



2012 National Strategy for Suicide Prevention: GOALS AND OBJECTIVES FOR ACTION

A report of the U.S. Surgeon General
and of the National Action Alliance for Suicide Prevention



September 2012

Acknowledgements

The development of this document was supported by the United States Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), through Grant No. SM059945 to Education Development Center, Inc., for the Suicide Prevention Resource Center. Design and review were supported by Gallup, under Contract No. HHS28300001T/HHS2832007000231, Ref No. 283-07-2301, SAMHSA, HHS.

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Suggested Citation

U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. Washington, DC: HHS, September 2012.

Preface from the Surgeon General

As U.S. Surgeon General and co-lead of the National Strategy for Suicide Prevention Task Force, I am honored to present the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action.

A little more than 10 years ago, one of my predecessors, Surgeon General David Satcher, issued the first National Strategy for Suicide Prevention. This document was a landmark that helped launch an organized effort to prevent suicide across the nation. But a great deal has changed since that document was issued in 2001, and so I am proud to follow in Dr. Satcher's footsteps and release this updated strategy to help guide and galvanize us all to address the tragedy and the burden of suicide.

The strategy-revision process was initiated and overseen by the National Action Alliance for Suicide Prevention, of which I am honored to be a member and to which I am particularly grateful. This innovative public-private partnership represents a new approach to enlisting all Americans in the fight to prevent suicide. Its multisectoral nature has great promise to really move us forward in this effort.

Suicide is a problem that touches the lives of many Americans. Many of us know a friend or a loved one who has attempted or died from suicide. Perhaps we have considered or attempted suicide ourselves. Some of us may have been affected as a result of a suicide in our community, school, workplace, or place of worship.

Despite these very personal experiences, most Americans are surprised to learn that between 2001 and 2009, an average of 33,000 suicide deaths occurred each year in the United States. Suicide is among the top five causes of death for adults under age 45 in the United States, and in 2009, more Americans died from suicide than from motor vehicle traffic-related injuries.

Those who die by suicide are far from the only ones affected by this tragedy. Suicide exacts a heavy toll on those left behind as well. Loved ones, friends, classmates, neighbors, teachers, faith leaders, and colleagues all feel the effect of these deaths. Sadly, these deaths are just one measure of the challenge we face. For every American who dies by suicide, many others attempt suicide, and many more suffer the despair that leads them to consider taking their own life. Fortunately, it doesn't have to be this way. There is much we can do, and the strategy that follows provides ways each of us can do our part.

The effect of suicide on communities across our nation goes beyond the personal. Suicide affects some of the most important concerns of our time. Suicide among those who serve in our Armed Forces and among our veterans has been a matter of national concern. The largest number of suicidal deaths each year occurs among middle-aged men and women, sapping the workforce we need to grow our economy. The fact that suicidal behavior occurs among some of our most marginalized citizens is a call to action we must embrace.

Reducing the number of suicides requires the engagement and commitment of people in many sectors in and outside of government, including public health, mental health, health care, the Armed Forces, business, entertainment, media, and education. This update of the strategy drew on suicide prevention experts from all these sectors, and I want to express my thanks to those who contributed to this document.

As the Surgeon General, I want to help make Americans aware of the heavy burden suicide imposes on our nation, and more importantly, do everything I can to help reduce the toll that suicide takes on America. That is what this document is all about.

No matter where we live or what we do every day, each of us has a role in preventing suicide. Our actions can make a difference. While a document alone will not prevent a single suicide, I hope that this document will help spur and leverage all of our actions so we can make real progress now in preventing suicide. We have no time to waste.

Regina M. Benjamin, MD, MBA
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Surgeon General

From the National Council for Suicide Prevention

As the member organizations of the National Council for Suicide Prevention (NCSP), we are pleased to offer our support for the updated National Strategy for Suicide Prevention. We believe it will focus suicide prevention in our nation now and in the years ahead.

As a council composed of the leading national not-for-profit organizations dedicated to suicide prevention and to supporting survivors of suicide loss, we are grateful for the efforts to ensure that the new National Strategy was thoughtful, comprehensive, and included clear goals for reducing the incidence of suicide in America. We commend all those involved, specifically the National Strategy for Suicide Prevention Task Force, for carrying forward the excellent work started by former Surgeon General David Satcher and for leading this initiative to update and revise the National Strategy for Suicide Prevention.

Revising the National Strategy was no small task. It required the collective wisdom, expertise, and input from researchers and scientists, clinicians and health experts, those who have attempted suicide, and those who are bereaved by suicide, as well as many other stakeholders. It required input from multiple sectors—public, private, and nonprofit—as well as time and money. Ultimately, it required making difficult but important decisions regarding priorities for the future. We thank you for doing all of this, especially in light of the current economic climate.

The members of the NCSP are grateful for the opportunity to have served as advisors in the development of this document. After a decade of advancements in suicide prevention, we remain concerned that the nation is still in a period of rising suicide rates. Therefore, we believe that the timing for a revised National Strategy is right and that it offers an improved framework for achieving our ultimate goal of saving lives.

We also believe that the new National Strategy reflects the history of what we have learned about suicide prevention and advances our understanding of best approaches to reducing the incidence of suicide. Further, it will serve as a template for states, tribes, local communities, and public and private entities as they work to prevent suicide.

The NCSP stands ready to join our partners in the public and private sectors to fully implement the revised National Strategy. Through the collective expertise of the NCSP member organizations and through our willingness to collaborate with others, we remain dedicated to working aggressively to prevent further loss of life from suicide and to the improved health of all our citizens.

Respectfully submitted,

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From the National Action Alliance for Suicide Prevention

As co-chairs of the National Action Alliance for Suicide Prevention (Action Alliance), we are honored to present this revised version of the National Strategy for Suicide Prevention.

This strategy recognizes that suicide is a complicated issue that requires equally complex solutions. Effective solutions need to incorporate multiple approaches at multiple levels. Effective prevention programs and policies stress the importance of wellness, resiliency, and protective factors; effective suicide response and intervention programs address risk factors, mental health and substance abuse services, and crisis response for those who are struggling with suicidal behaviors; and effective support programs are required for those who have been touched by suicide or suicidal behavior.

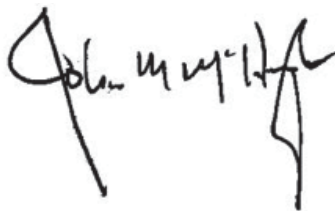
We believe that suicide is preventable when the right resources and services are in place. We also recognize that there is a lot of work to do to ensure that those who are most in need receive the services and support they require. It is our hope that this strategy will continue to guide suicide prevention efforts and save lives in communities across the United States.

The original National Strategy for Suicide Prevention called for the establishment of a public-private partnership to help guide the implementation of the goals and objectives recommended in the National Strategy. Launched in September 2010 by Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates, the Action Alliance is that partnership. The Action Alliance was established with a clear mission: to advance the National Strategy for Suicide Prevention by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the National Strategy, and cultivating the resources needed to sustain progress.

This report is the culmination of the efforts of the Action Alliance's National Strategy Revision Task Force, co-led by Surgeon General Regina Benjamin and Jerry Reed, Director of the Suicide Prevention Resource Center. It represents the voice and input of countless individuals from across the country who provided thoughtful comments and feedback throughout the revision process.

The Action Alliance is committed to advancing the National Strategy for Suicide Prevention. We will continue to identify and advance high-priority objectives of the National Strategy that require leverage and coordination at the national level.

Thank you for your dedication to preventing suicide.



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Dedication

To those who have lost their lives by suicide,

To those who struggle with thoughts of suicide,

To those who have made an attempt on their lives,

To those caring for someone who struggles,

To those left behind after a death by suicide,

To those in recovery, and

To all those who work tirelessly to prevent suicide and suicide attempts in our nation.

We believe that we can and we will make a difference.

Contents

Introduction	10
Strategic Direction 1:.....	29
Healthy and Empowered Individuals, Families, and Communities	
Strategic Direction 2:.....	40
Clinical and Community Preventive Services	
Strategic Direction 3:.....	50
Treatment and Support Services	
Strategic Direction 4:.....	66
Surveillance, Research, and Evaluation	
Appendix A:	75
National Strategy for Suicide Prevention Goals and Objectives for Action Summary List	
Appendix B:	81
Crosswalk of Goals and Objectives from 2001 to 2012	
Appendix C:	94
Brief History of Suicide Prevention in the United States	
Appendix D:	101
Groups With Increased Suicide Risk	
Appendix E:	131
General Suicide Prevention Resources	
Appendix F:	138
Glossary	
Appendix G:	145
Federal Working Group Agency Descriptions	
Acknowledgments.....	157
References.....	164

Introduction

Suicide is a serious public health problem that causes immeasurable pain, suffering, and loss to individuals, families, and communities nationwide. Many people may be surprised to learn that suicide was one of the top 10 causes of death in the United States in 2009.¹ And death is only the tip of the iceberg. For every person who dies by suicide, more than 30 others attempt suicide.² Every suicide attempt and death affects countless other individuals. Family members, friends, coworkers, and others in the community all suffer the long-lasting consequences of suicidal behaviors.

Key Facts:

Suicide is the 10th leading cause of death, claiming more than twice as many lives each year as does homicide.¹

On average, between 2001 and 2009, more than 33,000 Americans died each year as a result of suicide, which is more than 1 person every 15 minutes.¹

More than 8 million adults report having serious thoughts of suicide in the past year, 2.5 million report making a suicide plan in the past year, and 1.1 million report a suicide attempt in the past year.³

Almost 16 percent of students in grades 9 to 12 report having seriously considered suicide, and 7.8 percent report having attempted suicide one or more times in the past 12 months.⁴

Suicide places a heavy burden on the nation in terms of the emotional suffering that families and communities experience as well as the economic costs associated with medical care and lost productivity. And yet suicidal behaviors often continue to be met with silence and shame. These attitudes can be formidable barriers to providing care and support to individuals in crisis and to those who have lost a loved one to suicide.

More than a decade has passed since Surgeon General David Satcher broke the silence surrounding suicide in the United States by issuing *The Surgeon General's Call to Action to Prevent Suicide*.⁵ Published in 1999, this landmark document introduced a blueprint for suicide prevention and guided the development of the National Strategy for Suicide Prevention (National Strategy). Released in 2001, the National Strategy set forth an ambitious national agenda for suicide prevention consisting of 11 goals and 68 objectives.⁶

What has changed since the National Strategy was released in 2001? Where have efforts been successful, and where is more work needed? What new findings from scientific research can help enhance suicide prevention efforts and improve the care provided to those who have been affected by suicide? What lessons learned can help guide suicide prevention efforts in the years to come?

To assess progress made to date and identify remaining challenges, the Substance Abuse and Mental Health Services Administration (SAMHSA) commissioned the report *Charting the Future of Suicide Prevention*.⁷ Published in 2010, the report identified substantial achievements in suicide prevention in the years following the release of the National Strategy. Examples include the enactment of the

Garrett Lee Smith Memorial Act, the creation of the National Suicide Prevention Lifeline (800-273-TALK/8255) and its partnership with the Veterans Crisis Line, and the establishment of the Suicide Prevention Resource Center (SPRC). Other areas of progress include the increased training of clinicians

and community members in the detection of suicide risk and appropriate response, and enhanced communication and collaboration between the public and private sectors on suicide prevention. The report also described remaining challenges and identified priority areas for action.

Informed by this assessment, the National Action Alliance for Suicide Prevention (Action Alliance), a public-private partnership focused on advancing the National Strategy, formed an expert task force to revise and update the National Strategy. This document is the product of that task force's deliberations and also reflects substantial input from individuals and organizations nationwide with an interest in suicide prevention. The revised National Strategy is a call to action that is intended to guide suicide prevention actions in the United States over the next decade.

The National Strategy includes 13 goals and 60 objectives that have been updated to reflect advances in suicide prevention knowledge, research, and practice, as well as broader changes in society and health care delivery that have created new opportunities for suicide prevention. Some of the major developments addressed in the revised National Strategy include:

- A better understanding of how suicide is related to mental illness, substance abuse, trauma, violence, and other related issues;
- New information on groups that may be at an increased risk for suicidal behaviors;
- Increased knowledge of the types of interventions that may be most effective for suicide prevention; and
- An increased recognition of the importance of implementing suicide prevention efforts in a comprehensive and coordinated way.

Because suicide is closely linked with mental illness,⁸ in the past, suicide prevention was often viewed as an issue that mental health agencies and systems should address. However, the vast majority of persons who may have a mental disorder do not engage in suicidal behaviors.⁹ Moreover, mental health is only one of many factors that can influence suicide risk. For example, enhancing connectedness to others has been identified as a strategy for preventing suicidal behaviors and other problems.¹⁰ All of us can play a role in helping to make this protective factor more widely available.

Suicide prevention is not exclusively a mental health issue. It is a *health* issue that must be addressed at many levels by different groups working together in a coordinated and synergistic way. Federal, state, tribal, and local governments; health care systems, insurers, and clinicians; businesses; educational institutions; community-based organizations; and family members, friends, and others—all have a role to play in suicide prevention. The revised National Strategy reflects this understanding.

Suicide prevention efforts must involve a wide range of partners and draw on a diverse set of resources and tools. The National Strategy seeks to do so by integrating suicide prevention into the mission, vision, and work of a wide range of organizations and programs in a comprehensive and coordinated way.

A comprehensive approach to suicide prevention is described on pages 12 and 13. In this description, a person who is struggling with depression and thoughts of suicide is given the services and support he or she needs to recover from these challenges and regain a sense of complete physical, mental, emotional, and spiritual health and well-being.

A Comprehensive Approach to Suicide Prevention

This description highlights some of the many clinical and community services and supports that should be available to a person who struggles with depression and thoughts of suicide.

In the community, when the person interacts with family members, friends, physicians, and others:

- Reduced prejudice about mental disorders and suicide makes it more likely that the person will let others know about symptoms and seek help;
- Responsible media reporting of mental illness and suicide reduces prejudice and prevents contagion;
- A well-implemented public awareness campaign raises cognizance of the signs and symptoms of mental disorders and risks for suicide and of where help is available locally;
- Training of community service providers makes it easier to identify the person at risk and increases appropriate referrals;
- Systems are in place to ensure that the person is referred to and safely transported to the appropriate facility for evaluation; and
- Reducing access to lethal means makes it less likely that the person will engage in suicidal behaviors.

At the primary care provider or emergency department:

- Screening improves the likelihood that the person will receive appropriate evaluation and treatment;
- Training on recognition of risk and quality of care increases the likelihood of a good outcome;
- The care provider accurately diagnoses and records the problems and ensures that the appropriate public health surveillance systems are notified or made aware of the diagnoses;
- The implementation of trauma-informed policies and practices ensures that the person is treated with respect and in a way that promotes healing and recovery;
- Easy access to mental health care referrals for individuals with suicide risk increases the likelihood of a better outcome;
- Education efforts by health care providers increase knowledge of the warning signs of suicide risk among the individual and his or her family and/or support network; and
- Continuous care and improved aftercare leads to better monitoring and followup of the at-risk individual over time.

In the community, while receiving care:

- Reduced prejudice regarding mental health issues and suicide leads to greater acceptance by family members and friends;
- The availability of high-quality mental health services that are linguistically and culturally appropriate makes it less likely that depression or related problems will recur;
- Sharing information, with the person's permission, among care providers allows treatment to be better coordinated and collaborative; and
- Resources are available to offer social support, resiliency training, problem-solving skills, and other protective factors to the person and his or her family members and/or support network.

In the community, after the person recovers:

- Education efforts help the person and his or her family members and/or support network maintain physical, mental, emotional, and spiritual health and well-being; and
- Systems are in place to evaluate the effectiveness and efficiency of the interventions provided.

This is an example of an integrated, synergistic, multilevel approach to suicide prevention. The National Strategy for Suicide Prevention challenges all who play a role in suicide prevention to integrate and coordinate efforts to ensure that these types of strategies are implemented in a comprehensive and collaborative way.

Understanding Suicide

Although some people may perceive suicide as the act of a troubled person, it is a complex outcome that is influenced by many factors. Individual characteristics may be important, but so are relationships with family, peers, and others, and influences from the broader social, cultural, economic, and physical environments.

There is no single path that will lead to suicide. Rather, throughout life, a combination of factors, such as a serious mental illness, alcohol abuse, a painful loss, exposure to violence, or social isolation may increase the risk of suicidal thoughts and behaviors.

Risk and Protective Factors

Suicide prevention efforts seek to reduce the factors that increase the risk for suicidal thoughts and behaviors and increase the factors that help strengthen, support, and protect individuals from suicide. Risk factors are characteristics that make it more likely that a person will think about suicide or engage in suicidal behaviors.¹⁰ Although risk factors generally contribute to long-term risk, stressful events, such as relationship problems, financial difficulties, or public humiliation could provide the impetus for a suicidal act.¹⁰

Protective factors are not just the opposite or lack of risk factors. Rather, they are conditions that promote strength and resilience and ensure that vulnerable individuals are supported and connected with others during difficult times, thereby making suicidal behaviors less likely.

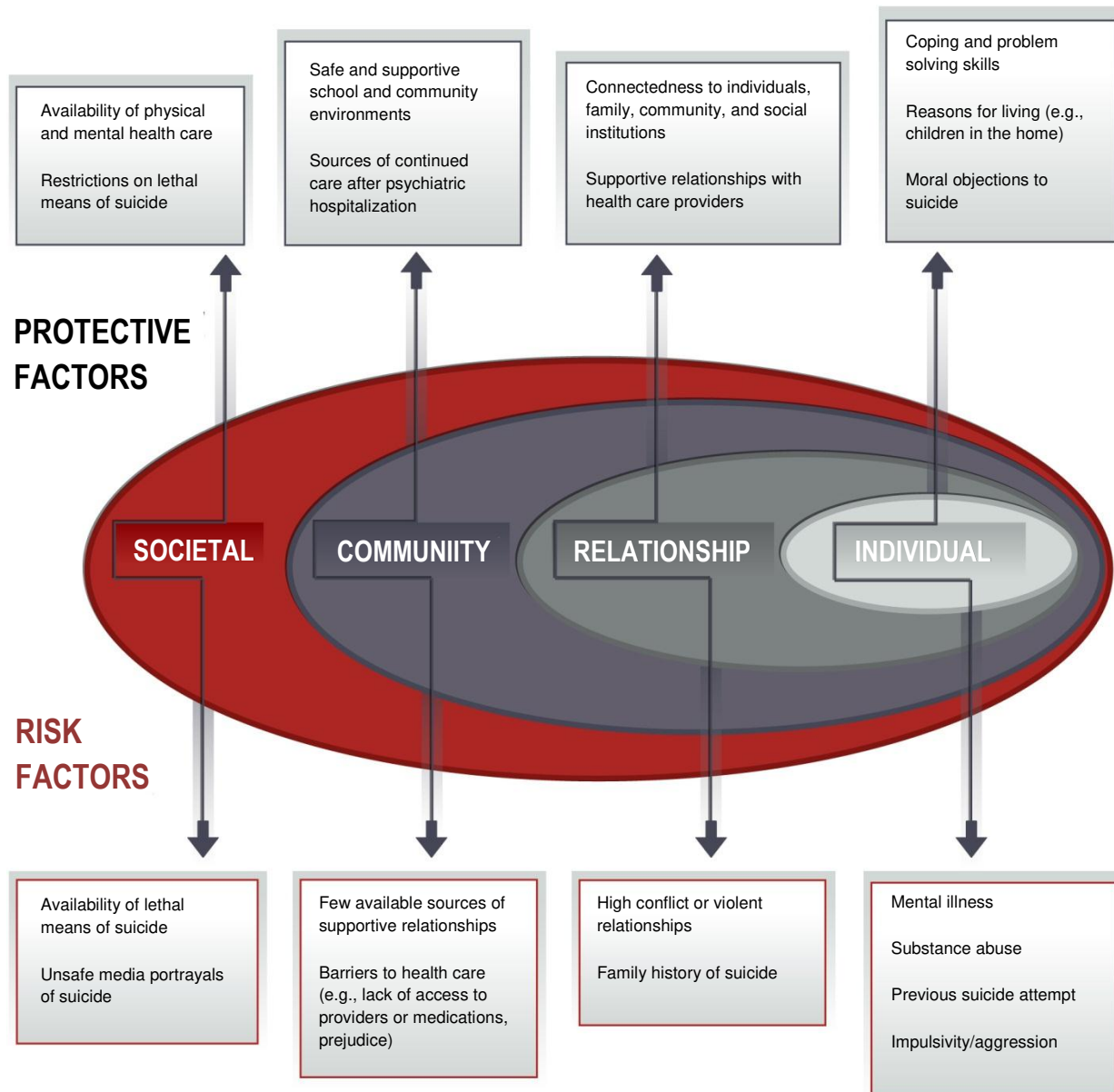
Risk and protective factors for suicidal behaviors can be found at many levels, from the individual to the community and society at large. The social ecological model (see figure on page 15) provides a useful framework for viewing these factors along four levels of influence: individual, relationship, community, and societal. The figure lists the major risk and protective factors for suicidal behaviors identified in the literature.¹⁰⁻¹² Because these factors can vary between individuals and across settings, the examples listed in the figure are not comprehensive.

Key Terms

- **Affected by suicide.** All those who may feel the effect of suicidal behaviors, including those bereaved by suicide, community members, and others.
- **Behavioral health.** A state of mental and emotional being and/or choices and actions that affect wellness. Behavioral health problems include mental and substance use disorders and suicide.
- **Bereaved by suicide.** Family members, friends, and others affected by the suicide of a loved one (also referred to as *survivors of suicide loss*).
- **Means.** The instrument or object used to carry out a self-destructive act (e.g., chemicals, medications, illicit drugs).
- **Methods.** Actions or techniques that result in an individual inflicting self-directed injurious behavior (e.g., overdose).
- **Suicidal behaviors.** Behaviors related to suicide, including preparatory acts, suicide attempts, and deaths.
- **Suicidal ideation.** Thoughts of engaging in suicide-related behavior.
- **Suicide.** Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
- **Suicide attempt.** A nonfatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

These definitions reflect how these terms are used in the National Strategy for Suicide Prevention. For more information, including detailed definitions used in suicide surveillance, see the glossary in Appendix F.

EXAMPLES OF RISK AND PROTECTIVE FACTORS IN A SOCIAL ECOLOGICAL MODEL



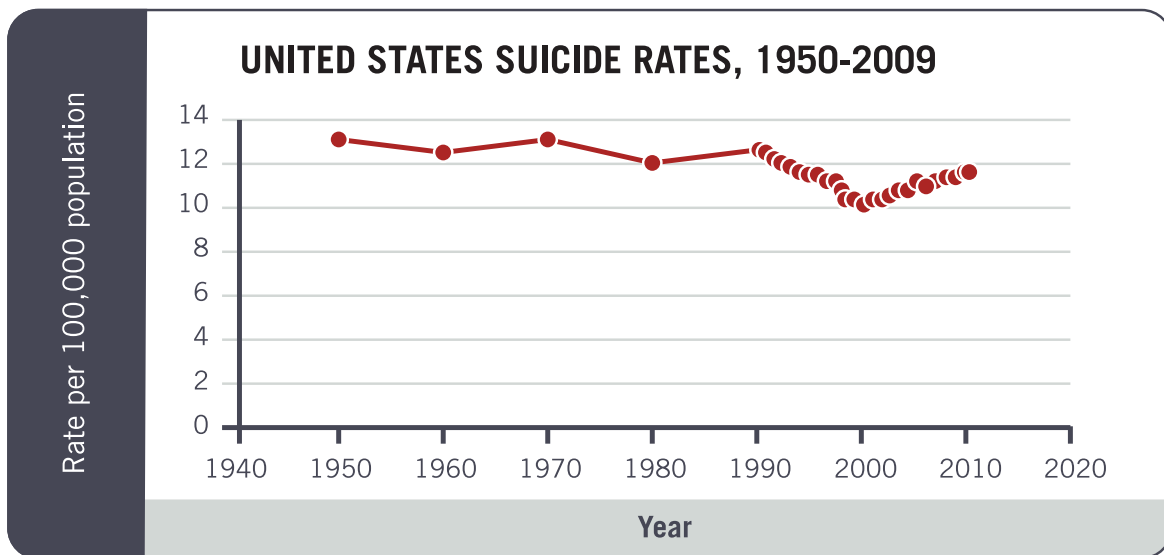
Adapted from: Dahlberg LL, Krug EG. Violence—a global public health problem. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World report on violence and health. Geneva, Switzerland: World Health Organization; 2002:1–56.

Suicide is closely linked with mental and substance use disorders¹³ and shares risk and protective factors with other types of self-directed violence,¹⁴ interpersonal violence,¹⁵ and other related problems. As a result, efforts to reduce the risk factors and to increase the protective factors for suicide are likely to also help prevent or reduce these and other problems. For example, a comprehensive suicide prevention program implemented by the U.S. Air Force (see box on page 21) was found to not only prevent suicide but also to reduce family violence and homicide.¹⁶

The Prevalence of Suicidal Behaviors

Estimates from the Centers for Disease Control and Prevention (CDC) indicate that 36,909 people died from suicide in the United States in 2009, the most recent year for which these data are available.¹ In absolute numbers, this represents an increase from 2008, when 36,035 people died from suicide.¹⁷

The graph: United States Suicide Rates, 1950–2009, shows changes in the suicide rate from 1950 to 2009. Within this time period, suicide rates were lowest in 2000, at 10.44 per 100,000 people. They have since increased to 11.77 per 100,000 people.¹



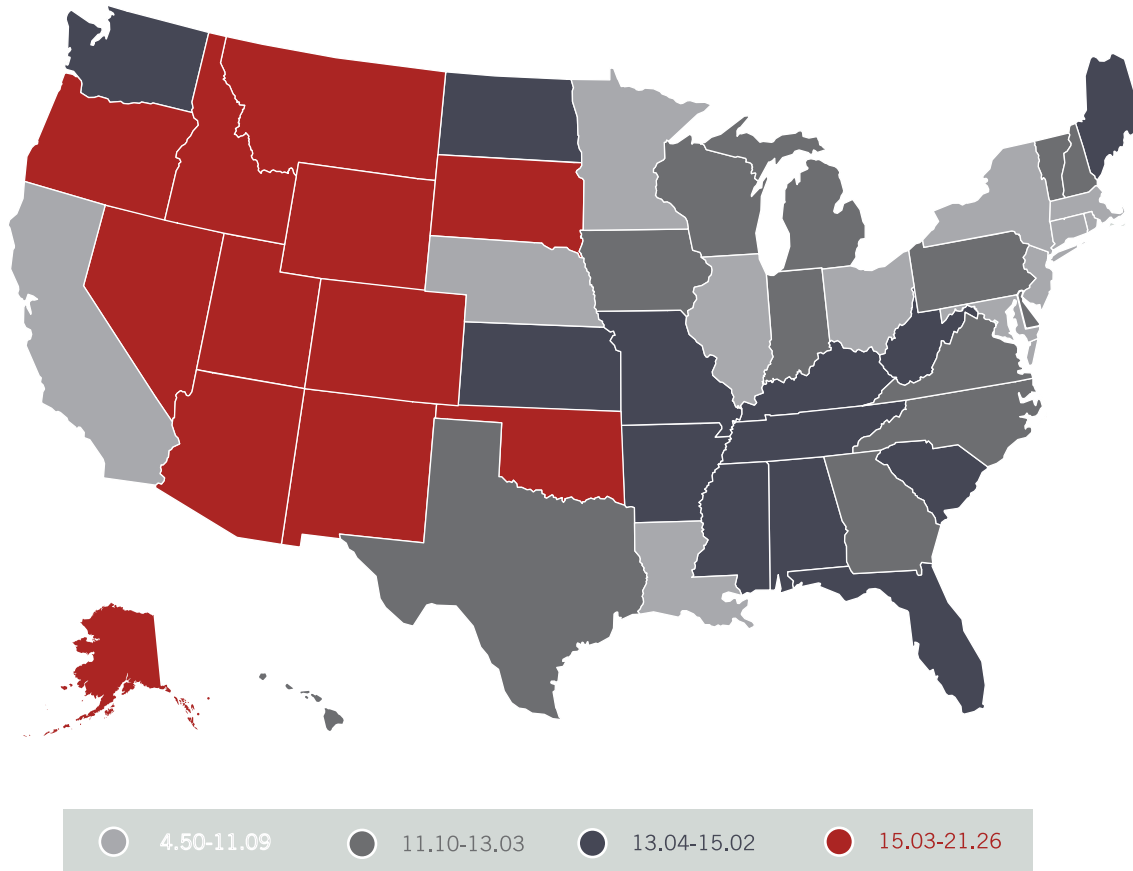
SOURCE: Death data are from the National Vital Statistics System operated by the National Center for Health Statistics, CDC. Age-adjusted rates for 1950–2009 were obtained from WISQARS (www.cdc.gov/injury/wisqars).

The prevalence of suicide varies by region and state. Suicide rates are higher in the western part of the country than in other regions (see map on page 17).¹

Suicide rates are only part of the picture. Existing data indicate that many people think about suicide and may also engage in suicidal behaviors. During 2008 and 2009, an estimated 8.3 million (annual average) adults aged 18 years and older (3.7 percent of the adult U.S. population) reported having suicidal thoughts in the past year.¹⁸ The prevalence of having suicidal thoughts ranged from 2.1 percent in Georgia to 6.8 percent in Utah. In addition, an estimated 1 million adults in the United States reported making a suicide attempt in the past year.

Suicide-related thoughts and behaviors are also common among youth. According to the 2011 Youth Risk Behavior Survey, more than 1 in 7 high school students nationwide reported having seriously considered attempting suicide in the 12 months before the survey.⁴ In addition, 7.8 percent of students, or about 1 in 13 reported having attempted suicide in the past year.

AGE-ADJUSTED SUICIDE RATES PER 100,000 POPULATION BY STATE, UNITED STATES, 2009
NATIONAL AGE-ADJUSTED RATE, 2009: 11.77

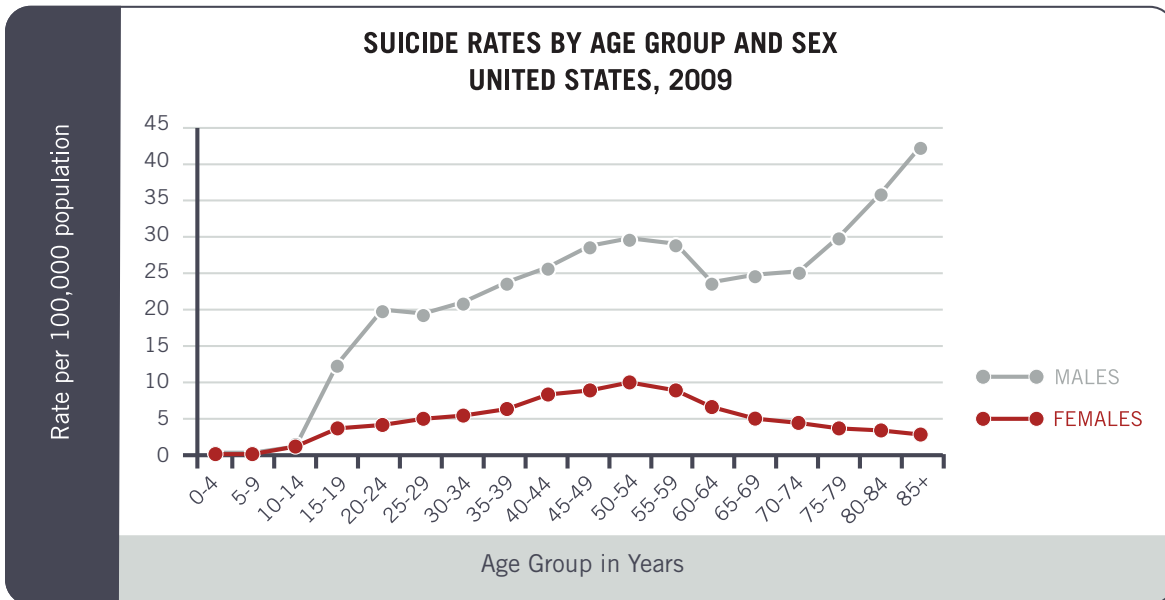


SOURCE: Death data are from the National Vital Statistics System operated by the National Center for Health Statistics, CDC. Age-adjusted rates for 2009 were obtained from WISQARS (www.cdc.gov/injury/wisqars).

Many barriers make it difficult to know exactly how common suicidal behaviors are in the general population and in particular subgroups. Suicides are often underreported, in part because it may be difficult to determine intent. In some cases, existing data collection instruments may fail to include questions that would help determine the prevalence of suicidal behaviors among particular groups. For example, because death certificates do not indicate sexual orientation and gender identity, rates of deaths by suicide in lesbian, gay, bisexual, and transgender (LGBT) populations are unknown. The quality of some death investigations needs to improve. Additionally, in some states, key data sources such as death certificates and medical examiner reports may not yet be linked. The National Violent Death Reporting System (NVDRS)¹⁹ helps to address this limitation, but the system is currently available in only 18 states. Data on the national prevalence of suicide are available from a related online system, Web-Based Injury Statistics Query and Reporting System (WISQARS).²⁰

Differences Among Groups

Existing data suggest important differences among demographic and other groups regarding suicidal thoughts and behaviors. For example, women are more likely than men to have thoughts about suicide and to attempt suicide, but men are more likely than women to die by suicide.¹⁹ Suicide methods also differ. Overall, men are more likely to use firearms in a suicide attempt, and women are more likely to use poisoning.¹



SOURCE: Death data are from the National Vital Statistics System operated by the National Center for Health Statistics, CDC. Age-adjusted rates for 2009 were obtained from WISQARS (www.cdc.gov/injury/wisqars).

Although white men 75 years of age and older have the highest rates of suicide, most deaths from suicide occur among white men in midlife, who make up a larger part of the population.¹ Suicide rates among young people 15–24 years of age are generally not higher than among adults. However, because young people are less likely than older people to die from medical conditions such as heart disease and cancer, suicide is one of the top three causes of death in this population, along with unintentional injuries and homicides.¹ Moreover, suicidal behaviors are particularly common among some subgroups of youth. For example, it is estimated that 14 to 27 percent of American Indian/Alaska Native adolescents have attempted suicide.²¹⁻²³

Having a mental and/or a substance use disorder can greatly increase the risk for suicidal behaviors.¹³ Suicide rates are particularly high among individuals with mood disorders such as major depression and bipolar disorders. Suicidal thoughts and/or behaviors are common among patients with bipolar disorders, and suicide rates are estimated to be more than 25 times higher for these patients than among the general population.^{24, 25} Another mental disorder that may increase the risk for suicide is schizophrenia. Suicide has been estimated to occur in approximately 5 percent of patients with this disorder.²⁶

Alcohol and drug abuse are second only to mood disorders as the most frequent risk factors for suicidal behaviors. In 2008, alcohol was a factor in approximately one-third of suicides reported in 16 states.²⁷ Having both a substance use disorder and a mental disorder, particularly a mood disorder, also has been found to increase suicide risk.²⁸

Some medical conditions, including cancer and chronic diseases that impair physical function and/or lead to chronic pain, also may increase the risk for suicidal behaviors.²⁹ Research also suggests that engaging in acts of self-injury may lead to suicide later in life.³⁰ This has been found to be true in cases when the self-injury involves the intent to die, as well as in cases when there is no suicidal intent (also referred to as *nonsuicidal self-injury*, or NSSI).³¹

Warning Signs of Suicide

- Talking about wanting to die;
- Looking for a way to kill oneself;
- Talking about feeling hopeless or having no purpose;
- Talking about feeling trapped or being in unbearable pain;
- Talking about being a burden to others;
- Increasing the use of alcohol or drugs;
- Acting anxious, agitated, or reckless;
- Sleeping too little or too much;
- Withdrawing or feeling isolated;
- Showing rage or talking about seeking revenge; and
- Displaying extreme mood swings.

The more of these signs a person shows, the greater the risk of suicide. Warning signs are associated with suicide but may not be what causes a suicide.

What To Do

If someone you know exhibits warning signs of suicide:

- Do not leave the person alone;
- Remove any objects that could be used in a suicide attempt;
- Call the U.S. National Suicide Prevention Lifeline at 800–273–TALK/8255; and
- Take the person to an emergency room or seek help from a medical or mental health professional.

Adapted from Recommendations for Reporting on Suicide website (www.reportingonsuicide.org.)

Individuals in some settings, systems, and professions may be at an increased risk for suicidal thoughts and/or behaviors compared to the general population. Suicide is often the most common cause of death in secure justice settings.³² More than 400 suicides occur each year in local jails at a rate three times greater than among the general population, and suicide is the third leading cause of death in prisons.³³⁻³⁵ In the past decade, increases in the rate of suicide among members of the U.S. Armed Forces has led to the implementation of extensive prevention programs in all branches of the military. In addition, concern about suicide among veterans has also led to extensive suicide prevention efforts. There is also concern that youth in the foster care system may be at an increased risk for suicidal behaviors and other related problems.^{36, 37} More research is needed to better understand suicide risk among this population and to develop appropriate responses.

Other groups identified as having a higher risk for suicidal thoughts and/or behaviors than the general population include LGBT populations³⁸ and individuals who have been bereaved by suicide.³⁹ For more information on these and other groups, see Appendix D.

More research is needed to better understand why suicide rates may be particularly low among some groups, such as African American women. In 2009, the suicide rate among black women aged 20–59 years was 2.77 per 100,000, the lowest rate among adults in this age range.¹ It is possible that factors such as greater social support, larger extended families, and deeper religious views against suicide may help protect some groups from suicide. A better understanding of these and other protective factors would help inform future suicide prevention efforts.

Preventing Suicide

Suicide prevention requires a combination of universal, selective, and indicated strategies.⁹ *Universal* strategies target the entire population. *Selective* strategies are appropriate for subgroups that may be at increased risk for suicidal behaviors. *Indicated* strategies are designed for individuals identified as having a high risk for suicidal behaviors, including someone who has made a suicide attempt.

Just as suicide has no one single cause, there is no single prevention activity that will prevent suicide. To be successful, prevention efforts must be comprehensive and coordinated across organizations and systems at the national, state/territorial, tribal, and local levels. As with other health promotion efforts, suicide prevention programs should be culturally attuned and locally relevant.

Evidence-Based and Promising Practices

Advances in research and practice have created new opportunities for suicide prevention. For example, new evidence suggests that a number of interventions may be particularly useful for helping individuals at risk for suicide. Some of these proven strategies are: the use of cognitive behavior therapy,^{40, 41} crisis lines,⁴² and efforts that promote continuity of care for individuals being treated for suicide risk.⁴³ More is also known about the effectiveness and risks associated with antidepressant use by some groups with high suicide risk.⁴⁴ These tools and approaches need to be refined and made more available and accessible.

Recent evaluations have identified system-wide interventions that combine multiple suicide prevention strategies and that are sustained over time as being particularly promising. For example, the experience of the U.S. Air Force Suicide Prevention Program (AFSPP)¹⁶ (see box) has shown that leadership, policy, practices, and accountability can combine to produce very impressive successes. These findings should be shared and adapted for use in different settings.

U.S. Air Force Suicide Prevention Program (AFSPP)

Since 1996, the U.S. Air Force has implemented a community-based suicide prevention program featuring 11 initiatives. Strategies include:

- Increasing awareness of mental health services and encouraging help-seeking behaviors;
- Involving leadership;
- Including suicide prevention in professional training;
- Developing a central surveillance system for tracking fatal and nonfatal self-injuries;
- Allowing mental health professionals to deliver community preventive services in nonclinical settings;
- Establishing trauma stress response teams; and
- Conducting a behavioral health survey to help identify suicide risk factors.

Evaluation findings indicate that the program reduced the risk of suicide among Air Force personnel by one-third.¹⁶ Participation in the program was also linked to decreases in homicide, family violence (including severe family violence), and accidental death.

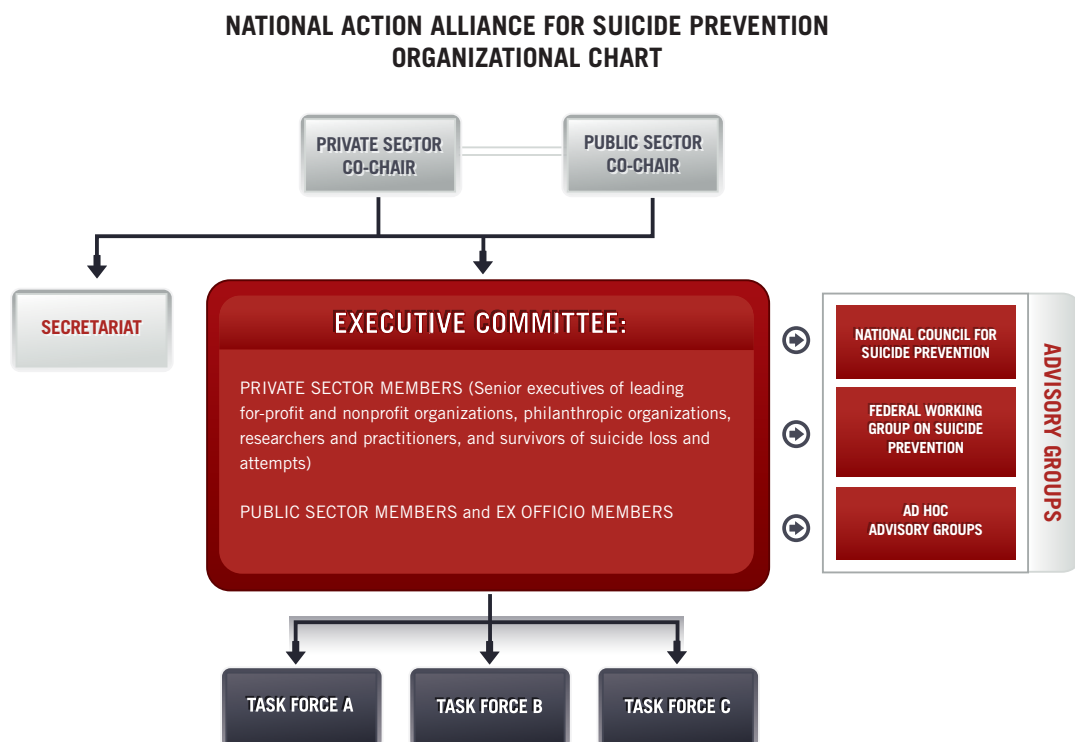
Research has also helped clarify the link between early childhood adverse events and suicide later in life, and of the role of connectedness in protecting individuals from a wide range of health problems, including suicide.⁴⁵ Efforts that promote overall health and that help build positive relationships can play an important role in suicide prevention. As a result, suicide prevention must be integrated into the work of a broad range of partners that provide programs and services in these areas. Suicide prevention is everyone's business.

Two online resources—the National Registry of Evidence-Based Programs and Practices (NREPP) and the Best Practices Registry (BPR)—are helping to disseminate these findings so they may be more widely used. NREPP, a searchable online registry maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA), provides information on more than 220 interventions supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment. BPR, a registry that focuses specifically on suicide prevention programs, is maintained by the national Suicide Prevention Resource Center (SPRC) in collaboration with the American Foundation for Suicide Prevention, with funding from SAMHSA.⁴⁶ More information on these and other resources is included in Appendix E.

The 2012 National Strategy for Suicide Prevention

The 2012 National Strategy for Suicide Prevention represents the culmination of an intensive consultation process coordinated by the National Action Alliance for Suicide Prevention (Action Alliance), a national partnership composed of more than 200 representatives from the public and private sectors. Launched in September 2010, the Action Alliance is dedicated to advancing the National Strategy by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives, and cultivating the resources needed to sustain progress.

