Suicide Risk Assessment and Intervention

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Introduction: What is Suicide?

Suicide is when people direct violence at themselves with the intent to end their lives, and they die because of their actions. It's best to avoid the use of terms like "committing suicide" or a "successful suicide" when referring to a death by suicide as these terms often carry negative connotations. Suicide is an acute, deliberate act of self-harm, undertaken by an individual with at least some intention to die, that results in death.

A suicide attempt is when people harm themselves with the intent to end their lives, but they do not die because of their actions. We may often ask ourselves, "Who is at Risk for Suicide?" Suicide does not discriminate. People of all genders, ages, and ethnicities can be at risk.

The main risk factors for suicide are prior suicide attempt, Depression and other mental health disorders, Substance abuse disorder, family history of a mental health or substance abuse disorder, family history of suicide, family violence, including physical or sexual abuse, having guns or other firearms in the home, being in prison or jail, being exposed to others' suicidal behavior, such as a family member, peer, or media figure, medical illness, and being between the ages of 15 and 24 years or over age 60.

Even among people who have risk factors for suicide, most do not attempt suicide. It remains difficult to predict who will act on suicidal thoughts. Most people who have risk factors for suicide will not kill themselves. However, the risk for suicidal behavior is complex. Research suggests that people who attempt suicide may react to events, think, and make decisions differently than those who do not attempt suicide.

These differences happen more often if a person also has a disorder such as depression, substance abuse, anxiety, borderline personality disorder, and psychosis. Risk factors are important to keep in mind; however, someone who has *warning signs* of suicide may be in more danger and require immediate attention (NIMH, 2018).

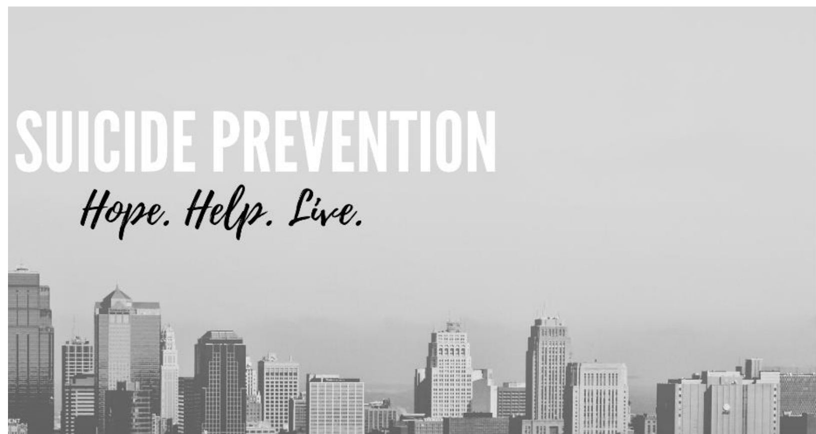
Chapter 1. Warning Signs of Suicide

A. Warning Signs of Suicide

National Institutes of Health NIH Publication No. TR 18-6389, Suicide in America: Frequently Asked Questions (2018)

Retrieved from: https://www.nimh.nih.gov/health/publications/suicide-faq/index.shtml

The behaviors listed below may be signs that someone is thinking about suicide.



- Talking about wanting to die or wanting to kill themselves
- Talking about feeling empty, hopeless, or having no reason to live
- Planning or looking for a way to kill themselves, such as searching online, stockpiling pills, or newly acquiring potentially lethal items (e.g., firearms, ropes)
- Talking about great guilt or shame
- Talking about feeling trapped or feeling that there are no solutions
- Feeling unbearable pain, both physical or emotional
- Talking about being a burden to others
- Using alcohol or drugs more often
- Acting anxious or agitated
- Withdrawing from family and friends
- Changing eating and/or sleeping habits

- Showing rage or talking about seeking revenge
- Taking risks that could lead to death, such as reckless driving
- Talking or thinking about death often
- Displaying extreme mood swings, suddenly changing from very sad to very calm or happy
- Giving away important possessions
- Saying goodbye to friends and family
- Putting affairs in order, making a will

Do People Threaten Suicide to Get Attention?

Suicidal thoughts or actions are a sign of extreme distress and an alert that someone needs help. Any warning sign or symptom of suicide should not be ignored. All talk of suicide should be taken seriously and requires attention. Threatening to die by suicide is not a normal response to stress and should not be taken lightly.

If You Ask Someone About Suicide, Does It Put the Idea Into Their Head?

Asking someone about suicide is not harmful. There is a common myth that asking someone about suicide can put the idea into their head. This is not true. Several studies examining this concern have demonstrated that asking people about suicidal thoughts and behavior does not induce or increase such thoughts and experiences. In fact, asking someone directly, “Are you thinking of killing yourself,” can be the best way to identify someone at risk for suicide.

B. What Should I Do if I Am in Crisis or Someone I Know Is Considering Suicide?

If you or someone you know has warning signs or symptoms of suicide, particularly if there is a change in the behavior or new behavior, get help as soon as possible.

Often, family and friends are the first to recognize the warning signs of suicide and can take the first step toward helping an at-risk individual find treatment with someone who specializes in diagnosing and treating mental health conditions. If someone is telling you that they are going to kill themselves, do not leave them alone. Do not promise anyone that you will keep their suicidal thoughts a secret. Make sure to tell a trusted friend or family member, or if you are a student, an adult with whom you feel comfortable.

In providing therapeutic services for an individual, it is important at the very beginning of providing services to explain the limits of confidentiality as it applies to their safety. It is expected the social worker/counselor will provide the resources, including breaking confidentiality in order to protect a client who is an imminent danger to themselves. This may include calling law enforcement and/or an emergency psychiatric assessment team to help determine whether a person should be place on a psychiatric hold in a facility to protect their safety and stabilize them.

What if Someone Is Posting Suicidal Messages on Social Media?

Knowing how to get help for a friend posting suicidal messages on social media can save a life. Many social media sites have a process to report suicidal content and get help for the person posting the message. In addition, many of the social media sites use their analytic capabilities to identify and help report suicidal posts. Each offers different options on how to respond if you see concerning posts about suicide. For example:

- Facebook Suicide Prevention webpage can be found at www.facebook.com/help/594991777257121/

  [use the search term “suicide” or “suicide prevention”].
- Instagram uses automated tools in the app to provide resources, which can also be found online at https://help.instagram.com

[use the search term, "suicide," self-injury," or "suicide prevention"]

- Snapchat's Support provides guidance at https://support.snapchat.com

  [use the search term, "suicide" or "suicide prevention"]
- Tumblr Counseling and Prevention Resources webpage can be found at https://tumblr.zendesk.com

  [use the search term "counseling" or "prevention," then click on "Counseling and prevention resources"].
- Twitter's Best Practices in Dealing With Self-Harm and Suicide at https://support.twitter.com

  [use the search term "suicide," "self-harm," or "suicide prevention"].
- YouTube's Safety Center webpage can be found at https://support.google.com/youtube [use the search term "suicide and self-injury"].

If you see messages or live streaming suicidal behavior on social media, call 911 or contact the toll-free National Suicide Prevention Lifeline at 1–800–273–TALK (8255), or text the Crisis Text Line (text HOME to 741741) available 24 hours a day, 7 days a week. Deaf and hard-of-hearing individuals can contact the Lifeline via TTY at 1–800–799–4889. All calls are confidential. This service is available to everyone. People—even strangers—have saved lives by being vigilant.

C. What Treatment Options and Therapies Are Available?

Effective suicide intervention practices are based on research findings and tested to see how various programs benefit various specific groups of people. For example, research has shown that borderline personality disorder is a risk factor for suicidal behavior, and there are programs that are effective in reducing suicide attempts.

Among its research on suicide, the National Institute of Mental Health (NIMH) has supported research on strategies that have worked well for those who have mental health conditions related to suicide such as depression and anxiety. These mainly include types of psychotherapies (such as cognitive behavioral therapy or dialectical behavioral therapy). NIMH also conducts research on suicide risk screening tools for health care clinicians to use as a guide for screening patients for suicide risk.

Talking to Your Doctor

Suicide is often not discussed in medical visits where physical symptoms are more of the focus. If you have thoughts of suicide, tell your health care provider. Asking questions and providing information to your doctor or health care provider can improve your care. Talking with your doctor builds trust and leads to better results, quality, safety, and satisfaction.

(NIMH, 2018)

D. Are certain groups of people at higher risk than others?

According to the Centers for Disease Control and Prevention (CDC), men are more likely to die by suicide than women, but women are more likely to attempt suicide. Men are more likely to use more lethal methods, such as firearms or suffocation. Women are more likely than men to attempt suicide by poisoning. Also per the CDC, certain

demographic subgroups are at higher risk. For example, American Indian and Alaska Native youth and middle-aged persons have the highest rate of suicide, followed by non-Hispanic White middle-aged and older adult males. African Americans have the lowest suicide rate, while Hispanics have the second lowest rate. The exception to this is younger children. African American children under the age of 12 have a higher rate of suicide than White children. While younger preteens and teens have a lower rate of suicide than older adolescents, there has been a significant rise in the suicide rate among youth ages 10 to 14. Suicide ranks as the second leading cause of death for this age group, accounting for 425 deaths per year and surpassing the death rate for traffic accidents, which is the most common cause of death for young people. (NIMH, 2020)

National Institute of Mental Health (NIMH), *Suicide in America: Frequently Asked Questions*, 2020: Retrieved from https://www.nimh.nih.gov/health/publications/suicide-faq/tr18-6389-suicideinamericafaq_149986.pdf

People at Greater Risk of Suicide

Thoughts of suicide can touch any person anywhere, but there are some groups in the U.S. that are at greater risk for different reasons.

Adults Over the Age of 45

Middle-aged people, especially men, have the highest rate of suicide compared to other groups. Eighty percent of all deaths by suicide in the U.S. are among men and women age 45-54. Men ages 85 and older have the highest rate of any group in the country. Many factors contribute to this risk, including isolation, a history of violence, and access to lethal means.

American Indians

Young American Indian men—especially in the Northern Plains—are at high risk for suicide compared to other groups. While many of the risk factors are the same as those affecting other groups, young American Indian men face additional challenges such as historical trauma, cultural distress, poverty, geographic isolation, and suicide in the community that can cause increased stress.

Alaskan Natives

Young men living in Alaska are greatly affected by suicide, wrestling with stigma and silence. In 2017, Alaska had the second highest rate of suicide in the nation. But new prevention efforts and knowledge are making headway in counteracting challenges such as mental health and substance abuse problems. (SAMHSA, 2020)

Substance Abuse and Mental Health Services Administration, *Preventing Suicide*, (2020) Retrieved from https://www.samhsa.gov/suicide/at-risk

LGBTQ+

The LGBTQ+ community is diverse and strong, but may be disproportionately at-risk for suicidal feelings and other mental health struggles because of the discrimination and prejudice they too often are up against.
We all have a role in preventing suicide. Learn how to support and be an ally to your LGBTQ+ loved ones.

Be an ally: If you're straight, publicly show your support for the LGBTQ+ community. If you're LGBTQ+, affirm your identity and offer support to loved ones.
Know the facts: Over 80% of LGBTQ+ youth have been assaulted or threatened, and every instance of victimization in an LGBTQ+ person's life more than doubles the likelihood of self-harming.
Ask and listen: Be an active part of your LGBTQ+ loved ones' support systems and check in with them often. If they show any warning signs for suicide, be direct. Tell them it's OK to talk about suicidal feelings. Practice active listening techniques and let them talk without judgment.
Get them help and take care of yourself: Don't be afraid to get your loved one the help they might need. The Lifeline is always here to talk or chat, both for crisis intervention and to support allies.
Strong family bonds, safe schools and support from caring adults can all protect LGBTQ youth from depression and suicidality

Family and community support: For transgender children and youth, family and community support makes all the difference. (NCPL, 2020)

National Suicide Prevention Lifeline (NCPL), “LGBTQ+” 2020, Retrieved from https://suicidepreventionlifeline.org/help-yourself/lgbtq/

Chapter 2. Types of Suicidal Thought and Behaviors

Center for Substance Abuse Treatment. Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 50. HHS Publication No. (SMA) 15-4381. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009, Update review 2017*.

Updated Citation information from SAMHSA Editor’s Note:

*“2017**

Published in 2009, Treatment Improvement Protocol (TIP) 50 contains much information that remains useful to today’s reader. Noted below are topical areas where more current information and resources supplant or add to the content found in the TIP. Clinical Updates The Consensus Panel was not reconvened to review and update the clinical information in TIP 50. However, a literature search covering 2009 to mid-2017 found little information that would affect the recommendations in the TIP.”

Retrieved from https://store.samhsa.gov/product/TIP-50-Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/SMA15-4381

A. Definitions

- **Suicidal ideation**: Suicidal ideation is much more common than suicidal behavior. Suicidal ideation (or thoughts) exists on a continuum of severity from fleeting, vague thoughts of death to persistent and highly specific considerations of suicide. Thoughts may only occur periodically or may be unrelenting.

- **Suicide plans:** Suicide plans are significant because they signal a more serious risk of carrying out suicidal behavior than does suicidal ideation without planning. Suicide planning exists on a continuum from vague and unrealistic plans to highly specific and feasible plans. Serious suicide planning may also involve rehearsal or preparation for a suicide attempt.

- **Suicidal intention:** Suicidal intention (also called “intent”) signals high, the acute risk for suicidal behavior. Having suicidal intent is always serious because it signals that the client intends to make a suicide attempt. Some indicators of high intent include drafting a suicide note or taking precautions against discovery at the time of an attempt.

- **Suicide preparation:** Behaviors that suggest preparation signal high, the acute risk for suicide. Preparation can take many forms, such as writing a suicide note

or diary entry, giving away possessions, writing a will, acquiring a method of suicide (e.g., hoarding pills, buying a weapon), making a method more available (e.g., moving a gun from the attic to beside the bed), visiting a site where suicide may be carried out (e.g., driving to a bridge), rehearsing suicide (e.g., loading and unloading a weapon), and saying goodbye to loved ones directly or symbolically.

- **Suicide attempt:** A suicide attempt is a deliberate act of self-harm, undertaken by an individual who has at least some intent to die, that does not result in death. Attempts have two major elements: the subjective level of intent to die (from the client's subjective perspective, how intensely did he or she want to die and to what extent did he or she expect to die?) and the objective lethality of the act (from a medical perspective, how likely was it that the behavior would have led to death?). Although all suicide attempts are serious, those with high intent (client clearly wanted and expected to die) and high lethality (behavior could have easily led to death) are the most serious.

- **Suicide:** Suicide is an acute, deliberate act of self-harm, undertaken by an individual with at least some intention to die, that results in death.

- **Non-suicidal self-injury (NSSI):** NSSI (e.g., self-mutilation or self-injury by cutting for the purpose of self-soothing with no wish to die and no expectation of dying) is distinguished from a suicide attempt or suicide because NSSI does not include suicidal intent. NSSI is also commonly referred to in the literature as "deliberate self-harm" or "suicidal gesture." This Quick Guide and the TIP upon which it is based do not focus on NSSI. However, suicidal behaviors and NSSI can coexist in the same person, and both can lead to serious bodily injury.

- **Self-destructive behaviors:** Behaviors that are repeated and may eventually lead to death (e.g., drug abuse, smoking, anorexia, reckless driving, getting into fights) are distinguished from suicidal behavior because an act of suicide is an acute action intended to cause death in short order.

B. Getting Ready to Address Suicidality

It is important for you to be comfortable and competent when asking your clients questions about suicidal ideation and behavior. It may be challenging to balance your own comfort level with your need to obtain accurate and clear information to best help the client, particularly as you are learning more about suicidality.

Thoughts To Consider.

Be direct. Be direct. We must often talk with clients about socially taboo topics. Become comfortable talking with clients directly about their thoughts of killing themselves. Doing so can save lives.

Increase your knowledge about suicide. Knowing some of the circumstances in which people become suicidal, how suicidality manifests, what warning signs might indicate possible suicidal behavior, what questions to ask to identify suicidality, and—perhaps most important—the range of effective interventions for suicidality increases your competence and comfort.

Do what you already do well. Faced with a suicidal client, many counselors turn into the "suicide police," aggressively questioning and demanding assurances of safety from the client. Don't lose sight of what makes you a successful counselor: empathy, good therapeutic skills, and awareness of client resistance.

Practice, practice, practice. Nobody does something best the first time around. Get comfortable with asking all clients in substance abuse treatment about suicide. Learn to look for risk factors and warning signs. Consider attending a workshop at which you can enhance and practice your skills.

Get good clinical supervision. There is no substitute for working with an experienced supervisor to help you fine-tune your skills in working with suicidal clients. Good supervision should offer you opportunities to learn more about suicidality, become more aware of your own strengths and limitations in working with people who are suicidal and practice new skills. Supervision also provides you with the oversight and input necessary to ensure that you are following the highest level of ethical and professional standards of practice.

Work collaboratively with clients. It is an unfounded stereotype that most people don't want to talk about their suicidality. Most, in fact, do want to talk with you; they want to collaborate and cooperate with you to reduce their pain. We almost always get better results by inviting collaboration than by acting independently.

Recognize the limits of confidentiality when suicidality is involved. Confidentiality rules change when clients are in imminent danger of killing themselves. However, just because a client voices a desire to die does not allow you to violate confidentiality. Know the limits of confidentiality when working with suicidal clients and always consult an experienced supervisor.

10 Points To Remember About Suicidality

1. Almost all clients who are suicidal are ambivalent about living or not living. Wishing to both die and live is typical of most individuals who are suicidal. Take suicidal thinking seriously and consider ways to reinforce a client's sense of hope. Do everything you can to support the side of the client that wants to live, but do not trivialize or ignore signs of wanting to die.

2. Suicidal crises can be overcome. Fortunately, acute suicidality is a transient state. Even individuals at high long-term risk spend more time being non-suicidal than being suicidal. Moreover, most people who have made serious

suicide attempts but then receive acute medical and/or psychiatric care are relieved that they did not die. The challenge is to help clients survive the acute suicidal crisis period until such time as they want to live again.

3. Although suicide cannot be predicted with certainty, suicide risk assessment is valuable. Suicide risk assessment is a valuable clinical tool because it can ensure that those requiring more services get the help that they need.

4. Suicide prevention actions should extend beyond the immediate crisis. Just because someone is no longer at imminent suicide risk does not mean that he or she is "out of the woods." Clients in substance abuse treatment who have long-term risk factors for suicide (e.g., depression, child sexual abuse history, marital problems, repeated substance abuse relapse) require treatment of these issues whether or not the clients show any indication of current risk for suicide. Individuals with histories of serious suicidal thoughts or suicide attempts but no recent suicidal thoughts or behaviors need to be monitored to identify any recurrence of suicidality.

5. Suicide contracts are not recommended and are never sufficient. Safety contracts or "no suicide contracts" are never sufficient as a deterrent to suicidal behavior. Use this Quick Guide and its accompanying TIP to choose from among the many other strategies that promote safety. Use contracts sparingly, if at all.

6. Some clients will be at risk for suicide even after becoming clean and sober. Abstinence should be a primary goal for any client with a substance use disorder and suicidal thoughts and/or behaviors. Indeed, risk will diminish for most clients when they achieve abstinence. Nonetheless, some individuals remain at risk even after achieving abstinence. Some clients in substance abuse recovery that remain at risk include those with independent depression, unresolved difficulties that promote suicidal

thoughts (e.g., partner breakup, ongoing domestic violence or other traumas, impending legal difficulties), or certain personality disorders.

7. Suicidal thoughts and behaviors must always be taken seriously. Any indications of suicidality must be taken seriously, including those that involve little risk of death; any suicidal thoughts must be carefully considered in relation to the client's history and current presentation. Clients with histories of attempted suicide warrant particular attention.

8. Persons who are suicidal generally show warning signs. Fortunately, individuals who are experiencing suicidality usually give warning signs, which come in many forms (e.g., expressions of hopelessness, suicidal communication) and are often repeated. The difficulty is in recognizing these signs for what they are; often, signs are not seen until after a suicide attempt.

9. It is best to ask all clients in substance abuse treatment directly about suicide. You may never know about a client's suicidality unless you ask the right questions. Many clients will be willing to talk about their histories and their current thoughts about suicide, but only if they are asked. The questions you need to ask are discussed on page 32 of this Quick Guide under the heading "G: Gather Information."

10. The outcome does not tell the whole story. Most clients who are experiencing suicidal thoughts—and even those who make an attempt—don't die. Death by suicide is, fortunately, a relatively uncommon event. You cannot assume that because someone does not die, appropriate treatment has been provided. Likewise, despite the best of assessments and precautions, sometimes an individual does die. This does not mean that the individual has received improper treatment.

C. Warning Signs for Suicide

Warning signs are defined as acute indications of elevated risk. In other words, they signal potential risk for suicidal behavior in the near future. Warning signs may be evident at intake or may arise during the course of treatment. Warning signs, which can be direct or indirect, always require asking follow-up questions.

Direct indications of acute suicidality are given the highest priority. They are:

- **Suicidal communication:** Someone threatening to hurt or kill him- or herself or talking of wanting to hurt or kill him- or herself.

- **Seeking access to the method:** Someone looking for ways to kill him- or herself by seeking access to firearms, pills, or other means.

- **Making preparations**: Someone talking or writing about death, dying, or suicide when such topics are out of the ordinary for the person to address.

Each of the direct warning signs indicates a potential for suicidal behavior in its own right and, if present, requires rigorous follow-up. Indirect warning signs, on the other

hand, may or may not signal risk for acute suicidal behavior (e.g., substance abuse is the norm among your clients). In all cases, warning signs require follow-up questions to determine whether they indicate acute suicidality.

You may observe indirect warning signs in substance abuse clients who are not suicidal. Nonetheless, these warning signs are critical to follow up on to determine the extent to which they may signal acute risk for suicidal behavior. You can remember them by the mnemonic **IS PATH WARM:**

I = Ideation
S = Substance abuse
P = Purposelessness
A = Anxiety
T = Trapped
H = Hopelessness
W = Withdrawal
A = Anger
R = Recklessness
M = Mood changes

Some of the IS PATH WARM warning signs are self-evident (e.g., substance abuse); others require a brief explanation. “Purposelessness” refers to a lack of a sense of purpose in life or reason for living. “Trapped” refers to perceiving a terrible

situation from which there is no escape. “Withdrawal” refers to increasing social isolation. “Anger” refers to rage, uncontrolled anger, or revenge-seeking. “Anxiety” is a broad term that refers to severe anxiety, agitation, and/or sleep disturbances. The phrase “mood changes” refers to dramatic shifts in emotions. Warning signs are often in evidence following acute stressful life events. Among people who abuse substances, the break-up of a partner relationship is most common. It is also important to look for warning signs in your clients when relapse occurs and during acute intoxication. Stressful life events include:

- Break-up of a partner relationship.
- Experience of trauma.
- Legal event.
- Job loss or other major employment setbacks.
- Financial crisis.
- Family conflict or disruption.
- Relapse.
- Intoxication.

D. Risk Factors and Protective Factors

Risk factors are defined as indicators of long-term (or ongoing) risk. They differ from direct warning signs, which signal immediate risk. Risk factors for suicidal thoughts and behaviors among individuals with substance use disorders have been well researched (Conner, Beautrais, & Conwell, 2003; Conner et al., 2007; Darke & Ross, 2002; Ilgen et al., 2007; Murphy et al., 1992; Preuss et al., 2002; Roy, 2001; Schneider et al., 2006).The following list of risk factors, although not exhaustive, is informed by this research:

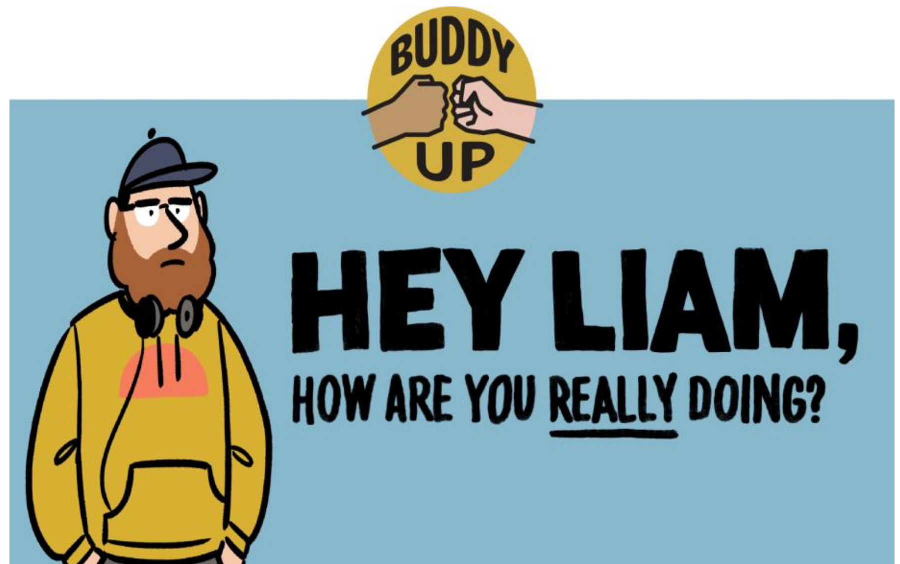
- Prior history of suicide attempts (most potent risk factor, although about half of all deaths by suicide are first-time attempts)
- Family history of suicide
- Severe substance use or dependence (e.g., use of multiple substances, early onset of dependence)
- Co-occurring mental disorder
    - Depression (including substance-induced depression)
    - Anxiety disorders (especially PTSD)
    - Serious mental illness (schizophrenia, bipolar disorder)
    - Personality disorder (best-researched are borderline and antisocial personality disorders)
    - Anorexia nervosa
- History of child abuse (especially sexual abuse)
- Stressful life circumstances
- Unemployment and low level of education; job loss, especially when nearing retirement
- Divorce or separation
- Legal difficulties
- Major and sudden financial losses
- Social isolation; low social support
- Conflicted relationships
- Personality traits
    - Proneness to negative affect (sadness, anxiety, anger)
    - Aggression and/or impulsiveness
- Firearm ownership or access to a firearm

Protective Factors

Protective factors are defined as buffers that lower long-term risk. Unlike risk factors, factors that protect against suicidal behavior are not well researched (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). Reasons for living are perhaps the best researched protective factors in the literature (Linehan Goodstein, Nielsen, & Chiles, 1983; Oquendo Dragasti et al., 2005). Protective factors vary with cultural values. For example, in cultures where extended families are closely knit, family support can act as a protective factor.

The following are known and likely protective factors:

- Reasons for living
- Being clean and sober
- Attendance at 12-Step support groups
- Attendance at a place of worship and/or internalized spiritual teachings against suicide
- Presence of a child in the home and/or child-rearing responsibilities
- Intact marriage
- Trusting relationship with a counselor, physician, or other service providers
- Employment



- Trait optimism (a tendency to look at the positive side of life)

A caution about protective factors: If acute suicide warning signs and/or multiple risk factors are in evidence, the presence of protective factors does not change the bottom-line assessment that preventive actions are necessary, nor should the presence of such protective factors give you a false sense of security. Although protective factors may sustain someone showing ongoing signs of risk (e.g., due to chronic depression), they do not immunize clients from suicidal behavior and may afford no protection in acute crises.

F. GATE: A Four-Step Process for Identifying and Responding to Suicidality

The role of substance abuse treatment counselors in addressing clients' suicidal thoughts and behaviors can be represented by the acronym **GATE:**

Gather information,
Access supervision,
Take action,
Extend the action.

G: Gather information

There are two steps to gathering information:

(1) screening and spotting warning signs

Screening consists of asking very brief, uniform questions at intake to determine if further questions about suicide risk are necessary. Spotting warning signs consist of identifying telltale signs of potential risk.

Gathering information is different from formal assessment because an assessment is a process by which a professional synthesizes and interprets information. Substantial training, supervision, and experience are required to have sufficient clinical judgment to make the fine distinctions necessary for assessment. But substance abuse counselors should be prepared to collect information from clients about suicidality and to perform basic suicide screening.

As much as possible, you should avoid “stacking” questions (peppering clients with one closed-end question after the other), which tends to generate defensiveness and/or false reassurances of safety. If a client’s answers are unclear or if you sense some defensiveness, consider asking the same question in a different way later in the interview. Although clients will not always be able or willing to provide greater clarity regarding their suicidality, ambiguous or vague answers are always important to pursue further because they may signal discomfort with the topic, anxiety about disclosure, evasiveness, and/or uncertainty (e.g., “I don’t know,” “I’m not sure”).

(2) asking follow-up questions.

Ask follow-up questions when clients respond “yes” to one or more screening questions or any time you notice a warning sign(s). The purpose of asking follow-up questions is to have as much information as possible so that you and your supervisor and/or treatment team can develop a good plan of action. You should convey as much information as possible to another provider, should you make a referral or request a consultation.

If your agency does not provide you with standard screening question(s) on suicidal thoughts and behaviors, use the questions provided below. They introduce the topic of suicide and screen for suicidal thoughts and attempts. The timing of the questions is important; it is better to ask them in the context of a larger discussion of, for instance, mood or quality of life. Ask the same screening questions verbatim for every new client.

Introducing the topic (use either statement):

1. Now I am going to ask you a few questions about suicide.
2. I have a few questions to ask you about suicidal thoughts and behaviors. Screening for suicidal thoughts (ask either question):
3. Have you thought about killing yourself?
4. Have you thought about carrying out suicide? Screening for suicide attempts (ask either question):
5. Have you ever tried to take your own life?
6. Have you ever attempted suicide?

Note that the introductory items are brief and straightforward. With slight word changes, items 3 and 5 are taken from an interview for the study of alcoholism that has been used in research on suicidal thoughts and behaviors, and items 4 and 6 are taken from a national survey that has provided information on suicidal thoughts and behaviors in the general population. The National Suicide Prevention Lifeline has produced a wallet-sized card for counselors entitled “Assessing Suicide Risk: Initial Tips for Counselors” that lists five questions counselors can ask about suicide. The card also lists the warning signs contained in “IS PATH WARM” and offers brief advice on actions to take with people who are at risk. The card is available in the TIP and online at http://store.samhsa.gov/product/National-Suicide-Prevention-Lifeline-Wallet-CardAssessing-Suicide-Risk-Initial-Tips-for-Counselors/ SVP13-0153. Bulk copies (item SVP06-0153) can be ordered at http://store.samhsa.gov.

Additional options for screening

Multi-item measures that contain one or more items that ask about suicidal thoughts or behaviors may also be used for screening, and sometimes the client has previously taken such a test and the actual answers will be in the client records. Items that ask about suicidality can be found on several widely used measurement instruments or interview questions—the Beck Depression Inventory-II (BDI-II) and the Patient Health Questionnaire-9 (PHQ-9) are two examples. The BDI-II must be purchased (http://www.pearsonassessments.com), but the PHQ-9 is in the public domain (http://www.integration.samhsa.gov/images/res/PHQ%20-%20 Questions.pdf). Both require users to meet qualification standards to ensure accurate and ethical use. If a client endorses any level of suicidality on the relevant items of any such measure, you should ask follow-up questions. TIP 42, Substance Abuse Treatment for Persons with Co-Occurring Disorders, contains useful suicide screening options for persons with co-occurring disorders.

Asking follow-up questions

Sample follow-up questions about suicidal thoughts:

1. Can you tell me about the suicidal thoughts?
2. If the client requires more direction, try some of the following questions:
    - What brings them on?
    - How strong are they?
    - How long do they last?
3. If you do not already know the answers to the following questions, ask:
    - Have you made a plan? (If yes) What is your plan?
    - Do you have access to a method of suicide—a gun? A stockpile of drugs or medications?
    - Do you intend to attempt suicide?

Always ask an open-ended question first (see sample question 1). Clients may tell you spontaneously all of the information you need to know. Open-ended questions can help you avoid "grilling" the client. Information not provided by clients may be elicited with follow-up questions to determine data such as the precipitants, strength, and duration of the suicidal thoughts (see sample question 2). If information related to planning, method, and intent does not come to light spontaneously, always gather these critical pieces of information (see sample question 3). A client's inability or unwillingness to provide the necessary information may be an indicator of increased risk; note this in discussion with your treatment team or supervisor.

Gathering additional information about suicide attempts is straightforward. Ask the client to explain the attempt through an open-ended question, such as "Please tell me about the attempt"; ask follow-up questions to find out more. If more than one suicide attempt occurred, ask about the most recent attempt and the most severe attempt (if different from the most recent act).

The answers to these questions will help characterize the seriousness of suicidal behavior. Sample follow-up questions about suicide attempts:

1. Please tell me about the attempt.
2. If the client requires more direction, ask questions such as the following:
    - What brought it on?
    - Where were you?
    - Were you drinking or high?
3. If you do not already know:

    To gather information about lethality, ask:

    - What method did you use to try to kill yourself?
    - Did you receive emergency medical treatment?

    To gather information about intent, ask:

    - Did you want to die?
    - How strong was the desire to die?

- Afterward, were you relieved you survived, or would you rather have died?

