increased by 8.4 percent, from 31.1 hospitalizations per 100,000 population in 2001 to 33.7 hospitalizations

[64] THCIC, Department of State Health Services

per 100,000 population in 2022. The rate in the counties in the LifePath Systems LSA increased by 26 percent, from 39.7 hospitalizations per 100,000 population in 2001 to 50 hospitalizations per 100,000 population in 2022.

Figure 41 outlines the hospitalization for suicide attempt rates in SCI Region Three by LMHA and LBHA LSA from 2000-2022.

Figure 41. Hospitalization for Suicide Attempt in SCI Region Three, 2000-2022[65]



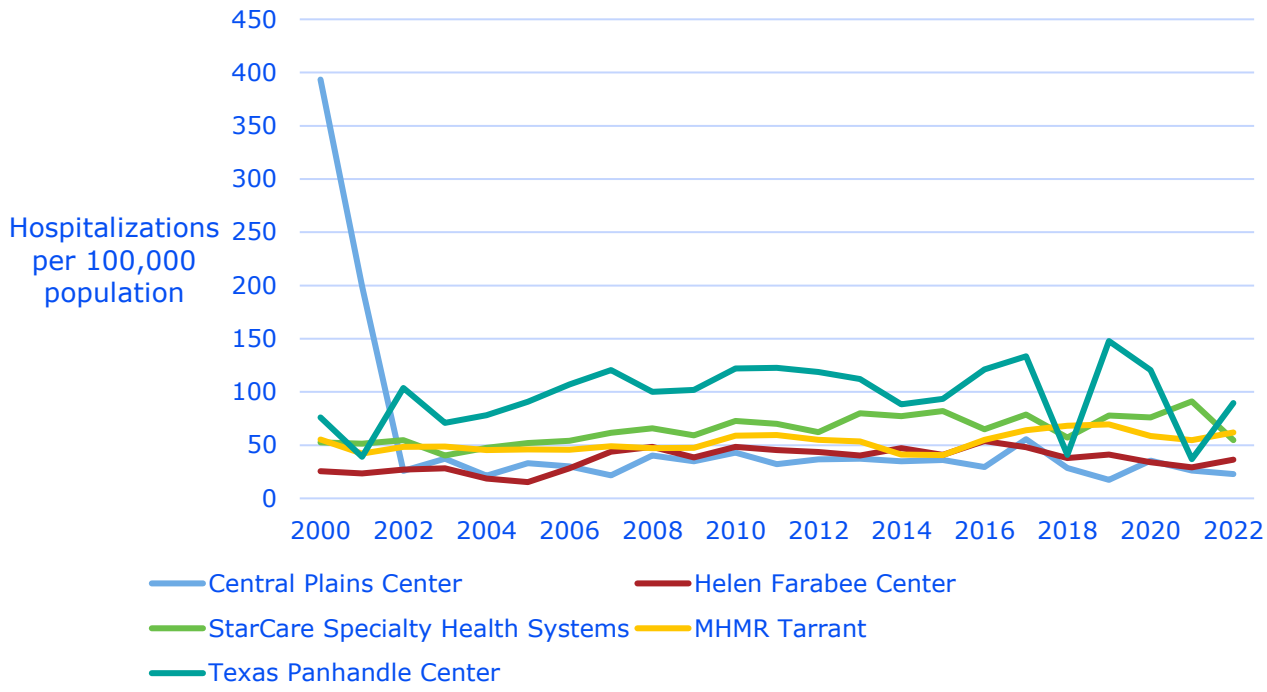
The counties in the Central Plains Center LSA saw a decrease of 88.5 percent, from 199.2 hospitalizations per 100,000 population in 2001 to 22.9 hospitalizations per 100,000 population in 2022. The rate in the counties in the Helen Farabee Center LSA increased by 54.4 percent, from 23.5 hospitalizations per 100,000 in 2001 population to 36.3 hospitalizations per 100,000 population in 2022. The rate in Tarrant County in the My Health My Resources of Tarrant County LSA increased by 47.1 percent, from 42 hospitalizations per 100,000 population in 2001 to 61.8 hospitalizations per 100,000 population in 2022. The rate in the counties served in the StarCare Specialty Health System LSA increased by 6.3 percent, from 51.3 hospitalizations per 100,000 population in 2001 to 54.6 hospitalizations per 100,000 population in 2022. The rate in the counties in the Texas Panhandle Center

[65] THCIC, Department of State Health Services

LSA increased by 129.6 percent, from 39 hospitalizations per 100,000 population in 2001 to 89.5 hospitalizations per 100,000 population in 2022.

Figure 42 outlines the hospitalization for suicide attempt rates in SCI Region Three by LMHA and LBHA LSA from 2000-2022.

Figure 42. Hospitalization for Suicide Attempt in SCI Region Three, 2000-2022[66]



SCI Region Four

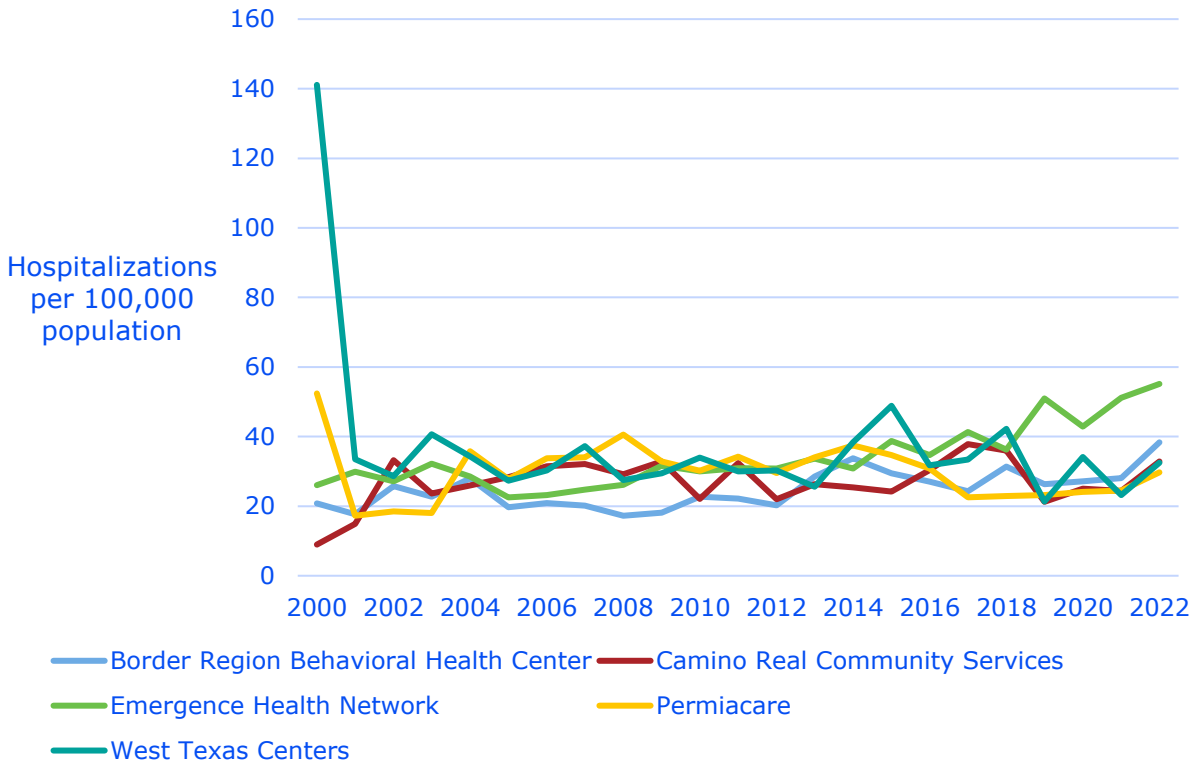
The hospitalization rate for suicide attempt decreased in about half of LMHA and LBHAs in SCI Region Four between 2001 and 2022. The counties in the Camino Real Community Services LSA saw an increase of 120.2 percent, from 14.9 hospitalizations per 100,000 population in 2001 to 32.9 hospitalizations per 100,000 population in 2022. The rate in the counties in the West Texas Centers LSA decreased by 3 percent, from 33.5 hospitalizations per 100,000 in 2001 population to 32.5 hospitalizations per 100,000 population in 2022. El Paso County in the Emergence Health Network LSA increased by 84.5 percent, from 29.9 hospitalizations per 100,000 population in 2001 to 55.1 hospitalizations per 100,000 population in 2022. The rate in the counties served in the Permiacare LSA increased by 72 percent, from 17.3 hospitalizations per 100,000 population in 2001 to 29.7 hospitalizations per 100,000 population in 2022. The rate in the counties in

[66] THCIC, Department of State Health Services

the Border Region Behavioral Health Center LSA increased by 117.3 percent, from 17.6 hospitalizations per 100,000 population in 2001 to 38.3 hospitalizations per 100,000 population in 2022.

Figure 43 outlines the hospitalization for suicide attempt rates in SCI Region Four by LMHA and LBHA LSA from 2000-2022.

Figure 43. Hospitalization for Suicide Attempt in SCI Region Four, 2000-2022[67]



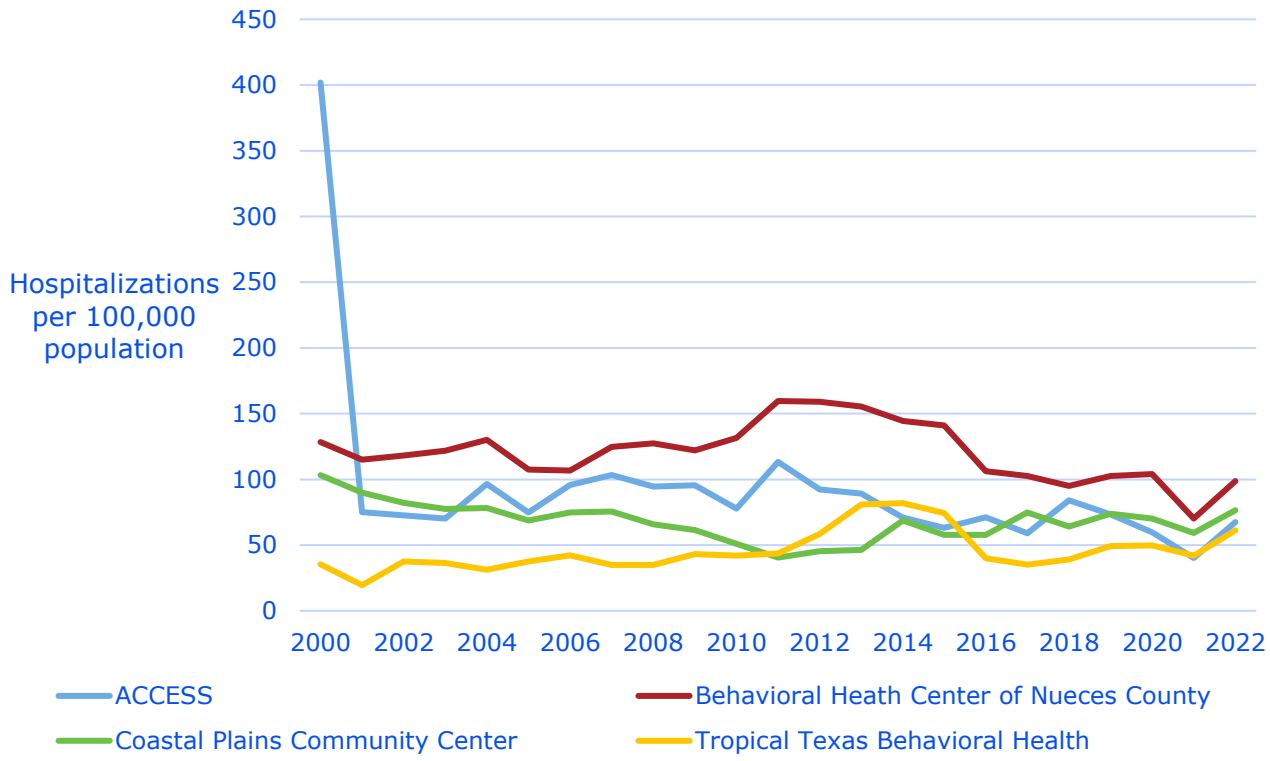
The counties in the Coastal Plains Community Center LSA saw a decrease of 14.7 percent, from 89.9 hospitalizations per 100,000 population in 2001 to 76.7 hospitalizations per 100,000 population in 2022. The rate in the counties in the ACCESS LSA decreased by 10.1 percent, from 75 hospitalizations per 100,000 population in 2001 to 67.5 hospitalizations per 100,000 population in 2022. Nueces County in the Nueces Center for Mental Health and Intellectual Disabilities LSA decreased by 14.3 percent, from 115.1 hospitalizations per 100,000 population in 2001 to 98.7 hospitalizations per 100,000 population in 2022. The rate in the counties in the Tropical Texas Behavioral Health LSA increased by 213.7 percent,

[67] THCIC, Department of State Health Services

from 19.5 hospitalizations per 100,000 population in 2001 to 61.3 hospitalizations per 100,000 population in 2022.

Figure 44 outlines the hospitalization for suicide attempt rates in SCI Region Four by LMHA and LBHA LSA from 2000-2022.

Figure 44. Hospitalization for Suicide Attempt in SCI Region Four, 2000-2022[68]



Snapshot of Local Mental Health Authority and Local Behavioral Health Authority Local Service Areas

The following section provides maps of the suicide attempt hospitalization rate (per 100,000 population) for the LMHA and LBHA LSAs providing a snapshot in time to compare the rates across regions. The first map shows 2002; the second shows 2012; and the third shows the most recent available data, 2022.

ID Number	LMHA and LBHA LSAs
1	ACCESS

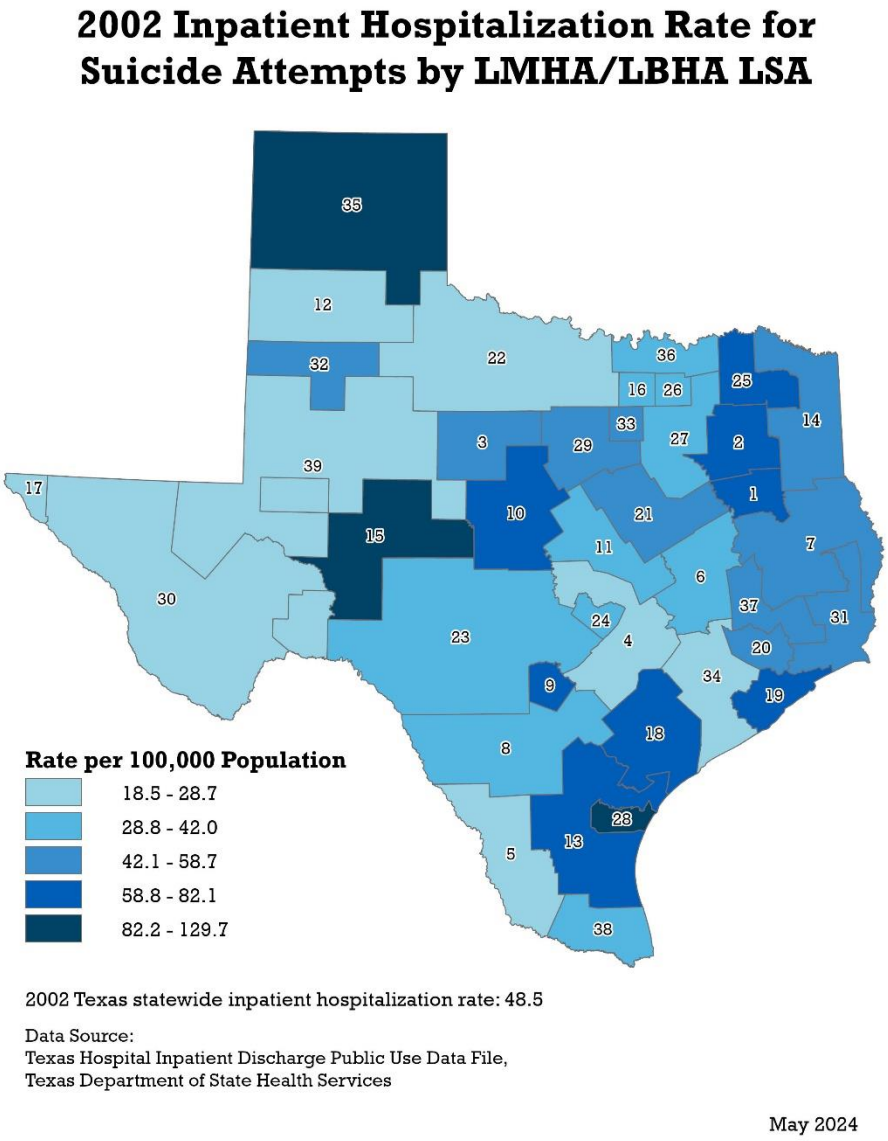
[68] THCIC, Department of State Health Services

ID Number	LMHA and LBHA LSAs
2	Andrews Center Behavioral Healthcare System
3	Betty Hardwick Center
4	Bluebonnet Trails Community Services
5	Border Region Behavioral Health Center
6	MHMR of Brazos Valley
7	Burke Center
8	Camino Real Community Services
9	The Center of Health Care Service
10	Center for Life Resources
11	Central Counties Services
12	Central Plains Services
13	Coastal Plains Community Center
14	Community Healthcore
15	MHMR of Concho Valley
16	Denton County
17	Emergence Health Network
18	Gulf Bend Center
19	Gulf Coast Center
20	The Harris Center for Mental Health and IDD
21	Heart of Texas
22	Helen Farabee
23	Hill Country Centers
24	Integral Care
25	Lakes Regional
26	Lifepath Systems
27	North Texas Behavioral Health Authority
28	Nueces Center
29	Pecan Valley Centers
30	PermiaCare
31	Spindletop Center
32	StarCare
33	Tarrant County
34	Texana Center
35	Texas Panhandle Centers
36	Texoma Community Center
37	Tri-County Behavioral Healthcare
38	Tropical Texas Behavioral Health
39	West Texas Centers

In 2002, the highest rate of hospitalizations for suicide attempt was in the counties in the MHMR Service for the Concho Valley LSA with 129.7 hospitalizations per 100,000 population. Nueces County in the Nueces Center for Mental Health and Intellectual Disabilities LSA had a similarly high rate of 118.3 hospitalizations per 100,000 population. The lowest rate was in the counties in the PermiaCare LSA with 18.5 hospitalizations per 100,000 population. The counties in the Central Plains Center Emergence Health Network, and Helen Farabee Centers LSAs also had low rates of 25.7 hospitalizations per 100,000 population, 27.1 hospitalizations per 100,000 population, and 27.1 hospitalizations per 100,000 population, respectively. The state rate was 48.5 hospitalizations per 100,000 population.

Figure 45 outlines the hospitalization rate for suicide attempts per 100,000 population by LMHA and LBHA LSA in 2002.

Figure 45. Rates of Hospitalization for Suicide Attempt per 100,000 Population by LMHA and LBHA LSA, Texas 2002[69] [70]



[69] THCIC, DSHS

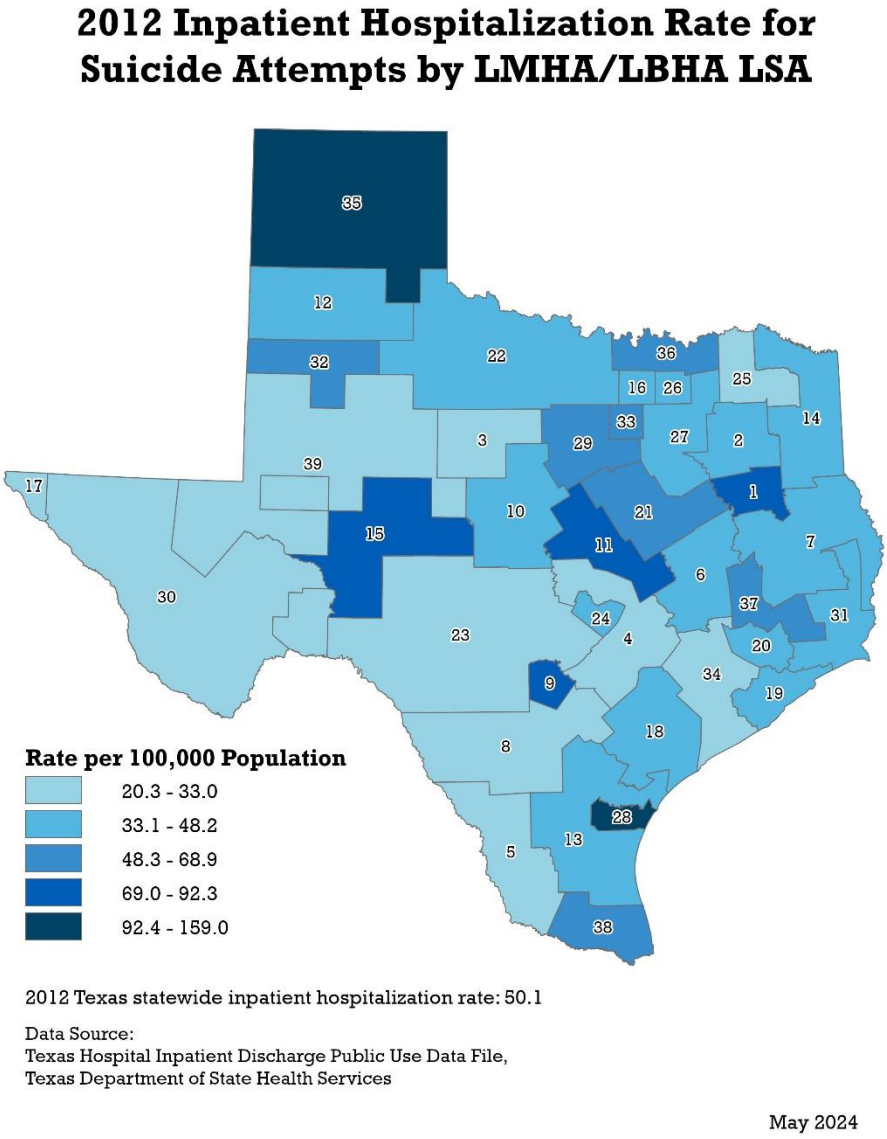
[70] The data reflects persons residing in the geographic LSAs of the LMHAs and LBHAs.

In 2012, the highest rate of suicide attempt hospitalization was in Nueces County in the Nueces Center for Mental Health and Intellectual Disabilities LSA with a rate of 159 hospitalizations per 100,000 population. The counties in the Texas Panhandle Center LSA also had a high rate of 118.8 hospitalizations per 100,000 population.

The lowest rate was in the counties in the Border Region Behavioral Health Center LSA with a rate of 20.3 hospitalizations per 100,000 population. The counties in the Camino Real Community Services and Texana Center LSAs also had lower rates with rates of 22 hospitalizations per 100,000 population and 23.7 hospitalizations per 100,000 population, respectively. The state rate was 50.1 hospitalizations per 100,000 population.

Figure 46 outlines the hospitalization rate for suicide attempts per 100,000 population by LMHA and LBHA LSAs in 2012.