Chaired by the Honorable John M. McHugh, Secretary of the Army, and the Honorable Gordon H. Smith, President and CEO of the National Association of Broadcasters, the Action Alliance brings together highly respected national leaders representing more than 200 organizations. At its core is an executive committee supported by several task forces (see Organizational Chart).



In 2010, the Action Alliance created an expert task force dedicated to the National Strategy for Suicide Prevention. The task force implemented a revision process that included the following sources of input:

- An online survey conducted on the Action Alliance website;
- Listening sessions held in conjunction with national conferences;
- Two workshops in Washington, DC, in June 2011; and
- Review of drafts by members of the Action Alliance and its task forces, other national and international experts, and others with an interest in suicide prevention.

Several key documents (see box at right) and findings from suicide prevention strategies implemented by countries such as Australia and the United Kingdom also informed the development of the revised National Strategy.

The 2012 National Strategy for Suicide Prevention is closely aligned with the National Prevention Strategy,⁴⁷ which was developed by the National Prevention, Health Promotion, and Public Health Council as established by the Affordable Care Act. The comprehensive National Prevention Strategy's goal is to increase the number of Americans who are healthy at every stage of life, by shifting from a focus on sickness and disease to a focus on wellness and prevention. Three of its seven priority areas—mental and emotional well-being, preventing drug abuse and excessive alcohol use, and injury- and violence-free living—are directly related to suicide prevention. Like the National Prevention Strategy, the 2012 National Strategy for Suicide Prevention emphasizes that prevention should be woven into all aspects of our daily lives. Everyone—government, business, academics, health care industry, communities, and individuals—has a role in helping to prevent suicide.

Key Documents Informing the Revision

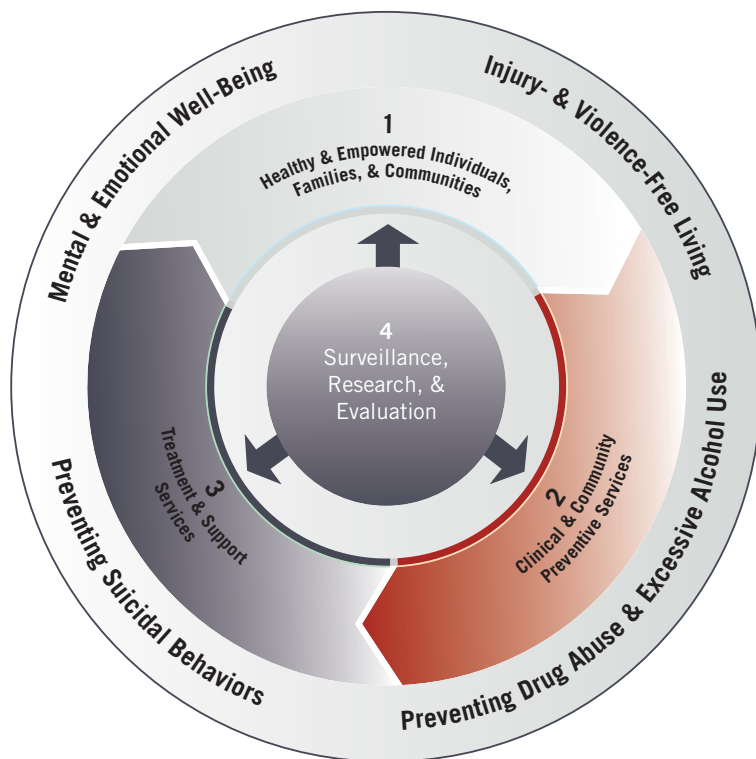
- *National Prevention Strategy*, National Prevention, Health Promotion, and Public Health Council, 2011
- *HealthyPeople 2020*, U.S. Department of Health and Human Services, 2010
- *Charting the Future of Suicide Prevention*, SPRC and SPAN USA, 2010
- *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, IOM, 2009
- *Reducing Suicide: A National Imperative*, IOM, 2002
- *World Report on Violence and Health*, WHO, 2002
- *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies*, UN, 1996

Organization of the 2012 National Strategy for Suicide Prevention

The 2012 National Strategy for Suicide Prevention is organized into four interconnected strategic directions (see figure):

1. Healthy and Empowered Individuals, Families, and Communities
2. Clinical and Community Preventive Services
3. Treatment and Support Services
4. Surveillance, Research, and Evaluation

ORGANIZATION OF GOALS AND OBJECTIVES



This organization represents a slight change from the AIM (Awareness, Intervention, Methodology) framework adopted in the 2001 National Strategy. The *Awareness* area has been included under *Healthy and Empowered Individuals, Families, and Communities*. The goals and objectives formerly included in the *Intervention* area have been spread across the first three strategic directions. *Methodology* has been expanded to include not only surveillance and research but also program evaluation. The 2001 goals and objectives have been updated, revised, and in some cases, replaced to reflect advances in knowledge and areas where the proposed actions have been completed. For a list of the revised goals and objectives, see Appendix A. A crosswalk

from the original to the revised list is provided in Appendix B.

The four strategic directions are interrelated and interactive, rather than stand alone areas. Several broad themes are at the core of the National Strategy and are addressed across all four strategic directions (see box on page 25).

Although some groups have higher rates of suicidal behaviors than others, the goals and objectives do not focus on specific populations or settings. Rather, they are meant to be adapted to meet the distinctive needs of each group, including new groups that may be identified in the future as being at an increased risk for suicidal behaviors. Appendix D provides information on groups currently identified as having increased suicide risk.

Themes Shared Across Strategic Directions

Suicide prevention efforts should:

- Foster positive public dialogue; counter shame, prejudice, and silence; and build public support for suicide prevention;
- Address the needs of vulnerable groups, be tailored to the cultural and situational contexts in which they are offered, and seek to eliminate disparities;
- Be coordinated and integrated with existing efforts addressing health and behavioral health and ensure continuity of care;
- Promote changes in systems, policies, and environments that will support and facilitate the prevention of suicide and related problems;
- Bring together public health and behavioral health;
- Promote efforts to reduce access to lethal means among individuals with identified suicide risks; and
- Apply the most up-to-date knowledge base for suicide prevention.

Suicide prevention interventions, products, and services should be tailored to the cultural, linguistic, and other needs of each group. As an example, the National Standards on Culturally and Linguistically Appropriate Services (CLAS),⁴⁸ issued by the U.S. Department of Health and Human Services (HHS) Office of Minority Health, can be a useful resource for providing health care services that are culturally and linguistically appropriate. Additional information about making information and services appropriately accessible to persons with disabilities and to people who have a limited English proficiency may be found at the Office for Civil Rights website (www.hhs.gov/ocr).

Looking Ahead

The 2012 National Strategy for Suicide Prevention represents a comprehensive, long-term approach to suicide prevention. The goal of saving lives, as measured by sustainably lower national and regional suicide rates, can only be achieved by a mosaic of coherent actions that complement each other.

Suicide occurs in all parts of our society and in all regions, affecting people of all ages. No group is immune, and the factors that contribute to these preventable deaths are multiple and complex. Thus, no single approach will suffice. The 13 goals and 60 objectives included in the National Strategy are meant to work together in a synergistic way to promote wellness, increase protection, reduce risk, and promote effective treatment and recovery. They represent a roadmap that, when followed, will lead to the vision of a nation free from the tragic experience of suicide.

Identifying Priority Areas for Action

The goals and objectives in the revised National Strategy are broad in scope and encompass a wide range of activities.

Many different groups at the local, regional, and national levels (e.g., federal or local government, educational institutions, workplaces, health systems) can play a role in advancing particular objectives. As a result, it is not possible to include specific target dates for the completion of each objective, as was done in the 2001 National Strategy. All groups that have an interest in suicide prevention can use the goals

and objectives to identify their own priority areas, thereby contributing to the full implementation of the National Strategy.

A careful assessment of needs, resources, and opportunities can help guide the identification of priorities. As an example, the Action Alliance conducted this type of assessment to identify its four priority areas for 2012–14:

1. Integrating suicide prevention into health care reform and encouraging the adoption of similar measures in the private sector;
2. Transforming health care systems to significantly reduce suicide;
3. Changing the public conversation about suicide and suicide prevention; and
4. Increasing the quality, timeliness, and usefulness of surveillance data regarding suicidal behaviors.

Each priority area is aligned with one or more National Strategy objectives (see table listing Action Alliance priority areas for 2012–14 on page 27). For example, priority area 2—Transforming health care systems to significantly reduce suicide—is closely linked with Objective 8.1—Promote the adoption of “zero suicides” as an aspirational goal by health care and community support systems that provide services and support to defined patient populations. Evidence from several system-level interventions conducted in the United States as well as abroad (see box for lessons from the United Kingdom on page 28) suggests that this type of approach has a tremendous potential for saving lives.

Several considerations helped guide the development of this action agenda.

Potential effect on suicide-related morbidity and mortality. Reducing the burden of suicide in the nation is a key area of concern. The selection of priority areas must take into account the potential for saving lives, preventing injury, and lowering the costs associated with suicidal behaviors. For example, because the greatest numbers of suicide deaths occur among white men in midlife, efforts targeting this group may have the greatest short-term effect on reducing the suicide rate. Similarly, efforts targeting high-risk groups, such as persons who have attempted suicide, may have the potential to help lower suicide rates more quickly than other strategies.

Existing opportunities for action. In selecting areas for action, it is important to take advantage of existing programs, opportunities, and resources, including initiatives that are already underway and that could be expanded or brought to scale in the short term. Examples include expanding the NVDRS system to additional states and territories and promoting the adoption of system-level approaches to suicide prevention and major depression that have been implemented by the U.S. Air Force¹⁶ and the Henry Ford Health System,⁴⁹ among others.

Availability of data for measuring progress. Assessing the availability of sources of data for measuring progress is another key consideration. Although the surveillance of suicide-related data has improved over the years, data may not yet be available to measure progress toward every objective in the National Strategy. When data sources are not available, mechanisms for collecting the data must be put into place so that progress can be measured and monitored in future years.

ACTION ALLIANCE PRIORITY AREAS: 2012–14		
Priority Area	National Strategy Objective(s)	Implementation
1. Integrate suicide prevention into health care reform and encourage the adoption of similar measures in the private sector.	Objective 1.5: Integrate suicide prevention into all relevant health care reform efforts.	Work in partnership with the Centers for Medicare & Medicaid Services (CMS) to ensure that suicide prevention is integrated into CMS's policies and program guidance to providers under Medicare and Medicaid.
2. Transform health care systems to significantly reduce suicide.	Objective 8.1: Promote the adoption of “zero suicides” as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.	Promote the adoption of “zero suicides” as an organizing goal for clinical systems care for defined populations. Recruit early adopters to implement the Suicide Care in Systems framework within their respective organizations and highlight successful programs.
3. Change the public conversation about suicide and suicide prevention.	Objective 2.1: Develop, implement, and evaluate communication efforts designed to reach defined segments of the population. Objective 2.3: Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.	Leverage the media and national leaders to change the national narratives about suicide and suicide prevention to messages that promote hope, connectedness, social support, resilience, treatment, and recovery.
4. Increase the quality, timeliness, and usefulness of surveillance data regarding suicidal behaviors.	Objective 11.1: Improve the timeliness of reporting vital records data. Objective 11.2: Improve the usefulness and quality of suicide-related data.	Work with CDC to improve the quality, timeliness, and usefulness of the data collected and to expand existing data systems.

Partners and roles. The 60 objectives included in the National Strategy address various areas, including health promotion; treatment of high-risk individuals; care for those who have been bereaved by suicide; and issues related to surveillance, research, and evaluation. The selection of priority objectives must take into account existing organizations, agencies, or other groups that may be interested and able to contribute to progress in specific areas. These partners may be willing to take on specific roles, such as serving as the lead organization for a priority area or helping to collect data and measure progress.

These types of considerations may be useful to other groups as they identify their own priority areas for action. Each group is encouraged to identify the objective(s) that are most relevant to the individuals they serve, and where its actions are most likely to yield positive results. The sections that follow provide examples of how different groups can help advance the goals and objectives in each of the National Strategy's four strategic directions.

The National Strategy hopes to energize and sustain the efforts of those who already are engaged in suicide prevention by demonstrating how their work is connected to a larger movement aimed at addressing this serious problem. For those not yet engaged, the National Strategy identifies areas where their future contributions can make a difference in advancing suicide prevention in their communities. For those experiencing a suicide loss or struggling with thoughts of suicide, the National Strategy provides ideas on how to turn pain into recovery and hope for a better future.

Making this vision a reality requires all members of our communities to be involved. Each and every one of us has a role to play in preventing suicide and promoting health, resilience, recovery, and wellness for all.

Lessons From the United Kingdom

The adoption of a range of suicide prevention recommendations by mental health systems across England and Wales has been found to greatly reduce suicide rates among patients. A 2012 study examined changes in suicide rates as public sector mental health service settings began to implement the following nine suicide prevention recommendations:⁵⁰

- Providing 24-hour crisis teams;
- Removing ligature points (materials that could be used for suicide);
- Conducting followup with patients within 7 days of discharge;
- Conducting assertive community outreach, including providing intensive support for people with severe mental illness;
- Providing regular training to frontline clinical staff on the management of suicide risk;
- Managing patients with co-occurring disorders (mental and substance use disorder);
- Responding to patients who are not complying with treatment;
- Sharing information with criminal justice agencies; and
- Conducting multidisciplinary reviews and sharing information with families after a suicide.

In 1998, few of the 91 mental health services in the study were carrying out any of these recommendations. By 2004, about half were implementing at least seven recommendations, and by 2006, about 71 percent were doing so. Over time, as more recommendations were implemented, suicide rates among patients declined. Each year, from 2004 to 2006, mental health services that implemented seven or more recommendations had a lower suicide rate than those implementing six or fewer. Among all recommendations, providing 24-hour crisis care was linked to the largest decrease in suicide rates.

Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities

The goals and objectives in this strategic direction seek to create supportive environments that will promote the general health of the population and reduce the risk for suicidal behaviors and related problems. As noted in the Introduction, suicide shares risk and protective factors with mental and substance use disorders, trauma, and other types of violence, such as bullying and domestic violence. As a result, a wide range of partners can contribute to suicide prevention, including organizations and programs that promote the health of children, youth, families, working adults, older adults, and others in the community. All of these partners should integrate suicide prevention into their work.

Eliminating the biases and prejudices associated with suicidal behaviors, mental and substance use disorders, and exposure to violence is a key area of concern within this strategic direction. In particular, there is a need to increase the understanding that mental and substance use disorders respond to specific treatments and that recovery is possible.

Communication efforts, such as campaigns and social marketing interventions, can play an important role in changing knowledge, attitudes, and behaviors to promote suicide prevention. Safe and positive messages addressing mental illness, substance abuse, and suicide can help reduce prejudice and promote help seeking. These types of messages can help create a supportive environment in which someone who is experiencing problems feels comfortable seeking help, and where families and communities feel empowered to link a person in crisis with sources of care and assist the person in attaining or regaining a meaningful life.

Goal 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.

Suicide prevention should be infused into programs carried out in diverse settings and systems, such as workplaces, schools, law enforcement and criminal justice settings, health care provider offices, community-based agencies, and faith-based organizations. Greater coordination of efforts among different stakeholders and settings can increase the reach and effect of suicide prevention activities, while preventing duplication and promoting greater cost-effectiveness of efforts.

In particular, it is important to take advantage of existing programs and efforts that address risk and protective factors for suicidal behaviors, including programs that may not yet include suicide prevention as an area of focus. For example, many school-based programs seek to prevent drug use and violence among youth by building problem-solving skills and increasing connectedness to teachers, mentors, and other caring adults in the community. These types of strategies can also be useful for suicide prevention.

An example of a coordinated approach addressing multiple issues that share risk and protective factors is the Good Behavior Game.⁵¹ This universal classroom behavior management method, used in first- and second-grade classrooms, has been shown to contribute to the prevention of suicidal ideation, as well as drug and alcohol use disorders, regular smoking, antisocial personality disorder, delinquency, and incarceration for violent crimes. Several replications have provided similar results.

Objective 1.1: Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.

Suicide prevention should be integrated into the work of all organizations and programs that provide services and support in the community. These organizations and programs include, but are not limited to:

- Businesses, employers, and workplaces;
- Faith-based programs;
- Family, youth, and community service providers and organizations;
- Funeral homes;
- Hotlines, crisis lines, and call centers;
- Organizations and programs that provide health care;
- State and local aging services networks, and other programs that support older adults; and
- Educational institutions, law enforcement, the justice system, and other institutions in the community.

Health care providers, teachers, social workers, employers, members of the business community, and other local resources can play an important role in suicide prevention. Strategies to involve these stakeholders include obtaining support from members of school boards and other administrative structures, and infusing suicide prevention into key professional meetings. Chambers of commerce and trade associations can also be helpful partners in engaging the business community.

Integrating suicide prevention into the work of these community partners will promote greater understanding of suicide and help counter the prejudice, silence, and denial that can prevent individuals from seeking help. It also will support the delivery of suicide prevention activities that are culturally competent, safe, and available to individuals who may lack access to health care.

Objective 1.2: Establish effective, sustainable, and collaborative suicide prevention programming at the state/territorial, tribal, and local levels.

Suicide prevention is often organized differently at the state/territorial, tribal, and local levels, which can make it difficult for the many agencies and programs involved in suicide prevention to work collaboratively. Increased coordination of suicide prevention activities among these various partners could

help improve services and outcomes, while promoting the greater sustainability of suicide prevention efforts over the long term. The type of collaboration that will work best may vary by state/territory, tribe, or community.

Clarifying each agency's areas of focus and responsibility may be an important first step. This clarification can make it easier for different agencies to work together and to obtain support for their respective suicide prevention efforts. It also may be useful to identify a lead agency at the state and local levels that could help bring together different partners with a role to play in suicide prevention. As an example, a recent report from the Safe States Alliance identifies ways to organize and coordinate violence prevention efforts.⁵² The report presents the consensus of an expert panel regarding the roles that public health agencies at the federal, state/territorial, tribal, and local levels could play in the prevention of violence, including suicide prevention.

Objective 1.3: Sustain and strengthen collaborations across federal agencies to advance suicide prevention.

Because suicide affects many different groups and is related to mental health, substance abuse, trauma, violence, injury, and other issues, many federal agencies have a role to play in suicide prevention. The Federal Working Group (FWG) is an important mechanism for maintaining collaboration across these agencies (see Appendix G for more information). Formed in 2000, the FWG brings together several federal agencies to share information and coordinate efforts. The group meets regularly and publishes a *Compendium of Federal Activities*.

Although sharing information and coordinating efforts across agencies is useful, a more proactive and dedicated approach could have a greater effect in preventing suicide in the nation. For example, the improved coordination of funding priorities at the federal level could help strengthen the infrastructure for delivering suicide prevention services at the state/territorial, tribal, and local levels.

Objective 1.4: Develop and sustain public-private partnerships to advance suicide prevention.

The 1996 United Nations (U.N.) report addressing the development of national strategies for suicide prevention recommended that no single agency, organization, or governmental body have sole responsibility for suicide prevention.⁵³ Taking into account this recommendation, the 2001 National Strategy called for the creation of a national public and private partnership to advance and coordinate the implementation of suicide prevention in the United States.⁶ This partnership is the National Action Alliance for Suicide Prevention (Action Alliance), formed in September 2010 to catalyze, cultivate, and champion the cause of suicide prevention.

The 2001 National Strategy also called for the development of state suicide prevention plans. Nearly all states have developed a statewide plan, but the plans vary in focus and depth. Although most plans cover the lifespan, many have limited funding to implement suicide prevention activities. While developing a state suicide prevention plan is an important first step, more work is needed to implement these plans

fully. The development of partnerships with the private sector at the state/territorial, tribal, and local levels would help strengthen and advance the implementation of suicide prevention plans.

Objective 1.5: Integrate suicide prevention into all relevant health care reform efforts.

Changes in health care systems and policies provide important opportunities for integrating and enhancing suicide prevention efforts. Health care reform efforts that increase access to care for mental and substance use disorders can greatly contribute to suicide prevention. Examples include federal and state parity laws requiring equal health insurance coverage for care for behavioral health (i.e., care for mental and/or substance use disorders) as for physical health problems. Health care reform efforts can also be used to create financial incentives for incorporating suicide prevention activities into clinical settings, and to encourage the better coordination or integration of physical and behavioral health services. As an example, the Prevention and Public Health Fund created by the Affordable Care Act provides support to states and communities for integrating these services.

Efforts addressing changes to health care systems can provide opportunities to expand the use of practices that are known to prevent suicide. For example, promoting the early identification of individuals with high suicide risk and increasing the availability of effective treatments and followup care are important strategies for improving health outcomes among these patients.

Integrating suicide prevention into health care reform is one of the four priority objectives identified by the Action Alliance for 2012–14. The Action Alliance is working in partnership with the Centers for Medicare & Medicaid Services (CMS) to ensure that suicide prevention is integrated into CMS policies and program guidance to providers under Medicare and Medicaid. For example, as part of an incentive program encouraging providers and hospitals nationwide to adopt electronic health records, CMS is considering the adoption of quality measures specifically related to suicide.⁵⁴ In addition, the Action Alliance is working with other HHS Operating Divisions, such as the Health Resources and Services Administration, to incorporate suicide prevention into health care reform.

Goal 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.

A wide range of communication efforts, such as communication campaigns and social marketing interventions, can play an important role in suicide prevention. These efforts can help change knowledge, attitudes, and behaviors among specific segments of the population; this can promote changes in the environment that will support suicide prevention. For example, the dissemination of positive messages that focus on recovery and hope can help reduce the biases and prejudices associated with mental and substance use disorders and with suicide. Using these interventions can increase understanding of the barriers to seeking help and provide information that will empower individuals to take action.

Communication efforts addressing suicide prevention should be research-based and reflect safe messaging recommendations specific to suicide. The channels and messages that are most appropriate will vary

depending on the targeted segment of the population. For example, messages targeting policymakers can promote the understanding that suicide is a preventable public health problem, and that mental and physical health are equal and inseparable components of overall health. Family members and friends may benefit from messages conveying the idea that mental and substance use disorders are real illnesses that respond to specific treatments. Individuals in crisis may benefit from information regarding crisis lines and other sources of assistance. These efforts should be conducted at multiple levels and align with other suicide prevention interventions, such as training programs for health care providers or school-based suicide prevention programs.

Objective 2.1: Develop, implement, and evaluate communication efforts designed to reach defined segments of the population.

Research findings from communication, social marketing, and other relevant disciplines should inform the development of all communication efforts addressing suicide prevention. For example, communication campaigns addressing suicide prevention should incorporate the principles of effectiveness identified in the literature. These principles include conducting formative research, using behavior theory, segmenting the audience, identifying and using effective channels and messages, conducting process evaluation to ensure high message exposure, and using an appropriate design for outcome evaluation.⁵⁵ *Making Health Communication Programs Work*,⁵⁶ a resource guide created by the National Cancer Institute, may be useful to program planners implementing health communication efforts addressing suicide prevention. Another useful resource is Centers for Disease Control and Prevention's (CDC) online Gateway to Health Communication & Social Marketing Practice.⁵⁷

Communication efforts should target defined audiences, or segments of the population, such as groups with higher suicide risk (see Appendix D), school personnel, or others. Demographic factors, such as age, income, or gender, may be used to identify different audience segments, along with factors related to the action being promoted. Efforts promoting behavior change should convey a clear call to action and provide specific information the audience needs to act. For example, a media campaign that tries to motivate individuals in crisis to seek help should provide information on the warning signs for suicide and on where to go for help (see Introduction for this information).

Objective 2.2: Reach policymakers with dedicated communication efforts.

Communications efforts designed to educate policymakers are especially important because policy and systems change are long lasting and efficient ways to advance suicide prevention. These policymakers may include federal, state, and local officials; tribal council members; and institutional and organizational leaders and their research and policy staff, among others. To be most effective, messages should link to specific actionable requests and reflect an understanding of broader issues of concern to the policymaker. However, HHS grant or contract funds may not be used in connection with activities designed to influence policymakers.

An important first step to educating policymakers may be increasing their understanding of suicide, its impact on their constituents and stakeholders, and effective solutions. These outcomes can motivate leaders to take action by promoting suicide prevention initiatives, policies, and programs. Describing effective programs of federal, state/territorial, tribal, and nonprofit agencies and local coalitions will help build support for suicide prevention plans. It also may be useful to share evaluation data that show success in reducing risk and increasing protective factors for suicide.

Suicide prevention can address sensitive topics such as the use of alcohol and other substances. There is also growing consensus among researchers that prejudice and discrimination play a role in the higher rates of mental disorders and suicide attempts among some populations.⁵⁸ Placing the focus on promoting public safety may help diffuse these types of tensions. Communications efforts should be framed in ways that will speak to diverse policymakers at the national, state, tribal, and local levels, and build broad support for suicide prevention.

Objective 2.3: Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.

Technology is changing the way we communicate, and the pace at which new communications tools are introduced continues to accelerate. These media and applications include interactive educational and social networking websites, e-mail outreach, blogs, mobile apps, and programs using mobile devices and texting. Mobile health apps have become increasingly popular, particularly among young adults.⁵⁹ Other innovative applications currently being developed and applied to suicide prevention include virtual worlds, gaming, and text analysis.⁶⁰

Emerging media and applications provide new opportunities for suicide prevention, particularly for persons who may be socially isolated or otherwise difficult to reach. A promising example is the chat line operated by the U.S. Department of Veterans Affairs (VA) crisis line call center.⁶¹ Another example comes from the social media website Facebook. With the rise of cyberbullying and suicidal status updates, in 2012, Facebook announced a new feature allowing users to anonymously report their friends' suicidal posts. The person posting suicidal content receives an e-mail from Facebook with instructions on how to start a private chat with an online crisis representative from the National Suicide Prevention Lifeline (800-273-TALK/8255). Mobile apps are also now available to help people with depression chart their moods and access crisis lines.

Suicide prevention efforts must consider the best ways to use existing and emerging communication tools and applications, such as websites and social media, to promote effective suicide prevention efforts, encourage help seeking, and provide support to individuals with suicide risk. While more research is needed on how to best use emerging communication in suicide prevention, some guidance is available on best practices for the use of social media in health promotion. A guide from CDC offers several recommendations, such as: carefully planning how social media fits into an overall communications effort, understanding the level of effort needed to maintain these channels, and using these tools strategically by

making choices based on audience.⁶² Another CDC publication provides guidance on how to write more effectively using social media channels, such as Facebook, Twitter, and mobile phone text messaging.⁶³

Suicide prevention programs that incorporate emerging technologies have a responsibility to ensure the safety of users. They should consider in advance how to monitor these channels regularly and respond to disclosures of suicidal thoughts or behaviors. These programs should include links to online crisis resources, such as the Lifeline (800-273-TALK/8255). In addition, because many of these media include user-generated content, it is important to think about how to ensure that messages are positive and promote hope, connectedness, social support, resiliency, and help seeking.

Objective 2.4: Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.

Family members, friends, teachers, coaches, coworkers, and others can play an important role in recognizing when someone is in crisis and connecting the person with sources of help. However, many of these persons may not know the warning signs of suicidal behavior or where a distressed person can go for help (see warning signs in the Introduction). It is crucial to widely disseminate information on warning signs, skills for interacting with individuals in crisis, and available resources (see Appendices D and E). In doing so, it is important to use communication strategies that are research-based, thoughtfully planned, and designed to meet the needs of specific groups. Incorporating stories of individuals who received help and benefited may motivate others to take action.

In particular, there is a need to increase awareness of the role of crisis lines, such as the National Suicide Prevention Lifeline/Veterans Crisis Line (800-273-TALK/8255) and other local crisis services, in providing services and support to individuals in crisis. These service providers connect individuals in crisis with local sources of quality support, risk assessment, and thoughtful intervention. A crisis line that offers followup calls and services after an acute crisis can also help enhance safety and connect individuals with appropriate care and services. New and emerging technologies, such as telehealth, chat and text services, and online support groups, also show promise in allowing people to connect virtually to sources of care.

Goal 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.

Although knowledge of effective treatment for mental and substance use disorders has increased over the years, the prejudice associated with these disorders and with suicide continues to prevent many individuals from seeking help. There is a need to support efforts to eliminate prejudice and discrimination, and to increase awareness of the factors that can help offer protection from suicide risk.

As noted in the Introduction, connectedness to others, including family members, teachers, coworkers, community organizations, and social institutions, has been identified as an important protective factor.⁴⁵ These positive relationships can help increase a person's sense of belonging, foster a sense of personal worth, and provide access to sources of support.

It is also important to increase the understanding that mental and substance abuse disorders are treatable and that recovery is possible. All in the community should understand the important role they can play in promoting resilience and wellness and in promoting the full recovery of those who may be experiencing problems.

Objective 3.1: Promote effective programs and practices that increase protection from suicide risk.

Many factors can help prevent suicide by promoting physical, mental, emotional, and spiritual wellness. As noted in the Introduction, these protective factors include problem-solving skills and social support that can help individuals cope with emotional distress. The use of these tools should be the norm rather than the exception. They should be taught at early ages to strengthen the ability of individuals and communities to overcome challenges and crises.

Connectedness to others is another key protective factor that reduces suicide risk. Several programs that have been shown to decrease suicidal thoughts or behaviors include connectedness components. For example, a program for American Indian/Alaska Native (AI/AN) youth engaged natural helpers from the community to identify and connect with at-risk youth.⁶⁴ Connectedness was also the main component of a post-crisis suicide prevention program for adults who presented in a hospital emergency department (ED) for nonfatal, suicidal behaviors.⁶⁵ Evidence from these and other programs suggest that promoting connectedness is a viable strategy for preventing suicidal behaviors.

Policies and programs that foster social connectedness can help promote mental and physical health and recovery. In particular, these programs and policies should focus on the groups that may be the most isolated or marginalized. For example, social isolation can contribute to suicide and suicide attempts among older adults, many of whom may have lost friends and family and/or have activity limitations that make it difficult to stay connected with others. Family connectedness has been found to play an especially strong protective role against suicidal behaviors among lesbian, gay, and bisexual youth.⁶⁶

Many groups and organizations in the community, including schools, other youth-serving organizations, faith-based organizations, and local aging services networks, can contribute to suicide prevention by enhancing connectedness. These organizations can help ensure that social support is more widely available from peers and others. Specific training addressing suicide prevention could enhance these providers' ability to provide support to individuals at risk and make appropriate referrals.

Objective 3.2: Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.

Bias, prejudice, and discrimination discourage many people from seeking help, or even from sharing the psychological distress that could lead to suicidal behaviors. In some cases, cultural or religious beliefs that oppose suicide may help protect some individuals from suicidal behaviors. In others, they may present barriers to help seeking and can increase the distress of those who have been bereaved by suicide.

Strategies for addressing cultural or religious beliefs related to suicidal behaviors will be most effective when they are grounded in a full understanding of and respect for the cultural context of these beliefs.

Broad communication, public education, and public policy efforts are needed to promote mental health, increase understanding of mental and substance use disorders, and eliminate barriers to help seeking. These efforts should increase awareness that no one is immune from experiencing these disorders. Seeking treatment should be seen not as a sign of weakness, but as a step toward recovery.

Objective 3.3: Promote the understanding that recovery from mental and substance use disorders is real and possible for all.

Social attitudes, bias, and discrimination often present barriers to treatment and undermine the recovery of persons with mental or substance use disorders. Friends and family, health professionals, and others may at times be overly protective or pessimistic about what someone with a mental or substance use disorder will be able to achieve. These attitudes can undermine the person's hope for the future and ability to recover. A better understanding of crisis, trauma, and recovery can help individuals and groups in the community promote resilience and wellness among all.

It is important to increase awareness that, in most cases, individuals who have a mental or substance use disorder can recover and regain or attain meaningful lives. The disorder does not define the individual and, in fact, the experience can provide an opportunity for reflection and change. Family members, peers, mentors, individuals who have attempted suicide, individuals who have been bereaved by suicide, and members of the faith community can be important sources of support. These individuals can help promote hope and motivation for recovery; provide support for addressing specific stressors, such as the loss of a job; and help foster a sense of meaning, purpose, and hope.

Goal 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.

Americans spend a substantial amount of time with communications media, including computers and mobile devices. The media can contribute to suicide prevention by helping to combat prejudice, providing opportunities for peer-to-peer support, and linking individuals in crisis with sources of help. In contrast, when not used responsibly, the media can work against suicide prevention. Cluster suicides and suicide contagion have been documented.⁶⁷ Studies have shown that both news reports and fictional accounts of suicide in movies and television can lead to increases in suicide. As a result, it is important to encourage the media to present accurate and responsible portrayals of suicide and related issues (e.g., mental and substance use disorders, violence).

Too often, portrayals in the news and entertainment media perpetuate the misperception that suicide cannot be prevented. There is a need to shift the focus of these portrayals to stories of those who have struggled, found help and appropriate treatment, and recovered. Stories addressing mental illness,

substance abuse, and/or suicidal behaviors should promote hope, resiliency, and recovery. This approach can motivate family, friends, and others to provide support and protection to individuals who may be at risk for suicide and make it easier for a person in crisis to seek help and regain a meaningful life.

Objective 4.1: Encourage and recognize news organizations that develop and implement policies and practices addressing the safe and responsible reporting of suicide and other related behaviors.

Responsible, culturally competent coverage of suicide and other related behaviors can play an important role in preventing suicide contagion. Shortly after the 2001 National Strategy was released, several public and private groups came together to develop and promote a set of media recommendations entitled *Reporting on Suicide: Recommendations for the Media*. These recommendations were disseminated to the media through national, state, and tribal organizations. A followup workshop aimed at updating the recommendations took place in August 2009. Recommendations for media reporting of suicide were issued in April 2011 and are posted online (www.reportingonsuicide.org).⁶⁸

Objective 4.2: Encourage and recognize members of the entertainment industry who follow recommendations regarding the accurate and responsible portrayals of suicide and other related behaviors.

Depictions of suicide are common in the entertainment media. In 2009, the Entertainment Industries Council created a guide for the entertainment industry entitled *Picture This: Depression and Suicide Prevention*.⁶⁹ The guide can help creators of entertainment content provide responsible portrayals of suicidal behaviors, mood disorders, and related issues.

Recognition programs and other incentives can help promote greater awareness and adoption of these recommendations. Two examples are the PRISM Awards and the Voice Awards. The Voice Awards honor consumers and peer leaders who share their stories of recovery, as well as writers and producers who have given a voice to people with behavioral disorders by incorporating dignified, respectful, and accurate portrayals of these individuals into film and television productions. A nationally televised awards show, the PRISM Awards recognize the accurate depiction of substance abuse and mental illness prevention, treatment, and recovery in film, television, interactive, music, DVD, and comic book entertainment.

Objective 4.3: Develop, implement, monitor, and update guidelines on the safety of online content for new and emerging communication technologies and applications.

Recommendations relevant to new media are included on the website addressing the safe reporting of suicide discussed under Objective 4.1. All websites that post content developed by online users should adopt best practices to promote safety. At a minimum, the site should have a help center with supportive materials, policies addressing online safety, and information on crisis resources. Whenever possible, sites that host content generated by users should implement the latest recommendations on how to promote

the online safety of users. These recommendations should be continuously reviewed and updated to address new technologies, applications, and uses. As new media tools come into widespread use, recommendations related to suicide prevention should be continuously reviewed and updated for use with these technologies.

Objective 4.4: Develop and disseminate guidance for journalism and mass communication schools regarding how to address consistent and safe messaging on suicide and related behaviors in their curricula.

Schools of journalism, film, and other disciplines in the communications field play an important role in training future journalists, writers, editors, photographers, directors, and other producers of media content. The responsible depiction of suicidal behaviors and behavioral disorders should be addressed in educational curricula of these schools and by the professions' ethics governing bodies.

Because the sensational sells, many forces may push journalists to cover suicide in ways that are not consistent with suicide prevention. Curriculum guidance should recognize this reality and make the case for the responsible portrayal of suicide in ways that will resonate with journalists and other content developers.

What You Can Do to Advance the Goals and Objectives in Strategic Direction 1 of the National Strategy for Suicide Prevention

The Federal Government Can:

- Provide information on suicide prevention to the federal workforce. (Objective 1.1)
- Participate in the National Action Alliance for Suicide Prevention, a public-private partnership dedicated to advancing the National Strategy for Suicide Prevention. (Objective 1.4)
- Ensure that promotion of the National Strategy for Suicide Prevention is included in the overall advancement and oversight of the National Prevention Strategy. (Objective 1.4)

State, Territorial, Tribal, and Local Governments Can:

- Identify a lead agency to coordinate and convene public and private stakeholders, assess needs and resources, and develop and implement a comprehensive strategic suicide prevention plan. (Objective 1.2)
- Develop and implement an effective communications strategy for promoting mental health and emotional well-being that incorporates traditional and new media. (Objective 2.1)
- Disseminate *Recommendations for Reporting on Suicide* to news organizations. (Objective 4.1)

Businesses and Employers Can:

- Implement organizational changes to promote the mental and emotional health of employees. (Objectives 1.1 and 3.1)
- Ensure that mental health services are included as a benefit in health plans and encourage employees to use these services as needed. (Objective 1.5)

Health Care Systems, Insurers, and Clinicians Can:

- Communicate messages of resilience, hope, and recovery to patients, clients, and their families with mental and substance use disorders. (Objective 3.3)

Schools, Colleges, and Universities Can:

- Implement programs and policies to prevent abuse, bullying, violence, and social exclusion. (Objectives 1.1 and 3.1)
- Implement programs and policies to build social connectedness and promote positive mental and emotional health. (Objectives 1.1 and 3.1)
- Integrate information about the responsible depiction of suicide and suicide-related behaviors into the curricula of schools of journalism, film, and other communications disciplines. (Objective 4.4)

Nonprofit, Community-, and Faith-Based Organizations Can:

- Participate in local coalitions of stakeholders to promote and implement comprehensive suicide prevention efforts at the community level. (Objective 1.2)
- Develop and implement communication strategies that convey messages of help, hope, and resiliency. (Objectives 2.1 and 3.2)
- Provide opportunities for social participation and inclusion for those who may be isolated or at risk. (Objective 3.1)

Individuals and Families Can:

- Build strong, positive relationships with family and friends. (Objective 3.1)
- Become involved in their community (e.g., mentor or tutor youth, join a faith or spiritual community, reach out to older adults in the community). (Objective 3.1)

Strategic Direction 2: Clinical and Community Preventive Services

Suicide affects people of all ages in all parts of the country. The factors that contribute to these preventable deaths are multiple and complex. Some of the factors that can increase the risk for suicidal behaviors may be longstanding, such as having a substance use disorder. Others, such as the loss of a loved one or career failure, may be recent events that could increase the immediate risk for suicidal behaviors. Suicide prevention requires that support systems, services, and resources be in place to promote wellness and help individuals successfully navigate these challenges.

Clinical and community-based programs and services play a key role in promoting wellness, building resilience, and preventing suicidal behaviors among various groups. Clinical preventive services, including suicide assessment and preventive screening by primary care and other health care providers, are crucial to assessing suicide risk and connecting individuals at risk for suicide to available clinical services and other

sources of care. Screening for depression and alcohol misuse have been endorsed by the United States Preventive Services Task Force and are now covered as preventive services under Medicare.

A wide range of community partners, including schools, workplaces, and faith-based organizations, also have an important role to play in delivering prevention programs and services to diverse groups at the local level. These community-based professionals and organizations should be competent in serving various groups, including racial, ethnic, sexual, and gender minorities, in a way that is culturally and linguistically appropriate. Greater coordination among community and clinical preventive service providers can have synergistic effects in preventing suicide and related behaviors.

Goal 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.

Suicide prevention requires that appropriate community-based and preventive clinical supports be available at the state/territorial, tribal, and local levels to assist individuals with suicide risk. These programs should support the active participation of a diverse range of community members in suicide prevention programs, including professionally trained helpers and other care providers. Clinical and community-based services should seek to promote wellness, reduce risk factors, increase resilience and protective factors, link individuals in crisis with appropriate services and supports, and address the environmental and social conditions that can contribute to suicidal behaviors.

In developing, implementing, and monitoring programs, it is critical to use suicide prevention strategies that have been shown to be effective. As noted in the Introduction, two important resources for identifying evidence-based programs and best practices are NREPP and BPR. For more information on these and other resources, see Appendix E.

Objective 5.1: Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.

The goal of saving lives can only be achieved by a combination of efforts at multiple levels. States, territories, tribes, and communities can play an important role in implementing suicide prevention programs that can meet the needs of diverse groups. In doing so, it is important to involve multiple partners, including agencies and organizations involved in public health, behavioral health, injury prevention, and other areas.

Suicide prevention efforts should engage multiple partners and sectors, focus on the entire lifespan, and provide services that are culturally and geographically appropriate. Although most states have a suicide prevention plan in place, there is much variation among plans. For example, while most plans focus on the entire lifespan, some address only children and/or youth. Most plans do not include private sector involvement. Furthermore, many do not identify staff positions that are fully dedicated to suicide prevention and that can support the work of planning, implementation, and evaluation at the community level. It is also important to ensure that suicide prevention efforts include a diverse mix of

community level participants. In addition, these efforts should be evaluated and modified accordingly to assure effectiveness.

Objective 5.2: Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.

Many institutions, agencies, and organizations in the community have a role to play in promoting health, reducing risk factors, increasing protective factors, training personnel who are in contact with individuals with suicide risk, and providing support to individuals in crisis. As noted in the Institute of Medicine's (IOM) 2009 report *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, these settings include the home, school, and neighborhood agencies. A few examples include:

- Faith-based organizations;
- Institutions in the justice system;
- Law enforcement institutions;
- Organizations providing health care;
- Organizations serving older adults;
- Schools, youth-serving organizations, colleges, universities, and vocational training institutions;
- Veterans service organizations; and
- Workplaces.

Engaging these and other community groups can greatly expand the reach of suicide prevention efforts, making it possible to provide assistance and support to individuals who may be most vulnerable and/or underserved.

Objective 5.3: Intervene to reduce suicidal thoughts and behaviors in populations with suicide risk.

As noted in the Introduction, several groups may be at an increased risk for suicidal behaviors. Risk and protective factors can vary across communities and change over time. Different interventions are needed to meet the distinctive needs of these diverse groups. Local and state suicide prevention programs must continuously identify at-risk groups and develop and implement programs tailored to these groups' unique needs. Each planned initiative should also rigorously assess outcomes, both desired and unanticipated. Many seemingly sensible prevention programs have proven futile, in large part because they were not designed to carefully define, monitor, and assess important implementation steps.

Several groups that have a higher risk for suicidal behavior are listed in Appendix D, which includes information on specific risk and protective factors, evidence-based interventions and best practices for suicide prevention, and resources.

Objective 5.4: Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.

Having a serious mental disorder such as major depression or bipolar disorders is a recognized risk factor for suicidal behaviors.⁷¹ This is particularly true if the person also has a substance use disorder. Yet many individuals with these disorders lack access to behavioral health care.

Health care systems should be encouraged to recognize and respond to mental and substance use problems in the same way they respond to physical health problems. Parity laws, which have been enacted at the federal and state levels, seek to accomplish this by requiring that health care plans provide the same level of benefits (e.g., visit limits, deductibles, copayments) for a mental or substance use disorder as for a physical health problem.

Greater coordination among the different programs that provide services addressing mental health, substance use, and physical health care will also increase access to care. This coordination can range from information sharing among different service providers to the delivery of these various services in the same setting. These linkages will help provide multiple access points for behavioral health care (many “right doors” to treatment), thereby helping to ensure that individuals who may be at risk for suicidal behaviors are connected to appropriate sources of care.

Goal 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.

Restricting access to suicide methods that are highly lethal and commonly used is a proven strategy for decreasing suicide rates.^{72,73} While some suicidal crises last a long time, others are short-lived. Reducing access to lethal means during periods of crisis can make it more likely that the person will delay or survive a suicide attempt. In either case, the person’s odds of long-term survival are improved.