The lessons that apply to asking about suicidal thoughts also apply here: Ask an open-ended question first, ask follow-up questions to determine the circumstances of the attempt (e.g., precipitating event, setting, the role of acute alcohol or drug use), and, if information related to lethality and intent does not come to light spontaneously, always gather these critical pieces of information (see sample question 3)

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Summary of G: Gather information

Gathering information consists of collecting relevant facts. Screening questions should be asked of all clients when you note warning sign(s) and whenever you have a concern about suicide, whether or not you can pinpoint the reason. Inquiries about suicidal thoughts and attempts always start with an open-ended question that invites the client to provide more information. Follow-up questions are then asked to gather additional critical information. Routine monitoring of suicide risk throughout treatment should be a basic standard in all substance abuse treatment programs.

It is important to ask follow-up questions when a client answers “yes” to a screening question at intake, when you note a warning sign, or at any time during the course of treatment when you suspect the client is suicidal, even if you can’t pinpoint why. Follow-up questions and their answers give you as much information as possible for discussing the situation with your supervisor or team and allow you to convey solid information if referring to another provider.

A: Access supervision and/or consultation

You should never attempt to manage suicide risk alone, even if you have substantial specialized training and education. With cases involving clients who are suicidal, two or three heads are almost always better than one. Therefore, speak with a supervisor, an experienced consultant who has been vetted by your agency, and/or your multidisciplinary treatment team when working with a client who you suspect may be dealing with suicidal concerns. It is a collective responsibility, not yours alone, to formulate a preliminary impression of the seriousness of the risk and to determine the action(s) that will be taken. Accessing supervision or consultation can provide invaluable input to promote the client's safety, give you needed support, and reduce your personal liability.

You should not make a judgment about the seriousness of suicide risk or try to manage suicide risk on your own unless you have an advanced mental health degree and specialized training in suicide risk management and it is understood by your agency that you are qualified to manage such risk independently. For this step, obtaining consultation does not refer merely to getting input from a peer. Although such input may be helpful, consultation is a more formal process whereby information and advice are obtained from

(a) a professional with clear supervisory responsibilities,

(b) a multidisciplinary team that includes such person(s), and/or

(c) a consultant experienced in managing clients who are suicidal who has been vetted by your agency for this purpose.

When obtaining supervision or consultation, assemble all the information you have gathered on your client's suicidal thoughts and/or suicide attempts through screening and follow-up questions, as well as data from other sources of information (e.g., other providers, family members, treatment records).

In some circumstances, you will need to obtain immediate consultation. In other circumstances, obtaining consultation at regularly scheduled supervision or team meetings may be sufficient (regular consultation). The examples listed below are for illustrative purposes only; other circumstances requiring immediate consultation may exist.

Circumstances at intake that require immediate supervision or consultation include:

- Direct warning signs are evident (suicidal communication, seeking access to the method, making preparations).
- Follow-up suicide screening questions suggest that there is a current risk.
- Follow-up questions to indirect warning signs suggest that there is a current risk.
- Additional information (e.g., from the referral source, a family member, or the client's medical record) suggests that there is a current risk.

Circumstances during treatment that require immediate supervision or consultation include:

- Emergence (or re-emergence) of direct warning signs.
- Emergence (or re-emergence) of indirect warning signs that, on follow-up questioning, suggest current risk.
- Your client's answers to suicide screening questions asked during the course of treatment suggest current risk.
- Additional information (e.g., from another provider/family member) suggests current risk.

Circumstances at intake that require regularly scheduled supervision or consultation include:

- One or more indirect warning signs are present, but follow-up questions indicate no reason to suspect current risk for suicidal behavior per se (e.g., the client is socially isolated and abusing substances but otherwise shows no indications of suicidality).

- One or more risk factors are present, but there are no accompanying warning signs or other indications to suggest the current risk for suicidal behavior.

- During the screening, your client discloses a history of suicidal thoughts or suicide attempt(s), but there are no accompanying warning signs or other indications to suggest current risk for suicidal behavior.

- Additional information (e.g., from the referral source or a family member) suggests that your client has a history of suicidal thoughts or attempts, but there are no accompanying warning signs or other indications to suggest current risk for suicidal behavior.

Circumstances during treatment that require access to regularly scheduled supervision or consultation include:

- Your client reports (or alludes to) a history of suicidal thoughts that you had not previously been aware of, but there are no accompanying warning signs or other indications of current risk for suicidal behavior.

- Your client reports (or alludes to) prior suicide attempt(s) that you had not previously been aware of, but there are no accompanying warning signs or other indications of current risk for suicidal behavior.

- Additional information (e.g., from another provider or family member) suggests a history of suicidal thoughts or attempts that you had not previously been aware of, but there are no accompanying warning signs or other indications of current risk for suicidal behavior.

- Your client with a history of suicidal thoughts or behavior experiences an acute stressful life event or a setback in treatment (e.g., substance abuse relapse), but there are no accompanying warning signs or other indications of current risk for suicidal behavior.

Know who your consultant (supervisor, team, outside consultant) is for issues of suicidality in your program, what your agency policy is regarding acutely suicidal clients, and where such patients should be referred. Having this information in advance can free you to focus on the immediate situation when a crisis arises. If you suspect that information on acute suicidality might arise in a session, alert your supervisor in advance that you might contact him or her for information, support, or consultation while the client is still in your office.

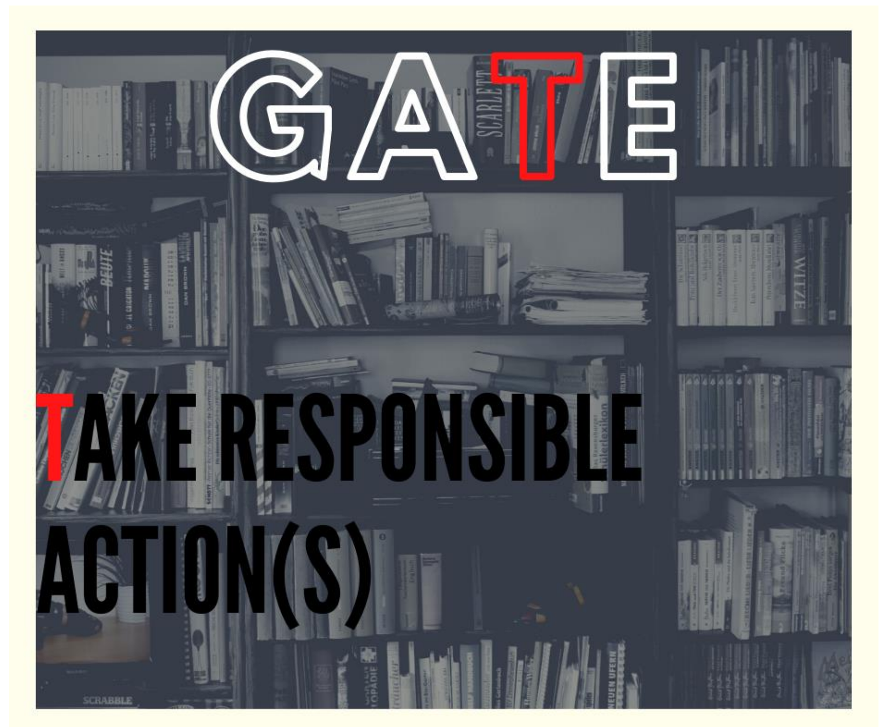
Summary of A: Access supervision or consultation

Risk for suicidal behavior may be evident at intake or at any time during the course of treatment. Supervision or consultation to address risk may be obtained immediately or at a regularly scheduled time, depending on the urgency of the situation. Having a plan in place ahead of time for obtaining immediate supervision or consultation will help ensure a therapeutic response and will avoid unnecessary distress and scrambling. Immediate supervision or consultation should be obtained when clients exhibit direct suicide warning signs or when, at intake, they report having made a recent suicide attempt. Substance abuse relapse during treatment is also an indication for supervisory involvement for clients who have histories of suicidal behavior or attempts.

T: Take responsible action(s)

A useful guiding principle in taking responsible action is that your actions should make good sense in light of the seriousness of suicide risk. This section explains this principle, applies it to taking responsible action(s) and provides a list of potential actions. In the legal system, the standard used to assess responsibility and liability is to compare a given practitioner's judgment and behavior with what another equally trained and experienced treatment practitioner would have done in the same circumstances. The key factor—although not the only factor—in considering the action(s) to take is a judgment about the seriousness of the risk. Seriousness is defined as the likelihood that a suicide attempt will occur and the potential consequences of an attempt. Briefly, if a client is judged to be likely to carry out a suicide attempt (e.g., has persistent suicidal thoughts and a clear plan), there is high seriousness. In contrast, if a client is judged to be unlikely to carry out an attempt (e.g., has fleeting ideation, no clear plan, and no intention to act), there is lower seriousness.

Judgments about the degree of seriousness of risk should be made in consultation with a supervisor and/or a treatment team, not by a counselor acting alone.



The actions taken should be sensible in light of the information that has been gathered about suicidal thoughts and/or previous suicide attempts. Although the potential actions are many, they can

generally be described along a continuum of intensiveness. In instances of greater seriousness, you will generally take more intensive actions. For less serious circumstances, you will be more likely to take less intensive actions. Note that “less intensive” does not equate to inaction; it merely indicates that there may be more time to formulate a response, the actions may be of lower intensity, and/or fewer individuals and resources may be involved.

In some instances, an immediate response is required. In general, responses that require immediate action may be considered more intensive. Examples of immediate actions include arranging transportation to a hospital emergency department for evaluation, contacting a spouse to have him or her arrange for removing a gun from the home and safely storing it elsewhere, and arranging on the spot to have a mental health specialist in your program further evaluate a client. Examples of nonimmediate, but important, actions include referring a client to an outpatient mental health facility for evaluation, scheduling the client to see a psychiatrist, and ordering past mental health records from another provider.

Some interventions are clearly more intensive than others. These include interventions that reduce freedom of movement (e.g., arranging an ambulance to transport a client to a hospital emergency department), are expensive (e.g., inpatient hospitalization), compromise privacy (e.g., contacting the police to check on a high-risk client), and/or restrict autonomy (e.g., asking a spouse to arrange for safe storage of a weapon). Other interventions in managing suicide risk, although less intensive, may also go beyond the usual care of a substance abuse client and may be experienced by the client as unnecessary or intrusive. Arranging further assessment with an outpatient mental health treatment provider or through a home visit by a mental health mobile crisis team, for instance, may be seen as burdensome to the client. Less intensive interventions do not reduce freedom of movement, do not sacrifice privacy, are comparatively inexpensive, and do not restrict autonomy.

Another aspect of intensiveness concerns the number of individuals involved (e.g., client, case manager, counselor, mental health professional, concerned spouse) and the number of actions taken (e.g., psychiatric medications, substance abuse counseling, family sessions, case management coordination). In general, the greater the number of interventions and the more individuals involved, the more intensive the action(s).

What actions can you take?

The list of actions below is not exhaustive but includes the most common actions. At times, one action will suffice, whereas, at other times, more than one (and perhaps many) will be required. You and your supervisor or team will strive to take those actions that make good sense in terms of their intensity. Your actions should match the seriousness of the risk. Often, your response will involve arranging a referral (if the necessary resources are not available within your agency).

Some actions you might be expected to take include:

- Gathering additional information from the client to assist in developing a more accurate clinical picture and treatment plan.
- Gathering additional information from other sources (e.g., spouse, other providers).
- Arranging a referral:
    - To a clinician for further assessment of suicide risk (after gathering additional information and reviewing with a clinical supervisor).
    - To a mental health counselor.
    - To a provider for medication management.
    - To an emergency provider (e.g., hospital emergency room) for acute risk assessment.
    - To a mental health mobile crisis team that can provide outreach to clients who cannot or will not come into the agency for screening and assessment.
    - To a more intensive substance abuse treatment setting.

- Restricting access to means of suicide.
- Temporarily increasing the frequency of care, including more frequent telephone check-ins.
- Temporarily increasing the level of care (e.g., refer to day treatment).

Involving a case manager (e.g., to coordinate care, to check on the client occasionally).

- Involving the primary care provider.
- Encouraging the client to attend (or increase attendance at) 12-Step meetings, such as Alcoholics Anonymous, Narcotics Anonymous, or Cocaine Anonymous.
- Enlisting family members or significant others (selectively, depending on their health, closeness to the client, and motivation) in observing indications of a return of suicide risk.
- Observing the client for signs of a return of risk.
- Creating a safety card with the client in the event of a return of acute suicidality.

Referring a client who is ambivalent about treatment or is resisting treatment

It is common to make referrals for further evaluation, treatment of suicide risk, treatment of a mental health condition (e.g., depression), or a combination of services. Sometimes, however, a client will not agree that referral is necessary or simply will not wish to accept it. Discussing the reasons for your actions and listening to and acknowledging client concerns will usually soften the stance of clients who resist referral. Eliciting client input as to what he or she believes would be most helpful and using these suggestions, as appropriate, can also go a long way toward eliciting cooperation. Anything appropriate that you can do to give a client a sense of choice or control will be helpful.

Although a referral for emergency evaluation is usually not necessary and less intensive action(s) will typically suffice, there will be times when such an action is needed. In these instances, a resistant client may become more willing if provided some

sense of control—for example, through a question such as “Would you prefer to call your family before you go to the emergency department or would you rather I call them after you get there?”

In the end, if a client refuses to cooperate in additional evaluation, you (in close coordination with your supervisor or team) will need to take the necessary steps to arrange for the evaluation (e.g., by arranging an ambulance or police escort) as described in your agency policy. The client should not be left unaccompanied while such arrangements are being made. Supervisors can facilitate their counselors’ current knowledge of the organization’s policy on emergency referrals by reviewing it with them on a regular basis, as appropriate.

A note on inpatient treatment for suicidality: It is important that counselors, clients, and their family members know what to expect from inpatient psychiatric hospitalization. Generally, the treatments are short term (5–7 days); if the clinical team concludes that suicidality is substance-induced (roughly 40 percent of admissions are deemed thus), the stay may be shorter. During a brief hospitalization, there is typically only enough time to plan and begin the individualized therapeutic strategies with the client. As a result, most or all of the psychosocial difficulties that prompted admission will need to be addressed on an ongoing basis when the client returns to regular treatment.

Summary of T: Take responsible action

The intensiveness of the actions that you take in coordination with your supervisor or team should make good sense in light of the information that you have gathered, with more serious risk requiring more intensive action(s). The action(s) may include referring the client for a formal assessment or for additional treatment. Taking the time to prepare clients for a referral and providing them some sense of control will be helpful in eliciting their cooperation.

E: Extend the action(s)

A common misconception is that suicide risk is an acute problem that, once dealt with, ends. Unfortunately, individuals who are suicidal commonly experience a return of suicide risk following any number of setbacks, including relapse to substance use, a distressing life event (e.g., break up with a partner), increased depression, and so forth. Sometimes, suicidal behavior even occurs in the context of substantial improvement in mood and energy. Therefore, monitoring for signs that suggest the return of suicidal thoughts or behavior is essential.

Safety Cards and Safety Plans

For all clients who exhibit suicidal risk, create a detailed safety plan with the client in the event of relapse to alcohol or drugs and invite the client to contact you (or an emergency hotline) in the event of acute suicidality. Also consider developing with the client a written safety card that includes, at a minimum:

- A 24-hour crisis hotline number (e.g., 1–800–273– TALK).
- The phone number and address of the nearest hospital emergency department.
- The counselor’s contact information.
- Contact information for additional supportive individuals that the client may turn to when needed (e.g., 12-Step sponsor, family member).

To maximize the likelihood that the client will make use of the card, it should be personalized and created with the client (not merely handed to him or her). Discuss with the client the type(s) of signs and situations that would warrant using one or more of the resources on the card. It is ideal to create a wallet-size card with this information so clients can easily keep it with them. Have backup copies of the card available in the event that the client loses the card so that it can be quickly replaced. Consistent with this TIP's emphasis on Extending the action, you should check in with the client from time to time to confirm that he or she still has the card (ask the client to show it to you) and remains willing to use it if the need arises. Counselors with advanced mental health training and experience in working with clients who are suicidal may be in a position to formulate a more detailed safety plan.

There is little empirical evidence to support no-suicide contracts (a client's agreement to contact the counselor or other resource before making a suicide attempt) as a stand-alone intervention. However, a related technique called a "commitment to treatment" agreement focuses the client's attention on specific behaviors (such as attending treatment sessions, setting recovery goals, completing homework assignments, and taking medications as prescribed) that support recovery, reduce suicidal thoughts and behaviors, and may be helpful for suicidal clients. Safety cards focus on preventing or intervening in crises, whereas commitment-to-treatment agreements focus on behaviors that positively support treatment outcomes.

Counselors with more experience and training in working with clients who are suicidal can develop an advanced skills safety plan. An example of this type of plan is described in Part 1, Chapter 2 of the TIP; these plans help clients recognize when direct and indirect warning signs are becoming more apparent, develop coping responses, and focus on emotional regulation.

There is also a tendency to refer a client experiencing suicidal thoughts and behaviors to another provider and then assume that the issue has been fully addressed. It is essential to follow up with the provider to determine that the client kept the appointment. It is also critical to coordinate care on an ongoing basis—for example, to alert another provider that a client has relapsed and may be vulnerable to suicidal thoughts. Extending the action emphasizes the importance of watching for the return of suicidal thoughts and behaviors, following up with referrals, and coordinating on an ongoing basis with providers who are addressing the client's suicidal thoughts and behaviors.

What extended actions can you take?

The list below mentions many common extended actions but is not exhaustive. It is in no particular order.

- When a referral appointment has been made with a mental health service provider (or other professional), confirm that the client has kept the appointment.
- Follow up with the hospital emergency department on clients referred for acute assessment.
- Coordinate with mental health treatment providers (or other professionals) on an ongoing basis.
- Coordinate with case managers on an ongoing basis.
- Check-in with the client about any recurrence of or change in suicidal thoughts or attempts.
- Check-in with family members (with the client's knowledge) about any recurrence of or change in suicidal thoughts or attempts.
- Reach out to family members to keep them engaged in the treatment process after a suicide crisis passes.
- Observe the client for signs of a return of risk.
- Confirm that the client still has a safety card in the event of a return to suicidality.

- Confirm that the client and, when appropriate, the family, still have an emergency phone number to call in the event of a return to suicidality.
- Confirm that the client still does not have access to a major method of suicide (e.g., gun, a stash of pills).
- Follow up with the client about suicidal thoughts or behaviors if a relapse (or other stressful life events) occurs.
- Monitor and update the treatment plan as it concerns suicide.
- Document all relevant information about the client's condition and your responses, including referrals made and the outcomes of the referrals.
- Complete a formal treatment termination summary when and under whatever circumstances this stage of care is reached.

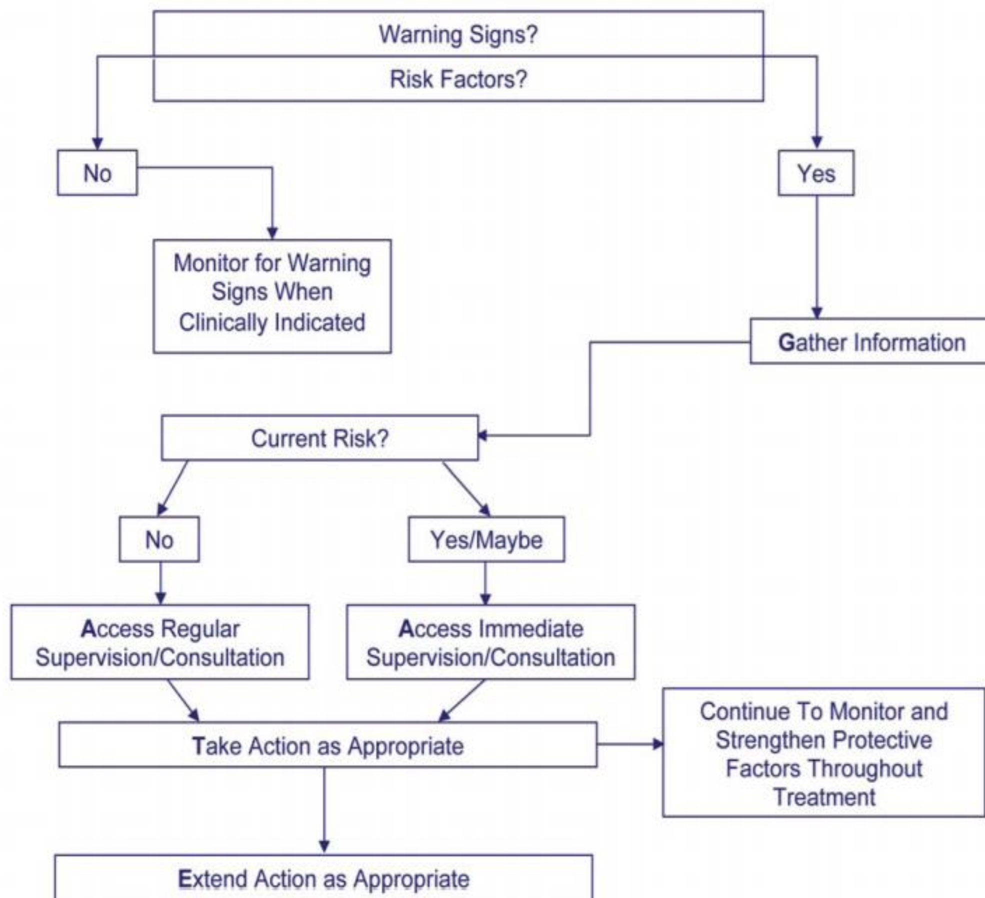
Summary of E: Extend the action

Suicide prevention efforts are not one-time actions. They should be ongoing because clients who have exhibited suicidality are vulnerable to a recurrence of risk. A team approach is also essential, as it requires you to follow up on referrals and coordinate with other providers in an ongoing manner. The actions listed above represent many, but not all, of the extended actions you may use to promote safety throughout treatment. Work closely with your supervisor or team in developing a plan of extended actions. Document the client's eventual progress and status at the point of treatment termination

Too often, suicide risk is dealt with acutely, on a one-time basis, and then forgotten. As with substance abuse, vulnerable clients may relapse into suicidal thoughts or behaviors. This means that you must continue to observe and check in with the client to identify a possible return of risk. Another common problem is referring a client who is suicidal but failing to coordinate or even follow up with the provider. Suicide risk management requires a team approach, and as your client's addiction counselor, you are an essential part of this team.

Documenting all actions, you have taken is important because it creates a medical and legal account of the client's care: what information you obtained, when and what actions were taken, and how you followed up on the client's substance abuse treatment and suicidal thoughts and behaviors. This record can be useful to your supervisors and consultants, your team, and other providers.

The figure below is a graphic representation of the elements of GATE. It is a decision tree designed to help you see how the completion of one element leads to decisions and specific actions in the next.



The elements in GATE reflect behaviors within your scope of competence as a substance abuse counselor that are relevant in helping clients at risk of suicide. You are familiar with gathering information from clients who have substance use disorders; this skill can be translated into gathering information about suicidal thoughts and behaviors. You know how to plan for the treatment of a client with a substance use disorder; this skill can be applied to planning for a client to address his or her suicidal thoughts and behaviors. You typically follow up with clients to coordinate care, check on referral appointments, monitor progress, and enlist support from family and community resources. These counselor activities are essential when working with clients who are suicidal. Supervision may be a regular part of your agency's program; with a client who is suicidal, it is a necessity.

If you have advanced training in a mental health discipline (such as social work, psychology, or professional counseling) along with specialized training in suicidality, you might also be prepared to take on other treatment tasks with clients who have suicidal thoughts and behaviors, such as assessment, specialized suicide interventions, or treatment of co-occurring mental disorders (e.g., depression, trauma-related disorders).

Documenting GATE

Documentation of suicidality is critical to promoting client safety, coordinating care among treatment professionals, and establishing a solid medical and legal record. Documentation entails providing a written summary of any steps taken pertaining to GATE along with a statement of conclusions that shows the rationale for the resulting plan. The plan should make good sense in light of the seriousness of the risk.

Case examples follow that illustrate documentation across a continuum of the seriousness of suicidality. Counselors, supervisors, or consultants may provide such documentation. Many programs and State regulatory bodies recommend or mandate a particular format in which this documentation should occur. Generally, such formats accommodate all of the information contained in the suggested GATE protocol. In the

following case examples, the italicized text is the actual note. These examples are ideals; notes made in routine clinical practice may fall short of this level of detail and organization. Nonetheless, the notes serve as models for documentation. Agencies may implement checklists as well (e.g., warning signs, risk, and protective factors) to help you with documentation. Even when using a checklist, a concluding statement and clearly articulated plan are always needed.

Documentation example 1

The following is from an intake evaluation of Roberta, a 40-year-old woman seeking treatment for cocaine dependence. The situation was not acute, so regular supervision was used and no immediate actions were taken.

Gather information: The client made a suicide attempt at age 31 by overdosing on over-the-counter sleeping pills following a sexual assault for which she received overnight treatment in a hospital emergency department. She was ambivalent about the suicide attempt and immediately afterward was relieved that she survived. Since that time, she has not reattempted; she reported no current or recent ideation, plan, or intent. She reported that she no longer uses sleeping pills and has none in her possession. She stated that her strong faith in God prevents her from making another attempt. No warning signs for suicidal behavior were evident.

Conclusion: There is a history of suicidal behavior but no indication of a need for action.

Access supervision: Her suicide-related history will be discussed at the next team meeting on January 14.

Documentation example 2

The following is from an intake evaluation of Mark, a 29-year-old man who is separated from his wife and is entering treatment for alcohol dependence. The situation required immediate supervision and intervention of intermediate intensity.

Gather information: Mark reports that he has thoughts of suicide when intoxicated (about once a week), during which he becomes preoccupied with the separation from his wife. The thoughts last a few hours until he falls asleep. They occur while he is home alone. He has not acted on them, reports no plan or intent to attempt suicide, and reports that he does not own a firearm. He reports no history of suicide attempts.

Access supervision: This writer took a break in the intake to review this information with the supervisor, John Davidson, LCSW.

Conclusion: It was concluded that emergency intervention is not required because Mark has not acted on his suicidal thoughts and has no plan or intent. However, further assessment is indicated given suicidal ideation, marital estrangement, and active alcohol dependence.

Take action: I reviewed these considerations with Mark and he agreed to a referral for an outpatient mental health evaluation. Mark has an appointment scheduled for June 18 at 1:00 p.m. with Martha Jones, M.S.W., of the Mental Health Clinic.

Extend the action: On Tuesday, June 17, this writer called Mark to remind him of his appointment. He said he remembered his appointment and planned to attend. I called the Mental Health Clinic late in the afternoon on June 18. Mark had kept his appointment and scheduled a second appointment for the following week.

The following is from a progress note for Fernando, a 22-year-old Iraq war veteran who had been doing well in treatment for dependence on alcohol and opiates but had missed group therapy sessions and not returned phone calls for the past 10 days. This situation occurred in a substance abuse clinic within a hospital and required accessing immediate supervision and interventions of high intensity.

Gather information: Fernando came in, unannounced, at 10:30 a.m. today and reported that he relapsed on alcohol and opiates 10 days ago and has been using daily and heavily since. The breathalyzer was .08, and he reported using heroin earlier this morning. He reported that he held his loaded rifle in his lap last night while high and drunk, contemplating suicide.

Access supervision: This writer's supervisor, Janice Davis, CDC, was called to join the session.

Conclusion: It was determined that emergency intervention is necessary because of intense substance use, suicidal thoughts with a lethal plan, and access to a weapon.

Take action: At 11:00 a.m., a hospital security guard and this writer escorted Fernando to the emergency department, where he was checked in. He was cooperative throughout the process.

Extend the action: Dr. McIntyre, the Emergency Department physician, determined that Fernando requires hospitalization. He is currently awaiting admission. This writer will follow up with the hospital unit after he is admitted and will raise the issue of his access to a gun.

The consensus panel agreed on eight competencies for working with clients who are suicidal in substance abuse treatment settings. These competencies are derived from a variety of resources, including *Practice Guideline and Resources for the Assessment and Treatment of Patients with Suicidal Behaviors* (American Psychiatric Association, 2003), *Assessing and Managing Suicidal Risk: Core Competencies for*

Mental Health Professionals (American Association of Suicidology, Suicide Prevention Resource Center, and Education Development Center, 2006), and *The Assessment and Management of Suicidality* (Rudd, 2006). They reflect the core knowledge, skills, and attitudes that you as a substance abuse counselor should incorporate to work effectively with clients who evidence suicidal thoughts and behaviors and form the basis for the skills presented in the vignettes in chapter 2 of this TIP. Few counselors will be proficient in all of these competencies.

References for Chapter 2

American Association of Suicidology (2006). *Assessment and management of suicide risk: Core competencies for mental health professionals. Participant manual*. Washington, DC: Education Development Center.

American Psychiatric Association. (2003). *Practice guideline and resources for the assessment and treatment of patients with suicidal behaviors.* Arlington, VA: American Psychiatric Association. Retrieved July 2, 2008, from http://www.psychiatryonline.com/pracGuide/pracGuideHome.aspx

Conner, K. R., Beautrais, A. L., & Conwell, Y. (2003). Risk factors for suicide and medically serious suicide attempts among alcoholics: Analyses of Canterbury Suicide Project data. *Journal of Studies on Alcohol, 64,* 551–554.

Conner, K. R., Hesselbrock, V. M., Meldrum, S. C., Schuckit, M. A., Bucholz, K. K., Gamble, S. A., et al. (2007). Transitions to, and correlates of, suicidal ideation, plans, and unplanned and planned suicide attempts among 3,729 men and women with alcohol dependence. *Journal of Studies on Alcohol and Drugs, 68,* 654–662.

Darke, S., & Ross, J. (2002). Suicide among heroin users: rates, risk factors and methods. *Addiction, 97,* 1383–1394.

Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (Eds.) *Reducing suicide: A national imperative* (2002). Washington, DC: National Academies Press.

Ilgen, M. A., Harris, A. H., Moos, R. H., & Tiet, Q. Q. (2007). Predictors of a suicide attempt one year after entry into substance use disorder treatment. *Alcoholism: Clinical and Experimental Research, 31,* 635–642.

Linehan, M. M., Goodstein, J. L., Nielsen, S. L., & Chiles, J. A. (1983). Reasons for stay- ing alive when you are thinking of killing yourself: The Reasons for Living Inventory. *Journal of Consulting and Clinical Psychology, 51,* 276–286.

Murphy, G. E., Wetzel, R. D., Robins, E., & McEvoy, L. (1992). Multiple risk factors predict suicide in alcoholism. *Archives of General Psychiatry, 49,* 459–463

Oquendo, M. A., Dragasti, D., Harkavy- Friedman, J., Dervic, K., Currier, D., Burke, A. K., et al. (2005). Protective factors against suicidal behavior in Latinos. *Journal of Nervous and Mental Disease, 193,* 438–443.

Preuss, U. W., Schuckit, M. A., Smith, T. L., Danko, G. P., Buckman, K., Bierut, L., et al. (2002). Comparison of 3190 alcohol-dependent individuals with and without suicide attempts. *Alcoholism: Clinical and Experimental Research, 26,* 471–477.

Roy, A. (2002). Characteristics of opiate dependent patients who attempt suicide. *Journal of Clinical Psychiatry, 63,* 403–407.

Rudd, M. D. (2006). *The assessment and management of suicidality.* Sarasota, FL: Professional Resource Press.

Schneider, B., Georgi, K., Weber, B., Schnabel, A., Ackermann, H., & Wetterling, T. (2006). Risk factors for suicide in substance-related disorders. *Psychiatrische Praxis, 33,* 81–87.

Chapter 3: Preventing Suicide: A Technical Package of Policy, Programs, and Practices.

Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., and Wilkins, N. (2017). Preventing Suicide: A Technical Package of Policies, Programs, and Practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
Retrieved from:

https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf

A. Preventing Suicide is a Priority

Suicide, as defined by the Centers for Disease Control and Prevention (CDC), is part of a broader class of behavior called self-directed violence. Self-directed violence refers to

behavior directed at oneself that deliberately results in injury or the potential for injury.[1] Self-directed violence may be suicidal or non-suicidal in nature. For the purposes of this document, we refer only to behavior where suicide is intended:

- **Suicide** is a death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

- **Suicide attempt** is defined as a non-fatal self-directed and potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Suicide is highly prevalent. Suicide presents a major challenge to public health in the United States and worldwide. It contributes to premature death, morbidity, lost productivity, and health care costs.[5] In 2015 (the most recent year of available death data), suicide was responsible for 44,193 deaths in the U.S., which is approximately one suicide every 12 minutes[6]. In 2015, suicide ranked as the 10th leading cause of death and has been among the top 12 leading causes of death since 1975 in the U.S.[7] Overall suicide rates increased 28% from 2000 to 2015.[6] Suicide is a problem throughout the life span; it is the third leading cause of death for youth 10–14 years of age, the second leading cause of death among people 15–24 and 25–34 years of age; the fourth leading cause among people 35 to 44 years of age, the fifth leading cause among people ages 45–54 and the eighth leading cause among people 55–64 years of age.