Figure 46. Rates of Hospitalization for Suicide Attempt per 100,000 Population by LMHA and LBHA LSA, Texas 2012[71] [72]



In 2022, the highest rates of suicide attempt hospitalizations were in Nueces County in the Nueces Center for Mental Health and Intellectual Disabilities and Texas Panhandle Centers LSAs with rates of hospitalization of 98.7 hospitalizations per 100,000 population and 89.5 hospitalizations per 100,000 population. The

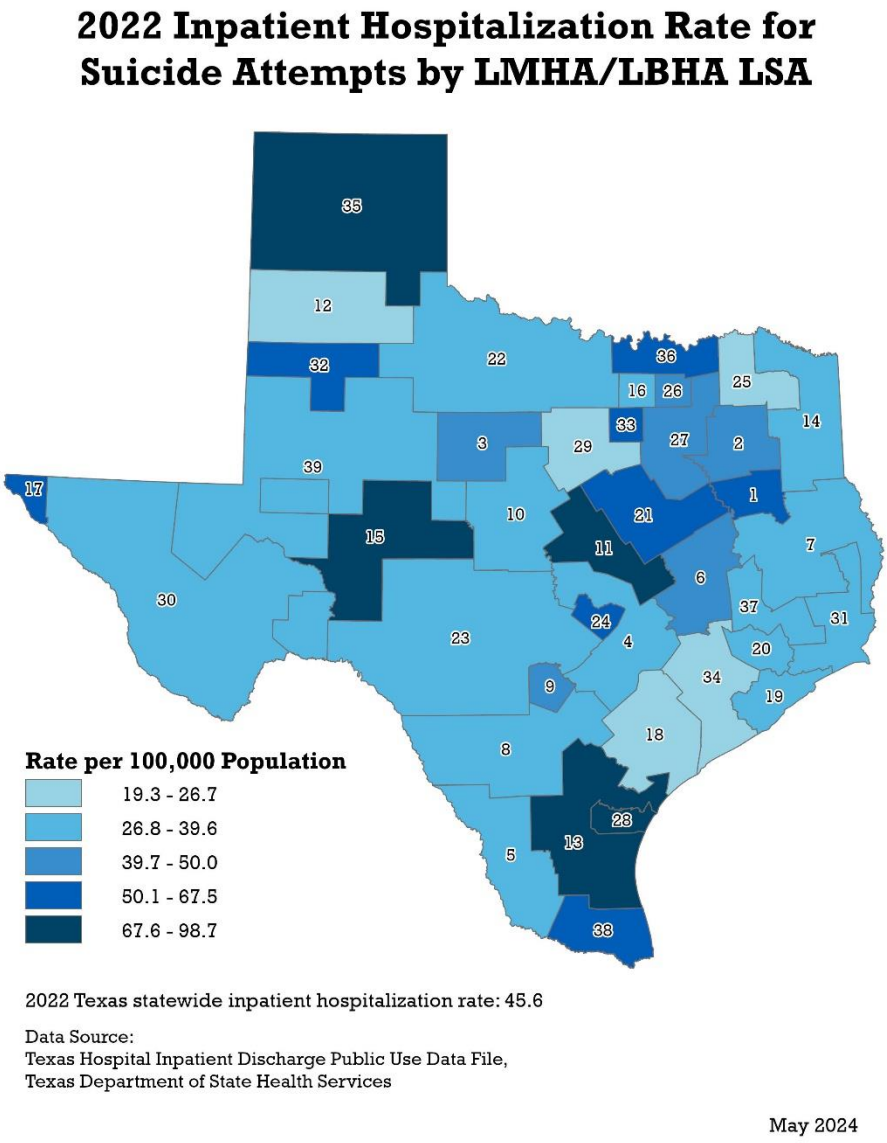
[71] THCIC, Department of State Health Services
[72] The data reflects persons residing in the geographic LSAs of the LMHA AND LBHA.

counties in the MHMR Services for the Concho Valley LSA had the next highest rate at 86.2 hospitalizations per 100,000 population.

The lowest rates were in the counties in the Texana Center, Central Plains Center, and Lakes Regional MHMR Center LSAs with rates of 19.3 hospitalizations per 100,000 population, 22.9 hospitalizations per 100,000 population, and 25 hospitalizations per 100,000 population, respectively. The state rate was 45.6 hospitalizations per 100,000 population.

Figure 47 outlines the hospitalization rate for suicide attempts per 100,000 population by LMHA and LBHA LSA in 2022.

Figure 47. Rates of Hospitalization for Suicide Attempt per 100,000 Population by LMHA and LBHA LSA, Texas 2022[73] [74]

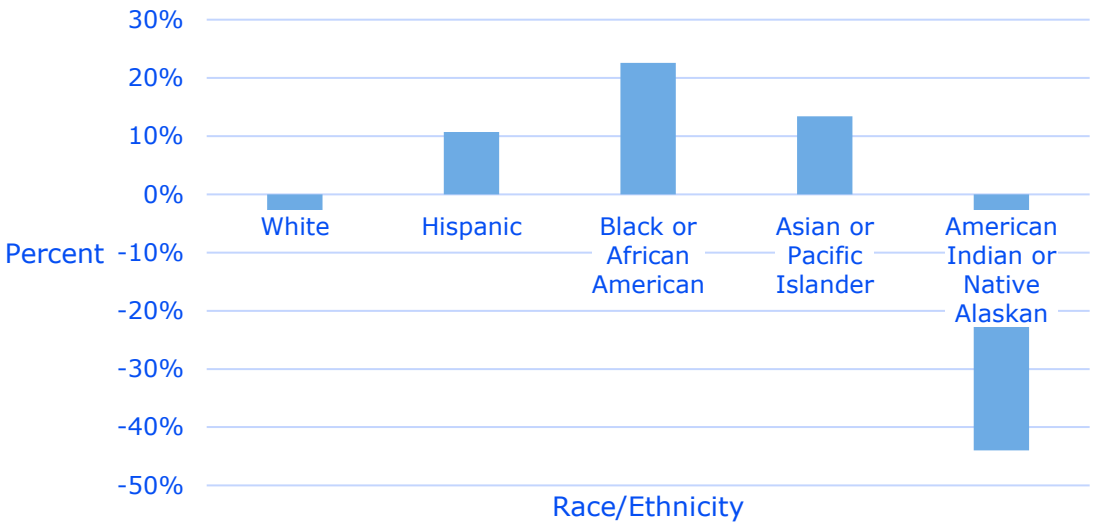


[73] THCIC, DSHS
[74] The data reflects persons residing in the geographic LSAs of the LMHA and LBHA.

Race and Ethnicity[75]

Figure 48 illustrates the changes in hospitalization rates for suicide attempts between 2001 and 2022 by race and ethnicity groups.

Figure 48. Changes in Inpatient Hospitalizations for Suicide Attempt by Race and Ethnicity Groups, 2001-2022[76]



The highest rates of inpatient hospitalization for suicide attempt are among white individuals. This category saw a small decrease in hospitalization rate of 2.8 percent, from 56.7 hospitalizations per 100,000 population to 55.1 hospitalizations per 100,000 population.

Black or African American individuals have the next highest rate of inpatient hospitalization for suicide attempt with a 22.6 percent increase of 37 hospitalizations per 100,000 population to 45.4 hospitalizations per 100,000 population between 2001 and 2022.

Hispanic individuals have relatively low rates of hospitalization and saw the smallest increase from 2001 to 2022. The rate increased 10.7 percent from 32.3 hospitalizations per 100,000 population to 35.8 hospitalizations per 100,000 population.

[75] See Table A33 in 0
[76] THCIC, Department of State Health Services

Asian or Pacific Islanders have the lowest overall hospitalization rate which increased by 13.4 percent from 12.3 hospitalizations per 100,000 population to 14 hospitalizations per 100,000 population.

American Indian or Alaskan Natives have the most unstable rate due to a relatively small population size in the denominator. That rate saw a 44 percent decrease from 27.3 hospitalizations per 100,000 population to 15.3 hospitalizations per 100,000 population. There were also spikes in the American Indian or Alaskan Native rates which occur beginning in the third quarter of 2013 and continue until the third quarter of 2015, for which there is not a current explanation.

Poison Control Center Data[77]

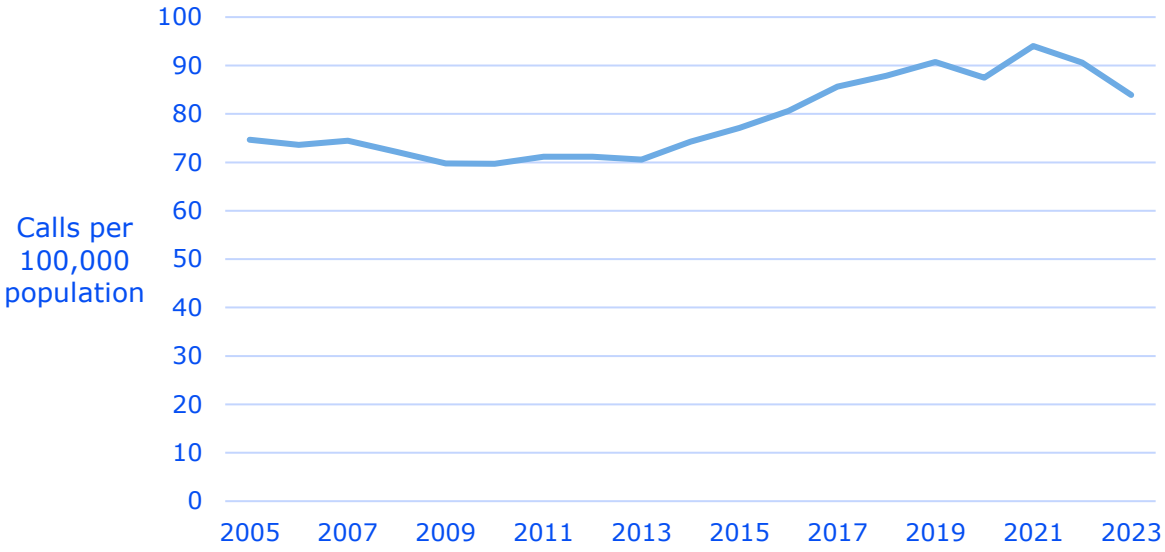
When a call is made to the Poison Control hotline, the caller identifies information about the subject of the call. The Poison Control Center receives calls from emergency departments, urgent care centers, doctors' offices, and the general public. Calls concerning self-inflicted poisonings are rising. The proportion of calls concerning adolescents is also increasing.

In the early 2000s, the percentage of calls of self-inflicted poisonings concerning adolescents 13-19 years old was about 32 percent; by 2015-2019, the percentage of calls for this reason concerning adolescents was 40 percent; and by 2021, the percentage of suspected suicide calls concerning adolescents was close to 60 percent. The number of calls Poison Control receives concerning suspected suicide attempts has been increasing in the time of available data, starting in 2005 when Poison Control received 17,007 calls, peaking in 2021 when the network received 28,018 calls and continuing into 2023 when they received 25,588 calls. This constituted a 12.4 percent increase in the call rate per 100,000 population, from 74.7 calls per 100,000 population in 2005 to 83.9 calls per 100,000 population in 2023.

Figure 50 outlines suspected suicide calls received by Texas Poison Control Network for 2005-2023.

[77] See Table A34 in 0

Figure 50. Texas Poison Control Network Suspected Suicide Attempt Calls, 2005-2023[78]



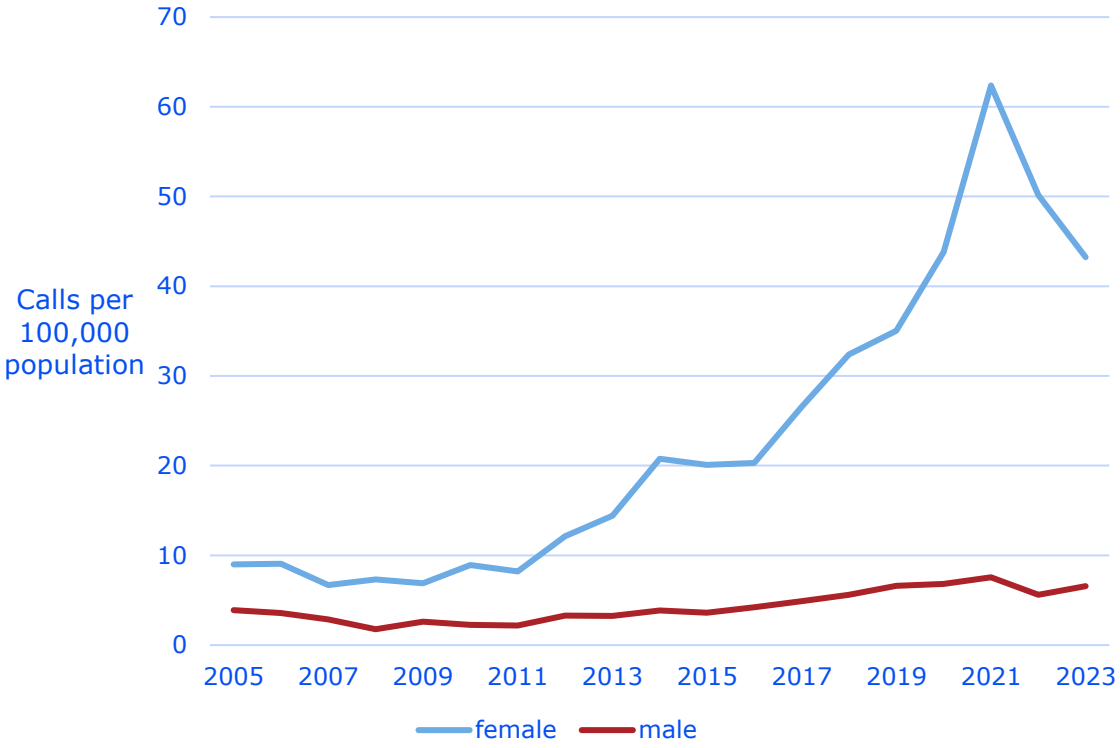
Age and Sex[79]

The highest rates for Poison Control calls concerning suspected suicide attempts occurred with female adolescents 13 to 19 years old. The rate was significantly lower among the 6 to 12-year-old population. The next highest rates were seen in the 20-29-year-old populations. Although the rates were very low in the youngest group, they saw the largest increase, 380.2 percent from 9 calls per 100,000 populations to 42.3 calls per 100,000 population for females and 68.5 percent from 3.9 calls per 100,000 population to 6.6 calls per 100,000 population for males.

Figure 51 outlines suspected suicide attempt calls concerning children aged 6-12 received by Texas Poison Control Network for 2005-2023 by sex.

[78] Texas Poison Control Network (TPCN), Department of State Health Services
[79] See Table A35, Table A36, Table A37, Table A38, and Table A39 in 0

Figure 51. Texas Poison Control Network Suspected Suicide Attempt Calls concerning 6–12-year-old children by sex, 2005-2023[80]

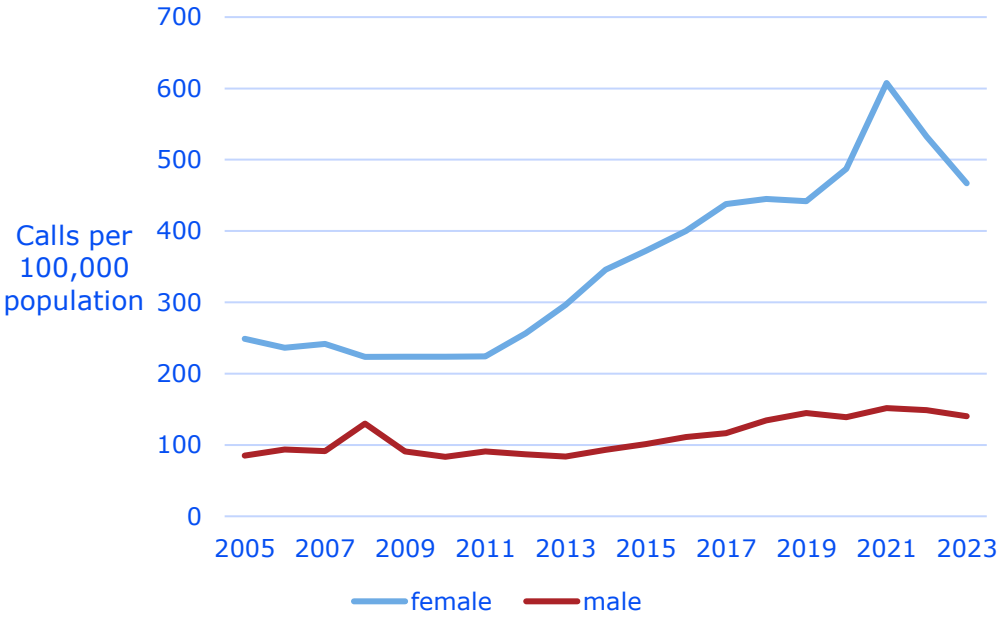


The adolescent age group of 13 to 19 years also saw an increase of 87.5 percent, rising from 249.1 calls per 100,000 population in 2005 to 467.1 calls per 100,000 population in 2023 for females and 64.9 percent rising from 85.2 calls per 100,000 population in 2005 to 140.4 calls per 100,000 population in 2023 for males.

Figure 52 outlines suspected suicide attempt calls concerning adolescents aged 13-19 received by Texas Poison Control Network for 2005-2023 by sex.

[80] Texas Poison Control Network (TPCN), Department of State Health Services

Figure 52. Texas Poison Control Network Suspected Suicide Attempt Calls concerning 13-19-year-old adolescents by sex, 2005-2023[81]

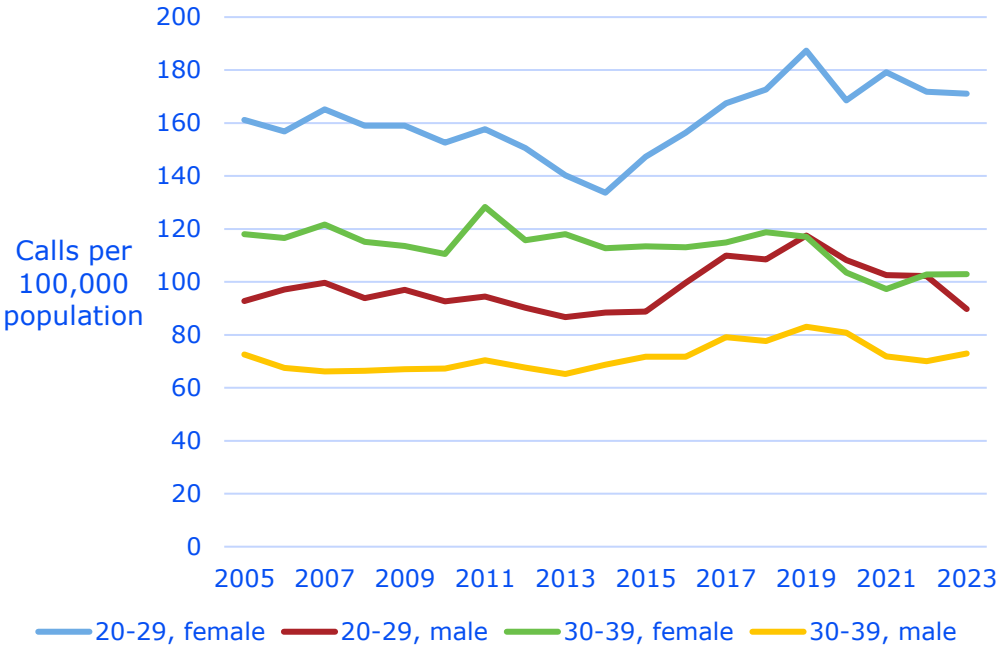


The rate among individuals 20-29-years old remained relatively stable with just a 6.2 percent increase, from 161.2 calls per 100,000 population in 2005 to 171.1 calls per 100,000 population in 2023 for females and a 3.3 percent decrease, from 92.7 calls per 100,000 population in 2005 to 89.7 calls per 100,000 population in 2021 for males. Meanwhile the rates among females 30-39 years old decreased by 12.8 percent from 118 calls per 100,000 population in 2005 to 102.9 calls per 100,000 population in 2023 and increased for males 30-39 years old 0.4 percent from 72.6 calls per 100,000 population in 2005 to 72.9 calls per 100,000 population in 2023.

Figure 53 outlines suspected suicide attempt calls among 20-29-year-old and 30-39-year-old adults received by Texas Poison Control Network for 2005-2023.

[81] Texas Poison Control Network (TPCN), Department of State Health Services

Figure 53. Texas Poison Control Center Suspected Suicide Attempt Calls Concerning 20–29-year-old and 30–39-year-old Adults by Sex, 2005-2023[82]

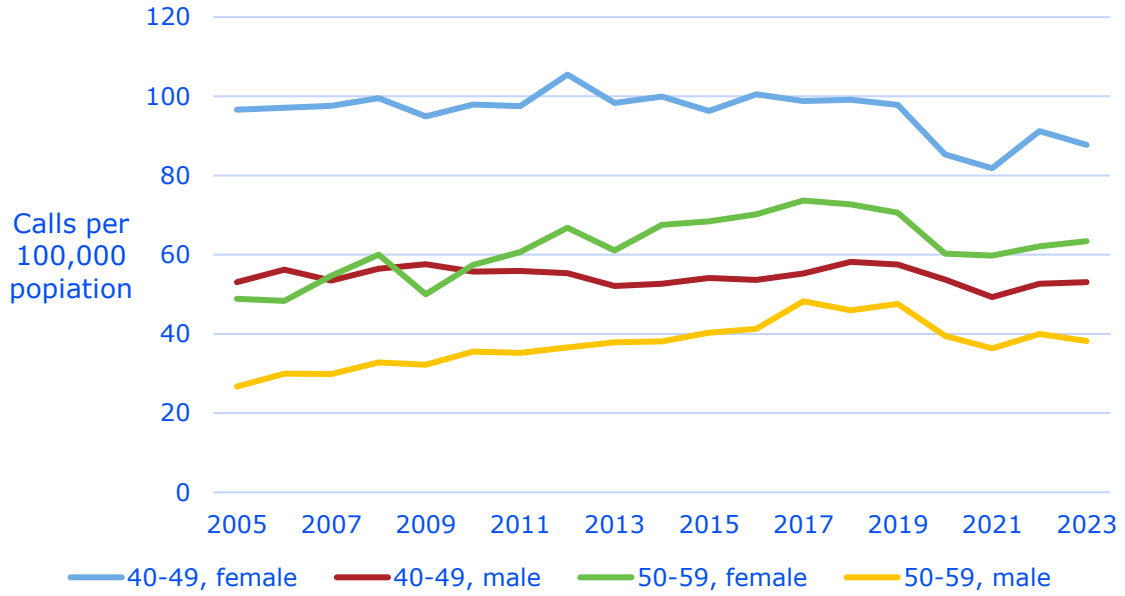


The rates of suspected suicide attempt calls to the Poison Control Network continue to decline with age through the middle adult years. The rate also decreased among the 40-49-year-old females with 9.3 percent decrease over the 19-year period. The 40-49-year-old group rate went from 96.7 calls per 100,000 population in 2005 to 87.7 calls per 100,000 population in 2023 for females and the 40-49-year-old male group rate remained the same, at 53.1 calls per 100,000 population in 2005 and 2023. However, the 50-59-year-old age group saw an increase of 29.8 percent for females and 42.9 percent for males, with female rates rising from 48.9 calls per 100,000 population 2005 to 63.4 calls per 100,000 population in 2023 and the male rates rising from 26.7 calls per 100,000 population in 2005 to 38.2 calls per 100,000 population in 2023.

Figure 54 outlines suspected suicide attempt calls among middle-aged adults received by Texas Poison Control Center by sex for 2005-2023.

[82] Texas Poison Control Network, Department of State Health Services

Figure 54. Texas Poison Control Center Suspected Suicide Attempt Calls Among Middle-Aged Adults by Sex, 2005-2023[83]



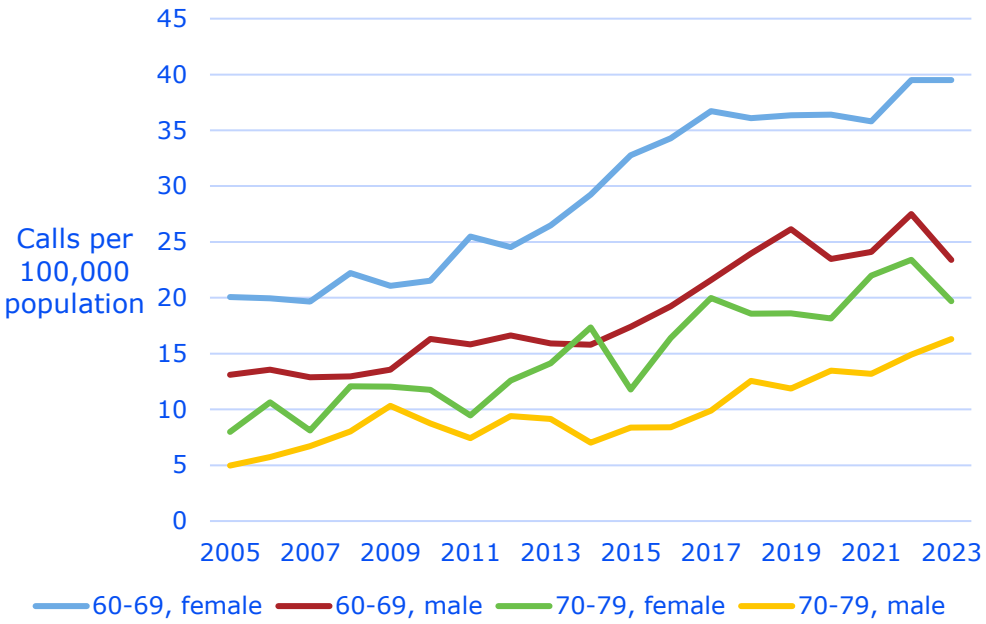
Older adults had the lowest Poison Control suspected suicide attempt call rates; however, this age group experienced large increases in rates of calls concerning suspected suicide attempt for adult populations over the nineteen-year period. Calls for females 60-69 increased 96.8 percent from a rate of 20.1 calls per 100,000 population in 2005 to 39.5 calls per 100,000 population 2023 while calls for males 60-69 increase 78.6 percent from a rate of 13.1 calls per 100,000 population in 2005 to 23.4 calls per 100,000 population in 2023. Calls for females 70-79 increased 146.6 percent from 8 calls per 100,000 population in 2005 to 19.7 calls per 100,000 population in 2023. Calls for males 70 to 79 increased 228 percent from 5 calls per 100,000 population in 2005 to 16.3 calls per 100,000 population in 2023.