In 2009, about half of suicides in the United States resulted from the use of firearms, followed by suffocation (24 percent), poisons and drug overdoses (14 percent), carbon monoxide gas (3 percent), and jumps (2 percent).¹ Psychological autopsy studies, other case control studies, and ecologic studies have found that firearm access is a risk factor for suicide in the United States.⁷⁴⁻⁷⁷ Individuals who own firearms are not more likely than others to have a mental disorder or have attempted suicide.⁷⁸⁻⁸⁰ Rather, the risk of a suicide death is higher among this population because individuals who attempt suicide by using firearms are more likely to die in their attempts than those who use less lethal methods.

Individuals experiencing significant distress or who have a recent history of suicidal behavior should not have easy access to means that may be used in a suicide attempt, including firearms, other weapons, medications, illicit drugs, chemicals used in the household, other poisons, or materials used for hanging

or suffocation. Installing bridge barriers or otherwise restricting access to popular jump sites may also prevent deaths, depending on specific local conditions.

Although this goal focuses on reducing access to lethal means among individuals at risk, evidence for means restriction has come from situations in which a universal approach was applied to the entire population. For example, the detoxification of domestic gas in the United Kingdom and discontinuation of highly toxic pesticides in Sri Lanka were universal measures associated with 30 percent and 50 percent reductions in suicide, respectively.^{81, 82}

Objective 6.1: Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.

Professionals who provide health care and other services to patients or clients at risk for suicide and their families and other caregivers are in a unique position to ask about the presence of lethal means and work with these individuals and their support networks to reduce access. These professionals may include health care providers, social service workers, clergy, first responders, school personnel, professionals working in the criminal justice system, and others who may interact with individuals in crisis. These providers can educate individuals with suicide risk and their loved ones about safe firearm storage and access, as well as the appropriate storage of alcoholic beverages, prescription drugs, over-the-counter medications, and poisons that may be available in the household. However, many may fail to do so, or do so only when a patient is identified as being at a very high risk for suicide.

There are steps that can be taken to prevent accidents as well as suicides. Providers should also educate patients and care providers about reducing the stock of medicine in the medicine cabinet to a nonlethal quantity, and locking medicines that are commonly abused (e.g., prescription painkillers and benzodiazepines, which are medications used to induce sleep, relieve anxiety and muscle spasms, and prevent seizures). This approach can be useful in helping to prevent suicide, as well as unintentional overdoses and substance abuse.

Objective 6.2: Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

Among persons who attempt suicide, those who use firearms are more likely to die than those who use other means. Reaching out to gun owners, firearm dealers, shooting clubs, hunting organizations, and others to promote firearm safety and increase their involvement in suicide prevention is an important strategy for reducing suicide risk.

Most firearm safety educational materials focus on the prevention of accidents rather than suicide. Brochures and websites promoting firearm safety to gun owners could include a statement regarding the importance of being alert to signs of suicide in a loved one and keeping firearms out of the person's reach. For example, all firearms in the household could be temporarily stored with a friend or relative or in storage facility. At a minimum, all guns should be securely locked away from the vulnerable person's access

until he or she has recovered. Partnering with gun-owner groups to craft and deliver this message will help ensure that it is culturally relevant, technically accurate, comes from a trusted source, and does not have an anti-gun bias.

Most gun-owner groups promote the safe storage of firearms when not in use (i.e., stored locked and unloaded, with ammunition locked separately) to protect against accidents, theft, and unauthorized use. The safe storage of firearms among the general population can help prevent suicide, particularly from attempts that take place during short-lived crises and attempts made by individuals living in a household where firearms are present. Gun-owner groups are in an excellent position to promote this message.

Objective 6.3: Develop and implement new safety technologies to reduce access to lethal means.

Many safety technologies can help prevent suicide by reducing access to lethal means of self-injury. New technologies can also be used to prevent suicide by poisoning by reducing the carbon monoxide content of motor vehicle exhaust, restricting pack sizes to prevent overdoses of more toxic medications, and encouraging the use of electronic pill dispensing lockboxes for people who rely on medication but are at risk of overdosing. Options for preventing suicide from jumps include incorporating architecturally unobtrusive barriers into the original design of high bridges and/or retrofitting bridges that are currently popular jump sites. These types of approaches should be used more widely. There is also a need to research, develop, and implement other technologies that will prevent suicide by reducing access to lethal means.

Goal 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

All community-based and clinical prevention professionals whose work brings them into contact with persons with suicide risk should be trained on how to address suicidal thoughts and behaviors and on how to respond to those who have been affected by suicide. These professionals include:

- Adult and child protective service professionals;
- Bank, mortgage, and financial service providers;
- Crisis line staff and volunteers;
- Divorce, family law, criminal defense, and other attorneys, as well as others involved in the criminal and civil justice systems;
- Employee assistance programs and other human resource professionals in the workplace;
- Educators and school personnel;
- Faith-based professionals;
- First responders, including law enforcement, fire department, and EMS;
- Funeral home directors and staff;

- Health care providers, including behavioral health care professionals;
- Professionals who serve the military and veterans;
- Providers of aging services; and
- Social service and human service providers.

Training programs should be tailored to the specific needs and roles of the providers and be regularly updated and refreshed to reflect new knowledge in the field and over time.

Objective 7.1: Provide training on suicide prevention to community groups that have a role in the prevention of suicide and related behaviors.

Thousands of first responders, crisis line volunteers, law enforcement professionals, clergy, teachers, school counselors, individuals working in the justice system and/or in law enforcement, and others who are on the frontlines of suicide prevention should be trained on suicide prevention. A number of training curricula exist to address the distinct needs of these various groups.⁸³ These training programs should continue to be implemented, evaluated, and updated. New programs should be developed to meet the needs of different at-risk populations and types of community service providers. In addition, there is a need to make education programs available to family members and others who are in close relationships with persons at risk for suicide or who have been affected by suicidal behaviors.

Objective 7.2: Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.

Mental health and substance abuse providers should have the essential foundation of attitudes, knowledge, and clinical prevention skills to address and reduce suicide risk and increase protective factors among patients. Caring for individuals with suicide risk requires being able to work collaboratively with the patient. Skill development, practice using those skills, and a culture of shared responsibility can help build comfort, confidence, and competency to engage and care for these individuals.

Training programs for mental health and substance abuse providers should seek to:

- Increase feelings of confidence and empowerment in working with patients with suicide risk;
- Address the emotional and legal issues associated with adverse patient outcomes, including death by suicide;
- Equip practitioners with attitudes, knowledge, and skills to cope with sentinel events (unanticipated events resulting in death or serious physical or psychological injury), along with effective clinical preventive procedures to minimize risk of litigation;
- Educate practitioners about how to exchange confidential patient information appropriately to promote collaborative care while safeguarding patient rights;

- Address the value of a team-based approach to management of suicide risk;
- Provide practitioners with clinical preventive skills to engage in shared services for persons with suicide risk, including addressing the value of shared responsibility and collaborative care, and increasing knowledge and skills for communicating collaboratively with patients, families, significant others, and other providers to ensure continuity of care;
- Include cultural competency training components specifically focused on ethnic/racial identity formation and LGBT identity development; and
- Address the provision of effective support services for those who have been bereaved by suicide.

These training objectives should guide the development of the core education and training guidelines discussed under Objective 7.3.

Objective 7.3: Develop and promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.

All education and training programs for health professionals, including graduate and continuing education programs for these professions, should adopt core education and training guidelines addressing the prevention of suicide and related behaviors. All degree-granting undergraduate and graduate programs in relevant professions should include these guidelines as a part of their curricula. Programs should also ensure that graduates achieve the relevant core competencies in suicide prevention appropriate for their respective discipline. For example, guidelines for the graduate and continuing education of clinicians should address the safer dispensing of medications for individuals at high risk for suicide. A useful resource for primary care providers is the review article *Practical Suicide-Risk Management for the Busy Primary Care Physician*, which provides a summary of how to identify patients at risk for suicide, assess them, and manage suicide risk.⁸⁴

Objective 7.4: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.

The inclusion of core education training in recertification or licensing programs can help ensure that professionals who have completed training acquire competence in addressing suicidal behaviors and remain competent over time. In most states and territories, physicians, psychologists, social workers, nurses, and other health professionals must complete licensing examinations or recertification programs in order to maintain active licenses and/or professional certifications. Accrediting and credentialing organizations should promote evidence-based and best practice suicide prevention training for the organizations and practitioners they accredit or credential. In addition, because suicide shares risk and protective factors with mental and substance use disorders, as well as with trauma and interpersonal violence, suicide-related curricula should be linked with training on these related topics. Accreditation

standards should be encouraged to require that professionals be trained and tested on that content via certification and licensing exams.

Many groups, including state governments, can help support the incorporation of suicide prevention into the training of professionals in various disciplines. As an example, the State of Washington has passed a law requiring that a broad array of health professionals (e.g., mental health counselors, psychologists, family therapists) complete a training program in suicide prevention at least once every 6 years. Known as the Matt Adler Suicide Assessment, Treatment, and Management Training Act of 2012, the law comes into effect in January 2014.

Objective 7.5: Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.

Communication and collaboration across multiple levels of care is a key to the successful management of suicide risk. Clinical preventive and communication protocols for clinicians and clinical supervisors, emergency workers, crisis staff, professionals who provide adult and child protective services, and others providing support to individuals with suicide risk can help improve communication and collaborative management of suicide risk. Care for individuals with suicide risk must be comprehensive and continuous until the risk is reduced. Each setting and service provider has an important role in verifying that the subsequent supportive services have the information and resources they need in order to help keep the individual safe.

Protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others should address the implementation of effective strategies for improving communication and collaboratively managing suicide risk. In particular, there is a need to promote the sharing of information among different providers and the use of team-based care for managing suicide risk.

A promising example of a collaborative care approach to suicide prevention is the Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT). Conducted in 20 primary care practices in urban, suburban, and rural areas, the study found that collaborative care was more effective than treatment as usual in reducing suicide risk in patients aged 60 years or older.⁸⁵ Care managers, including social workers, nurses, and psychologists, implemented the intervention, which helped physicians to recognize depression, offered recommendations, monitored depressive symptoms and side effects, offered interpersonal psychotherapy (IPT) to patients who refused medication, and provided followup, including making house calls to patients unable to travel. At the end of this 2-year trial, suicidal ideation was 2.2 times less likely in the collaborative care group than in the comparison group.

What You Can Do to Advance the Goals and Objectives in Strategic Direction 2 of the National Strategy for Suicide Prevention

The Federal Government Can:

- Provide education, training, and resources on the signs and symptoms of suicide and suicidal behaviors and where to go for help. (Objectives 5.2, 5.3, and 7.1)
- Support states, tribes, and communities in the implementation of suicide prevention interventions and policies. (Objectives 5.1 and 5.2)

State, Territorial, Tribal, and Local Governments Can:

- Identify groups at risk and work with various stakeholders to implement suicide prevention policies and programs that address the needs of these groups. (Objectives 5.2 and 5.3)
- Sponsor trainings and disseminate information on means restriction to mental health providers, professional associations, and patients and their families. (Objective 6.1)
- Sponsor medication take-back days and ongoing methods for the disposal of unwanted medications (e.g., secure collection kiosks at police departments or pharmacies). (Objective 6.1)

Businesses and Employers Can:

- Train employees and supervisors to recognize coworkers in distress and respond appropriately. (Objectives 5.2 and 7.1)

Health Care Systems, Insurers, and Clinicians Can:

- Screen for mental health needs, including suicidal thoughts and behaviors, and make referrals to treatment and community resources, as needed. (Objective 5.3)
- Incorporate lethal means counseling into suicide risk assessment protocols and address means restriction in safety plans. (Objective 6.1)
- Increase the capacity of health care providers to deliver suicide prevention services in a linguistically and culturally appropriate way. (Objective 7.2)

Schools, Colleges, and Universities Can:

- Ensure that students at risk of suicide have access to mental health and counseling services and are encouraged to use those services. (Objective 5.2)
- Train relevant school staff to recognize students at potential risk of suicide and refer to appropriate services. (Objective 7.1)
- Integrate appropriate core suicide prevention competencies into relevant curricula (e.g., nursing, medicine, allied health, pharmacy, social work, education). (Objective 7.3)

Nonprofit, Community-, and Faith-Based Organizations Can:

- Implement suicide prevention programs that address the needs of groups at risk for suicide and that are culturally, linguistically, and age appropriate. (Objective 5.3)
- Initiate partnerships with firearm advocacy groups (e.g., retailers, shooting clubs, manufacturers, firearm retail insurers) to increase suicide awareness. (Objective 6.2)

- Educate clergy, parent groups, schools, juvenile justice personnel, rehabilitation centers, defense and divorce attorneys, and others about the importance of promoting efforts to reduce access to lethal means among individuals at risk for suicide. (Goal 6)

Individuals and Families Can:

- Learn the signs and symptoms of suicide and suicidal behaviors and how to reach out to those who may be at risk. (Objective 5.3)
- Store household firearms locked and unloaded with ammunition locked separately and take additional measures if a household member is at high risk for suicide. (Objective 6.1)
- Dispose of unwanted medications, particularly those that are toxic or abuse-prone, and take additional measures (e.g., a medication lock box) if a member of the household is at high risk for suicide. (Objective 6.1)

Strategic Direction 3: Treatment and Support Services

Individuals at high risk for suicide require clinical evaluation and care to identify and treat mental health and medical conditions, and to specifically address suicide risk. In the past, it was believed that appropriately treating underlying conditions (e.g., mood disorders, substance abuse) would remove the risk for suicide. However, this is not always the case. A growing body of evidence suggests that suicide prevention is enhanced when specific treatments for underlying conditions are combined with strategies that directly address suicide risk.

Evidence-based and promising approaches for caring for high-risk patients include safety planning (i.e., working collaboratively with each patient to develop an action plan for times of crises) and specific forms of psychotherapy that can be used to support treatment for underlying mental health conditions. Addressing suicide risk may be particularly important when treating individuals who have survived a suicide attempt. There is now substantial evidence that interventions such as dialectical behavior therapy (DBT) and cognitive behavior therapy for suicide prevention (CBT-SP) can help reduce suicidal behaviors among these patients. In addition, clozapine has been found to be effective in reducing suicidal behaviors among patients with schizophrenia⁸⁶ and lithium shows promise in patients with mood disorders.⁸⁷

Principles that should guide care for individuals with high suicide risk include the following:

- Provision of evidence-based treatment as soon as possible after suicide risk is identified;
- Person- and relationship-centered care, which includes improving patient-provider communication, involving individuals with suicide risk in the development of safety plans, and providing care that is matched to the person's level of risk, needs, and preferences;
- Culturally competent care that addresses the needs of diverse groups of patients, including linguistic, racial/ethnic, sexual, and gender minorities;
- Multiple points of access to appropriate treatment and a focus on providing support in the least restrictive environment;
- Integration of care across various systems and settings (via several possible models, from communication and collaboration to full integration) and shared reporting of client outcomes;
- Continuity of care for individuals with suicide risk with a particular focus on immediate (if possible, within 48 hours) and continuous followup after a suicide attempt following discharge from a hospital, ED, or other inpatient facility;
- Appropriate empowerment of families and significant others in treatment, peer support, and post-discharge followup;
- Use of systems-level strategies, such as establishing the organizational goal of eliminating deaths by suicide, tracking and investigating suicide deaths, and using other continuous quality improvement efforts; and
- Recovery-oriented services that are based on the following understanding: recovery emerges from hope, is person-driven, occurs through many pathways, is holistic, is supported by peers and allies, is supported through relationships and social networks, is culturally based, is grounded in respect, is supported by addressing trauma, and involves the individual, family, and community.⁸⁸

Goal 8. Promote suicide prevention as a core component of health care services.

The use of comprehensive, systems-level strategies that make suicide prevention a core goal has been shown to improve outcomes for patients with suicide risk. A 2011 report by the Clinical Care and Intervention Task Force of the Action Alliance identified several of these programs.⁸⁹ Of these interventions, the most thoroughly researched is the U.S. Air Force Suicide Prevention Program, which has been found to reduce death by suicide by one-third.¹⁶

The integration of suicide prevention into the delivery of mental health services has also been found to help prevent suicides in the United Kingdom. A study that examined data from 91 mental health service organizations in England and Wales found that the implementation of key suicide prevention recommendations was associated with a reduction in suicide rates among patients.⁵⁰ Providing 24-hour

crisis care was associated with the greatest reduction in suicide rates. Other recommendations included: assertive, proactive outreach; followup within 7 days of inpatient discharge; training of clinical staff in the management of suicide risk every 3 years; a dual diagnosis policy for those with both mental disorders and substance abuse; and multidisciplinary review and information sharing with families following a suicide.

VA and its health system, the Veteran's Health Administration (VHA), also have adopted a comprehensive approach in which suicide prevention is a core component of mental health and substance abuse services. As part of this approach, a suicide prevention coordinator is placed at every VA medical center in the country. Preliminary data suggest that the implementation of these programs has been associated with a reduction in suicide among important high-risk subgroups of those receiving health care through the VHA, including men in midlife.^{90,91}

Other programs that have garnered attention for their comprehensive approaches and that report promising preliminary data include the Henry Ford Health System's (HFHS) "Perfect Depression Care"⁴⁹ and the Central Arizona Programmatic Suicide Deterrent Project.⁸⁹ Although more research is needed, initial findings suggest that progress can be made when health systems or other organizations focus on making suicide prevention a core priority by obtaining leadership support, changing the organizational culture around suicide prevention, and engaging each component of a system to assume its legitimate role in suicide prevention.

While providers of mental health and substance abuse services have a special responsibility for addressing suicide risk, suicide prevention should not be viewed as an area of specialization that applies only to these professionals or to a single setting, such as inpatient psychiatry. Suicide prevention requires the active engagement of health and social services, as well as the coordination of care across multiple settings, thereby ensuring continuity of care and promoting patient safety. Services addressing mental and substance use disorders, as well as suicide prevention, can be provided in numerous settings, including crisis centers, health centers, clinics, other locations serving particular groups (e.g., older adults), and in the home (e.g., visiting nurse services, home psychotherapy, or hospice care).

There is substantial evidence that discontinuities in treatment and fragmentation of care can increase the risk for suicide. Death by suicide in the period after discharge from inpatient psychiatric units is more frequent than at any other time during treatment.⁹² Similarly, the time following ED discharge also is a period of high risk for suicide.⁹³ There is also reason for substantial concern in the period following discharge from residential addiction treatment.⁹⁴ Proactive followup and active engagement strategies following discharge have been found to help reduce death by suicide and suicide attempts.^{65,95}

Increasing collaboration among providers is also a promising, viable, and efficient way to increase access to suicide prevention and treatment services. This approach can help minimize prejudice and discrimination, while increasing opportunities to improve overall health outcomes. Even in cases when full integration may not be feasible, increased coordination of services and continuity of care can greatly improve care and lead to better patient outcomes.

Objective 8.1: Promote the adoption of “zero suicides” as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.

In recent years, a small number of health care and community support systems that provide health care services to defined populations (also referred to as “boundaried” systems) have adopted a “zero suicides” goal for the population under their care. Within these types of health care systems, the goal of eliminating suicide can help set into place system-wide changes that enhance service access and quality through continuous improvement. Managing a system of care to achieve the goal of zero suicides requires organizations to evaluate performance rigorously and use adverse events as opportunities to improve their capacity to save lives. It also requires putting into place mechanisms to support clinicians in the aftermath of a patient’s death by suicide.

Historically, there have been varied responses to providers who have lost patients to suicide. These have ranged from the sense that some deaths are inevitable in severe cases of mental illness, just as they are in cases of advanced cancer or heart failure, to the view that each death must reflect a failure or lapse in treatment. Although neither of these perspectives is universal, it is clear that each death represents an opportunity for systems and providers to evaluate the care they have delivered and to consider opportunities for improvement. Part of the zero suicides strategy may be for health systems to conduct a root cause analysis (a structured process used to determine the causes of an event) of suicide attempts and deaths, and to use findings to try to continuously improve service quality by focusing on systems issues rather than individual blame. The HFHS Perfect Depression Care program provides an example of this promising approach.^{49, 96}

Objective 8.2: Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.

Trusting therapeutic relationships are fundamental to reducing suicide risk and promoting recovery and wellness. These relationships are most productive when the patient is actively engaged in making choices that will keep him or her safe. There is a need to promote culturally appropriate strategies that will foster therapeutic alliances between patients and providers. The personal needs, wishes, and resources of the patient should be the foundation for developing a plan for continuing care and safety. This plan should be developed through direct and open communication and should engage and empower the patient. Where appropriate and practical, families and significant others should be engaged and empowered as well.

Psychiatric hospitalization, voluntary or involuntary, may be an effective mechanism for preventing suicide over the short term. However, the decision to hospitalize could be a barrier to the development of a long-term therapeutic alliance between the patient and his or her mental health providers. Short-term gains in safety may be neutralized or even outweighed by longer-term increases in risk if patients are reluctant to disclose suicidal thoughts because they perceive a lack of acceptance or sensitivity to cultural values, or if they are afraid of losing their autonomy or being forced into treatment. One way to address this trade-off

is to ensure that inpatient psychiatric units are recovery-oriented and prepared to ensure continuity of care at the point of discharge. Another strategy is to develop alternatives to hospitalization for persons who are not at imminent risk.

There is also a need to identify alternatives to coercion, restraint, and involuntary treatment as ways to ensure the safety of patients in crisis. Because past trauma or abuse increases the risk for suicide, confining people against their will can retraumatize patients. It may also make these patients reluctant to seek help in the future for fear of being discriminated against, traumatized, or imprisoned. There is a need to develop and implement protocols for delivering services in the least restrictive settings consistent with safety.

Protocols should be developed and implemented for delivering services to persons with high suicide risk that promote collaboration and responsiveness. At a minimum, these protocols would instill attitudes and beliefs on the value of shared responsibility and collaborative care and promote effective communication with patients, families, and significant others.

Objective 8.3: Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.

Timely access to care is critically important to individuals in crisis. Crisis hotlines, online crisis chat/intervention services, self-help tools, crisis outreach teams, and other services play an important role in providing timely care to patients with high suicide risk. Virtual or remote care, such as telephone calls to crisis hotlines, and counseling by telephone, texting, or the Internet allow individuals in crisis to access help 24 hours a day, 7 days a week. This type of care typically is available at low or no cost to individuals in crisis and provides immediate access, convenience, and a higher level of anonymity than face-to-face therapy arrangements.

Providing detailed instructions about how to access care 24 hours a day, 7 days a week is a critical part of safety planning for providers working with patients at high risk. It is unrealistic to expect individual providers to be available at all hours. There may be limitations to the coverage that provider organizations can offer. Providing patients with information about how and when to access care in an ED may be necessary but not sufficient. Access to virtual or remote care is critical for augmenting the care provided at clinics and private practices, which usually have limited hours of operation, and also can be useful for reaching rural and underserved populations.

Objective 8.4: Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.

Patients leaving the ED or hospital inpatient unit after a suicide attempt, or otherwise at a high risk for suicide, require rapid, proactive followup. Having survived a suicide attempt is one of the most significant risk factors for later death by suicide. The risk is particularly high in the weeks and months following the attempt, including the period after discharge from acute care settings such as EDs and inpatient psychiatric

units.^{97, 98} Among patients with high suicide risk, particularly those who have attempted suicide, immediate followup and continuity of care are crucial to promoting positive outcomes.⁴³

When patients with high suicide risk come to an ED, they may receive limited mental health services,⁹⁹ may not receive adequate treatment for underlying mental health or substance use disorders, and frequently do not receive any followup care.^{100, 101} All patients who present to the ED for a suicide attempt or who are at risk for suicide require mental health evaluations. Should they not require acute inpatient care, they should be informed about risks during the discharge period and be referred for mental health services before discharge from the ED. However, although referral is necessary, it may not be sufficient. There is increasing evidence that specific outreach programs can be highly effective in increasing the proportion of patients who engage in mental health care after hospitalization.¹⁰²

For patients who are transferred from the ED to medical-surgical services for the treatment of injuries related to a suicide attempt, followup mental health evaluations should be conducted before discharge to decide between transfer to a mental health inpatient unit or referral to outpatient care. These evaluations should consider the support available from family and friends and the patient's clinical status. Before a decision to discharge is made, followup appointments for mental health care should be made and patients (and families or friends) should be coached about the importance of continuity in care.

All patients who are admitted to an inpatient mental health unit require followup mental health services after discharge, as well as connections to community-based supports. Health care systems should seek to dramatically shorten the time between inpatient discharge and followup outpatient treatment. For example, EDs and others providing services to these patients could set a goal of ensuring that followup occurs within 48 hours or, at most, within a week of discharge.

Continuity of care following a suicide attempt should represent a collaborative approach between patient and provider that gives the patient a feeling of connectedness. Strategies may include telephone reminders of appointments, providing a "crisis card" with emergency phone numbers and safety measures, and/or sending a letter of support.¹⁰³ Many types of motivational counseling and case management can also be used to promote adherence to the recommended treatment.

Objective 8.5: Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.

Health care delivery systems should evaluate performance rigorously and incorporate suicide prevention and appropriate responses to suicide attempts in continuous quality improvement efforts, as a way to improve their capacity to save lives at risk. Such efforts could include formal root cause analyses of suicide attempts and deaths by suicide, supervisory reviews, reviews of aggregate data for trends, or focused quality assurance studies on issues related to suicide risk. Health care systems should consider whether the implementation of lessons learned can be part of a strategy aimed at eliminating suicides and part of overall quality improvement. Such reviews should focus on identifying systemic issues where improvement

holds promise for increasing the quality of care, and should not focus on attributing blame to providers or to individuals in crisis.

Objective 8.6: Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.

To be effective in suicide prevention, providers of mental health and substance abuse services must coordinate services with each other and with other service providers in the community. It is generally recognized that mental health and substance abuse services can have a greater impact when community gatekeepers refer at-risk patients to these specialized providers. The effects of mental and substance use services can also be enhanced when specialized providers refer patients to community programs that can augment care.

Timely and effective cooperation, collaboration, and communication between mental health and substance use providers and sources of support in the community are critical to promote patient safety and recovery. Mental health and substance abuse providers should develop linkages with community-based supports such as community agencies for suicide prevention, mental health advocacy organizations, aging services organizations, veterans support organizations, and programs providing peer support services. These programs can help foster a sense of connection and belonging and provide critically needed services including employment and vocational help, housing assistance, social interactions that are not focused on illness, and peer support.

Objective 8.7: Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.

Increased collaboration and coordination among suicide prevention programs, health care systems addressing mental health and substance abuse, and local crisis centers can help provide a continuum of care for individuals at risk for suicide. Health care providers and organizations that conduct assessments of suicide risk must have access to mental health and substance abuse services for patients with high suicide risk. Such support can be obtained from local mental health providers or can be provided remotely (e.g., telephone, online) by crisis service organizations.

A growing network of crisis services organizations can serve an effective option for continuous care. Many, including the certified crisis centers in the National Suicide Prevention Lifeline (800-273-TALK/8255) network, offer trained personnel who can conduct remote assessments, coordinate linkage for care, and provide followup for persons at risk. A prototype for integrating crisis and clinical services is the VA crisis line and its relationship with the National Suicide Prevention Lifeline. In the VA system, call responders regularly interact with providers at the medical center nearest to the patient to arrange and facilitate followup.

The Massachusetts Statewide Advocacy for Veterans' Empowerment (SAVE) program provides another example of the benefits of coordinating services.¹⁰⁴ The program works to prevent suicide and mental

health distress by serving as a liaison with the various agencies within the federal and state governments, thereby ensuring access to benefits and services that address these issues and contribute to a positive transition to civilian life.

Objective 8.8: Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid followup after discharge.

Patients with high suicide risk often are treated at EDs, and may be hospitalized as a way to prevent a suicide attempt. Although this can be an effective strategy and is necessary as a safety measure, there is a need to develop alternatives. Research has shown that the proportion of individuals attempting suicide who are discharged directly from the ED to the community has been increasing.¹⁰⁵ Discharge from the ED may be clinically appropriate, but it requires that adequate supports and followup be in place. In addition, not every ED has the capacity to provide suicide risk assessment.⁹⁹ One strategy is for primary care, mental health, and substance use programs to establish mechanisms to facilitate rapid access to their services when patients are in crisis. Another is to develop alternative services that can be accessed through EDs. For example, a crisis line could arrange for appointments with providers in the community while the patient is in the ED.

Collaborations among EDs and community providers, such as health and mental health centers, crisis centers, hotlines, and outreach teams, can improve the quality and continuity of care for these high-risk patients. These collaborations can help expand alternatives to EDs, such as the same day scheduling for mental health services and in-home crisis care, and secure rapid and continuous followup after discharge. Plans for discharge from the ED must incorporate linkages to other necessary levels of care (e.g., intensive outpatient, private therapist, pharmacological therapy). Organizations must recognize, accept, and implement shared service responsibilities among various clinical staff within the organization and among providers in the larger community.

Goal 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

Primary care physicians play an important role in the assessment and management of suicide risk. It is estimated that 75 percent of individuals who die by suicide are in contact with a primary care physician in the year before their death, and that 45 percent do so within one month of their death.¹⁰⁶ In contrast, only 20 percent of these patients saw a mental health professional in the preceding month.

Effective clinical and professional practices in the assessment and treatment of individuals with high suicide risk can help prevent these individuals from acting on their despair and distress in self-destructive ways. These practices should be grounded in evidence-based care or in best practices, in cases where promising approaches have been identified but more research is needed.

Suicide risk assessment programs often target patients with known risk factors for suicide, including those who have previously expressed suicidal thoughts or made a suicide attempt and persons with mood or substance use disorders. Treatment of patients with suicide risk often includes medication (e.g., antidepressants) and psychosocial approaches such as cognitive-behavioral therapy and supportive counseling. Because suicide attempts are known to be a strong predictor of future attempts and deaths by suicide, continuity of care is critical for these patients. Effective clinical care should include monitoring patients for a suicide attempt after an ED visit or hospitalization and providing outreach, mental health followup, therapy, and case management.

Objective 9.1: Adopt, disseminate, and implement guidelines for the assessment of suicide risk among persons receiving care in all settings.

The assessment of suicide risk is critical to identifying high-risk individuals and providing needed services and supports. Assessment of suicide risk should be an integral part of primary care, hospital care (particularly ED care), care for mental and substance use disorders, crisis response (e.g., help lines, mobile teams, first responders, crisis chat services), and of the care provided in skilled nursing facilities. Any person identified as being at a possible risk for suicide should be formally assessed for suicidal thoughts, plans, intent, access to lethal means, a history of previous attempts, the presence of acute risk factors (including problems in the family and other social relationships, work or school, finances, and the legal system), and level of risk. Persons identified as being at risk for suicide should have immediate access to needed clinical care and support.

Tools and methods to help detect risk, conduct assessments, intervene for safety, and deliver quality treatment and support are available but not widely used. Research has not yet identified a simple, easily administered scale leading to a score that can provide a quantifiable substitute for clinical decision-making and judgment. However, reliable and valid instruments do exist and can be a useful component of a full evaluation. Guidelines for risk assessment, along with appropriate tools and protocols, must be disseminated among all settings that provide care for individuals with suicide risk.

Strategies for assessing suicide risk should be tailored to the individual and context. For individuals in primary care without known risk factors, a staged approach may be useful, where evaluations for suicide risk are conducted when patients have a positive screen or show evidence of a mental health or substance use disorder or a chronic pain syndrome. In these cases, evaluations for the risk of suicide should be conducted at the initial diagnostic and treatment planning evaluation and when there are significant changes in symptoms and treatments. For individuals who have previously been at high risk, evaluations should be conducted on a frequent, regularly scheduled basis, when there are significant changes in symptoms or treatments, and when a person experiences stressful events. Guidelines for suicide risk assessment should be meaningfully related to the training objectives listed in Objective 7.2 of this National Strategy.

Objective 9.2: Develop, disseminate, and implement guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk.

Disjointed service delivery, lack of effective communication among caregivers, and clinician concerns associated with the possible loss of a patient to suicide are barriers to effective clinical care for persons with suicide risk. These barriers can create an environment where a person with suicide risk may feel reluctant to disclose suicidal thoughts and feelings to a helping professional because he or she senses discomfort and is afraid of being automatically referred to inpatient care. Unprepared caregivers, acting in isolation, are more likely to experience heightened anxiety than trained caregivers empowered to share the responsibility for managing suicide risk.

Guidelines on the treatment of specific mental health conditions are necessary, but they are not sufficient. There is a need for guidelines for clinical practice that address the care indicated for individuals identified as being at risk for suicide. These guidelines should reflect the latest evidence and best practices in care for patients with suicide risk. They should indicate how care should be modified to address the needs of patients at risk for suicide and specify what services and interventions should be provided to supplement care directed toward the underlying condition(s). At a minimum, these guidelines should address:

- Patient-centered care;
- Recovery-oriented mental health services;
- Building protection and resilience;
- Suicide prevention specific intervention planning and review;
- Safety planning;
- Effective therapeutic alliances;
- Communication among providers;
- Alignment of clinical approaches with needs (e.g., underlying psychiatric and/or substance use disorders, trauma support, complicated grief);
- Immediate access to crisis services;
- Continuity of care, including immediate followup after discharge from an inpatient unit following a suicide attempt; and
- Appropriate empowerment of families and significant others in treatment, peer support, and post-discharge followup.

Objective 9.3: Promote the safe disclosure of suicidal thoughts and behaviors by all patients.

Settings that provide care to patients with suicide risk must be nonjudgmental and psychologically safe places in which to receive services. Patients who have thoughts of suicide may feel embarrassed, guilty, and

fearful of disclosing their thoughts and feelings to others. These patients may also fear losing autonomy or the ability to make their own treatment decisions. To address these barriers to treatment, collaborative and non-coercive approaches should be used whenever possible. Health care providers and other caregivers must have the skills required to promote disclosure. Individuals contacting a potential helper must feel comfortable to disclose their desire or intent to die and their thoughts of suicide. They must feel confident that the potential caregiver will be accepting and in a position to offer nonjudgmental help.

Anxiety about asking suicide-related questions may also be a barrier to identifying individuals at risk. Education, training, and rehearsal of ways to address the disclosure of suicide risk can help ease these concerns. System-based approaches that give providers access to resources that can help them manage someone who is suicidal also can help reduce provider anxiety regarding the disclosure of suicide-related thoughts and behaviors. For example, VA places a suicide prevention coordinator at each medical center, as a resource for providers who need to make difficult clinical judgments.

Objective 9.4: Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for persons with suicide risk.

Family members, significant others, and close friends can play an important role in enhancing the safety of patients with suicide risk. These individuals should be trained to understand, monitor, and intervene with loved ones who are at risk for suicide. Because the exact timing of suicidal behaviors is very difficult to predict, it is important that key members of the family unit and social support network be knowledgeable about risk factors and about how to help protect an individual from suicide. These individuals (family members/support network) should know when to contact treatment providers or emergency services and how to take reasonable precautions to reduce access to lethal means. Family members need to feel able to ask directly about suicidal thoughts, but should not be placed in the position of providing around-the-clock “suicide watches.”

Involving the patient’s family and/or close friends is an important way to help ensure patients leaving the ED after a suicide attempt or those being discharged after inpatient care keep their followup appointments. These individuals also can help support patient adherence to important treatment decisions and followup arrangements.

Contact and collaboration between providers and patients’ family members or friends usually requires consent from the patient. Engaging the patient in arranging such contact and collaboration is important as a matter of both autonomy and effectiveness. However, in the context of suicide prevention, limited exceptions to these principles may be necessary.

Guidelines should be developed and implemented to help providers balance respecting autonomy versus ensuring safety in their work with patients with high suicide risk and their families. As an example, the American Association of Suicidology has developed a set of recommendations for inpatient and residential patients at high risk for suicide.¹⁰⁷ The recommendations seek to enhance the provision of care in inpatient and residential facilities and to promote, when possible, the involvement of families as meaningful members of the treatment team.

Objective 9.5: Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among patients receiving care for mental and/or substance use disorders.

Strategies for monitoring patients and identifying those at risk in a number of contexts are also needed. Monitoring should be more frequent and more focused for those people known to have risk factors such as mental or substance use disorders, chronic pain, or disability. Monitoring should be more intensive for those identified as being at high risk for suicidal behaviors. Clinical care for individuals at a high risk for suicide, including those who have survived a suicide attempt, should recognize and support recovery and should also be based on the understanding that individuals remain at risk for extended periods of time. Regularly scheduled monitoring should focus on evaluating changes in symptoms of medical and mental health conditions, changes in protective factors such as social networks, the occurrence and impact of stressful events, and the recurrence of suicidal ideation, plans, or intent.

Specialty centers that provide care for mental and substance use disorders should have in place policies, procedures, and programs designed to identify the level of suicide risk and intervene to prevent suicide among their patients. Evaluation of these policies and procedures over time can contribute to the more effective and efficient delivery of health care to patients with high suicide risk.

Although assessment and intervention are different processes, policies and procedures in these two areas must be coordinated. Put simply, a lack of knowledge and resources to respond to patients found to be at high risk for suicide could represent a barrier to case identification. Policies and procedures should recognize that managing a patient at a high risk for suicide can take more time than a standard encounter and may require the involvement of more than one provider.

As noted earlier, interventions for patients at risk for suicide should combine care for underlying conditions with strategies that directly address suicide risk. At the same time, it is important to reevaluate treatments for mental health and substance use disorders to ensure that they are appropriate, and that they address both the management of symptoms and recovery. For those with a serious mental illness, ensuring that the treatment plan is recovery oriented can be lifesaving.

Collaborative safety planning has been found to be a component of effective treatment of suicidal risk. Health systems such as VA have begun to require safety planning as an intervention within their systems for patients at high risk.

Objective 9.6: Develop standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs.

EDs are key settings for providing services to persons with high suicide risk, particularly those who have attempted suicide. In 2009, 374,486 people were treated in EDs for self-inflicted injuries.¹

Standardized protocols should be developed for use within EDs that allow for differentiated responses based on risk profiles and assessed clinical needs (e.g., intoxicated and suicidal, chronically suicidal,

suicidal with active psychosis). These protocols should emphasize patient-centered and stepped approaches that allow relative suicide risk to be assessed and matched with a continuum of services. For example, individuals who are identified as being at a high risk for suicide may require intensive outpatient suicide-specific mental health treatment. Those who are intoxicated and suicidal will, in general, have to be evaluated after they have become sober before they can be discharged. Seriously ill patients with high suicide risk may require partial hospitalization or short-term psychiatric inpatient stays.

Objective 9.7: Develop guidelines on the documentation of assessment and treatment of suicide risk and establish a training and technical assistance capacity to assist providers with implementation.

The proper documentation of assessment and treatment can improve the care of patients with high suicide risk and, at the same time, protect providers from allegations of malpractice. A proper assessment should identify the severity of a patient's risk for suicide, allowing for the development of critical treatment plan determinations. Decisions such as whether to hospitalize or whether a patient can be treated on an outpatient basis depend on the foreseeable risk of suicide and the patient's ability to work collaboratively to stay safe. The type of treatment that is recommended should be appropriate for the patient's level of risk, needs, and preferences. These issues require careful documentation. Training materials on evidence-based psychotherapies for suicide prevention and safety planning should include tools to support these interventions, such as chart templates used to document their delivery.

Goal 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

The mental health and medical communities often fail to provide needed services to individuals who have attempted suicide and to those who have been affected by a suicide attempt or death. Individuals who have made a suicide attempt may receive insufficient care in the community. Those who have been bereaved by suicide may receive little or no guidance or support for the traumatic impact of this occurrence.

While most individuals bereaved by suicide recover from the trauma, many people may suffer alone and experience harmful effects that can be devastating and sometimes long lasting. For these reasons, it is crucial to pay attention to the needs of these potentially vulnerable but underserved groups. In addition, deaths by suicide can affect whole organizations and communities, leading to concerns regarding suicide contagion, particularly among youth.

Objective 10.1: Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.

Guidelines for providing care and support to individuals bereaved by suicide are needed. Communities vary tremendously in the extent to which they provide these types of support services. Individuals

bereaved by suicide often have difficulty finding the services they need when they are ready to access them. Developing comprehensive national guidelines for effective support will provide a “roadmap” for the kinds of services that communities can work to provide for these groups. This support can include, but is not limited to, outreach teams of professionals and trained individuals who have been bereaved by suicide, face-to-face and online support groups, memorial services, and other opportunities for those who have been bereaved by suicide to interact with each other and find positive and culturally appropriate ways to deal with their grief.

The Action Alliance’s Task Force on Survivors of Suicide Loss is working toward the development of consensus guidelines for the creation and implementation of effective, comprehensive support programs for individuals affected by a suicide loss. The Task Force will review existing evidence regarding model services and programs, draft consensus guidelines incorporating input from various groups, and submit the guidelines for inclusion in the Best Practices Registry for Suicide Prevention.

Objective 10.2: Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.

Exposure to a suicide attempt or death, particularly of someone who is psychologically close, can have harmful effects on individuals and families, including increasing the risk for suicide in the person exposed.³⁹ Family and friends of individuals who attempt suicide can have similar reactions. The actual or threatened loss of a loved one by suicide is often shocking, painful, and unexpected. The reactions can be intense, complex, and long lasting, and may be accompanied by powerful emotions such as denial, anger, guilt, and shame. Each person will experience this grief in a unique way.

Because of the prejudice attached to suicide, family members and friends may not know how to help someone who has been affected by a suicide loss or attempt. Shame and embarrassment may prevent the person from reaching out for help. While support groups can be very helpful, individuals affected by suicide must also have access to knowledgeable professional services and supports.

Objective 10.3: Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.

Making a suicide attempt is a risk factor for later death by suicide.¹¹ Promoting the positive engagement of those who have attempted suicide in their own care is likely crucial in successfully reducing risk for suicide. In addition, these individuals can be powerful agents for challenging prejudice and activating hope for others.

Most successful suicide prevention strategies have used multiple components, but one underutilized intervention in suicide prevention has been peer support. Appropriate peer support plays an important role in the treatment of mental and substance use disorders and holds a similar potential for helping those

at risk for suicide. Guidelines and protocols are needed to support the development of such services for those who have attempted suicide, as well as technical assistance to assist with the dissemination and implementation of these tools.

Objective 10.4: Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.

The 2001 National Strategy described the phenomena of “suicide contagion” and “suicide clusters.” Contagion has been described as the process by which exposure to suicidal behaviors from interpersonal contacts or the media can lead to an increase in suicidal behaviors, particularly among adolescents and young adults. A suicide cluster has been defined as a group of suicides or suicide attempts, or both, that occur closer together in time and space than would normally be expected in a given community.⁶⁷

CDC has estimated that cluster suicides may account for 1 to 5 percent of suicides among adolescents and young adults.⁶⁷ In 1988, CDC issued recommendations for communities to use in the prevention and containment of suicide clusters.⁶⁷ These recommendations provide an important foundation for community suicide prevention efforts but have not been routinely implemented in communities experiencing clusters. In addition, the effect of differing cultural contexts (e.g., in American Indian/Alaska Native communities), has not been systematically analyzed, nor has the effectiveness of the recommendations been evaluated.

Objective 10.5: Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.

Clinicians, first responders, emergency personnel, and other medical professionals who lose a patient to suicide should be provided with support to deal with the emotional aftermath of this traumatic event. Such support should address trauma and grief reactions and potential suicide risk among caregivers. Mechanisms for review of such deaths should avoid blaming the caregiver. Instead, the goal should be to respond to the caregiver’s need for support and help the provider respond to patients who may be at risk for suicide in the future.

