CHARTING THE FUTURE OF SUICIDE PREVENTION:

A 2010 Progress Review of the National Strategy and Recommendations for the Decade Ahead

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Prepared by

the Suicide Prevention Resource Center (SPRC)

and

Suicide Prevention Action Network USA (SPAN USA),

a division of American Foundation for Suicide Prevention

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I. INTRODUCTION

During the second half of the twentieth century, suicide prevention leaders launched pioneering efforts in disparate areas of research, training, and survivor support. These early days of suicide prevention were marked by a lack of formal organization and little funding. The focus was on creating a compelling vision that would bring interested people on board and attract support. By the late 1990s these varied strands began to come together to form the beginnings of a *suicide prevention movement.* The movement was bolstered by new developments in research and interventions, changes in public attitudes about both suicide and the larger field of mental health, and the advocacy of survivors of suicide loss.

In 2001, the Surgeon General of the United States issued the National Strategy for Suicide Prevention (NSSP).[1] It laid out a series of goals and objectives designed to reduce the incidence of suicide and suicidal behaviors in the United States. Inherent in the NSSP was an acknowledgement that suicide is a serious public health problem that is preventable. The NSSP established a common reference point that allowed the disparate elements of the movement to see their own priorities, while influencing each of them to work within the overall framework of the NSSP. It has also served as a guide identifying shared goals that provided a credible rationale for gaining public and financial support. The process of creating the National Strategy provided leaders of elements of the nascent movement with an opportunity to work together, to learn that there was strength in collaboration, and to reach a consensus on shared goals.

> ***"The National Strategy has become a rallying cry for the movement; it gave us a foundation to build on and credibility advocating in the Statehouse."***
>
> --SPAN USA Survey Respondent

Since publication of the NSSP, activity in the field of suicide prevention has increased exponentially. Government agencies at all levels, schools, not-for-profit organizations, and businesses have initiated programs and public awareness campaigns to address suicide risks. But despite these increased suicide prevention efforts, figures show that in the U.S., the overall rate of suicide in the past decade remains essentially unchanged. In some demographic groups the rates are decreasing significantly; however, in others, the trend is upward. One can only conclude that, to date, the intensity and approach of the prevention campaign has not been a match for the complexities and depth of the suicide problem.

Each year since 2001, over 30,000 people have died by suicide in the United States – twice the number who die as a result of complications related to HIV/AIDS. Suicides outnumber homicides by three to two, and every year some 650,000 persons receive treatment in emergency rooms following suicide attempts.[2]

This document reviews developments in the field of suicide prevention in the nine years since the NSSP was published. As a snapshot taken at the end of this decade, it identifies the areas of most important progress as well as the critical areas that have gone relatively unaddressed. It also explores new issues or initiatives that have emerged to claim attention or offer solutions since the development of the NSSP in 2001. Its purpose is to inform discussions about future initiatives to achieve the ultimate public policy goal behind the NSSP: *to reduce the morbidity and mortality of suicidal behaviors*.

A. BACKGROUND

Until quite recently, with the exception of some support for suicide-related mental health research, suicide received meager attention in national policy. In 1996, survivors of suicide loss who saw the need to mobilize attention and the political will to prevent suicide formed the Suicide Prevention Advocacy Network USA (SPAN USA)[3] and launched a campaign to encourage the development of a national suicide prevention strategy for the United States. SPAN USA's efforts resulted in two Congressional Resolutions[4] recognizing suicide as a national problem and suicide prevention as a national priority, providing further impetus to develop a national suicide prevention strategy.

Based on recommendations from the United Nations and World Health Organization, the advocates also sought the creation of a public/private partnership to promote suicide prevention. They succeeded in gaining the support of Dr. David Satcher, then Surgeon General and Assistant Secretary for Health, U.S. Department of Health and Human Services (DHHS), to jointly sponsor a national conference that convened in Reno, Nevada, in October 1998. The "Reno Conference" was chaired by Surgeon General Satcher and attended by a broad array of participants including many federal agencies; representatives from every state and the District of Columbia; researchers; health, mental health and substance abuse clinicians; policymakers; suicide survivors; consumers of mental health services; and community activists and leaders. Based on the conference recommendations, Dr. Satcher issued a "Call to Action to Prevent Suicide" in July 1999,[5] declaring suicide a serious public health problem requiring attention and action. This initial effort to create an agenda for the nation framed suicide prevention through three constructs: Awareness, Intervention, and Methodology (AIM), and enumerated fifteen broad recommendations consistent with a public health approach to suicide prevention. The Reno Conference can be seen as the founding event for the modern suicide prevention movement and the "Call to Action" became its original charter.

At about the same time, two major DHHS reports brought new focus and attention to mental health and suicide. Dr. Satcher's office issued "Mental Health: A Report of the Surgeon General," the first publication of its kind, late in 1999. And in 2000, DHHS's sweeping agenda for the nation's public health, "Healthy People 2010,"[6] established targets for reducing the number of deaths by suicide within ten years. Advocates for suicide prevention seized the opportunity presented by these Federal efforts to shine a spotlight on suicide and related mental health concerns and to continue the push for a national suicide prevention strategy.

In early 2000, the Secretary of Health and Human Services established a Federal Steering Group (FSG),[7] to "...ensure resources identified...for the purpose of completing the National Strategy [for Suicide Prevention] are coordinated to speed its progress."[8] The FSG reviewed the recommendations of both the Reno Conference and the "Call to Action" and set an agenda to develop a comprehensive plan that would foster the development of suicide prevention activities at the local and State levels. This plan was the National Strategy for Suicide Prevention (NSSP).

The NSSP proposed a sweeping agenda of eleven goals and 68 objectives designed to offer a comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors.[9] The NSSP was to serve as a wide-ranging "catalyst for social change, with the power to transform attitudes, policies, and services."[10] It proposed an ambitious framework for tackling suicide, which included promoting public awareness campaigns and research on suicide alongside measures designed to address suicidal behavior on multiple levels including those associated with

the individual, peers, family, community and society. For the broader suicide prevention community, the NSSP immediately provided a common point of reference and a resource for advocacy at the state and local levels, while directing more attention on the needs of those bereaved by suicide.

In 2002, shortly following the release of the NSSP, the Institute of Medicine published "Reducing Suicide: a National Imperative,"[11] which delved into the state of the science of suicide prevention, knowledge gaps, prevention strategies, and research designs. The following year, the President's New Freedom Commission on Mental Health issued its report, "Achieving the Promise: Transforming Mental Health Care in America,"[12] highlighting in its first recommendation the need for a "national level public-private partnership to advance the goals and objectives of the NSSP."

> ***"Having a National Strategy is important. However, it appears that people have run with the easy parts, but have not implemented the harder parts of the strategy***."
>
> - Key Informant

One of the central objectives of the NSSP was to establish a public/private partnership to oversee its implementation. The partnership was to be funded with government and private monies, with a mission to ensure suicide prevention is a national priority, and to serve as the catalyst for implementation of key goals and objectives of the National Strategy for Suicide Prevention (NSSP).[13] In the fall of 2008, SAMHSA initiated a project to lay the groundwork for such an initiative by funding this report.

B. METHODS

This report provides an overarching look at the field of suicide prevention in the United States to identify in broad terms what has occurred since the release of the NSSP, as well as to highlight the most critical areas in which more needs to be done.

No formal evaluation of the impact of the NSSP was planned or conducted when the NSSP was released. Since the NSSP has served as a common reference point for those involved in the field, its organization was used in this report to identify and organize issues, actions, and problems. The review was designed to draw upon a wide variety of information culled from public sources and knowledgeable informants to paint a picture of developments and areas of need to be addressed in the field of suicide prevention.

By offering the advocates, clinicians, researchers, public health workers, decision makers and survivors engaged in suicide prevention a picture of what has been accomplished and what remains to be done, it is hoped this review will serve as a guide for measuring future progress, as well as a point of departure for further deliberations about how best to pursue the national goals embodied in the NSSP.[14]

To develop a methodology for the review, Project Team members:

- Convened a Planning Group comprised of individuals having important content knowledge of suicide prevention and the status of suicide prevention activities across the country;
- Asked Planning Group members to identify priority areas for information collection and provide input on topics to include in the review;

- Reviewed previous efforts that examined the progress of the NSSP;
- Identified the activities proposed by the NSSP that had transpired since 2001; and
- Identified activities that had occurred in the field that were not identified or proposed in the NSSP.

Based on initial discussions with the Planning Group, the Project Team decided to concentrate its efforts primarily in the following domains that were deemed central to understanding the developments and accomplishments since the NSSP was issued:

- Public education and awareness
- Public policy
- State planning and implementation
- Training
- Clinical care
- Research
- Surveillance
- Translation of science to practice

Additionally, the Planning Group identified cultural competence, coordination of care, and the central role of grassroots initiatives at State, Territorial, and local levels as cross-cutting themes to consider.[15]

Information gathering methods included:

- Compilation of Existing Information. The search for evidence of the implementation of the NSSP encompassed a wide variety of websites and various published and unpublished reports describing organizations, programs and projects. Additionally, SPRC staff conducted library research on several topics, including survey data on public perceptions, public information campaigns, accreditation standards for mental health clinical training programs, and the contents of State suicide prevention plans. Additionally, SPAN USA and SPRC staff prepared summary descriptions of activities that met specific NSSP objectives.

- Interviews with Key Informants. Approximately 30 leaders with a broad range of expertise and involvement in suicide prevention at local, state and national levels were identified and participated in interviews.

- Web-based survey. The project also benefitted from a web-based survey independently conducted by AFSP/SPAN USA in the summer of 2009 to gather the impressions of people across the broad suicide prevention community regarding progress made and important priorities for the future. Over 300 people participated, including survivors of suicide loss and suicide attempts; national, State, Territorial, and community leaders; Federal government officials, public and mental health providers; suicide prevention coalition members and leaders; teachers, trainers, and researchers.

This report is a synthesis of the information gathered through all three approaches.

The recommendations in this report were generated to add definition and clarity that is not reflected in the NSSP. They are founded on current perspectives and understanding that was not possible nearly a decade ago. This report does not repeat recommendations included in the NSSP.

II. REVIEW FINDINGS

A. OVERVIEW

There is much good news to celebrate in this report. In some instances, the initiatives called for in the NSSP have come to complete fruition, and often with considerable effect. It seems obvious that the NSSP has provided the roadmap for myriad activities, and consequently, a number of very important objectives have been achieved. Additionally, there have been significant achievements in the field that had not been anticipated at the time of the NSSP's launch. Unfortunately, in some areas evidence of attention or success is lacking. Overall, the amount of activity that contributes to suicide prevention nationwide is exponentially greater than in 2001 and continuing to grow. Unfortunately, the field lacks a means to assess the results or to guide future action. And on the single most important indicator, the rate of death by suicide, the results are mixed.

A number of factors that go beyond the boundaries of suicide prevention have contributed to the developments reviewed here. Chief among them are the public's engagement in a larger debate encompassing healthcare and mental health issues generally, and the willingness of opinion leaders or celebrities to speak out about their own battles with mental illness and suicidal thoughts and behaviors.

Some of the most noteworthy achievements that will be discussed include:

- Federal and State legislation that has advanced suicide prevention planning and programming, detection of suicide risk, and access to care.
- Establishment of the Suicide Prevention Resource Center, offering training, technical assistance, tools, and informational resources to the field.
- Establishment of a Best Practices Registry.
- Establishment of the Suicide Prevention Lifeline, a national network of suicide prevention crisis centers.
- Development of the initial elements of the National Violent Death Reporting System.
- Training for members of the public in detection of suicide risk and appropriate response.

Areas with movement, but requiring more still more investments:

- Research into the causes of suicide and effective interventions.
- Development, evaluation, replication, and implementation of more evidence-based programs, practices, and treatments.
- Development of effective public awareness and social marketing campaigns, including targeted messages for specific segments of the population that can change attitudes, norms and behaviors.
- Training of clinicians and other service providers to detect and respond to suicide risk.
- Access to behavioral healthcare and improved coordination across the continuum of care.
- Training for behavioral health providers in evidence-based or evidence-informed practices.
- Collaboration among agencies within States and Territories, and among federal agencies, and improved communication between the states, tribes, territorial and federal entities.
- Public education campaigns to reduce access to lethal means.
- Culturally competent interventions for tribes and other minority and culturally diverse populations.
- Suicide prevention in rural areas.
- Suicide prevention among middle-aged and older adults.
- Integration of suicide prevention practice into substance abuse programming.
- Timely dissemination of national injury surveillance data.
- Development and enhancement of monitoring systems for nonfatal suicidal behavior at the state, territorial, and local level.
- Coordinated national leadership to guide the direction and progress of the field.

The findings in this report are organized according to the AIM outline used in the Surgeon General's Call to Action and the NSSP itself: *A-Awareness, I-Intervention, M-Methodology*. An additional section highlighting the unique needs of special populations constitutes a fourth section. Recommendations that expand on or go beyond the objectives of the NSSP are inserted throughout the Findings section and are listed in Appendix A.

> ***"We need to get people other than the choir to sing. We need journalist associations, employee assistance programs, chambers of commerce, defense lawyers, pediatricians, family practitioners, and others to get involved. They see people every day that may be at risk and we need them to partake in the conversation."***
>
> - Key Informant

B. AWARENESS

The NSSP's Awareness goals and objectives focused on increasing awareness of suicide as a serious, but preventable public health problem, developing broad public support for action, reducing the stigma associated with mental disorders and substance abuse, and seeking services for these problems and for suicide risk. Recommended action included public information campaigns, convening of forums, use of the internet to disseminate information, recruiting new groups and institutions to suicide prevention, and establishing a "national coordinating body" to implement the NSSP.

Perhaps the most notable observed change in the intervening years since the NSSP launch in 2001 is the public's heightened awareness about suicide in general. According to polling conducted by a

national health research firm, 78% of Americans believe that many suicides are preventable with appropriate research, interventions, and services; moreover, 86% of the population believes that it is important to invest in suicide prevention.[16] Unfortunately this is the only survey that polled these questions; follow-up surveys are needed.