Numbers for call by sex for 80-89 and 90+ were suppressed for most of the years and rates could not be calculated.

[83] Texas Poison Control Network, Department of State Health Services

Figure 55 outlines suspected suicide attempt calls among older adults received by Texas Poison Control Center for 2005-2023.

Figure 55. Texas Poison Control Center Suspected Suicide Attempt Calls Among Older Adults, 2005-2023[84]



Emergency Department Outpatient Data

DSHS currently collects inpatient and outpatient data from hospitals and ambulatory surgical centers. DSHS began collecting emergency department data from hospitals on January 1, 2015, per Title 25 Texas Administrative Code (TAC), Chapter 421, Sections 421.71-421.78, and in conjunction with the collection of inpatient and outpatient data.[85] The first-year data was available is from 2016.

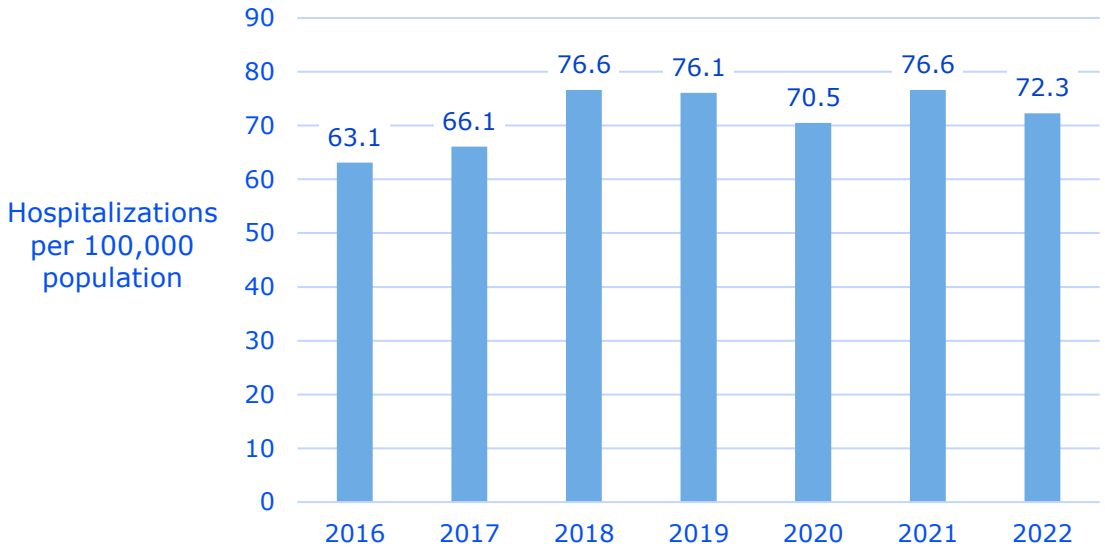
In the past five years, there have been about 20,000 emergency department visits each year for suicide attempt or NSSI where the patient has been treated and not admitted to the hospital. While these incidents only account for a small portion of emergency room visits each year, the number of visits in emergency departments for suicide attempt is more than five times the number of suicide deaths each year in Texas. Both the number of emergency room visits and the rate per 100,000 population have risen over these five years.

[84] Texas Poison Control Network, Department of State Health Services
[85] THCIC, Department of State Health Services

The statewide rate of emergency department hospitalizations has increased 14.6 percent, from 63.1 hospitalizations per 100,000 population in 2016 to 72.3 hospitalizations per 100,000 population in 2022.

Figure 56 outlines emergency department outpatient hospitalizations in Texas for suicide attempt for 2016-2022.

Figure 56. Texas Emergency Department Outpatient Hospitalizations for Suicide Attempt, 2016-2022[86]

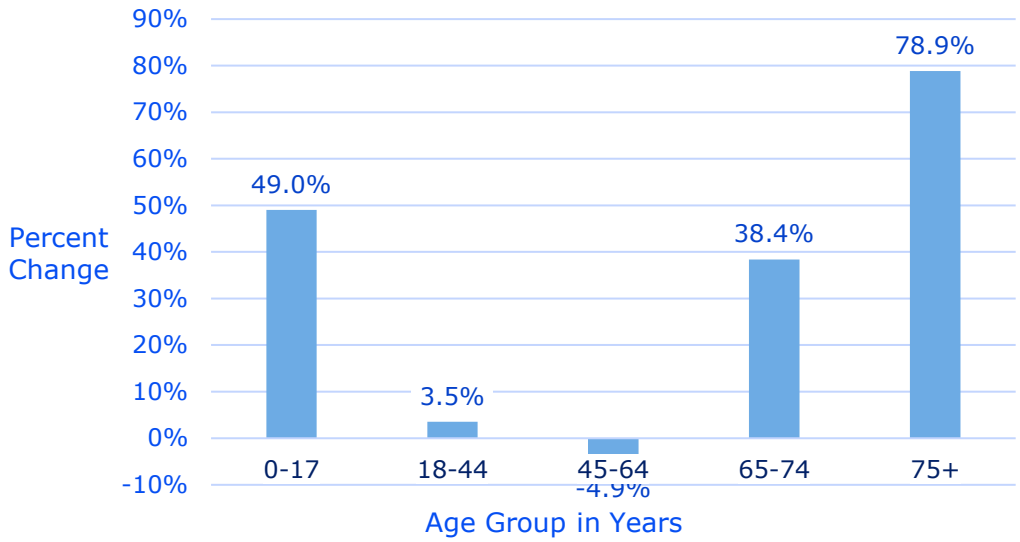


Age[87]

Figure 57 shows the percentage change in emergency department outpatient hospitalization rates for suicide attempt by age grouping for 2016-2022.

[86] THCIC, Department of State Health Services
[87] See Table A41 in Appendix A

Figure 57. Percentage Change in Texas Emergency Department Outpatient Hospitalization Rates for Suicide Attempt by Age Group, 2016-2022[88]



The largest increase in emergency department hospitalizations for suicide attempt was seen among the group with the lowest rates of such hospitalizations. Those 75 years and older saw an increase of 78.9 percent from 4.6 hospitalizations per 100,000 population in 2016 to 8.2 hospitalizations per 100,000 population in 2022.

The second largest increase in emergency department hospitalizations for suicide attempt was seen in the 0–17-year-old population with a 49 percent increase from 70.2 hospitalizations per 100,000 population in 2016 to 104.7 hospitalizations per 100,000 population in 2022.

A smaller increase in emergency department hospitalizations for suicide attempt was seen in the 65–74-year-old population with a 38.4 percent increase from 10 hospitalizations per 100,000 population in 2016 to 13.8 hospitalizations per 100,000 population in 2022.

The smallest increase in emergency department hospitalizations for suicide attempt was seen in the 18–44-year-old population with a 3.5 percent increase from 90.2 hospitalization per 100,000 population in 2016 to 93.4 hospitalizations per 100,000 population in 2022.

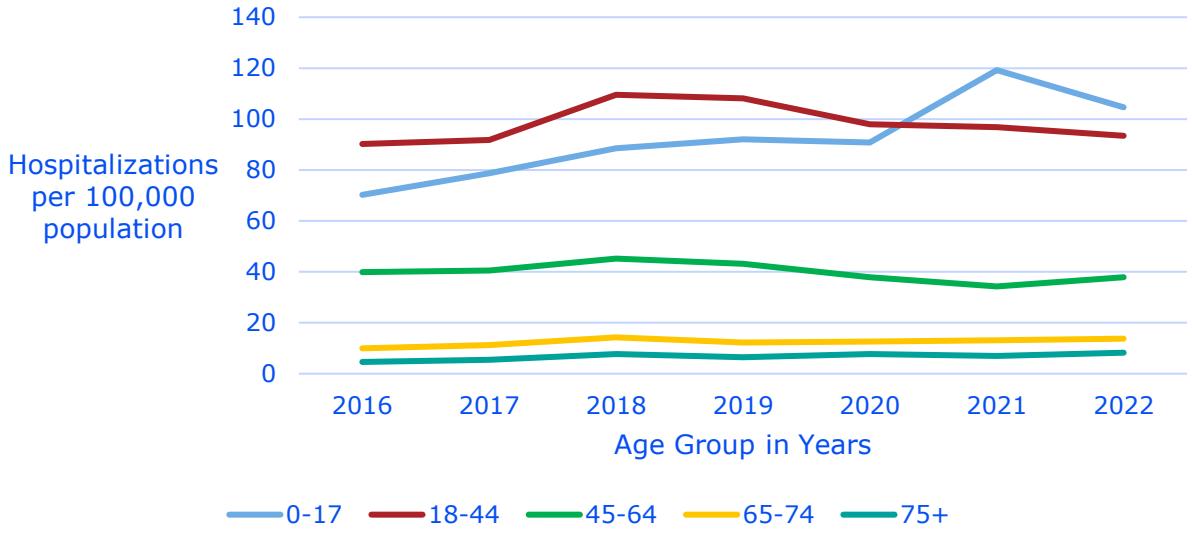
The only decrease in emergency department hospitalizations for suicide attempt was seen in the 45-64-year-old population with a 4.9 percent decrease from 39.8

[88] THCIC, Department of State Health Services

hospitalizations per 100,000 population in 2016 to 37.9 hospitalizations per 100,000 population in 2022.

Figure 58 outlines emergency department outpatient hospitalizations in Texas for suicide attempt by Age Group for 2016-2022.

Figure 58. Texas Emergency Department Outpatient Hospitalizations for Suicide Attempt by Age Group, 2016-2022[89]



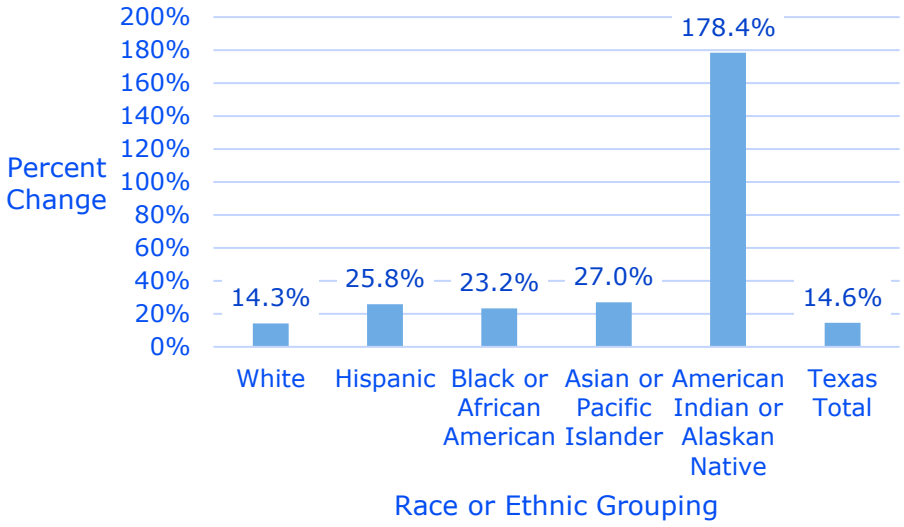
Race and Ethnicity[90]

Race and ethnicity groups visited Emergency Departments for suicide attempt or NSSI at different rates and with different levels of change over the seven years of available data.

Figure 59 shows the percentage change in emergency department outpatient hospitalization rates for suicide attempt by race or ethnicity for 2016-2022.

[89] THCIC, Department of State Health Services
[90] See Table A50 in Appendix A

Figure 59. Percentage Change in Texas Emergency Department Outpatient Hospitalization Rates for Suicide Attempt by Race or Ethnicity, 2016-2022[91]



The largest increase in emergency department outpatient hospitalization rates for suicide attempt was seen in American Indian or Alaskan Natives which increased 178.4 percent from 17.4 hospitalizations per 100,000 population in 2016 to 48.5 hospitalizations per 100,000 population in 2022.

The next largest increase in emergency department outpatient hospitalizations for suicide attempt was among Asian or Pacific Islanders who also had the lowest rates of emergency department outpatient hospitalization for suicide attempt with a 27 percent increase from 18 hospitalizations per 100,000 population in 2016 to 22.9 hospitalization per 100,000 population in 2022.

Black or African Americans had a 23.2 percent increase in emergency department outpatient hospitalizations for suicide attempt from 78.8 hospitalizations per 100,000 population in 2016 to 97.1 hospitalizations per 100,000 population in 2022.

The Hispanic population saw a similar increase in emergency department outpatient hospitalizations for suicide attempt with an increase of 25.8 percent from 45.7 hospitalizations per 100,000 population in 2016 to 57.6 hospitalizations per 100,000 population in 2022.

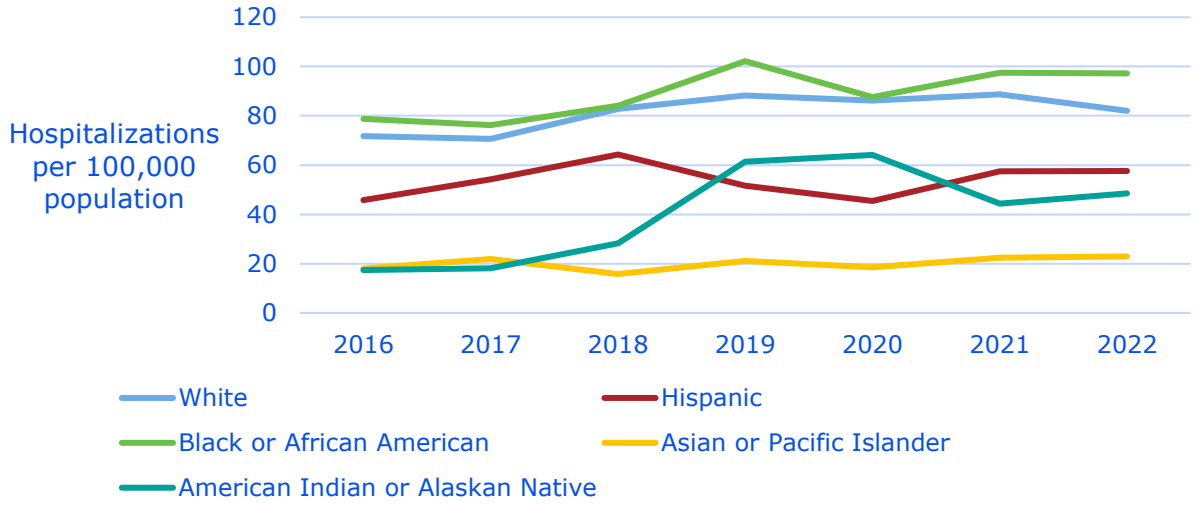
The smallest increase in emergency department outpatient hospitalization rates for suicide attempt was seen in whites who saw a 14.3 percent increase from 71.7

[91] THCIC, Department of State Health Services

hospitalizations per 100,000 population in 2016 to 82 hospitalizations per 100,000 population in 2022.

Figure 60 outlines emergency department outpatient hospitalizations in Texas for suicide attempt by Race or Ethnicity for 2016-2022.

Figure 60. Texas Emergency Department Outpatient Hospitalizations for Suicide Attempt by Race or Ethnicity, 2016-2022[92]



Local Mental and Behavioral Health Authorities[93]

The rate of outpatient emergency room hospitalizations varies across the state. The counties in the Helen Farabee Center LSA had the highest rates, followed by the counties in the Community Healthcore and Betty Hardwick Center LSAs. About one third of the LMHA and LBHA LSAs saw a decrease over the five years of data, while the rest saw an increase. Once again, for ease of graphing and explanation, the LMHA and LBHA LSAs will be broken out by SCI Regions.

SCI Region One

The largest increase in the rate of outpatient emergency room hospitalizations was in the counties in the Texana Center LSA with a 45.8 percent increase from 35.7 hospitalizations per 100,000 population in 2016 to 52.1 hospitalizations per 100,000 population in 2022. Harris County in the Harris Center for Mental Health and IDD LSA had the next largest increase of 32.6 percent from 45.3

[92] THCIC, Department of State Health Services
[93] See Table A42, Table A43, Table A44, Table A45, Table A46, Table A47, Table A48, and Table A49 in 0

hospitalizations per 100,000 population in 2016 to 60 hospitalizations per 100,000 population in 2022. The counties in the Tri-County Behavioral Healthcare LSA experienced a 32 percent increase rising from 65.7 hospitalizations per 100,000 population in 2016 to 86.7 hospitalizations per 100,000 population in 2022. The counties in the Gulf Bend Center LSA experienced 20.4 percent increases, rising from 81.2 hospitalizations per 100,000 population in 2016 to 97.8 hospitalizations per 100,000 population in 2022. The counties in the Burke Center LSA rose 15.3 percent, from 78.4 hospitalizations per 100,000 population in 2016 to 90.3 hospitalizations per 100,000 population in 2022. The counties in the Texoma Community Center and Spindletop Center LSAs experienced a 9.4 and an 8.4 percent increase with rates increasing from 72.4 hospitalizations per 100,000 population in 2016 to 79.3 hospitalizations per 100,000 population in 2022 and from 53.9 hospitalizations per 100,000 population in 2016 to 58.4 hospitalizations per 100,000 population in 2022, respectively.

The counties in the Community Healthcore and MHMR Authority of Brazos Valley LSAs experienced the highest decreases in SCI Region One with decreases of 14.3 percent and 9.2 percent, respectively. The counties in the Community Healthcore LSA saw rates decrease from 100.6 hospitalizations per 100,000 population in 2016 to 86.3 hospitalizations per 100,000 population in 2022. The counties in the MHMR Authority of Brazos Valley LSA decreased from 73.1 hospitalizations per 100,000 population in 2016 to 66.4 hospitalizations per 100,000 population in 2022. The counties in the Gulf Coast Center saw the smallest change, with a decrease of 0.5 percent from 60.4 hospitalizations per 100,000 population in 2016 to 60.1 hospitalizations per 100,000 population in 2022.

Figure 61 outlines the outpatient emergency department hospitalization rates for suicide attempts by LMHA LSA in SCI Region One for 2016-2022.

Figure 61. Outpatient Emergency Department Hospitalization for Suicide Attempt by LMHA LSA in SCI Region One, Texas 2016-2022[94]

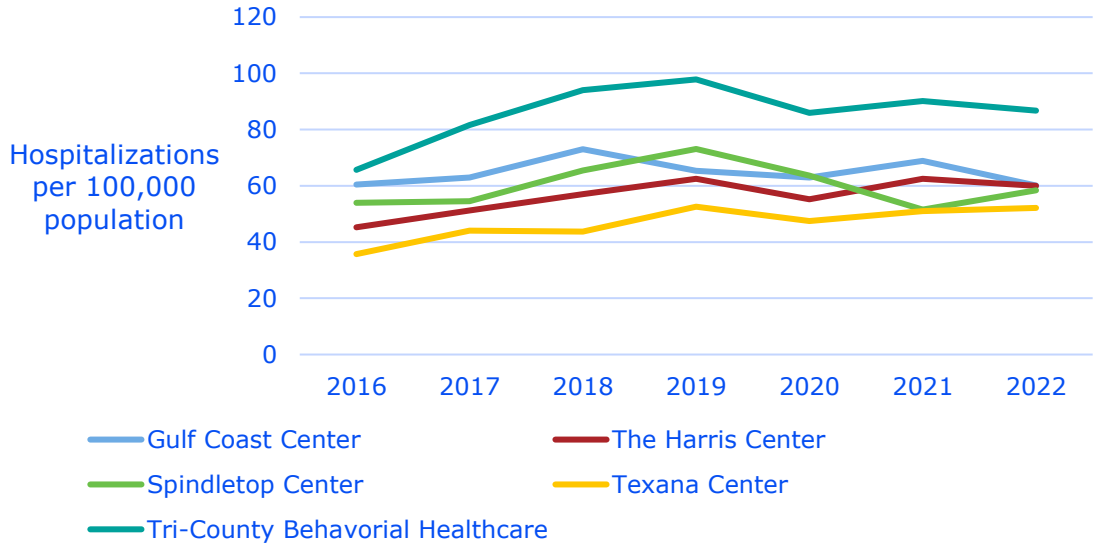
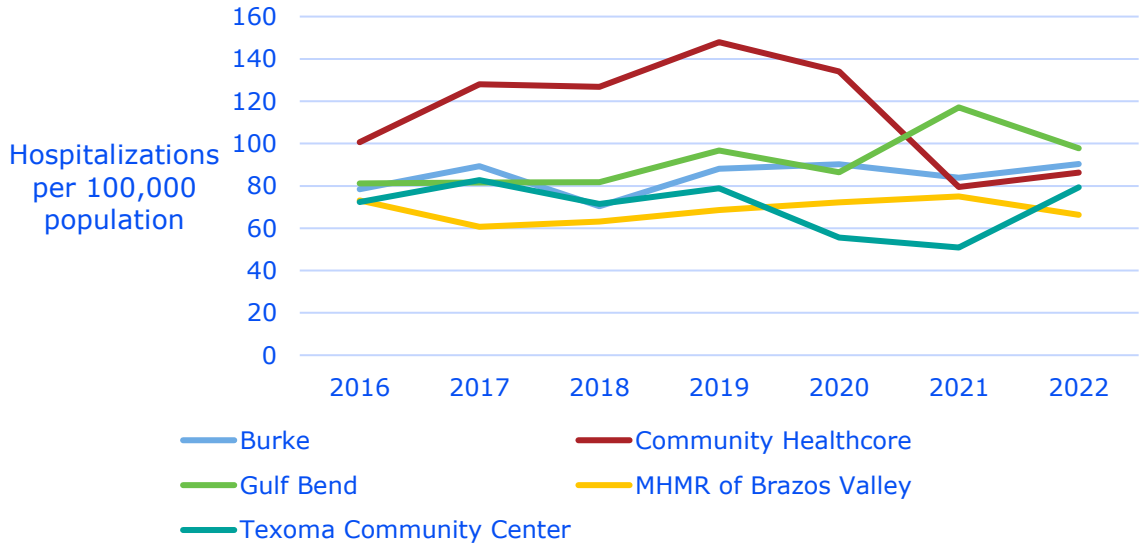


Figure 62 outlines the outpatient emergency department hospitalization rates for suicide attempts by LMHA LSAs in SCI Region One for 2016-2022.

Figure 62. Outpatient Emergency Department Hospitalization for Suicide Attempt by LMHA LSAs in SCI Region One, Texas 2016-2022[95]



[94] THCIC, Department of State Health Services
[95] THCIC, Department of State Health Services

SCI Region Two

The largest increase was in the counties in the Center for Life Resources LSA with a 69 percent increase from 69.8 hospitalizations per 100,000 population in 2016 to 117.9 hospitalizations per 100,000 population in 2022. The second largest increase was in the counties in the Heart of Texas Region MHMR with a 50.8 percent increase from 58.6 hospitalizations per 100,000 population in 2016 to 88.5 hospitalizations per 100,000 population in 2022. The counties in the Andrews Center had the next largest increase of 32.4 percent from 60.2 hospitalizations per 100,000 population in 2016 to 79.7 hospitalizations per 100,000 population in 2022. Bexar County in the Center for Health Care Services LSA experienced a 24.5 percent increase rising from 64.1 hospitalizations per 100,000 population in 2016 to 79.9 hospitalizations per 100,000 population in 2022. The counties in the Bluebonnet Trails Community Services LSA experienced a 17.5 percent increase, rising from 60.1 hospitalizations per 100,000 population in 2016 to 70.6 hospitalizations per 100,000 population in 2022. The counties in the Hill Country Mental Health and Developmental Disabilities Centers LSA saw rates increase 2.4 percent, from 73.8 hospitalizations per 100,000 population in 2016 to 75.5 hospitalizations per 100,000 population in 2022.