What You Can Do to Advance the Goals and Objectives in Strategic Direction 3 of the National Strategy for Suicide Prevention

The Federal Government Can:

- Promote access to high-quality mental health services and facilitate the integration of mental health services into a range of settings (e.g., Federally Qualified Health Centers, Bureau of Prisons, Indian Health Service, and VA facilities). (Objectives 8.3 and 8.6)
- Update and revise federal publications addressing the appropriate response after a suicide. (Objective 10.4)

State, Territorial, Tribal, and Local Governments Can:

- Disseminate information about the National Suicide Prevention Lifeline and other local or regional crisis lines. (Objective 8.3)
- Promote the availability of online support services and crisis outreach teams. (Objective 8.3)
- Develop protocols and improve collaboration among crisis centers, law enforcement, mobile crisis teams, and social services to ensure timely access to care for individuals with suicide risk. (Objective 8.3)

Businesses and Employers Can:

- Ensure that counselors in an employee assistance program (EAP) are well equipped to assess and manage suicide risk. (Objective 9.1)
- Ensure that mental health services offered to employees include grief counseling for individuals bereaved by suicide. (Objective 10.1)

Health Care Systems, Insurers, and Clinicians Can:

- Implement patient-informed alternatives to hospitalization for individuals with suicide risk. (Objective 8.2)
- Develop alternatives to treatment in an emergency department, such as same-day scheduling for mental health services and in-home crisis care. (Objective 8.8)
- Develop and implement protocols to ensure immediate and continuous followup after discharge from an ED or inpatient unit. (Objective 8.4)
- Educate family members and significant others about appropriate steps they can take to support individuals at suicide risk during treatment and/or after discharge from an ED or inpatient unit. (Objective 9.4)

Schools, Colleges, and Universities Can:

- Educate students who are in training to become mental health, social service, or health care providers on the identification and treatment of individuals at high risk for suicide. (Objective 9.2)

Nonprofit, Community-, and Faith-Based Organizations Can:

- Coordinate the services of community-based and peer-support programs with the support available from local providers of mental health and substance abuse services to better serve individuals at risk for suicide. (Objective 8.6)

Individuals and Families Can:

- Provide appropriate followup support to family members of individuals who have been discharged from an ED or inpatient unit, including reminders about appointments, and information on compliance with treatment plans and on ways to reduce access to lethal means. (Objective 9.4)
- Learn when to contact treatment providers or emergency services for loved ones who are at risk for suicide. (Objective 9.4)

Strategic Direction 4: Surveillance, Research, and Evaluation

The National Strategy's fourth strategic direction addresses suicide prevention surveillance, research, and evaluation activities, which are closely linked to the goals and objectives in the other three areas. Public health surveillance refers to the ongoing, systematic collection, analysis, interpretation, and timely use of data for public health action to reduce morbidity and mortality. In contrast, research and evaluation are activities that assess the effectiveness of particular interventions, thereby adding to the knowledge base in the area of suicide prevention.

The past decade has seen substantial improvements in suicide-related surveillance, research, and evaluation. However, additional efforts are needed to inform and guide suicide prevention efforts nationwide. The collection and integration of surveillance data should be expanded and improved. In addition, although some evidence is available regarding the effectiveness of particular interventions and approaches, there is a need to assess the effectiveness of new and promising practices.

Goal 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

The regular collection and rapid dissemination of suicide-related data are needed to guide appropriate public health action. The time between when an event takes place and when the data are ready for dissemination must be shortened. This is no simple task, as it involves collecting information on several behaviors (e.g., suicidal thoughts, attempts, deaths) that may be available at many levels (e.g., local, state, national). The information may come from several different sources, including vital statistics, EDs, inpatient hospital records, and urgent care centers, and may not be linked. In addition, there are continuing concerns and constraints regarding the accumulation of potentially identifiable data.

Examples of existing nationally representative data sources containing information regarding suicidal behaviors include:

- CDC's National Vital Statistics System: annual data on all suicide deaths occurring in the U.S.; available from WISQARS (www.cdc.gov/injury/wisqars);
- CDC's NVDRS: annual data on suicide deaths from 18 states; available from WISQARS (www.cdc.gov/injury/wisqars/nvdrs.html);
- CDC's Youth Risk Behavior Surveillance System: data released every 2 years on suicide ideation and attempts among high school students (www.cdc.gov/healthyyouth/yrbs/index.htm); and
- SAMHSA's National Survey on Drug Use and Health: annual survey that, since 2008, has included questions on suicidal thoughts and behaviors among adults (www.oas.samhsa.gov/nsduh.htm).

It is important to strengthen systems and to improve the quality of the data collected for surveillance purposes. It is equally necessary to enhance the ability of jurisdictions to use available information for strategic planning aimed at preventing suicidal behaviors.

Objective 11.1: Improve the timeliness of reporting vital records data.

Timeliness of reporting of national statistics on suicide mortality is a core issue. Although several states are able to rapidly provide information about suicide-related deaths, many others experience delays certifying and reporting these deaths. As a result, there is a two-year gap between the close of the calendar year and when the national data for that year become available. For example, data for 2009—the most recent final data available—were released in December of 2011. This makes it difficult to know when national suicide rates climb as a result of contextual factors, such as an economic crisis, as well as to plan interventions or to know if suicide prevention efforts are having an effect in reducing deaths by suicide. Efforts should be made to gradually reduce this gap with an ultimate target of 12 months.

Objective 11.2: Improve the usefulness and quality of suicide-related data.

Consistent suicide-related data can help public health practitioners better understand the scope of the problem, identify high-risk groups, and monitor the effects of suicide prevention programs. However, existing data regarding suicide and suicidal behavior continue to have many limitations. Deaths from suicide may be misclassified as homicides, accidents, or even as death from natural causes. Information available from death certificates is limited and provides an incomplete picture of the risk factors for suicide. For example, death data regarding sexual orientation and gender identity are generally not collected, so it is not possible to calculate a reliable suicide rate for LGBT people.

Death scene investigations can reveal important information about the circumstances of a suicide and its method. This information can be used to improve understanding of suicide and enhance prevention efforts. Emergency medical technicians, police, medical examiners, and coroners may all contribute to the collection of these data. There is a need to improve the quality and accuracy of death scene investigations by providing training to these responders.

Data on fatal and nonfatal self-directed violence often are not standardized. To address this issue, in 2011, CDC published the report *Self-Directed Violence Surveillance: Uniform Definitions and Recommended Data Elements*.¹⁰⁸ The definitions and data elements were developed in collaboration with the VA and have been adopted by the Department of Defense.

Lack of external cause-of-injury coding in administrative datasets (e.g., ED, hospital discharge) greatly reduces the utility of these datasets. The CDC has developed an action agenda for improving external cause coding that could be a useful framework for addressing this issue within these administrative datasets.¹⁰⁹

Efforts to link and analyze information coming from separate data systems, such as law enforcement, emergency medical services, and hospitals, are also needed. Such linked data can provide much more comprehensive information about an event, its circumstances, the occurrence and severity of injury, the type and cost of treatment received, and the outcome in terms of both morbidity and mortality.

Objective 11.3: Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.

The surveillance of suicidal behaviors and related issues (e.g., mental and substance use disorders) has improved over the years, but additional advances are needed. In particular, there is a need to increase the number of states and territories that are funded to integrate data sets as a part of NVDRS and to improve relevant data sets and facilitate access to them. In addition, staff members in states/territories, tribes, and local governments require training on how to analyze and interpret data for policy and prevention purposes.

Although national data provide an overall view of the problem, local data are key to effective prevention efforts. State/territorial, tribal, and local suicide rates vary considerably from national rates. There is a need to promote the development of local reports on suicide and suicide attempts, and to integrate data from multiple data management systems. These reports should describe the magnitude of the suicide problem and how suicide differentially affects particular groups. In addition, the reports should also address the use of mental health and substance use services. These publications would be useful in tracking trends in suicide rates over time, identifying changes in groups at risk and methods used, and evaluating suicide prevention efforts. At the local level, they could serve as a resource for developing timely and targeted interventions to prevent suicidal behaviors. State epidemiologists and suicide prevention coordinators could play an important role in supporting and providing assistance for these local efforts.

Objective 11.4: Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.

Existing sources of data on suicidal behaviors underestimate the burden that suicide-related problems place on our society. There is a need to increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors and related risk and protective

factors. Questions about suicide attempts should identify the person's age at the time of the attempt and whether medical attention was required. Data collection tools also should include questions that better identify vulnerable populations, such as items addressing sexual orientation and gender identity.

Exposure to suicide, particularly of someone emotionally close to the bereaved, can increase the risk for depression, complicated grief and trauma reactions, and suicide. Yet little is known about the number of people who have been exposed to suicide and about those who have been adversely affected by that exposure. Nationally representative surveys and other data collection instruments and systems should include questions on exposure to suicide and its links with suicidal thoughts and behaviors, mental and substance use disorders, and violence. Obtaining this data would help greatly in planning support services for those who have been bereaved by suicide.

There also is a need to collect suicide data on deaths among those who are currently receiving active inpatient or outpatient care (e.g., outpatient mental health care, inpatient cancer treatment). Although these events may be particularly amenable to prevention, there is currently no national system that can provide this information.

Goal 12. Promote and support research on suicide prevention.

Research on suicide prevention, and on the treatment of mental and substance use disorders, has increased considerably during the past 20 years. Findings have contributed to the development of assessment tools, resiliency-building interventions, and treatment and symptom-monitoring techniques. Continued advancements will lead to the development of better assessment tools, treatments, and preventive interventions. It also will lead to more effective and efficient therapeutic interventions for individuals who engage in suicidal behaviors.

Objective 12.1: Develop a national suicide prevention research agenda with comprehensive input from multiple stakeholders.

Everyone has a stake in the development and implementation of a national suicide research agenda that can ultimately be measured in terms of knowledge gained and measurable declines in suicide attempts and deaths. This agenda should build on existing knowledge of suicide prevention and surveillance findings to identify priority research areas. Topics could include: groups with increased suicide risk, gender and ethnic differences, social and economic factors, genetic contributions, protective factors, promising interventions for suicide prevention and treatment, and interventions for individuals who have been affected by suicide.

The Research Prioritization Task Force, launched under the Action Alliance, has developed a prioritization process that includes a stakeholder survey, portfolio analyses, and input by experts. The research summaries published in the 2002 IOM report *Reducing Suicide: A National Imperative*⁹ can serve as a starting point for updating the state of the science and research infrastructure needs.

Objective 12.2: Disseminate the national suicide prevention research agenda.

After the research agenda is developed, it should be disseminated to researchers and program planners at the local, regional, and national levels, so that it can inform the development of new suicide prevention interventions and programs. The research agenda will also be useful to the various groups that fund suicide prevention research in identifying knowledge gaps and areas of need.

As part of the prioritization process discussed in Objective 12.1, an inventory of currently funded suicide research will be created. Funders, both public and private, will be asked to provide annual updates of currently funded research to a web-based system that can be inventoried and queried. This effort will help facilitate funding coordination and serve as a way to disseminate to funders and program planners information on research that is currently in progress.

Moving forward, the research agenda should be updated on a regular basis, with input from its various users, to ensure that it remains relevant. Expanded surveillance efforts, discussed under Goal 11, will help enhance the ability of researchers and program planners to develop and evaluate interventions targeting specific groups. Updating the agenda to address new questions posed by program planners, agencies, and organizations will help ensure that it remains a living document that helps save lives.

Objective 12.3: Promote the timely dissemination of suicide prevention research findings.

Emerging suicide prevention research findings must be translated into recommendations and suggestions for practical application in multiple settings. Researchers should be encouraged to publish their findings so that practitioners can incorporate them into the development of new interventions targeting particular groups. There is also a need to disseminate these findings more widely via communication efforts targeting specific groups, such as health care providers, public health officials, providers of aging services, school officials, and others.

Objective 12.4: Develop and support a repository of research resources to help increase the amount and quality of research on suicide prevention and care in the aftermath of suicidal behaviors.

Conducting research on suicide prevention involves many challenges. Although the absolute number of suicides in a population may be cumulatively quite large, the risk of suicide to any given individual, even those with multiple risk factors, is relatively small. Suicide is a relatively rare outcome, which makes it difficult to conduct randomized controlled trials (RCTs) that evaluate the impact of an intervention in preventing suicide.

Researchers would benefit from information on the most appropriate research designs for rare events, and on appropriate outcomes that are suitable to answer well-defined research questions. Although RCTs are expensive, they could be done more economically by including only patients with high suicide risk, such as individuals who have recently attempted suicide. Suicide attempts, particularly medically serious suicide

attempts, may serve as a sufficiently powerful proxy (i.e., substitute) measure to address some specific research questions.

A national repository of research methods would be a useful resource for suicide prevention researchers. The repository could include a link to national databases (e.g., CDC, national, state/territorial, tribal, and local) that can be used as research tools. Other contents could include information on appropriate and rigorous study designs, common measures that should be used in research studies, successful implementation efforts and adaptations, and safety and ethical considerations.

Goal 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

Program evaluation is a driving force for planning effective suicide prevention strategies, improving existing programs, informing and supporting policy, and demonstrating the results of resource investments. Suicide prevention interventions should be guided by specific testable hypotheses and implemented among groups of sufficient size to yield reliable results. Given the state of the field, program evaluations should emphasize measurable behavioral outcomes, in addition to other outcomes (e.g., changes in knowledge or attitudes) and process measures (e.g., number of people attending program sessions).

Programs that share risk factors with suicide should be encouraged to incorporate suicide prevention components and related measures in their program design and evaluation plans. For example, suicide shares risk and protective factors with other forms of violence, including interpersonal violence among youth. These factors include problem-solving and coping skills and characteristics of school and community environments, such as bullying, intolerance, and prejudice.¹²⁸ Violence prevention approaches that address these types of shared factors, such as by promoting coping skills and family functioning, are likely to also contribute to suicide prevention. The evaluation of these interventions should incorporate suicide-related outcome measures as a way of assessing the potential effect of such programs on preventing suicidal behaviors.

Objective 13.1: Evaluate the effectiveness of suicide prevention interventions.

A broad range of interventions can be used for suicide prevention. Examples include: education and awareness programs, life skills development, the use of media reporting guidelines for suicide, school-based and other community programs, clinical provider training, screening for individuals at high risk, the use of crisis lines, medications, psychotherapy, and followup care for suicide attempts.^{72, 73, 110} Program evaluations and other studies must evaluate the effectiveness of these interventions and their impact on the prevention of suicide attempts and deaths. In particular, there is a need to implement and evaluate the effectiveness of interventions for individuals who have been bereaved by suicide, as few studies have focused specifically on this population.

Objective 13.2: Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.

Although the number of evaluated suicide prevention programs has increased over the years, findings from individual studies must be assessed and synthesized in order to understand the strength of the evidence in support of particular interventions. Systematic reviews serve an important role in the assessment and synthesis of research findings. These reviews can help identify effective interventions and provide recommendations for future programs and research.

Findings from a review of studies conducted in the United States and abroad suggest that interventions can be effective for preventing suicide including for example, physician education and the training of gatekeepers in institutional settings (e.g., the U.S. Air Force).⁷² Another umbrella review examined findings from six systematic reviews of multilevel suicide prevention interventions.⁷³ These interventions were defined as having multiple components and targeting different populations or several levels within a health care system and/or having more than one area of focus, such as combining medications with psychotherapy. The review found support for physician education and means restriction and improving access to care for individuals with suicide risk.

Although the umbrella review focused on interventions delivered in health care systems, multilevel suicide prevention interventions can also be conducted in other settings. As an example, a multilevel intervention could combine the following components: building life skills among high school students, training school staff as gatekeepers, ensuring the school has appropriate crisis protocols and has strong links to community referral resources, and other activities conducted in the community. These activities could include promoting the Lifeline (800-273-TALK/8255) to the general public and distributing gunlocks.

More research is needed to better understand the strength of the evidence in support of suicide prevention interventions. After findings are synthesized, they should be disseminated to promote the broader implementation of the specific types of interventions that have been found to be effective in preventing suicide.

Objective 13.3: Examine how suicide prevention efforts are implemented in different states, territories, tribes, and communities to identify the types of delivery structures that may be most efficient and effective.

Suicide prevention efforts are implemented differently across states/territories, tribes, and local communities. There is a need to evaluate the delivery structure of suicide prevention systems to identify these differences, and to assess the effectiveness of different system designs for the delivery of suicide prevention services. Findings from these assessments could be used to generate recommendations regarding the types of delivery structures that appear to be most efficient and effective.

Objective 13.4: Evaluate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.

The National Strategy represents a comprehensive, long-term approach to suicide prevention. As discussed in the Introduction section (under “Looking Ahead”), the goals and objectives are broad in scope and encompass a wide range of activities.

The National Strategy represents a roadmap that, when followed, will lead to the vision of a nation free from the tragic experience of suicide. Different groups (e.g., associations, government agencies, educational institutions, health systems) may find it useful to review the goals and objectives in the National Strategy and identify their own priority areas for action.

As an example, the Action Alliance has identified four priority areas for 2012–14 and will monitor progress toward their achievement. Several considerations helped guide the development of this action agenda, including the potential impact on suicide-related morbidity and mortality and the availability of organizations, agencies, or other groups that may be willing to take on different roles in implementing activities and evaluating progress.

What You Can Do to Advance the Goals and Objectives in Strategic Direction 4 of the National Strategy for Suicide Prevention

The Federal Government Can:

- Assist states in the transition to electronic death certificates through enhanced technical support. (Objectives 11.1 and 11.2)
- Promote the increased utilization of the National Violent Death Reporting System. (Objectives 11.2 and 11.3)
- Develop a standardized module of suicide-related questions that can be used in different surveys and data systems. (Objective 11.4)
- Support suicide-related research, including research on the risk and protective factors for suicide among different groups. (Objective 12.1)
- Promote the evaluation of suicide prevention programs and practices and the synthesis and dissemination of findings. (Objectives 13.1 and 13.2)

State, Territorial, Tribal, and Local Governments Can:

- Analyze and identify strategies to increase the efficiency of state-based processes for certifying, amending, and reporting vital records related to suicide deaths. (Objective 11.1)
- Implement CDC’s action plan for improving external cause of injury coding. (Objectives 11.2 and 11.3)
- Adopt recommended self-directed violence uniform definitions and data elements developed by CDC and VA. (Objective 11.2)

- Improve data linkage across agencies and organizations, including hospitals, psychiatric and other medical institutions, and police departments, to better capture information on suicide attempts. (Objective 11.2)

Businesses and Employers Can:

- Evaluate the effectiveness of workplace wellness programs in reducing suicide risk. (Objective 13.1)

Health Care Systems, Insurers, and Clinicians Can:

- Implement the recommendations for health care providers in CDC's action plan for improving external cause of injury coding within administrative data, such as emergency department and hospital discharge systems. (Objective 11.2)
- Routinely document suicide-related information (e.g., alcohol use, drug use, description of intent) in emergency department charts. (Objective 11.2)
- Initiate continuous quality improvement studies to determine the effectiveness of policies and procedures intended to rapidly connect individuals at risk for suicide with services. (Objective 13.1)

Schools, Colleges, and Universities Can:

- Conduct research to identify new, effective policy and program interventions to reduce suicide and suicidal behavior. (Objective 12.1)
- Share suicide-related research findings with state and local suicide prevention coalitions, health care providers, and other relevant practitioners. (Objective 12.3)

Nonprofit, Community-, and Faith-Based Organizations Can:

- Work with a local university to evaluate your suicide prevention program. (Objective 13.1)

Individuals and Families Can:

- Participate in surveys and other data collection efforts addressing suicide and related behaviors. (Objective 11.4)
- Support evaluation of suicide prevention programs. (Objective 13.1)

Appendix A: National Strategy for Suicide Prevention Goals and Objectives for Action Summary List

Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities

GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.

Objective 1.1: Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.

Objective 1.2: Establish effective, sustainable, and collaborative suicide prevention programming at the state/territorial, tribal, and local levels.

Objective 1.3: Sustain and strengthen collaborations across federal agencies to advance suicide prevention.

Objective 1.4: Develop and sustain public-private partnerships to advance suicide prevention.

Objective 1.5: Integrate suicide prevention into all relevant health care reform efforts.

GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.

Objective 2.1: Develop, implement, and evaluate communication efforts designed to reach defined segments of the population.

Objective 2.2: Reach policymakers with dedicated communication efforts.

Objective 2.3: Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.

Objective 2.4: Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.

GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.

Objective 3.1: Promote effective programs and practices that increase protection from suicide risk.

Objective 3.2: Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.

Objective 3.3: Promote the understanding that recovery from mental and substance use disorders is possible for all.

GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.

Objective 4.1: Encourage and recognize news organizations that develop and implement policies and practices addressing the safe and responsible reporting of suicide and other related behaviors.

Objective 4.2: Encourage and recognize members of the entertainment industry who follow recommendations regarding the accurate and responsible portrayals of suicide and other related behaviors.

Objective 4.3: Develop, implement, monitor, and update guidelines on the safety of online content for new and emerging communication technologies and applications.

Objective 4.4: Develop and disseminate guidance for journalism and mass communication schools regarding how to address consistent and safe messaging on suicide and related behaviors in their curricula.

Strategic Direction 2: Clinical and Community Preventive Services

GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.

Objective 5.1: Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.

Objective 5.2: Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.

Objective 5.3: Intervene to reduce suicidal thoughts and behaviors in populations with suicide risk.

Objective 5.4: Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.

GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.

Objective 6.1: Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.

Objective 6.2: Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

Objective 6.3: Develop and implement new safety technologies to reduce access to lethal means.

GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

Objective 7.1: Provide training on suicide prevention to community groups that have a role in the prevention of suicide and related behaviors.

Objective 7.2: Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.

Objective 7.3: Develop and promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.

Objective 7.4: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.

Objective 7.5: Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.

Strategic Direction 3: Treatment and Support Services

GOAL 8. Promote suicide prevention as a core component of health care services.

Objective 8.1: Promote the adoption of “zero suicides” as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.

Objective 8.2: Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.

Objective 8.3: Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.

Objective 8.4: Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.

Objective 8.5: Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.

Objective 8.6: Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.

Objective 8.7: Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.

Objective 8.8: Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid followup after discharge.

GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

Objective 9.1: Adopt, disseminate, and implement guidelines for the assessment of suicide risk among persons receiving care in all settings.

Objective 9.2: Develop, disseminate, and implement guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk.

Objective 9.3: Promote the safe disclosure of suicidal thoughts and behaviors by all patients.

Objective 9.4: Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for persons with suicide risk.

Objective 9.5: Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among patients receiving care for mental health and/or substance use disorders.

Objective 9.6: Develop standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs.

Objective 9.7: Develop guidelines on the documentation of assessment and treatment of suicide risk and establish a training and technical assistance capacity to assist providers with implementation.

GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

Objective 10.1: Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide, and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.

Objective 10.2: Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.

Objective 10.3: Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.

Objective 10.4: Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.

Objective 10.5: Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.

Strategic Direction 4: Surveillance, Research, and Evaluation

GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

Objective 11.1: Improve the timeliness of reporting vital records data.

Objective 11.2: Improve the usefulness and quality of suicide-related data.

Objective 11.3: Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.

Objective 11.4: Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.

GOAL 12. Promote and support research on suicide prevention.

Objective 12.1: Develop a national suicide prevention research agenda with comprehensive input from multiple stakeholders.

Objective 12.2: Disseminate the national suicide prevention research agenda.

Objective 12.3: Promote the timely dissemination of suicide prevention research findings.

Objective 12.4: Develop and support a repository of research resources to help increase the amount and quality of research on suicide prevention and care in the aftermath of suicidal behaviors.

GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

Objective 13.1: Evaluate the effectiveness of suicide prevention interventions.

Objective 13.2: Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.

Objective 13.3: Examine how suicide prevention efforts are implemented in different states/territories, tribes, and communities to identify the types of delivery structures that may be most efficient and effective.

Objective 13.4: Evaluate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.

Appendix B: Crosswalk of Goals and Objectives From 2001 to 2012

This appendix describes how the goals and objectives included in the 2001 National Strategy for Suicide Prevention (National Strategy) are addressed in the 2012 National Strategy. As noted in the Introduction, the goals and objectives have been updated, revised, and, in some cases, replaced to reflect advances in knowledge and areas where the proposed actions have been completed. For more information on the organization of the 2012 goals and objectives, see the Introduction section. For a list of the 2012 goals and objectives, see Appendix A.

GOAL OR OBJECTIVE		Notes	
2001		2012	
Goal 1	Increase awareness that suicide is a public health problem that is preventable.	Goal 2	The goal was expanded to address a broad range of communication efforts targeting various audiences.
1.1	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.	2.1 and 2.4	The objective was expanded to focus on changing the knowledge, attitudes, and behaviors of various audiences.
1.2	Establish regular national congresses on suicide prevention designed to foster collaboration with stakeholders on prevention strategies across disciplines and with the public.	1.1	The objective was revised to encourage the integration of suicide prevention into the values, culture, leadership, and work of a wide range of organizations and programs.
1.3	Convene national forums on issues likely to strongly influence effectiveness of suicide prevention messages.	N/A	Several organizations dedicated to suicide prevention conduct national meetings on a regular basis.
1.4	Increase the number of public and private institutions active in suicide prevention that are involved in collaborative dissemination of information on the World Wide Web.	2.3 and 4.3	The objective was modified to support an increase in all types of online communication efforts. The related Objective 4.3 focuses on guidelines addressing the safety of online content.
Goal 2	Develop broad-based support for suicide prevention.	Goal 1	The wording was revised: "Integrate and coordinate suicide prevention activities across multiple sectors and settings."
2.1	Expand Federal Steering Group (FSG) to improve federal coordination, help implement the NSSP, and coordinate future revisions.	Achieved and 1.3	The FSG was expanded and is now called the Federal Working Group. The objective was revised to focus on sustaining and strengthening federal collaborations.

GOAL OR OBJECTIVE		Notes	
2001		2012	
2.2	By 2002, establish public-private partnerships to advance and coordinate implementation of NSSP.	Achieved at national level and 1.4	The partnership was formed as the National Action Alliance for Suicide Prevention. The objective was expanded to support similar efforts at the state/territorial, tribal, and local levels.
2.3	Increase the number of national professional, voluntary, and other groups that integrate suicide prevention into ongoing programs and activities.	1.1	The objective now addresses the integration of suicide prevention into the values, culture, leadership, and work of a wide range of organizations and programs with a role to support suicide prevention activities.
2.4	Increase the number of nationally organized faith communities adopting institutional policies promoting suicide prevention.	1.1	(see above)
Goal 3	Goal 3: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.	Goal 3 and 3.2	The focus of the goal was broadened to promote greater knowledge of protective factors and of factors that promote wellness and recovery. Reducing prejudice and discrimination is addressed in Objective 3.2.
3.1	By 2005, increase the proportion of the public that views mental and physical health as equal and inseparable components of overall health.	3.2	Addressed in Objective 3.2, which focuses on reducing the prejudice and discrimination associated with suicide and suicide-related behaviors.
3.2	By 2005, increase the proportion of the public that views mental disorders as real illnesses that respond to specific treatments.	3.2 and 3.3	(see above) Also addressed in Objective 3.3, which focuses on promoting the understanding that recovery from mental and substance use disorders is possible.
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.	3.2 and 3.3	(see above)
3.4	By 2005, increase the proportion of those suicidal persons with underlying disorders who receive appropriate mental health treatment.	8.3	The new Objective 8.3 promotes timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.

GOAL OR OBJECTIVE		Notes	
2001		2012	
Goal 4	Develop and implement community-based suicide prevention programs.	Goal 5	The revised goal addresses the development, implementation, and monitoring of programs that promote wellness and prevent suicide and related behaviors.
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 their communities.	5.1	Nearly all states have a suicide prevention plan, but there is much variation among plans. Objective 5.1 supports improvements to the plans.
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.	5.2	The new Objective 5.2 includes programs conducted in various settings, including schools, which were previously addressed in separate objectives.
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.	5.2	(see above)
4.4	By 2005, increase the proportion of employers that ensure the availability of evidence-based prevention strategies for suicide.	5.2	(see above)
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.	5.2	(see above)
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.	5.2	(see above)
4.7	By 2005, increase the proportion of family, youth, and community service providers and organizations with evidence-based suicide prevention programs.	5.2	(see above)

GOAL OR OBJECTIVE				Notes
2001		2012		
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.	Achieved		The Suicide Prevention Resource Center was established in 2002.
Goal 5	Promote efforts to reduce access to lethal means and methods of self-harm.	Goal 6		The goal was revised to focus on reducing access to lethal means and methods among individuals with suicide risk.
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.	6.1		The wording was revised: "Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means."
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.	2.1		Public information campaigns and other communications efforts, including those addressing lethal means, are discussed in Objective 2.1.
5.3	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.	3.2 and 3.3		This is now addressed in Objective 3.2, which focuses on reducing prejudice and discrimination associated with behavioral health disorders, and in Objective 3.3, which focuses on promoting the understanding that recovery is possible.
5.4	By 2005, develop guidelines for safer dispensing of medications for individuals at heightened risk of suicide.	7.3		The objective is covered in Objective 7.3, which promotes the development and adoption of training guidelines for all health professions.
5.5	By 2005, improve automobile design to impede carbon monoxide-mediated suicide.	6.3		The objective was broadened to address all types of safety technologies.
5.6	By 2005, institute incentives for the discovery of new technologies to prevent suicide.	6.3		(see above)

GOAL OR OBJECTIVE		Notes	
2001		2012	
Goal 6	Implement training for recognition of at-risk behavior and delivery of effective treatment.	Goal 7	The wording was revised: "Provide training to community and clinical service providers on the prevention of suicide and related behaviors."
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.	7.3	The objective was broadened to address the education and training in all health professions and to include graduate and continuing education.
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.	7.3	(see above)
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.	7.3	(see above)
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.	7.1	The new Objective 7.1 addresses the training of all community providers.
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.	7.1	(see above)
6.6	By 2005, increase the proportion of correctional workers who have received training on identifying and responding to persons at risk for suicide.	7.1	(see above)

GOAL OR OBJECTIVE			Notes
2001		2012	
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.	7.1	(see above)
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.	7.1	(see above)
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.	7.4	The objective was revised to promote the adoption of core education and training guidelines on the prevention of suicidal self-directed violence and related behaviors by credentialing and accreditation bodies.
Goal 7	Develop and promote effective clinical and professional practices.	Goal 8	The goal was revised to promote suicide prevention as a core component of health care services.
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.	8.4	The objective was revised to promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.
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.	9.1	The objective was broadened to address the adoption of guidelines for the assessment of suicide risk among persons receiving care in all settings.
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.	9.5	The wording was revised: "Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among patients receiving care for mental and/or substance use disorders."
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.	9.2	The objective was broadened to address guidelines for clinical practice and continuity of care for all providers who treat persons with suicide risk.

GOAL OR OBJECTIVE		Notes	
2001		2012	
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.	10.5	The objective was slightly revised: "Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide."
7.6	By 2005, increase the proportion of patients with mood disorders who complete a course of treatment or continue maintenance treatment as recommended.	8.3	Addressed in Objective 8.3, which focuses on promoting timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.
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.	8.3	(see above)
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.	9.4	The wording was revised: "Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for persons with suicide risk."
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 health care programs (e.g., Medicaid, CHAMPUS/TRICARE, CHIP, Medicare).	N/A	Screening for depression and alcohol misuse have now been endorsed by the United States Preventative Services Task Force (USPSTF) and are now covered as preventative services under Medicare. The PHQ-9 has been incorporated into the CMS Minimum Data Set for nursing home assessment.
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.	N/A	Screening for depression and alcohol misuse have now been endorsed by the USPSTF and are now covered as preventative services under Medicare.

GOAL OR OBJECTIVE		Notes	
2001		2012	
Goal 8	Improve access to and community linkages with mental health and substance abuse services.	8.6, 8.7, and 8.8	Objective 8.6 addresses linkages between behavioral health service providers and community-based programs. Objective 8.7 addresses coordination between behavioral health systems and local crisis centers. Objective 8.8 addresses collaborations between emergency departments and other health care providers.
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.	5.4 and 1.5	Parity laws are addressed in Objective 5.4, which supports efforts to increase access to and delivery of effective programs and services for mental and substance use disorders. Objective 1.5 promotes the integration of suicide prevention into all relevant health care reform efforts.
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.	8.3	Covered in Objective 8.3, which promotes timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.
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.	N/A	The revised objectives are broad and not focused on specific settings or populations.
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.	N/A	(see above)
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.	N/A	(see above)

GOAL OR OBJECTIVE			Notes
2001		2012	
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.	N/A	(see above)
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.	10.1	The wording was revised: “Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.”
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.	Goal 8, 8.5	The incorporation of suicide prevention into continuous quality improvement efforts is an important theme in Goal 8 and is addressed in Objective 8.5.
Goal 9	Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.	Goal 4	Reworded to include online content: “Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.”
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.	4.2	Recommendations regarding accurate and responsible depictions have been developed. The objective was revised to encourage and recognize members of the entertainment media who follow the recommendations.
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.	4.2	(see above)
9.3	By 2005, increase the proportion of news reports on suicide that observe consensus reporting recommendations.	4.1	Recommendations regarding reporting have been developed. The objective was revised to encourage their use.

GOAL OR OBJECTIVE				Notes
2001		2012		
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.	4.4		The objective was broadened to include mass communication schools.
Goal 10	Promote and support research on suicide and suicide prevention.	Goal 12		Promote and support research on suicide prevention.
10.1	By 2002, develop a national suicide research agenda with input from survivors, practitioners, researchers, and advocates.	12.1 and 12.2		The Action Alliance's Research Prioritization Task Force is developing a national research agenda. The new Objective 12.2 addresses the dissemination and use of the research agenda.
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.	13.1 and 13.2		Objective 13.1 supports the evaluation of suicide prevention interventions. Objective 13.2 promotes the assessment, synthesis, and dissemination of the evidence obtained via these evaluations.
10.3	By 2005, establish and maintain a registry of prevention activities with demonstrated effectiveness for suicide or suicidal behaviors.	12.3 and 12.4		A best practices registry has been established by the Suicide Prevention Resource Center. The new Objective 12.3 focuses on the timely dissemination of suicide prevention research findings. The new Objective 12.4 focuses on the development of a repository of research resources.
10.4	By 2005, perform scientific evaluation studies of new or existing suicide prevention interventions.	13.1 and 13.2		Objective 13.1 supports the evaluation of suicide prevention interventions. Objective 13.2 promotes the assessment, synthesis, and dissemination of the evidence obtained via these evaluations.
Goal 11	Improve and expand surveillance systems.	Goal 11		The wording was revised: "Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention, and improve the ability to collect, analyze, and use this information for action."
11.1	By 2005, develop and refine standardized protocols for death scene investigations and implement these protocols in counties (or comparable jurisdictions).	11.2		Addressed in Objective 11.2, focuses on improving the usefulness and quality of suicide-related data.

GOAL OR OBJECTIVE		Notes	
2001		2012	
11.2	By 2005, increase the proportion of jurisdictions that regularly collect and provide information for follow-back studies on suicides.	11.2	(see above)
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.	11.2	(see above)
11.4	By 2005, implement a National Violent Death Reporting System (NVDRS) that includes suicides and collects information not currently available from death certificates.	11.3	NVDRS, a state-based surveillance system that collects facts from different sources about the same incident, has been established by the Centers for Disease Control and Prevention, and currently operates in several states. The expansion of NVDRS is referenced in Objective 11.3.
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.	11.3	The objective was broadened to promote the improvement and expansion of state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.
11.6	By 2005, increase the number of nationally representative surveys that include questions on suicidal behavior.	11.4	The objective was broadened to address other data collection instruments and systems, and to include questions on risk factors and exposure to suicide.
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 law enforcement agencies, emergency medical services, and hospitals.	11.3	Addressed in Objective 11.3, which seeks to expand the capacity to collect, analyze, report, and use suicide-related data.

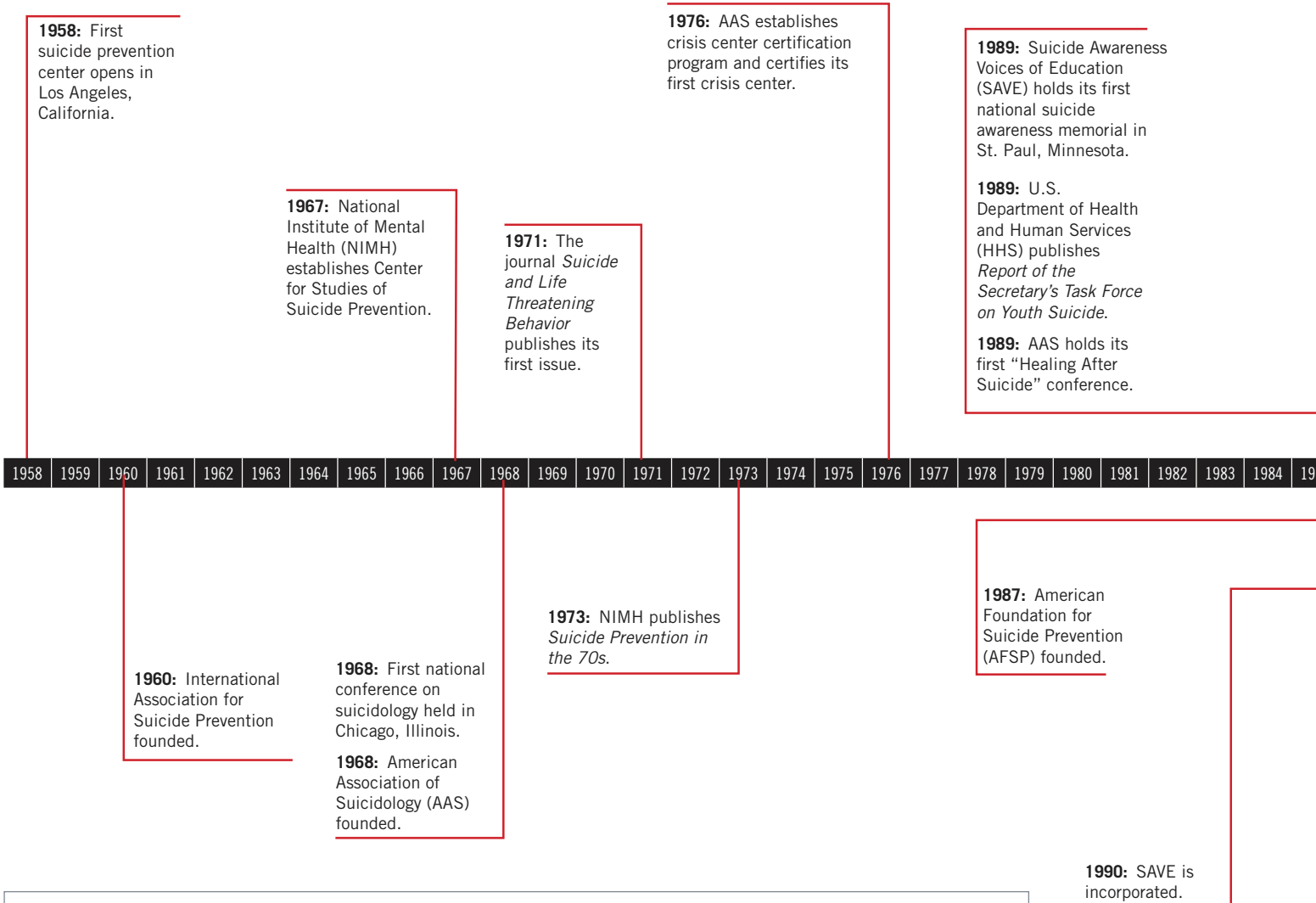
New objectives added in 2012:

- Objective 1.2: Establish effective, sustainable, and collaborative suicide prevention programming at the state/territorial, tribal, and local levels.
- Objective 2.2: Reach policymakers with dedicated communication efforts.
- Objective 3.1: Promote effective programs and practices that increase protection from suicide risk.
- Objective 5.3: Intervene to reduce suicidal thoughts and behaviors in populations with suicide risk.
- Objective 7.2: Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior and the delivery of effective clinical care for people with suicide risk.
- Objective 8.1: Promote the adoption of “zero suicides” as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.
- Objective 8.2: Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.
- Objective 8.5: Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.
- Objective 9.3: Promote the safe disclosure of suicidal thoughts and behaviors by all patients.
- Objective 9.6: Develop standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs.

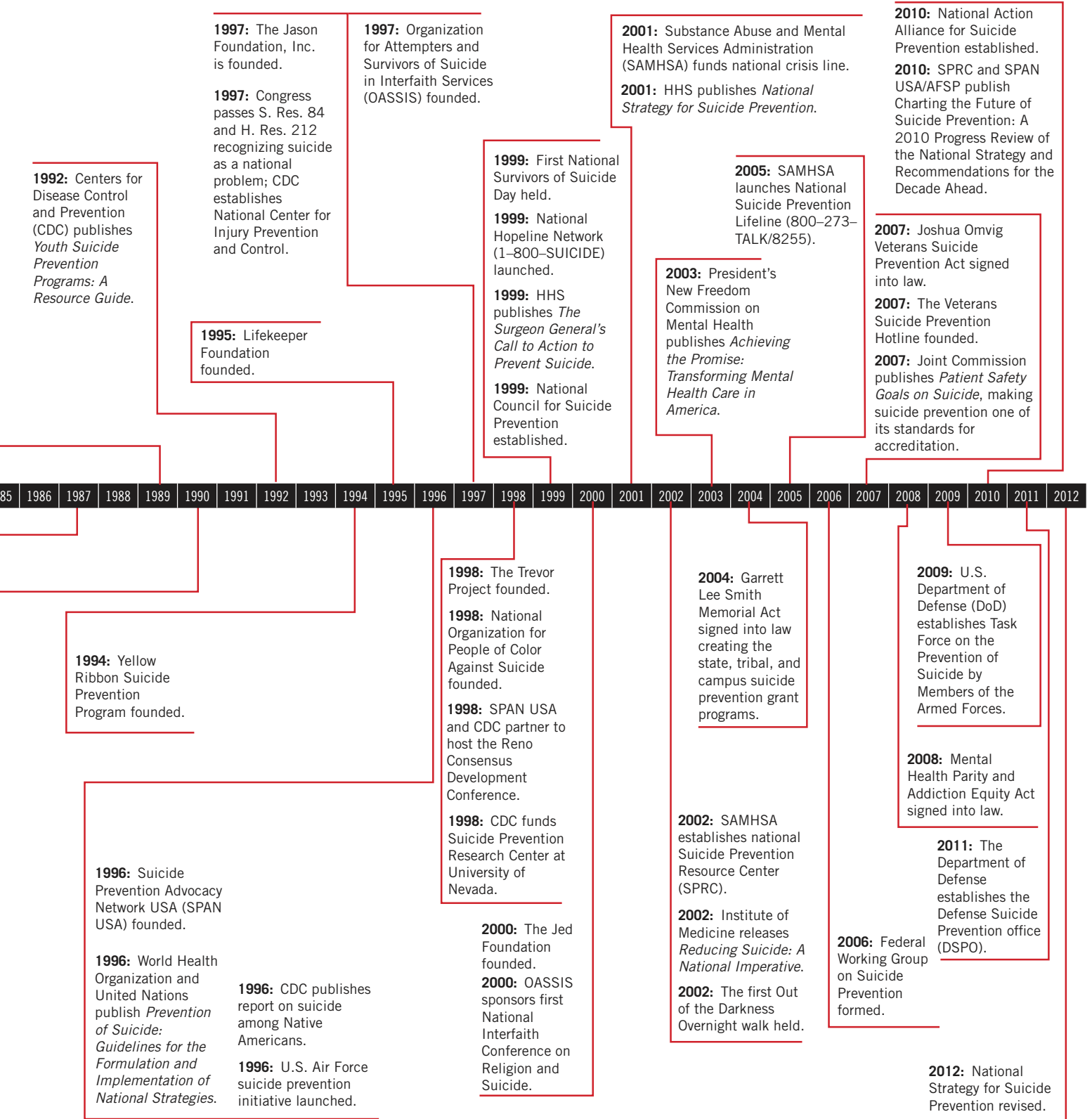
- Objective 9.7: Develop guidelines on the documentation of assessment and treatment of suicide risk, and establish a training and technical assistance capacity to assist providers with implementation.
- Objective 10.2: Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.
- Objective 10.3: Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.
- Objective 10.4: Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.
- Objective 12.2: Disseminate the national suicide prevention research agenda.
- Objective 13.3: Examine how suicide prevention efforts are implemented in different states/territories, tribes, and communities to identify the types of delivery structures that may be most efficient and effective.
- Objective 13.4: Evaluate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.