Suicide rates vary by race/ethnicity, age, and other population characteristics, with the highest rates across the life span occurring among non-Hispanic American Indian/Alaska Native (AI/AN) and non-Hispanic White population groups. In 2015, the

rates for these groups were 19.9 and 16.9 per 100,000 population, respectively. Other population groups disproportionately impacted by suicide include middle-aged adults (whose rates increased 35% from 2000 to 2015, with steep increases seen among both males (29%) and females (53%) aged 35–64 years[6]; Veterans and other military personnel (whose suicide rate nearly doubled from 2003 to 2008, surpassing the rate of suicide among civilians for the first time in decades)[8,9]; workers in certain occupational groups,[10,11] and sexual minority youth, who experience increased suicidal ideation and behavior compared to their non-sexual minority peers.

Suicides reflect only a portion of the problem.[15] Substantially more people are hospitalized as a result of nonfatal suicidal behavior (i.e., suicide attempts) than are fatally injured, and an even greater number are either treated in ambulatory settings (e.g., emergency departments) or not treated at all.[15] For example, during 2014, among adults aged 18 years and older, for every one suicide there were 9 adults treated in hospital emergency departments for self-harm injuries, 27 who reported making a suicide attempt, and over 227 who reported seriously considering suicide.[6,16]

Suicide is associated with several risk and protective factors. Suicide, like other human behaviors, has no single determining cause. Instead, suicide occurs in response to multiple biological, psychological, interpersonal, environmental, and societal influences that interact with one another, often over time.[1,5] The social-ecological model—encompassing multiple levels of focus from the individual, relationship, community, and societal—is a useful framework for viewing and understanding suicide risk and protective factors identified in the literature.[17] Risk and protective factors for suicide exist at each level. For example, risk factors include[1,5]

- **Individual level**: a history of depression and other mental illnesses, hopelessness, substance abuse, certain health conditions, previous suicide attempt, violence victimization and perpetration, and genetic and biological determinants

- **Relationship level:** high conflict or violent relationships, sense of isolation and lack of social support, family/ loved one's history of suicide, financial and work stress
- **Community level:** inadequate community connectedness, barriers to health care (e.g., lack of access to providers and medications)
- **Societal level:** availability of lethal means of suicide, unsafe media portrayals of suicide, stigma associated with help-seeking, and mental illness.

It is important to recognize that the vast majority of individuals who are depressed, attempt suicide, or have other risk factors, do not die by suicide.[18,19] Furthermore, the relevance of each risk factor can vary by age, race, gender, sexual orientation, residential geography, and socio-cultural and economic status.[1,5]

Protective factors, or those influences that buffer against the risk for suicide, can also be found across the different levels of the social-ecological model. Protective factors identified in the literature include effective coping and problem-solving skills, moral objections to suicide, strong and supportive relationships with partners, friends, and family; connectedness to school, community, and other social institutions; availability of quality and ongoing physical and mental health care, and reduced access to lethal means.[1,5] These protective factors can either counter a specific risk factor or buffer against a number of risks associated with suicide.

Suicide is connected to other forms of violence. Exposure to violence (e.g., child abuse and neglect, bullying, peer violence, dating violence, sexual violence, and intimate partner violence) is associated with an increased risk of depression, post-traumatic stress disorder (PTSD), anxiety, suicide, and suicide attempts.[20-26] Women exposed to partner violence are nearly 5 times more likely to attempt suicide as women not exposed to partner violence.[26] Exposure to adverse experiences in childhood, such as physical, sexual, emotional abuse and neglect, and living in homes with violence, mental health, substance abuse problems, and other instability, is also associated with increased risk for suicide and suicide attempts.[22,27] The psychosocial effects of violence

in childhood and adolescence can be observed decades later, including severe problems with finances, family, jobs, and stress—factors that can increase the risk of suicide.[28-30] Suicide and other forms of violence often share the same individual, relationship, community, and societal risk factors suggesting that efforts to prevent interpersonal violence may also prove beneficial in preventing suicide. CDC has developed technical packages for the different forms of interpersonal violence to help communities identify additional strategies and approaches (https://www.cdc.gov/violenceprevention/pub/technicalpackages.html). Further, just as risk factors may be shared across suicide and interpersonal violence, so too may protective factors overlap. For example, connectedness to one's community,[31] school,[32] family,[33] caring adults, and pro-social peers[36] can enhance resilience and help reduce the risk of suicide and other forms of violence.

The health and economic consequences of suicide are substantial. Suicide and suicide attempts have far-reaching consequences for individuals, families, and communities.[37-40] In an early study, Crosby and Sacks[41] estimated that 7% of the U.S. adult population, or 13.2 million adults, knew someone in the prior 12 months who had died by suicide. They also estimated that for each suicide, 425 adults were exposed, or knew about the death.[41] In a more recent study, in one state, Cerel et al[42] found that 48% of the population knew at least one person who died by suicide in their lifetime. Research indicates that the impact of knowing someone who died by suicide and/or having lived experience (i.e., personally have attempted suicide, have had suicidal thoughts, or have been impacted by suicidal loss) is much more extensive than injury and death. People with lived experience may suffer long-term health and mental health consequences ranging from anger, guilt, and physical impairment, depending on the means and severity of the attempt. Similarly, survivors of a loved one's suicide may experience ongoing pain and suffering including complicated grief,[44] stigma, depression, anxiety, posttraumatic stress disorder, and increased risk of suicidal ideation and suicide. Less discussed but no less important, are the financial and occupational effects on those left behind.[47]

The economic toll of suicide on society is immense as well. According to conservative estimates, in 2013, suicide cost $50.8 billion in estimated lifetime medical and work-loss costs alone.[47] Adjusting for potential under-reporting of suicide and drawing upon health expenditures per capita, gross domestic product per capita, and variability among states in per capita health care expenditures and income, another study estimated the total lifetime costs associated with nonfatal injuries and deaths caused by self-directed violence to be approximately $93.5 billion in 2013.[48] The overwhelming burden of these costs was from lost productivity over the life course, with the average cost per suicide being over $1.3 million.[48] The true economic costs are likely higher, as neither study included monetary figures related to other social costs such as those associated with the pain and suffering of family members or other impacts.

Suicide can be prevented. Like most public health problems, suicide is preventable.[1,5] While progress will continue to be made into the future, evidence for numerous programs, practices, and policies currently exists, and many programs are ready to be implemented now. Just as suicide is not caused by a single factor, research suggests that reductions in suicide will not be prevented by any single strategy or approach.[1,49] Rather, suicide prevention is best achieved by a focus across the individual, relationship, family, community, and societal-levels and across all sectors, private and public.

Assessing the Evidence

This technical package includes programs, practices, and policies with evidence of impact on suicide or risk or protective factors for suicide. To be considered for inclusion in the technical package, the program, practice, or policy selected had to meet at least one of these criteria:

a) meta-analyses or systematic reviews showing an impact on suicide;

b) evidence from at least one rigorous (e.g., randomized controlled trial [RCT] or quasi-experimental design) evaluation study that found significant preventive effects on suicide;

c) meta-analyses or systematic reviews showing the impact on risk or protective factors for suicide, or

d) evidence from at least one rigorous (e.g., RCT or quasi-experimental design) evaluation study that found significant impacts on risk or protective factors for suicide.

Finally, consideration was also given to the likelihood of achieving beneficial effects on multiple forms of violence; no evidence of harmful effects on specific outcomes or with particular subgroups; and feasibility of implementation in a U.S. context if the program, policy, or practice has been evaluated in another country.

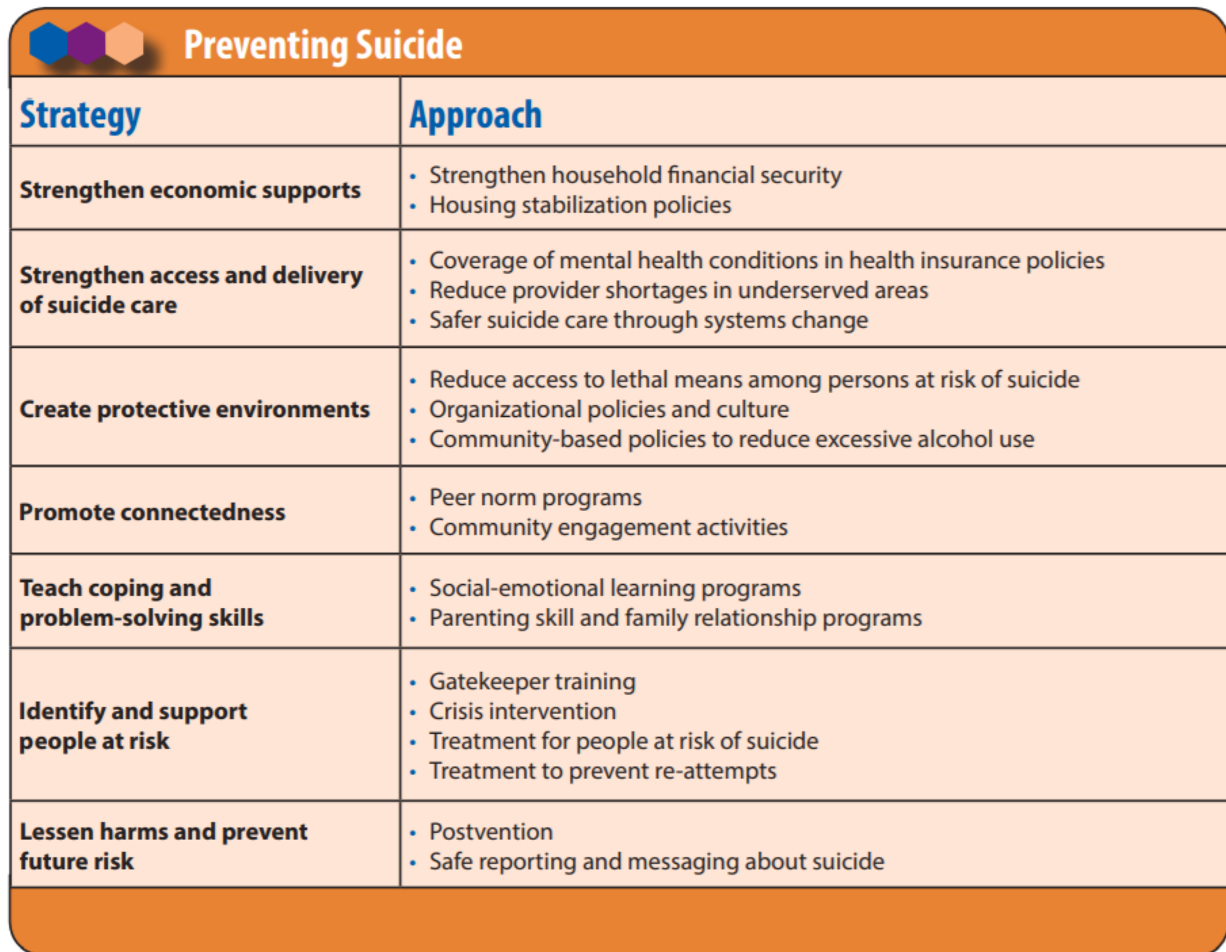
Within this technical package, some approaches do not yet have research evidence demonstrating an impact on rates of suicide but instead are supported by evidence indicating impacts on risk or protective factors for suicide (e.g., help-seeking, stigma reduction, depression, connectedness). In terms of the strength of the evidence, programs that have demonstrated effects on suicidal behavior (e.g., reductions in deaths, attempts) provide a higher level of evidence, but the evidence base is not that strong in all areas. For instance, there has been less evaluation of community engagement and family programs on suicidal behavior. Thus, approaches in this package that have effects on risk or protective factors reflect the developing nature of the evidence base and the use of the best available evidence at a given time.

It is also important to note that there is often significant heterogeneity among the programs, policies, or practices that fall within one approach or strategy in terms of the nature and quality of the available evidence. Not all programs, policies, or practices that utilize the same approach are equally effective, and even those that are effective may not work across all populations. Tailoring programs and conducting more evaluations may be necessary to address different population groups. The evidence-based

programs, practices, or policies included in the package are not intended to be a comprehensive list for each approach, but rather to serve as examples that have been shown to impact suicide or have beneficial effects on risk or protective factors for suicide.

Contextual and Cross-Cutting Themes

One important feature of the package is the complementary and potentially synergistic impact of the strategies and approaches. The strategies and approaches included in this technical package represent different levels of the social ecology, with efforts intended to impact the community and societal levels, as well as individual and relationship levels. The strategies and approaches are intended to work in combination and reinforce each other to prevent suicide (see box on page 12). The strategies are arranged in an order such that those strategies hypothesized to have the greatest potential for broad public health impact on suicide are included first, followed by those that might impact subsets of the population (e.g., persons who have already made a suicide attempt).



Preventing Suicide

Strategy	Approach
Strengthen economic supports	• Strengthen household financial security • Housing stabilization policies
Strengthen access and delivery of suicide care	• Coverage of mental health conditions in health insurance policies • Reduce provider shortages in underserved areas • Safer suicide care through systems change
Create protective environments	• Reduce access to lethal means among persons at risk of suicide • Organizational policies and culture • Community-based policies to reduce excessive alcohol use
Promote connectedness	• Peer norm programs • Community engagement activities
Teach coping and problem-solving skills	• Social-emotional learning programs • Parenting skill and family relationship programs
Identify and support people at risk	• Gatekeeper training • Crisis intervention • Treatment for people at risk of suicide • Treatment to prevent re-attempts
Lessen harms and prevent future risk	• Postvention • Safe reporting and messaging about suicide

It is important to note that these strategies are not mutually exclusive but each has an immediate focus. For instance, social-emotional learning programs, an approach under the Teach Coping and Problem-Solving Skills strategy, sometimes include components to change peer norms and the broader environment. The primary focus of these programs, however, is to provide children and youth with skills to resolve problems in relationships, school, and with peers, and to help youth address other negative influences (e.g., substance use) associated with suicide.

The goal of this package is to stress the importance of comprehensive prevention efforts and to provide examples of effective programs addressing each level of the social ecology, with the knowledge that some programs, practices, and policies may

impact multiple levels. Further, those that involve multiple sectors and that impact multiple levels of the social ecology are more likely to have a greater impact on the overall burden of suicide.

Suicide ideation, thoughts, attempts, and deaths vary by gender, race/ethnicity, age, occupation, and other important population characteristics.[6,50] Further, certain transition periods are also associated with higher rates of suicide (e.g., transition from working into retirement, transition from active duty military status to civilian status).[48,51] In fact, suicide risk can change along with dynamic risk factors. For example, individuals' coping skills may change during periods of crisis and heightened stress, limiting their normal ability to effectively solve problems and cope. Research indicates that suicide risk changes as a result of the number and intensity of key risk and protective factors experienced.[52] Ideally, the availability of multiple strategies and approaches tailored to the social, economic, cultural, and environmental context of individuals and communities are desirable as they may increase the likelihood of removing barriers to supportive and effective care and provide opportunities to develop individual and community resilience.[1]

Identifying programs, practices, and policies with evidence of impact on suicide, suicide attempts, or beneficial effects on risk or protective factors for suicide is only the first step. In practice, the effectiveness of the programs, policies, and practices identified in this package will be strongly dependent on how well they are implemented, as well as the partners and communities in which they are implemented. Practitioners in the field may be in the best position to assess the needs and strengths of their communities and work with community members to make decisions about the combination of approaches included here that are best suited to their context.

Data-driven strategic planning processes can help communities with this work.[53-55] These planning processes engage and guide community stakeholders through a prevention planning process designed to address a community's profile of risk and protective factors with evidence-based programs, practices, and policies. These

processes can also be used to monitor implementation, track outcomes, and make adjustments as indicated by the data. The readiness of the program for broad dissemination and implementation (e.g., availability of program materials, training, and technical assistance) can also influence program effects. Implementation guidance to assist practitioners, organizations, and communities will be developed separately.

This package includes strategies where public health agencies are well-positioned to bring leadership and resources to implementation efforts. It also includes strategies where public health can serve as an important collaborator (e.g., strategies addressing community and societal level risks), but where leadership and commitment from other sectors such as business, labor or health care are critical to implement a particular policy or program (e.g., workplace policies; treatment to prevent re-attempts). The role of various sectors in the implementation of a strategy or approach in preventing suicide is described further in the section on Sector Involvement.

In the sections that follow, the strategies and approaches with the best available evidence for preventing suicide are described.

B. Strengthen Economic Supports

Rationale

Studies from the U.S. examining historical trends indicate that suicide rates increase during economic recessions marked by high unemployment rates, job losses, and economic instability and decrease during economic expansions and periods marked by low unemployment rates, particularly for working-age individuals 25 to 64 years old.[56,57] Economic and financial strain, such as job loss, long periods of unemployment, reduced income, difficulty covering medical, food, and housing expenses, and even the anticipation of such financial stress may increase an individual's risk for suicide or may indirectly increase risk by exacerbating related physical and mental health problems.[58] Buffering these risks can, therefore, potentially

protect against suicide. For example, strengthening economic support systems can help people stay in their homes or obtain affordable housing while also paying for necessities such as food and medical care, job training, child care, among other expenses required for daily living. In providing this support, stress and anxiety and the potential for a crisis situation may be reduced, thereby preventing suicide. Although more research is needed to understand how economic factors interact with other factors to increase suicide risk, the available evidence suggests that strengthening economic supports may be one opportunity to buffer suicide risk.

Approaches

Economic supports for individuals and families can be strengthened by targeting household financial security and ensuring stability in housing during periods of economic stress.

Strengthening household financial security can potentially buffer the risk of suicide by providing individuals with the financial means to lessen the stress and hardship associated with a job loss or other unanticipated financial problems. The provision of unemployment benefits and other forms of temporary assistance, livable wages, medical benefits, and retirement and disability insurance to help cover the cost of necessities or to offset costs in the event of disability, are examples of ways to strengthen household financial security.

Housing stabilization policies aim to keep people in their homes and provide housing options for those in need during times of financial insecurity. This may occur

through programs that provide affordable housing such as through government subsidies or through other options available to potential homebuyers such as loan modification programs, move-out planning, or financial counseling services that help minimize the risk or impact of foreclosures and eviction.

Potential Outcomes

- Reductions in foreclosure rates
- Reductions in eviction rates
- Reductions in emotional distress
- Reductions in rates of suicide

Evidence

There is evidence suggesting that strengthening household financial security and stabilizing housing can reduce suicide risk.

Strengthen household financial security. The Federal State Unemployment Insurance Program allows states to define the maximum amount and duration of unemployment benefits that workers are entitled to receive after a job loss.[59] An examination of variations in unemployment benefit programs across states demonstrated that the impact of unemployment on rates of suicide was offset in those states that provided greater than average unemployment benefits (mean level: $7,990 per person in U.S. constant dollars). The effects of unemployment benefit programs were also consistent by sex and age group.[59] Another U.S. study examining the link between unemployment and suicide rates using monthly suicide data, length of unemployment (less than 5 weeks, 5-14 weeks, 15-26 weeks, and greater than 26 weeks), and job losses found that the duration of unemployment, as opposed to just the loss of a job, predicted suicide risk. Together, these results suggest that not only should state unemployment benefit programs be generous in their financial allocations, but also in their duration.

Other measures to strengthen household financial security (e.g., transfer payments related to retirement and disability insurance, unemployment insurance compensation, medical benefits, and other forms of family assistance) have also shown an impact on rates of suicide. A study by Flavin and Radcliff[61] examined the impact of states' per capita spending on transfer payments, medical benefits, and family assistance (Temporary Assistance to Needy Families—TANF) and total state spending on suicide rates between 1990- 2000, controlling for a number of suicide risk factors (e.g., residential mobility, divorce rate, unemployment rate) at the state level. As per capita spending on total transfer payments, medical benefits, and family assistance increased there was an associated decrease in state suicide rates. In terms of lives saved, Flavin and Radcliff calculated the cost of reducing a state's suicide rate by a full point for the years studied.[61] At the national level, they estimated 3,000 fewer suicides would occur per year nationwide if every state increased its per capita spending on these types of assistance by $45 per year.[61] Although this was a correlational study, the results demonstrate the potential benefits of policies that reach particularly vulnerable individuals during periods of great need. More evaluation studies are needed to further understand the outcomes impacted by programs such as these.

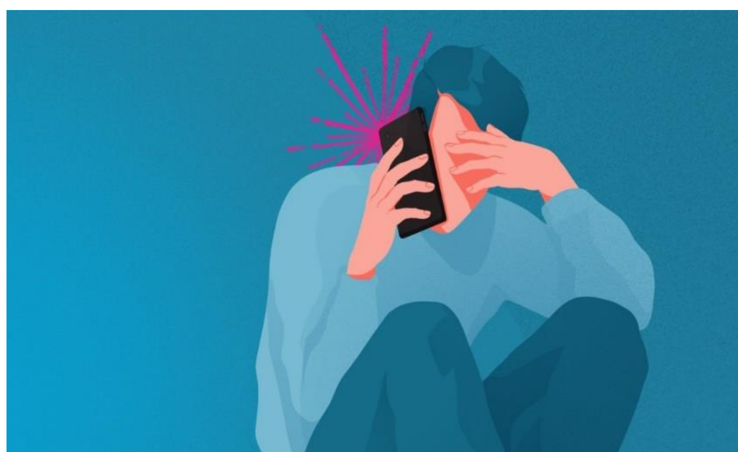
Housing stabilization policies. The Neighborhood Stabilization Program[62] was designed to help neighborhoods suffering from high rates of foreclosure and abandonment by slowing the deterioration of the neighborhoods and providing affordable housing options for low, moderate, and middle-income homebuyers. This program also offers financial assistance to eligible individuals for the purchase of a new home. Although this program has not been rigorously evaluated for its impact on suicide outcomes, it addresses foreclosure and eviction, which are risk factors for suicide. A longitudinal analysis of annual data on suicides and foreclosures demonstrated that as the proportion of foreclosed properties increased in U.S. states, so did the state suicide rate, particularly among working-age adults.[63] Another study of data from 16 U.S. states participating in the National Violent Death Reporting System found that suicides precipitated by home foreclosures and evictions increased more than 100% from 2005 (before the housing crisis began) to 2010 (after it had peaked).[57] Most of these suicides

occurred prior to the actual loss of the decedent's home. These findings suggest that integrating suicide prevention resources, messaging, and referrals into financial, foreclosure and move-out planning and counseling services may help to prevent suicide.

C. Strengthen Access and Delivery of Suicide Care

Rationale

While most people with mental health problems do not attempt or die by suicide,[18-19] and the level of risk conferred by different types of mental illness varies,[64-66] previous research indicates that mental illness is an important risk factor for suicide.[5-67] State-level suicide rates have also been found to be correlated with general mental health measures such as depression.[68-69] Findings from the National Comorbidity Survey indicate that relatively few people in the U.S. with mental health disorders receive treatment for those conditions.[70] Lack of access to mental health care is one of the contributing factors related to the underuse of mental health services.[71] Identifying ways to improve access to timely, affordable, and quality mental health and suicide care for people in need is a critical component to prevention. Additionally, research suggests that services provided are maximized when health and behavioral health care systems are set up to effectively and efficiently deliver such care.[72] Apart from treatment benefits, these approaches can also normalize help-seeking behavior and increase the use of such services.



Approaches

There are a number of approaches that can be used to strengthen access and delivery of suicide care, including:

Coverage of mental health conditions in health insurance policies. Federal and state laws include provisions for equal coverage of mental health services in health insurance plans that are on par with coverage for other health concerns (i.e., mental health parity).[73] Benefits and services covered include such things as the number of visits, copays, deductibles, inpatient/outpatient services, prescription drugs, and hospitalizations. If a state has a stronger mental health parity law than the federal parity law, then insurance plans regulated by the state must follow the state parity law. If a state has a weaker parity law than the federal parity law (e.g., includes coverage for some mental health conditions but not others), then the federal parity law will replace the state law. Equal coverage does not necessarily imply good coverage as health insurance plans vary in the extent to which benefits and services are offered to address various health conditions. Rather it helps to ensure that mental health services are covered on par with other health concerns.

Reduce provider shortages in underserved areas. Access to effective and state-of-the-art mental health care is largely dependent upon the training and the size of the mental health care workforce. Over 85 million Americans live in areas with an insufficient number of mental health providers; this shortage is particularly severe among low-income urban and rural communities.[74] There are various ways to increase the number and distribution of practicing mental health providers in underserved areas including offering financial incentives through existing state and federal programs (e.g., loan repayment programs) and expanding the reach of health services through telephone, video and web-based technologies. Such approaches can increase the likelihood that

those in need will be able to access affordable, quality care for mental health problems, which can reduce the risk of suicide.

Safer suicide care through systems change. Access to health and behavioral health care services is critical for people at risk of suicide; however, this is just one piece of the puzzle. Care should also be delivered efficiently and effectively. More specifically, care should take place within a system that supports suicide prevention and patient safety through strong leadership, workforce training, systematic identification and assessment of suicide risk, implementation of evidence-based treatments (see Identity and Support People at Risk), continuity of care, and continuous quality improvement. The care that is patient-centered and promotes equity for all patients is also of critical importance.[75]

Potential Outcomes

- Increased use of mental health services
- Lower rates of treatment attrition
- Reductions in depressive symptoms
- Reductions in rates of suicide attempts
- Reductions in rates of suicide

Evidence

There is evidence suggesting that coverage of mental health conditions in health insurance policies and improving access and the delivery of care can reduce risk factors associated with suicide and may directly impact suicide rates.

Coverage of mental health conditions in health insurance policies. The National Survey on Drug Use and Health (NSDUH) is a nationally representative survey of the U.S. population that provides data on substance use, mental health conditions, and service utilization.[50] Using data from this survey, Harris, Carpenter, and Bao[76] found that 12 months after states enacted mental health parity laws, self-reported use of mental healthcare services significantly increased. Moreover, subsequent research by Lang[69] examined state mental health laws and suicide rates between 1990 and 2004

and found that mental health parity laws, specifically, were associated with an approximate 5% reduction in suicide rates. This reduction, in the 29 states with parity laws, equated to the prevention of 592 suicides per year.[69]

Reduce provider shortages in underserved areas. One example of a program to improve access to mental health care providers in the National Health Service Corps (NHSC), which offers financial incentives to attract mental/behavioral health clinicians to underserved areas.[77] Programs such as NHSC encourage individuals to work in the mental health profession in locations designated as Health Professional Shortage Areas (HPSAs) in exchange for student loan debt repayment. A 2012 retention survey conducted by the Health Resources and Services Administration (HRSA), found that 61% of mental and behavioral health care providers continued to practice in designated mental health shortage areas after their four-year commitment to the NHSC.[78] Although this program has not been evaluated for impact on suicide, it addresses access to care, which is a critical component to suicide prevention.

Telemental Health (TMH) services refer to the use of telephone, video, and web-based technologies for providing psychiatric or psychological care at a distance.[79] TMH can be used in a variety of settings (e.g., outpatient clinics, hospitals, military treatment facilities) to treat a wide range of mental health conditions. It can also improve access to care for patients in isolated areas, as well as reduce travel time and expenses, reduce delays in receiving care, and improve satisfaction interacting with the mental health care system. A systematic review of TMH services found that services rated as high or good quality were effective in treating mental health conditions such as depression, schizophrenia, substance abuse, and suicidal ideation, and suicide.[79] Further, Mohr and colleagues[80] conducted a meta-analysis examining the effect of psychotherapy delivered specifically via telephone and found that it significantly reduced depressive symptoms in comparison to face-to-face psychotherapy. They also found that treatment attrition rates were significantly lower among patients receiving telephone-administered psychotherapy compared to patients receiving face-to-face therapy. Thus, TMH may not

only offer improved access to mental health care, but it may also ensure continuity of care, and thereby further reduce the risk of suicide.

Safer suicide care through systems change. Henry Ford Health System, which is a large health maintenance organization (HMO) in the state of Michigan, pioneered Perfect Depression Care,[81] the pre-cursor to what is now called Zero Suicide. The overall goal of Perfect Depression Care was to eliminate suicide among HMO members. More broadly, the goal of the program was to redesign the delivery of depression care to achieve "breakthrough improvement" in quality and safety by focusing on effectiveness, safety, patient-centeredness, timeliness, efficiency, and equity among patients. The program screened and assessed each patient for suicide risk and implemented coordinated continuous follow-up care system-wide.[81] An examination of the impact of the program found that there was a dramatic and statistically significant decrease in the rate of suicide between the baseline years, 1999 and 2000, and the intervention years, 2002-2009. During this time period, the suicide rate fell by 82%.[81,82] Further, among HMO members who received mental health specialty services, the suicide rate significantly decreased over time from 1999 to 2010 (110.3 to 47.6 per 100,000 population; p<.04) with a mean of 36.2 per 100,000 over the period.[83] Additionally, for those HMO members who accessed only general medical services as opposed to specialty mental health services, the suicide rate increased from 2.7 to 5.6 per 100,000 (p<.01).[83] Similarly, in the state of Michigan, rates of suicide in the general population increased over the period from 9.8 to 12.5 per 100,000 (p<.001).[83]

D. Create Protective Environments

Rationale

Prevention efforts that focus not only on individual behavior change (e.g., help-seeking, treatment interventions) but on changes to the environment can increase the likelihood of positive behavioral and health outcomes.[84] Creating environments that address risk and protective factors where individuals live, work, and play can help prevent suicide.[1,17] For example, rates of suicide are high among middle-aged adults who comprise 42.6% of the workforce; among certain occupational groups;[10,11] and among people in detention facilities (e.g., jail, prison),[86] to name a few. Thus, settings, where these populations work and reside, are ideal for implementing programs, practices, and policies to buffer against suicide. Changes to organizational culture through the implementation of supportive policies, for instance, can change social norms, encourage help-seeking, and demonstrate that good health and mental health are valued and that stigma and other risk factors for suicide are not.[87,88] Similarly, modifying the characteristics of the physical environment to prevent harmful behavior such as access to lethal means can reduce suicide rates, particularly in times of crisis or transition.[89,94]

Approaches

The current evidence suggests three potential approaches for creating environments that protect against suicide.

Reduce access to lethal means among persons at risk of suicide. Means of suicide such as firearms, hanging/ suffocation, or jumping from heights provide little opportunity

for rescue and, as such, have high case fatality rates (e.g., about 85% of people who use a firearm in a suicide attempt die from their injury).[95] Research also indicates that:

1) the interval between deciding to act and attempting suicide can be as short as 5 or 10 minutes,[96,97] and

2) people tend not to substitute a different method when a highly lethal method is unavailable or difficult to access.

Therefore, increasing the time interval between deciding to act and the suicide attempt, for example, by making it more difficult to access lethal means, can be lifesaving. The following are examples of approaches reducing access to lethal means for persons at risk of suicide:

- Intervening at Suicide Hotspots. Suicide hotspots, or places where suicides may take place relatively easily, include tall structures (e.g., bridges, cliffs, balconies, and rooftops), railway tracks, and isolated locations such as parks. Efforts to prevent suicide at these locations include erecting barriers or limiting access to prevent jumping, and installing signs and telephones to encourage individuals who are considering suicide, to seek help.[100]

- Safe Storage Practices. Safe storage of medications, firearms, and other household products can reduce the risk of suicide by separating vulnerable individuals from easy access to lethal means. Such practices may include education and counseling around storing firearms locked in a secure place (e.g., in a gun safe or lockbox), unloaded and separate from the ammunition; and keeping medicines in a locked cabinet or other secure location away from people who may be at risk or who have made prior attempts.[89,101]

Organizational policies and culture that promote protective environments may be implemented in places of employment, detention facilities, and other secured environments (e.g., residential settings). Such policies and cultural values encourage leadership from the top down and may promote prosocial behavior (e.g., asking for

help), skill-building, positive social norms, assessment, referral and access to helping services (e.g., mental health, substance abuse treatment, financial counseling), and development of crisis response plans, postvention and other measures to foster a safe physical environment. Such policies and cultural shifts can positively impact organizational climate and morale and help prevent suicide and its related risk factors (e.g., depression, social isolation).[88,102]

Community-based policies to reduce excessive alcohol use. Research studies in the United States have found that greater alcohol availability is positively associated with alcohol-involved suicides.[103-105] Policies to reduce excessive alcohol use broadly include zoning to limit the location and density of alcohol outlets, taxes on alcohol, and bans on the sale of alcohol for individuals under the legal drinking age.[105] These policies are important because acute alcohol use has been found to be associated with more than one-third of suicides and approximately 40% of suicide attempts.[105]

Potential Outcomes

- Increases in safe storage of lethal means
- Reductions in rates of suicide
- Reductions in suicide attempts
- Increases in help-seeking
- Reductions in alcohol-related suicide deaths

Evidence

The evidence suggests that creating protective environments can reduce suicide and suicide attempts and increase protective behaviors.