Growth in the number of state, territorial, and community coalitions, many of which have broadly disseminated suicide prevention training for the general population, has contributed to this increasing awareness. New Federal legislation, particularly aimed at preventing suicide by young adults and veterans, both reflects this increasing public awareness and public support and further advances it. Federal investments have also led to the development and widespread marketing of a national suicide prevention hotline. Not all of these achievements were anticipated or called for in the NSSP; however, they occurred within the context of awareness building activities encouraged by the NSSP.

Two unexpected societal developments also helped push suicide and suicide prevention into the limelight: record high numbers of suicides among members of the Armed Forces and anecdotal evidence that the recent economic crisis that forced millions of workers out of jobs, homes, and health care, contributed to an increase in suicidal behaviors. These tragic social problems have had the ancillary effect of drawing public awareness – and government response – to the issue of suicide prevention.

The following section of the review highlights several public awareness and public information campaigns and legislative initiatives that have helped raise awareness about suicide prevention since 2001.

1. Public Awareness and Public Information Campaigns

The suicide prevention movement has invested extensively and with great enthusiasm to increase awareness and understanding of the problem of suicide. Although the relationship to these activities cannot be determined, this review found a general agreement that public attitudes towards mental illness in general and suicide in particular have become less stereotyped and more compassionate. People seem to be more willing to discuss mental health problems and suicide openly, and to see the need for treatment (for themselves and others). This review also found a growing body of information about how to craft and disseminate effective communications campaigns, as well as brief documents providing recommendations for safe and effective messaging for suicide prevention.[17]

Public awareness campaigns have been undertaken by a host of public and private sector actors. Recently, three Departments of the Federal government have invested significantly in campaigns: Defense, Health and Human Services, and Veterans Affairs. These involve broadcast media PSAs, web presence, advertising on public transportation, and various leaflets and handouts. Additionally, many state and territorial suicide prevention efforts, including some funded with Federal grants, have launched state-wide public information campaigns, although no conclusions can be drawn about the specific impact these have had and there has been little or no research to evaluate their effectiveness.

Statewide public information campaigns were specifically recommended in the NSSP. A resource scan by the Suicide Prevention Resource Center (SPRC) in the spring of 2009 found that at least seventeen state agencies had developed public information campaigns with some level of statewide distribution:

Alabama	Louisiana	Pennsylvania
Alaska	Mississippi	Rhode Island
Arizona	Montana	Tennessee
Colorado	New Hampshire	Texas
Hawaii	New York	Vermont
Kentucky	Oregon	

Additional states described diverse media efforts that were not statewide or where planning had been delayed. In general, information was unavailable on the proportion of the population reached by these campaigns, and even the campaigns with some statewide implementation varied widely in their scope, intensity, and focus. Thus, it is unclear how many campaigns meet the NSSP's goal to increase the number of states in which public information campaigns exist.

The scan also revealed that examining statewide campaigns does not capture the full scope of public education work in suicide prevention since 2001. One private organization that has taken a lead in public awareness is Suicide Awareness Voices of Education (SAVE). SAVE has developed numerous campaigns, some of which were designed specifically to increase public knowledge of suicide prevention ("Prevent Suicide--Treat Depression," "Stop Depression from Taking another Life," "Treat Depression As If Your Life Depends on It," "You Can Too!" among others). SAVE reports that its campaigns alone have appeared in nearly every state in the country and have rendered over one billion exposures, however the effects of these mass media efforts have not been evaluated.

Another example is the success the field has had in raising broader awareness and public support through the establishment of walks for suicide prevention. The Out of the Darkness Walks organized by the American Foundation for Suicide Prevention (AFSP) were launched with a 26-mile walk in 2002 in Washington DC and have since expanded to nearly 200 locations in 47 states. According to AFSP, more than 100,000 people have walked for suicide prevention to date, generating over 120 million media impressions via print, radio, and television stories that focus on suicide causes, warning signs, and the need for prevention. The walks have also served to promote local suicide prevention resources and the National Suicide Prevention Lifeline. Again, evaluation is lacking, so that the larger effects on attitudes and beliefs of Americans about suicide and suicide prevention are not known.

In addition to these examples, scores of groups have produced suicide prevention posters, brochures, advertisements, or other communications materials in recent years. Few of these products, however, have been evaluated

> ***"A much better job needs to be done in the public health and suicide prevention community in terms of tailoring messages for specific audience segments. The suicide prevention community needs to look at how they develop products, services, and outreach with an eye to the way corporations have developed their own plans, products, etc., using the best communications science."***
>
> - Key Informant

in any systematic way. It is also not clear how many, if any, of the public information efforts were developed using principles for developing effective communications content: following a systematic planning process, conducting audience research, pretesting materials, using the communications efforts to support other related prevention approaches, and evaluating effectiveness.

A sampling of public information materials found many messages that are generally consistent with suicide prevention goals, for example: messages that promote help-seeking behavior, promote available resources, and emphasize that mental illness is treatable. Other aspects of the messages, however, raise potential concerns. For example, many general awareness materials provide statistics or statements about the extent of suicide that may leave the impression that suicide is relatively common—it is not. This practice may serve to normalize suicide, which runs counter to the safe messaging recommended by most suicide prevention experts. Presumably this information is designed to demonstrate the gravity of the problem and the need for action. Although messages of this tenor are well suited for policymakers who can direct resources toward suicide prevention, they may be harmful if given to the general population. Furthermore, many messages calling for "action" fail to specify what actions should be taken and how to take them.

Another concern is that many materials do not appear to be tailored to a defined target audience. No single slogan or message works for everyone, yet many campaigns seem to have a very general audience in mind. It is plausible that developing campaigns with the goal of reaching a large proportion of the population, such as a typical "statewide" campaign, results in messages that are less tailored, which according to the communications literature, are typically less likely to result in change. Experts in health communications suggested that the NSSP's objective to reach large portions of the population with public information campaigns has had the unintended consequence of prompting states and suicide prevention organizations to produce a few, very generalized campaigns rather than many campaigns tailored for distinct segments of the population.

Lastly, it appears that many of the current public awareness efforts "stand alone" without the benefit of being an integral part of a more comprehensive plan. These efforts are more effective when integrated with a comprehensive, multi-level suicide prevention program.

As a final note on the subject, the general consensus of informants for this report is that perceptions of stigma related to suicidal thoughts and behaviors still hinder our national dialog on the topic, as well as the overall progress at the community level.

Recommendation 1: Develop and implement plans to increase the proportion of public awareness and education campaigns that reflect both the fundamental principles of health communication and the safe messaging recommendations specific to suicide.

Recommendation 2: Promote the importance of using public awareness and education campaigns as an adjunct to other interventions rather than as stand-alone initiatives. Whenever possible, health communications campaigns should have much more specific goals than simply "raising awareness."

Recommendation 3: Promote the development of public awareness and information campaigns that are tailored for and targeted toward specific audiences and that describe the actions those audiences can and should take to prevent suicidal behaviors.

2. Federal Policy and Program Initiatives

This review found widespread recognition of the notable legislative and policy successes of the past decade to promote suicide prevention awareness and advance practice in the field. Two significant Federal legislative accomplishments since 2001 were passage of the Garrett Lee Smith Memorial Act and the Joshua Omvig Veterans Suicide Prevention Act.

> ***"Nationally, there has been a great increase in the amount of information available via the web through various suicide prevention organizations. This has aided groups on the State and local level to better assess their needs and access resources. Groups are better linked with each other and the subject is being discussed more openly on a local level."***
>
> - SPAN USA Survey Respondent

a. Garrett Lee Smith Memorial Act

The Garrett Lee Smith Memorial Act (GLSMA) is generally regarded as the single most significant legislative accomplishment in the field of suicide prevention during the past decade. The Act was named for the son of Senator Gordon Smith (R-OR), a college student who died by suicide in late 2003. It combined two legislative initiatives that were moving through Congress simultaneously: one for early identification and intervention of youth at risk for suicide and another focused on college suicide prevention programs. With strong support and advocacy by the suicide prevention and mental health communities, the bill passed unanimously in the Senate and with a strong majority in the House, and was signed into law by President George W. Bush in October 2004. The GLSMA created the first significant Federal grant program directed specifically at suicide prevention. Since its enactment, GLSMA has provided grants to States, Tribes, Territories, and institutions of higher education to develop and implement youth and college suicide prevention programs. As of 2009, these grants have been made to 44 States, one Territory, 20 Tribes or Tribal consortiums, and 87 colleges and universities. In addition, the GLSMA authorized ongoing funding for a Suicide Prevention Resource Center (SPRC). As of March 2009, $142.3 million had been appropriated for GLSMA grant programs, of which $20.73 million have been allocated to SPRC.[18] (The SPRC is described in more detail below.)

b. Military Suicide Prevention

Reports of high rates of suicide within the ranks of military members and veterans have elicited concern on the part of the U.S. Congress and strong responses from policymakers within the Departments of Defense and Veterans Affairs. Over the past decade each military service has launched suicide prevention policies and programs numbering in the hundreds in an effort to promote overall mental wellness and to combat suicide. More programs, unfortunately, do not necessarily result in desired outcomes, and to date there has been relatively little effort to scientifically measure the effectiveness of these programs, though this situation is changing rapidly, as will be discussed later in the report.

c. Joshua Omvig Veterans Suicide Prevention Act

The Joshua Omvig Veterans Suicide Prevention Act (named for a veteran of Operation Iraqi Freedom who died by suicide in 2005) was introduced in both the House and Senate in the 110th Congress. In the fall of 2007, the Senate and House passed the Omvig bill and it was signed into law by President Bush shortly afterwards. The Joshua Omvig Veterans Suicide Prevention Act (P.L. 110-110) directs the Secretary, Department of Veterans Affairs (VA), to develop and implement a comprehensive program designed to reduce the incidence of suicide among veterans. The law requires that the program include staff education, mental health assessments as part of overall health assessments, a suicide prevention coordinator at each Department medical facility, research on best practices for suicide prevention among veterans, research on mental healthcare for veterans who have experienced sexual trauma, 24-hour availability of mental healthcare to veterans, a toll-free hotline for veterans staffed 24/7 by appropriately trained mental health personnel, and outreach to and education for veterans and the families of veterans. In the past few years the Department of Veterans Affairs has become one of the most vibrant forces in the U.S. suicide prevention movement, implementing multiple levels of innovative and state of the art interventions, backed up by a robust evaluation and research capacity. More information on the VA's efforts appears later in this report.

d. Government Performance and Results Act (GPRA)

The Government Performance and Results Act of 1993 seeks to shift the focus of government decision making and accountability away from a preoccupation with the activities that are undertaken—such as grants dispensed or inspections made—to a focus on the results. In 1998, the Health Resources and Services Administration became an early adopter by establishing youth suicide as a performance measure for grants under its Maternal and Child Health Bureau. The Department of Justice has also invested significantly in improved surveillance of suicides among incarcerated populations and among clients of the juvenile justice system.

Indian Health Service (IHS) has developed a suicide surveillance reporting tool to document incidents of suicide in a standardized and systematic fashion. The suicide surveillance tool captures data related to a specific incident of suicide, such as date and location of act, method, contributing factors, and other useful epidemiological information. Local and national reports can be sorted by a number of different variables including the number of suicide events by sex, age, community, tribe, and others. The FY 2010 GPRA target is to collect data on 1,700 events.

Although these practices within the Federal government appear to be raising visibility of suicidal behaviors as an important performance measure, there would seem to be many more opportunities to reflect suicide outcomes as salient performance measures for government grant programs in behavioral healthcare and medical care delivery, and social service programs for children, families, and aging, in particular.

Recommendation 4: Implement suicide related GPRA performance measures in government grant programs serving populations at increased risk for suicide, such as aging services; mental health, substance abuse, and healthcare; labor; education; and Tribal programs.

3. Communication and Collaboration

The NSSP emphasized the need for greater communication and collaboration in the field of suicide prevention and significant advancements have been made. Although the number of conferences and meetings devoted to suicide prevention has increased over the past decade, significant demand exists for more opportunities to share ideas in face-to-face settings. Suggestions include conferences and symposia at both the national and regional levels that draw on knowledge and expertise within the suicide prevention community and provide a venue to share best practices and research findings.

a. Institutional Players

Two groups, the Federal Working Group (FWG) on Suicide Prevention and the National Council for Suicide Prevention (NCSP), were cited by stakeholders as examples of collaborative efforts among institutional players and national advocacy organizations. The Federal Working Group on Suicide Prevention meets to discuss Federal agency initiatives, promote collaboration among Federal agencies working on preventing suicide, and hear reports on current and potential programs. The FWG also requests and compiles input from its members on the efforts undertaken at the various Federal agencies that support any of the NSSP goals and objectives. A "Compendium of Federal Activities" is updated twice yearly.[19]

> ***"In the past, there were regional conferences where states were allowed to bring ten members of their state team. A lot of progress was made because of that. It's time to revisit a national conference tied to suicide prevention."***
>
> - Key Informant

The National Council for Suicide Prevention (NCSP), a coalition comprised of the nine national not-for-profit organizations each solely dedicated to suicide prevention, meets quarterly by telephone and once a year in person to discuss and work to advance the major initiatives in the field of suicide prevention. Discussions include roles and activities of Federal and state programs, research, advocacy, prevention, and intervention and postvention programs. The NCSP meets with the Federal Working Group twice per year, once in person and once by telephone, annually with the Director of NIMH, collaborates with other national organizations on various projects (such as the NCSP Suicide/Inhalant Abuse project with the Alliance for Consumer Education), develops position statements and acts as a collective voice for suicide survivors.

> ***"There is more communication, but we have failed to take advantage of the networks that have been created. Communication has been established, but not nearly enough. We need to figure out how to use the potential that lies there."***
>
> - Key Informant

b. Federal Government, States, Tribes and Territories

The review found a growing recognition that communication across the field has been greatly enhanced by the Garrett Lee Smith Memorial Act grant program and through the targeted efforts of SPRC and many others, and that these initiatives have given rise to the growth of Statewide and local coalitions, peer-to-peer learning, and web-enhanced communications and collaboration among communities of practice.