The counties in the Central Counties Services LSA experienced an 18.5 percent decrease, from 121.7 hospitalizations per 100,000 population in 2016 to 99.2 hospitalizations per 100,000 population in 2022. Travis County in the Integral Care LSA decreased 12.9 percent, from 69.2 hospitalizations per 100,000 population in 2016 to 60.3 hospitalizations per 100,000 population in 2022. The counties in the MHMR Services for the Concho Valley LSA experienced a 9 percent decrease with rates decreasing from 51.4 hospitalizations per 100,000 population in 2016 to 46.8 hospitalizations per 100,000 population in 2022. The counties in the Betty Hardwick Center LSA decreased 0.3 percent, from 117.1 hospitalizations per 100,000 population in 2016 to 116.7 hospitalizations per 100,000 population in 2022.

Figure 63 outlines the outpatient emergency department hospitalization rates for suicide attempts by LMHA LSAs in SCI Region Two for 2016-2022.

Figure 63. Outpatient Emergency Department Hospitalization for Suicide Attempt by LMHA LSAs in SCI Region Two, Texas 2016-2022[96]

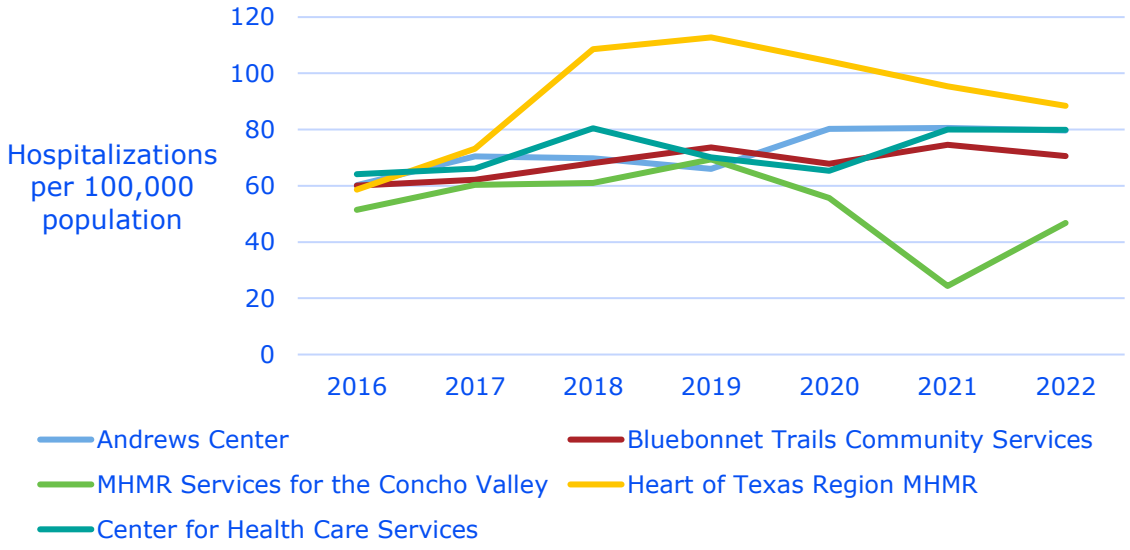
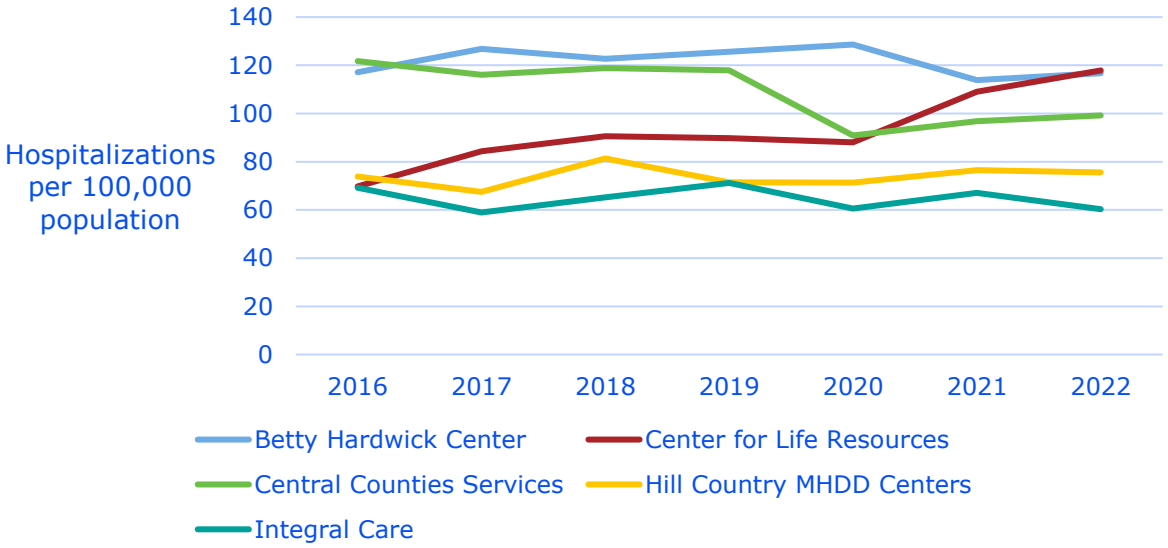


Figure 64 outlines the outpatient emergency department hospitalization rates for suicide attempts by LMHA LSAs in SCI Region Two for 2016-2022.

[96] THCIC, Department of State Health Services

Figure 64. Outpatient Emergency Department Hospitalization for Suicide Attempt by LMHA LSAs in SCI Region Two, Texas 2016-2022[97]



SCI Region Three

The largest increase in rate of outpatient emergency department hospitalizations was in Tarrant County in the My Health My Resources of Tarrant County LSA with a 39.5 percent increase from 68.1 hospitalizations per 100,000 population in 2016 to 95 hospitalizations per 100,000 population in 2022. The counties in the LifePath Systems LSA had the next largest increase of 28 percent from 51.8 hospitalizations per 100,000 population in 2016 to 66.4 hospitalizations per 100,000 population in 2022. The counties in the Central Plains Center LSA experienced a 21.1 percent increase rising from 65.8 hospitalizations per 100,000 population in 2016 to 79.7 hospitalizations per 100,000 population in 2022. The counties in the Lakes Regional Community Center LSA experienced a 14.4 percent increase with rates increasing from 64.3 hospitalizations per 100,000 population in 2016 to 73.6 hospitalizations per 100,000 population in 2022.

The counties in the Texas Panhandle Center LSA experienced the largest decrease of 20.6 percent, falling from 59.2 hospitalizations per 100,000 population in 2016 to 47 hospitalizations per 100,000 population in 2022. The counties in the Pecan Valley Centers for Behavioral and Developmental Healthcare LSA fell 17.7 percent, from 74.5 hospitalizations per 100,000 population in 2016 to 61.3 hospitalizations per 100,000 population in 2022. The counties in the Helen Farabee Center and

[97] THCIC, Department of State Health Services

North Texas Behavioral Health Authority LSAs saw decreases of 8 percent and 9 percent, falling from 107.3 hospitalizations per 100,000 population in 2016 to 98.8 hospitalizations per 100,000 population in 2022 and falling from 73.7 hospitalizations per 100,000 population in 2016 to 67.1 hospitalizations per 100,000 population in 2022, respectively. Denton County in the Denton County MHMR LSA saw rates decrease 5.8 percent, from 67.1 hospitalizations per 100,000 population in 2016 to 63.2 hospitalizations per 100,000 population in 2022. The counties in the StarCare Specialty Health System LSA experienced a decrease of 3.1 percent, decreasing from 69.5 hospitalizations per 100,000 population in 2016 to 67.3 hospitalizations per 100,000 population in 2022.

Figure 65 outlines the outpatient emergency department hospitalization rates for suicide attempts by LMHA and LBHA LSAs in SCI Region Three for 2016-2022.

Figure 65. Outpatient Emergency Department Hospitalization for Suicide Attempt by LMHA and LBHA LSAs in SCI Region Three, Texas 2016-2022[98]

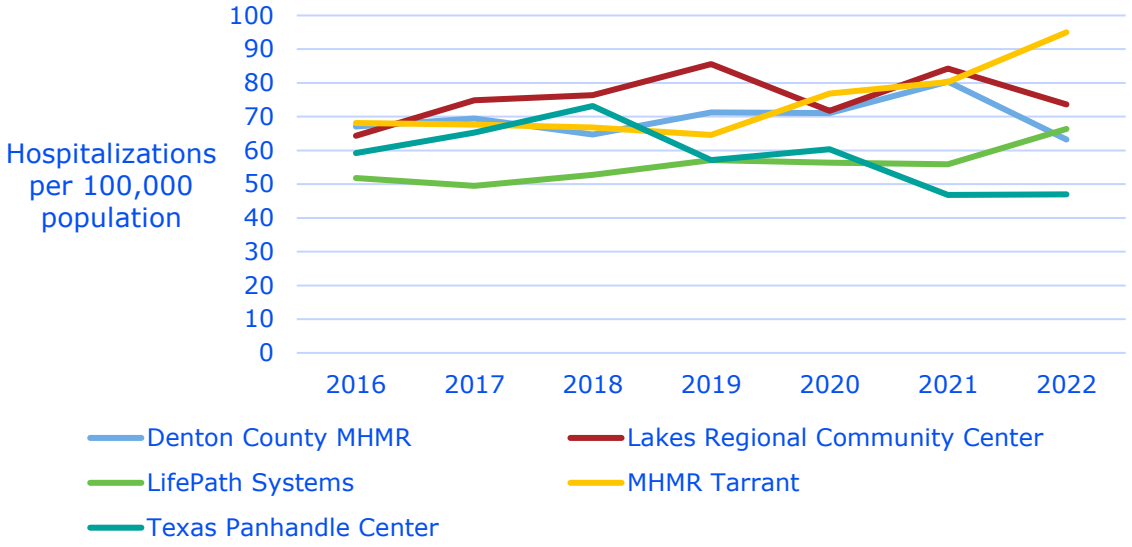
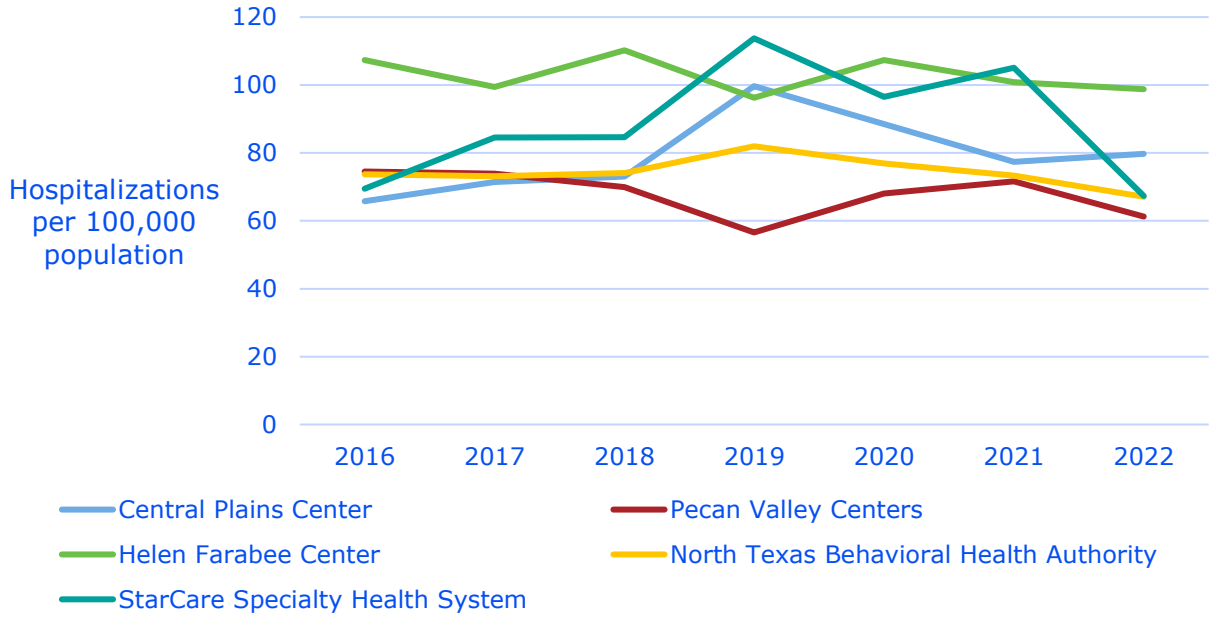


Figure 66 outlines the outpatient emergency department hospitalization rates for suicide attempts by LMHA and LBHA LSAs in SCI Region Three for 2016-2022.

[98] THCIC, Department of State Health Services

Figure 66. Outpatient Emergency Department Hospitalization for Suicide Attempt by LMHA and LBHA LSAs in SCI Region Three, Texas 2016-2022[99]



SCI Region Four

The largest increase in SCI Region Four was in Nueces County in the Behavioral Health Center of Nueces County LSA where the rate rose by 56.1 percent, from 64.5 hospitalizations per 100,000 population in 2016 to 100.7 hospitalizations per 100,000 population in 2022. The counties in the Permiacare and Emergence Health Network LSAs saw similar increases of 25.4 percent and 28.1 percent, rising from 58.4 hospitalizations per 100,000 population in 2016 to 73.2 hospitalizations per 100,000 population in 2022 and from 53.5 hospitalizations per 100,000 population in 2016 to 68.6 hospitalizations per 100,000 population in 2022, respectively. The next largest increase was in the counties in the Coastal Plains Community Center LSA, rising 17.8 percent, from 85.6 hospitalizations per 100,000 population in 2016 to 100.9 hospitalizations per 100,000 population in 2022. The counties in the Tropical Texas Behavioral Health LSA saw an increase of 12.7 percent, increasing from 46.2 hospitalizations per 100,000 population in 2016 to 52.1 hospitalizations per 100,000 population in 2022. The counties in the ACCESS LSA saw a 10.3 percent increase from 129.8 hospitalizations per 100,000 population in 2016 to 143.1 hospitalizations per 100,000 population in 2022. The counties in the Camino Real Community Services LSA saw an 8.8 percent increase from 67.1

[99] THCIC, Department of State Health Services

hospitalizations per 100,000 population in 2016 to 73 hospitalizations per 100,000 population in 2022. The counties in the Border Region Behavioral Health Center LSA saw the smallest increase of 2.2 percent, from 59.8 hospitalizations per 100,000 population in 2016 to 61.1 hospitalizations per 100,000 population in 2022.

The only decrease was seen in the counties in the West Texas Centers LSA, with a decrease of 14.6 percent, from 97.6 hospitalizations per 100,000 population in 2016 to 83.3 hospitalizations per 100,000 population in 2022.

Figure 67 outlines the outpatient emergency department hospitalization rates for suicide attempts by LMHA and LBHA LSAs in SCI Region Four for 2016-2022.

Figure 67. Outpatient Emergency Department Hospitalization for Suicide Attempt by LMHA and LBHA LSAs in SCI Region Four, Texas 2016-2022[100]

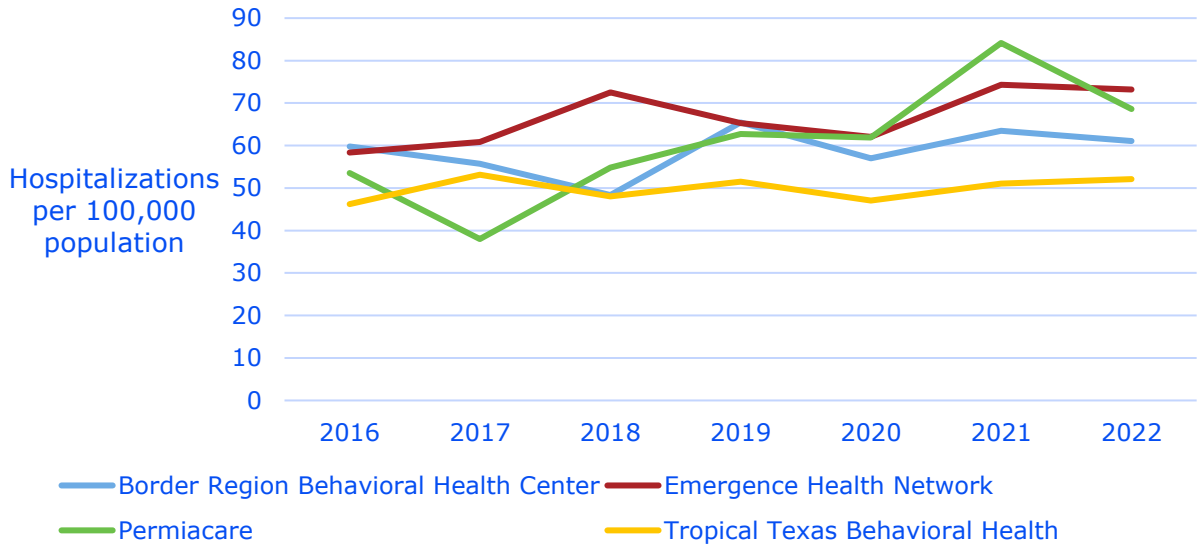
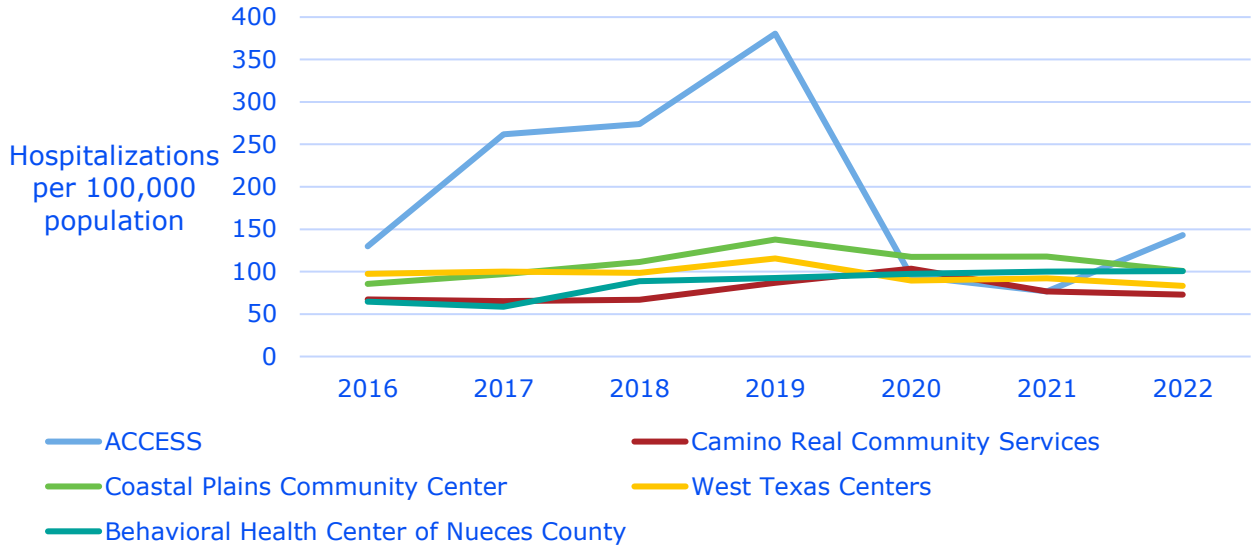


Figure 68 outlines the outpatient emergency department hospitalization rates for suicide attempts by LMHAs and LBHAs in SCI Region Four for 2016-2022.

[100] THCIC, Department of State Health Services

Figure 68. Outpatient Emergency Department Hospitalization for Suicide Attempt by LMHA and LBHA LSAs in SCI Region Four, Texas 2016-2022[101]



Snapshot of Local Mental Health Authority and Local Behavioral Health Authority Local Service Areas

The following section provides maps of the suicide attempt outpatient emergency department hospitalization rate (per 100,000 population) for the LMHA and LBHA LSAs providing a snapshot in time to compare the rates across regions. The first map shows 2016 and the second shows the most recent available data, 2022.

In 2016, the highest rate of outpatient emergency department hospitalizations for suicide attempt was in the counties in the Helen Farabee Centers LSA with 201.3 hospitalizations per 100,000 population. The counties in the ACCESS and Central Counties Services LSAs had similarly high rates of 129.8 hospitalizations per 100,000 population and 121.7 hospitalizations per 100,000 population, respectively. The lowest rate was in El Paso County in the Emergence Health Network LSA with 14.8 hospitalizations per 100,000 population. The counties in the Tri-County Behavioral Healthcare LSA also had a low rate of 25 hospitalizations per 100,000 population. The state rate was 63.1 hospitalizations per 100,000 population.

[101] THCIC, Department of State Health Services

Figure 69 outlines the emergency department outpatient hospitalization rate for suicide attempts per 100,000 population by LMHA and LBHA LSAs in 2016.

ID Number	LMHA and LBHA LSAs
1	ACCESS
2	Andrews Center Behavioral Healthcare System
3	Betty Hardwick Center
4	Bluebonnet Trails Community Services
5	Border Region Behavioral Health Center
6	MHMR of Brazos Valley
7	Burke Center
8	Camino Real Community Services
9	The Center of Health Care Service
10	Center for Life Resources
11	Central Counties Services
12	Central Plains Services
13	Coastal Plains Community Center
14	Community Healthcore
15	MHMR of Concho Valley
16	Denton County
17	Emergence Health Network
18	Gulf Bend Center
19	Gulf Coast Center
20	The Harris Center for Mental Health and IDD
21	Heart of Texas
22	Helen Farabee
23	Hill Country Centers
24	Integral Care
25	Lakes Regional
26	Lifepath Systems
27	North Texas Behavioral Health Authority
28	Nueces Center
29	Pecan Valley Centers
30	PermiaCare
31	Spindletop Center
32	StarCare
33	Tarrant County
34	Texana Center
35	Texas Panhandle Centers
36	Texoma Community Center
37	Tri-County Behavioral Health

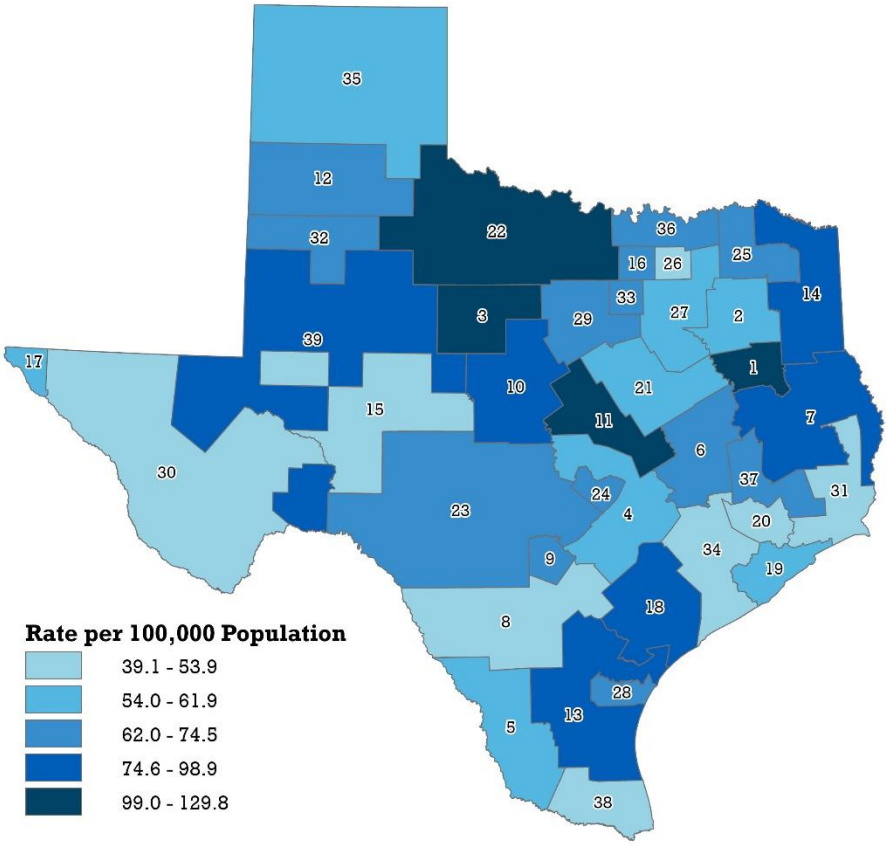
ID Number	LMHA and LBHA LSAs
38	Tropical Texas Behavioral Health
39	West Texas Centers

Figure 69. Rates of Outpatient Emergency Department Hospitalization for Suicide Attempt per 100,000 population by LMHA and LBHA LSAs, Texas 2016[102] [103]

[102] THCIC, Department of State Health Services

[103] The data reflects persons residing in the geographic LSAs of the LMHA AND LBHA.