Reduce access to lethal means among persons at risk of suicide. A meta-analysis examining the impact of suicide hotspot interventions implemented in combination or in isolation, both in the U.S. and abroad, found associated reduced rates of suicide.[100,107] For example, after erecting a barrier on the Jacques-Cartier bridge in Canada, the

suicide rate from jumping from the bridge decreased from about 10 suicide deaths per year to about 3 deaths per year.[108] Moreover, the reduction in suicides by jumping was sustained even when all bridges and nearby jumping sites were considered, suggesting little to no displacement of suicides to other jumping sites. Further evidence for the effectiveness of bridge barriers was demonstrated by a study examining the impact of the removal of safety barriers from the Grafton Bridge in Auckland, New Zealand. After the removal of the barrier, both the number and rate of suicide increased five-fold.[93,109]

Another form of means reduction involves the implementation of safe storage practices. In a case-control study of firearm-related events identified from 37 counties in Washington, Oregon, and Missouri, and from 5 trauma centers, researchers found that storing firearms unloaded, separate from ammunition, in a locked place or secured with a safety device was protective of suicide attempts among adolescents.[110] Further, a recent systematic review of the clinic and community-based education and counseling interventions suggested that the provision of safety devices significantly increased safe firearm storage practices compared to counseling alone or compared to the provision of economic incentives to acquire safety devices on one's own.[101]

Another program, the Emergency Department Counseling on Access to Lethal Means (ED CALM), trained psychiatric emergency clinicians in a large children's hospital to provide lethal means counseling and safe storage boxes to parents of patients under age 18 receiving care for suicidal behavior. In a pre-post quality improvement project, Runyan et al[89] found that at post-test 76% (of the 55% of parents followed up, n=114) reported that all medications in the home were locked up as compared to fewer than 10% at the time of the initial emergency department visit. Among parents who indicated the presence of guns in the home at pre-test (i.e., 67%), all (100%) reported guns were currently locked up at the post-test.[89]

Organizational policies and culture. Together for Life is a workplace program of the Montreal Police Force implemented to address suicide among officers. Policy and program components were designed to foster an organizational culture that promoted

mutual support and solidarity among all members of the Force. The program included training of supervisors, managers, and all units to improve competencies in identifying suicidal risk and to improve the use and awareness of existing resources. The program also included an education campaign to improve awareness and help-seeking.[111] Police suicides were tracked over 12 years and compared to rates in the control city of Quebec. The suicide rate in the intervention group decreased significantly by 78.9% to a rate of 6.4 suicides per 100,000 population per year compared to an 11% increase in the control city (29.0 per 100,000).[111]

Another example of this approach is the United States Air Force Suicide Prevention Program. The program included 11 policy and education initiatives and was designed to change the culture of the Air Force surrounding suicide. The program uses leaders as role models and agents of change, establishes expectations for behavior related to awareness of suicide risk, develops population skills and knowledge (i.e., education and training), and investigates every suicide (i.e., outcomes measurement). The program represents a fundamental shift from viewing suicide and mental illness solely as medical problems and instead sees them as larger service-wide problems impacting the whole community. Using a time-series design to examine the impact of the program on various violence-related outcomes, researchers found that the program was associated with a 33% relative risk reduction in suicide.[112] The program was also associated with relative risk reductions in related outcomes including moderate and severe family violence (30% and 54%, respectively), homicide (51%), and accidental death (18%).[112] A longitudinal assessment of the program over the period 1981 to 2008 (16 years before the 1997 launch of the program and 11 years post-launch) found significantly lower rates of suicide after the program was launched than before.[87] These effects were sustained over time, except in 2004, which the authors found was associated with less rigorous implementation of program components in that year than in the other years

Finally, while the evidence is still being built for suicide prevention in correctional facilities, preliminary evidence suggests organizational policies and practices that

include routine suicide prevention training for all staff; standardized intake screening and risk assessment; provision of shared information between staff members (especially in transitioning or transferring of inmates); varying levels of observation; safe physical environment; emergency response protocols; notification of suicidal behavior/suicide through the chain of command; and critical incident stress debriefing and death review can potentially reduce suicide.[102] When these policies and practices were implemented across 11 state prisons in Louisiana, suicide rates dropped 46%, from a rate of 23.1 per 100,000 before the intervention to 12.4 per 100,000 the following year.[113] Similar programs have seen declines in suicide both in the United States and in other countries.

Community-based policies to reduce excessive alcohol use. While multiple policies to limit excessive use of alcohol exist, several studies on alcohol outlet density and risk factors for suicide, such as interpersonal violence and social connectedness,[115-118] suggest that measures to reduce alcohol outlet density can potentially reduce alcohol-involved suicides. Additionally, a longitudinal analysis of alcohol outlet density, suicide mortality, and hospitalizations for suicide attempts over 6 years in 581 California zip codes, indicated that greater density of bars, specifically, was related to greater suicide and suicide attempts, particularly in rural areas.[119]

E. Promote Connectedness

Rationale

Sociologist, Emile Durkheim theorized in 1897 that weak social bonds, i.e., lack of connectedness, were among the chief causes of suicidality.[120] Connectedness is the degree to which an individual or group of individuals are socially close, interrelated or share resources with others.[121] Social connections can be formed within and between multiple levels of the social ecology,[17] for instance between individuals (e.g., peers, neighbors, co-workers), families, schools, neighborhoods, workplaces, faith communities, cultural groups, and society as a whole. Related to connectedness, social capital refers to a sense of trust in one's community and neighborhood, social integration, and also the availability and participation in social organizations.[122-123] Many ecological cross-sectional and longitudinal studies have examined the impact of aspects of social capital on depression symptoms, depressive disorder, mental health more generally, and suicide. While the evidence is limited, existing studies suggest a positive association between social capital (as measured by social trust and community/neighborhood engagement), and improved mental health.[124-125] Connectedness and social capital together may protect against suicidal behaviors by decreasing isolation, encouraging adaptive coping behaviors, and by increasing belongingness, personal value, and worth, to help build resilience in the face of adversity. Connectedness can also provide individuals with better access to formal supports and resources, mobilize communities to meet the needs of its

members, and provide collective primary prevention activities to the community as a whole.[121]

Approaches

Promoting connectedness among individuals and within communities through modeling peer norms and enhancing community engagement may protect against suicide.

Peer norm programs seek to normalize protective factors for suicide such as help-seeking, reaching out and talking to trusted adults, and promote peer connectedness. By leveraging the leadership qualities and social influence of peers, these approaches can be used to shift group-level beliefs and promote positive social and behavioral change. These approaches typically target youth and are delivered in school settings but can also be implemented in community settings.[126]

Community engagement activities. Community engagement is an aspect of social capital.[127] Community engagement approaches may involve residents participating in a range of activities, including religious activities, community clean-up, and greening activities, and group physical exercise. These activities provide opportunities for residents to become more involved in the community and to connect with other community members, organizations, and resources, resulting in enhanced overall physical health, reduced stress, and decreased depressive symptoms, thereby reducing the risk of suicide.

Potential Outcomes

- Increases in healthy coping attitudes and behaviors
- Increases in referrals for youth in distress
- Increases in help-seeking behaviors
- Increases in positive perceptions of adult support

Evidence

Current evidence suggests a number of positive benefits of peer norm and community engagement activities, although more evaluation research is needed to examine whether these improvements in factors that protect against suicidal behavior translate into reduced suicide attempts and deaths.

Peer norm programs. Evaluations show that programs such as Sources of Strength can improve school norms and beliefs about suicide that are created and disseminated by student peers. In a randomized controlled trial of Sources of Strength conducted with 18 high schools (6 metropolitans, 12 rural), researchers found that the program improved adaptive norms regarding suicide, connectedness to adults, and school engagement.[36] Peer leaders were also more likely than controls to refer a suicidal friend to an adult. For students, the program resulted in increased perceptions of adult support for suicidal youths, particularly among those with a history of suicidal ideation, and the acceptability of help-seeking behaviors. Finally, trained peer leaders also reported a greater decrease in maladaptive coping attitudes compared with untrained leaders.[36]

Community engagement activities. A vacant lot greening initiative was undertaken in Philadelphia between 1999 and 2008. Local residents and community members worked together to green 4,436 lots (or 7.8 million square feet) in four areas of the city. Researchers found significant reductions in community residents' self-reported level of stress, a risk factor for suicide, and engagement in more physical exercise, a protective factor for suicide, than residents in control vacant lot areas. There is some evidence for other cross-cutting benefits, including reductions in firearm assaults and vandalism.[128,129]

F. Teach Coping and Problem-Solving Skills

Rationale

Building life skills prepares individuals to successfully tackle everyday challenges and adapt to stress and adversity. Life skills encompass many concepts, but most often include coping and problem-solving skills, emotional regulation, conflict resolution, and

critical thinking. Life skills are important in protecting individuals from suicidal behaviors.[126] Suicide prevention programs that focus on life and social skills training are drawn from social cognitive theories,[130] surmising that suicidal behavior is attributed to either direct learning and modeling or environmental and individual (e.g., hopelessness) characteristics. The inability to employ adequate strategies to cope with immediate stressors or identify and find solutions for problems has been characterized among suicide attempters.[131] Teaching and providing youth with the skills to tackle everyday challenges and stressors is, therefore, an important developmental component to suicide prevention.

Approaches

Social-emotional learning programs and parenting skills and family relationship programs are two approaches for teaching coping and problem-solving skills.

Social-emotional learning programs focus on developing and strengthening communication and problem-solving skills, emotional regulation, conflict resolution, help-seeking, and coping skills. These approaches address a range of risk and protective factors for suicidal behavior. They provide children and youth with skills to resolve problems in relationships, school, and with peers, and help youth address other negative influences (e.g., substance use) associated with suicide.[126] These approaches are typically delivered to all students in a particular grade or school, although some programs also focus on groups of students considered to be at high risk for suicide. Opportunities to practice and reinforce skills are an important part of programs that work.[132]

Parenting skill and family relationship programs provide caregivers with support and are designed to strengthen parenting skills, enhance positive parent-child interactions, and improve children's behavioral and emotional skills and abilities.[132] Programs are typically designed for parents or caregivers with children in a specific age range and can be self-directed or delivered to individual families or groups of families. Some programs have sessions primarily with parents or caregivers while others include sessions for

parents or caregivers, youth, and the family. Specific program content typically varies by the age of the child but often has consistent themes of child development, parent-child communication and relationships, and youth's interpersonal and problem-solving skills.

Potential Outcomes

- Reductions in suicide ideation
- Reductions in suicide attempts
- Reductions in suicide risk behaviors (i.e., depression, anxiety, conduct problems, substance abuse)
- Improvements in help-seeking behavior
- Improvements in social competence and emotional regulation skills
- Improvements in problem-solving and conflict management skills

Evidence

Several social-emotional learning and parenting and family relationship programs have been shown in rigorous evaluations to improve resilience and reduce problem behavior and risk factors for various behaviors, including ones closely related to suicide, such as depression, internalizing behaviors, and substance abuse.[133]

Social-emotional learning programs. The Youth Aware of Mental Health Program (YAM) is a program developed for teenagers aged 14–16 that uses interactive dialogue and role-playing to teach adolescents about the risk and protective factors associated with suicide (including knowledge about depression and anxiety) and enhances their problem-solving skills for dealing with adverse life events, stress, school, and other problems.[134] In a cluster-randomized controlled trial conducted across 10 European Union countries and 168 schools, students in schools randomized to YAM were significantly less likely to attempt suicide and have severe suicidal ideation at the 12-month follow-up compared to students in control schools which received educational materials and care as usual. Overall, the relative risk of youth suicide attempts among the YAM group was reduced by over 50% demonstrating that out of 1000 students, five

attempted suicide in the YAM group compared to 11 in the control group. Additionally, related to severe suicide ideation, in the YAM group, relative risk fell by 49.6%.[134]

Another example is the Good Behavior Game (GBG), which is a classroom-based program for elementary school children aged 6–10. The program uses a team-based behavior management strategy that promotes good behavior by setting clear expectations for good behavior and consequences for maladaptive behavior.[135] The goal of the GBG program is to create an integrated classroom social system that is supportive of all children being able to learn with little aggressive or disruptive behavior. Two cohorts of youths participated in the program in 1985-86 and 1986-87 school years when they were in the first and second grades. A number of proximal and distal outcomes were assessed among the two cohorts over time. With respect to distal suicide-related outcomes, an outcome evaluation of the GBG indicated that individuals in the first cohort, who were assigned to participate in GBG when they were in the first grade, reported half the adjusted odds of suicidal ideation and suicide attempts when assessed approximately 15 years later, between the ages of 19 to 21, compared to peers who had been in a standard classroom setting. The beneficial effect of the program was consistent for suicidal ideation regardless of whether baseline covariates were included.[135] The GBG effect on attempts was less robust in some adjusted models including caregiver mental health. In the second cohort of GBG students, neither suicidal ideation nor suicide attempts were significantly different between GBG and the control interventions.[135] The researchers believed this may have been due to a lack of implementation fidelity, including less mentoring and monitoring of teachers. GBG was also found to be associated with reduced risk of later substance abuse and other suicide risk factors among the first cohort of students. Results for the second cohort were generally smaller but in the desired direction.[136]

Parenting skill and family relationship programs. Parenting and family skills training approaches have shown promising impacts in preventing key risk factors associated with suicide. For example, the Incredible Years (IY) is a comprehensive group training program for parents, teachers, and children designed to reduce conduct and substance

abuse problems (two important suicide risk factors in youth) by improving protective factors such as responsive and positive parent-teacher-child interactions and relationships, emotional self-regulation and social competence (all protective factors for suicide).[132] The program includes 9-20 sessions offered in community-based settings (e.g., religious, recreation centers, mental health treatment centers, and hospitals). Several studies have demonstrated the effect of the IY program on reducing internalizing symptoms, such as anxiety and depression, and child conduct problems.[137,138] The program is also associated with improved problem-solving and conflict management; these skills were maintained at 1-year follow-up.[139-141] Additionally, the program demonstrated greater benefits in mother-rated child internalizing symptoms, compared to the waitlisted control group, when parent, child, and teacher components were included.[132]

Additionally, Strengthening Families 10–14 is a program that involves sessions for parents, youth, and families with the goal of improving parents' skills for disciplining, managing emotions and conflict, and communicating with their children; promoting youths' interpersonal and problem-solving skills; and creating family activities to build cohesion and positive parent-child interactions. The premise of the program is that developing these skills for both parents and children will reduce internalizing behavior and adolescent substance abuse, two important risk factors for suicide.[142] Strengthening Families has been shown to significantly decrease externalizing behaviors, such as aggression, alcohol use, and drug use among youth participants, as well as reduce depression, alcohol use, and drug use among participating families.[142]

G. Identify and Support People at Risk

Rationale

In order to decrease suicide, care of, and attention to, vulnerable populations are necessary, as these groups tend to experience suicidal behavior at higher than average

rates. Such vulnerable populations include, but are not limited to, individuals with lower socioeconomic status or who are living with a mental health problem; people who have previously attempted suicide; Veterans and active duty military personnel; individuals who are institutionalized, have been victims of violence, or are homeless; individuals of sexual minority status; and members of certain racial and ethnic minority groups.[8,9,12,13,143] Supporting people at risk requires proactive case finding and effective response, crisis intervention, and evidence-based treatment. Finding optimal ways of identifying the at risk individuals, customizing services to make them more accessible (e.g., Internet-based services when appropriate) and engaging people in evidence-based care (e.g., through such measures as collaborative treatment), remain key challenges.[81,144,145] Simply improving or expanding services does not guarantee that those services will be used by people most in need, nor will it necessarily increase the number of people who follow recommended referrals or treatment. For example, some people living in disadvantaged communities may face social and economic issues that can adversely affect their ability to access supportive services.

Approaches

The following approaches focus on identifying and supporting people at increased risk of suicide.

Gatekeeper training is designed to train teachers, coaches, clergy, emergency responders, primary and urgent care providers, and others in the community to identify people who may be at risk of suicide and to respond effectively, including facilitating treatment-seeking and support services. Gatekeeper training may be implemented in a variety of settings to identify and support people at risk.[146]

Crisis intervention. These approaches provide support and referral services, typically by connecting a person in crisis (or a friend or family member of someone at risk) to trained volunteers or professional staff via telephone hotline, online chat, text messaging, or in-person. Crisis intervention approaches are intended to impact key risk factors for suicide, including feelings of depression, hopelessness, and subsequent mental health care utilization.[147] Similar to means reduction, crisis interventions can put space or time between an individual who may be considering suicide and harmful behavior.

Treatment for people at risk of suicide can include various forms of psychotherapy delivered by licensed providers to help individuals with mental health problems and other suicide risk factors with problem-solving and emotional regulation. Treatment usually takes place in a one-on-one or group format between patients and clinicians and can vary in duration from several weeks to ongoing therapy, as needed. Treatment that employs collaborative (i.e., between patient and therapist or care manager) and/or integrated care (e.g., the linkage between primary care and behavioral health care) can help engage and motivate patients, thereby increasing retention in therapy and decreasing suicide risk.[148-150]

Treatment to prevent re-attempts. These approaches typically include follow-up contact and use diverse modalities (e.g., home visits, mail, telephone, e-mail) to engage recent suicide attempt survivors in continued treatment to prevent re-attempts.[151] Treatment may focus on improved coping skills, mindfulness, and other emotional regulation skills, and may include case management home visits to increase adherence to treatment and continuity of care; and one-on-one interpersonal therapy and/or group

therapy. Approaches that engage and connect people who have attempted to peers and providers are especially important because many attempters do not present to aftercare; 12%-25% re-attempt within a year and 3%-9% of attempt survivors die by suicide within 1 to 5 years of their initial attempt.[151]

Potential Outcomes

- Reductions in suicidal ideation
- Reductions in suicide attempts
- Reductions in suicide rates
- Reductions in depression and feelings of hopelessness
- Reductions in re-attempts
- Improvements in coping skills
- Increases in treatment engagement and compliance with medications

Evidence

The current evidence suggests that identifying people at risk of suicide and the continued provision of treatment and support for these individuals can positively impact suicide and its associated risk factors.

Gatekeeper training. Applied Suicide Intervention Skills Training (ASIST) is a widely implemented training program that helps hotline counselors, emergency workers, and other gatekeepers to identify and connect with suicidal individuals, understand their reasoning for living and dying, and assist with safely connecting those in need to available resources. In a study employing a randomized controlled trial, Gould, Cross, Pisani, Munfakh, & Kleinman[152] evaluated the training across the National Suicide Prevention Lifeline network of hotlines over the period 2008-2009. Using data from 1,410 suicidal individuals who called 17 Lifeline centers, the researchers found that callers who spoke with ASIST-trained counselors were significantly more likely to feel less depressed, less suicidal, less overwhelmed, and more hopeful by the end of their call, compared to callers who spoke to non-ASIST trained counselors. Counselors trained in ASIST were also more skilled at keeping callers on the phone longer and

establishing a connection with them. However, training in ASIST did not result in more comprehensive suicide risk assessments than usual care training.[152]

Gatekeeper training has also been a primary component of the Garret Lee Smith (GLS) Suicide Prevention Program, which has been implemented in 50 states and 50 tribes. A multi-site evaluation assessed the impact of community gatekeeper training on suicide attempts and deaths by comparing the change in suicide rates and nonfatal suicidal behavior among young people aged 10–24 in counties implementing GLS training, with the trajectory observed in similar counties that did not implement these trainings. Counties that implemented GLS trainings had significantly lower youth suicide rates one year following the training implementation.[153] This finding equates to a decrease of 1 suicide death per 100,000 youth ages 10 to 24, or the prevention of approximately 237 deaths in the age group, between 2007 and 2010. Counties implementing GLS program activities also had significantly lower suicide attempt rates among youth ages 16 to 23 in the year following implementation of the GLS program than did similar counties that did not implement GLS activities (4.9 fewer attempts per 1000 youths).[154] More than 79,000 suicide attempts may have been prevented during the period examined.

Crisis intervention. Suicide prevention hotlines are one way to provide crisis intervention. In an evaluation of the effectiveness of the National Suicide Prevention Lifeline to prevent suicide, 1,085 suicidal individuals who called the hotline completed a standard risk assessment for suicide, and 380 of those completed a follow-up assessment between 1 and 52 days (mean=13.5 days) after the initial assessment. Researchers found that over half of the initial sample was seriously considering suicide when they called, and they had a plan for their suicide. Researchers also found that among follow-up participants, there was a significant decrease in psychological pain, hopelessness, and intent to die between initiation of the call (time 1) to follow-up (time 3).[155] Between time 2 (end of the call) to time 3, the effect remained for psychological pain and hopelessness, but was not significant for intent to die, suggesting that greater

effort at outreach during and following the call is needed for callers with high levels of suicide intent.

Treatment for people at risk of suicide. The Improving Mood—Promoting Access to Collaborative Treatment (IMPACT) program aims to prevent suicide among older primary care patients by reducing suicide ideation and depression. IMPACT facilitates the development of a therapeutic alliance, a personalized treatment plan that includes patient preferences, as well as a proactive follow-up (biweekly during an acute phase and monthly during continuation phase) by a depression care manager.[156] The program has been shown to significantly improve quality of life and to reduce functional impairment, depression, and suicidal ideation over 24-months of follow-up[156,157] relative to patients who received care as usual.

Collaborative Assessment and Management of Suicidality (CAMS), is a therapeutic approach for suicide-specific assessment and treatment. The program's flexible approach can be used across treatment settings and clinician theoretical orientations and involves the clinician and patient working together in an interactive assessment process to develop patient-specific treatment plans. Sessions are collaborative and involve constant patient input about what is and is not working with the ultimate goal of enhancing the therapeutic alliance and increasing treatment motivation in the suicidal patient. CAMS has been tested and supported in 6 correlational studies,[144] in a variety of inpatient and outpatient settings, and in one RCT with several additional RCTs underway. A feasibility trial with a community-based sample of suicidal outpatients randomly assigned to CAMS or enhanced care as usual (intake with a

psychiatrist or psychiatric nurse practitioner followed by 1-11 visits with a case manager and medication as needed) found better treatment retention among the CAMS group and significant improvements in suicidal ideation, overall symptom distress, and feelings of hopelessness at the 12-month follow-up.[158]

Other examples include Dialectical Behavioral Therapy (DBT) and Attachment-Based Family Therapy (ABFT). DBT is a multicomponent therapy for individuals at high risk for suicide and who may struggle with impulsivity and emotional regulation issues. The components of DBT include individual therapy, group skills training, between-session telephone coaching, and a therapist consultation team. In a randomized controlled trial of women with recent suicidal or self-injurious behavior, those receiving DBT were half as likely to make a suicide attempt at the two-year follow-up than women receiving community treatment (23% vs 46%), required less hospitalization for suicide ideation, and had lower medical risk across all suicide attempts and self-injurious acts combined.[159]

ABFT is a program for adolescents aged 12–18 and is designed to treat clinically diagnosed major depressive disorder, eliminate suicidal ideation, and reduce dispositional anxiety.[160] A randomized controlled trial of ABFT found that suicidal adolescents assigned to ABFT experienced significantly greater improvement in suicidal ideation over 24 weeks of follow-up than did adolescents assigned to enhanced usual care. Additionally, a significantly higher percentage of ABFT participants reported no suicidal ideation in the week prior to assessment at 12 weeks than did adolescents receiving enhanced usual care (69.2% vs. 34.6%) and at 24 weeks (82.1% vs. 46.2%).[160]

The Veterans Affairs Translating Initiatives for Depression into Effective Solutions project (TIDES) uses a depression care liaison to link primary care and mental health services. The depression care liaison assesses and educates patients and follows-up with both patients and providers between primary care visits to optimize treatment. This collaborative care increases the efficiency of providing mental health services by

bringing mental health care to the primary care setting, where most patients are first detected and subsequently treated for many mental health conditions. An evaluation of TIDES found significant decreases in depression severity scores among 70% of primary care patients.[161] TIDES patients also demonstrated 85% and 95% compliance with medication and follow-up visits, respectively.[161]

Treatment to prevent re-attempts. Several strategies that aim to prevent re-attempts have demonstrated an impact on reducing suicide deaths. For example, Emergency Department Brief Intervention with Follow-up Visits is a program that involves a one-hour discharge information session that addresses suicidal ideation and attempts, distress, risk, and protective factors, alternatives to self-harm, and referral options, combined with nine follow-up contacts over 18 months (at 1, 2, 4, 7, 11 weeks and 4, 6, 12, 18 months). Follow-up contacts are either conducted by phone or through home visits according to a specific timeline for up to 18 months. A randomized controlled trial that enrolled suicide attempters from eight hospital emergency departments in five countries (Brazil, India, Sri Lanka, Iran, and China) found that a brief intervention combined with nine follow-up visits over 18 months was associated with significantly fewer deaths from suicide relative to a treatment-as-usual group (0.2% versus 2.2%, respectively).[162]

Another example of treatment to prevent re-attempts involves active follow-up contact approaches such as postcards, letters, and telephone calls intended to increase a patient's sense of connectedness with health care providers and decrease isolation.[151] These approaches include expression of care and support and typically invite patients to reconnect with their provider. Contacts are made periodically (e.g., monthly or every few months in the first 12 months post-discharge with some programs continuing contact for two or more years). In a meta-analysis conducted by Inagaki et al[151] interventions to prevent repeat suicide attempts in patients admitted to an emergency department for suicide attempt were found to reduce re-attempts by approximately 17% for up to 12 months post-discharge; however, the effects of these approaches beyond 12 months on re-attempts has not yet been demonstrated.[151] Also, because the number

of trials and associated sample sizes included in this meta-analysis were small, it was not possible to determine the effect of active contact and follow-up approaches on suicide.

In a randomized controlled trial of the post-crisis suicide prevention long-term follow-up contact approach, Motto and Bostrom[163] found that patients who refused ongoing care but who were randomized to be contacted by letter four times per year had a lower rate of suicide over two years of follow-up than did patients in the control group who received no further contact. Other studies have also shown post-crisis letters and coping cards to be protective against suicide ideation and attempts.[164,165]

Finally, Cognitive Behavior Therapy for Suicide Prevention (CBT-SP) is an example of a therapeutic approach to prevent re-attempts. It uses a risk-reduction, relapse prevention approach that includes an analysis of proximal risk factors and stressors (e.g., relationship problems, school or work-related difficulties) leading up to and following the suicide attempt; safety plan development; skill-building; and psychoeducation. CBT-SP also has family skill modules focused on family support and communication patterns as well as improving the family's problem-solving skills. A randomized controlled trial of CBT-SP found that 10-session outpatient cognitive therapy designed to prevent repeat suicide attempts resulted in a 50% reduction in the likelihood of a suicide re-attempt among adults who had been admitted to an emergency department for a suicide attempt relative to treatment as usual.[166]

G. Lessen Harms and Prevent Future Risk

Rationale

Millions of people are bereaved by suicide every year in the United States and throughout the world.[5] Risk of suicide and suicide risk factors has been shown to increase among people who have lost a friend/peer, family member, co-worker, or other close contacts to suicide.[167] Care and attention to the bereaved are therefore of high importance. Despite often good intentions, media and others responding to suicide may add to this risk. For example, research suggests that exposure to sensationalized or otherwise uninformed reporting on suicide may heighten the risk of suicide among vulnerable individuals and can inadvertently contribute to what is known as suicide contagion.[168,169]

Approaches

Some approaches that can be used to lessen harm and reduce future risk of suicide include postvention and safe reporting and messaging following a suicide.

Postvention approaches are implemented after a suicide has taken place and may include debriefing sessions, counseling, and/or bereavement support groups for surviving friends, family members, or other close contacts. These programs have not

typically been evaluated for their impact on suicide, attempts, or ideation, but they may reduce survivors' guilt, feelings of depression, and complicated grief.[170]

Safe reporting and messaging about suicide. The manner in which information on a recent suicide is communicated to the public (e.g., school assemblies, mass media, social media) can heighten the risk of suicide among vulnerable individuals and can inadvertently contribute to suicide contagion. Reports that are inclusive of suicide prevention messages, stories of hope and resilience, risk and protective factors, and links to helping resources (e.g., hotline), and that avoid sensationalizing events or reducing suicide to one cause, can help reduce the likelihood of suicide contagion.[171]

Potential Outcomes

- Reductions in suicidal ideation
- Reductions in suicide attempts
- Reductions in rates of suicide
- Reductions in psychological distress
- Improvements in reporting following suicide
- Reductions in contagion effects related to suicide

Evidence

Current evidence suggests that postvention and safe reporting and messaging can impact risk and protective factors for suicide.

Postvention. One example of a postvention program with evidence of impact on risk and protective factors for suicide is the StandBy Response Service (StandBy). StandBy provides clients with face-to-face outreach and telephone support through a professional crisis response team. Site coordinators develop customized case management plans, referring clients to other existing community services matched to their needs.[172] In a study by Visser, Comans, and Scuffham,[172] StandBy clients were significantly less likely to be at high risk for suicidality (suicide ideation and attempts) and had less psychological distress than a suicide bereaved comparison group who had

not had contact with the StandBy program (48% and 64% respectively). Additionally, research suggests that active postvention approaches in which outreach to suicide survivors occurs at the scene of a suicide is associated with intake into treatment sooner, greater attendance at support group meetings, and attendance at more meetings compared to passive postvention (i.e., approaches where survivors self-refer for services).[173]

Safe reporting and messaging about suicide. One way to ensure safe reporting and messaging about suicide is to encourage news media to adhere to Recommendations for Reporting on Suicide (http://www.reportingonsuicide. org). The most compelling evidence supporting these recommendations for reporting comes from Austria. After a sharp increase in suicides on the Viennese subway, media guidelines were introduced and an interrupted time-series design was used to evaluate the national impact of the guidelines on subsequent suicides. Changes in the quality and quantity of media reporting resulted in a nationwide significant reduction of 81 suicides annually.[169] Finally, research suggests that not only does reporting on suicide in a negative way (e.g., reporting on suicide myths and repetition) have harmful effects on suicide, but reporting on positive coping skills in the face of adversity can also demonstrate protective effects against suicide.[174] Reports of individual suicidal ideation (not accompanied by reports of suicide or suicide attempts) along with reports describing a "mastery" of a crisis situation where adversities were overcome were associated with significant decreases in suicide rates in the time period immediately following such reports.[174]

H. Sector Involvement

Public health can play an important and unique role in addressing suicide. Public health agencies, which typically place prevention at the forefront of efforts and work to create broad population-level impact, can bring critical leadership and resources to bear on this problem. For example, these agencies can serve as a convener, bringing together partners and stakeholders to plan, prioritize, and coordinate suicide prevention

efforts. Public health agencies are also well positioned to collect and disseminate data, implement preventive measures, evaluate programs, and track progress. Although public health can play a leadership role in preventing suicide, the strategies and approaches outlined in this technical package cannot be accomplished by the public health sector alone. As noted in the National Strategy for Suicide Prevention[1] the integration and coordination of prevention activities across sectors and settings are critical for expanding the reach and impact of suicide prevention efforts.

Other sectors vital to implementing this package include, but are not limited to, education, government (local, state, and federal), social services, health services, business, labor, justice, housing, media, and organizations that comprise the civil society sector such as faith-based organizations, youth-serving organizations, foundations, and other non-governmental organizations. Collectively, these sectors can make a difference in preventing suicide by impacting the various contexts and underlying risks that contribute to suicide.

The strategies and approaches described in this technical package are summarized in the Appendix along with the relevant sectors that are well-positioned to lead implementation efforts. For example, business and labor, the health sector (including insurers, providers, and health systems), and government entities are in the best position to implement programs and policies that Strengthen Economic Supports and Strengthen Access and Delivery of Suicide Care. These types of supports go beyond individual behavior change and require commitment and support from those sectors that can directly address some of the underlying risks and the environmental contexts that increase the risk of suicide. Public health entities can play an important role by gathering and synthesizing information to inform policy, raise awareness, and evaluate the effectiveness of various policies. Moreover, partnerships with non-governmental and community organizations can be instrumental in increasing awareness of and garnering support for policies affecting individuals and families.

The public health sector has been at the forefront of many community-based prevention efforts, working collaboratively with schools and community-based organizations, to change social norms and positively impact health behavior. Public health is well suited to take on a similar leadership role in Promoting Connectedness through peer norm and community engagement activities and supporting the development, evaluation, and adoption of effective programs that Teach Coping and Problem-Solving Skills to prevent the risk of suicide in the first place. These programs are often delivered in school and community settings, making education and non-governmental organizations vital partners in prevention.

Businesses, workplaces, and local and state government entities, on the other hand, are in the best position to establish policies and support practices that Create Protective Environments where people live, work, and play. Public health entities can serve in an important role by gathering and synthesizing information, working with other governmental agencies (e.g., criminal justice, defense) and agencies within the executive branch of their state or local government in support of policy and other approaches, and evaluating the effectiveness of measures taken. In a similar fashion, public health entities can partner with schools, workplaces, and community organizations to implement and evaluate prevention programs, policies, and practices geared toward creating safe, healthy, and supportive environments.

Finally, this technical package includes a number of interventions delivered in hospital, primary care, behavioral health care, and community settings designed to Identify and Support People at Risk. The intensity and activities for many of these interventions require the expertise of professionals who are licensed and trained to deliver critical intervention support. The health, social services, and justice sectors can work collaboratively to support individuals at high-risk for suicide and their families. These activities also require coordination of supports across various service providers and community organizations.

Regardless of strategy, action by many sectors will be necessary for the successful implementation of this package. In this regard, all sectors can play an important and influential role in preventing the risk of suicide in the first place and lessening the immediate and long-term harms of suicidal behavior by helping those in times of crisis get the services and support they need.

I. Monitoring and Evaluation

Monitoring and evaluation are necessary components of the public health approach to prevention. It is important to have timely and reliable data to monitor the extent of the problem and to evaluate the impact of prevention efforts. Data are also necessary for prevention planning and implementation.