Appendix C: Brief History of Suicide Prevention in the United States

NATIONAL MILESTONES IN SUICIDE PREVENTION



Suicide prevention efforts in the United States started in the 1950s, through the pioneering efforts of a small group of dedicated clinicians interested in better understanding suicide and its prevention. These early efforts were expanded upon in the 1980s with the support and passion of individuals who had been bereaved by a suicide loss. With limited funding and formal organization, these individuals and their grassroots organizations set out to place suicide on the national agenda. Their combined efforts over time culminated with the release of the 2001 National Strategy for Suicide Prevention. These dedicated advocates, organizations, and communities have remained at the forefront of suicide prevention activities nationwide.



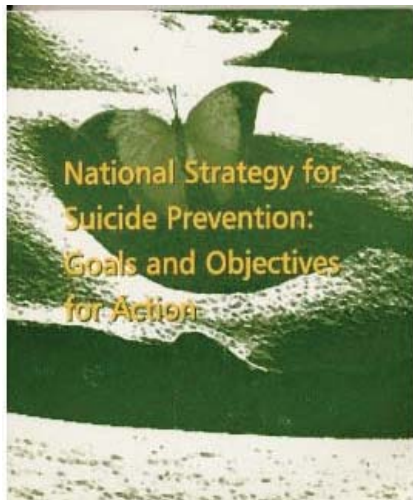
First Steps

In 1958, the first suicide prevention center in the United States opened in Los Angeles, California, with funding from the U.S. Public Health Service. Other crisis intervention centers followed. In 1966, the Center for Studies of Suicide Prevention (later the Suicide Research Unit) was established at the National Institute of Mental Health (NIMH) of the National Institutes of Health (NIH). This was followed by the creation of national nonprofit organizations dedicated to the cause of suicide prevention.

In 1970, NIMH convened a task force in Phoenix, Arizona, to discuss the status of suicide prevention in the United States. NIMH presented the findings in the 1973 report *Suicide Prevention in the 70s*, which also identified future directions and priorities.¹¹¹ In 1983, the Centers for Disease Control and Prevention (CDC) established a violence prevention unit that brought public attention to a disturbing increase in youth suicide rates. In response, the Secretary of the U.S. Department of Health and Human Services (HHS) established a Task Force on Youth Suicide, which reviewed the existing evidence and issued recommendations in 1989.¹¹²

The Push for a National Strategy

Suicide became a central issue in the United States in the mid-1990s, when survivors of suicide loss saw the need to mobilize attention and the political will to prevent suicide in the nation. Using the United Nations (U.N.) guidelines for the creation and implementation of national strategies published in 1996,⁵³ these grassroots groups launched a citizen-initiated campaign to encourage the development of a



national strategy in the United States. These efforts resulted in two Congressional Resolutions—S. Res. 84 and H. Res. 212 of the 105th Congress—recognizing suicide as a national problem and suicide prevention as a national priority.

As recommended in the U.N. guidelines, these groups set out to establish a public and private partnership that would be responsible for promoting suicide prevention in the United States. This innovative public-private partnership jointly sponsored a national consensus conference on suicide prevention in Reno, Nevada, which developed a list of 81 recommendations.

The Reno conference is viewed as the founding event of the modern suicide prevention movement. Informed by its findings, in 1999, Surgeon General David Satcher issued his *Call to Action to Prevent*

Suicide, which emphasized suicide as a serious public health problem requiring attention and action.⁵ This document introduced a blueprint for addressing suicide prevention through a number of efforts organized under the framework of “Awareness, Intervention, and Methodology” (AIM). It included 15 broad recommendations consistent with a public health approach to suicide prevention, along with goal statements and broad objectives.

Key Points From Reno, Nevada, Conference

1. Suicide prevention must recognize and affirm the value, dignity, and importance of each person.
2. Suicide is not solely the result of illness or inner conditions. The feelings of hopelessness that contribute to suicide can stem from societal conditions and attitudes. Therefore, everyone concerned with suicide prevention shares a responsibility to help change attitudes and eliminate the conditions of oppression, racism, homophobia, discrimination, and prejudice.
3. Some groups are disproportionately affected by these societal conditions, and some are at greater risk for suicide.
4. Individuals, communities, organizations, and leaders at all levels should collaborate to promote suicide prevention.
5. The success of this strategy ultimately rests with individuals and communities across the United States.

A year later, the HHS Secretary formed a Federal Steering Group to coordinate efforts and ensure resources for the development of the national strategy. The group brought together individuals and organizations from the public and private sectors to collaborate in this effort and sought input through four strategically located national public hearings. These efforts culminated with the release of the *National Strategy for Suicide Prevention* in 2001.⁶

The National Strategy for Suicide Prevention (National Strategy) set forth an ambitious agenda, consisting of 11 goals and 68 objectives, organized under the AIM framework described in the Surgeon General's *Call to Action*. The document was meant to serve as a wide-ranging “catalyst for social change, with the power to transform attitudes, policies, and services (p. 27).”⁶ For the broader suicide prevention community, the National Strategy provided a common point of reference and a resource for advocacy at the state and local levels, while directing more attention to the needs of those affected by suicide.

Key Developments and Accomplishments

In the years that followed, several other key developments helped advance suicide prevention in the nation. Among these was the 2002 report *Reducing Suicide: A National Imperative*, which summarized the state of the science base, gaps in knowledge, strategies for prevention, and research designs for the study of suicide.⁹ This landmark report presented findings from a 13-member committee formed by the Institute of Medicine in 2000, at the request of several federal agencies.

Another important document was the 2003 report *Achieving the Promise: Transforming Mental Health Care in America*, prepared by the New Freedom Commission on Mental Health.¹¹³ Assembled by President George W. Bush in 2002, the commission was asked to study the mental health service delivery system, and to make recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbances to live, work, learn, and participate fully in their communities. After 1 year of study, and after reviewing research and testimony, the group issued its final report, which identified six goals and corresponding recommendations.

Activity in the field of suicide prevention has grown dramatically since the National Strategy was issued in 2001. Government agencies at all levels, schools, nonprofit organizations, and businesses have started programs to address suicide prevention. *Charting the Future of Suicide Prevention*, a progress report commissioned by the Substance Abuse and Mental Health Services Administration (SAMHSA) and released in October 2010, discusses many of these accomplishments.⁷

Federal Policy Initiatives

Enacted in 2004, the Garrett Lee Smith Memorial Act (GLSMA) is the most important legislative accomplishment in the field of youth suicide prevention in the past decade. The act was named for Sen. Gordon Smith's (R-OR) son, a college student who died by suicide in late 2003. The GLSMA created the first significant federal grant program directed specifically at suicide prevention. Administered by SAMHSA, the program provides grants to states, tribes, territories, and institutions of higher education for the implementation of youth and college suicide prevention efforts. More than 300 GLSMA suicide prevention grants have been funded since the program's inception, including 27 grants funded through the Prevention and Public Health Fund created by the Affordable Care Act.

Another federal law, the Joshua Omvig Veterans Suicide Prevention Act (JOVSPA) of 2007, has supported the development of a comprehensive program to reduce the incidence of suicide among veterans. Named for a veteran of Operation Iraqi Freedom who died by suicide in 2005, the act directed the Secretary of the U.S. Department of Veterans Affairs (VA) to implement a comprehensive suicide prevention program for veterans. Components include staff education, mental health assessments as part of overall health assessments, a suicide prevention coordinator at each VA medical facility, research efforts, 24-hour mental health care, a toll-free crisis line, and outreach to and education for veterans and their families. In the summer of 2009, VA added a one-to-one "chat service" for veterans who prefer to reach out for assistance using the Internet.

Program Initiatives

In 2001, SAMHSA established the country's first program with the mission of effectively reaching and serving all persons at risk of suicide in the United States through a national network of local, certified crisis call centers. This program, now called the National Suicide Prevention Lifeline (800-273-TALK/8255) serves as a central switchboard, seamlessly connecting callers to a crisis center geographically nearest the caller from among a national network of more than 150 crisis centers in 49 states. It provides services in English and Spanish, 24 hours a day, 7 days a week. It also includes a feature allowing callers to press "1" and be connected to a VA crisis center. The Lifeline also operates a website (www.suicidepreventionlifeline.org) and works closely with social networking websites. In October 2011, the Lifeline answered its 3 millionth call.

The Lifeline used evaluation results to introduce best practice standards used across the network. To improve service quality, SAMHSA funded two evaluations of network crisis center practices in 2003-04. These evaluations culminated in groundbreaking findings for the field, released in 2005 and published in 2007.^{114, 115} These findings demonstrated both effective crisis center practices (e.g., significant reductions in caller distress and suicidal risk) and needs for improvement (e.g., better risk assessment, more uniform approaches for callers at imminent risk of suicide, a need to monitor calls and more follow up with callers).

The creation of the first national resource center on suicide prevention was another important accomplishment. Established by SAMHSA in 2002, the Suicide Prevention Resource Center (SPRC) conducts a broad range of activities intended to improve the development, implementation, and evaluation of suicide prevention programs and practices. The center disseminates information, products, and services to various audiences through its website (www.sprc.org), online and face-to-face training programs, webinars, and direct consultation and support from its expert staff. SPRC also maintains an online library and clearinghouse of suicide prevention information and a registry of evidence-based programs and best practice recommendations.

The 2001 National Strategy specifically called for the creation of a national violent death reporting system to gather information from several data sources that were not otherwise linked. In Fiscal Year 2002, Congress appropriated funds for the development and implementation of the National Violent Death Reporting System (NVDRS). Originally implemented in six states, the system was extended to a total of 18 states in Fiscal Year 2009, via a congressional appropriation of \$3.5 million. The system collects data on violent deaths from four primary sources: death certificates, police reports, medical examiner and coroner reports, and crime laboratories. Data are available for public use through the Web-Based Injury Statistics Query and Reporting System (WISQARS, at www.cdc.gov/injury/wisqars/index.html).

The 2001 National Strategy also called for the development of comprehensive state suicide prevention plans that would coordinate across government agencies; involve the private sector; and support plan development, implementation, and evaluation in communities. Today, nearly all states have a suicide prevention plan in place and some have formed public-private partnerships to advance their plans. Although these suicide prevention plans vary in terms of the groups they serve, involvement of the private

sector, and resources available for services, their development represents an important first step and achievement in the field of suicide prevention.

Recent Developments

Recent milestones in the history of suicide prevention in the United States include the formation of the National Action Alliance for Suicide Prevention, in 2010, and the revision of the National Strategy in 2012. These milestones represent continuing progress toward the prevention of suicide in this country. For more on these recent developments, see the Introduction section.

Appendix D: Groups With Increased Suicide Risk

As noted in the Introduction, many factors make it difficult to identify the subgroups of the population that may have an increased risk for suicidal behaviors. Risk and protective factors are varied, interact in different ways, and may change over time. Some risk and protective factors may be more important to one group than to another. The types of suicidal behaviors that are most common also vary across groups. For example, suicide rates may be particularly high in some groups, but suicide attempts may be more common in others. In addition, limitations associated with the collection of suicide-related data can also make it difficult to obtain prevalence estimates for specific groups.

This appendix provides information on suicide risk among the following groups, which have been identified as being at a higher risk for suicidal behaviors than the general population:

- American Indians/Alaska Natives;
- Individuals bereaved by suicide;
- Individuals in justice and child welfare settings;
- Individuals who engage in nonsuicidal self-injury (NSSI);
- Individuals who have attempted suicide;
- Individuals with medical conditions;
- Individuals with mental and/or substance use disorders;
- Lesbian, gay, bisexual, and transgender (LGBT) populations;
- Members of the Armed Forces and veterans;
- Men in midlife; and
- Older men.

Additional information on these groups is available from the Suicide Prevention Resource Center's (SPRC) online library (www.sprc.org/search/library). For evidence-based and best practices programs and guidelines, please visit the National Registry of Evidence-Based Programs and Practices (www.nrepp.samhsa.gov), and the Best Practices Registry for Suicide Prevention (www.sprc.org/bpr). General resources on suicide prevention are listed in Appendix E.

American Indians/Alaska Natives

In 2009, the suicide rate among American Indians/Alaska Natives (AI/AN) was 11.91 per 100,000, which is similar to the overall U.S. rate of 11.77.¹ However, suicide rates are much higher among AI/AN youth than among youth overall. In 2009, the rate of suicide among AI/AN youth aged 10 to 18 years was 10.37 per 100,000, compared with an overall rate of 3.95 per 100,000.¹ Suicide is the second leading cause of death among AI/AN youth aged 10 to 34 years, with young Native men aged 20 to 24 having the highest rate of

suicide in the AI/AN population: 40.79 deaths per 100,000.¹ Although suicide rates vary widely among individual tribes, it is estimated that 14 to 27 percent of AI/AN adolescents have attempted suicide.²¹⁻²³

Research indicates that cultural continuity,¹¹⁶ high levels of cultural spiritual orientation,¹¹⁷ and connectedness to family and friends²¹ are protective factors for suicidal behaviors among AI/AN populations. Specific risk factors particular to this group include alcohol and other substance use,¹¹⁸ discrimination,^{119, 120} limited mental health services access and use,^{121, 122} and historical trauma.^{123, 124} Findings from the Adverse Childhood Experiences (ACE) study suggest that there is a strong and positive correlation between the number of adverse events in a child's life and the probability for negative outcomes during adulthood.¹²⁵ In reservation settings, AI/AN youth have considerable exposure to suicide and may be at particular risk for contagion.¹²⁶ Much of the research available on AI/AN racial and ethnic disparities does not include urban (non-reservation) areas, where a majority (78 percent) of Native people in the United States live.¹²⁷ Compared with other racial and ethnic groups, few resources are devoted to the health needs of the urban AI/AN population,¹²⁸ and many have experienced losses of community, language, and ethnic identity.¹²⁹

Several federal initiatives, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) Garrett Lee Smith and Native Aspirations programs and the Indian Health Service (IHS) Methamphetamine and Suicide Prevention Initiative, support suicide prevention efforts among AI/AN populations. AI/AN communities have implemented a range of culturally specific prevention and intervention approaches to address the holistic needs of families and individuals affected by suicide and other health disparities. These efforts include reducing risk behaviors (e.g., substance use, bullying, violence) and promoting protective factors (e.g., cultural practices, community connectedness and healing, improved access to appropriate services, skills enhancement). Recent efforts have included the development of crisis response protocols aimed at ensuring that available services and traditional supports are interconnected. Many tribes have also adapted mainstream suicide prevention programs, including trainings, crisis lines, mentoring, and school-based programs, for use in local AI/AN communities.

Many efforts are underway to better document the effectiveness of these holistic approaches in Native communities. A comprehensive, public health-based prevention program in a southwestern tribal community showed significant reduction in suicidal acts among youth.⁶⁴ The American Indian Life Skills Development program, a school-based curriculum for AI/AN youth aged 14 to 19, showed reductions in feelings of hopelessness and increases in problem-solving skills.¹³⁰ Positive youth development programs, such as Project Venture, while recognized as an evidence-based approach for substance use prevention, also showed positive results in terms of suicide prevention. Many of the specific tactics that suicide prevention research points to as effective (e.g., increased social integration, connection building) have been a part of Project Venture for 20 years.¹³¹

Community-based surveillance systems, such as the one developed by the White Mountain Apache, demonstrate that tribal-specific surveillance can identify unique risk and protective factors for particular

populations to guide local suicide prevention programs.^{132, 133} Practice-based evidence also plays an important role and complements evidence-based practices in addressing suicide and other health issues among AI/AN populations.

Resources

Adolescent Suicide Prevention Program Manual: A Public Health Model for Native American Communities, 2011

SPRC

www.sprc.org/library/AdolescentSP_ProgramManuaPH_ModelNA_Communities.pdf

The Adolescent Suicide Prevention Program (1989–2005) significantly lowered youth suicide rates in a Native community in the Southwest United States. This manual outlines methods for community involvement, culturally framed public health approaches, outreach efforts, behavioral health programs, program evaluation, and sustainability.

AI/AN National Suicide Prevention Strategic Plan (2011–2015), August 2011

IHS, U.S. Department of Health and Human Services (HHS)

www.ihs.gov/MedicalPrograms/Behavioral/documents/AIANNationalSPStrategicPlan.pdf

This strategic plan provides a comprehensive and integrated approach to reducing the loss and suffering that result from suicidal behaviors among the AI/AN population.

Ensuring the Seventh Generation: A Youth Suicide Prevention Toolkit for Tribal Child Welfare Programs, 2009

National Indian Child Welfare Association (NICWA)

www.nicwa.org/YouthSuicidePreventionToolkit/YSPToolkit.pdf

This toolkit for tribal child welfare workers and care providers discusses risk factors, warning signs, prevention and intervention strategies that can be applied in child welfare agencies, and mobilization of support networks for particular children.

Indian Health Service American Indian/Alaska Native Suicide Prevention Website

www.ihs.gov/NonMedicalPrograms/nspn

This website provides AI/AN communities with culturally appropriate information about best and promising practices, training opportunities, tools for adapting mainstream programs to tribal needs, ongoing activities, potential partnerships, and other information regarding suicide prevention and intervention.

SPRC American Indian/Alaska Native Suicide Prevention Pages

www.sprc.org/aian

These web pages offer information on suicide prevention in AI/AN communities, including local and promising practices, sustaining efforts, resources, publications, and data sources.

To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults, 2010

SAMHSA, HHS

www.sprc.org/library/Suicide_Prevention_Guide.pdf

This guide supports AI/AN communities in developing effective, culturally appropriate, and comprehensive suicide prevention planning and postvention responses for youth and young adults.

Individuals Bereaved by Suicide

The impact of suicide can be profound and sometimes devastating for those who are left behind. Each year, more than 13 million people in the United States report that they have known someone who died by suicide that year.¹³⁴ Conservative estimates suggest that there are typically at least five or six family members who are affected when a family member takes his or her life, and perhaps as many as 30 to 60 people in the larger social network who also may be affected.¹³⁵ Moreover, exposure to suicide carries risks for elevated rates of guilt, depression, and other psychiatric symptoms, complicated grief, and social isolation. Alarming, there is also compelling evidence that individuals bereaved by suicide (also referred to as “survivors of suicide loss”) may have an increased risk for suicide completion themselves.³⁹ Therefore, to paraphrase Edwin Shneidman, helping those who have been bereaved by suicide is a direct form of suicide prevention with a population known to be at risk.

In the years since the National Strategy was released, the movement to support individuals bereaved by suicide has intensified significantly. Innovative grassroots community programs have formed outreach teams who visit the newly bereaved at home, face-to-face, and through online support groups, annual memorial services, survivor conferences, and other types of innovative support services. National organizations such as the American Foundation for Suicide Prevention (AFSP), Suicide Awareness Voices of Education (SAVE), and the American Association of Suicidology (AAS) have also increased their efforts to provide help and comfort to those bereaved by suicide. Examples include AFSP’s International Survivors of Suicide Day gatherings around the country and the Survivor Conference within the AAS annual meeting.

Despite these commendable efforts, research suggests that many individuals who have been bereaved by suicide experience difficulty mobilizing themselves to seek help, knowing where to find services in their communities, and knowing how to cope when the services are inadequate to meet their diverse and complicated needs.¹³⁶ The lack of services may include an absence of information about where to find resources, a scarcity of peer-to-peer opportunities to interact with other survivors in a safe and facilitated setting, and a dearth of mental health professionals who have the training and experience to work effectively with the special needs of this population.

As has happened in other nations, coordinated leadership at the national, state/territorial, tribal, and local levels will be needed to build a support infrastructure for people bereaved by suicide. Several goals for services can be identified. Every person bereaved by suicide should receive compassionate care from first

responders (e.g., police, emergency medical professionals, clergy, funeral professionals) and should receive information about where to get additional help if and when he or she is ready to seek it. As different people will use different types of resources, often at different points in their grieving process, a second goal should encompass the development of a variety of support services within local communities. These include, but are not limited to, educational and self-help literature about grief after suicide, survivor outreach teams, face-to-face and online support groups, and referral assistance in finding clinicians who understand grief, trauma, and the special problems of those who have been bereaved by suicide. Increased education about the impact of suicide and the needs of the bereaved by suicide should be included in the training of first responders and mental health and substance use professionals. And lastly, the national suicide research agenda should include studies that will expand knowledge of the impact of suicide on those left behind, and of interventions that will be effective in helping a diverse range of people who are exposed to the sometimes overwhelming impact of suicide.³⁹

Resources

American Association of Suicidology (AAS)

www.suicidology.org/web/guest/suicide-loss-survivors

The survivor pages on the AAS website include the e-newsletter *Surviving Suicide*, a directory of survivor support groups, a resource list, and materials for clinicians who have lost a patient and/or family member to suicide. AAS has also produced the *SOS Handbook*, a quick reference booklet for suicide survivors.

American Foundation for Suicide Prevention (AFSP)

www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=742A015C-D811-979A-AB84379C813F8D93

AFSP reaches out to those who have been bereaved by suicide to offer support and to provide opportunities for them to get involved in educational, outreach, awareness, advocacy, and fundraising programs. It sponsors International Survivors of Suicide Day, a global observance where individual communities host awareness events. It also offers peer support resources, such as an e-network, a support groups directory, and the Survivor Outreach Program.

Lifeline Gallery: Stories of Hope and Recovery

www.lifeline-gallery.org

This website, which is part of the National Suicide Prevention Lifeline (800-273-TALK/8255), includes a section where those who have been bereaved by suicide can share with others their experiences of how the death by suicide of a loved one affected them, their family, and their community.

Suicide Awareness Voices of Education (SAVE)

http://www.save.org/index.cfm?fuseaction=home.viewPage&page_id=EB883CA2-7E90-9BD4-C5E35440BC7761EE

SAVE's website survivor section provides information on coping with suicide loss, talking with children about suicide, and responding to person who has been bereaved by suicide, as well as networking resources such as a survivor groups directory and the Bereavement Caregiver Blog. Its print materials include the booklet *Suicide: Coping With the Loss of a Friend or Loved One* and the book *Suicide Survivors: A Guide For Those Left Behind*.

The Link Counseling Center

www.thelink.org

The Link provides services and support to those who have lost a loved one to suicide, including workshops, resource materials, telephone counseling, information and referrals, and trainings for survivors and professionals on creating and facilitating support groups for survivors.

Individuals in Justice and Child Welfare Settings

Suicide is often the single most common cause of death in secure justice settings.³² More than 400 suicides occur annually in local jails at a rate three times greater than among the general population, and suicide is the third leading cause of death in prisons.³³⁻³⁵ Youth involved in the juvenile justice and child welfare systems have a high prevalence of many risk factors for suicide. Although statistics on prevalence are unavailable, juveniles in confinement have life histories that put them at higher suicide risk, including experiences such as mental disorders and substance abuse; physical, sexual, and emotional abuse; and current and prior self-injurious behavior.¹³⁷ Youth in foster care share many of these traumatic experiences. In one study, children in foster care were almost three times more likely to have considered suicide and almost four times more likely to have attempted suicide than those who had never been in foster care.³⁷ Suicide among youth in contact with the juvenile justice system occurs at a rate about four times greater than the rate among youth in the general population.¹³⁸⁻¹⁴³ Research suggests that youth engage in more than 17,000 incidents each year in juvenile facilities, that more than half of all detained youth reported current suicidal ideation, and that one-third also had a history of suicidal behaviors.^{144, 145}

Risk factors for suicide among both juvenile and adult inmates include: a history of or existing mental illness and substance abuse; a history of suicidal behaviors; lack of mental health care; a history of abuse (e.g., emotional, physical, sexual); family discord/abuse; impulsive aggression; a history of interpersonal conflict; prior involvement in special education; legal/disciplinary problems; family history of suicide; poor family support; prior offenses; referral to juvenile court; and coming from a single-parent home.^{139-143, 146} Protective factors against suicide among juvenile and adult inmates include: a sense of control over one's own destiny; problem-solving and conflict resolution skills; adaptable temperament; support from and connections to family and community; positive school or employment experience; specific plans for the future; religious/spiritual/cultural beliefs that protect against suicide; housing that is "suicide-resistant" (i.e., free of protruding objects and means/methods for suicide) and that is proximal to staff and peers; and availability of mental health services that are provided consistently by qualified, trained, and supportive staff who provide strong community linkages and referrals and ensure continuity of care.^{21, 143, 147}

Experts theorize that jail suicides may have two primary causes: (1) jail environments are conducive to suicidal behaviors; and (2) the inmate faces a crisis situation.¹⁴⁸ Studies conducted by the National Center on Institutions and Alternatives and commissioned by the U.S. Department of Justice (DoJ) recommend that all sites develop and implement comprehensive policies and programming addressing suicide prevention, intervention, and care in the aftermath of a suicide death or attempt. These policies and programs should include: initial and annual training for all direct care, medical, and mental health personnel; initial intake and ongoing assessment of incarcerated persons; enhanced communication along the continuum of justice system; levels of supervision for persons at risk of self-harm and suicide; appropriate suicide-resistant housing; intervention; reporting; mortality/morbidity incident review; and critical incident stress debriefing.¹⁴⁶ Because inmates can be at risk for suicide at any point during confinement, the biggest challenge for those who work in the justice system is to view the issue as requiring a continuum of comprehensive suicide prevention services aimed at the collaborative identification, continued assessment, and safe management of individuals at risk for suicidal behaviors.

A dramatic reduction in the rate of suicide within county jails throughout the United States in the past 20 years has been attributed to increased staff training, better identification of inmates who may be at risk for suicidal behaviors, and the implementation of comprehensive programming.³² Recent efforts for suicide prevention for youth involved in the juvenile justice system include: targeting state-level juvenile justice agency directors/administrators with training developed to encourage comprehensive policy development; training direct care staff working in juvenile facilities; improving data collection and research within the population; increasing collaboration between mental health and juvenile justice systems; and improving policy and programming.¹⁴⁹

Resources

Endangered Youth: A Report on Suicide Among Adolescents Involved with the Child Welfare and Juvenile Justice Systems, 2006

Connecticut Center for Effective Practices

www.chdi.org/endangereyouth

This report offers an interdisciplinary framework that addresses the suicide risk for children, youth, and their families involved in the child welfare and juvenile justice systems. Case studies illustrate the challenges confronting families, communities, and professionals, while offering opportunities for learning and development of effective service delivery.

Ensuring the Seventh Generation: A Youth Suicide Prevention Toolkit for Tribal Child Welfare Programs, 2009

NICWA

www.nicwa.org/YouthSuicidePreventionToolkit/YSPToolkit.pdf

Intended for tribal child welfare workers and care providers, this toolkit discusses suicide risk factors associated with children in child welfare; warning signs caseworkers and care providers should watch for; suicide prevention and intervention strategies that can be applied in child welfare agencies; and mobilization of support networks around particular children.

Juvenile Suicide in Confinement: A National Survey, 2009

National Center on Institutions and Alternatives
Office of Juvenile Justice and Delinquency Prevention

www.ncjrs.gov/pdffiles1/ojjdp/213691.pdf

This report presents findings from the first national survey of juvenile suicides in confinement and offers recommendations for preventing suicide in juvenile facilities.

National Study of Jail Suicide: 20 Years Later, 2010

National Center on Institutions and Alternatives and the National Institute of Corrections, DoJ

static.nicic.gov/Library/024308.pdf

This study presents the most comprehensive information on inmate suicides throughout the United States. It challenges jail and health care officials and their staffs to remain diligent in identifying and managing people at highest risk.

Preventing Suicide in Jails and Prisons, 2007

World Health Organization (WHO) and International Association for Suicide Prevention

www.who.int/mental_health/prevention/suicide/resource_jails_prisons.pdf

This article is aimed at correctional administrators who develop or implement mental health programs and correctional officers responsible for the safety and custody of suicidal inmates. It provides general background on suicide and identifies a number of key prevention components.

Suicide Prevention in Custody

National Center on Institutions and Alternatives (NCIA)

www.ncianet.org/services/suicide-prevention-in-custody

This section of NCIA's website contains links to a number of resources on suicide prevention in jails and prisons, including *Guiding Principles to Suicide Prevention in Correctional Facilities*, 2011.

Suicide Prevention in Juvenile Correctional Facilities

SPRC

www.sprc.org/training-institute/juvenile-correctional-curriculum

This section of SPRC's website contains links to resources on suicide prevention among youth in contact with the juvenile justice system, a two-part webinar, and a packet of handouts on suicide prevention in juvenile correctional facilities.

Individuals Who Engage in Nonsuicidal Self-Injury

NSSI has been defined as the direct and intentional destruction of one's own body tissue in the absence of any intent to die.¹⁵⁰ NSSI includes behaviors such as cutting the skin with a sharp instrument and can also involve hitting, scratching, or burning the skin. These acts can lead to serious injury requiring medical treatment, infection, permanent scarring, and accidental death. They also have been linked to an increased risk of future suicidal thoughts, attempts, or death by suicide.³⁰

Research studies have often combined individuals who engage in self-injury with or without suicidal intent. Intentional self-injury, regardless of motivation or degree of suicidal intent, is often referred to as deliberate self-harm (DSH).¹⁵¹ This definition thus includes both suicide attempts and acts with other motives or intentions.

Research of NSSI and DSH populations shows a relatively strong relationship between self-injury and suicidal behaviors. An Australian study found that approximately 30 percent of patients presenting with self-poisoning to an emergency department (ED) reported previous episodes of self-harm.¹⁵² Of patients who presented to the ED on more than one occasion, 3 percent died by suicide within 5 years and 4 percent within 10 years. In a followup study of deliberate self-harm conducted in the United Kingdom, death by suicide was 17 times more frequent than expected in those who had previously presented to a general hospital with deliberate self-harm.³¹ In another U.K. followup study of deliberate self-harm, there was an approximately 30-fold increase in risk of suicide compared with the general population. Suicide rates were highest within the first 6 months after the first self-harm episode. A systematic review of the international literature on fatal and nonfatal repetition of self-harm found that after 1 year, nonfatal repetition of self-harm behaviors was approximately 15 percent.¹⁵³ The review found that suicide risk was hundreds of times higher among self-harm patients than in the general population.

Researchers see NSSI as falling along a continuum of self-harmful behavior that has suicide at the endpoint. Self-injuring adolescents who attempt suicide have greater suicidal ideation and depressive symptoms than adolescents who only engage in self-injury.¹⁵⁴ Regardless of whether an individual who engaged in self-injury reports having suicidal intent (DSH) or not (NSSI), research indicates that these individuals are at increased risk for repetition of these behaviors as well as of dying by suicide within 10 years.³¹

Resources

Cornell Research Program on Self-Injurious Behavior in Adolescents and Young Adults

www.crpsib.com

This program conducts research on self-injury in adolescents and young adults and translates the knowledge gained into resources and tools for understanding and treating self-injury. The website summarizes the program's work and provides links and resources with information on preventing, detecting, and treating self-injurious behavior.

Self-Injury Outreach & Support (SiOS)

www.sioutreach.org

SiOS is an international nonprofit outreach organization that provides resources and guides for both people who self-injure and those who can help them recover, including families and friends and school, mental health, and medical professionals. It offers research-informed coping strategies and a page where individuals can share their stories of recovery.

Signs of Self-Injury Prevention Program

Screening for Mental Health

www.mentalhealthscreening.org/programs/youth-prevention-programs/sosi

This education program is for high school students in a classroom setting. It teaches students about the signs and symptoms of self-injury, appropriate peer responses to a friend who self-injures, and the importance of adult intervention. Students determine their personal risk for self-injurious behaviors and develop coping skills for overcoming thoughts of self-injury.

Understanding Nonsuicidal Self-Injury in Suicide Prevention

SPRC

www.sprc.org/training-institute/r2p-webinars/understanding-nonsuicidal-self-injury-suicide-prevention

This webinar reviews a NSSI high school prevention program that has been shown to be effective. It uses this program as an example in demonstrating how to differentiate NSSI from suicide, understand how NSSI is a risk factor for suicide, learn the components of a self-injury prevention program for high schools, and understand outcome data related to an evaluation of the program.

Individuals Who Have Attempted Suicide

A previous suicide attempt is a known predictor of suicide death.¹¹ A study of individuals who had survived a serious suicide attempt, conducted in New Zealand, found that almost half made another attempt or subsequently died by suicide within 5 years.¹⁵⁵ Many individuals do not receive ongoing treatment or mental health care after an attempt, although they may continue to experience suicidal thoughts.¹⁵⁶ In addition, a study conducted in the United Kingdom found that many people who die by suicide do so within 30 days of having been discharged from a hospital for a previous attempt, often before an appointment for services.⁹⁸

The vast majority of these deaths are preventable. A developing literature base on the role of protective and social factors and landmark projects designed to learn from the experience of individuals who have attempted suicide provide insight regarding new strategies for reducing reattempts, including approaches focused on challenging the prejudice, shame, and silence that surround suicide attempts.

Even after a positive experience in a primary care or psychiatric program, recent attempt survivors can struggle with reintegrating into their homes, schools, and workplaces.¹⁵⁷ Feelings of shame and self-doubt and fear of biased reactions are just some of the experiences they describe. Within many communities,

silence, prejudice, and misunderstanding about the subject of suicide create barriers to open discussion. This culture of “don’t ask, don’t tell” can foster rejection, social isolation, and even discrimination if the suicide attempt is known. Spouses, parents, and others need help adjusting, as well as tools, evidence-based information, and programs for supporting people who survive an attempt.

Research suggests that even simple efforts to challenge isolation and provide follow-up support to people living in the community after an attempt can have a powerful impact and reduce future attempts.¹⁵⁸

A program that used hand-written postcards with brief personal messages showed remarkable results in reducing reattempt hospital admissions, revealing that a small amount of effort in the area of social support may be very powerful.¹⁵⁹ In addition, a growing number of programs that provide suicide attempt survivors with self-help tools and social support show great promise in reducing isolation and empowering people to manage their own suicide risk and mental health.

In the last 15 years, several organized efforts have emerged to learn from and serve the needs of people who have attempted suicide outside the traditional clinical services sector. In October 2005, the first National Conference for Survivors of Suicide Attempts, Health care Professionals, Clergy, and Laity was held in Memphis, Tennessee. The summary report of that conference is one of the first documents to articulate the perspectives of individuals who have attempted suicide.¹⁶⁰ Two years later, in July 2007, the National Suicide Prevention Lifeline (800-273-TALK/8255) sponsored a project that provided even more specific and rich information to better serve the needs of this population.¹⁶¹

Simultaneously, across the nation and internationally, there has been a significant increase in the number and variety of mental health consumer peer support and peer specialist services that may provide meaningful ongoing supports for people who have survived suicide attempts. These programs, which have been recognized as evidence-based practices by SAMHSA, provide social support that is not framed in terms of crisis and that can be an important resource for personal mental health maintenance and recovery.¹⁶² Such initiatives can empower and motivate people after an attempt, while at the same time challenge prejudice and shame in the area of suicide. These efforts can also increase social support for suicide reduction and contribute to increased funding and resources for preventing recurring attempts.

Although many communities are initiating programs and supports that can prevent people from reattempting, more and better strategies are needed. Technical assistance efforts, combined with the broad dissemination of resources and information to communities across America, have great potential to reduce suicide death. Resources for attempt survivors, such as *Stories of Hope and Recovery*, developed by SAMHSA and the National Suicide Prevention Lifeline (800-273-TALK/8255), hold promise for reducing prejudice and for promoting collaborative approaches for treatment engagement with attempt survivors. The *After an Attempt* brochure, distributed by SAMHSA, provides basic information for attempt survivors, family, and providers in English and Spanish for distribution in hospitals. Increased resources, peer support groups, web-based supports, informational DVDs, and trainings for health care providers are needed to ensure that individuals who have attempted suicide, along with their families and friends, receive the support, advice, and information they need to find the most direct path to recovery.

Resources

American Association of Suicidology

www.suicidology.org/web/guest/suicide-attempt-survivors

AAS has a collection of resources for those who have survived a suicide attempt and are looking for support and information. They include pamphlets, stories of others who have attempted suicide, and links to research about attempt survivors.

Continuity of Care for Suicide Prevention and Research: Suicide Attempts and Suicide Deaths Subsequent to Discharge from the Emergency Department or Psychiatry Inpatient Unit, 2010

SPRC

www.sprc.org/library/continuityofcare.pdf

This is a comprehensive report offering recommendations for the ongoing care of patients at risk for suicide who have been treated in EDs and hospitals. It discusses 10 principles for improved continuity of care and provides examples of seven integrated systems of care in the United States and Europe.

Individuals With Medical Conditions

Several physical illnesses are associated with an increased risk for suicidal behaviors.²⁹ The factors that may help explain this increased risk vary by medical condition but can include chronic pain, cognitive changes that make it difficult to make decisions and solve problems, and the challenges and emotional toll that can be associated with long-term conditions and limitations.

Cancers

Cancer is one of the most common physical illnesses associated with elevated suicide risk. The National Cancer Institute has identified cancers of the mouth, throat, and lung as risk factors for suicidal behaviors.¹⁶³ While suicide risk tends to be highest in the first few months after diagnosis, risk remains elevated in the first 5 years.¹⁶⁴ Fear associated with how the disease is perceived and managed, rather than the fear of death itself, is a frequent precipitator of suicidal behaviors.¹⁶⁵ The consequences or side effects of treatment can also result in psychological problems.¹⁶⁶ Fatigue and/or exhaustion, some of the most frequently reported side effects of cancer treatments, can be a risk factor for suicidal behaviors.¹⁶⁷ In addition, depression and anxiety are common in cancer patients. About 63 to 85 percent of individuals with cancer who die by suicide meet criteria for severe depression, anxiety, and thought disorder.¹⁶⁸ It is not always clear whether these types of mental disorders are triggered by the disease, occur as a consequence of the disease, or are an adverse effect of the treatment itself.¹⁶⁵

Degenerative Diseases of the Central Nervous System

Huntington Disease: The prevalence of suicide is believed to be two to four times greater in individuals with Huntington disease than among the general population.¹⁶⁹ The lifetime history of suicide attempts ranges from 4.8 to 17.7 percent.¹⁷⁰ Major depressive disorder may be present in up to half of patients with

Huntington's disease and is thought to be a consequence of the disease itself, rather than a psychological reaction to having a serious illness.¹⁷⁰ In addition, anxiety disorders, obsessive-compulsive disorders, psychosis, mania, aggression, irritability, impulsivity, and personality changes have all been reported in patients with the disease.

Multiple Sclerosis: Studies confirm an increased risk of suicide among patients with multiple sclerosis.¹⁷¹ Lifetime prevalence rates of depression range from 37 to 54 percent, and the prevalence rate of depression is almost three times the lifetime prevalence reported in the general population.¹⁷² Generalized anxiety disorder, panic disorder, and bipolar affective disorder (manic episodes) are also present more frequently in these patients.

Parkinson's Disease: Parkinson's disease is often associated with one or more psychiatric or cognitive disorders, such as depression, psychosis, and dementia.¹⁷³ Most of the observations support the hypothesis that depression is a primary consequence of brain dysfunction, although situational factors may contribute to mood changes to some extent.¹⁷⁴ Suicide and suicide attempts are uncommon despite the fact that the rates of suicidal ideation are elevated. Depression seems to be the most important predictor of suicide ideation.

Traumatic Injuries of the Central Nervous System

Spinal Cord Injury: Suicide and suicide attempts occur more frequently in those with spinal cord injuries (SCI) than in the general population.^{175, 176} People with SCI are five times as likely to experience depression compared with the general population, and the rates of depression following a traumatic spinal cord injury may be as high as 45 percent. Others have found that 10 to 13 percent of SCI patients suffer from anxiety²³⁹ and high levels of post-traumatic stress disorder.¹⁷⁷

Traumatic Brain Injury: People with moderate to severe traumatic brain injury (TBI) may have widespread cognitive impairment that can affect attention, memory, executive functioning, language and communication, visual-spatial skills, and processing speed.¹⁷⁸ TBI survivors may also have perceptual deficits and motor deficits. Executive brain dysfunction is a contributing factor related to suicidal behaviors.¹⁷⁹ A review of the literature found that on the whole, there is an increased risk of death by suicide (three to four times greater for those with severe TBI), a higher frequency of attempts, and clinically significant suicidal ideation in 21 to 22 percent of the TBI population.¹⁸⁰

Other Disorders of the Central Nervous System

Epilepsy: Suicide rates in patients with epilepsy vary from 0 to 25 percent.¹⁸¹ Factors that can affect the rate of suicide include psychological stressors associated with epilepsy, seizure type and frequency, psychic auras, and the presence of associated psychopathology.¹⁸² Some studies suggest that suppression of seizures in longstanding epilepsy may be associated with suicide risk,¹⁸³ and that suicide does not occur among patients with severe epilepsy.¹⁸⁴ The WHO states that increased suicidal behavior in epilepsy is linked to increased impulsivity, aggression, and chronic disability often seen in persons with the illness, and that alcohol and drug abuse also contribute to a greater risk of suicide among these patients.¹⁸⁵

Migraine: In general, patients with migraine are two to four times more likely to develop depression, two to six times more likely to develop general anxiety disorder, five times more likely to develop obsessive-compulsive disorder, and up to seven times more likely to develop panic disorder than the general population. Furthermore, depressed patients are about three times more likely to develop migraine in their lifetime. Migraine with an aura is believed to have a stronger association with psychiatric conditions than migraine without an aura. The relationship between migraine and depression and anxiety appears to be bidirectional, with each increasing the risk of the other condition. The risk of suicide ideation and attempts is higher among migraine patients, especially in those who have migraine with aura.¹⁸⁶

HIV/AIDS

Most studies among individuals living with HIV report lifetime prevalence of suicide attempts that range from 22 to 50 percent.¹⁸⁷ Individuals with AIDS were 44 times more likely to attempt suicide than those without AIDS.¹⁸⁸

While most studies report that persons living with HIV/AIDS have much higher suicide rates than the general population or those with other life-threatening illnesses, studies have reported no significant differences in suicide rates between HIV-infected individuals and other groups at risk for suicide, such as injection drug users and psychiatric patients.^{189, 190} Hence, HIV status may not be the most relevant factor related to suicide, but rather that other suicide risk factors that are common among HIV-infected individuals play a more important role.¹⁹¹ Studies have shown that suicide attempts and suicide ideation among people with HIV occur most often in those who have a previous psychiatric history and other social and environmental risk factors for suicide.¹⁹² Mood, anxiety, substance abuse, and personality disorders are prevalent among those with HIV.¹⁸⁷

Chronic Kidney Disease

The following psychiatric disorders have been frequently observed in patients with severe end-stage kidney disease who require hemodialysis: affective disorders, dementia and delirium, drug-related disorders (e.g., alcohol dependence), schizophrenia and other psychoses, and personality disorders.¹⁹³ The prevalence of depressive disorders in hemodialysis patients is estimated at 20 to 30 percent, with a rate of 10 percent for major depression.¹⁹⁴ Hemodialysis patients with major depressive disorder commonly demonstrate a sense of hopelessness, as well as lack of pleasure and energy, and other depressive symptoms. This subset of patients has been noted to be the most likely to request withdrawal from hemodialysis.