> ***"The breadth of the NSSP was its weakness. We need to prioritize***."
>
> - Key Informant

It is also apparent, however, that many individuals working in the field remain unaware of the Federal efforts or feel that insufficient Federal effort trickles down to the community level. Furthermore, they think that there are too many duplicative efforts, e.g., state after state and community after community creating the same or similar public awareness and training materials. Also, states do not appear to be communicating their own successes or best practices with the Federal government or with other states. There is certainly a perceived need for yet more communication and coordination between the Federal government and the state entities responsible for suicide prevention. There also appears to be an unsatisfied desire for more communication among Tribes, where suicide rates are particularly high and more sharing of experiences could be helpful.

4. Public-Private Partnership

Before the ink was dry on the NSSP, Federal partners began the work of designing the organization that would fulfill a crucial piece of the strategy—a public-private partnership to catalyze and coordinate the implementation of some elements of the strategy. Planning efforts continued through the early years of the new century and included an elaborate effort to harness ideas generated by suicide prevention leaders across the country in an effort to prioritize the nation's agenda. The latest planning activity along these lines is this report and the work of the National Action Alliance Planning Group that guided it. In the first quarter of FY 2010, the seed funding to establish a National Action Alliance for Suicide Prevention (Action Alliance) was identified both from SAMHSA and from within the Suicide Prevention Resource Center grant. After extensive consultation with leaders in both the public and private sectors of the suicide prevention community, an Executive Secretary was hired and the foundation for the Action Alliance was laid. First-year plans call for naming two co-chairs (one from each of the public and private sectors), recruiting 30-40 Executive Committee members, establishing an action agenda for the first years' activities, and developing a broad funding base to sustain the work of the body. Not only will this entity provide coordination and set priorities for many of the nation's suicide prevention efforts, it will help advance a desperately needed recruiting effort to build collaborative relationships with other professional and service groups that can play key preventive roles for suicidal individuals.

C. INTERVENTION

The NSSP Intervention goals and objectives focused on statewide comprehensive suicide prevention plans, promotion of evidence-based clinical practices and prevention programs, training and technical assistance for community-based prevention programs, and training for recognition and

management of suicide risk. Professionals in the field of suicide prevention agree that early and effective intervention to prevent suicides requires that a number of factors be in place: better training and resources for gatekeepers—individuals in the community who identify people at risk for suicide and intervene, first responders, clinicians and public health officials; effective approaches to recognizing depression and other mental illnesses that contribute to suicide; adequate access to and coordination of care; reducing and restricting access to the lethal means by which individuals die by suicide; and high-functioning State and local suicide prevention coalitions that foster communication across the various components of public and private health and social service organizations. This section of the review examines the most prominent initiatives that have occurred in these areas.

1. State and Community Suicide Prevention

The NSSP called for comprehensive State suicide prevention plans that a) coordinate across government agencies, b) involve the private sector and c) support plan development, implementation and evaluation in communities. The NSSP noted that in 2001, while a number of States had suicide prevention plans, few were comprehensive and the plans did not uniformly link public health, mental health, and substance abuse programs. Moreover, not all addressed the entire life course and few involved all key stakeholders, such as education, justice, social services, and the private sector.[20]

Today there are 48 States with plans – clearly a sign of progress. As would be expected, the plans still vary in their depth and comprehensiveness, but the state of the field is far advanced from 2001. As mentioned above, it is evident from highlights of interviews with the leadership of several States that these plans and programs would benefit from increased coordination or more uniform practices.

The primary foci of State efforts appear to have been in increasing awareness, training of gatekeepers and building volunteer networks. As noted elsewhere, much of the work has been targeted towards youth suicide prevention. However, many States have developed or revised plans to address suicide across the life course and have intentionally designed multi-level approaches for the range of youth and elder serving organizations as well as the health and mental healthcare delivery systems. Interest in military and veteran suicide has further expanded State leaders' scope of addressing suicide prevention.

State suicide prevention leaders have varying levels of suicide prevention experience, with some involved in the field for over 15 years and others for as little as one. Many are engaged in the larger fields of violence prevention, mental health, or public health. A few have staff dedicated to suicide prevention; for others, suicide prevention is one of many areas of responsibility. In many cases, their efforts appear to have centered on developing Statewide plans and emphasize the importance of local participation. However, only a few States have intentionally addressed the third element of the NSSP's call to States: supporting the work of planning, implementation, and evaluation at the community level. Where community-level activities are evident, local groups have generally functioned on shoestring budgets and the recent economic downturn has further challenged their financial stability.

This review found that Michigan, Ohio, and Tennessee had each innovatively focused support on the community-level coalitions. In most cases, the State provided technical assistance (TA) to communities, including series of training and TA conferences, in order to help them identify existing or build new public health-oriented collaboratives to advance suicide prevention. The community collaboratives included a cross-section of social and health service providers and they recognized faith-based organizations as being especially important in reducing stigma and providing venues for community training. Each of these States was able to track, by county, the progress in planning and implementation and used this information to plan future activities.

Another community-level pioneering effort of note is the Connect Suicide Prevention Program developed by NAMI NH (The National Alliance on Mental Illness New Hampshire). Utilizing a public health approach that includes planning, implementation and evaluation, Connect addresses key objectives of the NSSP by working across systems and bringing together individuals, peers, families, service providers and State agencies to address community risk and protective factors and work together on suicide prevention efforts. Through the use of "best practice" protocols and training, Connect reduces gaps between service providers, improves access to care and promotes an integrated community response to suicide prevention, intervention and postvention.

> ***"As a mental health practitioner and suicide survivor, I have become more aware of the growing number of resources. I'm not sure, however, that most people are aware of the resources that exist."***
>
> - SPAN USA Survey Respondent

Recommendation 5: Promote more active and systematic state support of suicide prevention planning, implementation, and evaluation at the community level; systematically share successes across States.

2. Suicide Prevention Resource Center

One of the most significant advances since the launch of the NSSP was the establishment of the Suicide Prevention Resource Center (SPRC). Created by funding through SAMHSA in October 2002, SPRC now receives funding through the Garrett Lee Smith Memorial Act and represents an important step towards fulfilling the NSSP goal to develop "one or more training and technical resource centers to build capacity for States and communities to implement and evaluate suicide prevention programs." Its work has become a central focus for efforts to address many of the NSSP's Intervention goals and objectives.

SPRC provides a wide variety of services, including: technical assistance, training programs, field support, library and clearinghouse, and support for GLSMA grantees -- all of which are intended to

improve the development, implementation, and rigorous evaluation of effective suicide prevention programs and practices.

Information, products, and services are disseminated through SPRC's website, www.sprc.org; its online library, http://library.sprc.org/; its online and face-to-face training programs; webinars in various formats; and consultation and support directly from its expert staff. Consultation can occur by telephone, email, or face-to-face at meetings and conferences. The SPRC website is accessed by over 20,000 unique visitors monthly. SPRC also produces a weekly electronic newsletter for online subscribers, "The Weekly Spark." The Weekly Spark contains announcements and information about suicide, suicide prevention and mental health issues, offering brief summaries of national, state and international news; analyses of relevant research findings; descriptions of funding opportunities, and links to additional resources. SPRC has produced well over 50 reports or other printed resources[21] to support suicide prevention activities across the medical and public health sectors.

3. Access to and Coordination of Effective Care

a. Evidence-based Therapies

Since the release of the NSSP, research has produced the first evidence that certain psychotherapies, such as cognitive behavioral therapy (CBT) and dialectical behavioral (DBT) are effective in preventing repeat suicide attempts. One study provided ten weeks of CBT for attempt survivors, who were identified after presenting themselves in an inner city emergency room. After eighteen months, the results showed a fifty percent reduction in repeat attempts.[22] Both of these therapies are included in the National Registry of Evidence-based Programs and Practices and the SPRC/AFSP Best Practices Registry. Unfortunately, there is a shortage of clinicians trained to provide these evidence-based psychotherapies. Some experts believe that until clinical training programs for the major mental health disciplines include training in these evidence-based therapies, the gap between research and clinical practice will remain.[23]

b. Coordination and Continuity of Care

It is generally agreed that the healthcare system fails to adequately address continuity and coordination of care. This is a particular problem for suicidal individuals. One of the most common, and perhaps detrimental, examples is suicidal patients who are treated in emergency departments. In this setting, patients generally don't receive adequate treatment to address underlying mental illnesses or substance use problems; nor do they leave connected with the kind of follow-up outpatient care that could expedite their recovery.

> ***"We are putting screening in the hands of primary care people, but treatment rates are down. The treatment for depression has actually decreased in the last five years."***
>
> - Key Informant

The importance of providing follow up services promptly after emergency department discharge is highlighted by findings from the South Carolina National Violent Death Reporting System that ten percent of all the suicides in South Carolina had been seen in an emergency department within the previous 60 days.[24] The importance of prompt follow-

up after inpatient discharge was also highlighted by a major study by the Veterans Administration which showed the period after inpatient discharge to be the time of greatest risk for suicide for depressed veterans.[25] The potential benefits of intervening at these times is also highlighted by the fact that the only two randomized controlled trials that have shown reductions in death by suicide both involved follow-up after an acute suicidal crisis[26]. Additional research focusing on the potential for suicide prevention during and after emergency department care is now also being supported by both NIMH (ED SAFE), and the Veterans Administration (SAFE Vets).

According to a June 2009 draft report produced by the AAS on behalf of SPRC, "suicide is a public health problem for which continuity of care is one essential means for effective prevention." The report suggests that continuity of care forms "a solid, patient-centered framework around which to organize health care systems."[27]

Recommendation 6: Expand efforts to provide effective follow up care after emergency department discharge of suicidal persons.

Recommendation 7: Expand efforts to provide effective follow up care after inpatient discharge of suicidal persons.

There is also consensus among stakeholders that primary care settings must become more engaged in suicide prevention. Too often, primary care clinicians do not have the training to identify and respond to suicidal patients. Additionally, they may not have the ability to follow up with a referral to a mental healthcare professional, simply because there are not enough mental healthcare professionals to adequately treat the population at large. In 2009, SPRC, with its partner the Western Interstate Commission for Higher Education, released a toolkit for use in rural primary care practices to help incorporate evidence-based and evidence-informed suicide prevention approaches into day-to-day practice.[28] In the same year, AAS released a 1.5 hour training module tailored specifically to primary care clinicians. These resources support what may become the preferred approach to care: co-management of patients by primary care and mental health professionals using a chronic disease management model in the context of the patient-centered medical home. This emerging model will need to undergo rigorous evaluation and continuous quality improvements.

Recommendation 8: Promote evidence-based and evidence-informed practices for reducing suicide risk among primary care patients.

Although examples of comprehensive, community-wide efforts to provide coordinated care may be limited, noteworthy progress is being made in the Departments of Veterans Affairs (VA) and Defense (DoD). Within the VA, as of October 2009, there are over three hundred suicide prevention coordinators servicing all VA Medical Centers. These Suicide Prevention Coordinators interact regularly with the VA Suicide Prevention Hotline and help provide monitoring, follow-up, and enhanced services to veterans identified as at high risk. The Blue Ribbon Work Group that examined the VA's suicide prevention programs found that the Veterans Health Administration (VHA) had developed a comprehensive strategy to address suicides and suicidal behavior that included a number of initiatives and innovations that hold great promise for preventing suicide attempts and completions. Evaluation of the impact of these efforts will be of critical importance not only to

promote continuous improvement in VHA's suicide prevention efforts, but also to inform suicide prevention efforts across the nation and reach veterans who do not utilize VHA services.

In the Department of Defense, intensive efforts are being made to utilize a community-wide approach to suicide prevention and to coordinate suicide prevention efforts during transitions between installations and between deployment and garrison, as well as when leaving the services and transitioning to VA care. Efforts are being made to coordinate treatment between VA and the DoD through data sharing. This data sharing will assist service members and veterans, so that the records of diagnoses and treatment can follow service personnel to the VA after a tour of duty or following discharge from military service. Given the complexities of these government systems, it bears watching to see what kind of progress is made and whether it can be replicated in the private sector health system.

"There's no doubt at all that as we look at health reform, mental health coverage is a critical part of making Americans well and healthy, and early identification, ongoing treatment, access to psychotropic drugs …are critical components."

- The Honorable Kathleen Sebelius, Secretary, Health and Human Services, April 2009

Recommendation 9: Evaluate and assess practices being implemented in the VA for dissemination to the broader healthcare delivery system.

Recommendation 10: Evaluate and assess practices being implemented in the Department of Defense for potential dissemination for community-based suicide prevention efforts.