2016 Outpatient Hospitalization Rate for Suicide Attempts by LMHA/LBHA LSA



2016 Texas statewide outpatient hospitalization rate: 63.1

Data Source:
Texas Outpatient Hospital Discharge Public Use Data File,
Texas Department of State Health Services

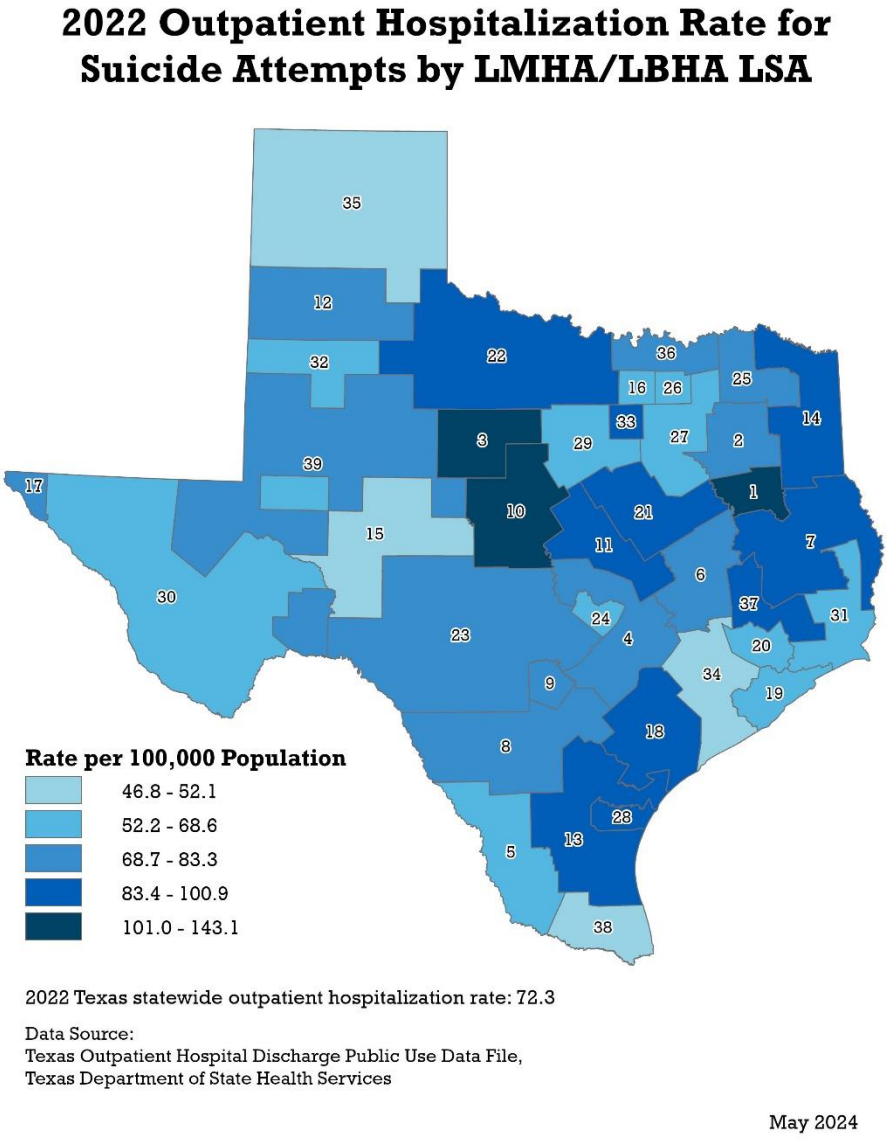
May 2024

In 2022, the highest rate of outpatient emergency department hospitalizations for suicide attempt was in the counties in the ACCESS LSA with 143.1 hospitalizations per 100,000 population. The counties in the Center for Life Resources and Betty Hardwick Center LSAs had the next highest rates of 117.9 hospitalizations per 100,000 population and 116.7 hospitalizations per 100,000 population, respectively. The lowest rate was in the counties in the MHMR Services for the Concho Valley and Texas Panhandle Centers LSAs with emergency department outpatient hospitalization rates of 46.8 hospitalizations per 100,000 population and 47 hospitalizations per 100,000 population, respectively. The counties in the Tropical Texas Behavioral Health and Texana Center LSAs also had a low rate of

52.1 hospitalizations per 100,000 population. The state rate was 72.3 hospitalizations per 100,000 population.

Figure 70 outlines the emergency department outpatient hospitalization rate for suicide attempts per 100,000 population by LMHA and LBHA LSA in 2022.

Figure 70. Rates of Outpatient Emergency Department Hospitalization for Suicide Attempt per 100,000 population by LMHA and LBHA LSA, Texas 2022[104] [105]



[104] THCIC, Department of State Health Services

[105] The data reflects persons residing in the geographic LSAs of the LMHA AND LBHA.

Limitations of Emergency Department Outpatient Data

The Emergency Department Outpatient dataset only includes emergency departments that are physically connected to hospitals. Due to this limitation, this analysis does not include visits to freestanding emergency rooms.

Like the Hospital Discharge Dataset, the Emergency Room Outpatient Public Use Data File is suppressed in multiple ways to protect the confidentiality of patients, beyond excluding all personal health identifiers. If the diagnosis codes include drug, alcohol, or HIV, then the sex of the patient is suppressed. Since about half of the suicide admissions data had sex suppressed, it was not possible to include analysis based on sex in this report.

Behavioral Risk Factor Surveillance System

The Texas Behavioral Risk Factor Surveillance System (BRFSS) is a random digit telephone survey of non-institutionalized adults throughout the state of Texas that collects data about residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. It is part of a system of surveys coordinated by the CDC beginning in 1984 that are conducted in all fifty states, the District of Columbia, and three U.S. territories. Nationwide, BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world. The Texas BRFSS interviews about 10,000 people each year. Surveys are conducted in English and Spanish and last about 25-30 minutes. The results are weighted on 14 different variables, to match the true population of the state of Texas. Therefore, the results are representative of all adults living in Texas, not just those who answered the survey. More than half of respondents receive their call on a cell phone. The survey was answered by 60 percent cell phone and 40 percent landline in 2016 and 2017 and increased to 70 percent cell phone and 30 percent landline in 2018.

The Texas BRFSS includes questions about chronic disease prevalence, risk behaviors, demographics, health care utilization, and preventative health behaviors. Four questions concerning suicide were added to the Texas BRFSS in 2016, 2017, and 2018. The questions ask 1) if the respondent seriously considered attempting suicide in the past 12 months, 2) attempted suicide in the past 12 months, 3) how many times (if they said yes to the previous question), and 4) if any suicide attempt in the past 12 months required medical attention (only asked if they answered yes to the second question).

Suicide Attempt

The results from three years of BRFSS data are insufficient to analyze suicide attempt in adults in Texas. The questions regarding suicide were specifically placed at the end of the survey due to being sensitive in nature.

As a result, not all survey respondents answered those questions as respondents often drop out of the survey before its completion due to its length. Even with the extensive sample of 10,000 per year, a very small number of individuals responded that they had attempted suicide in the past 12 months. The overall prevalence of attempting suicide in the past 12 months was 0.6 percent.

Given the rarity of the event, rates by demographics or regions could not be calculated with any accuracy. For example, there was a calculated rate for whites, but the rates for Black or African Americans, Hispanics, and others were all unstable due to the low prevalence rates. The BRFSS team estimates it will take at least five years of data to make stable estimates based on demographics and this data collection is still underway.

Suicidal Ideation[106]

Suicidal ideation was reported to have occurred slightly more often and is thus easier to analyze. The highest rates of suicidal ideation were in young adults, 18-24 years old. Males and females had essentially the same rates and rates across race and ethnicity (where they could be calculated) were similar.

In the figures below, the blue lines represent confidence interval of the survey data. A confidence interval is a range of values that describes the certainty of an estimate based on survey results. The BRFSS is a random sample and therefore, confidence intervals are used to account for any potential sampling error.

Figure 71 outlines suicidal ideation in the past 12 months by young adults and adults for 2016-2018.

[106] See Table A51, Table A52, and Table A53 in 0

Figure 71. Suicidal Ideation in the Past 12 Months by Young Adult and Adult, Texas BRFSS, 2016-2018[107]

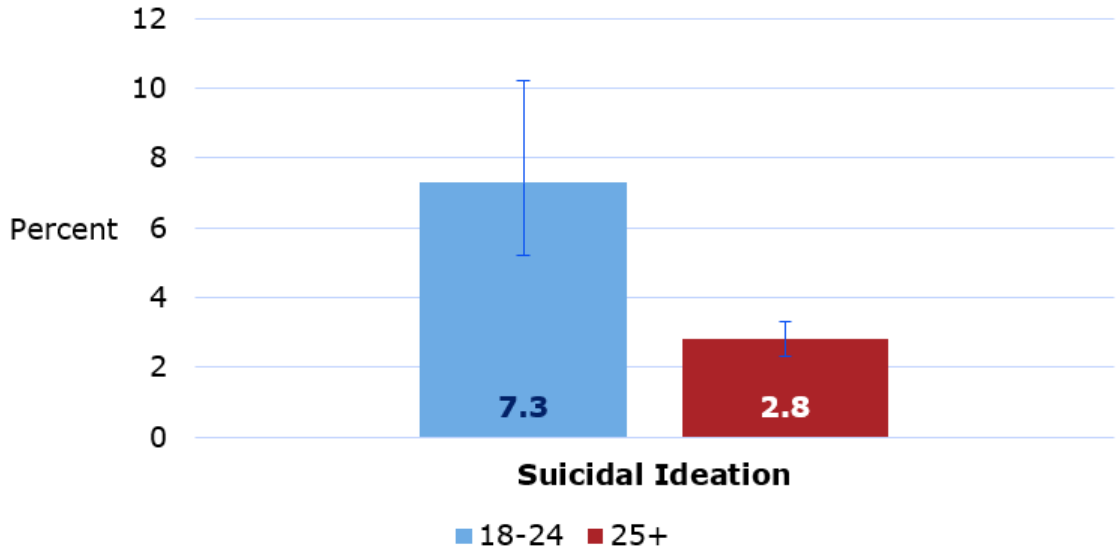


Figure 72 outlines suicidal ideation in the past 12 months by sex for 2016-2018.

[107] Behavior Risk Factor Surveillance System Data, Center for Health Statistics, Department of State Health Services

Figure 72. Suicidal Ideation in the Past 12 Months by Sex, Texas BRFSS, 2016-2018[33]

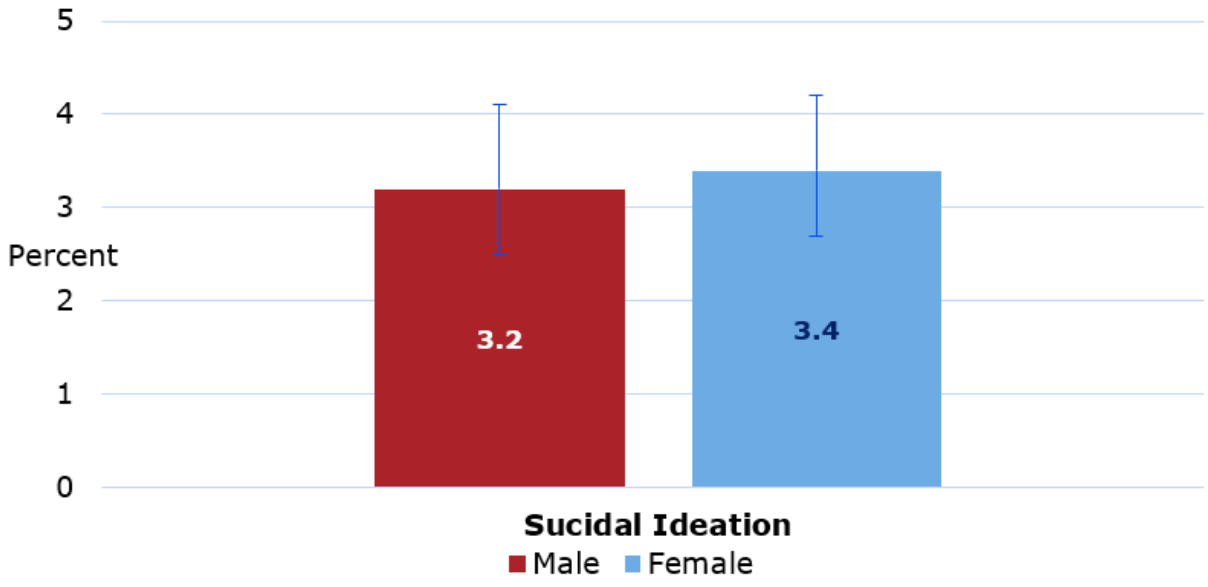
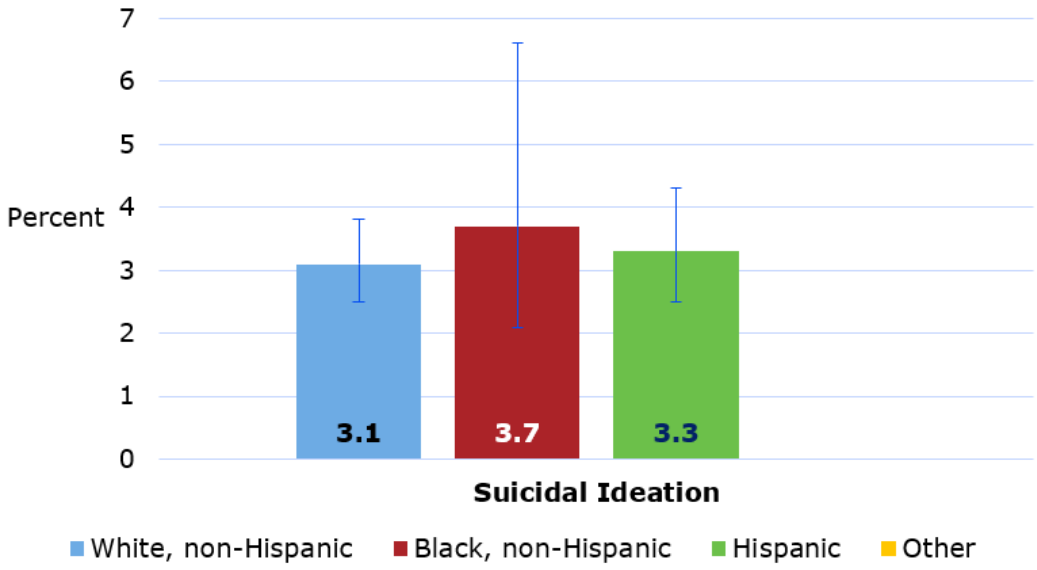


Figure 73 outlines suicidal ideation in the past 12 months by race and ethnicity for 2016-2018.

Figure 73. Suicidal Ideation in the Past 12 Months by Race and Ethnicity, Texas BRFSS, 2016-2018[108][109]



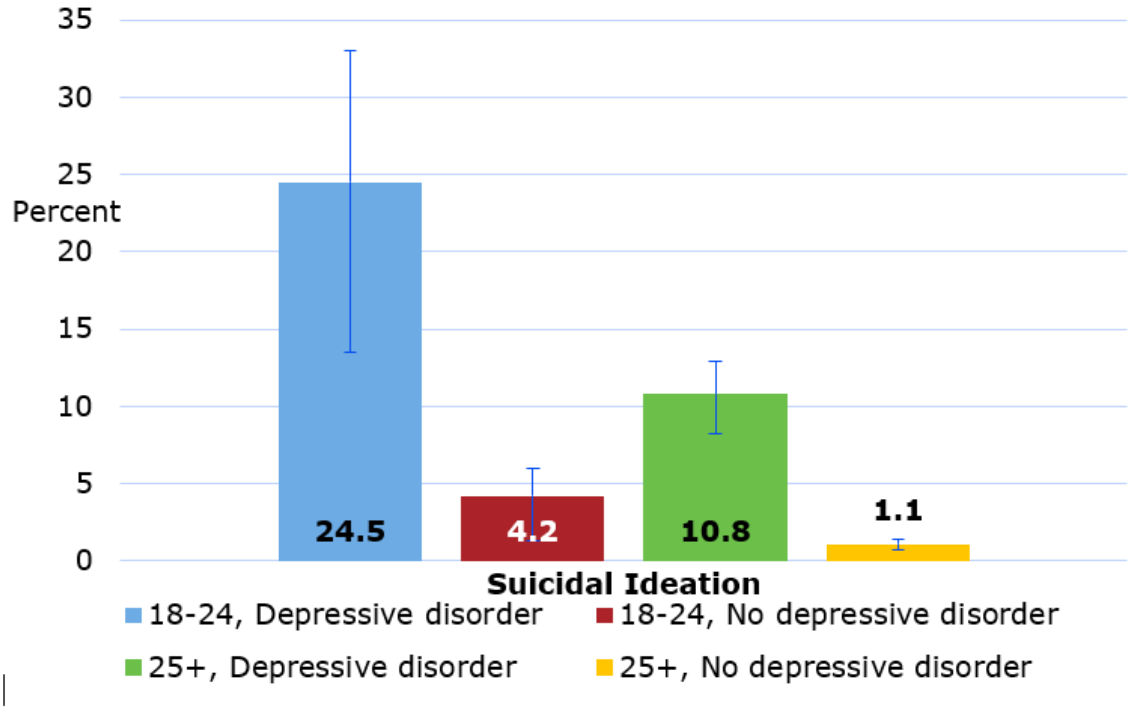
Three factors were found to increase the risk of having suicidal ideation in the past 12 months for both the 18-24-year-old age group and the over 25-year-old age group. The first factor was the individual having been diagnosed with a depressive disorder. The second factor found to increase the risk of having suicidal ideation in the past 12 months for both the 18-24-year-old age group and the over 25-year-old age group was sexual orientation. The third risk factor is having a disability.

Young adults were about six times as likely to have suicidal ideation if they had been diagnosed with a depressive disorder and adults were about ten times as likely.[xii]

Figure 74 outlines suicidal ideation in the past 12 months by age group and depressive disorder status for 2016-2018.

[108] Figure 74 includes an "other" category but there is no corresponding bar for other in the graph. This is because the numbers were too small to calculate a stable estimate.
[109] Behavior Risk Factor Surveillance System Data, Center for Health Statistics, Department of State Health Services

Figure 74. Suicidal Ideation in the Past 12 Months by Age Group and Depressive Disorder Status, Texas BRFSS 2016-2018[110]



The third risk factor is having a disability. Disability status in the BRFSS is based on a series of six questions asking about the respondents' ability to do certain activities. The questions ask if the respondent: is deaf or has serious difficulty hearing; has difficulty seeing even with corrective lenses; has serious difficulty concentrating, remembering or making decisions due to a physical, mental, or emotional condition; has serious difficulty walking or climbing stairs; has difficulty dressing or bathing; or has difficulty completing errands alone such as shopping or visiting a doctor's office due to a physical, mental, or emotional condition. If the respondent answers yes to any of these questions, they are considered to have a disability for the purposes of analysis.

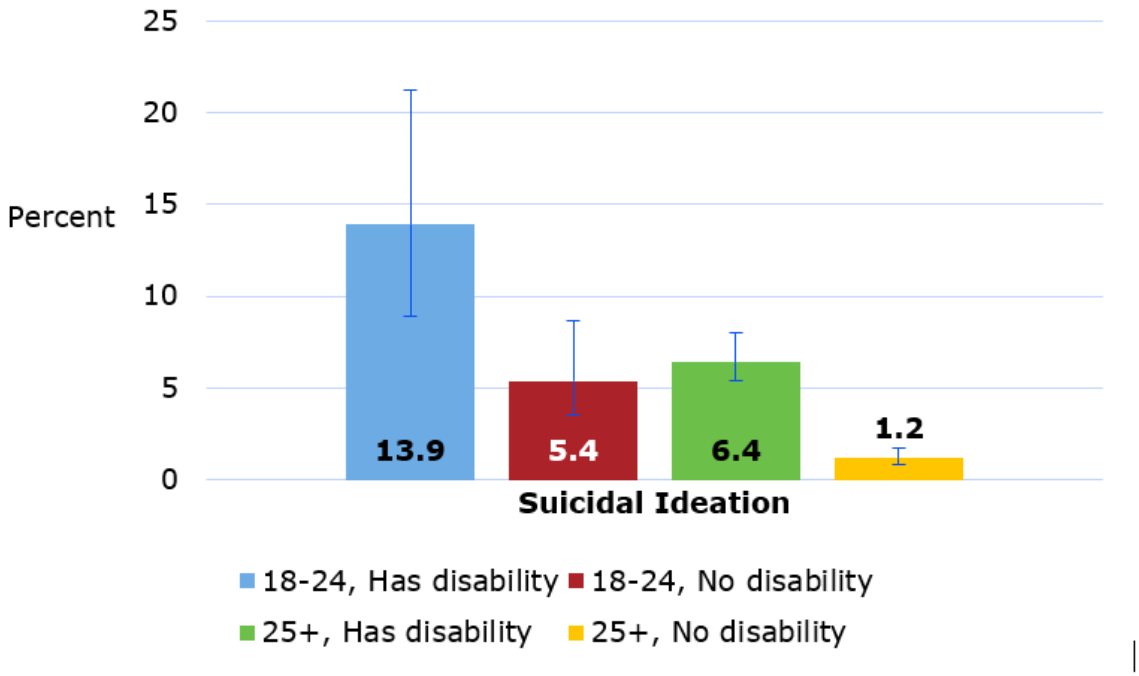
Among the 18-24-year-old age group, individuals who responded yes to at least one of the questions regarding disability status were two and a half times as likely

[110] Behavior Risk Factor Surveillance System Data, Center for Health Statistics, Department of State Health Services

to have also had suicidal ideation. In the 25 years and older age group, these individuals were more than five times as likely to have suicidal ideation.[xiii]

Figure 76 outlines suicidal ideation in the past 12 months by age group and disability status for 2016-2018.

Figure 76. Suicidal Ideation in the Past 12 Months by Age Group and Disability Status, Texas BRFSS, 2016-2018[111]



Limitations of Behavioral Risk Factor Surveillance System (BRFSS)

The relative rarity of suicide attempt among most adults makes it difficult to estimate rates even in a large-scale telephone survey like the BRFSS. There is also some consideration that individuals who have attempted suicide may have more difficulty reporting their suicidal thoughts, or ideation, on a telephone interview with a live person than on an anonymous written survey instrument. As there is distinctively more suicidal ideation among the younger population, it may be appropriate to assume that there are also more suicide attempts among the younger population. This is considered a limitation because the survey is well responded to by older adults but there is difficulty obtaining responses from young

[111] Behavior Risk Factor Surveillance System Data, Center for Health Statistics, Department of State Health Services

adults. While the weighting of the survey data fixes that issue for most areas, it would not help with the low number of respondents who admit to attempting suicide in the past 12 months.

This section has not been updated since the last version of this report. Collection of five years of data from the Texas BRFSS is currently underway and should be available in late 2025.

Youth Risk Behavior Survey

The Texas Youth Risk Behavior Survey (YRBS) is a biennial survey of students in randomly selected classrooms in randomly selected high schools conducted in odd-numbered years. It monitors health-related behaviors that contribute to the leading causes of morbidity and mortality in adolescence and adulthood.

The YRBS asks five questions concerning suicide. All questions ask about the period of the past 12 months. The first question asks if the student has been sad or depressed for at least two weeks such that they discontinued their usual activities. The next two questions ask about suicidal ideation and if the student made a plan to attempt suicide. The last questions ask if the student has attempted suicide, if so, how many times, and if medical attention was required for any of the attempts.