Gathering ongoing and systematic data is important for prevention efforts. However, it is also important to gather data that are uniform and consistent across systems. Consistent data allow public health and other entities to better gauge the scope of the problem, identify high-risk groups, and monitor the effects of prevention programs and policies. Currently, it is common for different sectors, agencies, and organizations to employ varying definitions of suicidal ideation, behavior, and death that can make it difficult to consistently monitor specific outcomes across sectors and over time. For example, the manner in which deaths are classified can change from one jurisdiction to another and can change based on local medical and/or medico-legal standards.[4] CDC's uniform definitions and recommended data elements for self-directed violence provide a useful framework to help ensure that data are collected in a consistent manner across surveillance systems. [4]

Surveillance systems exist at the federal, state, and local levels. It is important to assess the availability of surveillance data and data systems across these levels to identify and address gaps in the systems. CDC's National Vital Statistics System (NVSS) and the National Violent Death Reporting System (NVDRS)[175] are examples of surveillance systems that provide data on deaths from suicide. NVSS is a nationwide

surveillance system that collects demographic, geographic, and cause-of death data from death certificates.[7] NVDRS is a state-based surveillance system (currently in 40 states, the District of Columbia, and Puerto Rico) that combines data from death certificates, law enforcement reports, and coroner or medical examiner reports to provide detailed information on the circumstances of violent deaths, including suicide, which can assist communities in guiding prevention approaches.[175] Data from state and local Child Death Review teams and Suicide Death Review Teams[176] (which are in a few states) offer another source to identify deaths and obtain insight into the gaps in services, systems and modifiable risk factors for suicide.

The National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP) provides nationally representative data about all types and causes of nonfatal injuries treated in U.S. hospital emergency departments, and can be used to assess national rates of, and trends in, self-harm injuries by cause (e.g., falls, poisoning, etc.), age, race/ ethnicity, sex, disposition (where the injured person goes when released from the emergency department).[6]

In addition to information on deaths and nonfatal injuries, there are also surveillance systems that provide national, state, and some local estimates of suicidal behavior. The Youth Risk Behavior Surveillance System (YRBSS) collects information from a nationally representative sample of 9–12 grade students and is a key resource in monitoring health-risk behaviors among youth, including whether youth have seriously considered attempting suicide, attempted suicide, made a plan, or required treatment by a doctor or nurse for a suicide attempt that resulted in an injury, poisoning, or overdose.[177] The YRBSS data are obtained from a national school-based survey conducted by CDC as well as from state, territorial, tribal, and large urban school district surveys conducted by education and health agencies.[177] The National Survey on Drug Use and Health (NSDUH)[50] is an annual survey of the civilian, noninstitutionalized population aged 12 years and older. NSDUH provides both national and state-level estimates of substance use (alcohol, tobacco, illicit drugs, and non-medical use of prescription drugs); mental health (past year mental illness, co-occurring illnesses); and

service utilization, along with suicide ideation, suicide plans, and suicide attempts. NSDUH is a key resource to track trends in suicide-related risk factors in the population and to help identify groups at increased risk.[50]

It is also important at all levels (local, state, and federal) to address gaps in responses, track progress of prevention efforts and evaluate the impact of those efforts, including the impact of this technical package. Evaluation data, produced through program implementation and monitoring, is essential to provide information on what does and does not work to reduce rates of suicide and its associated risk and protective factors. Theories of change and logic models that identify short, intermediate, and long-term outcomes are an important part of program evaluation.

The evidence-base for suicide prevention has advanced greatly over the last few decades. However, additional research is needed to understand the impact of programs, policies, and practices on suicide (and suicide attempts, at a minimum), as opposed to merely examining their effectiveness on risk factors. More research is also needed to examine the effectiveness of primary prevention strategies (before risk occurs) and community-level strategies to prevent suicide at the population level. It will be important for researchers to test the effectiveness of combinations of the strategies and approaches included in this package. Most existing evaluations focus on approaches implemented in isolation, but there is potential to understand the synergistic effects within a comprehensive prevention approach. Lastly, there are also many potential opportunities to build and strengthen partnerships across program areas (e.g., violence prevention, substance abuse prevention) to evaluate the impact of different approaches on multiple outcomes.

J. Conclusion

Suicide is a serious public health problem. Rates of suicide have been on the rise for more than a decade and the costs stretch well into the billions of dollars each year. While suicide is a rare outcome statistically, its human impact has a ripple effect that is

far-reaching. Each of us likely interacts with suicide survivors, those with lived experience, and those with thoughts of suicide on a daily basis—at home, at work, and in our communities. Suicide and suicide attempts are public health issues of societal concern. There are a number of barriers that have impeded progress, including, for example, stigma related to help-seeking, mental illness, being a survivor, and fear related to asking someone about suicidal thoughts. Fortunately, like many public health problems, suicide is preventable,[1,5] and more is being done to prevent suicide than ever before, as evidenced by the work of the National Action Alliance for Suicide Prevention,[39,40,75,88] the release of the first world report on suicide,[5] and more timely surveillance data, to name just a few examples.

In an effort to continue pushing the field and society further towards prevention, this technical package includes strategies and approaches that ideally would be used in a comprehensive, multi-level and multi-sectoral way. It includes strategies and approaches to prevent the risk of suicide in the first place, as well as strategies focused on lessening the immediate and long-term harms of suicidal behavior. It includes strategies that range from a focus on the whole population regardless of risk to strategies designed to support people at the highest risk. Importantly, this technical package extends the bounds of the typical prevention strategies to consider approaches that go beyond individual behavior change to better address risk factors impacting communities and populations more broadly (e.g., economic policies to strengthen housing and financial security).

While the evidence base continues to emerge, the collection of programs, policies, and practices laid out here are available for implementation now. In keeping with good public health practice, the intent is that monitoring and evaluation will play a key role in that implementation. Moreover, as new evidence becomes available, this technical package can be refined to reflect the current state of the science.

In closing, and in keeping with a message of resilience as spoken by those with lived experience, “hope, help, and healing is possible.”

References for Chapter 3

1. U.S. Office of the Surgeon General, National Action Alliance for Suicide Prevention. 2012 National strategy for suicide prevention: goals and objectives for action. Washington, D.C.: HHS; 2012.

2. National Action Alliance for Suicide Prevention. Action Alliance priorities. 2017; http://actionallianceforsuicideprevention.org/priorities.

3. Frieden TR. Six components necessary for effective public health program implementation. Am J Public Health. 2014;104(1):17-22.

4. Crosby AE, 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.

5. World Health Organization. Suicide prevention: a global imperative. Geneva, Switzerland: WHO Press; 2014.

6. Centers for Disease Control and Prevention. Web-Based Injury Statistics Query and Reporting System (WISQARS). Atlanta, GA: National Center for Injury Prevention and Control. Available online: http://www.cdc.gov/injury/wisqars/index.html.

7. Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System. https://www.cdc.gov/nchs/nvss/deaths.htm.

8. Bachynski KE, Canham-Chervak M, Black SA, Dada EO, Millikan AM, Jones BH. Mental health risk factors for suicides in the US Army, 2007–8. Inj Prev. 2012;18(6):405-412.

9. Lineberry TW, O'Connor SS. Suicide in the US Army. Mayo Clinic Proceedings. 2012;87(9):871-878.

10. McIntosh WL, Spies E, Stone DM, Lokey CN, Trudeau AR, Bartholow B. Suicide rates by occupational group - 17 states, 2012. MMWR Morb Mortal Wkly Rep. 2016;65(25):641-645.

11. Han B, Crosby AE, Ortega LA, Parks SE, Compton WM, Gfroerer J. Suicidal ideation, suicide attempt, and occupations among employed adults aged 18–64 years in the United States. Compr Psychiatry. 2016;66:176-186.

12. Kann L, McManus T, Harris WA, et al. Youth Risk Behavior Surveillance - United States, 2015. MMWR CDC Surveill Summ. 2016;65(6):1-174.
13. Russell ST, Joyner K. Adolescent sexual orientation and suicide risk: evidence from a national study. Am J Public Health. 2001;91(8):1276-1281.
14. Stone DM, Luo F, Ouyang L, Lippy C, Hertz MF, Crosby AE. Sexual orientation and suicide ideation, plans, attempts, and medically serious attempts: evidence from local Youth Risk Behavior Surveys, 2001-2009. Am J Public Health. 2014;104(2):262-271.
15. Crosby AE, Han B, Ortega LA, Parks SE, Gfroerer J. Suicidal thoughts and behaviors among adults aged ≥18 years-- United States, 2008-2009. MMWR CDC Surveill Summ. 2011;60(13):1-22.
16. Lipari R, Piscopo K, Kroutil LA, Kilmer Miller G. Suicidal thoughts and behavior among adults: results from the 2014 National Survey on Drug Use and Health. NSDUH Data Review 2015; https://www.samhsa.gov/data/sites/default/files/ NSDUH-FRR2-2014/NSDUH-FRR2-2014.pdf.
17. Dahlberg LL, Krug EG. Violence-a global public health problem. In: Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World Report on Violence and Health. Geneva, Switzerland: World Health Organization; 2002:1-21.
18. Owens D. Fatal and non-fatal repetition of self-harm: systematic review. Br J Psychiatry. 2002;181(3):193-199.
19. Olfson M, Gerhard T, Huang C, Crystal S, Stroup TS. Premature mortality among adults with schizophrenia in the United States. JAMA Psychiatry. 2015;72(12):1172-1181.
20. Bossarte RM, Karras E, Lu N, et al. Associations between the Dartment of Veterans Affairs' suicide prevention campaign and calls to related crisis lines. Public Health Rep (Washington, D.C.: 1974). 2014;129(6):516-525.
21. Chapman DP, Whitfield CL, Felitti VJ, Dube SR, Edwards VJ, Anda RF. Adverse childhood experiences and the risk of depressive disorders in adulthood. J Affect Disord. 2004;82(2):217-225.
22. Dube SR, Anda RF, Felitti VJ, Chapman DP, Williamson DF, Giles WH. Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life

span: findings from the Adverse Childhood Experiences Study. JAMA. 2001;286(24):3089-3096.
23. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) Study. Am J Prev Med. 1998;14(4):245-258.
24. Klomek AB, Sourander A, Gould M. The association of suicide and bullying in childhood to young adulthood: a review of cross-sectional and longitudinal research findings. Can J Psychiatry. 2010;55(5):282-288.
25. Leeb RT, Lewis T, Zolotor AJ. A review of physical and mental health consequences of child abuse and neglect and implications for practice. American Journal of Lifestyle Medicine. 2011;5(5):454-468.
26. World Health Organization. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: World Health Organization; 2013.
27. Bellis MA, Hughes K, Leckenby N, et al. Adverse childhood experiences and associations with health-harming behaviours in young adults: surveys in eight eastern European countries. Bull World Health Organ. 2014;92(9):641-655.
28. Haegerich TM, Dahlberg LL. Violence as a public health risk. American Journal of Lifestyle Medicine. 2011;5(5):392-406.
29. Wilkins N, Tsao B, Hertz M, Davis R, Klevens J. Connecting the dots: an overview of the links among multiple forms of violence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2014.
30. Hamby S, Grych J. The web of violence: exploring connections among different forms of interpersonal violence and abuse. Briefs in Sociology. New York, NY: Springer; 2013.
31. Kleiman EM, Riskind JH, Schaefer KE, Weingarden H. The moderating role of social support on the relationship between impulsivity and suicide risk. Crisis. 2012;33(5):273-279.
32. Carter M, McGee R, Taylor B, Williams S. Health outcomes in adolescence: associations with family, friends and school engagement. J Adolesc. 2007;30(1):51-62.

33. Maimon D, Browning CR, Brooks-Gunn J. Collective efficacy, family attachment, and urban adolescent suicide attempts. J Health Soc Behav. 2010;51(3):307-324.
34. Capaldi DM, Knoble NB, Shortt JW, Kim HK. A systematic review of risk factors for intimate partner violence. Partner Abuse. 2012;3(2):231-280.
35. Losel F, Farrington DP. Direct protective and buffering protective factors in the development of youth violence. Am J Prev Med. 2012;43(2 Suppl 1):S8-S23.
36. Wyman PA, Brown CH, LoMurray M, et al. An outcome evaluation of the Sources of Strength suicide prevention program delivered by adolescent peer leaders in high schools. Am J Public Health. 2010;100(9):1653-1661.
37. Dunne EJ, McIntosh JL, Dunne-Maxim K, eds. Suicide and its aftermath: understanding and counseling the survivors. New York: Norton; 1987.
38. Mishara BL. The impact of suicide. New York: Springer; 1995.
39. National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force. The way forward: pathways to hope, recovery, and wellness with insights from lived experience. Washington, D.C. : Author; 2014.
40. National Action Alliance for Suicide Prevention: Survivors of Suicide Loss Task Force. Responding to grief, trauma, and distress after a suicide: U.S. national guidelines. Washington, D.C. : Author; 2015.
41. 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.
42. Cerel J, Maple M, De Venne A, Moore M, Flaherty C, Brown M. Exposure to suicide in the community: prevalence and correlates in one US state. Public Health Rep (Washington, D.C.: 1974). 2016;131(1):100-107.
43. Chapman AL, Dixon-Gordon KL. Emotional antecedents and consequences of deliberate self-harm and suicide attempts. Suicide Life Threat Behav. 2007;37(5):543-552.
44. Mitchell AM, Kim Y, Prigerson HG, Mortimer-Stephens M. Complicated grief in survivors of suicide. Crisis. 2004;25(1):12-18.
45. Sudak H, Maxim K, Carpenter M. Suicide and stigma: a review of the literature and personal reflections. Acad Psychiatry. 2008;32(2):136-142.

46. Cerel J, McIntosh JL, Neimeyer RA, Maple M, Marshall D. The continuum of "survivorship": definitional issues in the aftermath of suicide. Suicide Life Threat Behav. 2014;44(6):591-600. 47. Florence C, Simon T, Haegerich T, Luo F, Zhou C. Estimated lifetime medical and work-loss costs of fatal injuries-United States, 2013. MMWR Morb Mortal Wkly Rep. 2015;64(38):1074-1077.
48. Shepard DS, Gurewich D, Lwin AK, Reed GA, Jr., Silverman MM. Suicide and suicidal attempts in the United States: costs and policy implications. Suicide Life Threat Behav. 2016;46(3):352-362.
49. Silverman MM, Maris RW. The prevention of suicidal behaviors: an overview. Suicide Life Threat Behav. 1995;25(1):10-21.
50. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. National Survey on Drug Use and Health. 2016; https://nsduhwebesn.rti.org/respweb/project_description.html.
51. Desai RA, Dausey DJ, Rosenheck RA. Mental health service delivery and suicide risk: the role of individual patient and facility factors. Am J Psychiatry. 2005;162(2):311-318.
52. Turecki G. Epigenetics and suicidal behavior research pathways. Am J Prev Med. 2014;47(3):S144-S151.
53. Edwards RW, Jumper-Thurman P, Plested BA, Oetting ER, Swanson L. Community readiness: research to practice. Journal of Community Psychology. 2000;28(3):291-307.
54. Hawkins JD, Catalano RF, Kuklinski MR. Communities that care. Encyclopedia of Criminology and Criminal Justice: Springer; 2014:393-408.
55. Plested BA, Edwards RW, Jumper-Thurman P. Community readiness: a handbook for successful change. Fort Collins, CO: Tri-Ethnic Center for Prevention Research. 2006.
56. Luo F, Florence CS, Quispe-Agnoli M, Ouyang L, Crosby AE. Impact of business cycles on US suicide rates, 1928-2007. Am J Public Health. 2011;101(6):1139-1146.
57. Fowler KA, Gladden RM, Vagi KJ, Barnes J, Frazier L. Increase in suicides associated with home eviction and foreclosure during the US housing crisis: findings from 16 National Violent Death Reporting System States, 2005-2010. Am J Public Health. 2015;105(2):311-316.

58. Stack S, Wasserman I. Economic strain and suicide risk: a qualitative analysis. Suicide Life Threat Behav. 2007;37(1):103-112.
59. Cylus J, Glymour MM, Avendano M. Do generous unemployment benefit programs reduce suicide rates? A state fixedeffect analysis covering 1968-2008. Am J Epidemiol. 2014;180(1):45-52.
60. Classen TJ, Dunn RA. The effect of job loss and unemployment duration on suicide risk in the United States: a new look using mass-layoffs and unemployment duration. Health Econ. 2012;21(3):338-350.
61. Flavin P, Radcliff B. Public policies and suicide rates in the American states. Social Indicators Research. 2009;90(2):195-209.
62. U.S. Department of Housing and Urban Development. Neighborhood Stabilization Program. https://www. hudexchange.info/programs/nsp/, 2017.
63. Houle JN, Light MT. The home foreclosure crisis and rising suicide rates, 2005 to 2010. Am J Public Health. 2014;104(6):1073-1079.
64. Arsenault-Lapierre G, Kim C, Turecki G. Psychiatric diagnoses in 3275 suicides: a meta-analysis. BMC Psychiatry. 2004;4:37.
65. Harris EC, Barraclough B. Suicide as an outcome for mental disorders: a meta-analysis. Br J Psychiatry. 1997;170:205-228.
66. Tyrer P, Reed GM, Crawford MJ. Classification, assessment, prevalence, and effect of personality disorder. Lancet. 2015;385(9969):717-726.
67. Harris EC, Barraclough B. Excess mortality of mental disorder. Br J Psychiatry. 1998;173:11-53.
68. Mark TL, Shern DL, Bagalman JE, Cao Z. Ranking America's mental health: an analysis of depression across the states. Alexandria, VA: Mental Health America. 2007.
69. Lang M. The impact of mental health insurance laws on state suicide rates. Health Econ. 2013;22(1):73-88.
70. Wang PS, Demler O, Kessler RC. Adequacy of treatment for serious mental illness in the United States. Am J Public Health. 2002;92(1):92-98.
71. Cunningham PJ. Beyond parity: primary care physicians' perspectives on access to mental health care. Health Aff (Millwood). 2009;28(3):w490-501.

72. Coffey CE. Building a system of perfect depression care in behavioral health. Jt Comm J Qual Patient Saf. 2007;33(4):193-199.
73. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPEA), HR 1424, 110th Congress. 2008.
74. U.S. Department of Health and Human Services Health Resources and Services Administrations. Designated health professional shortage areas statistics. https://www.hudexchange.info/programs/nsp/, 2017.
75. National Action Alliance for Suicide Prevention: Clinical Workforce Preparedness Task Force. Suicide prevention and the clinical workforce: guidelines for training. Washington, D.C.: Author; 2014.
76. Harris KM, Carpenter C, Bao Y. The effects of state parity laws on the use of mental health care. Med Care. 2006;44(6):499-505.
77. Health Resources & Services Administration. National Health Service Corps. 2017; https://www.nhsc.hrsa.gov/.
78. U.S. Department of Health and Human Services Health Resources and Services Administrations. National Health Service Corp clinician retention: a story of dedication and commitment. 2016. https://nhsc.hrsa.gov/currentmembers/ membersites/retainproviders/retentionbrief.pdf.
79. Hailey D, Roine R, Ohinmaa A. The effectiveness of telemental health applications: a review. The Can J Psychiatry. 2008;53(11):769-778.
80. Mohr DC, Vella L, Hart S, Heckman T, Simon G. The effect of telephone-administered psychotherapy on symptoms of depression and attrition: a meta-analysis. Clinical Psychology: Science and Practice. 2008;15(3):243-253.
81. Coffey CE. Pursuing perfect depression care. Psychiatr Serv. 2006;57(10):1524-1526.
82. Coffey CE, Coffey MJ, Ahmedani BK. An update on perfect depression care. Psychiatr Serv. 2013;64(4):396.
83. Coffey M, Coffey C, Ahmedani BK. Suicide in a health maintenance organization population. JAMA Psychiatry. 2015;72(3):294-296.
84. Haddon W. Advances in the epidemiology of injuries as a basis for public policy. Public Health Rep. 1980;95(5):411-421.

85. Toosi M. Labor force projections to 2024: The labor force is growing, but slowly. Washington, D.C.: Bureau of Labor Statistics; Monthly Labor Review. 2015:1-33.
86. Noonan ME. Mortality in State Prisons, 2001-2014 Bureau of Justice Statistical Tables. 2016;250150(December).
87. 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.
88. National Action Alliance for Suicide Prevention Workplace Task Force. Comprehensive Blueprint for Workplace Suicide Prevention. Washington, D.C. : Author; 2015.
89. Runyan CW, Becker A, Brandspigel S, Barber C, Trudeau A, Novins D. Lethal means counseling for parents of youth seeking emergency care for suicidality. West J Emerg Med. 2016;17(1):8-14.
90. Miller M, Warren M, Hemenway D, Azrael D. Firearms and suicide in US cities. Inj Prev. 2015;21(e1):e116-119.
91. Crosby AE, Espitia-Hardeman V, Ortega L, Lozano B. Alcohol and suicide. Alcohol: Science, Policy and Public Health. 2013:190-193.
92. Kaplan MS, McFarland BH, Huguet N, et al. Acute alcohol intoxication and suicide: a gender-stratified analysis of the National Violent Death Reporting System. Inj Prev. 2013;19(1):38-43.
93. Beautrais AL, Gibb SJ, Fergusson DM, Horwood LJ, Larkin GL. Removing bridge barriers stimulates suicides: an unfortunate natural experiment. Aust NZ J Psychiat. 2009;43(6):495-497.
94. Stokes ML, McCoy KP, Abram KM, Byck GR, Teplin LA. Suicidal ideation and behavior in youth in the juvenile justice system: a review of the literature. Journal of Correctional Health Care. 2015;21(3):222-242.
95. Elnour AA, Harrison J. Lethality of suicide methods. Inj Prev. 2008;14(1):39-45.
96. Simon OR, Swann AC, Powell KE, Potter LB, Kresnow MJ, O'Carroll PW. Characteristics of impulsive suicide attempts and attempters. Suicide Life Threat Behav. 2001;32(1 Suppl):49-59. 97. Deisenhammer EA, Ing CM, Strauss R, Kemmler G, Hinterhuber H, Weiss EM. The duration of the suicidal process: how much time is left for

intervention between consideration and accomplishment of a suicide attempt? J Clin Psychiatry. 2009;70(1):19-24.
98. Hawton K. Restricting access to methods of suicide: rationale and evaluation of this approach to suicide prevention. Crisis. 2007;28(S1):4-9.
99. Yip P, Caine E, Yousuf S, Chang S-S, Wu K, Chen Y-Y. Means restriction for suicide prevention. Lancet. 2012;379(9834): 2393-2399.
100. Cox GR, Owens C, Robinson J, et al. Interventions to reduce suicides at suicide hotspots: a systematic review. BMC Public Health. 2013;13(1):1-12.
101. Rowhani-Rahbar A, Simonetti JA, Rivara FP. Effectiveness of interventions to promote safe firearm storage. Epidemiol Rev. 2016;38(1):111-124.
102. Hayes LM. Suicide prevention in correctional facilities: reflections and next steps. Int J Law Psychiatry. 2013;36(3-4):188- 194.
103. Giesbrecht N, Huguet N, Ogden L, et al. Acute alcohol use among suicide decedents in 14 US states: impacts of offpremise and on-premise alcohol outlet density. Addiction. 2015;110(2):300-307.
104. Escobedo LG, Ortiz M. The relationship between liquor outlet density and injury and violence in New Mexico. Accid Anal Prev. 2002;34(5):689-694.
105. Xuan Z, Naimi TS, Kaplan MS, et al. Alcohol policies and suicide: a review of the literature. Alcohol Clin Exp Res. 2016;40(10):2043-2055.
106. Cherpitel CJ, Borges GLG, Wilcox HC. Acute alcohol use and suicidal behavior: a review of the literature. Alcoholism: Clinical and Experimental Research. 2004;28(5 SUPPL.):18S-28S. 107. Pirkis J, Too LS, Spittal MJ, Krysinska K, Robinson J, Cheung YTD. Interventions to reduce suicides at suicide hotspots: a systematic review and meta-analysis. Lancet Psychiatry. 2015;2(11):994-1001.
108. Perron S, Burrows S, Fournier M, Perron PA, Ouellet F. Installation of a bridge barrier as a suicide prevention strategy in Montreal, Quebec, Canada. Am J Public Health. 2013;103(7):1235-1239.
109. Beautrais AL. Effectiveness of barriers at suicide jumping sites: a case study. Aust NZ J Psychiat. 2001;35(5):557-562.
110. Grossman DC, Mueller BA, Riedy C, et al. Gun storage practices and risk of youth suicide and unintentional firearm injuries. JAMA. 2005;293(6):707-714.

111. Mishara BL, Martin N. Effects of a comprehensive police suicide prevention program. Crisis. 2012;33(3):162-168.
112. 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.
113. Hayes LM. Prison Suicide: an overview and a guide to prevention. The Prison Journal. 1995;75(4):431-456.
114. Barker E, Kõlves K, De Leo D. Management of suicidal and self-harming behaviors in prisons: systematic literature review of evidence-based activities. Archives of Suicide Research. 2014;18(3):227-240.
115. Rush BR, Gliksman L, Brook R. Alcohol availability, alcohol consumption and alcohol-related damage. I. The distribution of consumption model. J Stud Alcohol. 1986;47(1):1-10.
116. Gruenewald PJ, Remer L. Changes in outlet densities affect violence rates. Alcohol Clin Exp Res. 2006;30(7):1184-1193.
117. Lipton R, Gruenewald P. The spatial dynamics of violence and alcohol outlets. J Stud Alcohol. 2002;63(2):187-195.
118. Lippy C, DeGue S. Exploring alcohol policy approaches to prevent sexual violence perpetration. Trauma, Violence, & Abuse. 2016;17(1):26-42.
119. Johnson FW, Gruenewald PJ, Remer LG. Suicide and alcohol: do outlets play a role? Alcohol Clin Exp Res. 2009;33(12):2124-2133.
120. Durkheim E. Suicide: a study in sociology (translated by JA Spaulding and G Simpson). New York, NY: Free Press. (Original work published 1897). 1897/1951.
121. Centers for Disease Control and Prevention. Strategic direction for the prevention of suicidal behavior: promoting individual, family, and community connectedness to prevent suicidal behavior. 2009; Available at: http://www.cdc.gov/ViolencePrevention/pdf/Suicide_Strategic_Direction_Full_version-a.pdf.
122. Muennig P, Cohen AK, Palmer A, Zhu W. The relationship between five different measures of structural social capital, medical examination outcomes, and mortality. Soc Sci Med. 2013;85:18-26.

123. Beyer KM, Layde PM, Hamberger LK, Laud PW. Does neighborhood environment differentiate intimate partner femicides from other femicides? Violence Against Women. 2015;21(1):49-64. 124. Whitley R, McKenzie K. Social capital and psychiatry: review of the literature. Harv Rev Psychiatry. 2005;13(2):71-84.
125. De Silva MJ, McKenzie K, Harpham T, Huttly SR. Social capital and mental illness: a systematic review. J Epidemiol Community Health. 2005;59(8):619-627.
126. Wyman PA. Developmental approach to prevent adolescent suicides: research pathways to effective upstream preventive interventions. Am J Prev Med. 2014;47(3 Suppl 2):S251-256. 127. Centers for Disease Control and Prevention. Principles of community engagement. CDC/ATSDR Committee on Community Engagement. 1997. https://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf
128. Branas CC, Cheney RA, MacDonald JM, Tam VW, Jackson TD, Ten Have TR. A difference-in-differences analysis of health, safety, and greening vacant urban space. Am J Epidemiol. 2011;174(11):1296-1306.
129. Branas CC, Kondo MC, Murphy SM, South EC, Polsky D, MacDonald JM. Urban blight remediation as a cost-beneficial solution to firearm violence. Am J Public Health. 2016;106(12):2158-2164.
130. Bandura A. Social foundations of thought and action: a social cognitive theory. Prentice-Hall, Inc; 1986.
131. Pollock LR, Williams JM. Problem-solving in suicide attempters. Psychol Med. 2004;34(1):163-167.
132. Herman KC, Borden LA, Reinke WM, Webster-Stratton C. The impact of the Incredible Years parent, child, and teacher training programs on children's co-occurring internalizing symptoms. Sch Psychol Q. 2011;26(3):189-201.
133. Knox MS, Burkhart K, Hunter KE. ACT against violence parents raising safe kids program: effects on maltreatmentrelated parenting behaviors and beliefs. Journal of Family Issues. 2010. 134. Wasserman D, Hoven CW, Wasserman C, et al. School-based suicide prevention programmes: The SEYLE clusterrandomised, controlled trial. Lancet. 2014;385(9977):1536-1544.

135. Wilcox HC, Kellam SG, Brown CH, et al. The impact of two universal randomized first- and second-grade classroom interventions on young adult suicide ideation and attempts. Drug Alcohol Depend. 2008;95 Suppl 1:S60-73.
136. 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.
137. Webster-Stratton C, Reid MJ, Stoolmiller M. Preventing conduct problems and improving school readiness: evaluation of the Incredible Years teacher and child training programs in high-risk schools. Journal of Child Psychology and Psychiatry. 2008;49(5):471-488.
138. Webster-Stratton CH, Reid MJ, Beauchaine T. Combining parent and child training for young children with ADHD. Journal of Clinical Child & Adolescent Psychology. 2011;40(2):191-203.
139. Reid MJ, Webster-Stratton C, Hammond M. Follow-up of children who received the Incredible Years intervention for oppositional-defiant disorder: maintenance and prediction of 2-year outcome. Behavior Therapy. 2003;34(4):471-491.
140. Webster-Stratton C, Hammond M. Treating children with early-onset conduct problems: a comparison of child and parent training interventions. J Consult Clin Psychol. 1997;65(1):93-109.
141. Webster-Stratton C, Reid MJ, Hammond M. Preventing conduct problems, promoting social competence: a parent and teacher training partnership in head start. J Clin Child Psychol. 2001;30(3):283-302.
142. Spoth RL, Guyll M, Day SX. Universal family-focused interventions in alcohol-use disorder prevention: costeffectiveness and cost-benefit analyses of two interventions. J Stud Alcohol. 2002;63(2):219-228.
143. Curtin SC, Warner M, Hedegaard H. Increase in suicide in the United States, 1999-2014. NCHS Data Brief. Hyattsville, MD: National Center for Health Statistics; 2016.
144. Jobes DA. The Collaborative Assessment and Management of Suicidality (CAMS): an evolving evidence-based clinical approach to suicidal risk. Suicide Life Threat Behav. 2012;42(6):640-653.

145. Wilcox HC, Wyman PA. Suicide prevention strategies for improving population health. Child Adolesc Psychiatr Clin N Am. 2016;25:219-233.
146. Isaac M, Elias B, Katz LY, et al. Gatekeeper training as a preventative intervention for suicide: a systematic review. Can J Psychiatry.2009;54(4):260-268.
147. Gould MS, Munfakh JL, Kleinman M, Lake AM. National suicide prevention lifeline: enhancing mental health care for suicidal individuals and other people in crisis. Suicide Life Threat Behav. 2012;42(1):22-35.
148. Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. Arch Int Med. 2006;166(21):2314-2321.
149. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. Cochrane Database of Systematic Reviews. 2012;10(Art No CD006525).
150. Bruce ML, Ten Have TR, Reynolds III CF, et al. Reducing suicidal ideation and depressive symptoms in depressed older primary care patients: a randomized controlled trial. JAMA. 2004;291(9):1081-1091.
151. Inagaki M, Kawashima Y, Kawanishi C, et al. Interventions to prevent repeat suicidal behavior in patients admitted to an emergency department for a suicide attempt: a meta-analysis. J Affect Disord. 2015;175:66-78.
152. Gould MS, Cross W, Pisani AR, Munfakh JL, Kleinman M. Impact of Applied Suicide Intervention Skills Training on the National Suicide Prevention Lifeline. Suicide Life Threat Behav. 2013;43(6):676-691.
153. Walrath C, Garraza LG, Reid H, Goldston DB, McKeon R. Impact of the Garrett Lee Smith youth suicide prevention program on suicide mortality. Am J Public Health. 2015;105(5):986-993.
154. Godoy Garraza L, Walrath C, Goldston DB, Reid H, McKeon R. Effect of the Garrett Lee Smith Memorial Suicide Prevention Program on suicide attempts among youths. JAMA Psychiatry. 2015;72(11):1143-1149.
155. 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.

156. Hunkeler EM, Katon W, Tang L, et al. Long term outcomes from the IMPACT randomised trial for depressed elderly patients in primary care. BMJ. 2006;332(7536):259-263.
157. Unutzer J, Tang L, Oishi S, et al. Reducing suicidal ideation in depressed older primary care patients. J Am Geriatr Soc. 2006;54(10):1550-1556.
158. Comtois KA, Jobes DA, S. O'Connor S, et al. Collaborative assessment and management of suicidality (CAMS): feasibility trial for next-day appointment services. Depress Anxiety. 2011;28(11):963-972.
159. 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.
160. Diamond GS, Wintersteen MB, Brown GK, et al. Attachment-based family therapy for adolescents with suicidal ideation: a randomized controlled trial. J Am Acad Child Adolesc Psychiatry. 2010;49(2):122-131.
161. Rubenstein LV, Chaney EF, Ober S, et al. Using evidence-based quality improvement methods for translating depression collaborative care research into practice. Families, Systems, & Health. 2010;28(2):91-113.
162. 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.
163. Motto JA, Bostrom AG. A randomized controlled trial of postcrisis suicide prevention. Psychiatr Serv. 2001;52(6):828- 833.
164. Hassanian-Moghaddam H, Sarjami S, Kolahi AA, Carter GL. Postcards in Persia: randomised controlled trial to reduce suicidal behaviours 12 months after hospital-treated self-poisoning. Br J Psychiatry. 2011;198(4):309-316.
165. Wang YC, Hsieh LY, Wang MY, Chou CH, Huang MW, Ko HC. Coping card usage can further reduce suicide reattempt in suicide attempter case management within 3-month intervention. Suicide Life Threat Behav. 2016;46(1):106-120.
166. 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.