Arthritis

Arthritic disorders often co-occur with other physical conditions, especially chronic pain conditions including back pain, migraine, and other chronic headaches.¹⁹⁵ The association between arthritis and problems such as anxiety, substance use, and personality disorders has been demonstrated in large, population-based studies.^{196, 197} The relationship between arthritis and suicidal behavior may be largely

explained by comorbid mental health disorders alone or in combination with other factors such as level of pain and/or disability that are associated with a lower quality of life.¹⁹⁸

Asthma

Adolescents with asthma are more likely to report depressive symptoms, panic attacks, suicide ideation and behavior, and substance abuse when compared with those without asthma.¹⁹⁹⁻²⁰¹ It is not clear whether the association between asthma and depressive and anxiety disorders, as well as with suicidal ideation and behavior, results from a shared underlying process or from shared risk factors.

Resources

Medical Conditions Associated With Suicide Risk, Edited by A.L. Berman & M. Pompili, 2011

American Association of Suicidology

www.suicidology.org/web/guest/store

This book summarizes research on 25 medical conditions that are associated with suicide risk, such as cancer, TBI, and HIV and AIDS. It outlines risk factors to assess patients and provides recommendations for clinicians.

Individuals With Mental and/or Substance Use Disorders

Mental and substance use disorders are widely recognized as important risk factors for suicidal behaviors in all age groups. Having a substance use disorder along with as a mood disorder may be particularly likely to increase suicide risk.²⁸ Information on suicide risk and specific mental and substance use disorders is provided next, along with appropriate resources.

Mental Disorders

MOOD DISORDERS

Mood disorders are among the most common and may be the most life-threatening psychiatric illnesses.²⁰²

Major depressive disorder, also called *major depression* or *unipolar disorder*, is characterized by a combination of symptoms, such as sadness and loss of interest or pleasure in once-pleasurable activities, which interfere with everyday life. It has been estimated that 12 to 17 percent of individuals will experience a major depressive episode within their lifetime.²⁰³ Although a person may experience only a single episode, more often he or she may have several episodes throughout his or her life.

Bipolar disorders, also called *manic-depressive illness*, is characterized by dramatic mood swings, going from an overly energetic “high” (mania) to sadness and hopelessness (depression). People with bipolar disorders type I have had at least one manic episode along with periods of major depression. Those with bipolar disorders type II have periods of high energy levels and impulsiveness that are not as extreme as mania and also alternate with episodes of major depression. The estimated lifetime prevalence of bipolar disorders is 1.3 to 5 percent.²⁰³

More than 60 percent of suicidal deaths occur among individuals with mood disorders. Suicide risk is particularly high among individuals with bipolar disorders, which is strongly associated with suicide thoughts and behaviors. Over their lifetime, the vast majority (80 percent) of patients with bipolar disorders have either suicidal ideation or ideation plus suicide attempts.²⁴ In clinical samples, 14 to 59 percent of the patients have suicide ideation, and 25 to 56 percent attempt suicide at least once in their lifetime.²⁰⁴ Approximately 15 to 19 percent of patients with bipolar disorders die from suicide. The suicide rate among patients with bipolar disorders is estimated to be more than 25 times higher than the rate in the general population.²⁵

Several factors can increase the risk for suicide among patients who have mood disorders. These factors include a recent suicide attempt and a severe major depressive episode, often accompanied by feelings of hopelessness and guilt, a belief that there are few reasons for living, thoughts of suicide, agitation, insomnia, appetite and weight loss, and psychotic features.²⁰⁵ Suicidal behaviors among mood disorder patients occur almost exclusively during an acute, severe, major depressive episode.²⁰⁵

Among patients with major depressive disorder, risk factors for suicide include other comorbid psychiatric conditions, such as post-traumatic stress disorder (PTSD), dependent personality disorder, borderline personality disorder, and substance use disorders.²⁰⁶ Among those with bipolar disorders, risk factors include a family history of suicide, early onset of bipolar disorders, increasing severity of affective disorders, presence of mixed affective states, and abuse of alcohol or drugs.²⁰⁷

Major depressive disorder often fails to be recognized, diagnosed, or treated.²⁰³ It is believed that many men in midlife who have the disorder do not seek treatment for their symptoms, and even when they do, they often drop out of treatment before they reach remission.²⁰⁸ Evidence is mounting that individuals who have had a stroke or heart attack and/or have chronic diabetes are likely to develop depression related to their physical illnesses. Older individuals are particularly likely to do so.

Studies have shown that educating primary care providers in the assessment, treatment, and management of depression leads to reductions in suicide. Appropriate acute and long-term treatment of depressive disorders, including both pharmacological and nonpharmacological methods (especially cognitive behavioral therapy), greatly reduces the risk of suicide and attempted suicide in this high-risk population.²⁰⁵ Large-scale, long-term, European observational studies of former inpatients with bipolar disorders show that long-term use of mood stabilizers reduces the risk of suicide, compared to patients who stop taking medication. There is also some evidence that psychotherapies can improve compliance and increase the effectiveness of pharmacotherapy, thereby possibly providing more protection against suicide risk.²⁰⁵

ANXIETY DISORDERS

Anxiety disorders affect about 40 million American adults aged 18 and older (about 18 percent) in a given year.²⁰⁹ Unlike the relatively mild, brief anxiety caused by a stressful event like speaking in public, anxiety disorders last at least 6 months and can become worse if not treated. These disorders include the following: social phobia, simple phobia, generalized anxiety disorder, panic disorder, agoraphobia, PTSD, and obsessive-compulsive disorder (OCD).

The presence of any anxiety disorder is significantly associated with suicidal ideation and suicide attempts. Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance abuse, which may mask anxiety symptoms or make them worse. The presence of any anxiety disorder in combination with a mood disorder is associated with a higher likelihood of suicide attempts in comparison with a mood disorder alone.²¹⁰ Among adults in the general population (i.e., not in the Armed Forces or veterans), panic disorder and PTSD have been found to be more strongly associated with suicide attempts when there is a co-occurring personality disorder.²¹¹

BORDERLINE PERSONALITY DISORDER

Borderline personality disorder (BPD) is an emotional disorder characterized by a pervasive pattern of instability in interpersonal relationships, self-image, and emotions. Defining features of this disorder include an unstable mood, serious problems with emotion regulation, a wide range of impulsive behaviors, unstable interpersonal relationships, suicide, and chronic suicidal ideation.²¹²

It has been estimated that between 3 and 10 percent of patients with BPD die by suicide.²¹³ Recurrent suicide attempts, self-injury, and impulsive aggressive acts are often associated with BPD and often result in emergency and inpatient treatment. Suicides in BPD often occur late in the course of the illness and follow long courses of unsuccessful treatment.²¹⁴

The last few years have been marked by new data on the effectiveness of psychotherapies specifically designed for patients with BPD.²¹⁵ Research has shown that Dialectical Behavior Therapy (DBT) is effective in reducing the self-injurious behaviors associated with BPD.⁴¹ DBT specifically aims to modify the regulation of negative emotion. The main outcomes of DBT are reduced overdoses, ED visits for suicidal behaviors, frequency of self-directed violence, and hospital admissions. The efficacy of medications for BPD is not firmly established.

SCHIZOPHRENIA

Schizophrenia is a severe, chronic disorder characterized by disturbances in perception, thought, language, and social function. The risk for suicide in individuals suffering from schizophrenia is particularly high in the early stages of the illness (first 3–5 years of onset). A meta-analysis of more than 60 studies found that almost 5 percent of schizophrenic patients will die by suicide during their lifetimes, usually near the onset of the illness.²⁶ Surviving the initial period of heightened risk results in a lesser, although still considerable, risk of death by suicide.²⁶

The greatest indicator of suicide risk among people with schizophrenia is active psychotic illness (e.g., delusions) combined with symptoms of depression. Greater insight into the psychotic illness itself, the need for treatment, and the consequences of the disorder are strongly related to suicide risk.²¹⁶ Increased risk for suicide is also associated with higher levels of education and higher socioeconomic status. Alcohol abuse has been reported in studies examining suicide attempts.

Newer nonpharmacological therapies, such as cognitive enhancement therapy, may have great potential for improving the individual's social and occupational functioning.²¹⁷ Findings from a recent review suggest

that an integrated psychosocial and pharmacological approach may be useful, and that treating depressive symptoms in patients with schizophrenia is an important component of suicide risk reduction.⁸⁷

Resources

Continuity of Care for Suicide Prevention and Research: Suicide Attempts and Suicide Deaths Subsequent to Discharge From the Emergency Department or Psychiatry Inpatient Unit, 2010

SPRC

www.sprc.org/library/continuityofcare.pdf

This is a comprehensive report offering recommendations for the ongoing care of patients at risk for suicide who have been treated in EDs and hospitals. It discusses 10 principles for improved continuity of care and provides examples of seven integrated systems of care in the United States and Europe.

Mental Health America

www.mentalhealthamerica.net/

Mental Health America (MHA, formerly the National Mental Health Association) is an advocacy organization addressing all mental and substance use conditions nationwide and advocates for quality mental health and substance abuse services. It is a coproducer of *Safeguarding Your Students Against Suicide*, proceedings from an expert panel on preventing suicide on college campuses. Its web page includes suicide warning signs, how individuals can intervene to help, and links to resources. MHA also has local affiliates across the United States.

National Alliance on Mental Illness

www.nami.org

National Alliance on Mental Illness (NAMI) is a membership organization dedicated to building better lives for Americans affected by mental illness. NAMI advocates for access to services, treatment, supports, and research. It sponsors awareness events, provides training about mental illness, and sponsors the NAMI Helpline—a phone crisis line. NAMI has state organizations and local affiliates across the United States.

National Institute of Mental Health, NIH, HHS

www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml

The National Institute of Mental Health (NIMH) website section on suicide prevention includes information and resources useful for a variety of audiences, including researchers, health care professionals, and consumers. NIMH also conducts research on suicide and suicide prevention. Research updates can be found through “News From the Field: Research Findings of NIMH-funded Investigators at EurekAlert!” at: <http://search.eurekalert.org/e3/query.html?qt=youth+suicide+prevention&charset=iso-8859-1&qc=ev3rel&rf=1&col=ev3rel>.

Substance Abuse and Mental Health Services Administration, HHS

www.samhsa.gov

SAMHSA funds and supports the National Lifeline and SPRC and manages the Garrett Lee Smith grant program, which funds state, territorial, and tribal programs to prevent suicide among youth. It has

developed the National Registry of Evidence-Based Programs and Practices (NREPP), which reviews evidence of effectiveness for prevention programs on topics related to mental and substance use disorders, including suicide. SAMHSA also sponsors several prevention campaigns.

Suicide Prevention Efforts for Individuals With Serious Mental Illness: Roles for the State Mental Health Authority, 2008

National Association of State Mental Health Program Directors (NASMHPD)

www.sprc.org/library/SeriousMI.pdf

This report outlines the State Mental Health Authority's (SMHA) leadership role in preventing suicide among people with serious mental illness. It suggests ways in which SMHAs can increase collaboration, raise awareness of the signs of suicide, and intervene to save lives.

Substance Use Disorders

Alcohol and drug abuse are second only to depression and other mood disorders as the most frequent risk factors for suicide.²¹⁸ According to data from the National Violent Death Reporting System (NVDRS), in 2008 alcohol was a factor in approximately one-third of suicides reported in 16 states.²⁷ Opiates, including heroin and prescription painkillers, were present in 25.5 percent of suicide deaths, antidepressants in 20.2 percent, cocaine in 10.5 percent, marijuana in 11.3 percent, and amphetamines in 3.4 percent.

Suicide is a leading cause of death among people with substance use disorders (SUDs). Substance use may increase the risk for suicide by intensifying depressive thoughts or feelings of hopelessness while at the same time reducing inhibitions to hurting oneself.²¹⁹ Alcohol and some drugs can cause a “transient depression,” heighten impulsivity, and cloud judgment about long-term consequences of one's actions.

About 8.5 percent of U.S. adults are estimated to have an alcohol use disorder, which includes alcohol dependence and alcohol abuse.¹³ About one-fourth of all the suicides in the United States are estimated to occur among individuals with alcohol use disorders.⁹ Acute (e.g., binge drinking episodes) and chronic use of alcohol are associated with suicidal behaviors.²²⁰⁻²²² Among individuals with alcohol use disorders, suicide frequently takes place within the context of a major depression and interpersonal stressors. Aggression, impulsivity, hopelessness, and partner-relationship disruptions are also risk factors.²²³ Studies have shown that depression is present in 45 percent²²⁴ to more than 70 percent²²⁵ of those with alcohol and substance use disorders who die by suicide.

Although less is known about the relationship between suicide risk and other drug use, the number of substances used seems to be more predictive of suicide than the types of substances used.²²⁶ Findings from a few initial studies suggest that treatment of drug abuse may help reduce the risk for future suicidal behaviors.²²⁷

SUDs and chronic substance use can lead to consequences and losses that contribute to suicide risk factors. Individuals in treatment for substance use disorders and/or transitioning between levels of care may be especially vulnerable.²²⁸ A large number of people in treatment have co-occurring mental disorders that increase suicide risk, particularly mood disorders. At the time these individuals enter treatment, their

substance abuse may be out of control, they may be experiencing a number of life crises, and they may be at peaks in depressive symptoms. In addition, mental disorders associated with suicidal behaviors, such as mood disorders, PTSD, anxiety disorders, and some personality disorders, often co-occur among people who have been treated for substance use disorders. Crises that are known to increase suicide risk, such as relapse and treatment transitions, may occur during treatment. According to one study, compared with the general population, individuals treated for alcohol abuse or dependence have a 10 times greater risk of eventually dying by suicide.²²⁸ Among those who inject drugs, the risk is about 14 times greater than in the general population.²²⁸

More is known about the factors that increase the risk of suicidal behaviors among this population than about the factors that may be protective. SUDs share many risk factors with suicide: family history of suicide or child abuse; history of mental disorders, particularly mood disorders; history of or family history of addiction; impulsiveness; feelings of isolation; barriers to mental health and/or treatment; relational, social, work, or financial losses; physical illness/chronic pain; access to lethal methods; and prejudice associated with asking for help.

Perceiving that there are clear reasons to live is thought to be an important protective factor in this group. Other protective factors may include: a child at home and/or childrearing responsibilities; an intact marriage; a trusting relationship with a counselor, physician, or other service provider; employment; religious attendance and/or belief in religious teachings against suicide; and an optimistic or positive outlook. Sobriety can be a protective factor, along with attendance of mutual support group meetings.

Resources

National Institute on Alcohol Abuse and Alcoholism, NIH, HHS

www.niaaa.nih.gov

National Institute on Alcohol Abuse and Alcoholism (NIAAA) provides leadership in the national effort to reduce alcohol-related problems. Alcohol is a significant risk factor for suicide, and the NIAAA publishes studies on how alcohol use interacts with conditions such as depression and stress to contribute to suicide. NIAAA also provides data on alcohol involvement in suicide.

National Institute on Drug Abuse, NIH, HHS

www.nida.nih.gov

National Institute on Drug Abuse (NIDA) funds and publishes studies on the effects of substance abuse on mental health, including suicide, and hosts *Suicide Studies Lectures*, which review current standards to define, classify, assess, and treat suicide-related disorders that sometimes play a role in drug abuse and addiction. NIDA also sponsored a landmark workshop, *Drug Abuse and Suicidal Behavior*.

Substance Abuse and Mental Health Services Administration, HHS

www.samhsa.gov

SAMHSA funds and supports the National Lifeline and SPRC and manages the Garrett Lee Smith grant program, which funds state, territorial, and tribal programs to prevent suicide among youth.

It has developed NREPP, which reviews evidence of effectiveness for prevention programs on topics related to mental and substance use disorders, including suicide. SAMHSA also sponsors several prevention campaigns.

Substance Abuse and Suicide Prevention: Evidence and Implications—A White Paper, 2008

Center for Substance Abuse Treatment (CSAT), SAMHSA, HHS

www.samhsa.gov/matrix2/508SuicidePreventionPaperFinal.pdf

This white paper provides an overview of the advances made over the past decade in substance abuse prevention and treatment and suicide prevention. It addresses the epidemiology of suicide, provides an overview of what we know about the impact of substance abuse on suicide risk, and explores suicide prevention in the context of behavioral health promotion and illness prevention.

TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment, 2009

www.kap.samhsa.gov/products/manuals/tips/pdf/TIP50.pdf

Video companion:

www.store.samhsa.gov/product/Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/VA10-TIP50

TIP 50 provides counselors with tools to use in treatment and agency administrators with ways to ensure that suicide ideation is detected and addressed early and appropriately. *TIP 50* also provides insights on how various drugs used by clients might affect mood and addresses cultural and gender issues that could influence behavior.

Lesbian, Gay, Bisexual, and Transgender Populations

Studies over the last four decades suggest that LGBT individuals may have an elevated risk for suicide ideation and attempts. Attention to this disparity has been limited, in part because neither the U.S. death certificate nor the NVDRS identify decedents' sexual orientation or gender identity. Thus, it is not known whether LGBT people die by suicide at higher rates than comparable heterosexual people.

Across many different countries, a strong and consistent relationship between sexual orientation and nonfatal suicidal behavior has been observed.²²⁹ A meta-analysis of 25 international population-based studies found the lifetime prevalence of suicide attempts in gay and bisexual male adolescents and adults was four times that of comparable heterosexual males.²³⁰ Lifetime suicide attempt rates among lesbian and bisexual females were almost twice those of heterosexual females. Lesbian, gay, and bisexual (LGB) adolescents and adults were also found to be almost twice as likely as heterosexuals to report a suicide attempt in the past year. A later meta-analysis of adolescent studies³⁸ concluded that LGB youth were three times more likely to report a lifetime suicide attempt than heterosexual youth, and four times as likely to make a medically serious attempt. Across studies, 12 to 19 percent of LGB adults report making a suicide attempt, compared with less than 5 percent of all U.S. adults; and at least 30 percent of LGB adolescents report attempts, compared with 8 to 10 percent of all adolescents. To date, population-based studies have not identified transgender participants, but numerous nonrandom surveys show high rates of suicidal

behavior in that population, with 41 percent of adult respondents to the 2009 National Transgender Discrimination Survey reporting lifetime suicide attempts.²³¹

Most studies have found suicide attempt rates to be higher in gay/bisexual males than in lesbian/bisexual women, which is the opposite of the gender pattern found in the general population. As in the overall population, there is some evidence that the frequency of suicide attempts may decrease as LGB adolescents move into adulthood,²³² although patterns of suicide attempts across the lifespan of sexual minority people have not been conclusively studied. Within LGB samples, especially high suicide attempt rates have been reported among African American, Latino, Native American, and Asian American subgroups.²³³⁻²³⁵

Suicidal behaviors in LGBT populations appear to be related to “minority stress,”²³⁶ which stems from the cultural and social prejudice attached to minority sexual orientation and gender identity. This stress includes individual experiences of prejudice or discrimination, such as family rejection, harassment, bullying, violence, and victimization. Increasingly recognized as an aspect of minority stress is “institutional discrimination” resulting from laws and public policies that create inequities or omit LGBT people from benefits and protections afforded others.^{231, 237-240} Individual and institutional discrimination have been found to be associated with social isolation, low self-esteem, negative sexual/gender identity, and depression, anxiety, and other mental disorders. These negative outcomes, rather than minority sexual orientation or gender identity per se, appear to be the key risk factors for LGBT suicidal ideation and behavior. An additional risk factor is contagion resulting from media coverage of LGBT suicide deaths that presents suicidal behavior as a normal, rational response to anti-LGBT bullying or other experiences of discrimination. Further research is needed to explore the pathways to suicidal behaviors for transgender individuals, including the impact of prejudice and discrimination.

Factors that foster and promote resilience in LGBT people include family acceptance,²³⁹ connection to caring others and a sense of safety,⁶⁶ positive sexual/gender identity, and the availability of quality, culturally appropriate mental health treatment.⁵⁸ Strategies for preventing suicidal behaviors in LGBT populations include: reducing sexual orientation and gender-related prejudice and associated stressors; improving identification of depression, anxiety, substance abuse, and other mental disorders; increasing availability and access to LGBT-affirming treatments and mental health services; reducing bullying and other forms of victimization that contribute to vulnerability within families, schools, and workplaces; enhancing factors that promote resilience, including family acceptance and school safety; changing discriminatory laws and public policies; and reducing suicide contagion.

Collaboration between suicide prevention and LGBT organizations is needed to ensure the development of culturally appropriate suicide prevention programs, services, and materials, and to facilitate access to care for at-risk individuals. A promising example is the development of guidelines for media in talking about suicide in LGBT populations²⁴¹ created by a coalition of AFSP and several national LGBT organizations. Another critical need is closing knowledge gaps through additional research and improved surveillance. Efforts are underway to expand the inclusion of sexual orientation and gender identity measures in federal health and mental health surveys, and to develop and test procedures for postmortem identification of LGBT people in NVDRS.

Resources

American Foundation for Suicide Prevention: LGBT Initiative

www.afsp.org/index.cfm?page_id=6FB9BA00-7E90-9BD4-C33BD398EAAE73C0

This initiative works on suicide prevention among the LGBT population in a number of ways, including producing a conference, funding research grants, working to improve how the media covers anti-gay bullying, helping its chapter volunteers bring understanding of suicide into their local LGBT communities, and creating LGBT mental health educational resources and training tools.

Stop Bullying Website

www.stopbullying.gov

A website that provides information from various government agencies on what bullying is, what cyberbullying is, who is at risk, and how individuals can prevent and respond to bullying.

Suicide Prevention Among LGBT Youth: A Workshop for Professionals Who Serve Youth

SPRC

www.sprc.org/training-institute/lgbt-youth-workshop

This is a free workshop kit to help staff in schools, youth-serving organizations, and suicide prevention programs take action to reduce suicidal behavior among LGBT youth. It contains a Leader's Guide, sample agenda, PowerPoint presentations, sample script, and handouts.

The Trevor Project

www.thetrevorproject.org

This national organization focused on crisis and suicide prevention among lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth provides a 24-hour, toll-free, crisis intervention phone line (1-866-488-7386); an online, social networking community for LGBTQ youth aged 13 to 24 and their friends and allies; educational programs for schools; and advocacy initiatives.

Members of the Armed Forces and Veterans

The suicide rate for active duty military personnel has historically been significantly lower than the rate for a comparable population of Americans. However, both the numbers and rates of suicide have been increasing over the past decade. In 2001, the U.S. Department of Defense (DoD) recorded 160 total suicides for a rate of 10.3 per 100,000.²⁴² Suicide rates began to increase in 2006, driven primarily by a steady upward trend in the number of suicides in the Army and Marine Corps. In 2009, the DoD identified 309 total active duty suicides, for a rate of 18.3 per 100,000. The number of suicides has been on the rise in the Reserve Component (RC) as well. In 2009, there were 104 suicides of service members who were in the RC and not on active duty at the time of the event.²⁴³ In 2010, this number increased to 180, with the Army National Guard having the largest increase in the total number of suicides from 48 in 2009 to 101 in 2010.

For calendar year 2010, service members who were white and under the age of 25, junior enlisted (E1–E4), or high school educated were at increased risk for suicide relative to comparison groups in the general population.²⁴⁴ Service members most frequently used firearms as the means for suicide. Drug overdose was the most frequent method for suicide attempts, and the misuse of prescription medication was more frequent than illegal drugs. Most service members were not known to have communicated their potential for self-harm with others prior to suicide or attempted suicide. The majority of service members who died by suicide did not have a known history of a mental or substance use disorder. Finally, the overwhelming majority of suicides occurred in a nondeployed setting, and more than half of those who died by suicide did not have a history of deployment.

The Centers for Disease Control and Prevention (CDC) estimates that veterans account for approximately 20 percent of the deaths from suicide in America.²⁴⁵ There is controversy in the scientific literature about whether suicide rates are higher among veterans than among other Americans after controlling for sex, age, and minority status.^{246, 247} However, rates appear to be increased among two important groups: veterans who have recently returned from service in Afghanistan and Iraq,²⁴⁸ and those who receive health care services from the Veterans Health Administration (VHA),²⁴⁹ the health care system operated by the U.S. Department of Veterans Affairs (VA). In the most recent years for which data are available, suicide rates for male VHA patients were approximately 1.4 times greater than for other American men. For female VHA patients, rates were approximately twice as high as among American women. Both increases reflect the higher rates of medical and mental health conditions, disability, and other risk factors for suicide that occur among VHA patients. In VHA, as in DoD, firearms represented the most common means for suicide and overdoses represented the most common means for attempts.²⁴⁸ Approximately half of all suicides in VHA occurred among patients known to have mental health conditions.²⁵⁰ An increase in the suicide rate among returning veterans first appeared in 2006,²⁴⁸ and rates continue to be monitored closely. The rates as observed echo the increase that occurred for the first few years after veterans returned from service in Vietnam.²⁵¹

Efforts to identify individuals at risk and to monitor the military and veteran populations as a whole are currently in place in at DoD and VA. Mental health services have been enhanced in both departments, and an array of suicide prevention programs have been implemented.

In DoD, the Deputy Assistant Secretary of Defense for Readiness (DASD(R)) leads a collaborative effort across the Department to address suicide. The *Final Report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces*²⁵¹ has served as a catalyst for the Department to review and assess all policies and programs that relate to suicide prevention. Based on the report and action plans developed from it, a departmental implementation memorandum was signed by the Under Secretary of Defense for Personnel and Readiness in September 2011 to guide the Department's ongoing efforts.

Established in November 2011, the Defense Suicide Prevention Office (DSPO) is part of the DoD's Office of the Under Secretary of Defense for Personnel and Readiness. DSPO oversees all strategic development, implementation, centralization, standardization, communication, and evaluation of DoD suicide programs, policies, and surveillance activities. To reduce the impact of suicide on Service members and their families, DSPO uses a range of approaches related to policy, research, communications, and behavioral health. DSPO works closely with the Army, Navy, Air Force, Marine Corps, Coast Guard and National Guard Bureau, as well as other governmental and nongovernmental agencies, to support Service members and strengthen a resilient and ready force. DSPO strives to help foster a climate that encourages Service members to seek help for their behavioral health issues.

VA's current suicide prevention began with the approval of its *Mental Health Strategic Plan* in 2004. Implementation of the plan led to an increase in core mental health staff on a national level, by 50 percent; from about 14,000 in 2005 to about 21,000 by the end of 2010.²⁴⁸ Moreover, it led to developing the *Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics*,²⁵² a policy document that specifies requirements for services that must be available to all veterans with mental health conditions.

The VA suicide prevention program is based on the principle that prevention requires ready access to high-quality mental health services within the health care system, supplemented by two additional components: (1) public education and awareness activities promoting engagement for those who need help; and (2) availability of specific services addressing the needs of those at high risk. Activities have included creating a national office for suicide prevention, partnering with SAMHSA and its Lifeline program to add a veterans' call center to its national 800-273-TALK/8255 crisis line, funding suicide prevention coordinators with support staff in each VA medical center, and initiating public information strategies focused on promoting the use of the crisis line and of VA services for those in need.

Resources

Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury

www.dcoe.health.mil/SuicidePreventionWarriors.aspx

The Defense Centers of Excellence (DCoE) suicide prevention page includes information and campaign materials to raise awareness and encourage help seeking and access to mental health services specific to service branches of the military, families, and veterans. The DCoE sponsors the Real Warriors Campaign, a multimedia portal with resources to promote resilience, facilitate recovery, and support reintegration of returning service members, veterans, and their families.

National Guard/Reserve

www.ng.mil/features/suicide_prevention/default.aspx

The website for the National Guard's suicide prevention program features a six-part film on resilience among National Guard personnel. Other resources include a media gallery, a list of military and

nonmilitary organizations with information on suicide, and news stories from National Guard leadership and other branches of the military.

Tragedy Assistance Program for Survivors

www.taps.org

Tragedy Assistance Program for Survivors (TAPS) provides information and services to those who have suffered the loss of a military loved one due to any cause. It offers webinar-based courses, six of which concern suicide, for mental health professionals. Other resources include crisis services, online support groups, seminars for survivors, and the Good Grief Camp for children grieving the loss of a loved one in the military.

U.S. Air Force Suicide Prevention Program

afspp.afms.mil

The Air Force Suicide Prevention Program (AFSPP) is listed on SAMHSA's NREPP. The Air Force requires annual suicide prevention training of all active duty, reserve, guard, and civilian employees. The program's website contains links to a wide range of resources.

U.S. Army Suicide Prevention Program

www.armyg1.army.mil/hr/suicide/default.asp

This program uses Applied Suicide Intervention Skills Training (ASIST) to prepare designated gatekeepers to recognize suicide risk and intervene. All Army personnel, including civilians, are required to participate in Ask, Care, and Escort (ACE) suicide prevention and awareness training. The website also includes awareness materials, data, and tools for commanders to develop suicide prevention programs.

U.S. Department of Defense Restoring Hope

www.defense.gov/home/features/2010/0810_restoringhope_resources/

This web page is a central portal with links to a wide range of suicide prevention and other mental health services, self-help resources, and awareness materials for military in all branches, veterans, providers, and families. Most of the links go to services and resources provided by DoD or VA.

U.S. Department of Defense Suicide Prevention Website

www.health.mil/News_And_Multimedia/Special_Features/suicide-prevention-awareness.aspx

This website provides information on recognizing symptoms of those at risk for suicide, links to suicide prevention in each branch of the military, and a list of outside organizations that can provide information and assistance.

U.S. Department of Defense/U.S. Department of Veterans Affairs Suicide Outreach

www.suicideoutreach.org

This website is a resource collection providing access to support hotlines, self-assessments, treatment options, professional resources and forums, and various multimedia tools. It supports all members of the U.S. Armed Forces and reserve components, veterans, families, and providers.

U.S. Department of Veterans Affairs Mental Health Information

www.mentalhealth.va.gov

This web page serves as a portal for VA mental health services, resources, and programs such as the National Suicide Prevention Crisis Line veterans chat; information on suicide prevention and PTSD; and the Make the Connection Campaign, where veterans can share stories of their experience reintegrating into civilian life.

U.S. Department of Veterans Affairs Suicide Prevention Website

www.veteranscrisisline.net

This website describes the services of the Veterans Crisis Line, a toll-free, confidential resource that connects veterans in crisis and their families and friends with specially trained VA responders. It also includes information on warning signs and awareness and campaign materials.

U.S. Marines Suicide Prevention Program

www.usmc-mccs.org/suicideprevent/

The United States Marine Corps (USMC) program *Never Leave a Marine Behind* is a suicide prevention training program with modules geared toward officers, enlisted soldiers, families, and providers. It also provides awareness materials, help resources, and data.

U.S. Navy Suicide Prevention Program

www.public.navy.mil/bupers-npc/support/suicide_prevention/Pages/default.aspx

This program consists of four elements: Training, Intervention, Response, and Reporting. Annual suicide prevention training is required of active, reserve, and civilian employees. The website lists trainings and resources. Materials include the Navy Leaders Guide, which describes a broad range of supportive interventions, resources, and strategies for supporting sailors in distress.

Men in Midlife

While suicide rates have tended to decrease or remain stable for most age groups in the past two decades, suicides in middle adulthood have increased.^{253, 254} Men in their adult years, from their early 20s through their 50s, account for the bulk of suicides and the majority of years of life lost due to suicide.²⁵⁵ Yet there has been little research on this demographic group, when compared with the number of studies conducted with adolescents and older adults.

Although research exploring the recent surge in suicide in midlife is lacking, existing studies suggest that the factors that may increase the risk for suicidal behaviors in this group are similar to those among other age groups and in both sexes: mental illness that can be discerned from retrospective analyses (particularly mood disorders), substance use disorders (particularly alcohol abuse), and access to lethal means.^{28, 80} However, these factors are likely to be exacerbated by other risk-related characteristics that occur more frequently among males, such as the underreporting of mental health problems,²⁵⁶ a reluctance to seek help,²⁵⁷ engagement in interpersonal violence,²⁵⁸ distress from economic hardship (e.g., unemployment),

and dissolution of intimate relationships.²⁵⁹ More research is needed on the pathways and mechanisms that contribute to suicide among midlife men, using developmental approaches that examine the occurrence and timing of risk factors as they are expressed across the life course.

Very few systematic, large-scale efforts have addressed the prevention of suicide among men in midlife. Although the AFSP is an example,^{260, 261} it remains uncertain whether the lessons gleaned from this closed system can be readily generalized to broader society. Prevention efforts are especially challenging for men because they are less likely to show signs of depression, report suicidal ideation, or seek help or accept it from others, and they often hide their suicide plans or preparations.

Several projects have focused on organizational-level components for early intervention and education.^{260, 262, 263} Although studies in other countries point to the positive protective effects of means restriction,^{264, 265} no such programs have been successfully implemented in the United States. In terms of changing individual-level trajectories toward suicide, early classroom interventions to enhance interpersonal skills have been shown to reduce suicidal behaviors in early adulthood.²⁶⁶ Additional targets for intervention include: preventing exposure to violence in early developmental periods, such as bullying/peer victimization, childhood abuse, and domestic violence; enhancing academic engagement and reducing school drop-out rates; mitigating or preventing persisting alcohol and drug misuse; and developing a diverse array of community-based programs that engage men who otherwise would not seek care in traditional health settings or in settings that provide care for mental or substance use disorders.²⁵⁴ Many of these efforts now are being focused on veterans. However, few data are available at this time to identify a particular evidence-based suicide prevention approach targeting men in midlife.

Resources

Although there are no resources specific to midlife adult suicide prevention, some interventions that focus on workplace settings and gatekeeper training may be particularly relevant to reaching people in this age range.

LivingWorks

www.livingworks.net

LivingWorks is an organization that delivers training in suicide prevention to various groups, including the general public, caregivers, and professionals. Its training programs include ASIST, suicideTALK, safeTALK, and suicideCARE.

QPR Institute

www.qprinstitute.com (Under “QPR for Organizations,” click on “Business.”)

The QPR Institute is centered on the “question, persuade, refer” strategy of suicide prevention training for gatekeepers. The institute offers training and information materials tailored for a variety of organizations and workplace settings, including businesses and corporations.

ValueOptions Strategic Principles for Suicide Prevention

www.valueoptions.com/suicide_prev/html%20paged/Strategy.htm

This website is designed to help create a comprehensive suicide prevention plan for workplaces. It includes materials for senior management, articles, tip sheets, posters, banner graphics, a self-scoring quiz, and sample e-mail messages, as well as instruction on what the prevention plan should include.

Working Minds: Suicide Prevention in the Workplace

www.workingminds.org

This is a joint program by the Carson J. Spencer Foundation and the Colorado Department of Public Health and Environment, Office of Suicide Prevention, aimed at preventing suicide among working-aged people, particularly men. It provides informational materials and in-person trainings, and features a toolkit for employers to provide training to employees on what to do when facing a suicide crisis that impacts the workplace.

Workplace Strategies for Mental Health

Great-West Life Centre for Mental Health in the Workplace

www.gwlcentreformentalhealth.com/display.asp?l1=7&l2=101&l3=116&d=116&

This website contains a page on suicide prevention and intervention, as well as other information and tools for addressing mental health issues in the workplace.

Older Men

Older men, in particular those who are white, have disproportionately high rates of death by suicide. In 2009, the rate of death by suicide among older white men was 30.15 per 100,000—almost three times the rate among the general population (11.77 per 100,000).¹

Several factors can increase the risk for suicidal behaviors among older men, including the presence of a mental disorder. Research suggests that older adults who die by suicide are more likely to meet criteria for affective disorders (especially major depressive disorder) than younger adults.²⁶⁷ Other important risk factors include physical illness and functional decline. Finally, an extensive body of literature indicates that social disconnection increases risk for death by suicide in older men.²⁶⁷

Suicide in late life is qualitatively different than in younger adults. Older adults are more likely than younger adults to die by suicide as a result of their first suicide attempt, in part because older adults are more likely than younger adults to use highly lethal means to attempt suicide.²⁶⁷ Another important difference is that older adults are less likely than younger adults either to have reported suicidal ideation or to have sought mental health treatment prior to their deaths.²⁶⁸ Interestingly, however, research suggests that most older adults who die by suicide are seen by primary care physicians in the last three months of life.¹⁰⁶

Although many suicide prevention efforts have targeted youth, older adults have also become a focus of suicide prevention. 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 United States will have the same copay (20 percent) for mental health care as for physical health care.

Several interventions appear to offer significant promise for the prevention of suicide in late life. Most of these interventions have focused on treating depressive symptoms.²⁶⁷ Because older men do not generally seek mental health treatment, the most effective methods of treating mood disorders in older adults may involve integrating evidence-based depression treatment into the work of primary care offices, social service agencies, and aging services organizations that focus on addressing the needs of older adults. Research has shown that collaborative care models that combine pharmacological and psychosocial treatments for depressive symptoms may be particularly useful. Finally, there is evidence that interventions that attempt to decrease social isolation and disconnection in late life may reduce risk for death by suicide.²⁶⁷

Resources

It Takes a Community: Report on the Summit on Opportunities for Mental Health Promotion and Suicide Prevention in Senior Living Communities, 2010

www.sprc.org/library_resources/items/it-takes-community-report-summit-opportunities-mental-health-promotion-and-s

This is a report of the October 2008 “It Takes a Community” summit to advance discussion and action to improve the mental health and reduce the risk of suicide among residents of senior living communities (SLCs). It provides a framework of whole population, at-risk population, and crisis response approaches and includes findings from focus groups of SLC residents.

Late Life Suicide Prevention Toolkit: Life Saving Tools for Health Care Providers, 2006 Canadian Coalition for Seniors’ Mental Health

www.ccsmh.ca/en/projects/suicide.cfm

These training materials include an interactive, case-based DVD, the *National Guidelines for Seniors’ Mental Health: The Assessment of Suicide Risk and Prevention of Suicide*, a clinician pocket card, a Facilitator’s Guide, and a PowerPoint presentation.

Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities, 2011 SAMHSA

www.store.samhsa.gov/product/SMA10-4515

This toolkit contains resources to help staff in SLCs promote emotional health and prevent suicide among their residents. The toolkit also provides resources to help residents become active participants in mental health promotion and suicide prevention efforts.

Appendix E: General Suicide Prevention Resources

This appendix contains selected reports, guidelines, and other key resources on general aspects of suicide prevention. It also includes descriptions of federal agencies and national organizations that focus on suicide prevention. These groups can often provide program materials, trainings, and other resources. For information and resources for specific groups at increased risk for suicide, see Appendix D.

Suicide Prevention National Strategy Documents

United States

National Strategy for Suicide Prevention

National Action Alliance for Suicide Prevention

www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html

www.actionallianceforsuicideprevention.org/NSSP

www.samhsa.gov/nssp

The National Strategy for Suicide Prevention provides the framework for suicide prevention for the United States. First published in 2001 and then updated in 2012, the National Strategy represents the combined work of advocates, clinicians, researchers, survivors, and others. It lays a framework for action to prevent suicide and guides the development of an array of services and programs.

Charting the Future of Suicide Prevention: A 2010 Progress Review of the National Strategy and Recommendations for the Decade Ahead, 2010

Education Development Center, Inc.

www.sprc.org/library/ChartingTheFuture_Fullbook.pdf

This report reviews developments in the field of suicide prevention in the 9 years following the publication of the National Strategy for Suicide Prevention. It identifies the areas of most important progress, as well as crucial areas that have gone relatively unaddressed. It also explores new issues and initiatives that have emerged to claim attention or offer solutions.

Reducing Suicide: A National Imperative, 2002

Institute of Medicine

<http://www.nap.edu/openbook.php?isbn=0309083214>

This Institute of Medicine report, commissioned by several federal agencies, summarizes the state of the science base, gaps in knowledge, strategies for prevention, and research designs for the study of suicide.

Australia

Living Is for Everyone (LIFE) Framework, 2007

Australian Government Department of Health and Ageing Commonwealth of Australia, Canberra

<http://www.livingisforeveryone.com.au/Home.html>

England

Consultation on Preventing Suicide in England: A Cross-Government Outcomes Strategy to Save Lives, 2011

United Kingdom Department of Health

www.dh.gov.uk/en/Consultations/Liveconsultations/DH_128065

This document proposes a new suicide prevention strategy for England.

Ireland

Reach Out: Irish National Strategy for Action on Suicide Prevention 2005–2014

National Office for Suicide Prevention, Ireland

www.nosp.ie/reach_out.pdf

New Zealand

New Zealand Suicide Prevention Action Plan 2008–2012: The Evidence for Action

Ministry of Health, Wellington, New Zealand

www.spinz.org.nz/file/downloads/pdf/file_48.pdf

Norway

National Plan for Suicide Prevention 1994–1998, 1999

Norwegian Health Board

www.med.uio.no/klinmed/english/research/centres/nssf/articles/prevention/The_national_plan_for_suicide_prevention_1994-1998.pdf

The Norwegian Plan for Suicide Prevention Follow-up Project 2000–2002: Building on Positive Experiences, 2001

Norwegian Journal Suicidologi, no. 1

www.med.uio.no/klinmed/english/research/centres/nssf/articles/prevention/MehlumAndReinholdt.pdf

Scotland

Refreshing the National Strategy and Action Plan to Prevent Suicide in Scotland: Report of the National Suicide Prevention Working Group, 2010

The Scottish Government

www.scotland.gov.uk/Publications/2010/10/26112102/0

This report describes the revised Scottish national strategy for suicide prevention.

Media Reporting on Suicide

Picture This: Depression and Suicide Prevention, 2009

www.eiconline.org/resources/publications/z_picturethis/Disorder.pdf

This is a guide for content creators in the entertainment industry that addresses issues within the areas of depression and suicide prevention. These issues include those as identified by mental health experts, advocates, policymakers, and others working to improve public awareness about and reduce instances of depression and suicide.

Recommendations for Reporting on Suicide, 2011

Substance Abuse and Mental Health Services Administration (SAMHSA), U. S. Department of Health and Human Services (HHS)

www.reportingonsuicide.org

This website presents research-based recommendations for reporting on suicide, including suggestions for online media, message boards, bloggers, and “citizen journalists.”

Evidence-Based and Best Practices for Suicide Prevention

Best Practices Registry for Suicide Prevention

Suicide Prevention Resource Center (SPRC) and American Foundation for Suicide Prevention (AFSP)

www.sprc.org/bpr

This registry contains approximately 100 suicide prevention programs, including student curricula and peer leader programs, gatekeeper trainings, and trainings for health and mental health professionals. The registry is organized into three sections. *Section I: Evidence-Based Programs* lists interventions that have undergone evaluation and demonstrated positive outcomes. Most of these are the suicide prevention programs in SAMHSA’s National Registry of Evidence-Based Programs and Practices (NREPP). *Section II: Expert and Consensus Statements* lists statements that summarize the current knowledge in the suicide prevention field and provide best practice recommendations to guide program and policy development. *Section III: Adherence to Standards* lists suicide prevention programs and practices whose content has been reviewed for accuracy, likelihood of meeting objectives, and adherence to program design standards.

National Registry of Evidence-Based Programs and Practices

SAMHSA, HHS

www.nrepp.samhsa.gov

NREPP is a searchable online registry of roughly 230 interventions supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment. It includes a small number of interventions focused on suicide prevention and treatment. The registry connects members of the public to intervention developers so that they can learn how to implement these approaches in their communities.

Suicide Data and Surveillance

National Violent Death Reporting System (NVDRS)

Centers for Disease Control and Prevention (CDC), HHS

www.cdc.gov/injury/wisqars/nvdrs.html

NVDRS is a surveillance system that links data from law enforcement, coroners and medical examiners, vital statistics, and crime laboratories to assist each participating state in designing and implementing tailored prevention and intervention efforts, including for suicide. NVDRS also pools these data to better depict the scope and nature of violence.