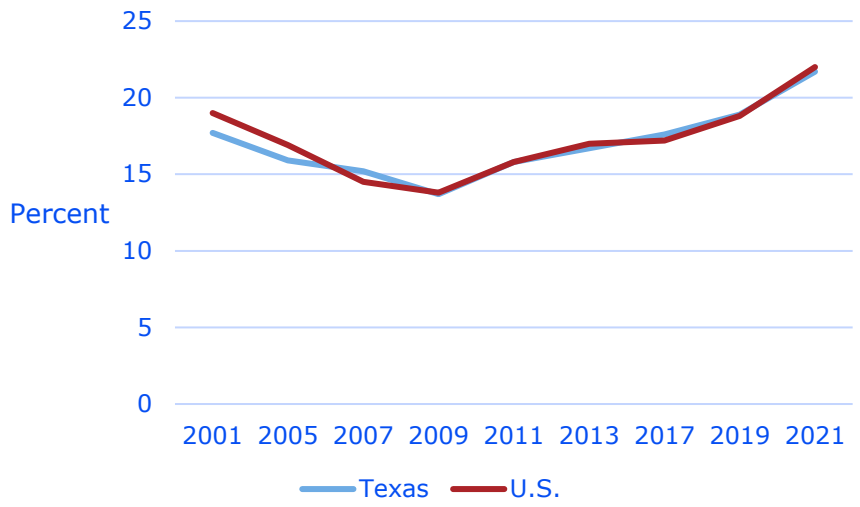
Suicidal Ideation[112]

The rate of suicidal ideation, or seriously considering attempting suicide, among Texas high school students is similar to that of students nationwide. The rate has remained the same, statistically, over the past 20 years. At the time of this report, 2023 data for Texas and the nation had not been released.

Figure 77 outlines the percentage of Texas and U.S. high school students who seriously considered attempting suicide in the past 12 months for 2001-2021.

[112] See Table A54 in 0

Figure 77. High School Students Who Seriously Considered Suicide in the Past 12 Months, Texas and the U.S., YRBS 2001-2021[113]



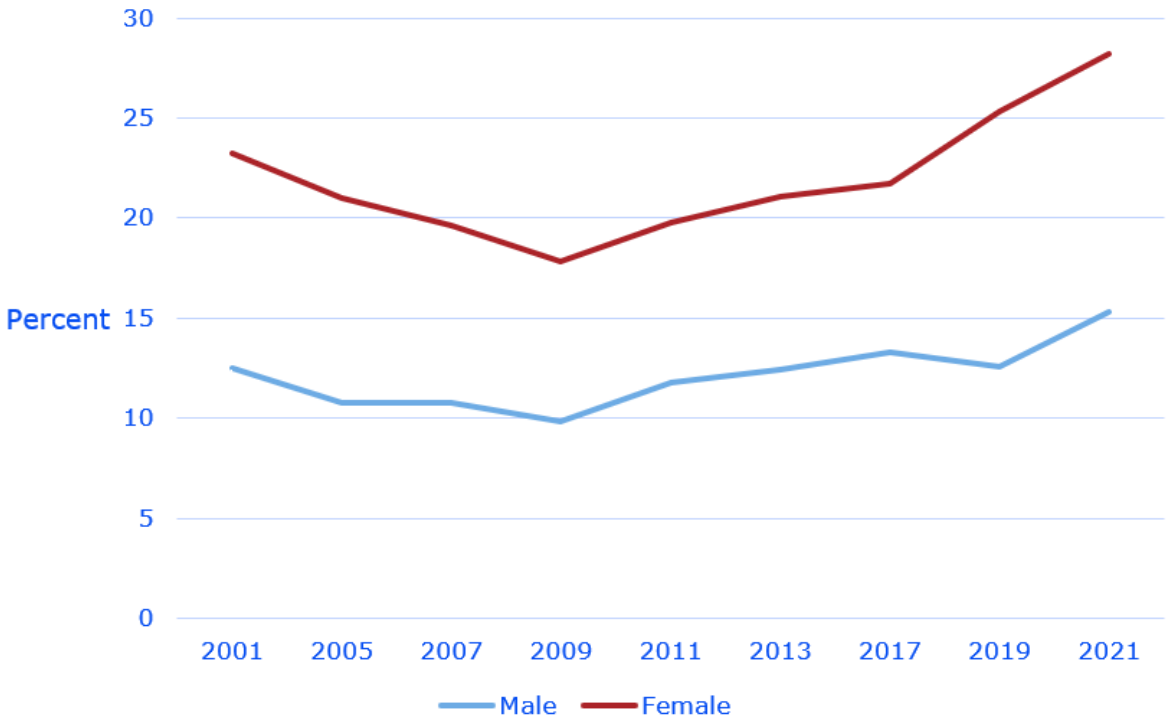
Sex[114]

Females are nearly twice as likely as males to seriously consider suicide. The net change in rates from 2001-2019 is different, with the rate for females increasing by 21.6 percent, from 23.2 percent to 28.2 percent, and the rate for males increasing by 22.4 percent, from 12.5 percent to 15.3 percent.

Figure 78 outlines the percentage of Texas high school students who seriously considered suicide in the past 12 months by sex for 2001-2021.

[113] Centers for Disease Control and Prevention, 2001-2017 Youth Risk Behavior Survey Data, available at www.cdc.gov/yrbs
[114] See Table A55 in 0

Figure 78. Texas High School Students Who Seriously Considered Suicide in the Past 12 Months by Sex, Texas YRBS, 2001-2021[115]



Race and Ethnicity[116]

Suicidal ideation rates by race and ethnicity in the YRBS should be cautiously considered since the sample size can be small for Black or African Americans and other categories causing the differences to rarely be statistically significant. The rate for the other race category is high, but not statistically significant. Over the past 20 years there is a 9.9 percent increase in this group's rate, from 24.2 percent to 26.6 percent.

Hispanic rates are also higher than white rates during some years, but not others. There is a net increase of 3 percent in the rate of suicidal ideation among Hispanic students, from 19.9 percent to 20.5 percent.

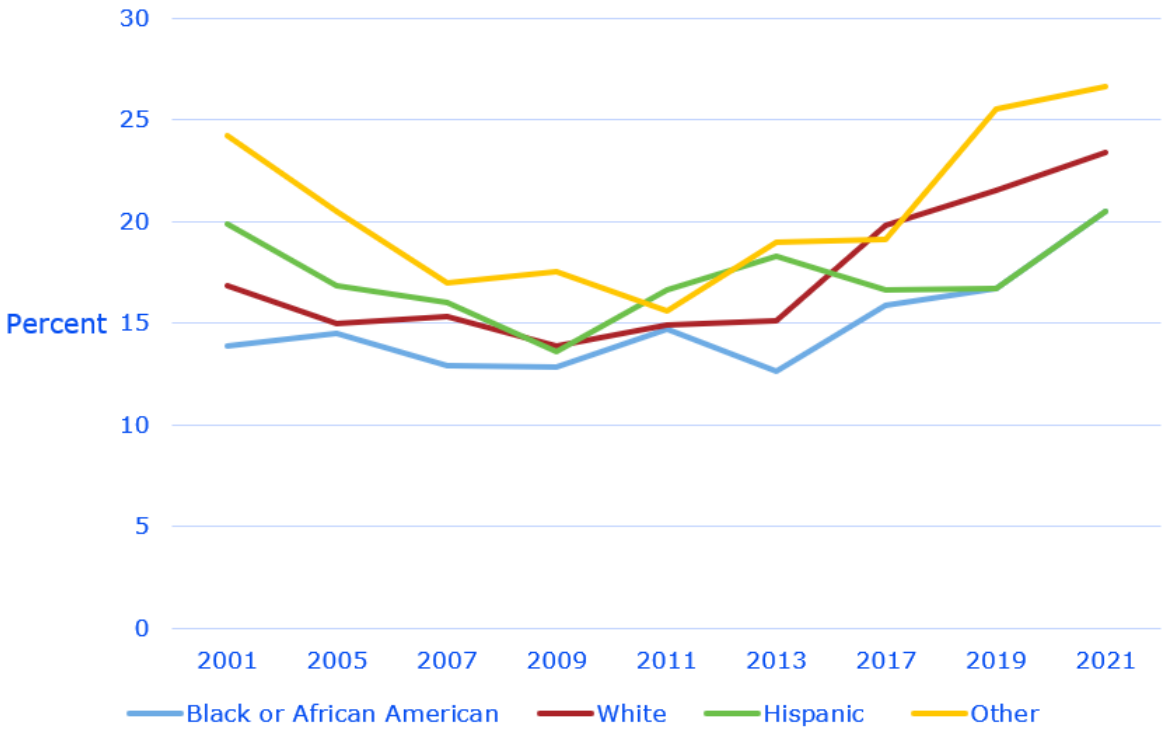
The largest increase was in Black or African American students where the rate increased 47.5 percent, from 13.9 percent to 20.5 percent. There was also an

[115] Youth Risk Behavior Survey Data, Center for Health Statistics, Department of State Health Services
[116] See Table A56 in 0

increase in the rates among white students of 39.3 percent, from 16.8 percent to 23.4 percent.

Figure 79 outlines the percentage of Texas high school students who seriously considered suicide in the past 12 months by race and ethnicity for 2001-2021.

Figure 79. Texas High School Students Who Seriously Considered Suicide in the Past 12 Months by Race and Ethnicity, Texas YRBS 2001-2021[117]



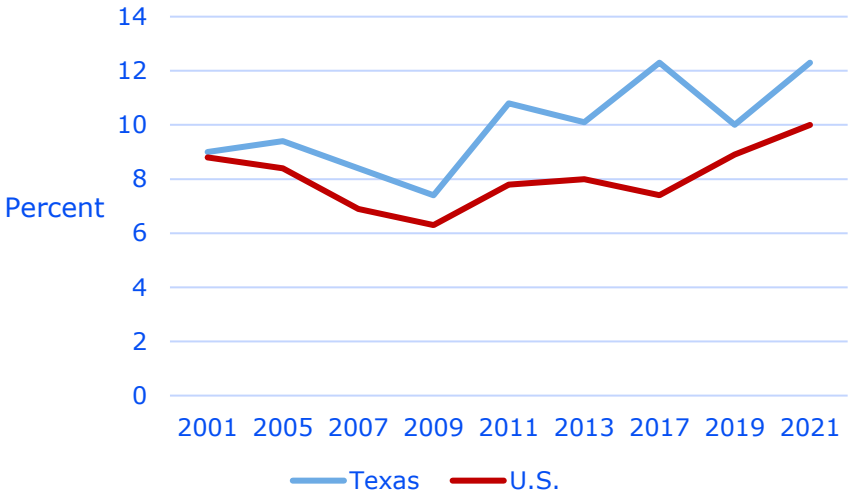
Suicide Attempt[118]

Texas' suicide attempt rate for high school students is higher than the national rate. The rate has increased 36.7 percent since Texas began measuring the rate in 2001, while the U.S. rate has stayed the same in the same period. The U.S. data for 2021 was not available.

[117] Youth Risk Behavior Survey Data, Center for Health Statistics, Department of State Health Services
[118] See Table A57 in 0

Figure 80 outlines the percentage of Texas and U.S. high school students who attempted suicide in the past 12 months for 2001-2021.

Figure 80. Texas High School Students Who Attempted Suicide in the Past 12 Months in Texas and the U.S., YRBS, 2001-2021[119]



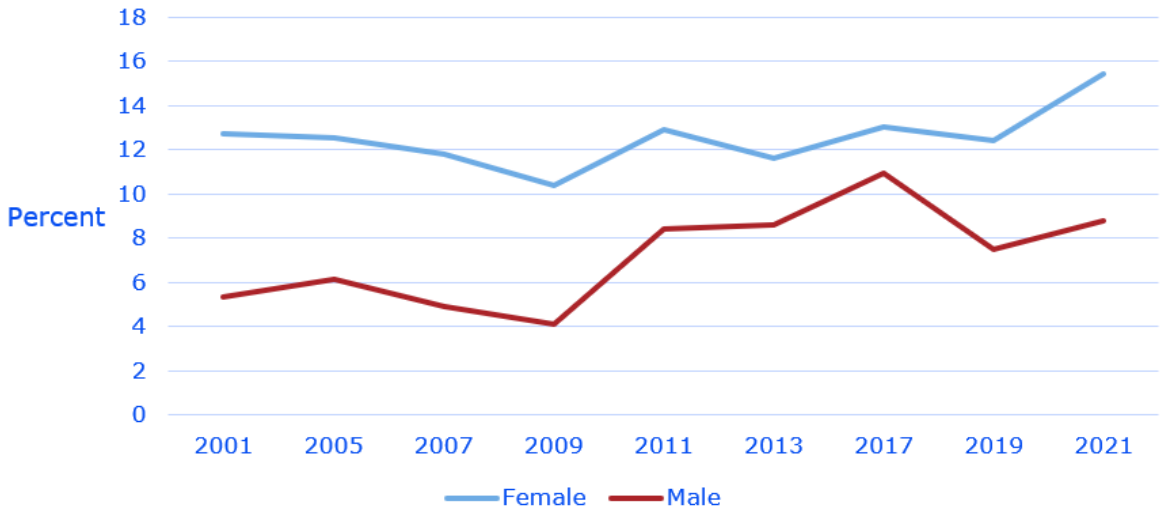
Sex[120]

The suicide attempt rate for high school students differs between males and females, with females having the higher rate of suicide attempt. The rate for females has increased by 21.3 percent from 12.7 percent to 15.4 percent, however, the rate for males has increased by 66 percent, from 5.3 percent to 8.8 percent.

Figure 81 outlines the percentage of Texas high school students who attempted suicide in the past 12 months by sex for 2001-2021.

[119] Centers for Disease Control and Prevention, 2017 Youth Risk Behavior Survey Data, available at www.cdc.gov/yrbs
[120] See Table A58 in 0

Figure 81. Texas High School Students Who Have Attempted Suicide in the Past 12 Months by Sex, Texas YRBS, 2001-2021[121]



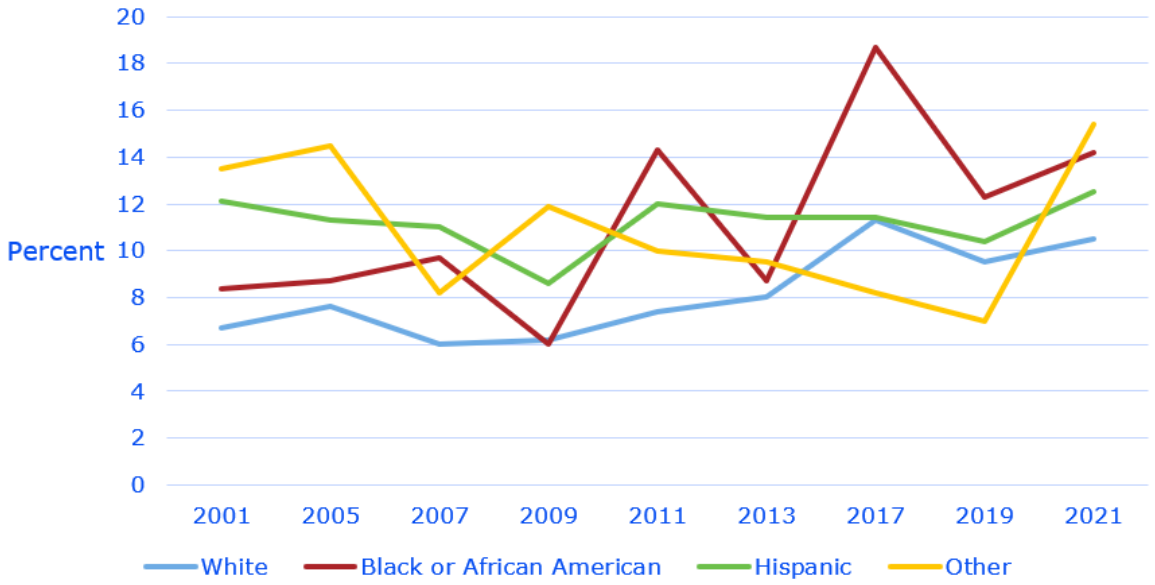
Race and Ethnicity[122]

Suicide attempt rates for high school students by race and ethnicity in the YRBS should be cautiously considered since the sample size can be small for Black or African American students and the other race categories causing the differences to rarely be statistically significant. Taking that into account, the rates of attempted suicide among white students appears to be the lowest of the race and ethnicity groupings; however, this rate still increased between 2001 and 2021 by 56.7 percent, from 6.7 percent to 10.5 percent. Black or African American students saw the greatest increase, with a 69 percent increase, from 8.4 percent to 14.2 percent. The rate among Hispanic students increased 3.3 percent, from 12.1 percent to 12.5 percent. The rate among other students was highly variable but increased overall by 14.1 percent, from 13.5 percent to 15.4 percent.

Figure 82 outlines the percentage of Texas high school students who attempted suicide in the past 12 months by race and ethnicity for 2001-2021.

[121] Youth Risk Behavior Survey Data, Center for Health Statistics, Department of State Health Services
[122] See Table A59 in 0

Figure 82. Texas High School Students Who Attempted Suicide in the Past 12 Months by Race and Ethnicity, Texas YRBS, 2001-2021[123]



Limitations of Youth Risk Behavior Survey Data

Because of the small numbers of students in some racial and ethnic subgroups who participate in any single Texas YRBS, the suicide ideation and attempt estimates may lack precision. The range around the estimate most likely to contain the true value is much broader than it would be with a larger sample size. The survey results are from self-reported data, but research suggests that adolescents are as likely to tell the truth as adults Many steps are taken to remove invalid responses, as well as to demonstrate the confidentiality and importance of the survey to participants. The YRBS is reliant on schools to participate to achieve a necessary participation rate for generalizable data. In 2015, Texas did not achieve the necessary school participation rate, so there is no data for that year. Similarly, the 2003 Texas data was insufficient and could not be used.

[123] Youth Risk Behavior Survey Data, Center for Health Statistics, Department of State Health Services

SBHCC Suicide Related Policies and Programs

Article IX, Section 10.04(f) requires the SBHCC to update the H.B. 3890 *Report on Suicide and Suicide Prevention in Texas*, which includes a list of all state statutes related to suicide and suicide prevention, intervention, and postvention. Appendix B lists the pertaining state statutes alphabetically by code area and then in numerical order. These statutes were collected through the work of Denise Brady, J.D., for the Texas Suicide Prevention Council in 2015 and, for more recent statutes, research on the legislative library website.

Included in this listing are many Education Code statutes relating to issues such as: school staff development; School Health Advisory Councils; health curriculum; and safe, supportive schools. The section on Health and Safety Code concerns establishment of a death review committee, Mental Health First Aid (MHFA), sharing of data, and early mental health intervention for youth. Further statutes include programs for veterans, standard for juvenile corrections officers, and child safety awareness.

Policies

As an update to the H.B. 3980 report, this section includes agency rules and policies related to suicide and suicide prevention, intervention, and postvention. Policies for state agencies were collected from member organizations of the SBHCC and updated for this report. The information is listed exactly as received.

Department of Family and Protective Services (DFPS)

Youth Connection Website

DFPS operates a Youth Connection website for older teens and youth who have aged out of the Texas foster care system. The content is governed by statute, rule, or policy and was determined to be useful information for the population. Suicide prevention content for individuals struggling with thoughts of suicide or who want to help someone struggling with thoughts of suicide includes the 988 Suicide and Crisis Line (988) and an option call, text or chat online. The chat, text or call is 24/7, free, and confidential support to help an individual or someone they know who is dealing with depression or thoughts of suicide. There are also special numbers for Spanish speakers: (1-888-628-9454) and the deaf: (1-800-799-4889). Content related to Suicide Prevention was added in September 2017. The Youth Connection Website is temporarily unavailable and under review.

DFPS Prevention and Early Intervention 2022-2026 Five Year Plan

As part of the preventing child maltreatment and fatalities, there is a component that will emphasize suicide prevention for teens. In its 2022-2026 Five Year Strategic Plan, one of the plan's seven objectives over the next five years includes "Utilizing Research to Inform the Most Effective Prevention Strategies". Under this objective one strategy is "Review and evaluate long-term and emerging trends through the Office of Child Safety, as well as current community and programmatic needs related to preventing child maltreatment, child maltreatment fatalities and near fatalities, to promote and support child safety at the local and state levels."

DFPS Prevention and Early Intervention (PEI), transferring to HHSC on 9/1/2024) will update its Suicide Prevention Toolkit that includes social media posts, resources, and graphics to help raise awareness about the importance of mental

health and suicide prevention. This toolkit is published and updated in September. PEI will convene a state-wide safety summit with stakeholders, community providers, and other state agencies to identify ways PEI can partner with communities to address child fatalities and near fatalities, including those caused by physical abuse, unsafe sleep practices, and preventable drownings. Utilizing a public health approach, PEI will focus resources on equipping communities with tools and resources specific to suicide prevention for teens. Additionally, ongoing safety trainings will be provided to increase awareness and safety practices both within communities as well as with providers and home visitors.

DFPS Policy 6420 Rights of Children and Youth in Foster Care

Policy number 6420 Rights of Children and Youth in Foster Care (CPS October 2017) includes a requirement that CPS staff must provide Form 2530 CPS Rights of Children and Youth in Foster Care to all children and youth in CPS foster care, as required by Social Security Act, Section 475A(b), 42 U.S.C. §675A(b) and Texas Family Code §263.008. It specifies that CPS staff must review Form 2530 with the child and the caregiver no later than 72 hours from the date when the child comes into foster care, or a placement change is made. Right #37 says that "As a child or youth in foster care I have the right to:

Be involved in decisions about my medical care:

1. I may consent to my own treatment in some cases if allowed by the health care provider. For example, the law allows me to consent to my own counseling for suicide prevention, drug or alcohol problems, or sexual, physical or emotional abuse, and I can agree to be treated for serious contagious or communicable diseases.
2. If I am pregnant and unmarried, I can agree to hospital, medical or surgical treatment, other than abortion, related to the pregnancy. If I have a child who is in my legal care, I can consent to all medical care for my child.
3. If I am 16 years old or older, I have the right to ask a judge to legally authorize me to make some or all of my own medical decisions, such as which kinds of medications I should take."

This policy has been in effect since 2009.

Health and Human Services Commission

26 TAC Chapter 301, Subchapter G outlines the contract administration functions of Community Services and Behavioral Health Service Contractors at HHSC with community mental health services through general provisions, organizational standards, and standards of care.

26 TAC §301.351(e)(6) requires crisis service providers to maintain documentation of lethality, and specifically refers to suicide as an example.

HHSC has developed rules to implement Human Resources Code §42.0433. These rules became effective in September 2022. The requirements will be in 26 TAC Chapters 748 (Minimum Standards for General Residential Operations) and 749 (Minimum Standards for Child-Placing Agencies)."

Texas Commission on Jail Standards (TCJS)

Suicide Intake Screening Form

The TCJS must create a form for jails to determine at intake whether an inmate may be experiencing mental illness. If affirmative, the jail notifies a magistrate. This policy has been in effect since 2000.

Training: Assessing for Suicide, Medical, and Mental Impairments.

TCJS developed and delivered training for county jailers in awareness of mental illness. This policy was in effect from 2013 to 2017.

Mental Health Trainers

TCJS employed trainers, delivering mental health awareness training to county jailers across Texas. This training is offered through the Texas Commission on Law Enforcement (TCOLE). This policy has been in effect since 2017.

New Suicide Prevention Training

TCJS provides training for county jailers in suicide prevention via a TCOLE course credit. This policy has been in effect since 2020.

Texas Department of Criminal Justice (TDCJ)

Administrative Directive 02.15 - Operations of the Emergency Action Center and Reporting Procedures for Serious or Unusual Incidents

The Emergency Action Center (EAC) is responsible for receiving all reports of serious or unusual incidents and notifying appropriate entities and administrative staff. Reported information shall be made available to TDCJ administration to ensure availability of the necessary information to make critical decisions that affect the safety and security of the public and all divisions of the TDCJ. The EAC operates 24 hours per day, 7 days a week. This policy has been in effect since 1985.

Administrative Directive 06.56 – Procedures for Handling Offenders Identified as Suicide Risks

There is a directive establishing guidelines for the referral of and working with offenders identified as suicide risk. An offender is considered to be a suicide risk when behavior appears to have the intent or definite potential of leading to self-inflicted physical harm or death. Staff must immediately and effectively respond to suicidal behavior. This policy has been in effect since 1985.