Recommendation 11: Promote collaboration between public and private partners to engage military families and veterans families in suicide prevention efforts.

c. Mental Health Parity and Addiction Equity Act (2008)

Culminating a decade long campaign by the mental health community, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 was enacted into law on October 3, 2008. This Federal legislation aims to equalize benefits for mental health and substance use disorders with medical and surgical benefits in group health insurance plans covering more than fifty employees. The law became effective on January 1, 2010. Under this new law, 113 million people across the country have the right to non-discriminatory mental health coverage, including 82 million individuals enrolled in self-funded plans (regulated under the Employee Retirement Income Security Act [ERISA]), who are not covered by state parity laws.[29]

While the NSSP specifically called for parity laws at the State (rather than the Federal) level, the enactment of this Federal legislation marks a major advancement in the field of suicide prevention. Experts agree that roughly ninety percent of adolescents and adults who die by suicide suffered from depression or another diagnosable mental or substance use disorder, or both, at the time of their death.[30]

In July 2008, Congress also applied mental health parity to Medicare, to be phased in beginning in 2010. The law provides Medicare mental health equity by reducing the currently required fifty percent mental health co-insurance to twenty percent, making it on par with coverage for all other outpatient services.[31]

Once the Federal parity law was effective in January 2010, many patients who were effectively locked out of the system because they could not afford treatment may have found coverage more affordable. But that solution can only be applied to consumers with appropriate healthcare insurance; far too many persons at risk are left out of the system altogether and a familiar pattern develops: emergency treatment in a hospital setting without follow-up outpatient care, until, all too often, the next suicide attempt occurs. A point raised by many informants to this review was that progress in suicide prevention will only be achieved through fundamentally better access to and coordination of an unbroken chain of care among healthcare providers.

d. State Level Insurance Parity

As mentioned earlier, the NSSP specifically called for an increase in the number of States that require health insurance plans to cover mental health and substance abuse services on par with physical health services. In 2001, 34 States had a mental health parity law.[32] Since 2001, an additional nine States have established mental health parity laws,[33] and seven States have increased the scope of their laws.[34]

4. Substance Abuse and Suicide

The NSSP focused attention on the connection between substance abuse and suicide prevention in several areas, including reduction of stigma, increasing access to and community linkages with services, and improvement of reporting and portrayals in the entertainment and news media.[35] Compared to the emphasis placed on mental health problems, the suicide prevention movement has focused relatively little attention on the intersection of substance abuse and suicide since 2001.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has taken two specific steps to achieve the NSSP goals that include substance abuse. In 2009, SAMHSA released, "*Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*."[36] This Treatment Improvement Protocol (TIP) is designed to serve as a set of best-practices guidelines based on empirical evidence and expert consensus for addressing suicidal thoughts and behaviors in the treatment of substance use disorders. At the end of 2008, SAMHSA released a white paper on the topic of suicide prevention and substance abuse.[37] The paper, "Substance Abuse and Suicide Prevention: Evidence and Implications: A White Paper" summarizes what is known about the interrelationship and provides an overview of advances that have been made in the last decade.

Outside of SAMHSA, a major advancement in terms of access to substance use services was achieved as part of the previously discussed Federal mental health parity law and State laws on mental health parity. The Federal law (as well as several State laws) mandates that substance use services along with mental health services must be provided in parity with physical health services.

Recommendation 12: Increase efforts to integrate suicide prevention practices into substance abuse prevention and treatment services.

5. Training Initiatives

The NSSP recognized that effective and evidence-based training that cuts across all strata of professions and services is fundamental to suicide prevention. This requires that standards be adopted so that a variety of individuals in and outside of the healthcare professions receive adequate training in recognizing the signs of suicide risk. Gatekeepers, defined as persons who interact with people in environments of work, play, or natural community settings, are likely to be the first persons to recognize signs of at-risk behavior or warning signs. Healthcare professionals (apart from trained mental health specialists) also regularly come in contact with persons at risk during the normal course of their practice and need adequate training. And mental health professionals need better and more focused training on recognizing, assessing and managing suicide risk in their patients, including the use of evidence-based therapies.

a. Clinical Training

QPR Institute (QPR stands for Question, Persuade, Refer) led the field in developing the first suicide triage training program for practicing clinicians, called the QPRT Suicide Risk Assessment and Risk Management Training Program. The program was first introduced in 1998 and is designed to reduce morbidity and mortality among healthcare consumers by standardizing the detection, assessment, documentation and management of patients at elevated risk for suicidal behaviors in all settings and across the age span. The QPRT Suicide Risk Assessment and Risk Management Inventory (adult, pediatric and hospital versions) are guided clinical interviews developed through expert consensus and are anchored in the existing scientific literature on suicide risk assessment. The curriculum consists of eight modules. Eight hours of classroom time, or ten hours in the online version, are required to complete the program. An expanded three-credit college classroom version is available through the School of Social Work at Eastern Washington University, Cheney, Washington. Since 2001, about 7,000 individuals have been trained in this program, and over 100 faculty certified to teach the curriculum.

> ***"There is little research on the effectiveness of training. Without this kind of research, you can train people, but you can't guarantee that it will really [contribute] to suicide prevention."***
>
> - Key Informant

One of SPRC's earliest training initiatives engaged the American Association of Suicidology and its members for the purpose of articulating core competencies for mental health professionals in detecting, assessing and managing suicide risk. Their work resulted in the first comprehensive, competency-based curriculum for practicing mental health professionals that could be widely disseminated. By 2005, SPRC had established a distinct unit known as the SPRC Training Institute to disseminate the resulting one-day course, "Assessing and Managing Suicide Risk" (AMSR). According to its developers, the workshop is designed for psychiatrists, psychologists, licensed counselors, social workers, with tailored versions for college and university counseling center staff and employee assistance professionals. A faculty of 77 mental health professionals,

located throughout the United States, has been certified to deliver the AMSR course. Over 250 workshops have been delivered to more than 11,000 mental health professionals in 40 states and five countries outside the U.S. An independent multi-site evaluation showed that training participants achieved significant gains in knowledge and self-assessments of both confidence and competence, all sustained through the six-month follow-up assessment. The program is a collaboration of AAS and SPRC.

> ***"I think there are still deficiencies in the standards for risk assessment and management. I find many of my professional colleagues think they have enough information until something happens***."
>
> - SPAN USA Survey Respondent

Subsequently, AAS developed the "Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians" (RRSR) program, designed to train mental health professionals to better recognize patients at risk for suicide and develop assessment-based treatment plans to manage that risk. According to AAS, the two-day curriculum, delivered by a faculty of master trainers, is based in the knowledge content developed by the AAS for the AMSR program (see above) and includes additional emphasis on skill development, particularly on the formulation of risk and its associated treatment planning. RRSR training has been provided to over 2,000 clinical mental health professionals in twenty-four States and one Canadian province. Eighty percent of those professionals trained to date reported having made specific changes in their clinical practice as a consequence of the RRSR training.

Recommendation 13: Evaluate the capacity of continuing education clinician training programs to produce behavioral outcomes that improve clinical practice and outcomes. On the basis of evaluation, make curriculum improvements if needed; promote mass dissemination of continuing education to practicing behavioral health providers.

b. Gatekeeper Training

Thousands of first responders, correctional workers, crisis line volunteers, law enforcement professionals, clergy, teachers, school counselors, nurses, and other community and professional helpers in a position to have first contact with persons at risk for suicide are the "gatekeepers," those individuals on the frontlines of suicide prevention. Curricula for gatekeepers range from one hour education to raise awareness to two-day trainings to teach and build intervention skills. While more evidence is needed to determine the effectiveness of these curricula, there is an assumption in the suicide prevention community that training gatekeepers needs to be an integral part of comprehensive suicide prevention programs. Several of the gatekeeper training programs listed in the Best Practices Registry (the SPRC/AFSP listing of reviewed suicide prevention programs) are described below. The gatekeeper programs developed by QPR Institute and Living Works Education were the first developed and are by far the most widely utilized.

The QPR Institute offers two levels of gatekeeper training. The first, QPR Suicide Triage (8 hours), is a derivative program of QPRT for any and all persons who, during the course of their work, may encounter individuals in crisis. The QPR Suicide Triage Training program teaches participants how to probe for and initially assess immediate risk for suicidal behaviors, and how to immediately enhance protective factors. QPR Suicide Triage training includes the same two foundation lectures presented to mental health professionals in the clinical training curriculum discussed above, as well as

exercises and skill building role plays. The second, the QPR Gatekeeper Training for Suicide Prevention program (1-2 hours), is designed to teach people in all walks of life, lay and professional, how to recognize, assist and refer potentially at-risk individuals to further assessment and care. QPR Gatekeeper Training programs have been delivered to over 750,000 individuals since 2001.

LivingWorks Education (LWE) developed Applied Suicide Intervention Skills Training (ASIST) in 1983 to facilitate early prevention and intervention for at-risk individuals with thoughts of suicide. The two-day ASIST program offers both a standardized and a customized gatekeeper workshop designed for members of care-giving groups. Since 2001, more than 180,000 individuals have participated in ASIST workshops. To complement ASIST, a shorter (3 hour) curriculum, safeTALK, was designed in 2004-2005 by LWE to teach participants to recognize and engage persons who might be contemplating suicide and connect them with the appropriate community resources. Over 60,000 have participated in this training since 2006.

The Yellow Ribbon International Suicide Prevention Program, founded in 1994, has developed two gatekeeper training programs. "Be a Link!" is a two-hour adult gatekeeper training program. The program can be implemented in a variety of settings including schools, workplaces, and community organizations. The training provides participants with knowledge to help them identify youth at risk for suicide and refer them to appropriate resources for help. "Ask 4 Help!" is a one-hour curriculum for senior high, middle school and college students that provides students with knowledge intended to increase help-seeking for themselves or on behalf of others.

The evidence base for gatekeeper training is still weak, despite widespread dissemination. The few randomized control trials that exist suggest that "train everyone" models using brief curricula do little more than raise awareness and that targeting more in-depth training to individuals fulfilling roles that put them in meaningful relationships with the target population would be more cost-effective. A summary of gatekeeper training research concluded that the practice "holds great promise as part of a multi-faceted strategy".[38]

Recommendation 14: Continue to evaluate and refine gatekeeper training in various contexts; modify curricula in a continuous quality improvement mode. Implement gatekeeper training in the context of comprehensive suicide prevention programs.

c. Community Competency Training

In 2002, SPRC contracted with AAS to develop a suicide prevention curriculum that addresses the core knowledge and skills necessary for States and communities to develop comprehensive and effective suicide prevention plans and programs.

From this curriculum, the SPRC Training Institute developed "Strategic Planning for Suicide Prevention (SPSP): Core Competencies in Community Suicide Prevention" -- flexible offerings for suicide prevention coalitions and planning groups. SPRC has teamed with SPAN USA to train 29 coalitions and groups, with a total enrollment of 825 individuals since September 2005. This training is designed to enhance participants' leadership and collaboration skills, and, in line with the NSSP, prepare them to collect and present suicide-related data and information, select and implement

suicide prevention programs in their communities, and determine the effectiveness of the programs they implement. The training also helps build participants' comfort and ability to communicate effectively about suicide and suicide prevention.

A number of trainings beyond those identified above are in use in communities across the nation, but are disseminated much less broadly. For all, rigorous evaluations looking for behavioral changes as outcomes are needed.

Recommendation 15: Develop and widely disseminate training on core public-health competencies, including strategic planning, to coalition members via the World Wide Web.

d. Standards for Clinical Training Programs

The NSSP calls for training of healthcare professionals in recognizing at-risk behaviors and delivering effective treatment. Recognizing that many health professionals are inadequately trained to assess, refer, treat and manage suicidal clients and patients (NSSP, p 79), this goal seeks to fill gaps in training programs and raise accreditation standards for programs training nurses, physicians, physician assistants, social workers, psychologists, counselors, and other relevant professions.

This review looked for evidence of changes in accreditation and/or provider testing standards since 2001 by searching published literature on the websites of relevant professional associations and accrediting bodies. It examined standards for eleven professional groups: physician specialties (psychiatry, family practice, pediatrics and emergency medicine), substance abuse counselors, employee assistance professionals, and behavioral health providers (psychology, social work, psychiatric nursing, counseling, and marriage and family therapy). Only the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) had increased attention on suicide in its 2009 standards compared to the previous version, dated 2001. Two other accrediting organizations (National Association for Alcoholism and Drug Abuse Counselors [NAADAC] and Employee Assistance Certification Commission [EACC]) have limited mention of suicide in their certification examinations, but not accreditation standards. Suicide is briefly mentioned in the Accreditation Council for Graduate Medical Education (ACGME) Program Requirements for Pediatrics, but is absent in training standards for the medical specialties of psychiatry, family practice and emergency medicine. Finally, suicide prevention models appear in the core curriculum in psychiatric nursing (2009), but are not mentioned in accreditation standards for training programs (2010).

Although this review found no accreditation standards pertaining to training programs in either addiction counseling or employee assistance, it found limited mention of suicide in exams for National Certified Addiction Counselor Levels I and II and for Master Addiction Counselor, and the test content and exam blue print provided by the EACC.

Anecdotally, we know that many individual training programs have voluntarily added curricula addressing suicide risk and treatment since 2001 and many professional associations and organizations have sought to provide their membership with relevant information and education on the topic. For instance, in Massachusetts, Garrett Lee Smith grant funding helped incorporate this

training into social work programs. Furthermore, it would seem reasonable that the high quality curricula developed for continuing education programs (discussed above) could be incorporated into professional training programs, speeding the enhancements. Since suicide shares risk and protective factors with many other behavioral health problems, including other forms of violence, it would seem important to link suicide related curricula with training covering other related topics. Still, without including a requirement in the accreditation standards for these training programs and testing professionals on that content in certification and licensing exams, the quality of this education will continue to vary widely and may not be congruent with the evidence base.

Recommendation 16: Convene organizations that establish standards of accreditation for professional and clinical training programs to develop and implement plans to ensure all training programs within specific professions include curricula on recognizing, assessing, and managing suicide risk and certification exams include questions on this content.

Recommendation 17: Incorporate extant curricula, or newly develop curricula content, to teach sate of the art, evidence-based practices in professional training programs and continuing education offerings.

e. State Training Requirements for School Personnel

In recent years, laws have been passed by several State legislative bodies recommending, or in some cases requiring, in-service training in suicide prevention for school personnel. The States are: California, Colorado, Louisiana, Massachusetts, Michigan, Mississippi, New Jersey, New York, Tennessee, Vermont, Virginia and Wisconsin.

The growth in the efforts to secure passage of legislation for suicide prevention training has often been triggered by grassroots efforts. One example is the campaign by the Jason Foundation in Tennessee for legislation to require that annual in-service training for teachers and principals include at least two hours of suicide prevention education. Other States have since adopted the language used in the Tennessee legislation.

Recommendation 18: Evaluate the cost and effectiveness of state-wide teacher training initiatives; use evaluation results to inform policy in States and Territories.