Self-Directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0, 2011

National Center for Injury Prevention and Control, CDC, HHS

www.cdc.gov/ViolencePrevention/pub/selfdirected_violence.html

To address the current lack of a uniform definition on fatal and nonfatal self-harm, CDC developed this resource to improve understanding of self-directed violence and standardize data collection. The definitions and data elements were developed in collaboration with the U.S. Department of Veterans Affairs and the U.S. Department of Defense.

Suicide Prevention Data Reports

Office of Applied Studies, SAMHSA, HHS

www.oas.samhsa.gov/suicide.cfm

This website lists reports that provide surveillance data on suicidal thoughts and behaviors.

Web-Based Injury Statistics Query and Reporting System (WISQARS)

CDC, HHS

www.cdc.gov/injury/wisqars

This is an interactive database system that provides customized reports of data from a variety of sources on fatal and nonfatal injuries, violent deaths, and cost of injury. The system features a large amount of data on suicide.

Suicidal Thoughts and Behaviors Among Adults

www.oas.samhsa.gov/2k9/165/Suicide.htm

This issue of *The National Survey on Drug Use and Health Report* examines suicidal thoughts and behaviors among adults aged 18 and older. Data are presented by age group, gender, and past year substance use disorder. All findings in the report are based on 2008 data.

Suicide Prevention Organizations

For organizations that focus on specific groups with increased suicide risk, see Appendix D.

American Association of Suicidology (AAS)

www.suicidology.org

AAS promotes research, public awareness programs, public education, and training for professionals and volunteers. It serves as a national clearinghouse for information on suicide, publishing and disseminating statistics and suicide prevention resources. AAS also hosts annual national conferences for professionals and survivors.

American Foundation for Suicide Prevention (AFSP)

www.afsp.org

AFSP funds research and offers educational programs and resources for professionals, survivors of suicide loss, and the public. With SPRC, AFSP coproduces the Best Practices Registry (BPR) for Suicide Prevention. AFSP's Public Policy Division, SPAN USA, promotes and keeps track of policies and legislation related to suicide prevention. AFSP chapters provide connections to local resources and services addressing suicide prevention. The chapters also organize awareness events.

International Association for Suicide Prevention (IASP)

www.iasp.info

IASP is an international suicide prevention membership organization dedicated to preventing suicidal behavior, alleviating its effects, and providing a forum for academics, mental health professionals, crisis workers, volunteers, and suicide survivors. IASP sponsors World Suicide Prevention Day, congresses, task forces, conferences, and awards for research in suicidology.

Jason Foundation

www.jasonfoundation.com

The Jason Foundation is an educational organization dedicated to the awareness and prevention of youth suicide. It produces educational curricula and training programs for students, educators, youth workers, and parents to help them identify and assist at-risk youth.

Means Matter, Harvard School of Public Health

www.hsph.harvard.edu/means-matter

The mission of the Means Matter campaign is to increase the proportion of suicide prevention groups that promote activities that reduce a suicidal person's access to lethal means of suicide. The website has a wide variety of information to help families, clinicians, suicide prevention groups, local communities, and colleges and universities.

National Council for Suicide Prevention (NCSP)

www.ncsponline.org

NCSP is a group of leading national suicide prevention organizations that comes together to speak as a collective voice on selected issues and is dedicated to advancing suicide prevention through leadership and advocacy. NCSP philosophy is rooted in the belief that collaboration between like organizations will help pool resources and strengthen member organizations' ability to effect positive change in the field.

National Organization for People of Color Against Suicide (NOPCAS)

www.nopcas.org

NOPCAS addresses suicide prevention, intervention, and postvention in communities of color. NOPCAS provides professional development and culturally appropriate training for lay and professional audiences as well as sponsoring survivor/bereavement support groups. It also provides the online crisis intervention network entitled "I'm Alive," staffed by certified volunteers, and a speakers bureau.

National Suicide Prevention Lifeline (Lifeline)

www.suicidepreventionlifeline.org

The Lifeline provides immediate assistance 24 hours a day, 7 days a week to individuals in suicidal crisis by connecting them to the nearest available suicide prevention and mental health service provider through a toll-free telephone number: 1-800-273-TALK (8255). The Lifeline also provides informational materials featuring the phone number, such as brochures, wallet cards, and posters.

Samaritans USA

www.samaritansusa.org

Samaritans USA provides services to those at risk for suicide, provides support for those who have experienced a loss due to suicide, and educates caregivers and health providers. Crisis lines are the cornerstone of Samaritans USA's services. Samaritans USA also provides suicide prevention education to the public and survivor support groups.

Suicide Awareness Voices of Education (SAVE)

www.save.org

SAVE's mission is to prevent suicide through public awareness and education, reduce prejudice, and serve as a resource for those touched by suicide. SAVE's prevention and education programs are designed to increase awareness and knowledge about brain illnesses and suicide, accessing community resources, and understanding and use of intervention skills to help prevent suicide.

Suicide Prevention Resource Center (SPRC)

www.sprc.org

SPRC is a SAMHSA-funded, national center that helps strengthen the efforts of state, tribal, community, and campus suicide prevention organizations and coalitions and organizations that serve populations with high suicide rates. It provides technical assistance, training, a variety of resource materials, a current awareness newsletter (*The Weekly SPARK*), and a searchable online library. In partnership with AFSP,

SPRC coproduces the BPR for Suicide Prevention. SPRC also provides organizational support for the National Action Alliance for Suicide Prevention.

The Jed Foundation

www.jedfoundation.org

The Jed Foundation works to promote emotional health and prevent suicide among college and university students. The Jed Foundation's programs include: ULifeline, an online resource that gives students access to campus-specific resources and allows them to take an anonymous mental health screening; the Half of Us campaign with mtvU, which uses online, on-air, and on campus programming to encourage help-seeking; Love is Louder, a movement online and in communities to build connectedness and increase resiliency; and more.

The Link Counseling Center

www.thelink.org

The Link provides services and support to those who have lost a loved one to suicide, including workshops, resource materials, telephone counseling, information, and referrals. The Link also offers trainings for survivors and professionals on creating and facilitating support groups for survivors.

Yellow Ribbon

www.yellowribbon.org

Yellow Ribbon is the producer of the adult gatekeeper training *Be a Link!*, and the youth program *Ask 4 Help!* Its services include providing technical assistance to states and communities and support to survivors, including a list of survivor support groups across the United States.

U.S. Government Agencies

Information on the federal agencies that are a part of the Federal Working Group on Suicide Prevention is provided in Appendix G. These agencies include the National Institute of Mental Health (NIMH), within the National Institutes of Health (NIH). The following two other NIH institutes also address issues related to suicide prevention.

National Institute on Alcohol Abuse and Alcoholism (NIAAA), NIH, HHS

www.niaaa.nih.gov

NIAAA provides leadership in the national effort to reduce alcohol-related problems. Alcohol is a significant risk factor for suicide, and NIAAA publishes studies on how alcohol use interacts with conditions such as depression and stress to contribute to suicide. NIAAA also provides data on alcohol involvement in suicide.

National Institute on Drug Abuse (NIDA), NIH, HHS

www.nida.nih.gov

NIDA funds and publishes studies on the effects of substance abuse on mental health, including suicide, and hosts *Suicide Studies Lectures*, which review current standards to define, classify, assess, and treat suicide-related disorders that sometimes play a role in drug abuse and addiction. NIDA also sponsored the landmark workshop *Drug Abuse and Suicidal Behavior*.

Appendix F: Glossary

Affected by suicide—All those who may feel the impact of suicidal behaviors, including those bereaved by suicide, as well as community members and others.

Affective disorders—See mood disorders.

Anxiety disorder—An unpleasant feeling of fear or apprehension accompanied by increased physiological arousal, defined according to clinically derived standard psychiatric diagnostic criteria.

Behavioral health—A state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. The term is also used to describe the service systems encompassing the promotion of emotional health; the prevention of mental and substance use disorders, substance use, and related problems; treatments and services for mental and substance use disorders; and recovery support.

Bereaved by suicide—Family members, friends, and others affected by the suicide of a loved one (also referred to as survivors of suicide loss).

Best practices—Activities or programs that are in keeping with the best available evidence regarding what is effective.

Bipolar disorders—A mood disorder characterized by the presence or history of manic episodes usually, but not necessarily, alternating with depressive episodes.

Bisexual—An adjective that refers to individuals whose sexual orientation or identity involves sexual, physical, and/or romantic attraction to both men and women.

Boundaried system—A health care and community support system that provides behavioral and other health care services to a defined population (e.g., Henry Ford Health System).

Community—A group of individuals residing in the same locality or sharing a common interest.

Comprehensive suicide prevention plans—Plans that use a multifaceted approach to addressing the problem, for example, including interventions targeting biopsychosocial, social, and environmental factors.

Comorbidity—The co-occurrence of two or more disorders, such as depressive disorder and substance use disorder.

Complicated grief—Feelings of loss, following the death of a loved one, which are debilitating and do not improve even after time passes. These painful emotions are so long lasting and severe that those who are affected have trouble accepting the loss and moving on with their lives. Also referred to “traumatic grief” or “prolonged grief.”

Connectedness—Closeness to an individual, group, or individuals within a specific organization; perceived caring by others; satisfaction with relationship to others; or feeling loved and wanted by others.

Contagion—A phenomenon whereby susceptible persons are influenced toward suicidal behavior through knowledge of another person's suicidal acts.

Culturally appropriate—A set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures, including the ability of the program to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.

Culture—The integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, faith, or social group.

Deliberate self-harm—See suicidal self-directed violence.

Depression—A constellation of emotional, cognitive, and somatic signs and symptoms, including sustained sad mood or lack of pleasure.

Epidemiology—The study of statistics and trends in health and disease across communities.

Evaluation—The systematic investigation of the value and impact of an intervention or program.

Evidence-based programs—Programs that have undergone scientific evaluation and have proven to be effective.

Gatekeepers—Those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine. They may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate. Examples include clergy, first responders, pharmacists, caregivers, and those employed in institutional settings, such as schools, prisons, and the military.

Gay—An adjective that refers to persons whose sexual orientation or identity involves sexual, physical, and/or romantic attraction to individuals of the same sex.

Gender identity—An individual's deeply-rooted internal sense of gender. For most individuals, the sex assigned to them at birth aligns with their gender identity. This is not true for some others, however, who identify as transgender.

Goal—A broad and high-level statement of general purpose to guide planning on an issue; it focuses on the end result of the work.

Health—The complete state of physical, mental, and social well-being, not merely the absence of disease or infirmity.

Health and safety officials—Law enforcement officers, firefighters, emergency medical technicians, and outreach workers in community health programs.

Healthy People 2020—The national prevention initiative that identifies opportunities to improve the health of all Americans, with specific and measurable objectives to be met by 2020.

Indicated intervention—Intervention designed for individuals at high risk for a condition or disorder or for those who have already exhibited the condition or disorder.

Intervention—A strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as providing lithium for bipolar disorders, educating providers about suicide prevention, or reducing access to lethal means among individuals with suicide risk).

Lesbian—An adjective that refers to women whose sexual orientation or identity involves sexual, physical, and/or romantic attraction to other women.

Lesbian, gay, bisexual, or transgender—A blanket term that refers to those who identify as lesbian, gay, bisexual, or transgender.

Ligature points—Elements in an environment that could be used to support a noose or other strangulation devices (especially, for a suicide attempt).

Means—The instrument or object used to carry out a self-destructive act (e.g., chemicals, medications, illicit drugs).

Means restriction—Techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Methods—Actions or techniques that result in an individual inflicting self-directed injurious behavior (e.g., overdose).

Mental disorder—A diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional, or social abilities; often used interchangeably with mental illness.

Mental health—The capacity of individuals to interact with one another and the environment in ways that promote subjective well-being, optimal development, and use of mental abilities (cognitive, affective, and relational).

Mental health services—Health services that are specifically designed for the care and treatment of persons with mental health problems, including mental illness. Mental health services include hospitals and other 24-hour services, intensive community services, ambulatory or outpatient services, medical management, case management, intensive psychosocial rehabilitation services, and other intensive outreach approaches to the care of individuals with severe disorders.

Mental illness—See mental disorder.

Minority stress—The high levels of chronic stress experienced by members of minority populations (including lesbian, gay, bisexual, or transgender populations) as a result of the prejudice and discrimination they experience from the dominant group in society.

Mood disorders—A term used to describe all mental disorders that are characterized by a prominent or persistent mood disturbance; disturbances can be in the direction of elevated expansive emotional states or, if in the opposite direction, depressed emotional states. These disorders include depressive disorders, bipolar disorders, mood disorders because of a medical condition, and substance-induced mood disorders.

Morbidity—The relative frequency of illness or injury, or the illness or injury rate, in a community or population.

Mortality—The relative frequency of death, or the death rate, in a community or population.

Nonsuicidal self-injury—Self-injury with no suicidal intent. Same as nonsuicidal self-directed violence (see Centers for Disease Control and Prevention surveillance definitions box at the end of this appendix).

Objective—A specific and measurable statement that clearly identifies what is to be achieved in a plan; it narrows a goal by specifying who, what, when, and where or clarifies by how much, how many, or how often.

Older adults—Persons aged 60 or more years.

Outcome—A measurable change in the health of an individual or group of individuals that is attributable to an intervention.

Personality disorders—A class of mental disorders characterized by deeply ingrained, often inflexible, maladaptive patterns of relating, perceiving, and thinking of sufficient severity to cause either impairment in functioning or distress.

Postvention—Response to and care for individuals affected in the aftermath of a suicide attempt or suicide death.

Prevention—A strategy or approach that reduces the likelihood of risk of onset or delays the onset of adverse health problems, or reduces the harm resulting from conditions or behaviors.

Protective factors—Factors that make it less likely that individuals will develop a disorder. Protective factors may encompass biological, psychological, or social factors in the individual, family, and environment.

Psychiatric disorder—See mental disorder.

Psychiatry—The medical science that deals with the origin, diagnosis, prevention, and treatment of mental disorders.

Psychology—The science concerned with the individual behavior of humans, including mental and physiological processes related to behavior.

Rate—The number per unit of the population with a particular characteristic, for a given unit of time.

Resilience—Capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

Risk factors—Factors that make it more likely that individuals will develop a disorder. Risk factors may encompass biological, psychological, or social factors in the individual, family, and environment.

Root cause analysis—Root cause analysis (RCA) is a step-by-step method that leads to the discovery of a fault's first or root cause. RCA uses a systematic approach to identify the progression of actions and consequences that led to an undesired event. In the context of suicide prevention, an RCA investigation means tracing the cause and effect trail from a suicide attempt or death back to the root cause.

Safety plan—Written list of warning signs, coping responses, and support sources that an individual may use to avert or manage a suicide crisis.

Screening—Administration of an assessment tool to identify persons in need of more indepth evaluation or treatment.

Screening tools—Instruments and techniques (e.g., questionnaires, check lists, self-assessment forms) used to evaluate individuals for increased risk of certain health problems.

Selective intervention—Intervention targeted to subgroups of the population whose risk of developing a health problem is significantly higher than average.

Self-directed violence (same as self-injurious behavior)—Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-directed violence can be categorized as either nonsuicidal or suicidal.

Self-inflicted injuries—Injuries caused by suicidal and nonsuicidal behaviors such as self-mutilation.

Sexual orientation—An individual's sexual, physical, and/or romantic attraction to men, women, both, or neither.

Social support—Assistance that may include companionship, emotional backing, cognitive guidance, material aid, and special services.

Specialty treatment centers (e.g., mental health, substance abuse)—Health facilities where the personnel and resources focus on specific aspects of psychological or behavioral well-being.

Stakeholders—Entities including organizations, groups, and individuals that are affected by and contribute to decisions, consultations, and policies.

Substance use disorder—A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use; includes maladaptive use of legal substances such as alcohol; prescription drugs such as analgesics, sedatives, tranquilizers, and stimulants; and illicit drugs such as marijuana, cocaine, inhalants, hallucinogens, and heroin.

Suicidal behaviors—Behaviors related to suicide, including preparatory acts, as well as suicide attempts and deaths.

Suicidal self-directed violence—Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.

Suicidal ideation—Thoughts of engaging in suicide-related behavior.

Suicidal intent—There is evidence (explicit and/or implicit) that at the time of injury the individual intended to kill him or herself or wished to die and that the individual understood the probable consequences of his or her actions.

Suicidal plan—A thought regarding a self-initiated action that facilitates self-harm behavior or a suicide attempt; often including an organized manner of engaging in suicidal behavior such as a description of a time frame and method.

Suicide—Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

Suicide attempt—A nonfatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Suicidal behaviors—Acts and/or preparation toward making a suicide attempt, suicide attempts, and deaths by suicide.

Suicide crisis—A suicide crisis, suicidal crisis, or potential suicide, is a situation in which a person is attempting to kill him or herself or is seriously contemplating or planning to do so. It is considered a medical emergency, requiring immediate suicide intervention and emergency medical treatment.

Suicide attempt survivors—Individuals who have survived a prior suicide attempt.

Suicide loss survivors—See bereaved by suicide.

Surveillance—The ongoing, systematic collection, analysis, and interpretation of health data with timely dissemination of findings.

Transgender—Someone whose gender identity or expression is different from the sex that was assigned to them at birth. Some transgender individuals take steps to physically and/or legally transition from one sex to another.

Unintentional—Term used for an injury that is unplanned; in many settings, these are termed accidental injuries.

Universal intervention—Intervention targeted to a defined population, regardless of risk (this could be an entire school, for example, and not the general population, per se).

Uniform Definitions for Use in Surveillance, CDC 2011

These definitions are from the 2011 report *Self-Directed Violence Surveillance: Uniform Definitions and Recommended Data Elements*, published by the Centers for Disease Control and Prevention (see Appendix E for more information). Developed in collaboration with the Department of Veterans Affairs, the definitions are meant to help standardize the collection of data on fatal and nonfatal self-directed violence.

Nonsuicidal self-directed violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent.
Other suicidal behavior including preparatory acts	Acts or preparation toward making a suicide attempt, but before potential for harm has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away).
Self-directed violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.
Suicidal ideation	Thoughts of engaging in suicide-related behavior.
Suicidal intent	There is evidence (explicit and/or implicit) that at the time of injury the individual intended to kill self or wished to die and that the individual understood the probable consequences of his or her actions.
Suicidal plan	A thought regarding a self-initiated action that facilitates self-harm behavior or a suicide attempt. This will often include an organized manner of engaging in suicidal behavior such as a description of a time frame and method.
Suicidal self-directed violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.
Suicide	Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
Suicide attempt	A nonfatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

SOURCE: Crosby A, Ortega L, Melanson C. *Self-directed violence surveillance: Uniform definitions and recommended data elements*, Version 1.0. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2011. Available at www.cdc.gov/ViolencePrevention/pub/selfdirected_violence.html.

Appendix G: Federal Working Group Agency Descriptions

U.S. Department of Agriculture

Mission: To provide leadership on food, agriculture, natural resources, and related issues based on sound public policy, the best available science, and efficient management.

The U.S. Department of Agriculture (USDA) wants to be recognized as a dynamic organization that is able to efficiently provide the integrated program delivery needed to lead a rapidly evolving food and agriculture system.

USDA has created a strategic plan to implement its vision. The framework of this plan depends on these key activities: expanding markets for agricultural products and supporting international economic development; further developing alternative markets for agricultural products and activities; providing financing needed to help expand job opportunities and improve housing, utilities, and infrastructure in rural America; enhancing food safety by taking steps to reduce the prevalence of foodborne hazards from farm to table; improving nutrition and health by providing food assistance and nutrition education and promotion; and managing and protecting America's public and private lands working cooperatively with other levels of government and the private sector.

National Institute of Food and Agriculture

The National Institute of Food and Agriculture (NIFA) is an agency within USDA and part of the executive branch of the federal government. Congress created NIFA through the Food, Conservation, and Energy Act of 2008. NIFA's unique mission is to advance knowledge for agriculture, the environment, human health and well-being, and communities by supporting research, education, and extension programs in the Land-Grant University System and other partner organizations.

For additional information:

U.S. Department of Agriculture

Web address: www.usda.gov

National Institute of Food and Agriculture

Web address: www.csrees.usda.gov

U.S. Department of Defense

Mission: To provide the military forces needed to deter war and to protect the security of our country. The department's headquarters is at the Pentagon.

The Department of Defense (DoD) is America's oldest and largest government agency. With our military tracing its roots back to pre-Revolutionary War times, the DoD has grown and evolved with our nation.

Today, the department, headed by Secretary of Defense Leon E. Panetta, is not only in charge of the military, but it also employs a civilian force of thousands. With more than 1.4 million men and women on active duty and 718,000 civilian personnel, DoD is the nation's largest employer. Another 1.1 million serve in the National Guard and Reserve forces. More than 2 million military retirees and their family members receive benefits.

Headquarters of the DoD, the Pentagon is one of the world's largest office buildings. It is twice the size of the Merchandise Mart in Chicago, and has three times the floor space of the Empire State Building in New York. Built during the early years of World War II, it is still thought of as one of the most efficient office buildings in the world. Despite 17.5 miles of corridors it takes only seven minutes to walk between any two points in the building.

The nation's security depends on its defense installations and facilities being in the right place, at the right time, with the right qualities and capacities to protect our national resources. Those resources have never been more important as America fights terrorists who plan and carry out attacks on U.S. facilities and the American people. U.S. military service members and civilians operate in every time zone and in every climate. More than 450,000 employees are overseas, both afloat and ashore.

DoD manages an inventory of installations and facilities to keep Americans safe. The department's physical plant is huge by any standard, consisting of more than several hundred thousand individual buildings and structures located at more than 5,000 different locations or sites. When all sites are added together, DoD utilizes more than 30 million acres of land.

These sites range from the very small in size, such as unoccupied sites supporting a single navigational aid that sit on less than one-half acre, to the Army's vast White Sands Missile Range in New Mexico, which occupies more than 3.6 million acres, or the Navy's large complex of installations at Norfolk, Virginia, which includes more than 78,000 employees.

For additional information:

U.S. Department of Defense

Web address: www.defense.gov

U.S. Department of Education

Mission: To promote student achievement and preparation for global competitiveness by fostering educational excellence and ensuring equal access.

The U.S. Department of Education (ED) was created in 1980 by combining offices from several federal agencies. ED's 4,400 employees and \$68 billion budget are dedicated to:

- Establishing policies on federal financial aid for education, and distributing as well as monitoring those funds;
- Collecting data on America's schools and disseminating research;
- Focusing national attention on key educational issues; and
- Prohibiting discrimination and ensuring equal access to education.

Office of Safe and Healthy Students

The Office of Safe and Healthy Students, a program office within the Office of Elementary and Secondary Education, administers, coordinates, and recommends policy for improving the quality and excellence of programs and activities that are designed to:

- Provide financial assistance for: drug and violence prevention activities; activities that promote the health and well-being of students in elementary schools, secondary schools, and institutions of higher education; and school preparedness activities that contribute to improved conditions for learning. Activities may be carried out by other federal agencies, state and local educational agencies, and other public and private nonprofit organizations;
- Participate in the formulation and development of ED program policy and legislative proposals and in overall administration policies related to violence and drug prevention; this includes drafting program regulations;
- Participate in interagency committees, groups, and partnerships related to: drug and violence prevention, school preparedness, homeland security, missing and exploited youth, trafficked youth, and school health;
- Participate with other federal agencies in the development of a national research and data collection agenda for drug and violence prevention and preparedness; and
- Administer the department's programs relating to citizenship and civics education.

For additional information:

U.S. Department of Education

Web address: www.ed.gov

U.S. Department of Health and Human Services

Mission: The mission of the Department of Health and Human Services (HHS) is to enhance the health and well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences, underlying medicine, public health, and social services.

HHS is the government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS represents almost a quarter of all federal outlays, and it administers more grant dollars than all other federal agencies combined. HHS's Medicare program is the nation's largest health insurer, handling more than 1 billion claims per year. Medicare and Medicaid together provide health care insurance for one in four Americans.

HHS works closely with state and local governments, and many HHS-funded services are provided at the local level by state or county agencies or through private sector grantees. The department's programs are administered by 11 operating divisions, including eight agencies in the U.S. Public Health Service and three human services agencies. The department includes more than 300 programs, covering a wide spectrum of activities. In addition to the services they deliver, HHS programs provide for equitable treatment of beneficiaries nationwide, and they enable the collection of national health and other data.

Departmental leadership is provided by the Office of the Secretary. Also included in the department is the Office of Public Health and Science, the Office of the HHS Inspector General, and the HHS Office for Civil Rights. In addition, the Program Support Center, a self-supporting division of HHS, provides administrative services for HHS and other federal agencies.

For additional information:

U.S. Department of Health and Human Services

Web address: www.hhs.gov

Administration on Aging

Mission: To develop a comprehensive, coordinated, and cost-effective system of home and community-based services that helps elderly individuals maintain their health and independence in their homes and communities. To achieve this mission, the Administration on Aging (AoA) works with states and communities to enhance the availability of effective and coordinated services that are responsive to the needs and preferences of older persons, persons with disabilities, and their family caregivers.

AoA was established in 1965 with the passage of the Older Americans Act and is charged with advancing the concerns and interests of older people, persons with disabilities, and their family caregivers. To accomplish this vision, AoA administers a combination of competitive and formula grants that support the development, delivery, and evaluation of supportive services through the Aging Network, which consists of 56 State Units on Aging, 629 Area Agencies on Aging, 256 Tribal and Native organizations, 20,000 service providers, and thousands of volunteers. By leveraging public and private resources and partnerships, the Aging Network delivers streamlined access to a robust menu of supports, including long-term care services, nutrition programs, preventive health services, family caregiver programs, care transitions interventions, and supports that prevent elder abuse and promote elder rights.

Physical illness, emotional issues, and functional impairment are common risk factors for suicide among older adults. Through AoA's evidence-based health, dementia, and wellness programs, the Aging Network is developing a national system of effective programs, including depression care and suicide prevention programs, that help older adults, persons with disabilities, and their family caregivers maintain their health and independence. AoA envisions the continuation of a vibrant, integrated system that provides access to person-centered supportive services that promote physical and emotional well-being. AoA has recently become a part of the Administration for Community Living.

For additional information:

Administration on Aging

Web address: www.aoa.gov

Agency for Health Care Research and Quality

Mission: To improve the quality, safety, efficiency, and effectiveness of health care for all Americans. As 1 of 12 agencies within HHS, the Agency for Health Care Research and Quality (AHRQ) supports research that helps individuals make more informed decisions and improves the quality of health care services. AHRQ was formerly known as the Agency for Health Care Policy and Research.

AHRQ is committed to improving care safety and quality by developing successful partnerships and generating the knowledge and tools required for long-term improvement. The goal of its research is measurable improvements in health care in America, gauged in terms of improved quality of life and patient outcomes, lives saved, and value gained for what AHRQ spends.

To achieve its goals, the agency is committed to organizational excellence, the use of efficient and responsive business processes to maximize the agency's resources, and the effectiveness of its programs. The agency's overall focus is:

- Safety and quality: Reduce the risk of harm by promoting delivery of the best possible health care;
- Effectiveness: Improve health care outcomes by encouraging the use of evidence to make informed health care decisions; and
- Efficiency: Transform research into practice to facilitate wider access to effective health care services and reduce unnecessary costs.

AHRQ's customers include:

- Clinicians and other health care providers, such as hospitals;
- Consumers and patients;
- Health care policymakers at the federal, state, and local levels;
- Purchasers and payers, such as employers and public and private insurers; and
- Other health officials, such as hospital systems and medical school faculty.

For additional information:

Agency for Health Care Research and Quality

Web address: www.ahrq.gov

Centers for Disease Control and Prevention

Mission: Collaborate to create the expertise, information, and tools that individuals and communities need to protect their health—through health promotion, prevention of disease, injury and disability, and preparedness for new health threats.

The Centers for Disease Control and Prevention (CDC), a part of HHS, is the primary federal agency for conducting and supporting public health activities in the U.S. Through its centers, institutes, and offices, CDC works with partners throughout the nation and the world to monitor health, detect and investigate health problems, develop and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthful environments, and provide leadership and training.

CDC suicide prevention activities include efforts in the National Center for Health Statistics, National Center for Chronic Disease Prevention and Health Promotion, and National Center for Injury Prevention and Control. CDC maintains national data on suicides, conducts the Youth Risk Behavior Survey, and publishes reports on self-directed injury at all levels. Additional examples of CDC activities include promoting collaborations in specific communities for suicide prevention and conducting research on suicidal behavior and program evaluation.

For additional information:

Centers for Disease Control and Prevention

Web address: www.cdc.gov

National Injury Center's Division of Violence Prevention

Web address: www.cdc.gov/violenceprevention

Health Resources and Services Administration

Mission: To improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs.

Health Resources and Services Administration (HRSA) is the primary federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. Tens of millions of Americans get affordable health care and other help through HRSA's 100-plus programs and more than 3,000 grantees.

Comprising six bureaus and 10 offices, HRSA provides leadership and financial support to health care providers in every state and U.S. territory. HRSA grantees provide health care to uninsured people, people living with HIV/AIDS, and pregnant women, mothers, and children. They train health professionals and improve systems of care in rural communities.

HRSA oversees organ, bone marrow, and cord blood donation. It supports programs that prepare against bioterrorism, compensates individuals harmed by vaccination, and maintains databases that protect against health care malpractice and health care waste, fraud, and abuse.

Since 1943, the agencies that were HRSA precursors have worked to improve the health of needy people. HRSA was created in 1982, when the Health Resources Administration and the Health Services Administration were merged.

For additional information:

Health Resources and Services Administration

Web address: www.hrsa.gov

Indian Health Service

Mission: To raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/AN) to the highest level. The goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to AI/AN people.

The Indian Health Service (IHS) is the principal federal health care provider and health advocate for Indian people. IHS provides a comprehensive health service delivery system for approximately 2 million American Indians and Alaska Natives who belong to 566 federally recognized tribes in 36 states.

Within IHS, the Behavioral Health Division's mission is to instill balance, wellness, and resilience throughout AI/AN communities in partnership with tribes, tribal organizations, and urban Indian health organizations, as well as with federal, state, and local agencies. The division seeks to foster excellence in holistic approaches that promote healthy lifestyles, families, and communities. The division will coordinate national efforts to build capacity and share knowledge throughout Indian Country and will assist in the development, implementation, and evaluation of culture- and community-based programming.

Suicide Prevention: The IHS Suicide Prevention Initiative has provided a crucial framework and coordination capability to maximize available resources for addressing the tragedy of suicide in AI/AN communities. This initiative builds on the foundation of HHS's National Strategy for Suicide Prevention and the 11 goals and 68 objectives for the nation to reduce suicidal behavior and its consequences, while ensuring to honor and respect AI/AN traditions and practices.

IHS has five targeted approaches for suicide prevention and intervention: (1) Assist IHS, tribal, and urban Indian programs and communities in addressing suicide utilizing community level cultural approaches; (2) Identify and share information on best and promising practices; (3) Improve access to behavioral health services; (4) Strengthen and enhance IHS epidemiological capabilities; and (5) Promote collaboration between tribal and urban Indian communities with federal, state, and local community agencies.

The Methamphetamine and Suicide Prevention Initiative (MSPI) is a nationally coordinated program providing targeted methamphetamine and suicide prevention and intervention services. This initiative promotes the development of evidence-based and promising practices that are culturally appropriate prevention and treatment approaches to methamphetamine abuse and suicidal behaviors in a community-driven context. MSPI now supports 125 community developed prevention and intervention pilot programs across the country.

IHS maintains the IHS Community Suicide Prevention website to share information on best and promising practices nationally. The website provides culturally appropriate information about best and promising suicide prevention and early intervention programs and training opportunities.

For additional information:

Indian Health Service

Web address: www.ihs.gov/index.cfm

IHS American Indian and Alaska Native Suicide Prevention Website

Web address: www.ihs.gov/NonMedicalPrograms/nspn

National Institute of Mental Health

Mission: To transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure.

The National Institute of Mental Health (NIMH) was formally established in 1949 by Congress through the National Mental Health Act to establish a biomedical and behavioral research program to study individual, social, and economic problems of people with mentally illness in the United States. Over the past 60 years, NIMH research initiatives have evolved to include health services, research training, and health information dissemination with respect to the cause, diagnosis, treatment, control, and prevention of mental illness. To accomplish its work, NIMH administers several types of competitive grant programs, including research project grants, center grants, career awards, fellowships and training grants, and contracts. NIMH also supports the development of research resources that will help stimulate work in this field.

Current NIMH suicide prevention activities focus on multiple projects designed to develop the next generation of suicide prevention strategies. One notable activity is NIMH's partnership with the Department of the Army to conduct the Army Study to Assess Risk and Resilience in Service Members Project—the largest study of mental health risk and resilience ever conducted among military personnel. This project, a cooperative agreement led scientifically by NIMH, specifically looks to identify and understand factors related to risk for suicide among Army soldiers. The results will contribute significantly to our understanding of risk and resilience associated with suicide, both within the Army and among the broader adult population.

NIMH also has a lead role with the National Action Alliance for Suicide Prevention (Action Alliance), a public-private partnership tasked with developing the next *National Strategy for Suicide Prevention*. Alongside The Jed Foundation, NIMH is cochairing the Action Alliance's Research Task Force (RTF), which is developing a research agenda to reduce suicide morbidity (attempts) and mortality (deaths) by at least 20 percent in 5 years, and 40 percent or more in 10 years. To develop this agenda, RTF is reviewing public and private research portfolios, performing a targeted review of the research literature, statistically simulating the effects of potential interventions, and gathering input from more than 700 stakeholders through a multistage survey process. RTF's national research agenda will be structured around a set of short- and long-term strategic goals that address key issues in suicide prevention.

For additional information:

National Institute of Mental Health

Web address: www.nimh.nih.gov

Substance Abuse and Mental Health Services Administration

Mission: To reduce the impact of substance abuse and mental illness on America's communities. In order to achieve this mission, the Substance Abuse and Mental Health Services Administration (SAMHSA) has identified eight strategic initiatives to focus the agency's work on improving lives and capitalizing on emerging opportunities.

SAMHSA was established in 1992 and directed by Congress to target effectively substance abuse and mental health services to the people most in need and to translate research in these areas more effectively and more rapidly into the general health care system. Over the years, SAMHSA has demonstrated that prevention works, treatment is effective, and people recover from mental and substance use disorders. Behavioral health services improve health status and reduce health care and other costs to society. Continued improvement in the delivery and financing of prevention, treatment, and recovery support services provides a cost-effective opportunity to advance and protect the nation's health. To accomplish its work, SAMHSA administers a combination of competitive, formula, and block grant programs and data collection activities.

Suicide prevention activities of the Center for Mental Health Services (CMHS) within SAMHSA center on initiating national grant programs to implement and evaluate suicide prevention activities. CMHS is involved in developing suicide prevention guidelines for use in our nation's schools as well as supporting efforts to identify those children at greatest risk of suicide. In addition, SAMHSA sponsors conferences, workshops, and meetings to further national goals for suicide prevention. SAMHSA sponsors the National Suicide Prevention Lifeline, a national network of more than 150 crisis centers that are available to respond to those in emotional distress and their families and friends. SAMHSA also supports the Suicide Prevention Resource Center, which provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies, and to advance the National Strategy for Suicide Prevention.

For additional information:

Substance Abuse and Mental Health Services Administration

Web address: www.samhsa.gov

Center for Mental Health Services

Web address: www.samhsa.gov/about/cmhs.aspx

U.S. Department of Veterans Affairs

Mission: To fulfill President Abraham Lincoln's promise, "To care for him who shall have borne the battle, and for his widow, and his orphan," by serving and honoring the men and women who are America's veterans.

Although the Department of Veterans Affairs (VA) can trace its history back to the Revolutionary War, it became a cabinet-level Department in 1989. It includes three administrations: the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), and the National Cemetery Administration (NCA). These administrations coordinate services for more than 22 million Americans who are veterans. As of the end of 2010, more than 8 million veterans were enrolled in VHA, and more than 4 million veterans and survivors received VBA compensation and pension benefits. VHA provides patient-centered health care in 153 medical centers, 974 outpatient clinics, 288 Vet Centers, 98 residential care facilities, and 133 Community Living Centers that provide nursing home services. Approximately 6 million patients are treated during the year through more than 75 million outpatient visits. Altogether, VHA is the nation's largest integrated health care system. It functions in close collaboration with DoD to support returning veterans in their transition from active duty to their communities, and with a network of academic affiliates to facilitate interactions with other systems and providers of health care.

VA's activities in suicide prevention include outreach and public information, clinical services, education, and research. The Office of Suicide Prevention was established in 2007 as a part of VA's enhancement of its mental health programs to coordinate a program built on the principles that suicide prevention requires public health activities, ready access to high-quality mental health services, and clinical programs that specifically target individuals at high risk. The program centers around a call center linked with the SAMHSA-supported National Suicide Prevention Lifeline, suicide prevention coordinators in each of VHA's medical centers, and a structured public messaging campaign. The program also includes two centers of excellence that conduct research, provide education, and develop new clinical programs, one focused on clinical care, and the other on public health strategies.

For additional information:

Department of Veterans Affairs

Web address: www.va.gov

VA's Suicide Prevention Program

Web address: www.mentalhealth.va.gov/suicide_prevention

Acknowledgments

National Action Alliance for Suicide Prevention Executive Committee (EXCOM)

The Honorable Secretary John M. McHugh

Secretary of the Army
Public Sector Co-Chair

The Honorable Senator Gordon H. Smith

President and CEO
National Association of Broadcasters
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Talitha J. Arnold, MDiv

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We also would like to acknowledge the important contributions of the numerous individuals who provided input and public comments throughout the revision process.

References

1. Centers for Disease Control and Prevention. Fatal injury data, 2009. Web-based Injury Statistics Query and Reporting System. Available at www.cdc.gov/injury/wisqars/fatal.html. Accessed January 12, 2012.
2. McIntosh JL. U.S.A. suicide: 2009 official final data. Washington, DC: American Association of Suicidology; 2012. Available at www.suicidology.org/c/document_library/get_file?folderId=228&name=DLFE-494.pdf. Accessed May 23, 2012.
3. Substance Abuse and Mental Health Services Administration. *Utilization of mental health services by adults with suicidal thoughts and behavior*. (National Survey on Drug Use and Health. The NSDUH Report.) Rockville, MD: Author; 2011.
4. Centers for Disease Control and Prevention. Youth risk behavior surveillance—United States, 2011. *MMWR*. 2012;61(4):1-162.
5. U.S. Public Health Service. *The Surgeon General's call to action to prevent suicide*. Washington, DC: Author; 1999.
6. U.S. Department of Health and Human Services. *National strategy for suicide prevention: goals and objectives for action*. Rockville, MD: Author; 2001.
7. Suicide Prevention Resource Center (SPRC) and Suicide Prevention Action Network USA (SPAN USA). *Charting the future of suicide prevention: a 2010 progress review of the National Strategy and recommendations for the decade ahead*. David Litts, ed., Newton, MA: Education Development Center, Inc.; 2010.
8. Harris EC, Barraclough B. Suicide as an outcome for mental disorders. A meta-analysis. *Br J Psychiatry*. 1997;170:205-228.
9. Goldsmith S, Pellmar T, Kleinman A, Bunney W, eds. *Reducing suicide: a national imperative*. Washington, D.C.: Institute of Medicine, The National Academies Press; 2002.
10. Suicide Prevention Resource Center, Rodgers P. Understanding risk and protective factors for suicide: a primer for preventing suicide. Available at www.sprc.org/library_resources/items/understanding-risk-and-protective-factors-suicide-primer-preventing-suicide. Accessed May 12, 2012.
11. Fowler JC. Suicide risk assessment in clinical practice: pragmatic guidelines for imperfect assessments. *Psychotherapy*. 2012;49(1):81-90.
12. Sisask M, Varnik A. Media roles in suicide prevention: a systematic review. *Int J Environ Res Public Health*. 2012;9(1):123-138.
13. Pompili M, Serafini G, Innamorati M, et al. Suicidal behavior and alcohol abuse. *Int J Environ Res Public Health*. 2010;7(4):1392-1431.

14. Swahn MH, Ali B, Bossarte RM, et al. Self-harm and suicide attempts among high-risk, urban youth in the U.S.: shared and unique risk and protective factors. *Int J Environ Res Public Health*. 2012;9(1):178-191.
15. Lubell KM, Vetter JB. Suicide and youth violence prevention: the promise of an integrated approach. *Aggress Violent Behav*. 2006;11(2):167-175.
16. Knox KL, Litts DA, Talcott GW, Feig JC, Caine ED. Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: cohort study. *BMJ*. 2003;327(7428):1376.
17. Centers for Disease Control and Prevention. Fatal injury data, 2008. Web-based Injury Statistics Query and Reporting System. Available at www.cdc.gov/injury/wisqars. Accessed January 12, 2012.
18. Crosby AE, Han B, Ortega LA, Parks SE, Gfroerer J. Suicidal thoughts and behaviors among adults aged ≥ 18 years—United States, 2008–2009. *MMWR Surveill Summ*. 2011;60(SS13):1-22.
19. Centers for Disease Control and Prevention. National Violent Death Reporting System. Available at www.cdc.gov/violenceprevention/nvdrs/index.html. Accessed January 17, 2012.
20. Centers for Disease Control and Prevention. WISQARS™—Your source for U.S. injury statistics. Available at www.cdc.gov/injury/wisqars/facts.html. Accessed January 17, 2012.
21. Borowsky IW, Resnick MD, Ireland M, Blum RW. Suicide attempts among American Indian and Alaska Native youth: risk and protective factors. *Arch Pediatr Adolesc Med*. 1999;153(6):573-580.
22. Frank ML, Lester D. Self-destructive behaviors in American Indian and Alaska Native high school youth. *Am Indian Alsk Native Ment Health Res*. 2002;10(3):24-32.
23. Freedenthal S, Stiffman AR. Suicidal behavior in urban American Indian adolescents: a comparison with reservation youth in a southwestern state. *Suicide Life Threat Behav*. 2004;34(2):160-171.
24. Valtonen H, Suominen K, Mantere O, Leppamak iS, Arvilommi P, Isometsa ET. Suicidal ideation and attempts in bipolar I and II disorders. *J Clin Psychiatry*. 2005;66(11):1456-1462.
25. Tondo L, Isacsson G, Baldessarini R. Suicidal behaviour in bipolar disorders: risk and prevention. *CNS Drugs*. 2003;17(7):491-511.
26. Palmer BA, Pankratz VS, Bostwick JM. The lifetime risk of suicide in schizophrenia: a reexamination. *Arch Gen Psychiatry*. 2005;62(3):247-253.
27. Karch DL, Logan J, Patel N. Surveillance for violent deaths—National Violent Death Reporting System, 16 states, 2008. *MMWR Surveill Summ*. 2011;60(SS10):1-49.
28. Tondo L, Baldessarini RJ, Hennen J, et al. Suicide attempts in major affective disorder patients with comorbid substance use disorders. *J Clin Psychiatry*. 1999;60 Suppl 2:63-69.