167. Pitman A, Osborn D, King M, Erlangsen A. Effects of suicide bereavement on mental health and suicide risk. Lancet Psychiatry. 2014;1:86-94.
168. Etzersdorfer E, Sonneck G. Preventing suicide by influencing mass-media reporting: the Viennese experience, 1980– 1996. Arch Suicide Res. 1998;4(1):67-74.
169. Niederkrotenthaler T, Sonneck G. Assessing the impact of media guidelines for reporting on suicides in Austria: interrupted time series analysis. Aust N Z J Psychiatry. 2007;41(5):419-428.
170. Szumilas M, Kutcher S. Post-suicide intervention programs: a systematic review. Can J Public Health. 2011;102(1):18-29.
171. Bohanna I, Wang X. Media guidelines for the responsible reporting of suicide: a review of effectiveness. Crisis. 2012;33(4):190-198.
172. Visser VS, Comans TA, Scuffham PA. Evaluation of the effectiveness of a community-based crisis intervention program for people bereaved by suicide. Journal of Community Psychology. 2014;42(1):19-28.
173. Cerel J, Campbell FR. Suicide survivors seeking mental health services: a preliminary examination of the role of an active postvention model. Suicide Life Threat Behav. 2008;38(1):30-34.
174. Niederkrotenthaler T, Voracek M, Herberth A, et al. Media and suicide. Papageno v Werther effect. BMJ. 2010;341:c5841.
175. Centers for Disease Control and Prevention. National Violent Death Reporting System. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2017. Available online: https://www.cdc. gov/injury/wisqars/nvdrs.html.
176. The National Center for the Review & Prevention of Child Deaths. U.S. Child Death Review Programs. https://www. childdeathreview.org/cdr-programs/u-s-cdr-programs/.
177. Centers for Disease Control and Prevention, Brener ND, Kann L, et al. Methodology of the Youth Risk Behavior Surveillance System--2013. MMWR Recomm Rep. 2013;62(RR-1):1-20.

Chapter 4. Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Centers.

The following chapter is sourced from:
Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Centers. HHS Publication No. SMA-15-4416. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2015.
Retrieved from: https://store.samhsa.gov/product/Promoting-Emotional-Health-and-Preventing-Suicide/SMA15-4416?referer=from_search_result

About This Toolkit

This toolkit is a resource for senior center staff and volunteers. As a focus point for the community, senior centers connect older adults with a range of critical services and programs, including meals and nutrition programs, transportation services, health and wellness programs, and social and recreational activities. Therefore, these centers can play an important role in promoting emotional health among older adults and increasing the factors that may protect them from suicide. This toolkit will give you many ideas, examples, tools, and resources for integrating suicide prevention into the work you already do to support the well-being of older adults.

How can my senior center address suicide and other sensitive topics?

Suicide, depression, and problems with alcohol and medications are issues you may feel uncomfortable talking about or not qualified to address. But there are many individuals and organizations in your community who can help you talk about these issues and connect older adults to the help they need. These individuals include mental health providers who have been trained to lead educational sessions addressing these issues and to screen and counsel older adults and link them to sources of help.

Do older adults want to talk about emotional health?

You may be concerned that the older adults who come to your center will not want to talk about suicide and related mental health problems. It's true—if you were to schedule a workshop on "suicide prevention" or "depression," very few people would likely show up. But mental health educators and others who conduct these sessions at senior centers have found that older adults will indeed attend when these topics are framed in a more positive and engaging way (e.g., "Promoting Emotional WellBeing"). Older adults want to learn about these issues—both to improve their own health and wellness and to serve as a resource to their friends, family members, and others who may be experiencing problems.

Will older adults be willing to seek help?

You may be wondering, "What's the point of raising these issues? Older adults will not want to seek help because they don't want to be labeled as having a mental health problem." Many older adults may indeed be reluctant to do so—and that is why it's so important to let them know that depression, problems with alcohol and medications, and thoughts of suicide are not a normal part of aging and that effective treatment is available. If you notice signs that an older adult may have a problem, you can promote help-seeking by encouraging the person to talk with a counselor, a social worker, or his or her doctor. This can be a critical first step that can make a tremendous difference in that person's life.

Contents of the Toolkit

Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Centers (2015) is based on a similar resource for senior living communities published in 2011 by the Substance Abuse and Mental Health Services Administration (SAMHSA). This toolkit, which is tailored to the needs of senior centers, was developed for SAMHSA by the Education Development Center, Inc., with input from other federal agencies, senior center staff, and individuals and organizations who work with senior centers to provide services and support to older adults.

This toolkit includes the following:

- A Getting Started section that provides an overview of suicide among older adults and how senior centers can help address this important problem.
- A section on each of the three key strategies that senior centers can use to promote emotional well-being and prevent suicide among older adults. Each section describes recommended steps for carrying out the strategy and indicates relevant tools and resources.
- Nine tools for carrying out the three strategies.
- Three fact sheets that senior centers can share with older adults and their families as part of an educational session or other event.

The table that follows provides an at-a-glance look at the contents of this toolkit, showing how all the parts fit together. For each section and subsection of the toolkit, the table lists the steps that your senior center can take and the related tools and fact sheets.

Please feel free to adapt the information in this toolkit to best fit your needs and to share it with others who serve older adults in your community

Toolkit Sections, Steps, and Tools

Section and Steps	Tools and Fact Sheets
Getting Started	
• Educate staff, volunteers, and participants about suicide among adults. Older • Assess needs and develop a plan. • Identify and partner with behavioral health providers in your community • Identify others who can help you carry out each strategy.	Tool 1: Suicide among Older Adults Tool 2: Assessment Checklist Tool 3: Connecting to Behavioral Health Resources in the Community

<table>
<tr><th>Strategy 1: Promote Emotional Health</th><th></th></tr>
<tr><td>Provide Activities and Programs that Increase Protective Factors
Offer activities and programs that foster a sense of purpose, resilience, and other protective factors.
Provide activities and programs that integrate mental and physical health.
Invite a mental health educator to lead wellness sessions at your senior center.
Align programs and activities with the values, preferences, and cultural and linguistic needs of the older adults you serve.</td><td>Tool 4: Activities to Promote Health and Wellness</td></tr>
<tr><td>Support the Development of Social Connections
Establish a buddy system to welcome new participants.
Provide activities that help men, in particular, develop social connections.</td><td>Tool 5: Strategies for Establishing Social Networks

Fact Sheet 1: Looking Out for Well-Being of Yourself and Others</td></tr>
</table>

• Develop a policy for addressing bullying	
Strategy 2: Recognize and Respond to Suicide Risk	
Recognize the Warning Signs of Suicide • • Designate someone at your senior center to serve as the point person for addressing concerns related to suicide risk. • Identify a mental health professional in the community who will be your contact for advice and referrals. • Develop a written protocol for recognizing and immediately responding to the warning signs of suicide. • Provide training to staff, volunteers, and participants • If someone shows any signs of immediate risk, alert the designated person at your senior center. • Refer individuals who may be at serious, but not immediate risk of suicide to a mental health professional for further assessment and treatment.	Fact Sheet 2: Know the Warning Signs of Suicide

Recognize and Respond to Depression • Increase awareness of the symptoms of depression. • Identify community partners who can conduct educational sessions at your senior center to educate staff, volunteers, and older adults about depression.	Tool 6: Recognizing and Responding to Depression
Recognize and Respond to Medication and Alcohol Misuse • Increase awareness of the recommended drinking limit for older adults • Invite a behavioral health professional to make a presentation about alcohol and/or medication misuse for your staff and volunteers. • Invite a pharmacist to conduct a session on appropriate and inappropriate use of medications.	Tool 7: Recognizing and Responding to Medication and Alcohol Misuse
Increase Access to Care • Encourage older adults to seek care for behavioral health problems by using words that are neutral and nonthreatening.	Tool 3: Connecting to Behavioral Health Resources in the Community

• Suggest that older adults talk with their doctors about issues related to mental health and/or use of alcohol or medications. • Invite a local behavioral health care professional to come to your senior center to encourage help-seeking and describe available services. • Facilitate access to screening and treatment	
Strategy 3: Respond to a Suicide Attempt or Death	
• Develop one or more postvention protocols for responding to a suicide attempt or death* • Provide training to senior center staff and volunteers. • Contact an organization that provides postvention support to obtain its help in the event of a suicide death or attempt.	Tool 8: Community Support Meetings Fact Sheet 3: After a Suicide: What to Expect and How to Help

Getting Started

Senior centers vary tremendously in size, location, number of people served, funding sources, staffing, services, and activities—as well as in their approaches to mental health promotion and suicide prevention. This section provides an overview of suicide among older adults, presents three key strategies that senior centers can use to address this problem, and suggests steps for getting started.

Suicide among Older Adults. In 2013, more than 7,000 people age 65 or older died by suicide (CDC, 2013). Suicide rates are higher among older adults than in the general population (CDC, 2013). In addition to the thousands of older adults who die by suicide, many more have made suicide attempts and suffer from the emotional pain of suicidal thoughts.

Suicide rates are particularly high among older men—higher than among any other group in the United States (CDC, 2013). Although suicide attempts are more common among older women than older men (SAMHSA, 2013b), attempts are more likely to be fatal among men because men are more likely than women to use firearms (CDC, 2013).

Although older adults (both men and women) are less likely than younger adults to report serious thoughts of suicide or a suicide attempt (SAMHSA, 2013b), attempts are more likely to result in death among older adults than among younger people (Conwell, 1997; Fassberg et al., 2012).

Risk and Protective Factors. In most cases, suicide results from a combination of factors rather than a single cause. Studies suggest that some of the key risk factors for suicide among older adults include the following (Conwell, Van Orden, & Caine, 2011):

- Mental disorders, particularly depression
- Substance use problems (including abuse of prescription medications)
- Physical illness, disability, and pain
- Social isolation
- Stressful life events and losses
- Access to lethal means

Suicide is preventable. Several factors may help protect older adults from suicide and related behavioral health problems. Protective factors for suicide among older adults include the following (Conwell, et al., 2011):

- Receiving care for mental and physical health problems
- Social connectedness
- A sense of purpose or meaning
- Skills in coping and adapting to change
- Cultural or religious beliefs that discourage suicide

There is help and hope when individuals, families, and organizations such as senior centers join forces to prevent suicide.

Three Key Strategies. Senior center staff and volunteers can promote emotional health and prevent suicide among older adults by implementing three key strategies:

- **Strategy 1:** Promote emotional health. This strategy focuses on all older adults—regardless of individual risk for suicide. It includes providing a range of programs, services, and activities that support emotional health and helping older adults develop positive social connections.

- **Strategy 2:** Recognize and respond to suicide risk. This strategy focuses on identifying older adults who may be at risk for suicide, as well as related mental health or substance use problems, and linking them to sources of help. As senior center staff and volunteers work with older adults on a daily basis, they are in a unique position to notice signs of a problem and encourage help-seeking.

- **Strategy 3**: Respond to a suicide attempt or death. A suicide attempt or death can have a profound emotional impact on older adults and their families and

other caregivers, as well as on senior center staff and volunteers. This section of the toolkit offers information on how to support your staff, volunteers, and participants after a crisis.

What you can do

Educate staff, volunteers, and participants about suicide among older adults. Help increase awareness of the issue of suicide and educate senior center staff, volunteers, and participants by sharing copies of **Tool 1: Suicide among Older Adults.** It provides key facts, a detailed list of risk and protective factors, and suggestions for what you can do.

Assess needs and develop a plan. Assess how well your senior center is already addressing the three key strategies (see **Tool 2: Assessment Checklist),** and develop a plan for closing any existing gaps and making improvements. Consider scheduling a meeting with your board members, staff, and volunteers to review the checklist and identify the strategies and steps that are feasible for and important to your center. You can then follow the guidance in each relevant section of this toolkit to help you take those steps.

Identify and partner with behavioral health providers in your community. These include mental health centers and specialists, programs aimed at preventing and/or treating substance use disorders, pastoral counseling resources, support groups, and hospitals, all of whom can support the work of your center in many ways. This toolkit provides many examples of how these partnerships can be a win-win situation for all involved.

A Win-Win Situation

Partnerships between senior centers and behavioral health providers can benefit both parties in many ways.

Behavioral health providers can help senior centers by:

- Serving as valuable sources of consultation and referrals
- Providing trained specialists to lead workshops and sessions that educate older adults and/or senior center staff and volunteers on topics related to behavioral health
- Screening older adults for depression, substance use disorders, and/or suicide risk and connecting them to sources of care

Senior centers can support the work of behavioral health providers by:

- Helping them reach older adults in the community who may be unwilling to go to a specialist for help with a behavioral health problem
- Providing space for screenings and consultations at a trusted location that is easily accessible to older adults via transportation services
- Connecting providers to individuals and organizations serving older adults (e.g., meals and transportation services, home health aides) who can identify older adults in other settings (e.g., at home) who may need help.

Identify others who can help you carry out each strategy. Potential partners include health educators, who can lead sessions on health and wellness; primary care providers, who can offer preventive services and care for chronic health problems, thereby also reducing suicide risk; and others in the community who provide services for older adults, such as Meals on Wheels programs and home health aides.

All of these connections—among providers of services for older adults, behavioral health services, and other health care services—can promote better coordination of services and improved health and quality of life for the older adults you serve.

Tools you can use

- **Tool 1: Suicide among Older Adults** can help you increase awareness of the risk and protective factors for suicide among older adults. Distribute copies to staff and volunteers.
- **Tool 2: Assessment Checklist** will help you assess how well your senior center is addressing the three strategies and identify areas for improvement.
- **Tool 3: Connecting to Behavioral Health Resources in the** Community will help you develop a list of potential partners.

Other resources

Get Connected! Linking Older Adults with Medication, Alcohol, and Mental Health Resources is a toolkit that provides step-by-step information and resources, including fact sheets and screening tools, on how to establish a program to link older adults with medication, alcohol, and mental health treatment and support resources. Available at http://store.samhsa.gov/product/Linking-Older-Adults-With-Medication-Alcohol-and-MentalHealth-Resources/SMA03-3824.

Two **Issue Briefs** from the Administration for Community Living offer information about partnering with behavioral health providers and preventing suicide among older adults:

- Issue Brief 1: Aging and Behavioral Health Partnerships in the Changing Health Care Environment
- Issue Brief 4: Preventing Suicide in Older Adults

Available at http://www.aoa.acl.gov/AoA_Programs/HPW/Behavioral/index.aspx.

Strategy 1: Promote Emotional Health

Senior centers offer many activities and services that help older adults stay healthy and independent as they age—but centers can do even more. The factors that may help protect older adults from suicide and other behavioral health problems include personal

characteristics and skills and positive and caring social connections. This section describes ways to promote emotional well-being and to strengthen protective factors among all senior center participants, regardless of their individual risk for suicide.

Provide Activities and Programs that Increase Protective Factors

Studies suggest that the characteristics and skills that may help protect older adults from suicide include having a sense of purpose or meaning, self-esteem, social skills, flexibility, and skills in coping and adapting to change (Conwell, et al., 2011). Cultural or religious beliefs that discourage suicide and support self-preservation may also be protective.

Senior centers can increase these protective factors by offering activities and programs that older adults find interesting and enjoyable, build on their strengths, and help them develop new skills. Given that medical problems, disability, and pain may increase suicide risk, it is also important to provide activities and programs that help older adults manage chronic health conditions and adapt to changes in physical function. Whenever possible, these programs should convey the message that physical and mental health are strongly linked and that both are important to healthy aging.

What you can do

Offer activities and programs that foster a sense of purpose, resilience, and other protective factors. Consider activities that do the following:

- Help older adults prevent and manage health problems (e.g., sessions on topics such as diabetes self-management and injury prevention)

- Develop coping skills (e.g., workshops on issues such as loss and bereavement or caring for a spouse or partner)
- Provide a sense of purpose and opportunities to develop meaningful connections with others (e.g., volunteering and mentoring activities, intergenerational activities)
- Provide a sense of accomplishment and pleasure (e.g., word and number games, writing poetry or stories, cooking, using computers, woodworking, financial management)

A brief survey can be a great way to identify topics and activities of interest to your participants. Create a list of potential offerings and ask participants to rank order them and/or suggest their own ideas.

Provide activities and programs that integrate mental and physical health. Consider adding mind-body activities, such as mindfulness, meditative breathing, and yoga to your exercise and activity programs. When planning an educational session on a health problem, such as heart disease or diabetes, make sure that the session also addresses the relationship between mental and physical health (e.g., the link between heart disease and depression). You might offer chronic disease self-management workshops that include topics such as decision making, stress reduction, coping with pain, and the appropriate use of medications. Consider inviting behavioral health providers from your community to participate in health fairs and other events hosted by your senior center.

Invite a mental health educator to lead wellness sessions at your senior center. See the box for examples of wellness classes offered by senior centers in Colorado and Utah.

Wellness Classes: Ideas from Colorado and Utah

Senior Reach (http://www.seniorreach.org), a program in Colorado that partners with others in the community to support the well-being of older adults, sends wellness coordinators to lead classes at senior centers. Sample topics include:

- NO MORE REGRETS! Focusing on past regrets robs us of any happiness we can have right now.
- Taking In the Good. Savoring the good in our lives can help promote healing and a deep sense of inner contentment.
- Into the Stillness. During the holidays, take some time to just be still, through meditation, journaling, and ritual.
- Awakening to Joy. Focus on how to live our daily lives more mindfully.
- Calm in the Chaos. Typical holiday scenarios are followed by discussion and information on various coping techniques.
- The Journey of a Caregiver. Consider the passages involved in being a caregiver and ways to take care of oneself.

Valley Behavioral Health (http://www.valleycare.com), in Utah, has a Vital Aging Project that provides wellness classes at 19 senior centers. Class topics are selected via a needs assessment questionnaire completed by senior center participants. More than 15 wellness topics are offered, and participants are encouraged to make suggestions. Examples include:

- How I View Myself (Self-Esteem)
- Achieving a Healthy Mind, Body, and Soul
- Building Resilience • Creative Problem Solving
- Mindfulness and Relaxation Techniques • Adjusting to Transitions in Your Living Environment

Align programs and activities with the values, preferences, and cultural and linguistic needs of the older adults you serve. For example, if your senior center serves Spanish-speaking older adults, invite a Spanish-speaking mental health professional to lead a session on wellness. Be aware that some terms (e.g., depression) may not translate well into other languages. Choose culturally competent presenters, particularly individuals who come from the same culture as session attendees. (See sidebar for an example of a prevention program designed specifically for Native American older adults.) In addition to considering race/ethnicity and language, also take into account the needs and interests of other groups, such as people with disabilities and those who are lesbian, gay, bisexual, or transgender. Connect with organizations representing various groups in your community to find out more about the types of programs that different older adults may find appealing.

Tools you can use

Tool 4: Activities to Promote Health and Wellness provides additional examples of activities and programs your senior center may consider incorporating.

Other resources

Issue Brief 11: Reaching Diverse Older Adult Populations and Engaging Them in Prevention Services and Early Interventions provides information and examples on how to deliver culturally appropriate services. Available at http://www.aoa.acl.gov/AoA_

Programs/HPW/Behavioral/index.aspx. A Toolkit for Serving Diverse Communities, from the Administration on Aging, offers easy-to-use methods for providing respectful, inclusive, and sensitive services. Available at http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/DOCS/AoA_DiversityToolkit_Full.pdf.

Wise Elders Living Longer (WELL-Balanced): A Group Program for Native Americans

WELL-Balanced is a program developed by the National Resource Center on Native American Aging and the University of North Dakota Wellness Center specifically for Native American elders. The program uses exercise, information, and social interaction to help elders remain active and independent. It helps elders:

- Prevent falls
- Manage diabetes, arthritis, and hypertension
- Engage in social activity
- Increase their level of physical activity
- Develop strategies for independent living
- Have fun

WELL-Balanced program materials are available online at https://www.nrcnaa.org/well-balanced.

Support the Development of Social Connections

Being connected to others at the personal, family, and community levels has been identified as a key protective factor for older adults (CDC, 2006; Conwell, et al., 2011). Studies suggest that suicide may be less likely among older adults who have close friends and family members, participate in community activities, and/or are active in organizations than among those who have fewer connections. Belonging to a faith community and attending services also may help protect older adults from suicide by connecting them to sources of social support in the community. To be protective, these connections should "create positive interactions and feelings of being cared about" (Conwell, et al., 2011, p. 6).

Senior centers can provide older adults with a variety of opportunities to develop positive connections with their peers, staff, volunteers, and other service providers. These social networks may be particularly important to older adults who lack day-to-day contact with family and close friends.

What you can do

Establish a buddy system to welcome new participants. Ask current participants if they would like to volunteer to serve as buddies. When new participants come to your senior center, they can be connected with a buddy who will introduce them to the facilities, services, personnel, and other participants. Organizing "friendship tables" in dining locations is another way to welcome new members and help them develop positive connections.

Provide activities that help men, in particular, develop social connections. As noted in the Getting Started section, suicide rates are particularly high among older men. However, men are less likely than women to reach out socially. It is estimated that men make up only about 30 percent of senior center participants, or less than one in three (NCOA, 2012). This makes it especially important to attract men to your senior center by providing activities that they will find engaging. Consider conducting a community survey to identify activities and topics of interest to older men who live in your area. For example:

- Games such as pool, poker, and bridge
- Opportunities for men to work on meaningful projects of their choice (e.g., carpentry, restoring bicycles for a local school, gardening, mentoring on how to start a new business), at their own pace, while interacting with other older men
- Breakfast or lunch speakers who can address an issue of particular interest to the men in your community (e.g., local news and events, sports)
- Workshops or discussions on topics of interest to men in your community (e.g., a men's health issue)

Develop a policy for addressing bullying. Bullying is a social problem that affects people of all ages, including older adults. Bullying can happen in any place where older adults spend a lot of time together, such as dining areas and other shared facilities.

Consider adopting a formal protocol for preventing, recognizing, and stopping bullying at your senior center. The protocol should define bullying, give examples, indicate how and to whom one should report this type of behavior, and state the center's disciplinary policy (e.g., verbal warning, followed by written warning, followed by a suspension of senior center privileges).

Tools you can use

- Tool 5: **Strategies for Establishing Social Networks** offers more ideas on how to help older adults establish positive social connections.
- Distribute Fact Sheet 1: **Looking Out for the Well-Being of Yourself and Others** to senior center participants as part of a session or presentation on health promotion and wellness.

Other resources

For more on senior bullying, see a series of blog posts by two experts on the topic, Dr. Robin Bonifas and Marsha Frankel. Available at http://www.mybetternursinghome.com/senior-bullying-guest-post-by-robin-bonifasphd-msw-and-marsha-frankel-licsw/.

Recognizing and Stopping Bullying

Signs of bullying may include:

- Name calling, teasing, taunting, or threatening
- Pushing, hitting, destroying property, or stealing
- Shunning, excluding or ignoring, gossiping, spreading rumors, or mimicking
- Laying claim to certain spaces or areas in the building and leaving others out

Bullying can cause long-term harm to its victims. For bystanders, it creates a toxic environment of fear and distrust.

Ignoring bullying won't make it go away. Strategies for preventing and stopping bullying include:

- Creating a culture of equality and respect
- Increasing awareness of bullying via educational sessions and awareness materials
- Adopting a policy on bullying and posting it at your facility

Strategy 2: Recognize and Respond to Suicide Risk

Senior centers can play an important role in preventing suicide by identifying older adults who may be at immediate risk, taking appropriate follow-up actions to keep them safe, and connecting them to help they need. This section describes how to recognize and respond to the warning signs of suicide. Since suicidal behavior is closely linked to mental disorders and substance misuse, this section also addresses how to recognize and respond to depression and misuse of alcohol and medications among older adults.

Recognize the Warning Signs of Suicide

Senior center staff and volunteers should be able to recognize the warning signs of suicide and know how to respond immediately if someone displays any of them. This information may also be useful to the older adults at your center, as they may have friends, neighbors, or family members who are experiencing suicide risk.

What you can do

Designate someone at your senior center to serve as the point person for addressing concerns related to suicide risk. For example, you could designate the senior center director, a social worker, or other appropriate staff member to serve in this capacity.

Identify a mental health professional in the community who will be your contact for advice and referrals. Contact local behavioral health providers to identify one or more mental health professionals who can provide this assistance to your senior center

and its participants. (**See Tool 3: Connecting to Behavioral Health Resources in the Community** for more information on how to identify and contact behavioral health providers.)

Develop a written protocol for recognizing and immediately responding to the warning signs of suicide. The protocol should include information on how to recognize warning signs and behaviors. It should also indicate the senior center point person to notify and the community mental health provider to contact for assistance. Develop and disseminate a resource sheet that provides this information (e.g**., Fact Sheet 2: Know the Warning Signs of Suicide).**

Provide training to staff, volunteers, and participants. Consider partnering with a mental health provider who can provide training on how to identify and help individuals who may be showing these signs. When offering this training to senior center participants, also invite family members and other caregivers to attend. These individuals may be in a good position to notice changes in behavior that could indicate a problem.

If someone shows any signs of immediate risk, alert the designated person at your senior center. The following three behaviors may indicate that a person is at immediate risk of suicide (SPRC, 2014):

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself, such as searching online or obtaining a gun
- Talking about feeling hopeless or having no reason to live

If you see any of these signs, alert the point person at your senior center. He or she should immediately call your senior center's mental health contact in the community or the National Suicide Prevention Lifeline (1-800-273-8255). The goal is to connect the person to a mental health professional who can quickly assess for suicide risk. If you think the person is in immediate danger of attempting suicide, call 911. Stay with the person until help arrives, talking with him or her in a supportive tone.

Refer individuals who may be at serious, but less immediate risk of suicide to a mental health professional for further assessment and treatment. The following behaviors may indicate a serious risk, especially if the behavior is new, has increased, and/or seems related to a painful event, loss, or change:

- 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 or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

If you see any of these signs, alert the point person at your senior center. He or she should connect the person to your senior center's mental health contact in the community who can screen the person, determine whether a referral for treatment is appropriate, and facilitate treatment.

Tools you can use

- **Distribute Fact Sheet 2: Know the Warning Signs of Suicide** to your staff and volunteers and to older adults who visit your senior center as part of an educational session. Consider sharing it with other service providers (e.g., home health aides, personnel from transportation and meal programs) as well.
- Encourage or provide training on managing suicide risk for appropriate professional staff and volunteers. Consider setting up a time to view online webinars addressing suicide and other behavioral health issues among older adults. See links to available webinars in **Tool 9: Resources List.**

Partnering with Behavioral Health Providers to Educate Older Adults

Older adults can play an important role in recognizing and addressing suicide risk among their family members, friends, neighbors, and other older adults in the community. Partnering with local mental health providers can be a great way to educate older adults who come to your senior center about this important issue.

Valley Behavioral Health (http:// www.valleycares.com) in Utah and Oakland Family Services (http:// www.oaklandfamilyservices.org/ programs/oacs/oacs.html) in Michigan work in partnership with their local senior centers to educate older adults about behavioral health topics, including the warning signs for suicide. The two organizations lead educational workshops to do the following:

- Discuss the signs that a family member or friend may be at risk
- Offer guidance on how to respond
- Provide information about sources of mental health care in the community

These workshops use information adapted from Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities. Available at http:// store.samhsa.gov/product/ Promoting-Emotional-Health-andPreventing-Suicide/SMA10-4515.

Other resources

The **National Suicide Prevention Lifeline (1-800-273-TALK/8255)** is a 24-hour, toll-free, confidential suicide prevention hotline that provides crisis counseling and mental health referrals to anyone in suicidal crisis or emotional distress. Visit http://www.suicidepreventionlifeline.org.

The **Friendship Line (1-800-971-0016)** is the nation's only 24-hour toll-free hotline specifically for older and disabled adults. Trained staff and volunteers make and receive calls to and from individuals who are either in crisis or just in need of a friend. Visit http://www.ioaging.org/services-for-elders-and-caregivers/friendship-line.

Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities includes a trainer's manual that senior centers have adapted to provide training to senior center staff, volunteers, and participants. Available at http://store.samhsa.gov/product/Promoting-Emotional-Health-and-Preventing-Suicide/SMA10-4515.

Question, Persuade, Refer (QPR) Gatekeeper Training for Suicide Prevention is a one- to two-hour training, delivered by QPR-certified instructors or online, for staff, volunteers, and others who interact with older adults. It covers the warning signs of suicide and what to do, as well as what not to do. Although not specifically designed for older adults, QPR has been used successfully with staff in nursing homes. For more about this training, including associated costs, visit http://qprinstitute.com.

safeTALK is a half-day training, delivered by registered LivingWorks trainers who are assisted by a community resource person who can recommend local resources. It can be used to train senior center staff, volunteers, and others who interact with older adults, although it is not designed specifically for this audience. safeTALK helps participants identify people who are at risk for suicide and connect them with intervention resources. For more about this training, including associated costs, visit https://www.livingworks.net/programs/safetalk.

Recognize and Respond to Depression

Depression is a serious mental health problem that affects many older adults. Although depression is more common among women than among men, it is also a serious concern for men. Depression is not a normal part of aging—it is a mental health problem that can significantly diminish one's quality of life. Effective treatment, including medication and counseling, is available.

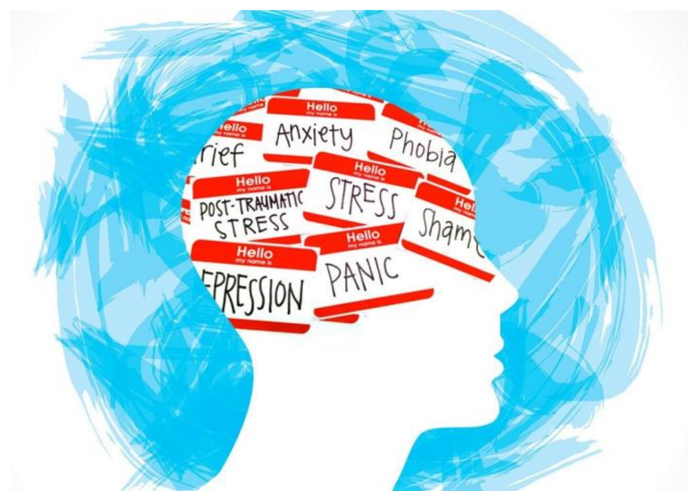
Senior centers can play an important role in increasing awareness of depression among staff, volunteers, and others who provide services to older adults, as well as to older adults themselves. All of these individuals can help identify others who may be experiencing problems and can encourage help-seeking.

What you can do

Increase awareness of the symptoms of depression.

Key symptoms include (APA, 2013):

- Depressed mood (e.g., feeling sad, empty) most of the time‡
- Loss of interest or pleasure in activities
- Weight loss or gain (changes in appetite)
- Disturbed sleep (sleeping too much or too little)
- Noticeable restlessness (agitation) or slow movement
- Fatigue or lack of energy
- Feelings of worthlessness or extreme guilt
- Difficulties with concentration or decision making
- Frequent thoughts of death or suicide, or a suicide attempt



Share this information with your staff and volunteers, but also let them know that these symptoms are similar to those of other medical conditions and may also vary among different groups (e.g., by age, sex, race/ethnicity). Only a mental health care provider can make a full evaluation and diagnosis.

Identify community partners who can conduct educational sessions at your senior center to educate staff, volunteers, and older adults about depression. These sessions can provide information on risk factors, the signs and symptoms of depression, self-help techniques, treatment, sources of professional help, and ways to take care of oneself to support one's emotional health and well-being. See the sidebar for an example of this type of partnership.

Tools you can use

- Share copies of **Tool 6: Recognizing and Responding to Depression** with your staff and volunteers.

Screening Older Adults for Depression and Connecting Them to Sources of Care

The Mental Health Association of New York City (MHA-NYC, http://www.mhaofnyc.org) conducts workshops at local senior centers that educate older adults about depression. At least two educators lead each emotional wellness workshop, which comprises an interactive discussion addressing emotional well-being, symptoms of depression, risk factors, and treatment.

At the start of each session, workshop leaders distribute information packets, including a depression knowledge survey and a screening tool (the PHQ-9). Before and after the discussion, leaders walk around the room, reviewing answers and encouraging help seeking in a nonthreatening way.

Lisa Furst, MHA-NYC Director of Education for the Geriatric Mental Health Alliance of New York, gives an example of what she might say: "Mary, you took the time to fill this out. I'd love to talk to you about it. This number suggests that depression could be getting in the way of your emotional wellness. I can't tell you based only on this piece of paper what is making you feel this way. But it would beneficial for you to talk to someone to know for sure if it is depression that is causing you to feel this way."