6. Survivor Support

The NSSP recognized that the aftermath of suicide deserves expanded and enhanced survivor support initiatives and calls for research to determine how best to assist survivors.[39] In the years since the NSSP's release, the movement to support survivors has intensified significantly. Local Outreach to Suicide Survivors (LOSS), developed by the Baton Rouge Crisis Intervention Center, is a pioneer in the movement, dating back to the 1970s. It is designed to offer immediate support to survivors as close to the time of death as possible. LOSS acts as a first response team when a suicide occurs, offering resources and hope to the newly bereaved, frequently at the scene of the death.[40]

Since the NSSP was issued, other organizations responded with numerous survivor support initiatives such as support groups and support group facilitator training, and active postvention approaches (such as the LOSS program), reaching out to the newly bereaved. For 20 consecutive years SAVE has sponsored its Annual Suicide Awareness Memorial where hundreds of people from many states gather to hear survivor stories and a national speaker, look at the Faces of Suicide pictures, and listen to a Memorial reading of the names of those who died by suicide. SAVE also started the first Named Memorial program for survivors to remember their loved ones that includes a Named Memorial Wall and on-line memorial recognition program.

> ***"Important resources have been developed with an eye towards broad-based prevention efforts, as well as survivor support. But, nationwide, the level of funding for suicide prevention research remains woefully low in light of the over 30,000 lives it takes each year."***
>
> - SPAN USA Survey Respondent

In 2008, AFSP launched its Survivor Outreach Program designed to facilitate volunteer "veteran" survivors who listen, show support, and provide information about local resources. Both the AFSP website and the AAS website offer lists of support groups and these sites are updated periodically. The Link Counseling Center of Atlanta, Georgia, is an example of an organization that delivers periodic training for leaders of support groups for survivors of suicide. AFSP also offers regionally disseminated face-to-face trainings for support group leaders annually and has a self-study package for those unable to attend in-person trainings. Online survivor support services and networking are also available, further reducing geographical barriers to peer support that is so important to many survivors.

National Survivors of Suicide Day, an initiative of AFSP, occurs annually on the Saturday before Thanksgiving. On that day, healing conferences for recently bereaved survivors take place throughout the U.S. Each conference site is organized locally by AFSP chapters or independent local groups and organizations; each is connected via a ninety-minute AFSP webcast. The program began in 1999, prior to the NSSP, and has grown from twenty conferences in 2001 to more than 200, including a rising number of international conference sites.

Finally, the Healing After Suicide conference occurs annually in conjunction with AAS's annual conference. The purpose of the Healing Conference is to: provide survivors with education and resources to help deal with their personal grief; assist mental health providers and other caregivers in understanding the unique grief and needs of survivors; and provide assistance to leaders of existing support groups and to participants who want to establish new support. In the recent past, the conference has been co-sponsored by AAS and SPAN USA; it features speakers, Lifekeeper Memory Quilts, and a healing ceremony.

Efforts to conduct research to better understand survivor issues are few. NIMH hosted a conference that proposed questions for survivor-focused research in 2003. Subsequently, SPAN USA issued a call for research papers, as well as a survey of support group practices, and AFSP is initiating a survivor registry of persons willing to participate in research.

Recommendation 19: Conduct research to better determine the effects of suicide on the bereaved and to identify effective approaches to mitigate those effects.

7. Means Restriction

Individuals who attempt suicide are often ambivalent and/or acting impulsively during a short period of crisis.[41] Easy access to highly lethal means of suicide, such as firearms, also puts individuals contemplating suicide at increased risk.[42] In recognition of this, the NSSP placed an emphasis on promoting efforts to reduce assess to lethal means and methods of self-harm.

During the course of this review and in conversations with key informants, several means restriction programs in the past decade were highlighted as exemplary. For instance:

- Harvard University operates "Means Matters," a public awareness program designed to educate the public that the means by which people attempt suicide—the how—is as critical to reducing the number of suicides as the why, when, and where.
- A Washington State based consortium (including the Harborview Injury Prevention Center) disseminates the LOK-IT-UP Campaign to raise awareness about the importance of safe firearm storage, inform the public about safe storage options, and promote the availability of safe storage devices. LOK-IT-UP is supported by: firearm retailers, firearm owners, parents, schools, law enforcement, public health, elected officials, community organizations, and healthcare providers.
- In New Hampshire, Dartmouth's Injury Prevention Center disseminates Counseling on Access to Lethal Means (CALM), a curriculum to train health and mental healthcare providers in conducting firearm safety counseling with clients and family members to reduce access by at-risk individuals. NAMI NH's Connect program includes protocols and training in reducing access to lethal means.
- The Maine Youth Suicide Prevention Program focuses on means reduction for guns, pills, and rope, and has also created a video titled "Kids and Guns: Making the Right Choice."
- Montana has two means restriction programs focused on law enforcement to provide gun locks at community events and train communities on safe storage practices through public service announcements.
- Oregon addresses lethal means by providing information for healthcare professionals on screening for access to lethal means among their potentially suicidal patients.

Recent statistics point to a slight decrease in deaths (from 5.27 per 100,000 in 1999 down to 3.86 per 100,000 in 2006[43]) by poison gases (including car exhaust emissions). And while there is no way to demonstrate a direct correlation between the downturn in death by carbon monoxide poisoning, some experts believe that stricter auto emissions standards may be responsible.

According to recent research both in the U.S. and worldwide, suicide prevention barriers on bridges have been shown to be effective at reducing suicide in some circumstances.[44] [45] These studies have

been used to promote U.S. policies aimed at adding barriers to bridges that have become magnets for suicide.

Most notable among these is the Golden Gate Bridge in San Francisco, which has seen over 1,300 suicide deaths since it opened in the late 1930s. The decision by the Golden Gate Bridge District in October 2009 to recommend installing netting to prevent further suicides from the San Francisco landmark illustrates how evidence can be used to bring about change. (It must be pointed out, however that the Golden Gate Bridge barrier has not yet been funded.) Despite the evidence that bridge barriers save lives, the high cost of installation remains a barrier to wider use, as does public objections to their aesthetics. The debate continues.

8. National Suicide Prevention Lifeline

In 2001, the evidence base regarding crisis lines was insufficient to warrant including them in the NSSP. Still, suicide crisis hotlines had become fixtures in many communities. The Samaritans, for example, operate a national and international network of locally-based hotlines that have been serving communities for over forty years. In the late 1990s the first effort to create a national suicide hotline received funding with the help of the late Senator Paul Wellstone (D-MN). Funding from SAMHSA provided through a cooperative agreement with the American Association of Suicidology (AAS) in September 2001 provided the first Federal support for a national suicide prevention hotline network utilizing the number 1-800-SUICIDE. In January 2005, SAMHSA established the National Suicide Prevention Lifeline through a grant with the Mental Health Association of New York City and its subsidiary Link2Health Solutions. Now, the Lifeline responds to callers to the hot line number 1-800-273-TALK (8255) and to 1-800-SUICIDE with assistance 24 hours a day, seven days a week. The Lifeline serves as a central switchboard connecting callers to a crisis center geographically nearest the caller from among a national network of more than 140 crisis centers in 49 states. Services are provided in English or Spanish language. A feature added in 2007 allows a caller to the National Suicide Prevention Lifeline to press "1" and be connected to a VA call center. After one year of operation, 62,000 veterans, family members, and friends of veterans had called the Lifeline/VA option. Among those callers, there had been 1,400 rescues initiated to prevent possible tragedies. In the summer of 2009, the VA added a one-to-one "chat service" for veterans who prefer reaching out for assistance using the internet.[46] Lifeline also operates a website, www.suicidepreventionlifeline.org, designed to deliver clear messaging and easy navigability to consumers in crisis, and participates on social networking sites.

Call volume continues to increase. In the month of January 2008, Lifeline answered just over 39,000 calls. By May 2009, the monthly count swelled to over 54,000. (It is worth noting that approximately 25% of those 54,000 calls were in some way related to the economic downturn).[47]

With the advent of SAMHSA's national coordinating role and through evaluations funded by SAMHSA, evidence for the

> ***"I have seen a focus by the Federal government to formalize the role of suicide prevention stakeholders. This has led to research of crisis hotlines and studies on best practices in prevention. My hope is that over the ensuing years there will be greater support and recognition for hotlines and the role they play in the community."***
>
> - SPAN USA Survey Respondent

effectiveness of crisis lines has grown rapidly.[48] New evidence conclusively showed that hotlines serve callers who are at serious risk for suicide, that callers exhibit significant decreases in intent to die, hopelessness and psychological pain from the beginning of the call to the end of the call, and that these effects continue for weeks after the call.[49] Other research also showed that adolescents who called a teen suicide prevention hotline demonstrated significant reductions in suicidal ideation and urgency, and a significantly improved mental state.[50]

While there is increased evidence of the effectiveness of suicide prevention hotlines, the quality of services provided has been shown to vary.[51] The recent development and dissemination by the National Suicide Prevention Lifeline of evidence-based standards with which to assess suicide risk in persons who call suicide prevention hotlines should increase the consistency and quality of hotlines.[52]

9. Media

This review identified important advancements in the interface among suicide prevention and the media—news, entertainment, and social media. Shortly after the release of the NSSP, a collaboration of the AFSP, AAS, the Annenberg Public Policy Center, and representatives of several Federal agencies produced and promoted a set of media recommendations entitled, "Reporting on Suicide: Recommendations for the Media" (2001). These Recommendations have been actively disseminated through national, State, and tribal organizations to members of the press and their influence is seen in various degrees over the years in stories written and broadcast on the topic of suicide.

In the entertainment media, the Entertainment Industries Council leveraged SAMHSA funding to facilitate collaborative work between the Hollywood creative community and suicide prevention experts to produce "Picture This: Depression and Suicide Prevention," a guide for creators in the entertainment industry which addresses issues within the realm of depression and suicide prevention. Published in 2008, the guide has fostered in-depth discussions between screenwriters, producers, and suicide prevention experts that, in at least some cases, have changed for the better the artistic approach to dealing with suicide content.

In May 2009, SAMHSA funded a new media summit. The summit brought together over fifty experts on suicide prevention, online safety and social media and, along with new media entrepreneurs, collaborated on ways to integrate suicide prevention practices into the virtual landscape. Other Federal agencies were represented, including the Department of Veterans' Affairs and the Indian Health Service. The event offered a unique cross-fertilization of ideas among people from varied and diverse professional backgrounds.[53]

A follow-up workshop aimed at updating and revising the 2001 media recommendations in light of new media took place in August 2009, sponsored by SAVE, AFSP, and the Annenberg Public Policy Center and supported in part by SAMHSA. Participants included staff from several Federal agencies, Lifeline, AAS, SPRC, and other suicide prevention national organizations, researchers, and experts in journalism and new media. New research, new technologies, input from content experts and others have been brought to the workgroup revising the recommendations.

Going forward, a number of key informants pointed to the potential roles for new media in the field of suicide prevention.

D. METHODOLOGY

The goals and objectives in the NSSP under Methodology focused on promoting research and evaluation in suicide and suicide prevention, and improving the data on which research, practice, and service planning are premised. A description of the leading initiatives of the last several years follows:

1. Best Practices Registry

Funded by SAMHSA, the Best Practices Registry for Suicide Prevention (BPR) received high marks from the key informants to this review. The foundational work for the BPR began in 2002 as collaboration between AFSP and SPRC to identify evidence-based practices in suicide prevention. In 2005, SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) took over this role and the AFSP/SPRC effort transitioned toward gathering expert and consensus guidelines and programs and practices that adhered to accepted standards in the field specific to suicide and suicide prevention. Now, programs listed on the Best Practices Registry address dozens of goals and objectives of the NSSP. These programs provide training and resources for people of all ages and roles.

The BPR is available online at SPRC's website (www.sprc.org). It is divided into three sections: Section I: Evidence-Based Programs (derived from SAMHSA's NREPP); Section II: Expert and Consensus Statements; and Section III: Programs that Adhere to Standards. Section III is further divided into four sub-categories: awareness materials, education and training programs, screening programs, and protocols and guidelines. Section II and Section III items are objectively reviewed for inclusion by AFSP and SPRC staff or independent expert consultants. As of July 2010, there were 65 unique items listed on the BPR.

2. Surveillance

Collecting accurate data on the number of suicide attempts is difficult because data are not pooled from the many potential sources such as emergency departments, in-patient hospital records, and urgent care centers. However, some important progress has been made recently. In 2009, SAMHSA's "National Survey on Drug Use and Health" reported on suicidal thoughts and behaviors among adults for the first time.[54] The report found that "In 2008, an estimated 8.3 million adults ages 18 or older (3.7 percent) had serious thoughts of suicide in the past year, 2.3 million (1.0 percent) made a suicide plan, and 1.1 million (0.5 percent) attempted suicide."[55] Estimates from other studies indicate there were averages of 507,000 visits to U.S. hospital emergency departments in each of 2005 and 2006 for self-directed violence, the majority of which are suicide attempts.[56]

The 2007 Youth Risk Behavior Survey found that among US high school students during the 12 months before the survey, 14.5% had seriously considered attempting suicide, 11.3% had made a plan about how they would attempt suicide, 6.9% had attempted suicide, and 2.0% had made a

suicide attempt that resulted in an injury, poisoning, or an overdose that had to be treated by a doctor or nurse.[57]

Although the Centers for Disease Control and Prevention (CDC) has tracked deaths by suicide in all states since 1933, very little is known about the risk factors and circumstances that preceded each death. To fill in some of these surveillance gaps, the NSSP specifically called for a "national violent death reporting system" to gather information from several data sources that are not otherwise linked. Key informants cited the National Violent Death Reporting System (NVDRS) as a significant tool in better understanding the public health challenges of suicide prevention. In fiscal year 2002, Congress appropriated funds for the development and implementation of NVDRS, to be housed within the CDC. The NVDRS collects data on violent deaths from four primary sources: death certificates, police reports, medical examiner and coroner reports, and crime laboratories. Individually, these sources explain violence only in a narrow context; together, they provide a more complete answer to the questions that surround violent death: who, what, when, where, how, and, in many cases, why. The NVDRS is critical in that it provides markers for potential points for intervention and ways to evaluate and improve violence prevention efforts.

It will be sometime in 2012 before we know definitively whether or not suicide rates climbed in the U.S. in response to the financial stress and unemployment brought on by the economic crisis.