Correctional Managed Health Care Policy Manual C-20.01 - Training for Correctional Officers

Ongoing health-related training and documentation is required at least every two years for all correctional officers. There is an annual in-service training on suicide prevention, heat-related illness, HIV/AIDS and Hepatitis. This policy has been in effect since 1985.

Correctional Managed Health Care Policy Manual A-11.1 - Procedure to be Followed in Cases of Offender Death

Specific procedures are outlined in the event of an offender's death. This policy has been in effect since 1985.

Correctional Managed Health Care Policy Manual E-32.1 - Receiving, Transfer and Continuity of Care Screening

There are guidelines for immediate identification and treatment of health care needs of offenders through receiving/transfer screening and for providing continuity of care. This policy has been in effect since 1985.

Correctional Managed Health Care Policy Manual E-35.1 - Mental Health Appraisal for Incoming Offenders

All incoming offenders admitted into the TDCJ will undergo an Intake Mental Health Appraisal by a qualified mental health professional (QMHP) to identify mental health indicators for mental health evaluation referral. This policy has been in effect since 1985.

Correctional Managed Health Care Policy Manual E-35.2 - Mental Health Evaluation

There is a mechanism to provide mental health evaluations of offenders identified as having potential mental health needs. This policy has been in effect since 1985.

Correctional Managed Health Care Policy Manual G-51.6 - Referral of an Offender for Admission to a Behavioral Health Facility

There is an outlined process for referring an offender for crisis management and possible admission into a behavioral health facility as a result of acute mental illness and/or suicidal/self-injurious behavior. This policy has been in effect since 1985.

Correctional Managed Health Care Policy Manual I-67.1 - Compelled Psychoactive Medication for Mental Illness

Psychoactive medications may be compelled by the treating practitioner for a patient who is imminently dangerous to self or others due to mental illness or at risk of significant deterioration. This policy has been in effect since 1989.

Correctional Managed Health Care Policy Manual G-53.1 - Suicide Prevention Plan

There is specialized programming, intervention, training and tracking for the prevention of offender suicide, which includes mental health observation, crisis management, and constant and direct observation. This policy has been in effect since 1995.

Texas Administrative Code Residential Services 163.39 (n) Health Care (3) Health Screening (iii)

Questionnaires for health screening include inquiries into and observations of mental health problems, including suicide attempts or ideation are documented. This policy has been in effect since 1997.

Texas Administrative Code Residential Services 163.39 (13) Suicide Prevention

Each facility shall have a written suicide prevention and intervention program reviewed and approved by a qualified medical or mental health professional. All staff with resident supervision responsibilities shall be trained in the implementation of the suicide prevention program. This policy has been in effect since 1997.

Correctional Managed Health Care Policy Manual A-08.9 - The Chronic Mentally Ill Treatment Program - (CMI-TP)

CMI-TP is a multidisciplinary program designed to treat and manage the identified chronic mentally ill offender who requires structured monitoring and supervision, in order to further stabilize their mental illness and assist in achieving their highest level of functioning. This policy has been in effect since 2002.

Correctional Managed Health Care Policy Manual A-08.10 - The Program for the Aggressive Mentally Ill Offender (PAMIO)

The program provides mental health evaluation and treatment for aggressive mentally ill offenders. The treatment program utilizes a multi-disciplinary approach through specific therapeutic modalities. The offender is expected to work their way through the program and demonstrate progress. Upon successful completion of the program, treatment staff will make a recommendation to the State Classification Committee to review the offender for a less restrictive housing assignment. This policy has been in effect since 2002.

Correctional Managed Health Care Policy Manual I-66.3 - Therapeutic Seclusion of Mental Health Patients

Behavioral health facilities may utilize therapeutic seclusion as a special treatment procedure for limited periods of time by physician or psychiatrist/psychiatric mid-level practitioner order.

The use of therapeutic seclusion requires clinical justification and is employed only to protect the patient from self-injury or injury to others. Therapeutic seclusion is not employed as punishment or as a convenience to staff. This policy has been in effect since 2002.

Executive Directive 02.17 - Serious Incident Reviews

The TDCJ will conduct a serious incident review for a serious or unusual incident involving TDCJ offenders and staff, as deemed necessary by the executive director. The review shall examine all aspects of the situation, determine the findings, and offer recommendations to the executive director for corrective action. This policy has been in effect since 2003.

American Correctional Association (ACA) Standards for Adult Correctional Institutions 4th and 5th Edition

Mental Health Program 4368 & 4369, Mental Health Screen 4370, Mental Health Appraisal 4371, Mental Health Evaluations 4372, Suicide Prevention and Intervention 4373. This policy has been in effect since 2003.

Standard Operating Procedures John T Montford Psychiatric/Medical Unit Texas Tech University Health Sciences Center SOP: JMP-043

Offenders may need inpatient treatment involving either short-term or extended hospitalization in a Behavioral Health Facility because of acute mental illness and/or suicidal/self-injurious behavior. This policy has been in effect since 2004.

Laundry Necessities Procedure Manual 19.08 - Suicide Blankets

Establishes that the laundry department has the responsibility to launder suicide blankets as requested by medical. Also, that the laundry department shall not make repairs to the suicide blankets. These blankets must be returned to the vendor. This policy has been in effect since 2005.

Security Memorandum 05.20 - Responding to an Offender Suicide or Attempted Suicide

Establishes a policy that staff shall immediately respond to an offender who is threatening or appears to be attempting suicide.

Staff shall make every effort to prevent an offender from attempting suicide and shall obtain immediate medical and/or mental health assistance for the offender. This policy has been in effect since 2007.

University of Texas Medical Branch (UTMB) Correctional Managed Care (CMC) Mental Health Services Departmental Policy Manual - MHS B-3 - Suicide Prevention

This policy provides specialized programming, intervention and training on the prevention of offender suicide. This policy has been in effect since 2007.

Youthful Offender Program (YOP) - Champion Program Operations Manual 02.06 – "Suicide Prevention, Risk, and Reporting"

This policy provides an overview for the Champion program staff concerning appropriate suicide prevention training, risk identification, notification, documentation, and reporting. This policy has been in effect since 2008.

Reentry and Integration Division – Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), Program Guidelines and Processes, PGP 01.02 Intensive Case Management

Each contracted LMHA is required to provide 24/7 crisis intervention services to offenders enrolled in case management. This policy has been in effect since 2009.

Reentry and Integration Division - TCOOMMI, Program Guidelines and Processes, PGP 01.07 Transitional Case Management

Each contracted LMHA is required to provide 24/7 crisis intervention services to offenders enrolled in case management. This policy has been in effect since 2009.

Safe Prisons/Prison Rape Elimination Act (PREA) Operations Manual, 07.01 - Visual Tracking Grid

This policy establishes a procedure and guidelines for maintaining a Visual Tracking Grid (VTG) of the unit to pinpoint locations of Safe Prisons/PREA related incidents occurring on the unit. The VTG provides a visual display of incidents to provide staff with awareness related to patterns, trends, times, and locations. This policy has been in effect since 2011.

Serious Violent Offender Reentry Initiative (SVORI) Program Operations Manual, SVORI 04.07 – Role Of Security Staff In SVORI

This policy provides an overview for the SVORI program staff concerning safety and security objectives to include suicide reporting procedures. This policy has been in effect since 2011.

Correctional Managed Health Care Policy Manual G-52.3 - Admission to the TDCJ Mental Health Therapeutic Diversion Program (MHTDP)

The MHTDP program targets offenders with mental health issues such as adjustment disorders, mood (depressive and bipolar disorder), anxiety (panic disorder, post-traumatic stress disorder and other anxiety disorders), impulse control disorders (intermittent explosive disorder and other emotional and behavioral difficulties resulting in emotional liability and behavioral disregulation). Participants receive both individual and group therapy designed to improve the offender's decision making, impulse control and quality of life. This policy has been in effect since 2014.

Our Roadway To Freedom Program (ORTF) Operations Manual 04.07 – "Role Of Security Staff In ORTF"

This policy provides an overview for the ORTF program staff concerning safety and security objectives to include suicide reporting procedures. This policy has been in effect since 2014.

Reentry and Integration Division, Program Guidelines and Processes, PGP 02.03 Release Processing

Each releasing offender is provided resources to assist post-release which includes the 988 Suicide and Crisis Lifeline. This policy has been in effect since 2015.

National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons, P-B-05 - Suicide Prevention and Intervention

Suicides are prevented, when possible, by implementing prevention efforts and intervention. This policy has been in effect since 2018.

NCCHC, Standards for Health Services in Prisons, P-E-05 - Mental Health Screening and Evaluation

Mental health screening is performed to ensure that urgent mental health needs are met. This policy has been in effect since 2018.

Female Cognitive Pre-Release Program (FCPRP) Operations Manual, FCPRP 04.02 – Role Of Security Staff In FCPRP

This policy provides an overview for the FCPRP program staff concerning safety and security objectives to include suicide reporting procedures. This policy has been in effect since 2019.

Texas Juvenile Justice Department (TJJD)

CMS 01.13: Mental Health Screening and Psychological Evaluation

TJJD has an agency internal policy which includes use of the suicide risk screening for orientation and assessment. It has been in effect for seven years.

CMS 06.71: Suicide Alert Procedures for High-Restriction Facilities

This is an agency internal policy for assessing, treating, and responding to youth with suicidal ideations and behaviors at the secure facilities. It has been in effect for eight years.

CMS 06.73: Suicide Alert Procedures for Medium-Restriction Facilities

This is an agency internal policy for assessing, treating, and responding to youth with suicidal ideations and behaviors at the halfway houses. It has been in effect for eight years.

GAP 380.9187: Suicide Alert Definitions

There is General Administrative Policy pertaining to defining suicide related terms used in the TJJD suicide prevention policies. It has been in effect for 14 years.

GAP 380.9188: Suicide Alert for High-Restriction Facilities

There is General Administrative Policy pertaining to procedures for identification, assessment, treatment, and protection of youth in secure facilities that may be at risk for suicide. It has been in effect for 14 years.

GAP 380.9189: Suicide Alert for Medium-Restriction Facilities

There is General Administrative Policy pertaining to procedures for identification, assessment, treatment, and protection of youth in halfway houses that may be at risk for suicide. It has been in effect for 14 years.

GAP 380.9190: Suicide Prevention for Parole

There is General Administrative Policy for procedures for the protection of youth on parole in the community who may be at risk for suicide. It has been effect for 14 years.

CMS 12.61: Suicide Prevention Procedures for Youth on Parole

There is agency internal policy for parole staff awareness and response to parole youth engaging in suicide behavior or ideation. It has been in effect for eight years.

Texas Military Department (TMD)

Draft Operations Order for FY20/21 for National Guard

Family Support Services (FSS) will develop Intervention Officer (SIO) with Applied Suicide Intervention Skills Training (ASIST) training and marketing plan in order to improve SIO/ASIST compliance. FSS will develop Master Resilience Trainer training and marketing plan and acquire addition funding for TMD counselors to sustain resiliency.

Army Regulation 600-63- Army Health Promotion

Implementation of the Community Health Promotion Program is aimed at enhancing readiness and reduce suicidal behaviors. It has been in effect 11 years and was revised in 2016.

H.B. 1025, 83rd Legislature, Regular Session, 2013

H.B. 1025 created the TMD Mental Health Initiative. It has been in effect for 10 years.

Army Regulation 600_85- Army Substance Abuse Program (Ch 12)

This regulation directs units to conduct Unit Risk Inventories at least annually (suicidal thoughts/activity are included in the survey). This policy has been in effect since 2012 and it was updated in 2016.

Department of Army Pamphlet 600-24- Health Promotion, Risk Reduction, and Suicide Prevention

This policy explains procedures for health promotion, risk reduction, and suicide prevention efforts to mitigate high-risk behaviors. It has been in effect for eight years.

Important Army Programs: Sexual Harassment/Assault Response and Prevention, Equal Opportunity, Suicide Prevention, Alcohol and Drug Abuse Prevention, and Resilience

This policy provides guidance for a more effective method of training, emphasizing leader involvement, and leveraging the Army's culture to improve the outcomes of these valuable programs to enhance the readiness and welfare of our Soldiers and units. It has been in effect five years.

Texas Tech University Health Sciences Center (TTUHSC)

TTUHSC Operating Policy: HSC OP 70.38, Employee Assistance Program

This policy establishes the procedures governing the use of and referral to the Employee Assistance Program (EAP). The policy also allows EAP to provide wellness workshops on select topics. Suicide prevention programs such as Question, Persuade, and Refer and MHFA have been offered as requested. The policy has been in effect since 1991.

Texas Veteran Commission (TVC)

Government Code, § 434.038, requires the TVC to coordinate with DSHS to incorporate a suicide prevention component as part of the accreditation training and examination for county veteran service officers.

Government Code, § 434.351 – § 434.401, specify TVC's requirements related to statewide coordination for the mental health program for veterans (MHPV) and the community collaboration initiative related to MHPV.

Programs

H.B. 3980 required a description of state agency initiatives since 2000 to address suicide and include the following information relating to each initiative: the administering state agency; the funding sources, including whether the funding was provided by a federal block grant, a federal discretionary grant, or state appropriations; the years of operation; and whether the initiative is an example of a community-based effort to address suicide. Programs were collected from agency members of the SBHCC, and the information is reported as provided.

DSHS

Texas Youth Suicide Prevention Grant

The Texas Youth Suicide Prevention Grant project was in effect for three years with three partners to increase services and referrals for youth when identified as being at risk for suicide. Partners included Mental Health America Texas, Air Force Base Medical Center in San Antonio Pediatric Clinic and Bexar County Center for Health Services LMHA.

Years Funded

FY 2008-FY 2011

Community Based Intervention

This is an example of community-based intervention.

Table 2: Funding for FY 2008-FY 2011 Texas Youth Suicide Prevention Grant

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$470,000	$470,000	$470,000	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$470,000**	**$470,000**	**$470,000**	**$0**	**$0**

Zero Suicide Texas Grant (ZEST)

The goals of the ZEST initiative were to improve identification, treatment and support services for high-risk youth by creating Suicide Safe Care Centers within the public mental health system; expanding and coordinating these best practice suicide prevention activities with other youth-serving organizations and community partners to create Suicide Safe Care Communities; and implementing research-informed training and communications efforts to create a Suicide Safe Care State.

Years Funded

FY 2012-FY 2016

Community Based Intervention

This is an example of community-based intervention.

Table 3: Funding for FY 2012-FY 2016 Zero Suicide Texas Grant (ZEST)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$440,000	$440,000	$189,000	$251,000
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$440,000**	**$440,000**	**$189,000**	**$251,000**

Statewide Suicide Plan and Programs

With support from the Maternal/Child Health (MCH) Block Grant, the program was able to host a symposium to raise public awareness, train providers and educate in suicide prevention best practices from national experts. Further new tools were developed, such as: an update of the Texas State Plan for Suicide Prevention; Suicide Safer Schools toolkit, model, and suicide prevention applications; webpage; toolkit and one pagers to address evidence-based, and best practice-based suicide prevention needs for stakeholders.

Years Funded

FY 2012-FY 2016

Community Based Intervention

This is an example of community-based intervention.

Table 4: Funding for FY 2012-FY 2016 Statewide Suicide Plan and Programs

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$175,000	$200,000	$1,000,000	$889,000	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$175,000**	**$200,000**	**$1,000,000**	**$889,000**	**$0**

Signs of Suicide (SOS)

SOS is a universal, school-based depression awareness and suicide prevention program designed for middle-school (ages 11-13) and high-school (13-17) students. It is designated as a program with evidence of effectiveness.

Years Funded

FY 2015-FY 2019

Community Based Intervention

This is not an example of community-based intervention.

Table 5: Funding for FY 2015-FY 2019 Signs of Suicide

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$18,428	$47,058	$45,962	$56,856	$18,626
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$18,428**	**$47,058**	**$45,962**	**$56,856**	**$18,626**

SOS

SOS is a universal, school-based depression awareness and suicide prevention program designed for middle-school (ages 11-13) and high-school (13-17) students. It is designated as a program with evidence of effectiveness.

Years Funded

FY 2020

Community Based Intervention

This is not an example of community-based intervention.

Table 6: Funding for FY 2020 Signs of Suicide (SOS)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$25,000	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$25,000**	**$0**	**$0**	**$0**	**$0**

TCJS

Suicide Intake Screening Form

This form is for jails to determine at intake whether an inmate may be experiencing mental illness. If it is affirmative, the jail notifies a magistrate.

Years Funded

FY 2020, FY 2015.
No budget line item.
Funded with existing funds.

Community Based Intervention

This is not an example of community-based intervention.

Table 7: Funding for FY 2020, FY 2015 Suicide Intake Screening Form

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Training: Assessing for Suicide, Medical, and Mental Impairments

This is training for county jailers in awareness of mental illness.

Years Funded

FY 2013 – FY 2017.
No budget line item.
Funded with existing funds.

Community Based Intervention

This is not an example of community-based intervention.

Table 8: Funding for FY 2013 – FY 2017 Training: Assessing for Suicide, Medical, and Mental Impairments

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Mental Health Trainers

TCJS employed trainers to deliver mental health awareness training to county jailers across Texas which is offered through TCOLE. It was extended for 2020 and 2021.

Years Funded

FY 2017 – FY 2019.

Community Based Intervention

This is not an example of community-based intervention.

Table 9: Funding for FY 2017 – FY 2019 Mental Health Trainers

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$176,022	$158,416	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$176,022**	**$158,416**	**$0**	**$0**	**$0**

Prison Safety Fund

The Prison Safety Fund enables county jails with 96 beds or less to purchase electronic monitoring equipment for high-risk areas of jail, may include areas housing inmates with mental illness. It was later extended to include jails with up to 288 beds.

Years Funded

FY 2018 and extended to FY 2019. Community Based Intervention

Community Based Intervention

This is not an example of community-based intervention.

Table 10: Funding for FY 2018-19 Prison Safety Fund

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$59,710	$247,506	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$59,710**	**$247,506**	**$0**	**$0**	**$0**

New Suicide Prevention Training

The New Suicide Prevention training is available for county jailers as a TCOLE course credit.

Years Funded

No budget line item.

Community Based Intervention

This is not an example of community-based intervention.

Table 11: Funding for New Suicide Prevention Training, FY 20-24

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

TVC

Veterans Mental Health Department (VMHD)

The VMHD is focused on ensuring access to competent mental health services for service members, veterans, and their families. VMHD accomplishes this task by providing training, certification, and technical assistance across Texas. In addition to connecting veterans in need directly to local services, VMHD also works with partners at the national, state, and local level to address veteran-specific issues including suicide prevention/intervention, veteran homelessness, military cultural competency, peer support services, military-related trauma, women and rural veterans, and justice involvement. Across all programming, VMHD is fortunate to have the broadest definition of veteran regardless of discharge status, branch of services, or having served one day or a career. All services including training, technical assistance, and direct services provided across VMHD programming are offered freely to all who are in need. VMHD is made up of the Justice Involved Veteran Program, the Homeless Veteran Initiative, the Community & Faith Based Program, the Provider Program, the Military Veteran Peer Network, and Veteran Suicide Prevention.

Years Funded

FY 2015-FY 2024.

Community Based Intervention

This is an example of community-based intervention.

Table 12: Funding for FY 2020-FY 2023 VMHD

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$313,200	$313,200	$313,200	$313,200	$313,200
Other	$0	$0	$0	$0	$0
Sub-total	**$313,200**	**$313,200**	**$313,200**	**$313,200**	**$0**

Community Suicide Prevention Trainings

TVC offers suicide prevention community helper trainings including AS+K About Suicide to Save a Life (AS+K) and Counseling on Access to Lethal Means to community members and veteran serving organizations.

Years Funded

FY 2021-present.

Community Based Intervention

This is an example of community-based intervention.

Table 12: Funding for FY 2021-FY 2023 Community Suicide Prevention Trainings

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

TJJD

Collaborative Assessment and Management of Suicidality (CAMS)

CAMS is an evidence-based therapeutic framework for suicide specific assessments of patient's suicidal risk. The clinician and patient engage in an interactive assessment process and the patient is actively involved in the development of their own treatment plan.

Years Funded

FY 2020.

Community Based Intervention

This is an example of community-based intervention.

Table 13: Funding for FY 2020 Collaborative Assessment and Management System (CAMS)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$10,000	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$10,000**	**$0**	**$0**	**$0**	**$0**

Zero Suicide Institute

The Zero Suicide Institute implements an approach that includes evidence-based practices for suicide prevention, coordinating trainings and adopting continuous quality improvement efforts including prevention-commitment to comprehensive suicide safer care. The institute works with Question Persuade Refer and Collaborative Assessment and Management of Suicidality by training staff on new modernized instruments to improve current suicide assessments and treatment.

Years Funded

FY 2020.

Community Based Intervention

This is an example of community-based intervention.

Table 14: Funding for FY 2020 Zero Suicide Institute

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$30,000	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$30,000**	**$0**	**$0**	**$0**	**$0**

Question Persuade Refer (QPR) - Training for Trainers

QPR is training for trainers and mental health professionals.

Years Funded

FY 2019.

Community Based Intervention

This is not an example of community-based intervention.

Table 15: Funding for FY 2019 QPR - Training for Trainers

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$29,278	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$29,278**	**$0**	**$0**	**$0**	**$0**

Wellness Project - Well Bed System

The Wellness Project is an electronic wellness check system where coaches virtually log their check ins of youth and enhances accountability of check ins for youth on suicide watch.

Years Funded

FY 2020.

Community Based Intervention

This is not an example of community-based intervention.

Table 16: Funding for FY 2020 Wellness Project - Well Bed System

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$444,445	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$444,445**	**$0**	**$0**	**$0**	**$0**

TDCJ[124]

EAC

The EAC is responsible for receiving all reports of serious or unusual incidents and notifying appropriate entities and administrative staff. Reported information shall be made available to the TDCJ administration to ensure availability of the necessary information to make critical decisions that affect the safety and security of the public and all divisions of the TDCJ. The EAC operates 24 hours per day, 7 days a week. It was formulated in 1985.

Years Funded

FY 2020-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 17: Funding for FY 2020-Present Emergency Action Center (EAC)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

[124] No funding information is available for TDCJ because funding was tied to other initiatives and could not be easily determined.

Correctional Officer - Suicide Prevention Training

In accordance with Correctional Managed Health Care Policy C-20.1 - Training for Correctional Officers in suicide prevention, heat-related illness, HIV/AIDS and Hepatitis is conducted and documented annually. This training was formulated in 1985. Training is being reevaluated and updated in FY 2024.

Years Funded

FY 2020-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 18: Funding for FY 2020-Present Correctional Officer - Suicide Prevention Training

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Assessments and Referral to Mental Health Services

Newly arrived offenders are screened for emergent medical and mental health needs immediately upon arrival by a member of health services staff. Offenders with urgent mental health needs are immediately referred to a mental health professional. A mental health appraisal that includes a structured interview is performed on all offenders within 14 days of arrival. A comprehensive mental health evaluation is conducted by a QMHP within 14 days of referral. This assessment was formulated in 1985.

Years Funded

FY 2000-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 19: Funding for FY 2000-Present Assessments and Referral to Mental Health Services

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Crisis Management

Offenders who present a significant and imminent danger to themselves are moved to Crisis Management at one of the psychiatric hospitals, Clements Unit or Mt. View Unit. Offenders who have mental health needs that cannot be met on an outpatient unit are moved to one of the psychiatric hospitals, Jester IV, Montford or Skyview. The inpatient facilities are designed and staffed to provide more intense diagnostics, treatment, monitoring and to manage more acute mental illness. These policies date back to at least 1985.

Years Funded

FY 2000-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 20: Funding for FY 2000-Present Crisis Management

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

TDCJ Suicide Prevention Task Force

The Suicide Prevention Working Group holds monthly meetings to discuss events leading up to, surrounding, and following a suicide. Appropriate recommendations for unit practices and future training initiatives are discussed to further aid in the prevention and response to suicide.

There is also an Annual Suicide Review Meeting conducted by agency staff and university medical providers to review all suicides. Based on the analysis of each suicide, policies and practices are reviewed and discussed to offer improvements in preventing suicides.