Workshop leaders encourage participants who may be showing signs of depression to talk with a health care provider. They also connect them to LIFENET, New York City's free and confidential mental health hotline service, which offers counselors and referrals.

Other resources

See **Get Connected! Linking Older Adults with Medication, Alcohol, and Mental Health Resources** for information, tools, and resources addressing depression, anxiety, and other mental health problems affecting older adults. Available at http://store.samhsa.gov/product/ Linking-Older-Adults-With-Medication-Alcohol-and-Mental-HealthResources/SMA03-3824.

Issue Brief 6: Depression and Anxiety: Screening and Intervention discusses how to help older adults who have mental health issues. Available at http://www.aoa.acl.gov/AoA_Programs/HPW/Behavioral/ index.aspx.

Recognize and Respond to Medication and Alcohol Misuse

The misuse of alcohol and/or medications may increase the risk for many health problems among older adults. As people get older, their metabolism slows, so the effects of alcohol are greater. Alcohol use may speed up normal declines in functioning due to aging; increase the risk of falls, injuries, and disability; and trigger or complicate many medical and mental conditions (SAMHSA, 2013a). Alcohol may also displace important nutrients in older people's diets, interfere with the intended effects of medications, and interrupt sleep at night.

Many older adults have chronic health conditions that require them to take several medications per day. Misusing medications, or combining alcohol with certain medications, can lead to serious side effects and medication interactions.

What you can do

Increase awareness of the recommended drinking limit for older adults. The National Institute on Alcohol Abuse and Alcoholism recommends that adults age 65 or older who are healthy and take no medications should drink no more than three alcoholic drinks on a given day, not to exceed seven drinks per week (NIAAA, n.d.). Women are advised to drink less than this because their bodies react differently to alcohol than men's bodies do. People with certain health conditions may need to drink less or not at all.

Invite a behavioral health professional to make a presentation about alcohol and/or medication misuse for your staff and volunteers. The presenter might discuss myths and facts about substance misuse among older adults, signs and symptoms of misuse, treatment, and sources of help in the community

Invite a pharmacist to conduct a session on appropriate and inappropriate use of medications. He or she can explain how medications should be taken, possible side effects, and interactions with alcohol, other medications, and supplements. The pharmacist can also review medications, answer questions, and provide tools, such as medication tracking charts.

Tools you can use

- Distribute copies of **Tool 7: Recognizing and Responding to Medication and Alcohol Misuse** to your staff and volunteers.

Other resources

Get Connected! Linking Older Adults with Medication, Alcohol, and Mental Health Resources offers information, tools, and resources addressing medication and alcohol misuse among older adults. Available at http://store.samhsa.gov/product/Linking-Older-Adults-With-Medication-Alcohol-and-Mental-Health-Resources/ SMA03-3824.

The following Issue Briefs provide information and resources on substance use problems and older adults:

- Issue Brief 2: Alcohol Misuse and Abuse Prevention
- Issue Brief 3: Screening and Preventive Brief Interventions for Alcohol and Psychoactive Medication Misuse/ Abuse
- Issue Brief 5: Prescription Medication Misuse and Abuse Among Older Adults

Available at http://www.aoa.acl.gov/AoA_Programs/HPW/Behavioral/index.aspx.

Increase Access to Care

Although proven interventions for mental health and substance use problems are available, many older adults with these behavioral health issues do not receive the treatment they need (Karlin, Duffy, & Gleaves, 2008). Studies show that most adults who die by suicide saw a primary care provider within one year before their death, but only a small minority had contact with mental health services (Luoma, Martin, & Pearson, 2002).

Many people of all ages may not feel comfortable seeking treatment for behavioral health problems. But help-seeking can be particularly difficult for older adults, who grew up at a time when attitudes about mental illness were very negative. Some may not realize that the symptoms they are experiencing could be caused by a mental illness (Karlin, et al., 2008).

Others may recognize that they need mental health care but may not know where to go for treatment. Transportation can also be a barrier, particularly for older adults who live in rural areas. In addition, feelings of hopelessness and helplessness linked to suicidal thoughts and depression may prevent help-seeking.

Culture and Help-Seeking

Cultural issues can affect help-seeking among older adults. Studies suggest that Chinese older adults, for example, may not want to admit to having thoughts of suicide for fear of disrupting family honor or “losing face” (Dong, Chen, Wong, & Simon, 2014). In another recent study, Korean older adults living in California reported not feeling comfortable seeking help for suicidal ideation from mental health care providers (Kim & Ahn, 2014). Poor English language skills are also a barrier to accessing care.

What you can do

Encourage older adults to seek care for behavioral health problems by using words that are neutral and nonthreatening. Keep in mind that some older adults may not react well to words such as counseling, mental illness, or alcoholic. Focus instead on health and wellness and improving quality of life. Use language such as “removing things that may be standing in the way of your physical and mental well-being,” or “talking with someone who can help.” Connect them with sources of help in your community.

Suggest that older adults talk with their doctors about issues related to mental health and/or use of alcohol or medications. Some older adults may be more comfortable talking with their primary care provider about such issues than going to a mental health provider. If an older adult chooses to seek help from a primary care provider, suggest that he or she write down the reason for the visit and any symptoms he or she may be experiencing and to present this information to the provider during the visit.

Invite a local behavioral health care professional to come to your senior center to encourage help-seeking and describe available services. Having an outside professional lead a group session may help participants feel more comfortable talking

about these issues. Ask the presenter to describe how useful it can be to talk with a specialist about life issues that make people, particularly older adults, feel sad, depressed, or anxious. He or she should also explain that clinicians are bound by rules of confidentiality that they may break only in cases when the client or someone else is in danger.

Facilitate access to screening and treatment. Consider different ways of partnering with local providers to connect older adults with behavioral health services. Models that are being used by senior centers in different parts of the country include the following

- A behavioral health specialist provides screening services at the senior center and refers older adults to counseling services if needed. These services may be offered at home or at the provider's facility.
- A local mental health agency sends a trained counselor to the senior center. The center provides a space where the counselor offers drop-in office hours or scheduled appointments on a regular basis (e.g., one day per week).
- A behavioral health professional offers group counseling sessions at the senior center

Increasing Access to Care: Ideas from Michigan and Pennsylvania

Oakland Family Services (http://www.oaklandfamilyservices.org/programs/oacs/oacs.html), a behavioral health provider in Michigan, describes a partnership with local senior centers that was successful in increasing access to behavioral health care. Through a SAMHSA grant, the partners worked together to train Meals on Wheels drivers serving 13 communities to look for signs of depression in older adults—simple things, such as not having changed clothes from one day to the next or not recognizing the driver. When a driver identified someone who might need help, the senior center outreach supervisor followed up by calling the person and asking, "How are you feeling today? We are offering a new program. We can send someone to talk with you about any concerns you may have, at no cost. Would

you like us to send someone to talk with you?" The behavioral health provider then called the person to set up an appointment, and sent a therapist to the person's home. The number of contacts increased from 72 in the first year to 200 the following year and 400 in the third year.

Another idea for increasing access to care comes from Get Busy Get Better: Helping Older Adults Beat the Blues, a program that was found to be effective in reducing depressive symptoms and improving quality of life among African Americans ages 55 years and older in Philadelphia (Gitlin et al., 2013). Conducted jointly by a senior center and a university research center, the tailored program randomly assigned participants to a home-based intervention or a wait-listed group. As part of the program, the research center trained care managers at the senior center and other agencies on how to screen for depression using a standardized tool. The training helped care managers effectively integrate depression assessment into the services they were providing to older adults in the community. As this program demonstrates, providing mental health training to care managers can be a great way to increase access to behavioral health care.

Tools you can use

- Use **Tool 3: Connecting to Behavioral Health Resources in the Community** to adapt the information you have gathered about community resources, and then share it with participants and their families. Ensuring that all participants know where they can go for help can decrease one key barrier to help-seeking.

Other resources

Issue Brief 11: Reaching Diverse Older Adult Populations and Engaging Them in Prevention Services and Early Interventions, from SAMHSA and the Administration on Aging, provides information and resources on how to reach and engage adults from different cultural backgrounds. Available at http://www.aoa.acl.gov/AoA_ Programs/HPW/Behavioral/index.aspx.

The SAMHSA Resource Center to Promote Acceptance, Dignity, and Social Inclusion Associated with Mental Health offers information, resources, and programs for providing a caring, welcoming, and supportive community that will help promote recovery and wellness for people with mental health problems and substance use disorders and for those who have experienced trauma. To learn more, visit http://www.promoteacceptance.samhsa.gov/ audience/adults/default.aspx.

Strategy 3: Respond to a Suicide Attempt or Death

Senior center staff and volunteers can play an important role in helping participants cope with a suicide attempt or death. These events can have a profound emotional impact on survivors—family members, friends, and others who knew the person involved.

People who are affected by a suicide attempt or death may experience feelings of grief, guilt, anger, shame, and embarrassment. In addition, exposure to a suicide death can also increase suicide risk among vulnerable individuals. Responding to suicide deaths and attempts in an appropriate way can help alleviate the pain caused by these incidents, promote healing, and help prevent similar attempts by others.

What you can do

Develop one or more postvention protocols for responding appropriately to a suicide attempt or death. The term postvention refers to "response to and care for individuals affected in the aftermath of a suicide attempt or suicide death" (HHS Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012, p. 141). Developing postvention protocols and sharing them with your staff and volunteers will help your senior center to respond promptly to these traumatic events.

A protocol for responding to a suicide death should indicate the following:

- The lead person for postvention support
- How to identify participants and others who may been affected by the event, including senior center staff and volunteers
- If, when, and how to offer a community support meeting
- How to provide individualized support to those who may need more help

Provide training to senior center staff and volunteers. The training should cover why the protocol was developed and how it should be used. It should also explain that exposure to a suicide attempt or death can increase suicide risk among people who are

vulnerable. As part of the training, share copies of **Fact Sheet 3: After a Suicide: What to Expect and How to Help**, and note that this is a good resource to share with all who may be affected by a suicide death.

Contact an organization that provides postvention support to obtain its help in the event of a suicide death or attempt. Behavioral health providers and suicide prevention organizations are good starting places.

Tools you can use

Tool 8: Community Support Meeting provides a facilitator guide for holding a community support meeting after a crisis.

Share **Fact Sheet 3: After a Suicide: What to Expect and How to Help** with older adults at your senior center.

Other resources

The **Suicide Prevention Resource Center Survivor Resource Sheet** lists a number of organizations, websites, and materials that can help people who have lost someone to suicide. Available at http://www.sprc.org/sites/sprc.org/files/Survivors.pdf.

Tool 1: Suicide among Older Adults

Key facts

Older adults are the fastest-growing segment of the U.S. population (Ortman, Velkoff, & Hogan, 2014). Baby-boomers began to turn 65 in 2011. By 2030, the U.S. Census projects that more than 20 percent of the U.S. population—almost 73 million adults—will be 65 or older (Ortman et al., 2014).

Suicide is an important problem affecting older adults. In 2013, 7,215 people ages 65 or older (16.1 per 100,000) died by suicide in the United States, compared to 12.6 per 100,000 among all age groups (CDC, 2013).

Suicide rates are particularly high among older men. While suicidal thoughts and attempts are more common among older women than older men (SAMHSA, 2013), men's attempts are more likely to be fatal. In 2013, the suicide rate among men ages 65 or older was 30.9 per 100,000—more than six times the rate among women of the same age (4.6 per 100,000) (CDC, 2013). The highest suicide rates in the country are among men ages 85 or older.

A key reason that men's suicide attempts are more likely to be fatal is that men are more likely to use firearms. In 2013, the vast majority (5,113 of 7,215, or 71 percent) of suicide deaths among older adults were linked to firearms—and men accounted for more than 91 percent (4,666 of 5,113) of such deaths (CDC, 2013). Other lethal means of suicide among older adults include poisoning and suffocation (e.g., hanging).

Older adults are less likely than younger adults to report serious thoughts of suicide or a suicide attempt (SAMHSA, 2013). And yet, suicide attempts are much more likely to result in death among all older adults than among those who are younger. Reasons that a suicide attempt may be more likely to be fatal in this population include the following (Conwell, 1997; Fassberg et al., 2012):

- Older adults plan carefully and use more deadly methods—particularly firearms.
- Suicide attempts by younger people are more impulsive, and they are less likely to use firearms.
- Older adults are more likely to live alone than other age groups and are less likely to be discovered and rescued than younger people.
- Many older adults are physically frail. They are less likely to recover from a suicide attempt than younger people.

Key Terms

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

Suicidal ideation. Thoughts of engaging in suicide-related behavior (Adapted from HHS Office of the Surgeon General and National Action Alliance for Suicide Prevention [NAASP], 2012.)

Risk and protective factors for suicide among older adults

In most cases, suicide results from a combination of factors rather than a single cause. Studies suggest that the following factors may be particularly important among older adults (Conwell, Van Orden, & Caine, 2011).

<table>
<tr><th>Risk Factors</th><th>Protective Factors</th></tr>
<tr><td>Risk factors are “characteristics that make it more likely that a person will think about suicide or engage in suicidal behaviors” (HHS Office of Surgeon General & NAASP, 2012, p. 13). Some factors may be long lasting—such as a chronic health condition—while others may be short-lived (e.g., a stressful event or a brief illness). Risk factors in older adults include the following:

Mental and/or substance use disorders

• Major depression and other mood disorders
• Substance use problems, particularly involving alcohol and medications

Physical illness, disability, and pain
• Medical conditions that are painful and/or affect one’s function and autonomy
• Having several health problems at the same time</td><td>Protective factors are characteristics of individuals and the environment that “strengthen, support, and protect individuals from suicide” (HHS Office of Surgeon General & NAASP, 2012, p. 13). Protective factors in older adults include the following:

Behavioral health and health care
• Assessment and care for mental and substance use disorders
• Care for medical conditions and physical health problems

Social connectedness
• Connections to others at the personal, family, and community levels
• Friends and family members in whom to confide
• Participation in community activities
• Relationships that create positive interactions and feelings of being cared about</td></tr>
</table>

Social factors • Social isolation • Important losses (e.g., of a loved one, job due to retirement, driver's license) • Relationship problems or conflicts • The feeling that one is a burden to others **Individual factors** • Being timid or hostile • Finding it difficult to adjust to change • Having serious financial problems **Other risk factors** • A previous suicide attempt and/or having a family member who died by suicide • Access to lethal means, such as firearms	**Personal characteristics and skills** • Sense of purpose or meaning • Self-esteem • Social skills • Flexibility • Skills in coping and adapting to change • Cultural or religious beliefs that discourage suicide and support self-preservation

What you can do

Working with partners to recognize and reduce risk factors and increase protective factors for suicide is at the heart of this toolkit's approach to suicide prevention.

If someone you know may be experiencing risk factors for suicide:

- Talk with the person in a caring, nonjudgmental way

- Encourage the person to attend wellness sessions or classes offered by your senior center
- Connect the person to supportive services available from the senior center (e.g., Meals on Wheels programs, assistance with financial planning)
- Connect the person to sources of counseling or other forms of help

Tool 2: Assessment Checklist

Promoting Emotional Health and Preventing Suicide among Older Adults

Questions				Review This Section of the Toolkit
For each question, circle the answer that best matches your current situation.				If you answered "No" or "Don't Know," consider taking the steps and using the tools and resources in the toolkit section listed below.
Getting Started				
Do your staff members and volunteers know what factors may increase the risk of suicide among older adults?	Yes	No	Don't Know	Getting Started section
Do you have a list of the behavioral health contacts in your community?	Yes	No	Don't Know	Getting Started section
Promote Emotional Health				
Do you offer a variety of activities that promote intellectual, creative, spiritual, and physical well-being?	Yes	No	Don't Know	Strategy 1: Provide Activities and Programs That Increase Protective Factors
Do you offer programs designed to promote social networks and community building?	Yes	No	Don't Know	Strategy 1: Support the Development of Social Connections
Recognize and Respond to Suicide Risk				
Have your staff and volunteers been trained on how to recognize the warning signs of suicide?	Yes	No	Don't Know	Strategy 2: Recognize the Warning Signs of Suicide
Do your staff and volunteers know how to identify symptoms of depression?	Yes	No	Don't Know	Strategy 2: Recognize and Respond to Depression
Do your staff and volunteers know how to identify problems with alcohol and/or medications?	Yes	No	Don't Know	Strategy 2: Recognize and Respond to Medication and Alcohol Misuse
Do you provide older adults with information and resources on depression, substance abuse, and suicide?	Yes	No	Don't Know	Strategy 2: Increase Access to Care
Respond to a Suicide Attempt or Death				
Do you have a plan and resources to help individuals bereaved by a suicide death?	Yes	No	Don't Know	Strategy 3: Respond to a Suicide Attempt or Death

Tool 3: Connecting to Behavioral Health Resources in the Community

You can develop a list of contacts in behavioral health organizations and programs in your local area where you can refer participants for treatment and from whom you can obtain services and educational programs for your senior center. Consider the following steps:

1. Contact some or all the following types of organizations and programs:

    - Mental health centers, including evaluation and crisis intervention teams
    - Hospitals, including emergency departments and psychiatric units
    - Psychiatric hospitals
    - Individual mental health providers, including psychiatrists, psychologists, and social workers
    - Pastoral counseling resources
    - Substance misuse treatment programs
    - Telephone hotlines for suicide, depression, and substance misuse
    - Support groups for different types of mental health, health, and substance misuse problems and for dealing with losses, such as of a spouse

The following national organizations and tools can provide you with local contacts:

SAMHSA Behavioral Health Treatment Services Locator
http://findtreatment.samhsa.gov/

National Suicide Prevention Lifeline—Crisis Center Locator
http://www.suicidepreventionlifeline.org/GetInvolved/Locator

American Psychological Association—Psychologist Locator
http://locator.apa.org

National Association of Social Workers
http://www.helppro.com/nasw/BasicSearch.aspx

National Alliance on Mental Illness—State Organizations and Local Affiliates
http://www.nami.org/Find-Your-Local-NAMI

American Foundation for Suicide Prevention—Local Chapters
http://www.afsp.org/local-chapters/find-your-local-chapter

As you connect with each organization or program, fill in a copy of the following form: Information Form for Behavioral Health Resources.

2. Fill in a copy of the Behavioral Health Resources Chart so that all of your contacts are in one place.
3. Make the chart available to all of your center staff.

Behavioral Health Resources Chart

In the first column, list the contact information for each organization or program. Then place an “X” in the box for each service that the organization or program provides.

Name of Organization or Program Contact Person Phone Number E-Mail Address	Mental Health Treatment	Substance Misuse Treatment	Support Groups	Consultation	Training for Staff	Education Programs for Older Adults and Their Families
N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A

Tool 4: Activities to Promote Health and Wellness

Social activities

Social activities fill many functions, including providing pleasure, helping older adults prevent and cope with loneliness, enhancing emotional support, and fostering relationships. Some examples are group trips to social, sporting, and cultural events; parties to celebrate holidays, birthdays, and other special occasions; and a hospitality room where coffee is served every morning or tea every afternoon. Many of the following ideas also involve social contact.

Health and wellness activities and programs

Group exercise classes and interactive games increase physical activity, balance, circulation, and flexibility. Walking and gardening provide physical activity and opportunities to get outdoors. Classes in relaxation, breathing techniques, yoga,

Qigong, or Tai Chi may help with stress reduction and overall wellness. Group games, such as health education bingo, and presentations that include a discussion component are interactive ways to convey health information.

Arts activities, such as creative writing, poetry readings, arts and crafts, photography, music, drama, and dance, can promote creativity, imagination, and self-expression.

Classes on health-related topics, such as nutrition, preventing falls, or managing chronic diseases (e.g., heart disease, diabetes), can help residents take better care of their own health.

Classes or groups on coping skills can help residents better deal with personal issues, such as loss and bereavement, aging, living with specific health conditions, sexuality, caring for a spouse or partner, stress, interpersonal communication, problem solving, financial issues, and organizing paperwork.

Spiritual and religious activities, such as religious services, celebration of religious holidays, prayer groups, meditation classes, and taking personal time for contemplation, may help participants find meaning, purpose, and value in life.

Positive life review. Also called reminiscence, this activity involves going back through one's life and putting together scrapbooks, journaling, and/ or writing life stories. It can be very helpful in the process of putting one's life in perspective and finding meaning, and it is also a form of creative expression. It can be done in groups, alone, or with another person as a guide, such as a student, a professional, or a friend.

Educational and skill-building activities

Classes that build knowledge and skills in such topics as computers, carpentry, cooking, sewing, gardening, financial management, and grandparenting may increase a sense of competence and self-esteem.

Intellectual activities, such as book groups, current events discussions, presentations, seminars, workshops, learning a new language, and interactive gaming may stimulate cognitive functioning and enhance self-esteem.

Mastery activities, such as crossword puzzles, word and number games, jigsaw puzzles, woodworking, writing poetry or stories, and painting, are pleasurable for many older adults, provide a sense of accomplishment, and are important for maintaining a positive mood.

Volunteering and mentoring

- Helping others may provide older adults with a sense of purpose or meaning. For example: Participants can identify ways to welcome new members and engage other participants in contributing their own skills, either within the senior center or in other settings.

- Within the senior center, participants can help organize and run events; develop and manage a newsletter; help other participants with household tasks, shopping, getting to appointments, and taking walks outside; or plant and maintain a community garden. Participants can also organize and run fundraisers or volunteer their time to the center as grant writers.

- Participants can teach or tutor children, teens, young adults, and other older adults, as well as tutor senior center staff and volunteers who are learning English as a second language.

- Outside the senior center, participants can volunteer for community organizations, such as ethnic and religious groups and the Service Corps of

Retired Executives. Other volunteering opportunities may be available from Senior Corps Programs sponsored by the Corporation for National and Community Service, such as RSVP, a volunteer network for adults ages 55 and older (http://www.nationalservice.gov/programs/ senior-corps/rsvp).

- Intergenerational activities can be effective in bringing young energy to older adults and enabling them to contribute to young people's lives. These activities can range from caring for preschool children to tutoring or mentoring school-age children. For ideas, visit the website of Generations United (http://www.gu.org), a national membership organization that advocates for the mutual well-being of children, youth, and older adults, and builds bridges between generations.

Behavioral health

- Invite a behavioral health provider to encourage help-seeking and describe available services. Ask the provider to describe how useful it can be to talk with a mental health professional about life issues that make people feel sad, depressed, or anxious. The provider should also explain that clinicians are bound by rules of confidentiality that they may break only in cases when the client or someone else is in danger.

Tool 5: Strategies for Establishing Social Networks

Welcoming new participants

- Hold events specifically to welcome new visitors to the senior center, where they can meet other participants and senior center staff and volunteers.

- Provide information to new participants on all the types of social connection and support available at the senior center.

- Coordinate buddy systems that match the new participant with someone who has been using the center for a longer time, or designate greeters who are available to welcome anyone new who comes to the center.

Maintaining connections

- Implement a telephone outreach program, in which participants make calls to other participants to check how they are doing and offer support. Predetermined times can be set for the calls. If an individual does not respond to daily calls made at set times, the caller alerts a designated emergency contact.
- Provide opportunities for participants to volunteer to do things to help others, such as taking a new member to dinner, providing support if a spouse dies, or making hospital visits.
- Provide training on the warning signs of suicide and listening skills.
- Encourage involvement in decision making that affects the senior center and helps build social networks for both individuals and the community as a whole. You can involve participants in the senior center's decision-making processes by asking them to participate in or contribute to the center's advisory, governing, or planning bodies.
- Offer small-group activities, such as knitting and quilting, that allow participants to share information and develop relationships.
- Encourage connections among older men who may come to the center for lunch by adding post-lunch activities, such as playing pool, cards, or Ping-Pong. Consider adding a "Fix-It" room, where community members can bring in items that need to be fixed, and senior center participants work together on the repairs. Offer educational sessions on topics related to men's health.

Tool 6: Recognizing and Responding to Depression

Many people mistakenly think that symptoms of mental illness, such as sadness, depression, and anxiety, are a natural part of the aging process or a grief response to

the loss of a spouse or other stressful live event. **Depression is a serious but treatable illness that needs immediate attention.**

Key symptoms of depression include the following (APA, 2013):

- Depressed mood (e.g., feeling sad, empty) most of the time§
- Loss of interest or pleasure in activities
- Weight loss or gain (changes in appetite)
- Disturbed sleep (sleeping too much or too little)
- Noticeable restlessness (agitation) or slow movement
- Fatigue or lack of energy
- Feelings of worthlessness or extreme guilt
- Difficulties with concentration or decision making
- Frequent thoughts of death or suicide, or a suicide attempt

Identifying late-life depression can be challenging. Many older adults may have symptoms that do not meet the full criteria for depression, but they may still be experiencing significant problems. In addition, symptoms of depression can be similar to those of other medical conditions, making depression more difficult to diagnose.

Older adults who have depression may be more likely than younger adults to report physical symptoms (e.g., nervousness, loss of appetite) than psychological ones (SAMHSA, 2013). Symptoms may also vary among different groups of older adults. A recent review found that among older Hispanics, symptoms of depression included

"weakness, multiple aches and pains, dizziness, palpitations, and sleep disturbances" (Sadule-Rios, 2012, p. 466).

Men and Women May Show Different Symptoms

Women with depression are more likely to have feelings of sadness, worthlessness, and excessive guilt. **Men** with depression are more likely to:

- Be very tired
- Be irritable
- Lose interest in once-pleasurable activities
- Have difficulty sleeping Men may be more likely than women to turn to alcohol or drugs when they are depressed.

They also may become frustrated, discouraged, angry, and sometimes abusive. Some men may behave recklessly. (Adapted from National Institute of Mental Health [n.d.].)

Assessment, diagnosis, and treatment

A number of screening tools can be used to screen older adults for depression. The tools will not give a definite diagnosis, but they can indicate that a problem may exist.

Depression screening is one of the free preventive services that an older adult's primary care provider may offer. All health plans that comply with the Patient Protection and Affordable Care Act (ACA), including Medicare Part B, cover this screening when delivered by a primary care provider from the health plan's network. Doctors who offer depression screening must be prepared to facilitate referrals to mental health treatment if needed.

Individuals who screen positive for depression should receive a full diagnostic evaluation from a mental health care provider. Treatment of depression often combines psychotherapy (talk therapy) and medication. However, many older adults fail to seek

treatment because of the fear of being labeled as having a mental illness. They may feel embarrassed or reluctant to seek help.

What you can do

Promote acceptance of mental health issues by sharing the following messages (SAMHSA, 2013):

- You are not alone. Depression, anxiety, and other mental health issues are more common than you think.
- These feelings are not your fault. Mental health issues are real health concerns.
- You may feel better if you talk to someone who can help. Treatment does work.
- The earlier you see a doctor or other health professional and get help, the better you will feel.

If you think that someone you know may be showing signs of depression, talk with a nurse, doctor, social worker, mental health professional, or member of the clergy. Your goal is to find someone who can speak to the person and help him or her find out if there is a problem and how to get help.

Tool 7: Recognizing and Responding to Medication and Alcohol Misuse

Recognizing medication and alcohol misuse among older adults can be difficult. Sometimes it may be hard to tell if a problem exists. People may mistake alcohol and drug problems for a bad mood, dementia, or delirium. But knowing what to look for can help.

Symptoms of alcohol or medication problems in older adults include the following:

- Blackouts
- Forgetfulness or trouble concentrating

- Frequent falls and unexplained bruising
- Shakes or tremors
- Constant irritability and altered mood
- Depression or anxiety
- Poor hygiene and self-neglect
- Sleep problems or daytime drowsiness
- Slurred speech
- Tremor, clumsiness, and trouble walking

Alcohol and medications can interact with each other to cause these symptoms. Also, drugs can interact with each other. Thus, it is crucial to make sure older adults take their medications properly.

Problems with alcohol

An alcohol problem is defined as drinking above the limits recommended by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), using alcohol while taking prescription medications, and/or using alcohol in any other way that is harmful.

How much alcohol is too much? Although everyone is different, NIAAA (n.d.) recommends that adults ages 65 or older who are healthy and take no medications drink no more than three alcoholic drinks on a given day, not to exceed seven drinks per week.

One drink is equal to one of the following:

- One 12-ounce can or bottle of regular beer or ale
- One 5-ounce glass of red or white wine
- One 1.5-ounce shot glass of hard liquor (spirits), such as gin, vodka, or whiskey. The label on the bottle will read 80 proof or less.

Women are advised to drink less than this because their bodies react differently to alcohol than men's bodies do. Older adults should not drink alcohol if they (1) take

prescription pain medications, sleeping pills, over-the-counter sleep aids, or medication for anxiety or depression; (2) have memory problems; and/or (3) have a history of falls or unsteady walking. It is crucial to address alcohol problems among older adults because these problems can be harmful and even fatal. However, these problems are often hard to recognize and address. Many older adults disapprove of and feel shame about alcohol misuse. Many do not want to seek professional help for what they consider a private matter. Relatives of older people with alcohol problems, particularly their adult children, may also be ashamed of the problem and choose not to address it.

A range of services are available for older adults who have alcohol problems or who are at risk. Types of treatment include individual counseling, group-based approaches, and approaches that combine medication with counseling.

Problems with prescription and over-the-counter medications

Medications of concern among older adults include those used to treat anxiety, depression, insomnia, and other mood disorders. Older adults also use over-the-counter medications, such as pain relievers and herbal supplements. Taking multiple medications and herbal supplements can lead to serious side effects and drug interactions.

Factors that can increase the risk of medication misuse include the following:

- Multiple physicians prescribing multiple drugs
- Inappropriate prescribing (e.g., prescribing the wrong medication or an inappropriate dose)
- Instructions and package inserts written in small print or confusing language
- Failure to tell the doctor about over-the-counter medications, vitamins, and herbal supplements
- Memory problems that make it difficult to keep track of medication schedules
- Problems taking medicine correctly because of alcohol use, depression, or self-neglect

- Missing instructions as a result of hearing or vision problems, memory problems, language barriers, and so forth

What you can do

If you think someone you know may be showing signs of medication or alcohol misuse, talk with a nurse, doctor, social worker, behavioral health professional, or member of the clergy. Your goal is to find someone who can speak to the person and help him or her find out if there is a problem and how to get help.

Tool 8: Community Support Meeting A death by suicide can have a huge impact on family members, friends, and other survivors. A community support meeting is one way to bring those affected by a suicide together, to share their stories and to reaffirm that they are not alone in their grief.

This brief guide for facilitating such a meeting was adapted from a program developed by college health professionals to help the larger university community come together in the aftermath of tragic events. Meilman & Hall (2006) note that administrators are bolstered by having a plan in place when adverse circumstances arise, and program participants feel taken care of when administrators have such a plan in place.

Facilitating a community support meeting

1. Opening The facilitator introduces attending staff members and makes a few comments regarding the confidentiality and duration of the meeting (1 hour). The facilitator requests that any members of the media identify themselves and leave unless they are willing to participate as affected individuals rather than as members of the press.

2. Brief description of the death or event ________________________________
[*insert your designee*] gives an official explanation of what is known about how the

death occurred so that all who are present are working from the same basic set of facts. This also offsets any potential adverse impact of the rumor mill.

3. Purpose of the meeting. The facilitator acknowledges that this is a difficult time, that participants are courageous for attending, and that it is important that the meeting be a helpful and healing gathering for the community. The facilitator reiterates the need for confidentiality, stating, "We want to ask that this session and the things we discuss be considered confidential within the confines of this room. Does everyone feel okay with that?"

4. Opening question The facilitator opens the conversation by posing a question to the group: "We feel sad about what has happened, but we did not know ____________________________ [*name of the deceased*] as well as you did, and we'd like to understand what [he or she] was like in order to be helpful. Can you tell us something about [name of the deceased] so that we can all share a common understanding? You can share your reflections as you feel comfortable. You may also choose not to share, although we hope you will be comfortable enough to speak."

5. Sharing stories This begins the heart of the process. In telling the story of the deceased, in reminiscing, in laughing, and in crying together, the grieving process is facilitated, and the community reconnects with itself. Simply put, the storytelling is the work. In a sense, talking can be viewed as the psychological equivalent of chewing—it breaks down an overwhelming experience into manageable, more easily digestible pieces.

6. Grieving process The facilitator makes a few very brief comments about grieving as a process that takes time, and he or she includes such words and phrases as *shock, disbelief, feeling disorganized, feeling despair, sadness, anger* (at the situation, at the person who died, at God)*, guilt, anxiety about oneself, and eventually acceptance*. The facilitator emphasizes that there is no right or wrong way to go through the situation and that, for a while, the grieving person may experience an emotional roller coaster.

7. The "what ifs . . . " Participants hold a discussion of the inevitable "what ifs" and "if onlys" that people often privately consider in the aftermath of a suicide. It is helpful when we ask residents to identify their own "what ifs" and to speculate out loud about the kinds of statements that others in the room may be considering, such as, "If only I had done, ______________________________ [*name of the deceased*] would still be alive." Through this discussion, we attempt to put perceived guilt on the table, identify it as being an impediment to grieving, and demonstrate to participants that they are not alone with their self-recriminations—that many people are wondering what more they could have done.