Initially, six States were funded for inclusion in the NVDRS, and by Fiscal Year 2009, Congress had appropriated $3.5 million to continue funding the implementation of NVDRS in a total of 18 States.

The CDC now makes available the NVDRS data for public use through the Web-based Injury Statistics Query and Reporting System (WISQARS) at www.cdc.gov/ncipc/wisqars. This interactive database, produced and managed by CDC, provides customized reports of fatal and nonfatal injury-related incidents and has been widely used by researchers, practitioners, Federal agencies, not-for-profit organizations, the media, and the public engaged in suicide prevention.

In December 2008, the CDC released "Deaths from Violence: A Look at 17 States Data from the National Violent Death Reporting System 2004-2005".[58] Several journal articles containing preliminary NVDRS data have been published and can be found at www.cdc.gov/injury. These documents provide further detail which States are using to produce annual reports on suicide that integrate data from multiple State data management systems.

Only with the expansion of the NVDRS to include all fifty States, the territories, and the District of Columbia will a comprehensive tracking system enable researchers and planners to fully identify regional differences in the patterns of violence across the country and tailor policies accordingly.

NVDRS alone, though, is not the solution to all our surveillance needs. Timeliness of reporting for national death certificates is a core issue. Due to the complex analytical methodologies the CDC uses to provide standardized, age-adjusted suicide data by county and State, there is more than a three year gap between the close of a calendar year and when data for that year become available. In 2010, 2007 data will be the most recent available. It will be sometime in 2012 before we know definitively whether or not suicide rates climbed in the U.S. in response to the financial stress and unemployment brought on by the economic crisis. Another glaring need is reliable suicide data for

deaths that occur in healthcare settings, as there is currently no national system that can provide these crucial data.

In addition to the problems regarding mortality data, the quality and availability of the data on nonfatal suicidal behavior are equally problematic. The concerns about discrepancies in nomenclature and accurate reporting apply here even more than with suicide deaths. Except for rare exceptions, there is neither systematic nor mandatory reporting of nonfatal suicidal behavior in the United States at the State, territorial, or local level, nor is there routine systematic collection of non-suicidal intentional self harm data.[59] The NSSP calls for State-produced annual reports on suicide attempts and completions, integrating data from multiple State data management systems. To our knowledge, this is still occurring on a very limited basis.

Recommendation 20: Develop methodologies that are capable of providing preliminary estimates of suicide rates and rapidly detecting meaningful changes in rates for specific demographic groups at the national level.

Recommendation 21: Develop a system to collect reliable data on suicide deaths that occur in healthcare settings.

3. Research Funding

A review of funding since the NSSP's release shows an increase in overall Federal funding for the National Institute of Mental Health and a fifty percent increase--from $23 million in 2001 to $36 million in 2007--in research dollars for suicide prevention. That allocation declined, however, in 2008 to $31 million. Outside of NIMH funding, the National Institutes of Health have awarded over 1,100 grants for research on suicide and suicide prevention between 2001 and 2007, with over 300 grants in 2007 alone.[60] The other agencies within NIH that are involved in suicide research include:

- National Institute on Alcohol Abuse and Alcoholism (NIAAA)
- National Institute of Child Health and Human Development (NICHD)
- National Institute on Drug Abuse (NIDA)
- National Center for Research Resources (NCRR)

In 2004, the National Institute of Mental Health, with additional funding from the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism, awarded grants to three Developing Centers for Interventions for the Prevention of Suicide (DCIPS), as called for in the 2002 IOM Report. The purpose of these five year grants was to establish core support for building research infrastructure for the study of preventive and treatment interventions for suicidality (severe ideation, attempts, deaths) related to mental health, substance use disorders and alcohol use disorders by qualified institutions with active research programs but without the existing capacity to mount the extensive and highly integrated research effort expected of an advanced center (e.g., Advanced Centers for Interventions and Services Research). The three Developing Centers were established at Columbia University College of Physicians and Surgeons, the University of Pennsylvania Medical College and the University of Rochester Medical College. After completion of the initial five year grants, NIH discontinued the program.

Research is also funded by the private sector. For instance, AFSP annually awards grants for research on suicide and its prevention, averaging $1.5 million per year since 2001. In 2006, AFSP launched a research initiative focused on developing and testing procedures that could ultimately lead to a national suicide attempt registry. AFSP collaborated with the three DCIPS universities on a two year pilot project based in psychiatric emergency rooms. The results of the pilot project are not yet published.

Most recently, in response to the alarming spike in suicides among soldiers, the National Institute of Mental Health (NIMH) signed a memorandum of agreement with the U. S. Army in October 2008 authorizing the NIMH to undertake the largest study of suicide and mental health among military personnel ever conducted, with $50 million in funding from the Army and $10 million from NIMH.[61] In July 2009, NIMH announced that an interdisciplinary team of four research institutions[62] will carry out the study. Researchers will be identifying risk and protective factors for suicide among soldiers and developing a stronger evidence base for effective and practical interventions to reduce suicide rates and address associated mental health problems.

> ***"Much of the research being conducted continues to be clinical or epidemiological in nature. This is needed, but I would also like to see more research focusing on prevention activities."***
>
> - SPAN USA Survey Respondent

Additionally, NIMH awarded the first of five annual $3 million grants for Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE), a multi-site trial based at Massachusetts General Hospital. The goal of the research project is to improve outcomes for suicidal individuals seeking care in emergency departments through better identification, care and follow-up.

The suicide prevention work of the VA is buttressed by the newly formed VISN 2 Center of Excellence at Canandaigua, NY. This center, associated with the University of Rochester, will lead suicide prevention research and evaluation for much of the VA's suicide prevention work.

In spite of these expenditures, this review found that suicide prevention stakeholders consider the relative paucity of both public and private sector funding for research to be one of the most serious challenges facing the suicide prevention community. Federal funding for research into suicide and suicide prevention is still disproportionately low when compared to government funded research into other leading causes of death, and recently, there has been a roughly nine percent decrease in funding in public health-oriented suicide prevention through the CDC. However, additional Federal government-funded research may be forthcoming as the Department of Defense and the Department of Veterans Affairs grapple with the rising numbers of suicides among the ranks of serving military and the possible spillover among veterans. Still, these funding increases do not begin to raise the level of funding for suicide prevention research to that of illnesses such as HIV/AIDS or breast cancer, conditions that kill numbers of Americans in roughly the same order of magnitude.

Recommendation 22: Support the development of a robust suicide research infrastructure that is commensurate with the magnitude of the public health burden.

Recommendation 23: Fast-track research to develop and evaluate effective therapies, as well as non-clinical suicide risk management techniques that take into account the widespread non-acceptance of mental health treatment modalities.

E. SPECIAL POPULATIONS AND EMERGING ISSUES

The need for cultural competency in planning and providing suicide prevention services and programs was a cross-cutting theme throughout this review. When dealing with mental health, substance abuse, and suicide prevention and intervention, specialists in suicide prevention deemed it crucial to take into consideration the way in which different cultures handle these issues. They also acknowledged that "culture" signifies more than ethnicity and noted that there are work and professional cultures, geographically-based cultures, and distinct cultural patterns within age groups.

Key informants emphasized that specific, targeted messaging and "community-based" approaches, as well as culturally-appropriate policies and services, are needed in order to reach distinct groups of people. The information below identifies notable prevention efforts that target specific audiences.

1. Youth

Attention to the youth suicide rate was called for in the NSSP and a number of initiatives designed to address youth suicide have been launched since 2001, most notably as a result of the Garrett Lee Smith Memorial Act, discussed elsewhere in this report.

The youth suicide rate, which had been declining from the late 1990s to 2004, reversed course and began to rise again about the same time evidence emerged that prescription medications for depression and other mood disorders were associated with suicidal ideation in youths and young adults. The U.S. Food and Drug Administration eventually imposed a "black box warning" label (a stark notice on the package insert that warns of potential serious adverse effects) on many antidepressant medications. Although causality has not been established, key informants to the review suggested that the black box warning had an unintended chilling effect on both prescribing rates and willingness by families with adolescent children to use the medications. After the warnings appeared, prescribing rates fell precipitously and the youth suicide rate ticked up. Since then, the rate has decreased slightly each year from 2005 to 2007, when it fell below the 2003 benchmark.

Since the NSSP launch, two groups have focused exclusively on advancing the cause of suicide prevention and mental health on college campuses. Active Minds, founded in 2001 by a survivor of a loved one's suicide, is a bona fide grassroots movement that has grown to include over 270 chapters nationwide. Active Minds brings programming to college campuses through its chapters by organizing "National Day without Stigma," "National Stress-Out Day," and "Send Silence Packing" and helps students avail themselves of counseling and other campus/community resources.

The Jed Foundation, founded in 2000 by a family after losing their college-age son to suicide, has contributed to college campus suicide prevention programs nationwide through its program "Half of Us," in collaboration with mtvU and the Transition Year Project. The Foundation has also sponsored the development of important tools and guides for campus policymakers, including "Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student" and "Student Mental Health and the Law."

In response to the particularly challenging problem of suicide in the juvenile justice system, the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention (OJJDP) released a report entitled "Characteristics of Juvenile Suicide in Confinement." The February 2009 report examines 110 juvenile suicides that occurred in confinement between 1995 and 1999. It describes the demographic characteristics and social history of victims and examines the characteristics of the facilities in which the suicides took place. Drawing on this data, the researchers offer recommendations to prevent suicides in juvenile facilities.[63]

Recognizing the elevated rates of suicidal thoughts and attempts among Gay, Lesbian, Bisexual, and Transgender (GLBT) youths, AFSP, SPRC, and the Gay and Lesbian Medical Association cosponsored a November 2007 workshop of researchers and other stakeholders. The meeting led to a private foundation grant to enable national GLBT organizations to develop accurate messaging around suicide prevention, encouraging them to make suicide prevention a part of their agenda. Research is being conducted to determine the best approaches and messaging for this segment of the population. At about the same time, SPRC released "Suicide Risk and Prevention for Lesbian, Gay, Bisexual, and Transgender Youth," a comprehensive summary of the evidence base with recommendations for practice.

Finally, in recent years, the use of social media by teens has led to unfortunate incidents of cyber-bullying, triggering the suicides of vulnerable young people. This is an area under-examined and difficult to legislate because of freedom of speech issues, but policymakers are beginning to acknowledge the problem.

2. Military and Veterans

Of all of the programs designed to prevent suicide within the military, the evidence-based U.S. Air Force Suicide Prevention Program is pointed to as a notable success. The Air Force Suicide Prevention Program, adopted in the mid-90s and supported by the top command, leveraged the leadership culture to tighten social connections and support, promote responsible help-seeking for personal problems, and to strengthen life skills among airmen. The program produced statistically significant reductions in suicides that were also accompanied by reductions in homicide, family violence, and unintentional injuries.[64] More recent experience in this program has illustrated the need for ongoing attention to sustain the effectiveness of prevention programs and it is currently undergoing refinement.

Since engaging in Operations Iraqi Freedom and Enduring Freedom, suicides have been occurring in alarmingly high numbers within the ranks of combat forces, including National Guard and Reservists. This is leading Defense and other Departments of the Federal government to address suicide prevention urgently and forcefully.

A variety of suicide prevention programs has been launched in each branch of the military in an effort to promote overall mental wellness and prevent suicide. There is general agreement, however, that more programs do not necessarily produce the desired outcomes and to date there has been only minimal effort to measure the effectiveness of these programs or the consistency of their implementation. Still, a *Washington Post* editorial in late July 2009 suggested that the Pentagon's efforts to gather and share data represent a benefit to society as a whole, the potential result of which "could result in strategies with applications in the struggle against suicide nationwide."[65] One of the biggest challenges is developing methods to provide support and services to National Guard and Reservists after they return to their civilian jobs post-deployment.

Addressing suicides among veterans, a Blue Ribbon panel assembled in 2008 found that the Veterans Health Administration "has developed a comprehensive strategy to address suicides and suicidal behavior that includes a number of initiatives and innovations that hold great promise for preventing suicide attempts and completions".[66] The VA has placed fulltime suicide prevention coordinators in every medical center, hired thousands of additional mental health professionals, provided training to clinical staff throughout its healthcare delivery system, launched a 24/7 crisis line/internet chat with the capacity to connect immediately to the VA's system of electronic health records and suicide prevention coordinators, and developed a Center of Excellence for suicide prevention to lead its research effort in suicide prevention. This is perhaps the most comprehensive suicide prevention initiative in history.

3. Adults in Mid-life

Much attention has focused on the young in this past decade, but suicide rates remain high and are climbing for other age groups. A five-year analysis of the nation's death rates released by the Centers for Disease Control and Prevention found that the suicide rate among 45 to 54 year olds increased 20 percent from 1999 to 2004, a larger increase than any other age group during the same period.[67]

Middle-aged men die by suicide at twice the baseline rate of other Americans and most of these men are employed.[68] Although white males account for eighty percent of all suicide deaths, there has been relatively little focus on this high-risk demographic group. Key informants noted that the workplace is a prime spot for early intervention due to the large amount of time people spend in the workplace "community" as well as the availability of an existing structure for face-to-face interaction: employee assistance programs (EAP). Nevertheless, efforts that seek to prevent suicides, even within EAPs, often do not mention suicide, but instead provide guidance (e.g., "tip sheets" for managers) on how to handle extreme stress.

Recommendation 24: Convene a task force to address suicide among adults in mid-life.

4. Racial/Ethnic Minorities

This review found many suicide prevention initiatives that have been designed to meet the specific needs of racial and ethnic populations in the nine years since the NSSP was launched. Although key

informants and stakeholders reported that new initiatives were being undertaken, they also reported that support for such efforts has been limited. This is true for each of the groups identified as "specific populations" by DHHS: African Americans; Hispanic/Latino Americans; Asian American/Pacific Islanders; and Native Americans, American Indians, and Alaska Natives.