29. Berman AL, Pompili M, eds. *Medical conditions associated with suicide risk*. Washington, DC: American Association of Suicidology; 2011.
30. Lofthouse N, Yager-Schweller J. Nonsuicidal self-injury and suicide risk among adolescents. *Curr Opin Pediatr*. 2009;21(5):641-645.
31. Hawton K, Harriss L, Zahl D. Deaths from all causes in a long-term follow-up study of 11,583 deliberate self-harm patients. *Psychol Med*. 2006;36(3):397-405.
32. World Health Organization and International Association for Suicide Prevention. *Preventing suicide in jails and prisons*. Geneva, Switzerland: WHO Document Production Services; 2007.
33. Hayes L. Suicide prevention in correctional facilities. In: Scott C, Gerbasi J, eds. *Handbook of correctional mental health*. Washington, DC: American Psychiatric Publishing; 2005:69-88.
34. Mumola C, Noonan M. *Deaths in custody statistical tables*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; 2008.
35. Mumola C. *Suicide and homicide in state prisons and local jails*. (Bureau of Justice Statistics Special Report). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; 2005.
36. Leslie LK, James S, Monn A, Kauten MC, Zhang J, Aarons G. Health-risk behaviors in young adolescents in the child welfare system. *J Adolesc Health*. 2010;47(1):26-34.
37. Pilowsky DJ, Wu LT. Psychiatric symptoms and substance use disorders in a nationally representative sample of American adolescents involved with foster care. *J Adolesc Health*. 2006;38(4):351-358.
38. Marshal MP, Dietz LJ, Friedman MS, et al. Suicidality and depression disparities between sexual minority and heterosexual youth: a meta-analytic review. *J Adolesc Health*. 2011;49(2):115-123.
39. Jordan J, McIntosh JL, eds. *Grief after suicide: Understanding the consequences and caring for the survivors*. New York: Routledge; 2011.
40. Brown GK, Ten Have T, Henriques GR, Xie SX, Hollander JE, Beck AT. Cognitive therapy for the prevention of suicide attempts: a randomized controlled trial. *JAMA*. 2005;294(5):563-570.
41. Linehan MM, Comtois KA, Murray AM, et al. Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Arch Gen Psychiatry*. 2006;63(7):757-766.
42. Knox KL, Kemp J, McKeon R, Katz IR. Implementation and early utilization of a suicide hotline for veterans. *Am J Public Health*. 2012;102 Suppl 1:S29-S32.
43. Knesper DJ. *Continuity of care for suicide prevention and research: suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit*. Newton, MA: Suicide Prevention Resource Center; 2010.

44. Wasserman D, Rihmer Z, Rujescu D, et al. The European Psychiatric Association (EPA) guidance on suicide treatment and prevention. *Eur Psychiatry*. 2012;27(2):129-141.
45. Centers for Disease Control and Prevention. Strategic direction for the prevention of suicidal behavior: promoting individual, family, and community connectedness to prevent suicidal behavior. Available at www.cdc.gov/ViolencePrevention/pdf/Suicide_Strategic_Direction_Full_Version-a.pdf. Accessed May 12, 2012.
46. Suicide Prevention Resource Center. Best practices registry (BPR) for suicide prevention. Available at www2.sprc.org/bpr/index. Accessed January 26, 2012.
47. National Prevention Council. *National prevention strategy*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2011. Available at www.healthcare.gov/prevention/nphpphc/strategy. Accessed April 20, 2012.
48. U.S. Department of Health and Human Services, Office of Minority Health. *National standards for culturally and linguistically appropriate services in health care: final report*. Washington, DC: Author; March 2001. Available at www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf. Accessed April 20, 2012.
49. Coffey CE. Building a system of perfect depression care in behavioral health. *Jt Comm J Qual Patient Saf*. 2007;33(4):193-199.
50. While D, Bickley H, Roscoe A, et al. Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006: a cross-sectional and before-and-after observational study. *Lancet*. 2012;379(9820):1005-1012.
51. Kellam SG, Mackenzie AC, Brown CH, et al. The good behavior game and the future of prevention and treatment. *Addict Sci Clin Pract*. 2011;6(1):73-84.
52. The Safe States Alliance. *Preventing violence: roles for public health agencies*. Atlanta, GA: Author; 2011.
53. United Nations. *Prevention of suicide: guidelines for the formulation and implementation of national strategies*. New York: Author; 1996.
54. Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. Medicare and Medicaid programs: electronic health record incentive program—stage 2. Available at www.regulations.gov#!documentDetail;D=CMS-2012-0022-0001. Accessed April 16, 2012.
55. Noar SM, Palmgreen P, Chabot M, Dobransky N, Zimmerman RS. A 10-year systematic review of HIV/AIDS mass communication campaigns: have we made progress? *J Health Commun*. 2009;14(1):15-42.
56. National Institutes of Health. *Making health communication programs work*. Washington, DC: National Cancer Institute; 2001. Available at www.cancer.gov/pinkbook. Accessed April 18, 2012.

57. Centers for Disease Control and Prevention. Gateway to health communication & social marketing practice. Available at www.cdc.gov/healthcommunication. Accessed April 18, 2012.
58. Haas AP, Eliason M, Mays VM, et al. Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: review and recommendations. *J Homosex*. 2011;58(1):10-51.
59. Fox S. *Mobile health 2010*. Washington, DC: Pew Research Center's Internet & American Life Project; October 19, 2010. Available at www.pewinternet.org/Reports/2010/Mobile-Health-2010.aspx. Accessed May 14, 2012.
60. Luxton DD, June JD, Kinn JT. Technology-based suicide prevention: current applications and future directions. *Telemed J E Health*. 2011;17(1):50-54.
61. U.S. Department of Veterans Affairs. Veterans crisis line website. Available at www.veteranscrisisline.net. Accessed April 17, 2012.
62. Centers for Disease Control and Prevention. *The health communicator's social media toolkit*. Atlanta, GA; July 2011. Available at www.cdc.gov/healthcommunication/ToolsTemplates/SocialMediaToolkit_BM.pdf. Accessed April 18, 2012.
63. Centers for Disease Control and Prevention. *CDC's guide to writing for social media*. Atlanta, GA; April 2012. Available at <http://www.cdc.gov/socialmedia/Tools/guidelines/pdf/GuidetoWritingforSocialMedia.pdf>. Accessed May 14, 2012.
64. May PA, Serna P, Hurt L, Debruyne LM. Outcome evaluation of a public health approach to suicide prevention in an American Indian tribal nation. *Am J Public Health*. 2005;95(7):1238-1244.
65. Motto JA, Bostrom AG. A randomized controlled trial of postcrisis suicide prevention. *Psychiatr Serv*. 2001;52(6):828-833.
66. Eisenberg ME, Resnick MD. Suicidality among gay, lesbian and bisexual youth: the role of protective factors. *J Adolesc Health*. 2006;39(5):662-668.
67. O'Carroll PW, Mercy JA, Steward JA. CDC recommendations for a community plan for the prevention and containment of suicide clusters. *MMWR Morb Mortal Wkly Rep*. 1988;37(S-6):1-12.
68. Recommendations for reporting on suicide. Available at www.reportingonsuicide.org. Accessed November 21, 2011.
69. Substance Abuse and Mental Health Services Administration (SAMHSA), Entertainment Industries Council (EIC). *Picture this: depression and suicide prevention*. Washington, DC: Substance Abuse and Mental Health Services Administration; 2009.
70. O'Connell M, Boat T, Warner K, eds. *Preventing mental, emotional, and behavioral disorders among young people: progress and possibilities*. Washington, DC: National Research Council and Institute of Medicine, The National Academies Press; 2009.

71. Rihmer Z. Suicide risk in mood disorders. *Curr Opin Psychiatry*. 2007;20(1):17-22.
72. Mann JJ, Apter A, Bertolote J, et al. Suicide prevention strategies: a systematic review. *JAMA*. 2005;294(16):2064-2074.
73. Van der Feltz-Cornelis CM, Sarchiapone M, Postuvan V, et al. Best practice elements of multilevel suicide prevention strategies. *Crisis*. 2011:1-15.
74. Brent DA. Firearms and suicide. *Ann N Y Acad Sci*. 2001;932:225-239; discussion; 239-240.
75. Brent DA, Bridge J. Firearms availability and suicide: evidence, interventions, and future directions. *Ame Behav Sci*. 2003;46(9):1192-1210.
76. Cummings P, Koepsell TD. Does owning a firearm increase or decrease the risk of death? *JAMA*. 1998;280(5):471-473.
77. Miller M, Hemenway D. Gun prevalence and the risk of suicide: A review. *Harvard Health Policy Rev*. 2001;2:29-37.
78. Ilgen MA, Zivin K, McCammon RJ, Valenstein M. Mental illness, previous suicidality, and access to guns in the United States. *Psychiatr Serv*. 2008;59(2):198-200.
79. Betz ME, Barber C, Miller M. Suicidal behavior and firearm access: results from the second injury control and risk survey. *Suicide Life Threat Behav*. 2011;41(4):384-391.
80. Miller M, Barber C, Azrael D, Hemenway D, Molnar BE. Recent psychopathology, suicidal thoughts and suicide attempts in households with and without firearms: findings from the National Comorbidity Study Replication. *Inj Prev*. 2009;15(3):183-187.
81. Kreitman N. The coal gas story. United Kingdom suicide rates, 1960-71. *Br J Prev Soc Med*. 1976;30(2):86-93.
82. Gunnell D, Fernando R, Hewagama M, Priyangika WD, Konradsen F, Eddleston M. The impact of pesticide regulations on suicide in Sri Lanka. *Int J Epidemiol*. 2007;36(6):1235-1242.
83. Suicide Prevention Resource Center (SPRC) and Suicide Prevention Action Network USA (SPAN USA). *Charting the future of suicide prevention: a 2010 progress review of the National Strategy and recommendations for the decade ahead*. David Litts, ed., Newton, MA: Education Development Center, Inc.; August 2010.
84. McDowell AK, Lineberry TW, Bostwick JM. Practical suicide-risk management for the busy primary care physician. *Mayo Clin Proc*. 2011;86(8):792-800.
85. Alexopoulos GS, Reynolds CF, 3rd, Bruce ML, et al. Reducing suicidal ideation and depression in older primary care patients: 24-month outcomes of the PROSPECT study. *Am J Psychiatry*. 2009;166(8):882-890.
86. Kasckow J, Felmet K, Zisook S. Managing suicide risk in patients with schizophrenia. *CNS Drugs*. 2011;25(2):129-143.

87. Dolgin E. The ultimate endpoint. *Nat Med*. 2012; 18(2):190-193.
88. Substance Abuse and Mental Health Services Administration. SAMHSA's definition and guiding principles of recovery – answering the call for feedback. Available at www.blog.samhsa.gov/2011/12/22/samhsa%E2%80%99s-definition-and-guiding-principles-of-recovery-%E2%80%93-answering-the-call-for-feedback. Accessed January 23, 2012.
89. Clinical Care and Intervention Task Force. *Suicide care in systems framework: a report to the National Action Alliance for Suicide Prevention's Executive Committee*. Washington, DC: National Action Alliance for Suicide Prevention; 2011.
90. Katz IR, McCarthy JF, Ignacio RV, Kemp J. Suicide among veterans in 16 states, 2005 to 2008: comparisons between utilizers and nonutilizers of Veterans Health Administration (VHA) services based on data from the National Death Index, the National Violent Death Reporting System, and VHA administrative records. *Am J Public Health*. 2012;102 Suppl 1:S105-S110.
91. Veterans Health Administration. *Report to the Office of Mental Health Operations*. Ann Arbor, MI: Serious Mental Illness Treatment Resource and Evaluation Center; 2011.
92. Valenstein M, Kim HM, Ganoczy D, et al. Higher-risk periods for suicide among VA patients receiving depression treatment: prioritizing suicide prevention efforts. *J Affect Disord*. 2009;112(1-3):50-58.
93. Weis MA, Bradberry C, Carter LP, Ferguson J, Kozareva D. An exploration of human services system contacts prior to suicide in South Carolina: an expansion of the South Carolina Violent Death Reporting System. *Inj Prev*. 2006;12 Suppl 2:ii17-ii21.
94. Center for Substance Abuse Treatment. *Addressing suicidal thoughts and behaviors in substance abuse treatment. Treatment Improvement Protocol (TIP) Series 50*. (HHS Publication No. (SMA) 09-4381). Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services; 2009. Available at www.kap.samhsa.gov/products/manuals/tips/pdf/TIP50.pdf. Accessed May 17, 2012.
95. Fleischmann A, Bertolote JM, Wasserman D, et al. Effectiveness of brief intervention and contact for suicide attempters: a randomized controlled trial in five countries. *Bull World Health Organ*. 2008;86(9):703-709.
96. Hampton T. Depression care effort brings dramatic drop in large HMO population's suicide rate. *JAMA*. 2010;303(19):1903-1905.
97. Valenstein M, Eisenberg D, McCarthy JF, et al. Service implications of providing intensive monitoring during high-risk periods for suicide among VA patients with depression. *Psychiatr Serv*. 2009;60(4):439-444.
98. Hunt IM, Kapur N, Webb R, et al. Suicide in recently discharged psychiatric patients: a case-control study. *Psychol Med*. 2009;39(3):443-449.

99. Baraff LJ, Janowicz N, Asarnow JR. Survey of California emergency departments about practices for management of suicidal patients and resources available for their care. *Ann Emerg Med.* 2006;48(4):452-458.
100. Olfson M, Marcus SC, Bridge JA. Emergency treatment of deliberate self-harm. *Arch Gen Psychiatry.* 2012;69(1):80-88.
101. Asarnow J, Baraff L, Berk M, et al. An emergency department intervention for linking pediatric suicidal patients to follow-up mental health treatment. *Psych Serv.* 2011;62(11):1303-1309.
102. Currier GW, Fisher SG, Caine ED. Mobile crisis team intervention to enhance linkage of discharged suicidal emergency department patients to outpatient psychiatric services: a randomized controlled trial. *Acad Emerg Med.* 2010;17(1):36-43.
103. Carter GL, Clover K, Whyte IM, Dawson AH, D'Este C. Postcards from the EDge project: randomised controlled trial of an intervention using postcards to reduce repetition of hospital treated deliberate self poisoning. *BMJ.* 2005;331(7520):805.
104. Department of Veterans' Services. Statewide Advocacy for Veterans' Empowerment (SAVE). Available at www.mass.gov/veterans/health-and-well-being/counseling/suicide-prevention-only/save.html. Accessed May 15, 2012.
105. Larkin GL, Beautrais AL. Emergency departments are underutilized sites for suicide prevention. *Crisis.* 2010;31(1):1-6.
106. Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. *Am J Psychiatry.* 2002;159(6):909-916.
107. American Association of Suicidology. *AAS recommendations for inpatient and residential patients known to be at elevated risk for suicide.* Washington, DC: American Association of Suicidology; 2005.
108. Crosby A, Ortega L, Melanson C. *Self-directed violence surveillance: uniform definitions and recommended data elements, Version 1.0.* Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2011.
109. National Center for Injury Prevention and Control. *Recommended actions to improve external-cause-of-injury coding in state-based hospital discharge and emergency department data systems.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; December 2009.
110. Shekelle P, Bagley S, Munjas B. *Strategies for suicide prevention in veterans.* Washington, DC; 2009.
111. Resnik HLP, Hathorne BC. *Suicide prevention in the 70s.* Rockville, MD: National Institute of Mental Health; 1973.

112. Alcohol, Drug Abuse, and Mental Health Administration. *Report of the Secretary's Task Force on Youth Suicide: Vols. 1-4*. Washington, DC: U.S. Government Printing Office (DHHS Publication No. ADM 89-1624); 1989.
113. New Freedom Commission on Mental Health. *Achieving the promise: transforming mental health care in America. Final report*. MD: DHHS Pub. No. SMA-03-3832. Rockville; 2003.
114. Kalafat J, Gould MS, Munfakh JL, Kleinman M. An evaluation of crisis hotline outcomes. Part 1: Nonsuicidal crisis callers. *Suicide Life Threat Behav*. 2007;37(3):322-337.
115. Gould MS, Kalafat J, Harrismunfakh JL, Kleinman M. An evaluation of crisis hotline outcomes. Part 2: Suicidal callers. *Suicide Life Threat Behav*. 2007;37(3):338-352.
116. Chandler MJ, Lalonde CE. Cultural continuity as a moderator of suicide risk among Canada's First Nations. In: Kirmayer L, Valaskakis G, eds. *The mental health of Canadian aboriginal peoples: transformations, identity and community*. Vancouver, Canada: University of British Columbia Press; 2008:221-248.
117. Garrouette EM, Goldberg J, Beals J, Herrell R, Manson SM. Spirituality and attempted suicide among American Indians. *Soc Sci Med*. 2003;56(7):1571-1579.
118. Centers for Disease Control and Prevention. Alcohol and suicide among racial/ethnic populations – 17 states, 2005–2006. *MMWR Morb Mortal Wkly Rep*. 2009;58(23):637-641.
119. Walls ML, Chapple CL, Johnson KD. Strain, emotion and suicide among American Indian youth. *Deviant Behav*. 2007;28(3):219-246.
120. Yoder KA, Whitbeck LB, Hoyt DR, LaFromboise T. Suicidal ideation among American Indian youths. *Arch Suicide Res*. 2006;10(2):177-190.
121. Mock CN, Grossman DC, Mulder D, Stewart C, Koepsell TS. Health care utilization as a marker for suicidal behavior on an American Indian Reservation. *J Gen Intern Med*. 1996;11(9):519-524.
122. Freedenthal S, Stiffman AR. “They might think I was crazy”: young American Indians’ reasons for not seeking help when suicidal. *J Adolesc Res*. 2007;22(1):58-77.
123. Brave Heart MY, DeBruyn LM. The American Indian holocaust: healing historical unresolved grief. *Am Indian Alsk Native Ment Health Res*. 1998;8(2):56-78.
124. U.S. Department of Health and Human Services. *To live to see the great day that dawns: preventing suicide by American Indian and Alaska Native youth and young adults*. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2010.
125. Centers for Disease Control and Prevention. *Adverse Childhood Experiences (ACE) Study*. Atlanta, GA: National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health; 2011. Available at www.cdc.gov/ace/index.htm. Accessed June 1, 2011.

126. Bender E. APA, AACAP suggest ways to reduce high suicide rates in Native Americans. *Psychiatr News*. 2006;41(12):6.
127. U.S. Census Bureau. The American Indian and Alaska Native population: 2010. *2010 Census Briefs*. Author; January 2012. Available at www.census.gov/prod/cen2010/briefs/c2010br-10.pdf. Accessed August 30, 2012.
128. Urban Indian Health Institute. *Urban American Indian and Alaska Native Youth: an analysis of select national data sources*. Seattle, WA: Seattle Indian Health Board; 2009.
129. Johnson T, Tomren H. Helplessness, hopelessness, and despair: identifying the precursors to Indian youth suicide. *Am Indian Cult Res J*. 1999;23(3):287-301.
130. LaFromboise T, Howard-Pitney B. The Zuni life skills development curriculum: description and evaluation of a suicide prevention program. *J Couns Psychol*. 1995;42(4):479-486.
131. Carter SL, Straits JE, Hall M. *Project Venture: Evaluation of a positive, culture-based approach to substance abuse prevention with American Indian youth*. Gallup, NM: Technical Report. The National Indian Youth Leadership Project; 2007.
132. Mullany B, Barlow A, Goklish N, et al. Toward understanding suicide among youths: results from the White Mountain Apache tribally mandated suicide surveillance system, 2001–2006. *Am J Public Health*. 2009;99(10):1840-1848.
133. Cwik MF, Barlow A, Tingey L, Larzelere-Hinton F, Goklish N, Walkup JT. Nonsuicidal self-injury in an American Indian reservation community: results from the White Mountain Apache surveillance system, 2007-2008. *J Am Acad Child Adolesc Psychiatry*. 2011;50(9):860-869.
134. Crosby AE, Sacks JJ. Exposure to suicide: incidence and association with suicidal ideation and behavior: United States, 1994. *Suicide Life Threat Behav*. 2002;32(3):321-328.
135. Berman A. Estimating the population of survivors of suicide: Seeking an evidence base. *Suicide Life Threat Behav*. 2011;41(1):110-116.
136. McMenamy JM, Jordan JR, Mitchell AM. What do suicide survivors tell us they need? Results of a pilot study. *Suicide Life Threat Behav*. 2008;38(4):375-389.
137. U.S. Department of Justice. *Juvenile suicide in confinement: a national survey*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention; 2009.
138. Memory J. Juvenile suicides in secure detention facilities: correction of published rates. *Death Stud*. 1989;13:455-463.
139. Alessi NE, McManus M, Brickman A, Grapentine L. Suicidal behavior among serious juvenile offenders. *Am J Psychiatry*. 1984;141(2):286-287.

140. Brent DA. Risk factors for adolescent suicide and suicidal behavior: mental and substance abuse disorders, family environmental factors, and life stress. *Suicide Life Threat Behav.* 1995;25 Suppl:52-63.
141. Gray D, Achilles J, Keller T, et al. Utah youth suicide study, phase I: government agency contact before death. *J Am Acad Child Adolesc Psychiatry.* 2002;41(4):427-434.
142. Hayes LM. Juvenile suicide in confinement—findings from the first national survey. *Suicide Life Threat Behav.* 2009;39(4):353-363.
143. Rohde P, Seeley JR, Mace DE. Correlates of suicidal behavior in a juvenile detention population. *Suicide Life Threat Behav.* 1997;27(2):164-175.
144. Parent D, Leiter V, Kennedy S, Livens L, Wentworth D, Wilcox S. *Conditions of confinement: juvenile detention and corrections facilities.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice; 1994.
145. Esposito CL, Clum GA. Social support and problem-solving as moderators of the relationship between childhood abuse and suicidality: applications to a delinquent population. *J Trauma Stress.* 2002;15(2):137-146.
146. Hayes L. *National study of jail suicide: 20 years later.* Washington, DC: National Institute of Corrections, US Department of Justice; 2010.
147. Wasserman GA, Jensen PS, Ko SJ, et al. Mental health assessments in juvenile justice: report on the consensus conference. *J Am Acad Child Adolesc Psychiatry.* 2003;42(7):752-761.
148. Pilnik L. Youth suicide and self-harm: what advocates need to know. *Child Law Practice.* June 2008;27(4):53-59.
149. Suicide Prevention Resource Center. *Suicide prevention in juvenile correctional facilities: a curriculum for state agency directors.* Newton, MA: Education Development Center, Inc.; 2008.
150. Nock MK, Favazza AR. Nonsuicidal self-injury: definition and classification. In: Nock MK, ed. *Understanding nonsuicidal self-injury: origins, assessment, and treatment.* Washington, DC: American Psychological Association; 2009:9-18.
151. Hawton K, Zahl D, Weatherall R. Suicide following deliberate self-harm: long-term follow-up of patients who presented to a general hospital. *Br J Psychiatry.* 2003;182:537-542.
152. Carter G, Reith DM, Whyte IM, McPherson M. Repeated self-poisoning: increasing severity of self-harm as a predictor of subsequent suicide. *Br J Psychiatry.* 2005;186:253-257.
153. Owens D, Horrocks J, House A. Fatal and non-fatal repetition of self-harm. Systematic review. *Br J Psychiatry.* 2002;181:193-199.
154. Brausch AM, Gutierrez PM. Differences in non-suicidal self-injury and suicide attempts in adolescents. *J Youth Adolesc.* 2010;39(3):233-242.

155. Beautrais AL. Further suicidal behavior among medically serious suicide attempters. *Suicide Life Threat Behav.* 2004;34(1):1-11.
156. Monti K, Cedereke M, Ojehagen A. Treatment adherence and suicidal behavior 1 month and 3 months after a suicide attempt: a comparison between two samples. *Arch Suicide Res.* 2003;7(2):167-174.
157. Cedereke M, Ojehagen A. Patients' needs during the year after a suicide attempt. A secondary analysis of a randomised controlled intervention study. *Soc Psychiatry Psychiatr Epidemiol.* 2002;37(8):357-363.
158. Liberman RP. Follow-up for parasuicidal patients. *Psychiatr Serv.* 2001;52(9):1254.
159. Motto JA, Bostrom AG. A randomized controlled trial of postcrisis suicide prevention. *Psychiatr Serv.* 2001;52:828-833.
160. Litts D, Beautrais A, Lezine DQ. *First national conference for survivors of suicide attempts, health care professionals, and clergy and laity: Summary of workgroup reports.* Newton, MA: Suicide Prevention Resource Center; 2008. Available at www.sprc.org/library/SOSAconf.pdf. Accessed August 30, 2012.
161. Macro International. *Lifeline service and outreach strategies suggested by suicide attempt survivors: final report of the Attempt Survivor Advisory Summit Meeting and individual interviews.* Rockville, MD: National Suicide Prevention Lifeline; 2007.
162. Substance Abuse and Mental Health Services Administration. *Consumer-operated services: the evidence.* HHS Pub. No. SMA-11-4633, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services; 2011.
163. National Cancer Institute. PDQ depression: suicide risk in cancer patients. Bethesda, MD: National Cancer Institute; 2011. Available at www.cancer.gov/cancertopics/pdq/supportivecare/depression/HealthProfessional/page4. Accessed June 30, 2011.
164. Lonnqvist JK. Physical illness and suicide. In: Wasserman D, ed. *Suicide: an unnecessary death.* London: Martin Dunitz; 2001:93-98.
165. DeLeo D, Meneghel G. The elderly and suicide. In: Wasserman D, ed. *Suicide: an unnecessary death.* London: Martin Dunitz; 2001:195-207.
166. Schlebusch L. Suicide risk and cancer. In: Berman AL, Pompili M, eds. *Medical conditions associated with suicide risk.* Washington, DC: American Association of Suicidology; 2011:59-74.
167. National Cancer Institute. PDQ depression: assessment, evaluation, and management of suicidal patients. Bethesda, MD: National Cancer Institute; 2011. Available at www.cancer.gov/cancertopics/pdq/supportivecare/depression/HealthProfessional/page5. Accessed June 30, 2011.

168. Akechi T, Ietsugu T, Sukigara M, et al. Symptom indicator of severity of depression in cancer patients: a comparison of the DSM-IV criteria with alternative diagnostic criteria. *Gen Hosp Psychiatry*. 2009;31(3):225-232.
169. Huntington G. On chorea. George Huntington, M.D. *J Neuropsychiatry Clin Neurosci*. 2003;15(1):109-112.
170. Fiedorowicz JG, Ruggle A, Paulsen JS. Suicide and Huntington disease. In: Berman AL, Pompili M, eds. *Medical conditions associated with suicide risk*. Washington, DC: American Association of Suicidology; 2011:173-186.
171. Stenager EN, Stenager E, Koch-Henriksen N, et al. Suicide and multiple sclerosis: an epidemiological investigation. *J Neurol Neurosurg Psychiatry*. 1992;55(7):542-545.
172. Samuel LS. Suicide and multiple sclerosis. In: Berman AL, Pompili M, eds. *Medical conditions associated with suicide risk*. Washington, DC: American Association of Suicidology; 2011:207-214.
173. Weintraub D, Stern MB. Psychiatric complications in Parkinson disease. *Am J Geriatr Psychiatry*. 2005;13(10):844-851.
174. Raja M. Suicide in Parkinson's disease. In: Berman AL, Pompili M, eds. *Medical conditions associated with suicide risk*. Washington, DC: American Association of Suicidology; 2011:215-228.
175. Hartkopp A, Bronnum-Hansen H, Seidenschnur AM, Biering-Sorensen F. Suicide in a spinal cord injured population: its relation to functional status. *Arch Phys Med Rehabil*. 1998;79(11):1356-1361.
176. Kennedy P, Rogers B, Speer S, Frankel H. Spinal cord injuries and attempted suicide: a retrospective review. *Spinal Cord*. 1999;37(12):847-852.
177. Hatcher MB, Whitaker C, Karl A. What predicts post-traumatic stress following spinal cord injury? *Br J Health Psychol*. 2009;14(Pt 3):541-561.
178. Lezak MD, Howieson DB, Loring DL, eds. *Neuropsychological assessment*. 4th ed. New York: Oxford University Press; 2004.
179. Jollant F, Bellivier F, Leboyer M, et al. Impaired decision making in suicide attempters. *Am J Psychiatry*. 2005;162(2):304-310.
180. Simpson G, Tate R. Suicidality in people surviving a traumatic brain injury: prevalence, risk factors and implications for clinical management. *Brain Inj*. 2007;21(13-14):1335-1351.
181. Jallon P. Mortality in patients with epilepsy. *Curr Opin Neurol*. 2004;17(2):141-146.
182. Mendez MF, Doss RC. Ictal and psychiatric aspects of suicide in epileptic patients. *Int J Psychiatry Med*. 1992;22(3):231-237.
183. Blumer D, Montouris G, Davies K, Wyler A, Phillips B, Hermann B. Suicide in epilepsy: psychopathology, pathogenesis, and prevention. *Epilepsy Behav*. 2002;3(3):232-241.

184. Janz D. *Die epilepsien: spezielle pathologie und therapie*. Stuttgart: George Thieme; 1969.
185. World Health Organization. *Preventing suicide: a resource for primary health care workers*. Geneva: WHO; 2000.
186. Amoozegar F, St. Germaine C, Becker WJ, Jette N. Suicide and migraines and chronic headaches. In: Berman AL, Pompili M, eds. *Medical conditions associated with suicide risk*. Washington, DC: American Association of Suicidology; 2011:193-205.
187. Cooperman NA. HIV/AIDS and suicide. In: Berman AL, Pompili M, eds. *Medical conditions associated with suicide risk*. Washington, DC: American Association of Suicidology; 2011:159-171.
188. Goodwin RD, Marusic A, Hoven CW. Suicide attempts in the United States: the role of physical illness. *Soc Sci Med*. 2003;56(8):1783-1788.
189. Malbergier A, de Andrade AG. Depressive disorders and suicide attempts in injecting drug users with and without HIV infection. *AIDS Care*. 2001;13(1):141-150.
190. Grassi L, Mondardini D, Pavanati M, Sighinolfi L, Serra A, Ghinelli F. Suicide probability and psychological morbidity secondary to HIV infection: a control study of HIV-seropositive, hepatitis C virus (HCV)-seropositive and HIV/HCV-seronegative injecting drug users. *J Affect Disord*. 2001;64(2-3):195-202.
191. Starace F, Sherr L. Suicidal behaviours, euthanasia and AIDS. *AIDS*. 1998;12(4):339-347.
192. Bellini M, Bruschi C. HIV infection and suicidality. *J Affect Disord*. 1996;38(2-3):153-164.
193. Kimmel PL, Cukor D, Cohen SD, Peterson RA. Depression in end-stage renal disease patients: a critical review. *Adv Chronic Kidney Dis*. 2007;14(4):328-334.
194. Cukor D, Peterson RA, Cohen SD, Kimmel PL. Depression in end-stage renal disease hemodialysis patients. *Nat Clin Pract Nephrol*. 2006;2(12):678-687.
195. Stang PE, Brandenburg NA, Lane MC, Merikangas KR, Von Korff MR, Kessler RC. Mental and physical comorbid conditions and days in role among persons with arthritis. *Psychosom Med*. 2006;68(1):152-158.
196. McWilliams LA, Clara IP, Murphy PD, Cox BJ, Sareen J. Associations between arthritis and a broad range of psychiatric disorders: findings from a nationally representative sample. *J Pain*. 2008;9(1):37-44.
197. He Y, Zhang M, Lin EH, et al. Mental disorders among persons with arthritis: results from the World Mental Health Surveys. *Psychol Med*. 2008;38(11):1639-1650.
198. Brennenstuhl S, Shaked Y, Fuller-Thomson E. Suicide risk and cancer. In: Berman AL, Pompili M, eds. *Medical conditions associated with suicide risk*. Washington, DC: American Association of Suicidology; 2011:27-38.

199. Kuo CJ, Chen VC, Lee WC, et al. Asthma and suicide mortality in young people: a 12-year follow-up study. *Am J Psychiatry*. 2010;167(9):1092-1099.
200. Goodwin RD, Marusic A. Asthma and suicidal ideation among youth in the community. *Crisis*. 2004;25(3):99-102.
201. Goodwin RD, Olfson M, Shea S, et al. Asthma and mental disorders in primary care. *Gen Hosp Psychiatry*. 2003;25(6):479-483.
202. Goodwin FK, Jamison KR. *Manic-depressive illness: bipolar disorders and recurrent depression*. New York: Oxford University Press; 2007.
203. Rihmer Z, Angst J. Epidemiology of bipolar disorders. In: Kasper S, Hirschfeld RMA, eds. *Handbook of bipolar disorders*. New York: Taylor & Francis; 2005:21-35.
204. Abreu LN, Lafer B, Baca-Garcia E, Oquendo MA. Suicidal ideation and suicide attempts in bipolar disorders type I: an update for the clinician. *Rev Bras Psiquiatr*. 2009;31(3):271-280.
205. Rihmer Z. Depression and suicidal behavior. In: O'Connor R, Plat S, Gordon J, eds. *International handbook of suicide prevention: research, policy, and practice*. West Sussex, UK: John Wiley & Sons; 2011.
206. Bolton JM, Pagura J, Enns MW, Grant B, Sareen J. A population-based longitudinal study of risk factors for suicide attempts in major depressive disorder. *J Psychiatr Res*. 2010;44(13):817-826.
207. Hawton K, Sutton L, Haw C, Sinclair J, Harriss L. Suicide and attempted suicide in bipolar disorders: a systematic review of risk factors. *J Clin Psychiatry*. 2005;66(6):693-704.
208. Hu G, Wilcox HC, Wissow L, Baker SP. Mid-life suicide: an increasing problem in U.S. Whites, 1999-2005. *Am J Prev Med*. 2008;35(6):589-593.
209. Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005;62(6):617-627.
210. Sareen J, Cox BJ, Afifi TO, et al. Anxiety disorders and risk for suicidal ideation and suicide attempts: a population-based longitudinal study of adults. *Arch Gen Psychiatry*. 2005;62(11):1249-1257.
211. Nepon J, Belik SL, Bolton J, Sareen J. The relationship between anxiety disorders and suicide attempts: findings from the National Epidemiologic Survey on Alcohol and Related Conditions. *Depress Anxiety*. 2010;27(9):791-798.
212. Soloff PH, Lynch KG, Kelly TM, Malone KM, Mann JJ. Characteristics of suicide attempts of patients with major depressive episode and borderline personality disorder: a comparative study. *Am J Psychiatry*. 2000;157(4):601-608.

213. Paris J. Personality disorders and suicidal behavior. In: Connor RC, Platt S, Gordon J, eds. *International handbook of suicide prevention: research, policy and prevention*. West Sussex, UK: John Wiley & Sons; 2011:109-118.
214. Paris J. *Personality disorders over time*. Washington, DC: American Psychiatric Press, Inc.; 2003.
215. Paris J. Clinical trials of treatment for personality disorders. *Psychiatr Clin North Am*. 2008;31(3):517-526, viii.
216. Amador X. Understanding and assessing insight. In: Amador X, David A, eds. *Insight and psychosis*. 2nd ed. New York: Oxford University Press; 2004.
217. Hogarty GE, Flesher S, Ulrich R, et al. Cognitive enhancement therapy for schizophrenia: effects of a 2-year randomized trial on cognition and behavior. *Arch Gen Psychiatry*. 2004;61(9):866-876.
218. Centers for Disease Control and Prevention. Suicides due to alcohol and/or drug overdose: a data brief from the National Violent Death Reporting System. Available at www.cdc.gov/ViolencePrevention/NVDRS/nvdrs_data_brief.html. Accessed December 22, 2011.
219. Skog O-J. Alcohol and suicide—Durkheim revisited. *Acta Sociol*. 1991;34(3):193-206.
220. Conner KR, Duberstein PR. Predisposing and precipitating factors for suicide among alcoholics: empirical review and conceptual integration. *Alcohol Clin Exp Res*. 2004;28(5 Suppl):6S-17S.
221. Mościcki EK. Epidemiology of completed and attempted suicide: toward a framework for prevention. *Clin Neurosci Res*. 2001;1(5):310-323.
222. Cherpitel CJ, Borges GL, Wilcox HC. Acute alcohol use and suicidal behavior: a review of the literature. *Alcohol Clin Exp Res*. 2004;28(5 Suppl):18S-28S.
223. McKeon RT. *Suicidal behavior*. Toronto, Ontario, Canada: Hogrefe & Huber; 2009.
224. Conner KR, Duberstein PR, Conwell Y. Age-related patterns of factors associated with completed suicide in men with alcohol dependence. *Am J Addict*. 1999;8(4):312-318.
225. Cheng AT. Mental illness and suicide. A case-control study in east Taiwan. *Arch Gen Psychiatry*. 1995;52(7):594-603.
226. Substance Abuse and Mental Health Services Administration. *Substance abuse and suicide prevention: evidence & implications—a white paper*. HHS Publication No. (SMA) 08-4352. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2008.
227. Ilgen MA, Harris AH, Moos RH, Tiet QQ. Predictors of a suicide attempt one year after entry into substance use disorder treatment. *Alcohol Clin Exp Res*. 2007;31(4):635-642.
228. Wilcox HC, Conner KR, Caine ED. Association of alcohol and drug use disorders and completed suicide: an empirical review of cohort studies. *Drug Alcohol Depend*. 2004;76 Suppl:S11-19.
229. Mathy RM. Suicidality and sexual orientation in five continents: Asia, Australia, Europe, North America, and South America. *Int J Sex Gend Stud*. 2002;7(2-3):215-225.

230. King M, Semlyen J, Tai SS, et al. A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*. 2008;8:70.
231. Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling M. *Injustice at every turn: a report of the National Transgender Discrimination Survey*. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force; 2011.
232. Russell ST, Toomey RB. Men's sexual orientation and suicide: evidence for U.S. adolescent-specific risk. *Soc Sci Med*. 2012;74(4):523-529.
233. Remafedi G. Suicidality in a venue-based sample of young men who have sex with men. *J Adolesc Health*. 2002;31(4):305-310.
234. Paul JP, Catania J, Pollack L, et al. Suicide attempts among gay and bisexual men: lifetime prevalence and antecedents. *Am J Public Health*. 2002;92(8):1338-1345.
235. Meyer IH, Dietrich J, Schwartz S. Lifetime prevalence of mental disorders and suicide attempts in diverse lesbian, gay, and bisexual populations. *Am J Public Health*. 2008;98(6):1004-1006.
236. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychol Bull*. 2003;129(5):674-697.
237. Hatzenbuehler ML, Keyes KM, Hasin DS. State-level policies and psychiatric morbidity in lesbian, gay, and bisexual populations. *Am J Public Health*. 2009;99(12):2275-2281.
238. Hatzenbuehler ML, McLaughlin KA, Keyes KM, Hasin DS. The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: a prospective study. *Am J Public Health*. 2010;100(3):452-459.
239. Ryan C, Russell ST, Huebner D, Diaz R, Sanchez J. Family acceptance in adolescence and the health of LGBT young adults. *J Child Adolesc Psychiatr Nurs*. 2010;23(4):205-213.
240. Blosnich JR, Bossarte RM, Silenzio VM. Suicidal ideation among sexual minority veterans: results from the 2005-2010 Massachusetts behavioral risk factor surveillance survey. *Am J Public Health*. 2012;102 Suppl 1:S44-47.
241. Movement Advancement Project (MAP). *Talking about suicide & LGBT populations*. Author; 2011. Available at: www.lgbtmap.org/talking-about-suicide-and-lgbt-populations. Accessed August 30, 2012.
242. US Army Medical System and Materiel Command, Medical Mortality Surveillance Division. Armed Forces Medical Examiner System: Data reported as of May 26th, 2011.
243. U.S. Army. *Army health promotion risk reduction suicide prevention report 2010*. Available at <http://csf.army.mil/downloads/HP-RR-SPReport2010.pdf>. Accessed August 30, 2012.

244. U.S. Department of Defense. *Department of Defense suicide event report (DoDSER): calendar year 2010 annual report*. National Center for Telehealth and Technology, Defense Centers of Excellence for Psychological Health & Traumatic Brain Injury; 2011.
245. Karch DL, Dahlberg LL, Patel N, et al. Surveillance for violent deaths—national violent death reporting system, 16 States, 2006. *MMWR Surveill Summ*. 2009;58(1):1-44.
246. Kaplan MS, Huguet N, McFarland BH, Newsom JT. Suicide among male veterans: a prospective population-based study. *J Epidemiol Community Health*. 2007;61(7):619-624.
247. Miller M, Barber C, Azrael D, Calle EE, Lawler E, Mukamal KJ. Suicide among U.S. veterans: a prospective study of 500,000 middle-aged and elderly men. *Am J Epidemiol*. 2009;170(4):494-500.
248. Veterans Health Administration. Administrative records and Internal briefings: Department of Veterans Affairs.
249. McCarthy JF, Valenstein M, Kim HM, Ilgen M, Zivin K, Blow FC. Suicide mortality among patients receiving care in the veterans health administration health system. *Am J Epidemiol*. 2009;169(8):1033-1038.
250. Ilgen MA, Bohnert AS, Ignacio RV, et al. Psychiatric diagnoses and risk of suicide in veterans. *Arch Gen Psychiatry*. 2010;67(11):1152-1158.
251. Watanabe KK, Kang HK. Mortality patterns among Vietnam veterans: a 24-year retrospective analysis. *J Occup Environ Med*. 1996;38(3):272-278.
252. Veterans Health Administration. *Uniform mental health services in VA medical centers and clinics. Handbook 1160.01*: Department of Veterans Affairs; 2008. Available at www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1762. Accessed August 30, 2012.
253. Hu G, Wilcox HC, Wissow L, Baker SP. Mid-life suicide: an increasing problem in U.S. Whites, 1999-2005. *Am J Prev Med*. 2008;35(6):589-593.
254. Caine ED, Knox KL, Conwell Y. Public health and population approaches for suicide prevention. In: Cohen NL, Galea, S., ed. *Population mental health: evidence, policy, & public health practice*. London & New York: Routledge; 2011:303-338.
255. Knox K, Caine E. Establishing priorities for reducing suicide and its antecedents in the United States. *Am J Public Health*. 2005;95(11):1898-1903.
256. Oliffe JL, Phillips MJ. Men, depression and masculinities: A review and recommendations. *J Mens Health*. 2008;5(3):194-202.
257. Addis ME, Mahalik JR. Men, masculinity, and the contexts of help seeking. *Am Psychol*. 2003;58(2):5-14.
258. Conner KR, Cox C, Duberstein PR, Tian L, Nisbet PA, Conwell Y. Violence, alcohol, and completed suicide: a case-control study. *Am J Psychiatry*. 2001;158:1701-1705.

259. Barth A, Sogner L, Gnambs T, Kundi M, Reiner A, Winker R. Socioeconomic factors and suicide: An analysis of 18 industrialized countries for the years 1983 through 2007. *J Occup Environ Med.* 2011;53(3):313-317.
260. Knox K, Litts D, Talcott G, Feig J, Caine E. Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: cohort study. *BMJ.* 2003;327(7428):1376.
261. Knox KL, Pflanz S, Talcott GW, et al. The US Air Force Suicide Prevention Program: implications for public health policy. *Am J Public Health.* 2010;100(12):2457-2463.
262. Gullestrup J, Lequertier B, Martin G. MATES in construction: impact of a multimodal, community-based program for suicide prevention in the construction industry. *Int J of Environ Res Public Health.* 2011;8(11):4180-4196.
263. Nakao M, Nishikitani M, Shima S, Yano E. A 2-year cohort study on the impact of an Employee Assistance Programme (EAP) on depression and suicidal thoughts in male Japanese workers. *Int Arch Occup Environ Health.* 2007;81(2):151-157.
264. Conwell Y, Duberstein PR, Connor K, Eberly S, Cox C, Caine ED. Access to firearms and risk for suicide in middle-aged and older adults. *Am J Geriatr Psychiatry.* 2002;10(4):407-416.
265. Mann JJ, Apter A, Bertolote J, et al. Suicide prevention strategies. *JAMA.* 2005;294(16):2064-2074.
266. Kellam SG, Brown CH, Poduska JM, et al. Effects of a universal classroom behavior management program in first and second grades on young adult behavioral, psychiatric, and social outcomes. *Drug Alcohol Depend.* 2008;95 Suppl 1:S5-S28.
267. Conwell Y, Thompson C. Suicidal behavior in elders. *Psychiatr Clin North Am.* 2008;31(2):333-356.
268. Conwell Y, Duberstein PR, Cox C, Herrmann J, Forbes N, Caine ED. Age differences in behaviors leading to completed suicide. *Am J Geriatr Psychiatry.* 1998;6(2):122-126.