Years Funded

FY 2000-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 21: Funding for FY 2000-Present TDCJ Suicide Prevention Task Force

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Correctional Managed Health Care Committee (CMHCC) Joint Morbidity and Mortality Suicide Subcommittee

The CMHCC group membership consists of psychiatrists and doctoral level psychologist appointed by the university Medical Directors and the TDCJ Health Services Division Director. This group is charged with the ongoing review of each TDCJ offender suicide from a clinical perspective to assess the quality of health care rendered in each case and identify trends that may assist in further development of additional suicide prevention measures. This group meets on a monthly basis and was formulated in 1994.

Years Funded

FY 2000-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 22: Funding for FY 2000-Present Correctional Managed Health Care Committee (CMHCC) Joint Morbidity and Mortality Suicide Subcommittee

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

TDCJ Office of Mental Health Monitoring and Liaison (OMHML) Suicide Monitoring Activities

OMHML reviews offender suicide, develops corrective action plans, and maintains statistical suicide data.

Years Funded

FY 2000-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 23: Funding for FY 2000-Present TDCJ Office of Mental Health Monitoring and Liaison (OMHML) Suicide Monitoring Activities

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

MHFA

MHFA Training is conducted by Certified MHFA Instructor for all medical and behavioral staff at the John T. Montford Unit. It was formulated in 1994.

Years Funded

FY 2000-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 24: Funding for FY 2000-Present MHFA Training

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Intensive Crisis Counseling - Outpatient Services

Offenders who are identified as possible risk for suicide and/or present in a crisis will be offered intensive crisis counseling by a QMHP. The QMHP will use Cognitive Therapy, Strategic/Solution Focused Therapy, and Reality Therapy strategies to lessen patient's response to precipitating events. This was formulated in 1994.

Years Funded

FY 2000-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 25: Funding for FY 2000-Present Intensive Crisis Counseling - Outpatient Services

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Transitional Success Group Treatment (TSG) on Intake Facilities

TTUHSC group programming on intake facilities focuses on successful transition into TDCJ. It addresses depression management, suicide prevention, and adjusting to correctional environment by using effective coping strategies. It was formulated in 1994.

Years Funded

FY 2000-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 26: Funding for FY 2000-Present Transitional Success Group Treatment (TSG) on Intake Facilities

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Staff Training

The agency has increased both Pre-Service and In-Service crisis intervention and mental health response training for correctional and parole staff. Officer training also includes content specific to suicide prevention and response. Pre-Service Training and annual In-Service Training include Crisis Intervention/Mental Health training.

Years Funded

FY 2002-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 27: Funding for FY 2002-Present Intensive Crisis Counseling - Outpatient Services

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Specialized Psychiatric Treatment Programs

Specialized psychiatric treatment programs for offender patients assigned to high security that do not require acute care inpatient psychiatric therapy have been instituted at the Clements Unit. PAMIO provides evaluation and treatment of mentally ill offenders with aggressive behavior. There are also two programs for the Chronically Mentally Ill (CMI) offenders, Inpatient CMI and Outpatient CMI.

Years Funded

FY 2002-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 28: Funding for FY 2002-Present Specialized Psychiatric Treatment Programs

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

UTMB Unit-Level Suicide Prevention and Intervention Training

Suicide Prevention training is conducted with unit UTMB Mental Health Staff in accordance with ACA Standard 4373.

Years Funded

FY 2003-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 29: Funding for FY 2003-Present University of Texas Medical Branch (UTMB) Unit-Level Suicide Prevention and Intervention Training

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

UTMB Suicide Prevention Training

Suicide Prevention training is conducted with UTMB Mental Health Staff in accordance with UTMB CMC Mental Health Services Department Policy Manual, Policy MHS B-3. Training is done at the following levels: regional, online, and at the UTMB CMC annual meeting.

Years Funded

FY 2007-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 30: Funding for FY 2007-Present University of Texas Medical Branch (UTMB) Suicide Prevention Training

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Rehabilitation Programs

TDCJ operates rehabilitation programs including the YOP Champion Program, the FCPRP, the SVORI Program, and ORTF. Each of these programs has policies in place concerning suicide prevention, identification, notification, documentation, and reporting.

Years Funded

FY 2008-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 31: Funding for FY 2008-Present Rehabilitation Programs

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

TCOOMMI

Each contracted LMHA is required by TCOOMMI policy to provide 24/7 crisis intervention services to offenders enrolled in case management.

Years Funded

FY 2009-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 32: Funding for FY 2009-Present TCOOMMI

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Regional Incident Reviews

A Regional Incident Review is conducted following an offender suicide, by an assembled team of staff not assigned to the unit at which the suicide occurred. The team reviews the circumstances of the incident including, but not limited to, a review of security procedures, correctional officer staffing, health services, physical plan and classification to identify any issues or trends which may prevent future occurrences.

Years Funded

FY 2010-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 33: Funding for FY 2010-Present Regional Incident Reviews

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Office of Inspector General Suicide Review

All in-custody deaths that are not physician attended deaths by natural causes or execution are referred to the Office of Inspector General for review and investigation as deemed appropriate.

Years Funded

FY 2010-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 34: Funding for FY 2010-Present Office of Inspector General Suicide Review

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Employee Information Pocket Card

The Employee Information Pocket Card provides staff with different scenarios that could indicate: Suicide High Risk Factors, Warning Statement, Signs an Offender Might be Suicidal, or Mood Changes.

Years Funded

FY 2012-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 35: Funding for FY 2012-Present Employee Information Pocket Card

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

MHTDP

The MHTDP program targets offenders with mental health issues such as adjustment disorders, mood (depressive and bipolar disorder), anxiety (panic disorder, PTSD and other anxiety disorders), impulse control disorders (intermittent explosive disorder, and other emotional and behavioral difficulties resulting in emotional liability and behavioral dysregulation). Participants receive both individual and group therapy designed to improve the offender's decision making, impulse control and quality of life.

Years Funded

FY 2014-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 36: Funding for FY 2014-Present Mental Health Therapeutic Diversion Program (MHTDP)

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Reentry Initiatives

Each releasing offender is provided resources to assist post-release which includes the national suicide prevention hotline.

Years Funded

FY 2015-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 37: Funding for FY 2015-Present Reentry Initiatives

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Online Distance Learning Course 1020 - Non-Violent Crisis Intervention

Online distance learning class is provided for licensed counselors to receive continuing education. The curriculum provides an overview of crisis intervention and offers valuable information such as suicide prevention, risk identification, and notification.

Years Funded

FY 2015-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 38: Funding for FY 2015-Present Online Distance Learning Course 1020 - Non-Violent Crisis Intervention

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Incoming Inmate Flyer

The incoming inmate flyer provides incoming inmates with different scenarios that could indicate: Suicide High Risk Factors, Warning Statement, Signs an Offender Might be Suicidal, or Mood Changes.

Years Funded

FY 2017-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 39: Funding for FY 2017-Present Incoming Offender Flyer

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

New Arrival Orientation Packet

Clients reporting to parole as a new arrival are provided a resource packet which includes the 24/7 crisis hotline phone number.

Years Funded

FY 2019-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 40: Funding for FY 2019-Present New Arrival Orientation Packet

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Executive Level Suicide Review Team

A team comprised of senior staff conducts an extensive review of each suicide to include staff and inmate interviews, policy reviews, and provides recommendations to executive leadership.

Years Funded

FY 2019-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 41: Funding for FY 2019-Present Executive Level Suicide Review Team

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Self-Harm Prevention Initiative

The purpose of the Self Harm Prevention Initiative is to facilitate collaboration and information sharing at each TDCJ unit. This initiative will provide training and education on suicide prevention, monitoring at-risk inmates as identified by the screening tool, and facilitate multi-disciplinary case staffing between partners on a consistent basis. Initial implementation currently focuses on two units to identify best practices for rollout statewide.

Years Funded

FY 2022-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 42: Funding for FY 2019-Present Executive Level Suicide Review Team

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

HHSC

Resilient Youth - Safer Environments (RYSE)

This Substance Abuse and Mental Health Services Administration (SAMSHA) funded grant creates comprehensive Suicide Safer Early Intervention and Prevention systems to support youth serving organizations, including Texas schools, mental health programs, educational institutions, juvenile justice systems, substance use programs, and foster care systems.

The target population, youth ages 10 to 24 years at elevated risk of suicide and suicide attempts, will receive enhanced services through best practice trainings, improved suicide care in clinical early intervention, and effective programming and treatment services in Galveston County which was negatively impacted by the trauma of Hurricane Harvey and a shooting in Santa Fe ISD schools.

Years Funded

FY 2019-FY 2024.

Community Based Intervention

This is an example of community-based intervention.

Table 43: Funding for FY 2020-FY 2024 RYSE

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$736,000	$736,000	$736,000	$736,000	$736,000
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$736,000**	**$736,000**	**$736,000**	**$736,000**	**$736,000**

SCI

SCI works through LMHAs and LBHAs to implement the Zero Suicide framework through two collaborative projects with the goal of providing effective suicide care to individuals at all stages in their suicide care journey. The Zero Suicide framework refers to a system-wide organizational commitment to safer suicide care in health and behavioral health care systems. The following four LMHAs have been identified as RSCSC pilot sites to oversee the development, implementation, and evaluation of SCI projects of other LMHAs and LBHAs in their region through the grant funding provided:

- The Harris Center for Mental Health and IDD;
- Integral Care;
- My Health My Resources of Tarrant County; and
- Tropical Texas Behavioral Health.

Years Funded

FY 2019 – present

Community Based Intervention

This is an example of community-based intervention.

Table 44: Funding for FY 2019 – FY 2023 SCI

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$1,979,315	$1,979,315	$1,979,315	$1,737,523	$1,737,523
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$1,979,315**	**$1,979,315**	**$1,979,315**	**$1,737,523**	**$1,737,523**

Staff Training

The agency has increased the availability of suicide prevention training to employees by offering AS+K About Suicide to Save a Life, ASIST, and Safety Planning Intervention training to employees.

Years Funded

N/A

Community Based Intervention

These are examples of community-based intervention.

Table 45: Funding for Staff Training

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$0**	**$0**	**$0**	**$0**	**$0**

Community-Based Crisis Programs (CBCP): crisis stabilization units, extended observation units, crisis residential units, and crisis respite units.

CBCPs are available 24/7 and include prompt face-to-face crisis assessments, crisis intervention services, and crisis follow-up and relapse prevention services in a residential setting. CBCPs may be staffed with mental health providers, peer providers, substance use disorder providers, medical professionals, or other professionals that offer assessment, support, and services to achieve psychiatric stabilization to individuals with behavioral health issues.

Years Funded

FY 2008-Present.

Community Based Intervention

This is an example of community-based intervention.

Table 46: Funding for FY 2019-2023 CBCP: crisis stabilization units, extended observation units, crisis residential units, and crisis respite units.

Fund Type	FY2019	FY2020	FY2021	FY2022	FY2023
General Revenue	$44,854,273	$44,854,273	$44,854,273	$44,854,273	$44,854,273
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$44,854,273**	**$44,854,273**	**$44,854,273**	**$44,854,273**	**$44,854,273**

Mobile Crisis Outreach Team (MCOT)

MCOTs are qualified professionals deployed into the community to provide a combination of services including emergency care, urgent care, and crisis follow-up and relapse prevention to children, adolescents, and adults in the community 24 hours a day, 7 days a week, every day of the year.

Years Funded

FY 2008-Present.

Community Based Intervention

This is an example of community-based intervention.

Table 46: Funding for FY 2019-FY 2023 MCOT

Fund Type	FY2019	FY2020	FY2021	FY2022	FY2023
General Revenue	Unknown	Unknown	Unknown	Unknown	Unknown
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$2,329,449	$2,329,449
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total				**$2,329,449**	**$2,329,449**

Exact general revenue dollars spent on MCOT services each year are unknown as LMHAs and LBHAs do not receive a specific allocation to support MCOT services. The funds used to pay for these services are included in the general allocation for crisis services in the base budget.

Crisis Hotline Services

The Crisis Hotline is a continuously available telephone service staffed by trained and competent crisis staff to provide crisis screening and access to crisis intervention services, mental health and substance use referrals support, and general mental health and substance use information to callers 24 hours a day, 7 days a week, every day of the year.

Years Funded

FY 2008-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 47: Funding for FY 2008- Crisis Hotline Services

Fund Type	Year One	Year Two	Year Three	Year Four	Year Five
General Revenue	Unknown	Unknown	Unknown	Unknown	Unknown
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Sub-total				**$0**	**$0**

Exact general revenue dollars spent on hotline services each year are unknown as LMHAs and LBHAs do not receive a specific allocation to support hotline services. The funds used to pay for these services are included in the general allocation for crisis services in the base budget.

National Suicide Prevention Lifeline (NSPL)/988 Suicide and Crisis Lifeline

Four Local Mental Health Authorities (The Harris Center, Emergence Health Network, Integral Care, and My Health My Resources of Tarrant County) participate as NSPL members within a national network of local crisis centers that provide free and confidential emotional support to people in suicidal or emotional distress 24 hours a day, 7 days a week.

Years Funded

FY 2020-present

Community Based Intervention

This is an example of community-based intervention.

Table 48: Funding for FY 2019-FY 2023 NSPL

Fund Type	FY2019	FY2020	FY2021	FY2022	FY2023
General Revenue	$0	$0	$0	$0	$0
Federal Funds, Discretionary Grant	$0	$814,822	$2,144,920	$243,580	$0
Federal Funds, Block Grant	$0	$0	$0	$5,384,439	$6,155,835
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$70,477	$23,000	$0
Sub-total		**$814,822**	**$2,215,397**	**$5,651,019**	**$6,155,835**

Private Purchased Beds (PPBs)/Community Mental Health Hospital (CMHH) beds

HHSC currently contracts with LMHAs and LBHAs, to provide inpatient level of care in the community under the G.2.2. Community Hospital strategy. The funding strategy and reporting requirements on HHSC funded beds can be grouped into two primary categories: first, the CMHH beds and second the PPBs. CMHHs and PPBs are staffed with medical and nursing professionals who provide 24-hour professional monitoring, supervision, and assistance in an environment designed to provide safety and security during an acute behavioral health crisis.

Years Funded

FY 2020-Present.

Community Based Intervention

This is not an example of community-based intervention.

Table 49: Funding for FY2019-FY2023 PPBs/CMHH Beds

Fund Type	FY2019	FY2020	FY2021	FY2022	FY2023
General Revenue	$95,385,955	$109,158,929	$109,062,517	$124,062,517	$124,062,517
Federal Funds, Discretionary Grant	$0	$0	$0	$0	$0
Federal Funds, Block Grant	$0	$0	$0	$0	$0
Interagency Contract	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Sub-total	**$95,385,955**	**$109,158,929**	**$109,062,517**	**$124,062,517**	**$124,062,517**

List of Acronyms

Acronym	Full Name
ACA	American Correctional Association
ACE	Adverse Childhood Experience
AIDS	Acquired Immune Deficiency Syndrome
AFSP	American Foundation for Suicide Prevention
ASIST	Applied Suicide Intervention Skills Training
BRFSS	Behavioral Risk Factor Surveillance System
CAMS	Collaborative Assessment and Management System
CDC	Centers for Disease Control and Prevention
CMC	Correctional Managed Care
CMI	Chronically Mentally Ill
DFPS	Department of Family and Protective Services
DSHS	Department of State Health Services
EAC	Emergency Action Center
FSS	Family Support Services
HIV	Human Immunodeficiency Virus
HHSC	Health and Human Services Commission
LBHA	Local Behavioral Health Authority
LMHA	Local Mental Health Authority
MCOT	Mobile Crisis Outreach Team
MHFA	Mental Health First Aid
MHMR	Mental Health and Mental Retardation
MHTDP	Mental Health Therapeutic Diversion Program
MRT	Master Resilience Trainer
MVPN	Military Veteran Peer Network
NSPL	National Suicide Prevention Lifeline
NSSI	Non-Suicidal Self-Injury
ORTF	Our Roadway to Freedom
OSAR	Outreach, Screening, Assessment, Referral
PADRE	Parenting Awareness Drug Risk Education
PAMIO	Program for the Aggressive Mentally Ill Offender
PESC	Psychiatric Emergency Services Centers
PRC	Prevention Resource Center
PTSD	Post-Traumatic Stress Disorder
QMHP	Qualified Mental Health Professional
QPR	Question, Persuade, and Refer
RSCSC	Regional Suicide Care Support Center
RYSE	Resilient Youth – Safer Environments
SBHCC	Statewide Behavioral Health Coordinating Council
SCI	Suicide Care Initiative
SMVF	Service members, veterans, and their families
SVORI	Serious Violent Offender Reentry Initiative
TCJS	Texas Commission on Jail Standards
TCOLE	Texas Commission on Law Enforcement
TCOOMMI	Texas Correctional Office on Offenders with Medical or Mental Impairments
TDCJ	Texas Department of Criminal Justice

Acronym	Full Name
THCIC	Texas Health Care Information Collection
TJJD	Texas Juvenile Justice Department
TMD	Texas Military Department
TPCN	Texas Poison Control Network
TTUHSC	Texas Tech University Health Sciences Center
TVC	Texas Veterans Commission
VMHD	Veterans Mental Health Department
YOP	Youthful Offender Program
YRBS	Youth Risk Behavior Survey
ZEST	Zero Suicide in Texas

Appendix A

Texas Agriculture Code

Farmer Mental Health and Suicide Prevention Program

Chapter 12, §12.051

Texas Civil Practice & Remedies Code

Assumption of the Risk: Affirmative Defense

Chapter 93, §93.001

Disregard of Declaration for Mental Health Treatment

Chapter 137, §137.008

Texas Code of Criminal Procedure

Deaths Requiring an Inquest

Chapter 49, §49.04

Medical Examiners/Death Investigations

Chapter 49, §49.25

Texas Education Code

Facilities Standards

Chapter 7, §7.061

District-Level Planning and Decision-Making

Chapter 11, §11.252

Educator Preparation

Chapter 21, §21.044

Continuing Education

Chapter 21, §21.054

Staff Development

Chapter 21, §21.451

Transfer of Victims of Bullying

Chapters 25 and 37, §25.0342 and §37.0832

Digital Citizenship

Chapter 28, §28.002

Essential Knowledge and Skills Curriculum

Chapter 28, §28.002

Health Curriculum

Chapter 28, § 28.002

Local School Health Advisory Council and Health Education Instruction

Chapter 28, §28.004

School Health Advisory Council and Suicide

Chapter 28, §28.004

Counselors

Chapter 33, §33.006

Student Code of Conduct

Chapter 37, §37.001

Discipline; Law and Order

Chapter 37, §37.0012, §37.002, §37.007 and §37.009

Discipline; Law and Order, and Occupations Code, Law Enforcement Officers

Chapter 37, Texas Education Code, §37.0812

Discipline, Law and Order

Chapter 37, §37.0832

Threat Assessment and Safe and Supportive School Program and Team

Chapter 37, §37.115

Multihazard Emergency Operations Plan

Chapter 37, §37.108 (f) (6)

Health and Safety; Psychotropic Drugs and Psychiatric Evaluations or Examinations

Chapter 38, §38.016

Trauma-Informed Care Policy

Chapter 38, §38.036

School-Based Health Centers - Parental Consent Required

Chapter 38, §38.053

Identification of Health-Related Concerns

Chapter 38, §38.057

Collaborative Task Force on Public School Mental Health Services

Chapter 38, §38.301-38.311

Funding for Suicide Prevention

Chapter 42, §42.168

School Safety Allotment

Chapter 48 §48.115

Requirements for Higher Education

Chapter 51, §51.9193-§51.9194

Texas Estates Code

Estate of Person who Dies by Suicide

Chapter 201, §201.061

Texas Family Code

Consent to Counseling

Chapter 32, §32.004

Medical Services to Minors in the Conservatorship of the State

Chapter 266, §266.009

Texas Government Code

Veterans County Service Offices

Chapter 434, §434.038

Mental Health Program for Veterans

Chapter 434, §434.351

Program for Veterans

Chapter 434, §434.401

Inmate Welfare

Chapter 501, §501.068

Fire Sprinkler Head Inspection

Chapter 511, §511.0097

Grants for Veterans' Programs

Chapter 531, §531.0992

Veteran Suicide Prevention Action Plan

Chapter 531, §531.0925

Suicide Prevention Subcommittee of the SBHCC

Chapter 531, §531.477

Texas Health & Safety Code

Texas Health and Human Services Commission Chapter 62, §62.052
Mental Health Promotion and Intervention, Substance Abuse Prevention and Intervention, and Suicide Prevention Chapter 161, § 161.325

Honoring Advance Directive or Do Not Resuscitate Order Not Aiding Suicide

Chapter 166, §166.047, §166.096

Personal Information

Chapter 193, §193.005

Memorandum of Understanding on Suicide Data

Chapter 193; §193.011

Convictions Barring Employment

Chapter 250, §250.006

Services for Children and Youth

Chapter 533, §533.040

Annual Status Report

Chapter 552, §552.103

Annual Status Report

Chapter 555, §555.103

Search Warrants

Chapter 573, §573.001

Court-Ordered Mental Health Services

Chapter 574, §574.034, §574.011

Administration of Medication to Patient under Court-Ordered Mental Health Services

Chapter 574, §574.103

Medication Emergency Defined

Chapter 574, §574.101, §592.151

Administration of Medication to Client Receiving Voluntary or Involuntary Residential Care Services or to a Client Committed to Certain Residential Care Facilities

Chapter 592, §592.152 – §592.153

Establishment of Review Team

Chapter 672, §672.001 – §672.013

Transmitting Requests for Emergency Aid

Chapter 772, § 772.112, § 772.212, § 772.312, § 772.515 and § 772.614

Mental Health First Aid Training

Chapter 1001, §1001.201 – §1001.206, §1001.2031

Mental Health Program for Veterans

Chapter 1001, §1001.221 – § 1001.224

Mental Health First Aid Report

Chapter 1001, §1001.205

Texas Human Resources Code

Suicide Prevention, Intervention, and Postvention Plan

Chapter 42, §42.0433

Office of Inspector General

Chapter 61, §61.0451

Juvenile Correctional Officers

Chapter 242, §242.009

Texas Occupations Code

Required Suspension, Revocation, or Refusal of License for Certain Offenses

Chapter 301, §301.4535

Disclosure of Certain Information Relating to Occupants

Chapter 1101, §1101.556

Training and Education for School District Peace Officers and School Resource Officers

Chapter 1701, §1701.262-§1701.263

Texas Penal Code

Protection of Life or Health

Chapter 9, §9.34

Aiding Suicide

Chapter 22, §22.08

Making a Firearm Accessible to a Child

Chapter 46, §46.13

Texas Property Code

Reporting a Suicide on a Property

Chapter 5, §5.008

Endnotes

[i] Texas State Demographer's Office and Centers for Disease Control and Prevention
[ii] Centers for Disease Control and Prevention
[iii] Crude death rate is the number of new cases (or deaths) occurring in a specified population per year, usually expressed as the number of cases per 100,000 population.
[iv] National Center for Health Statistics, Centers for Disease Control and Prevention, WONDER
[v] Jobes, D. A., Berman, A. L., & Josselman, A. R. (1987). Improving the Validity and Reliability of Medical-Legal Certifications of Suicide. *Suicide and Life Threatening Behavior*, *17*(4), 310–325.
[vi] Sussell, Aaron. "Suicide Rates by Industry and Occupation—National Vital Statistics System, United States, 2021." *MMWR. Morbidity and Mortality Weekly Report* 72 (2023).
[vii] Arif, A. A., Adeyemi, O., Laditka, S. B., Laditka, J. N., & Borders, T. (2021). Suicide mortality rates in farm-related occupations and the agriculture industry in the United States. *American journal of industrial medicine*, *64*(11), 960-968.
[viii] Brodsky, Beth S., and Barbara Stanley. "Adverse childhood experiences and suicidal behavior." *Psychiatric Clinics of North America* 31.2 (2008): 223-235.
[ix] Clements-Nolle, Kristen, et al. "Sexual identity, adverse childhood experiences, and suicidal behaviors." *Journal of Adolescent Health* 62.2 (2018): 198-204.
[x] as defined by the U.S. Office of Management and Budget
[xi] as defined by the U.S. Office of Management and Budget
[xii] Table 83 in Appendix A
[xiii] Table 85 in Appendix A