> ***"Broadly, people do recognize the unique needs of groups and that they are different for each cultural group, which is encouraging. People understand that there are many factors in the causality of suicide. People are confident that what works for Latina girls is not necessarily what works for Native American girls."***
>
> - Key Informant

Certain cultural practices may actually serve as protective factors, such as strong family ties, religious practices, and cultural ceremonies and rites. For instance, a sense of "belonging" and "ethnic identity" that comes from being part of a distinct ethnic group may serve as protective factors.[69] On the other hand, many barriers continue to slow the progress of suicide prevention among these groups. In some instances, cultural norms include stigma that prevents people from seeking help for mental health problems. While religion can be a protective factor, in certain segments of the culture religious beliefs about suicide hinder intervention or healing, particularly in the wake of a suicide attempt or death. In the course of this review, stakeholders repeatedly pointed to the shortage of service providers who understand a particular culture or speak the same language, limiting service availability. At times, the needs of smaller groups are not considered in broad-based suicide prevention efforts. For example, public information campaigns trying to reach the largest possible audience often overlook the unique needs of specific minority groups.

Fortunately, grassroots initiatives have emerged to advance the NSSP among minorities. One, the Asian American Suicide Prevention Initiative (AASPI), began in Chicago, IL, in 2005. Another older organization, the National Organization for People of Color Against Suicide (NOPCAS) provides a range of resources and organizes conferences to help communities of color address suicide. It offers a Counseling Certification Program in partnership with the QPR Institute, organizes support groups for survivors in three states, compiles listings of African American publications and dissertations, and maintains a Speakers Bureau. And Federal programs have been legislated, including the Garrett Lee Smith Memorial Act grants and various other SAMHSA initiatives, such as the Native Aspirations Program, which support suicide prevention efforts directed at Tribal youth. Promising interventions have also been developed in tribal communities such as the Athabaskan initiative,[70] Zuni Life Skills Program,[71] and follow up with youth who attempt suicide in the White Mountain Apache tribe.[72]

Other developments include adaptation of QPR for Native Americans and other populations; adaptation of AMSR to be culturally competent; the Lifeline Tribal initiative; and culturally competent materials developed by state and campus grantees.

New technologies are being used to reach specific target populations most notably via the internet. The Federal government's Indian Health Service (IHS) maintains a Community Suicide Prevention website, which provides culturally appropriate information on best and promising practices, training opportunities, and the tools for adapting mainstream programs for Tribal needs. Likewise, SAMHSA offers culturally appropriate information on its website. YouTube videos are appearing that aim to de-stigmatize and prevent suicide for specific groups such as Latino teens; however, most current

examples of these were produced by individuals who may not be paying attention to consensus recommendations regarding safe and effective messaging. Since its inception, SPRC has continued to develop resources and provide support for suicide prevention with racial and ethnic minorities, including: providing information on suicidal behavior in specific groups (LGBT white paper and resources, suicide fact sheets developed by SPAN USA); hiring Tribal Prevention Specialists who are expert in culturally competent work with Native communities; creating AI/AN pages on SPRC's website; joining IHS's national and international suicide prevention committees; and partnering with national organizations serving various minority populations.

5. Attempt Survivors

Addressing the needs of attempt survivors continues to challenge the suicide prevention movement. Recent attempt survivors struggle with many aspects of reintegration into their homes, schools, workplaces and communities. Feelings of shame, self-doubt, fear, and embarrassment are just some experiences attempt survivors describe. Spouses, parents and others need help adjusting and evidence-based information and programs need to be designed to help in this process.

Only in the last decade and a half have there been organized efforts to meet these needs. In 1996, Kenneth Tullis, M.D., of Memphis, Tennessee, along with fifteen other survivors of suicide attempts, founded Suicide Anonymous, the first ever twelve step program for people struggling with suicidal ideation and behaviors. A year later, the Organization for Attempters & Survivors of Suicide and Interfaith Services (OASSIS) was founded by James T. Clemons, Ph.D., the first national organization that included attempt survivors as a focus. Since then, activity in support of attempt survivors has steadily accelerated. In October 2005, the first National Conference for Survivors of Suicide Attempts, Healthcare Professionals, Clergy, and Laity was sponsored by OASSIS and SPAN USA and held in Memphis. The summary report of that conference is one of the first documents to articulate the perspectives of attempt survivors.[73] Two years later, in July 2007, the National Suicide Prevention Lifeline sponsored a project which provided even more specific and rich information to better serve suicide attempt survivors.[74]

The suicide prevention community recognizes that a previous suicide attempt is one of the strongest known predictors of suicide. According to one study of individuals who had survived a serious suicide attempt, almost half went on to make another attempt or subsequently died by suicide within five years.[75] Obviously, more and better strategies to reach and support survivors of suicide attempts are needed. The *After An Attempt* brochures, originally developed collaboratively by SPRC and NAMI and now distributed by SAMHSA, are tools in English and Spanish that were developed for distribution in hospitals to provide basic information to families and attempters.[76] Other tools are needed, too. Support groups, informational DVDs, and trainings for healthcare providers are required to ensure that survivors of an attempt, along with their families and friends, receive the support, advice, and information they need to find the most direct path to recovery.

Recommendation 25: Take steps to ensure evidence-based therapies discussed in the Intervention section of this report are available to more suicide attempt survivors.

Recommendation 26: Develop, evaluate, and disseminate other evidence-based clinical and non-clinical interventions for survivors of suicide attempts.

6. Older Adults

> ***"We have to have much more aggressive approaches to this population group. There is much stigma around older adult suicide, which creates limitations to access to care for this population."***
>
> - Key Informant

Older adults have become a focus in suicide prevention due to the extremely high rates among one segment of that population, white older men. Consequently, since 2001, many national and regional conferences have featured the topic and many states have broadened or are in the process of broadening their suicide prevention strategies to include older adults. Some States (e.g., Oregon and Maine) have separate plans for this age group. Mental health parity for Medicare is now being phased in so that seniors in the U.S. will pay the same co-pay (20%) for mental healthcare as for physical healthcare. In 2008, SAMHSA launched an initiative to develop toolkits for use in specific venues; a toolkit for senior living communities, *Promoting Mental Health and Preventing Suicide: A Toolkit for Senior Living Communities* was the first to be produced and is available for download from SAMHSA's website (http://download.ncadi.samhsa.gov/ken/pdf/SMA10-4515/toolkitoverview_final.pdf). Fortunately, the suicide rate for older Americans has been trending downward for nearly a decade.

7. Emerging Issues

Since the NSSP was released in 2001 the knowledge base has significantly developed, both in the understanding of suicidal behaviors and for suicide prevention. Some of the new evidence has already been discussed in this report. There are a few emerging issues in the field, about which we are only beginning to learn, that have not been addressed; these are mentioned below as issues that will require more attention by the field.

The first is suicide risk among the disabled. Although some discussion emerged on this topic prior to the release of the NSSP, this population was not addressed in any way in the NSSP, an apparent oversight. Obviously, the problem is still pertinent. Another is that of bullying. Concern over suicide risk related to bullying, including cyberbullying, has gradually increased over the past years culminating in new legislation and ordinances being passed in an effort to protect vulnerable youths. There have been a number of studies published on bullying, and although most have found an association between bullying (both as a perpetrator and victim) and suicidal behaviors, the best studies' multivariate analyses have not found a direct link.[77] Further investigation of the issue should shed more light on the problem and suggest appropriate responses. A third emerging issue—briefly mentioned above—involves the role of social media, both as a contributor to suicidal behaviors (e.g., when acting as a mediator in the formation of suicide pacts among adolescents) or as an instrument for suicide prevention (e.g., when a person divulges their intent for suicide through their social media page, opening the door for intervention or rescue.) It will be important for the field to learn how to harness this rapidly developing component of our culture for prevention. The final emerging issue we will address here fortunately occurs very rarely, but is devastating when it does: postpartum depression related infanticide and suicide. Improved clinical screening, detection and treatment of postpartum depression should help reduce this risk.

The emergence of these issues in the past decade could serve as a signal to the suicide prevention field that strategies and tactics will need to continually evolve along with the social scripts that appear to play such powerful roles in determining patterns of suicidal behaviors.[78]

III. CONCLUSION

> ***"New funding opportunities will be needed to ensure we can implement the programs and practices we now know to be effective."***
>
> - Key Informant

In 2010, nearly nine years after the release of the NSSP, the suicide prevention movement can celebrate myriad signal accomplishments, perhaps foremost among them, suicide prevention initiatives taking shape at the community level all across the country. It is in the context of communities where, according to Surgeon General Satcher's NSSP Preface, "human relationships breathe life into public policy." These community efforts are inspired and supported by the confluence of survivor passion, committed professionals, research and evaluation, and public and private funding. It is also evident that suicide is now a topic more easily discussed within families and in the general public and that this openness makes it easier for some people to seek help for mental health problems. Still, many challenges remain. In spite of a more open public discourse, discrimination and negative attitudes persist toward those with mental illness, those who seek mental healthcare, and most germane to this work, those contemplating or attempting suicide. Furthermore, some of that growth in public discourse may have created unintended consequences of lowering the threshold to suicide for those already at risk by not following accepted principles of health communication around suicide.

This review showed that the suicide prevention movement is still young and many core objectives of the NSSP have gone unaddressed. The recommendations generated from this review (summarized in Appendix A) should serve to refine the roadmap originally established by the NSSP. The challenge ahead is to organize and strengthen a viable, sustainable suicide prevention movement that can finally achieve the goal set by the NSSP: to reduce the rates of suicide and suicidal behaviors. A synthesis of the findings from this review suggests several opportunities underpinning the future evolution of the suicide prevention movement:

1. **Leadership.** The diversity and independent initiative of members of the suicide prevention movement have been its strength, generating momentum and enthusiasm. Since so little was being done prior to the NSSP's release, it made sense to encourage multiple independent endeavors. Now, in addition to leadership for specific concerns or programs, the movement as a whole needs leadership – from both current and new leaders – to sort out what is working from what simply sounds good, to drive the agenda toward priorities that will best move the entire field forward, to respond to changing constituencies, and to shift strategies as needs change. Forming a National Action Alliance for Suicide Prevention can provide critical components of that new leadership.

2. **Evidence base.** Notwithstanding the remarkable advancements since 2001, there is still much we do not know about what is effective in reducing the toll of suicide. In the next decade we need to fast-track the research, development, testing and dissemination of both public health and clinical interventions to reduce suicide risk.

3. **New partnerships.** Suicide shares risk and protective factors with most other significant public health problems, yet too often, the suicide prevention movement operates in its own silo. To be maximally effective the movement must develop strong partnerships with other public health movements and integrate its "best practices" into those used in other communities of practice.

4. **Activism.** The emergence of activism in suicide prevention in the late 1990s led to the creation of the NSSP. A challenge for the movement now will be to bring together the pioneering generation of the movement – advocates, researchers, clinicians, and others – with new adherents and the many others who simply agree with the goals and want to help. Grounded activism can lead to legislative actions that will effect policy changes, resulting in more funding for research, and mandates for better access and treatment. The movement's capacity for activism will be central to its future success.

5. **Collaboration and dialogue.** Collaboration has worked in the past and much more of it will be needed in the future to share knowledge and experience, forge common priorities or agendas, address new populations, and reach out to engage broader interest in suicide prevention. Dialogue is the foundation of collaboration. Using social networking tools and creating other new forums for dialogue and collaboration is integral to building a stronger, more effective suicide prevention movement. Strong dialogue will help prevent the field from endlessly re-creating wheels and spreading the limited funds too broadly to make a sustainable difference.

6. **Human and financial capital.** As the movement and its work evolve, organizations and initiatives will require significant new investment. Areas of accomplishment such as those identified in this review will require resources for continuation and ongoing improvement. Implementation of programmatic ideas shown to be effective will not occur without adequate financing and strong leadership. As the research enterprise matures, it increasingly warrants added resources. For many of those at highest risk for suicide, lack of health insurance poses one of the biggest barriers to recovery. Until now, funding for understanding and preventing suicide has borne no comparison to the magnitude of the public health problem. The total annual investment (public and private) is difficult to estimate reliably, yet it most certainly pales in comparison to even the direct medical costs associated with hospitalized suicide attempts, estimated to be over $1.5 billion annually. A primary objective for the movement must be to expand and enhance financial support well beyond this level.

This review describes many remarkable accomplishments across less than a decade, with little benefit of strong national coordination. All this is to be celebrated. Now, having taken stock of where we are in this journey of implementing the NSSP, we see where some of the next decade's challenges lie and we can begin planning to take next steps. This planning should be the first task of the National Action Alliance for Suicide Prevention.

APPENDIX A

Report Recommendations

Summary List

Recommendation 1: Develop and implement plans to increase the proportion of public awareness and education campaigns that reflect both the fundamental principles of health communication and the safe messaging recommendations specific to suicide.

Recommendation 2: Promote the importance of using public awareness and education campaigns as an adjunct to other interventions rather than as stand-alone initiatives. Whenever possible, health communications campaigns should have much more specific goals than simply "raising awareness."

Recommendation 3: Promote the development of public awareness and information campaigns that are tailored for and targeted toward specific audiences and that describe the actions those audiences can and should take to prevent suicidal behaviors.

Recommendation 4: Implement suicide related GPRA performance measures in government grant programs serving populations at increased risk for suicide, such as aging services; mental health, substance abuse, and healthcare; labor; education; and Tribal programs.

Recommendation 5: Promote more active and systematic state support of suicide prevention planning, implementation, and evaluation at the community level; systematically share successes across States.

Recommendation 6: Expand efforts to provide effective follow up care after emergency department discharge of suicidal persons.

Recommendation 7: Expand efforts to provide effective follow up care after inpatient discharge of suicidal persons.

Recommendation 8: Promote evidence-based and evidence-informed practices for reducing suicide risk among primary care patients.

Recommendation 9: Evaluate and assess practices being implemented in the VA for dissemination to the broader healthcare delivery system.

Recommendation 10: Evaluate and assess practices being implemented in the Department of Defense for potential dissemination for community-based suicide prevention efforts.

Recommendation 11: Promote collaboration between public and private partners to engage military families and veterans' families in suicide prevention efforts.

Recommendation 12: Increase efforts to integrate suicide prevention practices into substance abuse prevention and treatment services.

Recommendation 13: Evaluate the capacity of continuing education clinician training programs to produce behavioral outcomes that improve clinical practice and outcomes. On the basis of evaluation, make curriculum improvements if needed; promote mass dissemination of continuing education to practicing behavioral health providers.

Recommendation 14: Continue to evaluate and refine gatekeeper training in various contexts; modify curricula in a continuous quality improvement mode. Implement gatekeeper training in the context of comprehensive suicide prevention programs.

Recommendation 15: Develop and widely disseminate training on core public-health competencies, including strategic planning, to coalition members via the World Wide Web.

Recommendation 16: Convene organizations that establish standards of accreditation for professional and clinical training programs to develop and implement plans to ensure all training programs within specific professions include curricula on recognizing, assessing, and managing suicide risk and certification exams include questions on this content.

Recommendation 17: Incorporate extant curricula, or newly develop curricula content, to teach sate of the art, evidence-based practices in professional training programs and continuing education offerings.

Recommendation 18: Evaluate the cost and effectiveness of statewide teacher training initiatives; use evaluation results to inform policy in States and Territories.

Recommendation 19: Conduct research to better determine the effects of suicide on the bereaved and to identify effective approaches to mitigate those effects.

Recommendation 20: Develop methodologies that are capable of providing preliminary estimates of suicide rates and rapidly detecting meaningful changes in rates for specific demographic groups at the national level.

Recommendation 21: Develop a system to collect reliable data on suicide deaths that occur in healthcare settings.

Recommendation 22: Support the development of a robust suicide research infrastructure that is commensurate with the magnitude of the public health burden.

Recommendation 23: Fast-track research to develop and evaluate effective therapies, as well as non-clinical suicide risk management techniques that take into account the wide-spread non-acceptance of mental health treatment modalities.

Recommendation 24: Convene a task force to address suicide among adults in mid-life.

Recommendation 25: Take steps to ensure evidence-based therapies discussed in the Intervention section of this report are available to more suicide attempt survivors.

Recommendation 26: Develop, evaluate, and disseminate other evidence-based clinical and non-clinical interventions for survivors of suicide attempts.

APPENDIX B
NSSP GOALS AND OBJECTIVES
Summary List

Section 1: Awareness

1. Promote awareness that suicide is a public health problem that is preventable
2. Develop broad-based support for suicide prevention
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services

Section 2: Intervention

4. Develop and implement suicide prevention programs
5. Promote efforts to reduce access to lethal means and methods of self-harm
6. Implement training for recognition of at-risk behavior and delivery of effective treatment
7. Develop and promote effective clinical and professional practices
8. Increase access to and community linkages with mental health and substance abuse services
9. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media

Section 3: Methodology

10. Promote and support research on suicide and suicide prevention
11. Improve and expand surveillance systems

SECTION 1: AWARENESS	
1. Promote Awareness that Suicide is a Public Health Problem that is Preventable	
Objective 1.1:	By 2005, increase the number of States in which public information campaigns designed to increase public knowledge of suicide prevention reach at least 50 percent of the State's population.
Objective 1.2:	By 2005, establish regular national congresses on suicide prevention designed to foster collaboration with stakeholders on prevention strategies across disciplines and with the public.
Objective 1.3:	By 2005, convene national forums to focus on issues likely to strongly influence the effectiveness of suicide prevention messages.
Objective 1.4:	By 2005, increase the number of both public and private institutions active in suicide prevention that are involved in collaborative, complementary dissemination of information on the World Wide Web.
2. Develop Broad-Based Support for Suicide Prevention	
Objective 2.1:	By 2001, expand the Federal Steering Group to appropriate Federal agencies to improve

	Federal coordination on suicide prevention, to help implement the National Strategy for Suicide Prevention, and to coordinate future revisions of the National Strategy
Objective 2.2:	By 2002, establish a public/private partnership(s) (e.g., a national coordinating body) with the purpose of advancing and coordinating the implementation of the National Strategy.
Objective 2.3:	By 2005, increase the number of national professional, voluntary, and other groups that integrate suicide prevention activities into their ongoing programs and activities.
Objective 2.4:	By 2005, increase the number of nationally organized faith communities adopting institutional policies promoting suicide prevention.
3. Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse and Suicide Prevention Services.	
Objective 3.1:	By 2005, increase the proportion of the public that views mental and physical health as equal and inseparable components of overall health.
Objective 3.2:	By 2005, increase the proportion of the public that views mental disorders as real illnesses that respond to specific treatments.
Objective 3.3:	By 2005, increase the proportion of the public that views consumers of mental health, substance abuse, and suicide prevention services as pursuing fundamental care and treatment for overall health.
Objective 3.4:	By 2005, increase the proportion of those suicidal persons with underlying mental disorders who receive appropriate mental health treatment.
SECTION 2: INTERVENTION	
4. Develop and Implement Community-Based Suicide Prevention Programs	
Objective 4.1:	By 2005, increase the proportion of States with comprehensive suicide prevention plans that a) coordinate across government agencies, b) involve the private sector, and c) support plan development, implementation, and evaluation in its communities.
Objective 4.2:	By 2005, increase the proportion of school districts and private school associations with evidence-based programs designed to address serious childhood and adolescent distress and prevent suicide.
Objective 4.3:	By 2005, increase the proportion of colleges and universities with evidence-based programs designed to address serious young adult distress and prevent suicide.
Objective 4.4:	By 2005, increase the proportion of employers that ensure the availability of evidence-based prevention strategies for suicide.
Objective 4.5:	By 2005, increase the proportion of correctional institutions, jails and detention centers housing either adult or juvenile offenders, with evidence-based suicide prevention programs.
Objective 4.6:	By 2005, increase the proportion of State Aging Networks that have evidence-based suicide prevention programs designed to identify and refer for treatment of elderly people at risk for suicidal behavior.
Objective 4.7:	By 2005, increase the proportion of family, youth and community service providers and organizations with evidence-based suicide prevention programs.
Objective 4.8:	By 2005, develop one or more training and technical resource centers to build capacity for States and communities to implement and evaluate suicide prevention programs.
5. Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm	
Objective 5.1:	By 2005, increase the proportion of primary care clinicians, other health care providers, and health and safety officials who routinely assess the presence of lethal means (including firearms, drugs, and poisons) in the home and educate about actions to reduce associated risks.

Objective 5.2:	By 2005, expose a proportion of households to public information campaign(s) designed to reduce the accessibility of lethal means, including firearms, in the home.
Objective 5.3:	By 2005, develop and implement improved firearm safety design using technology where appropriate.
Objective 5.4:	By 2005, develop guidelines for safer dispensing of medications for individuals at heightened risk of suicide.
Objective 5.5:	By 2005, improve automobile design to impede carbon monoxide-mediated suicide.
Objective 5.5:	By 2005, improve automobile design to impede carbon monoxide-mediated suicide.
Objective 5.6:	By 2005, institute incentives for the discovery of new technologies to prevent suicide.
6. Implement Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment	
Objective 6.1:	By 2005, define minimum course objectives for providers of nursing care in assessment and management of suicide risk, and identification and promotion of protective factors. Incorporate this material into curricula for nursing care providers at all professional levels.
Objective 6.2:	By 2005, increase the proportion of physician assistant educational programs and medical residency programs that include training in the assessment and management of suicide risk and identification and promotion of protective factors.
Objective 6.3:	By 2005, increase the proportion of clinical social work, counseling, and psychology graduate programs that include training in the assessment and management of suicide risk, and the identification and promotion of protective factors.
Objective 6.4:	By 2005, increase the proportion of clergy who have received training in identification of and response to suicide risk and behaviors and the differentiation of mental disorders and faith crises.
Objective 6.5:	By 2005, increase the proportion of educational faculty and staff who have received training on identifying and responding to children and adolescents at risk for suicide.
Objective 6.6:	By 2005, increase the proportion of correctional workers who have received training on identifying and responding to persons at risk for suicide.
Objective 6.7:	By 2005, increase the proportion of divorce and family law and criminal defense attorneys who have received training in identifying and responding to persons at risk for suicide.
Objective 6.8:	By 2005, increase the proportion of counties (or comparable jurisdictions such as cities or tribes) in which education programs are available to family members and others in close relationships with those at risk for suicide.
Objective 6.9:	By 2005, increase the number of recertification or licensing programs in relevant professions that require or promote competencies in depression assessment and management and suicide prevention.
7. Develop and Promote Effective Clinical and Professional Practices	
Objective 7.1:	By 2005, increase the proportion of patients treated for self-destructive behavior in hospital emergency departments that pursue the proposed mental health follow-up plan.
Objective 7.2:	By 2005, develop guidelines for assessment of suicidal risk among persons receiving care in primary health care settings, emergency departments, and specialty mental health and substance abuse treatment centers. Implement these guidelines in a proportion of these settings.
Objective 7.3:	By 2005, increase the proportion of specialty mental health and substance abuse treatment centers that have policies, procedures, and evaluation programs designed to assess suicide risk and intervene to reduce suicidal behaviors among their patients.
Objective 7.4:	By 2005, develop guidelines for aftercare treatment programs for individuals exhibiting suicidal behavior (including those discharged from inpatient facilities). Implement these guidelines in a

	proportion of these settings.
Objective 7.5:	By 2005, increase the proportion of those who provide key services to suicide survivors (e.g., emergency medical technicians, firefighters, law enforcement officers, funeral directors, clergy) who have received training that addresses their own exposure to suicide and the unique needs of suicide survivors.
Objective 7.6:	By 2005, increase the proportion of patients with mood disorders who complete a course of treatment or continue maintenance treatment as recommended.
Objective 7.7:	By 2005, increase the proportion of hospital emergency departments that routinely provide immediate post-trauma psychological support and mental health education for all victims of sexual assault and/or physical abuse.
Objective 7.8:	By 2005, develop guidelines for providing education to family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide. Implement the guidelines in facilities (including general and mental hospitals, mental health clinics, and substance abuse treatment centers).
Objective 7.9:	By 2005, incorporate screening for depression, substance abuse and suicide risk as a minimum standard of care for assessment in primary care settings, hospice, and skilled nursing facilities for all Federally-supported healthcare programs (e.g., Medicaid, CHAMPUS/TRICARE, CHIP, Medicare).
Objective 7.10:	By 2005, include screening for depression, substance abuse and suicide risk as measurable performance items in the Health Plan Employer Data and Information Set (HEDIS).
8. Increase Access to and Community Linkages with Mental Health and Substance Abuse Services	
Objective 8.1:	By 2005, increase the number of States that require health insurance plans to cover mental health and substance abuse services on par with coverage for physical health.
Objective 8.2:	By 2005, increase the proportion of counties (or comparable jurisdictions) with health and/or social services outreach programs for at-risk populations that incorporate mental health services and suicide prevention.
Objective 8.3:	By 2005, define guidelines for mental health (including substance abuse) screening and referral of students in schools and colleges. Implement those guidelines in a proportion of school districts and colleges.
Objective 8.4:	By 2005, develop guidelines for schools on appropriate linkages with mental health and substance abuse treatment services and implement those guidelines in a proportion of school districts.
Objective 8.5:	By 2005, increase the proportion of school districts in which school-based clinics incorporate mental health and substance abuse assessment and management into their scope of activities.
Objective 8.6:	By 2005, for adult and juvenile incarcerated populations, define national guidelines for mental health screening, assessment and treatment of suicidal individuals. Implement the guidelines in correctional institutions, jails and detention centers.
Objective 8.7:	By 2005, define national guidelines for effective comprehensive support programs for suicide survivors. Increase the proportion of counties (or comparable jurisdictions) in which the guidelines are implemented.
Objective 8.8:	By 2005, develop quality care/utilization management guidelines for effective response to suicidal risk or behavior and implement these guidelines in managed care and health insurance plans.
9. Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media	
Objective 9.1:	By 2005, establish an association of public and private organizations for the purpose of promoting the accurate and responsible representation of suicidal behaviors, mental illness

	and related issues on television and in movies.
Objective 9.2:	By 2005, increase the proportion of television programs and movies that observe promoting accurate and responsible depiction of suicidal behavior, mental illness and related issues.
Objective 9.3:	By 2005, increase the proportion of news reports on suicide that observe consensus reporting recommendations.
Objective 9.4:	By 2005, increase the number of journalism schools that include in their curricula guidance on the portrayal and reporting of mental illness, suicide and suicidal behaviors.
SECTION 3: METHODOLOGY	
10. Promote and Support Research on Suicide and Suicide Prevention	
Objective 10.1:	By 2002, develop a national suicide research agenda with input from survivors, practitioners, researchers, and advocates.
Objective 10.2:	By 2005, increase funding (public and private) for suicide prevention research, for research on translating scientific knowledge into practice, and for training of researchers in suicidology.
Objective 10.3:	By 2005, establish and maintain a registry of prevention activities with demonstrated effectiveness for suicide or suicidal behaviors.
Objective 10.4:	By 2005, perform scientific evaluation studies of new or existing suicide prevention interventions.
11. Improve and Expand Surveillance Systems	
Objective 11.1:	By 2005, develop and refine standardized protocols for death scene investigations and implement these protocols in counties (or comparable jurisdictions).
Objective 11.2:	By 2005, increase the proportion of jurisdictions that regularly collect and provide information for follow-back studies on suicides.
Objective 11.3:	By 2005, increase the proportion of hospitals (including emergency departments) that collect uniform and reliable data on suicidal behavior by coding external cause of injuries, utilizing the categories included in the International Classification of Diseases.
Objective 11.4:	By 2005, implement a national violent death reporting system that includes suicides and collects information not currently available from death certificates.
Objective 11.5:	By 2005, increase the number of States that produce annual reports on suicide and suicide attempts, integrating data from multiple State data management systems.
Objective 11.6:	By 2005, increase the number of nationally representative surveys that include questions on suicidal behavior.
Objective 11.7:	By 2005, implement pilot projects in several States that link and analyze information related to self-destructive behavior derived from separate data systems, including for example law enforcement, emergency medical services, and hospitals.

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