It is also important to explain that suicide is complex and that there are many reasons for it, including relationships or failure at relationships, family issues, internal psychological conflicts, personal value systems, biology, logical and illogical thinking processes, tunnel vision (black-and-white thinking), conscious and unconscious processes, bottled-up anger directed at oneself, and religious beliefs. The facilitator explains that changing any of the "if onlys" would not have been likely to create a different outcome.

8. Wrap-up

The facilitator makes parting comments along these lines: "This gathering is important. It helps enhance a sense of community now when it's needed. You're in the fortunate position of having a community and being able to care for one another. Please look out for one another. If someone is isolated or having a hard time, invite him or her to talk about it."

9. Community resources

The facilitator identifies helpful resources within the senior center and in the broader community, including _______________________________ [*insert local resources*]. This may be a good time to distribute **Fact Sheet 3: After a Suicide: What to Expect and How to Help**.

10. Staff Availability The facilitator announces that staff will stay for a few minutes afterward in case anyone wants to talk individually.

11. Reviewing the meeting

At the next monthly staff meeting, the staff (and perhaps others who were involved in the community support meeting) assess their work and conduct a review of the meeting. This process helps the staff continually refine their approach and allows staff members who were not participants in the particular postvention to learn from it.

Tool 9: Resources List

For senior center staff and volunteers

Basic Information on Suicide Prevention

Older Americans Behavioral Health: Issue Brief Series

http://www.aoa.acl.gov/AoA_Programs/HPW/Behavioral/index.aspx#issue

Older Americans Behavioral Health: Webinar Series

http://www.aoa.acl.gov/AoA_Programs/HPW/Behavioral/index.aspx#webinars

Substance Abuse and Mental Health Services Administration (SAMHSA), Administration on Aging (AoA), and National Council on Aging (NCOA). (2011–2013) These resources cover key behavioral health issues that affect older adults, including suicide, depression, anxiety, and alcohol and prescription medication misuse, as well as prevention and treatment programs to address these problems. Note especially the items on preventing suicide and reaching diverse populations.

Toolkits with Guidance and Resources on Suicide Prevention and Behavioral Health Promotion

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

http://store.samhsa.gov/product/SMA10-4515

Substance Abuse and Mental Health Services Administration. (2011) This toolkit contains resources to help staff in senior living communities promote emotional health and prevent suicide among their residents and to help residents become active participants in mental health promotion and suicide prevention efforts. It includes information on recognizing and responding to people who are suicidal and/or have depression or substance misuse problems; responding to a suicide death; conducting one-hour trainings for staff, residents, and their families; and implementing a comprehensive suicide prevention program.

Get Connected! Linking Older Adults with Medication, Alcohol, and Mental Health Resources Substance Abuse and Mental Health Services Administration (SAMHSA), Administration on Aging (AoA), and National Council on Aging (NCOA). (revised 2013)

http://store.samhsa.gov/product/Linking-Older-Adults-With-Medication-Alcohol-and-Mental-Health- Resources/SMA03-3824

This toolkit provides step-by-step information and resources on how to establish a program to link older adults with resources on alcohol and medication misuse and mental health problems. Tools provided include a program coordinator's guide, fact sheets, screening tools, sample forms, and suggested curricula for program staff and for older adults.

A Toolkit for Serving Diverse Communities Administration on Aging (AoA) http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/DOCS/AoA_DiversityToolkit_Full.pdf

This toolkit offers easy-to-use methods for providing respectful, inclusive, and sensitive services. It covers assessing the needs of a community, identifying resources, designing services, and evaluating programs.

Telephone Lines for Older Adults in Crisis

National Suicide Prevention Lifeline 1-800-273-TALK (8255) http://www.suicidepreventionlifeline.org/

This 24-hour, toll-free suicide prevention hotline is available to anyone in suicidal crisis or emotional distress. Calls are routed to the nearest crisis center in a national network of more than 160 crisis centers, where trained counselors provide crisis counseling and mental health referrals. To connect online through the Crisis Chat service, go to http://www.suicidepreventionlifeline.org/GetHelp/LifelineChat.aspx.

Friendship Line 1-800-971-0016 http://www.ioaging.org/services-for-elders-and-caregivers/friendship-line

This phone line at the Institute on Aging is the nation's only 24-hour, toll-free hotline specifically for older and disabled adults. Trained staff and volunteers make and receive calls to and from individuals who are either in crisis or just in need of a friend.

Organizations and Programs with Additional Resources on Behavioral Health and Older Adults

National Council on Aging (NCOA)

http://www.ncoa.org

This nonprofit service and advocacy organization works with organizations across the country to help seniors improve their health, find jobs and benefits, live independently, and remain active in their communities.

NCOA's Center for Healthy Aging

http://www.ncoa.org/improve-health/center-for-healthy-aging/?

This center offers a number of resources on behavioral health.

National Institute of Senior Centers (NISC)

http://www.ncoa.org/national-institute-of-senior-centers/

Part of NCOA, this institute supports a national network of more than 2,000 senior center professionals. It promotes research, promising practices, professional development, and advocacy. It also offers the only national accreditation program for senior centers.

Administration on Aging (AoA)

http://www.aoa.acl.gov/AoA_Programs/HPW/Behavioral/index.aspx

The Administration on Aging is part of the Administration for Community Living, the federal agency on aging and disability. The Behavioral Health section offers a variety of resources on behavioral health in older adults.

Positive Aging Resource Center (PARC)

http://positiveaging.org

Brigham and Women's Hospital and the Harvard Medical School Division on Aging provides information and resources for older adults, caregivers, health and social service professionals, and policymakers.

Suicide Prevention Resource Center (SPRC) http://www.sprc.org

SPRC provides information, resources, training, and technical assistance related to suicide and suicide prevention.

SPRC Online Library

http://www.sprc.org/search/library/Older%20Adults%20%2855%252B%29?filters=type%3Alibrary_ resource%20tid%3A243

This online library contains a large number of materials related to older adults.

SPRC State Pages

http://www.sprc.org/states

Use the State Pages to find your state suicide prevention contact person and to learn about suicide prevention coalitions, programs, and activities in your area.

American Foundation for Suicide Prevention (AFSP)

http://www.afsp.org

AFSP offers educational programs and provides support to those affected by suicide.

Find Your Local Chapter:

http://www.afsp.org/local-chapters/find-your-local-chapter.

Contact your local AFSP chapter to find out about local resources, including support groups.

SAMHSA Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health

http://www.promoteacceptance.samhsa.gov/audience/adults/default.aspx

This center provides information, resources, and programs for providing a caring, welcoming, and supportive community that will help promote recovery and wellness for people with mental health problems and substance use disorders and for those who have experienced trauma.

For older adults and their families

Suicide Prevention

Suicide Warning Signs (wallet card) National Suicide Prevention Lifeline http://www.suicidepreventionlifeline.org/getinvolved/materials.aspx

Suicide Prevention for Seniors (brochure) SAVE (Suicide Awareness Voices of Education) http://www.save.org/index.cfm?fuseaction=shop.productDetails&product_id=78EE6EC5-E947-7D63- 23CC0B169CB38D7C

Suicide Prevention Resources for Survivors of Suicide Loss (resources list) Suicide Prevention Resource Center (SPRC). (2013) http://www.sprc.org/sites/sprc.org/files/Survivors.pdf

Depression

AgePage: Depression National Institute on Aging. (updated 2015) http://www.nia.nih.gov/health/publication/depression AgePage is also available in Spanish.

Older Adults and Depression National Institute of Mental Health http://www.nimh.nih.gov/health/publications/older-adults-and-depression/index.shtml

Alcohol Misuse

AgePage: Alcohol Use in Older People and Older Adults and Alcohol: You Can Get Help (booklet) National Institute on Aging. (updated 2015) http://www.nia.nih.gov/health/publication/alcohol-use-older-people AgePage is also available in Spanish.

Fact Sheets for Older Adults

These fact sheets are meant for senior center users, and you may also share them with staff and volunteers. Because they cover emotionally sensitive topics, the fact sheets should only be handed out in settings where they can be discussed. A social worker, a trained staff person, or a behavioral health specialist should be present to help explain the information, answer questions, and help older adults deal with any feelings that may come up.

Suggested settings in which the fact sheets can be distributed and discussed follow:

Fact Sheet 1: Looking Out for the Well-Being of Yourself and Others

- Workshops or presentations
- Health promotion or wellness programs

Fact Sheet 2: Know the Warning Signs of Suicide

- Workshops or presentations
- Support group run by a social worker or other mental health professional
- Individual sessions with a social worker or other mental health professional

Fact Sheet 3: After a Suicide: What to Expect and How to Help

- Community meetings, as described in **Tool 8: Community Support Meeting**
- Support group run by a social worker or other mental health professional
- Individual sessions with a social worker or other mental health professional

At the end of each fact sheet is space for you to fill in the names of relevant contact people at local agencies, such as community mental health centers or behavioral health providers, from whom participants or staff can seek help. Be sure to add this information before giving out the fact sheets.

Fact Sheet 1: Looking Out for the Well-Being of Yourself and Others

No matter what age you are, it is important to look out for your own emotional well-being. This is especially true for older adults because of the special challenges at this stage of life. Taking charge of your emotional well-being can make a big difference.

- Are you in pain?
- Do you feel depressed?
- Are you lonely?
- Have you experienced a loss?
- Can you think of someone else who may be experiencing these challenges, such as a spouse, friend, or acquaintance?

If you or someone you know may be going through a difficult time, know that help is available. Read on . . .

Take care of yourself

Your emotional well-being is affected by your health. If you need help or support, staff at your senior center can help you see a medical or mental health provider. They can also recommend health and wellness activities.

Here are some suggestions for taking care of your health:

- Make an appointment with a medical provider if you are in pain or have a physical illness.
- Seek treatment or talk to a counselor if you have depression or another mental health issue, or if you drink too much or are misusing medications.
- Join a support group to help you cope with the loss of family and friends, financial problems, or other personal issues.
- Stay active and exercise regularly. Try taking a group exercise class or going on walks.
- Eat a healthy diet. Avoid too much sugar, salt, fat, and caffeine.

Taking care of your physical and mental health will help you feel better and reduce your feelings of helplessness.

Get involved

Getting involved in intellectual and creative activities is a valuable way to build your skills and give you a sense of purpose. If an activity that interests you is not offered at your facility, activities:

- Attend a discussion group or presentation on a topic of interest to you
- Do arts and crafts activities
- Go to a poetry, music, or theater event at the facility
- Join or start a book club
- Take a class in sewing, computer, carpentry, or financial management

You can build skills or start a new hobby at any age. You just need to be willing to try.

Helping Others

Look out for the emotional well-being of other older adults. Someone might be helped by your friendship and encouragement to get involved in activities or to see a mental health professional.

Remember to be respectful. If you are concerned about someone, decide if it would be more helpful to talk with a staff member or a social worker about the person or to talk with the person directly.

Reach out

The well-being of older adults is affected by strong relationships with family, friends, and others. Here are some ways to help you build relationships in your senior center, share emotional support, and have fun:

- Go on group trips to social, sporting, and cultural events
- Attend parties to celebrate holidays, birthdays, and other special occasions
- Play bingo, bridge, or poker
- Join the committee to welcome new residents

- Mentor or be a buddy for new residents
- Join a committee involved in facility decision making
- Volunteer to help others in your local area

Reaching out to other senior center staff and participants will also help you look out for the emotional well-being of others.

Fact Sheet 2: Know the Warning Signs of Suicide

Have you ever heard someone make these statements? Have you thought them yourself?

- “They’d be better off without me.”
- “Don’t worry—I won’t be here to bother you much longer.”
- “I can’t deal with it any more. Life is too hard.”
- “I no longer want to live.”
- “Death seems like the only way out.”

Do either of the following descriptions sound like your neighbor, a friend, or yourself?

> The person has been drinking more than usual. He or she doesn’t think life has any purpose now that his or her spouse is gone. He or she yells at food servers or other senior center staff for taking too long.
>
> The person has stopped coming to exercise class. He or she paces around at night, unable to sleep. He or she reports feeling hopeless and that nothing in life will ever improve.

Know the warning signs of suicide.

The following three warning signs suggest that a person could be at immediate risk of suicide:

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself, such as searching online or obtaining a gun
- Talking about feeling hopeless or having no reason to live

Other behaviors that may also indicate a serious risk—especially if the behavior is new, has increased, and/or seems related to a painful event, loss, or change:

- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated, behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

These signs may suggest that someone is considering suicide. Get help if you notice any of these behaviors and moods in yourself or someone else. See the next page for information on what you can do.

What you can do

If someone you know is showing any of the warning signs of suicide, your goal is to encourage that person to seek help—but while that's easy to say, it's not always easy to do. People are sometimes uncomfortable seeking help for mental health problems. If they've never done it before, they may not know what to expect. The belief that we should be able to cope on our own can also prevent many of us from getting much-needed treatment.

If you or someone else shows one or more warning signs of suicide:

- In this senior center, contact:____
- In the community, contact the following mental health provider(s):

____

____

____

____

- If you are unable to reach a mental health provider, call the National Suicide Prevention Lifeline (1-800-273-8255).
- The goal is to connect the person to a mental health professional who can quickly assess for suicide risk. If you think the person is in immediate danger of attempting suicide, call 911. Stay with the person until help arrives, talking with him or her in a supportive tone.

Fact Sheet 3: After a Suicide: What to Expect and How to Help

A death by suicide can have a huge impact on family members, friends, senior center volunteers, staff, and other survivors of suicide loss. Whether you have lost someone by suicide or want to help another person who has, it is useful to know what to expect and how to best help someone else.

How to help yourself

Coping with a suicide can cause many emotions. Strong feelings are normal. No one has the same reaction, and emotions can change. Take time to figure out how you feel. You may be feeling any of the following:

- Disbelief
- Denial
- Grief
- Guilt
- Anger
- Shame

An attempted suicide often brings up some of these same emotions.

Here are some tips for coping:

- Give yourself time to deal with the loss and accept whatever emotions you feel. Remember that everyone grieves differently.
- The suicide of a family member or friend can affect your emotional health. Get help if you feel emotionally vulnerable yourself.
- Talk about the person who died with someone you trust—a family member, friend, member of the clergy, or senior center staff person.
- Honor the memory of the person who died—place pictures of the person in your room or write something about him or her.
- Express your feelings with a counselor or in a support group with others who are likely to understand what you are going through.
- Stay with your daily routine and take care of your basic needs—eat, sleep, and attend your regular activities.
- Be prepared for holidays and anniversaries, since they can be difficult emotionally. Consider doing something special in memory of the person who died.

Why Did It Happen? It's common to try to figure out why someone took his or her life—yet, the answers may not be known. The causes of suicide are complicated and different for each person. The person who died may be the only one able to answer your questions. At some point, most people accept that clear reasons may not exist and that knowing why will not change what happened. This acceptance is a key step in healing.

How to help others

How you feel about suicide will affect how you respond to others. Take the time to get clear about your feelings before you try to help someone else.

People who lose a friend or relative by suicide need a lot of support and understanding. The loss and shock of suicide can make a person more sensitive, so be extra careful not to say or do something that could make the person feel worse.

If you feel uncomfortable about suicide, it can be especially hard to know how to respond to someone who has experienced a loss like this. It is helpful to avoid judgment and blame related to the cause of death.

What to say

Express empathy, and acknowledge their pain and sadness.

- "I am so sorry for your loss."
- "I can see that you are hurting."

Ask if they want to talk about the person, and then just listen.

- "Do you want to talk about ______________________?"

Let them know that you care about their well-being.

- "I am here to support you in any way."

How Do You Feel?

Your attitude and feelings can make a big difference to someone who has lost a friend or loved one by suicide. Acceptance is key to helping them deal with the loss:

- Accept all their feelings.
- Accept that you will not be able to ease their pain.
- Accept that their loss can't be compared to anyone else's.
- Accept that the suicide was not an accident.
- Accept that healing will take a long time. Be patient and understanding.

Your understanding and support are what the person needs most.

What to do

- Be kind and reach out—send a card, have tea or lunch together, watch a television show or movie together
- Call and visit regularly
- Listen when they talk about their feelings and don't try to make them feel better
- Offer to help with their responsibilities, but don't take over unless they ask

Resources to help cope with a suicide

In this facility,
contact:____

In the local community,
contact:____

The National Suicide Prevention Lifeline (1-800-273-TALK [8255]) is available 24 hours a day, 7 days a week.

SOS: A Handbook for Survivors of Suicide by Jeffrey Jackson (2003) can be downloaded from http://www.sprc.org/library/SOS_handbook.pdf.

References for Chapter 4

Appendix–Additional Acknowledgments

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Chapter 5: National suicide prevention strategies: progress, examples and indicators.

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Retrieved from: https://www.who.int/mental_health/suicide-prevention/national_strategies_2019/en/

A. Introduction

Background

Globally, close to 800 000 people die by suicide every year; nearly one third of all suicides occur among young people. Suicide is the second leading cause of death among 15–29-year-olds and the second leading cause of death for females aged 15–19 years. These data correspond to an overall global age-standardized suicide rate of 10.5 per 100 000 population in 2016 – 13.7 and 7.5 per 100 000 for males and females respectively (WHO, 2018a).

Suicide continues to be a serious problem in high-income countries. However, 79% of all suicides occur in low and middle-income countries which bear the larger part of the global suicide burden (WHO, 2018a). Although in high-income countries three times as many men die by suicide as women, the male-to-female ratio for suicide is more even in low- and middle-income countries, at 1.6 men to each woman. Suicide rates for both

men and women are lowest in persons under 15 years of age and highest in persons aged 70 years or older in almost all regions of the world. In some regions, suicide rates increase steadily with age, while in others there is a peak in suicide rates in young people. In low- and middle-income countries, young adults and elderly women have much higher suicide rates than their counterparts in high-income countries, while middle-aged men in high-income countries have much higher suicide rates than those in low- and middle-income countries (WHO, 2014).

It is estimated that for each person who dies by suicide, more than 20 others attempt suicide. In fact, suicide attempts are an important risk factor for subsequent suicide (WHO, 2014).

When the family members, friends, colleagues, and communities of those who attempt suicide or die by suicide are taken into consideration, many millions of people worldwide are affected by suicide every year (Pitman et al., 2014; Cerel et al., 2018). Because suicide remains a sensitive issue, it is very likely that it is under-reported due to stigma, criminalization, and weak surveillance systems.

Social, psychological, cultural, and many other factors can interact to increase the risk of suicidal behavior, but the stigma attached to suicide means that many people who are in need of help feel unable to seek it. Risk factors for suicide include previous suicide attempts, mental health problems, harmful use of alcohol, drug use, job or financial loss, relationship breakdown, trauma or abuse, violence, conflict or disaster, and chronic pain or illness (WHO, 2014).

Unfortunately, suicide prevention is too often a low priority for governments and policy-makers. Suicide prevention needs to be prioritized on global public health and public policy agendas and awareness of suicide as a public health concern must be raised by using a multidimensional approach that recognizes social, psychological, and cultural impacts (WHO, 2014).

A national suicide prevention strategy is important because it indicates a government's clear commitment to prioritizing and tackling suicide while providing leadership and guidance on the key evidence-based suicide prevention interventions (WHO, 2014).

Global action to prevent suicide

In 2013, the WHO Mental Health Action Plan 2013–2020 was adopted by the World Health Assembly (WHO, 2013). The action plan describes suicide prevention as an important priority for achieving the global target of reducing the rate of suicide in countries by 10% by 2020. This action plan highlights that suicides are a serious public health problem worldwide and that, with appropriate efforts, suicides are preventable. National responses to suicide with comprehensive multisectoral suicide prevention strategies are essential to achieving this target. In 2015, the Sustainable Development Goals (SDGs), which are focused on what can be achieved by 2030, were adopted by the United Nations (UN) General Assembly. Far broader in scope than the

Millennium Development Goals, the third goal of the SDGs is to ensure healthy lives and promote well-being for all ages. Target 3.4 of the SDGs is to reduce premature mortality from noncommunicable diseases by one third by 2030 through prevention and treatment and the promotion of mental health and well-being. The suicide rate is an indicator of target 3.4. The prevention of suicide is not only important for individuals and families but also benefits the well-being of society, the health care system, and the economy at large.

National suicide prevention strategies in the historical context

In the early 1990s, the seminal document entitled Prevention of suicide: guidelines for the formulation and implementation of national strategies was published by the UN

following consultation with a variety of experts and with technical support from WHO. The document emphasized the need for intersectoral collaboration, multidisciplinary approaches, and continued evaluation and review, and also identified key elements as a necessary means of increasing the effectiveness of suicide prevention strategies (UN, 1996). Further, the document emphasized that nations seeking to address suicide require both a national suicide prevention strategy and a coordinating/leading body to develop, implement, and monitor the strategy.

Knowledge about suicidal behavior has increased greatly since the UN document was published. Research, for instance, has shown the importance of the interplay between biological, psychological, social, environmental, and cultural factors in determining suicidal behaviors. At the same time, epidemiology has helped us to identify many risks and protective factors for suicide both in the general population and in vulnerable groups – such as indigenous peoples, young pregnant women, immigrants, prisoners, military personnel and lesbian, gay, bisexual, transgender and intersex (LGBTI) persons. Cultural variability in suicide risk has become more apparent, with culture and religion playing roles both in increasing the risk of suicide and in protecting from suicidal behavior (WHO, 2014). In 2012, the UN document was followed by WHO's Public health action for the prevention of suicide: a framework that identified components and clear steps for developing a national suicide prevention strategy (WHO, 2012).

In 2014, WHO published its first-ever world suicide prevention report Preventing suicide: a global imperative (WHO, 2014). In this report, WHO's Director-General made a call to action for countries to employ a multisectoral approach that addresses suicide in a comprehensive manner, which brings together different stakeholders, and which is based on their current resources and contexts. Since then, the number of requests that the WHO has received from countries for technical assistance in suicide prevention or to review and comment on their new or revised national suicide prevention strategies has increased. WHO is working at headquarters, regional and country levels, together with collaborators and partners, including the International Association for Suicide Prevention (IASP), to respond to such requests.

When the UN guidelines were initially prepared, only Finland was known to have a government-supported systematic response to developing a national program for suicide prevention. Today, some 40 countries at all income levels have adopted a national suicide prevention strategy, with some countries already developing or implementing further revision(s) of their national strategy. However, only a few countries in the low-income and middle-income categories have adopted a national suicide prevention strategy, even though 79% of suicides occur in these settings.

The WHO MiNDbank online platform was created to provide quick and easy access to international resources and national/regional-level policies, strategies, laws and service standards for mental health and related areas such as suicide, substance abuse, disability, general health, and human rights. The available national strategies for suicide prevention are included in this repository and are searchable and accessible by country (see Annex 1 for an overview).
Another global effort to address suicide is the creation of World Suicide Prevention Day, organized by IASP. This day has been observed worldwide on 10 September each year since 2003, providing an important opportunity for countries to raise awareness about suicide and its prevention. For some countries, this event has facilitated the development of a national suicide prevention strategy. Furthermore, some countries have extended this day to a week or month in which to observe this important public health issue. In 2017, IASP launched a Special Interest Group on the development of effective national suicide prevention strategy and practice.

Objectives of this document

While a lot has been achieved since the UN report was published in the 1990s, there are still significant improvements to be made. This document encourages countries to continue the work where it is already ongoing, to strengthen suicide prevention efforts, and to place suicide prevention high on the political agenda, regardless of where a country stands currently in terms of suicide rate or suicide prevention efforts. By

focusing on selected examples, this document aims to serve as a resource and inspire governments and policy-makers
to establish their own national suicide prevention strategy adapted to their local situation. It is essential that governments assume a leadership role for a national suicide prevention strategy, as they are able to bring together stakeholders who may not otherwise collaborate. Governments are also in a unique position to develop and strengthen surveillance, and to provide and disseminate the data that is necessary to inform action (WHO, 2014).

Much of this document contains examples of national suicide prevention strategies by country. The examples reflect diverse approaches and backgrounds and aim to inform the reader by outlining the variety of ways to implement national suicide prevention strategies. An attempt has been made to include at least one example from each WHO region, without peer-review of the content of the strategies or indicators. Prior to the examples, key elements of a strategic approach to developing, implementing, and evaluating a comprehensive multisectoral national suicide prevention strategy are presented and are brought together in the LIVE LIFE approach. Common barriers to developing a national strategy are discussed, as are possible actions for addressing such barriers. A list of the countries known to have stand-alone national suicide prevention strategies is presented in Annex 1. Indicators reported for national strategies are contained in Annex 2.

Box 1. National suicide prevention strategy success stories: England

The Cross-Government Suicide Prevention Strategy for England was published in 2012, revised from the original 2002 strategy. It is comprehensive, based on evidence, and places an emphasis on cross-sectoral collaboration across national government, its agencies, and voluntary and charitable organizations. The strategy has seven key areas for action to reduce suicides across all sectors, including health

and social care, justice, and public health.

The suicide rate in England is currently close to the lowest on record and is low by European standards. After a rise following the global recession, it is now back on a downward trend. The male suicide rate has fallen for four consecutive years. The suicide rate in people using mental health services is also falling and the number of suicides by inpatients has reduced by half.

A number of factors have been important to this apparent success, namely: 1) broad support from professions, charities, academics, and government departments; 2) advocacy by bereaved families whose personal experiences have engaged political leaders and the media; 3) reliance on up-to-date data and evidence; 4) national oversight that allows the strategy to evolve to address emerging priorities; 5) partnership with national agencies such as the National Institute for Health and Care Excellence (NICE), which published clinical guidance on depression and self-harm, and Public Health England which published suicide prevention guidance for local government; and 6) links to wider mental health policy (e.g. on community care, psychological therapies and reduction of stigma).

Suicide prevention in England has risen up the political agenda and has achieved cross-party consensus. A national ambition was set in 2016 to reduce suicides by 10% by 2020. The prime minister published an update to the strategy in 2017 with an emphasis on young people and self-harm. Every local authority area in the country has a multi-agency suicide prevention plan in place and there is a national program to improve suicide prevention in the National Health Service, supported by an investment of £25 million, with a zero-suicide ambition for inpatient care.

The most important current focus is young people. The suicide rate in 15–19-year-olds is rising, in contrast to the general downward trend, and the rate of non-fatal self-harm in young people is also going up. The highest rates are in middle-aged men, a

group that is reluctant to seek help. Additionally, there are widespread concerns about online safety, stress on health professionals, gambling addiction, and social media. The aim is to ensure that national policy, cross-government working, and local suicide prevention plans reflect these new priorities.

B. Developing, implementing and evaluating a comprehensive multisectoral national suicide prevention strategy

Why national suicide prevention strategies are important

The importance of developing a national suicide prevention strategy has been comprehensively explored. The numerous benefits include (WHO, 2012):

- A national strategy not only outlines the scope and magnitude of the problem but, more crucially, recognizes that suicidal behavior is a major public health problem.
- A strategy signals the commitment of a government in addressing the issue.
- A cohesive strategy recommends a structural framework, incorporating various aspects of suicide prevention.
- A strategy provides authoritative guidance on key evidence-based suicide prevention activities – i.e. it identifies what works and what does not work.
- A strategy identifies key stakeholders and allocates specific responsibilities to them. Moreover, it outlines the necessary coordination among these various groups.
- A strategy identifies crucial gaps in existing legislation, service provision, and data collection.
- A strategy indicates the human and financial resources required for interventions.
- A strategy shapes advocacy, awareness-raising, and media communications.
- A strategy proposes a robust framework of monitoring and evaluation, thereby instilling a sense of accountability among those in charge of interventions.
- A strategy provides a context for a research agenda on suicidal behaviors

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How to get started

A country that decides to work on its national response to suicide prevention has an opportunity to tackle suicide prevention in a way that is meaningful to that country's context. Regardless of a country's current commitment to and resources for suicide prevention, the very process of establishing a national response can itself improve prevention (WHO, 2014). In countries where suicide prevention activities have not yet taken place, the emphasis is on identifying stakeholders and developing activities where the need is greatest or where resources already exist. It is also important to improve surveillance. In countries with some existing suicide prevention activities, a situation analysis can show what is already in place and where gaps need to be filled. Countries that already have a relatively comprehensive national response should focus on evaluation and improvement, updating their data, and emphasizing effectiveness and efficiency (WHO, 2014). Resources should be allocated to achieve both short-to-medium- and long-term objectives; there should be effective planning, and the strategy should be regularly evaluated, with findings feeding into future planning.

A strategic approach

A national suicide prevention strategy needs to be multisectoral, involving not only the health sector but also sectors such as education, labor, social welfare, agriculture, business, justice, law, defense, politics, and the media. The strategy should be tailored to each country`s cultural and social context. When conceptualizing and implementing a national suicide prevention strategy through an action plan, it is necessary to specify clear objectives, targets, indicators, timelines, milestones, designated responsibilities, and budget allocations. The government needs a strategic and systematic approach. Without an action plan, it is likely that progress will fall short. The following elements, which are in no particular order, are key to the success and sustainability of the national strategy (WHO, 2012). Some of these elements may need to occur before or simultaneously with others. Context-informed decisions are needed in order to establish a preferential order in any given context.

Identify stakeholders

It is important to identify the key stakeholders in suicide prevention when developing a national strategy. Suicide prevention needs to involve different actors and disciplines working on suicide prevention – such as different ministries, health administrations, nongovernmental and nonprofit organizations, universities, and civil society at different levels (national, regional, state or provincial, and community). Lead stakeholders are listed according to strategic actions for suicide prevention in WHO's Preventing suicide: a global imperative (WHO, 2014). Potential stakeholders at the community level can be found in WHO's Preventing suicide: a community engagement toolkit (WHO, 2018b).

Undertake a situation analysis

A thorough situation analysis, starting with the data available, identifies the extent of the problem in a particular geographical area (whether an entire country or a specific subregion of a country). The identification of barriers to implementation is an important part of the situation analysis in which all the barriers are listed and solutions are proposed to remove them systematically. Without barrier identification, national strategies may face challenges when implementing activities.

Assess resource

The availability of and access to both human and financial resources, for both development and implementation, are central to the success of any public health intervention, as is the willingness of policy-makers to engage with the key issues. The assessment of resources can also be included in the situation analysis.

Achieve political commitment

Without political commitment, strategies are likely to remain only on paper, being implemented only partially or not at all. Political commitment is essential for ensuring that suicide prevention receives the resources and attention that it requires from the national, state and local leaders. Achieving political commitment that is sustainable and

which transcends changes in the government is a long and arduous process, but it has the potential benefit of reaching the population and showing impact in the long term.

Address stigma

Stigma related to suicide remains a major obstacle to suicide prevention efforts. Those who are left behind or who have attempted suicide often face considerable stigma within their communities, which may prevent them from seeking help. Stigma can subsequently become a barrier to accessing suicide prevention services. This is of particular concern in countries where suicidal acts are criminalized. Furthermore, high levels of stigma may negatively affect the recording and reporting of suicide and suicide attempts.

Increase awareness

The process of developing a suicide prevention strategy offers opportunities to increase awareness about suicide. It is not necessary to wait until the implementation phase of a suicide prevention strategy to seek the media's support in highlighting the importance of suicide prevention. For an intervention to be successful, the public requires an understanding of the issue and the need for the intervention. Awareness efforts can also generate greater and more sustained involvement from stakeholders and buy-in from communities that recognize the importance of suicide prevention.

State clear objectives

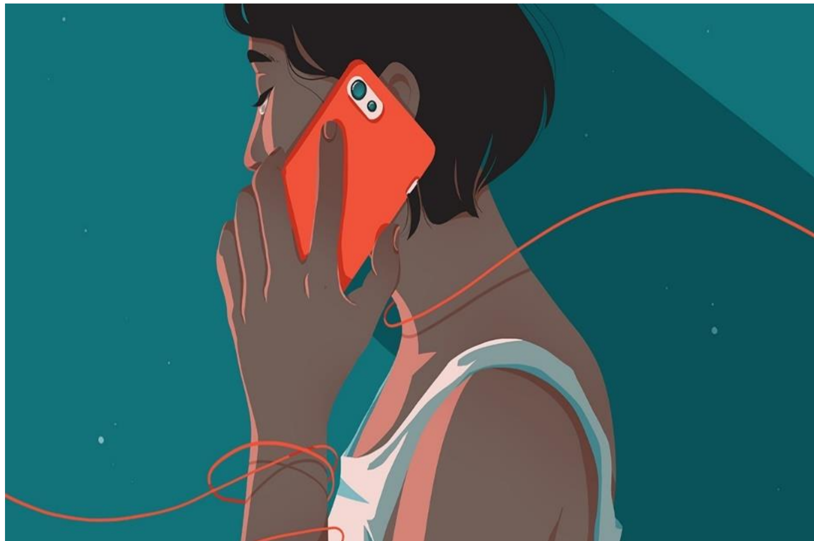
An effective suicide prevention strategy should have several parallel and interconnected objectives that need to be stated clearly.

Identify risk and protective factors

The identification of relevant risk and protective factors at the individual, family, community and societal level for both suicide and suicide attempts can help to determine the nature and type of interventions required in a given context (see also WHO, 2014; Hawton et al., 2016; Zalsman et al., 2016).

Select effective interventions

Based on relevant risk and protective factors, as well as the situation analysis and resources allocated, a national strategy and its action plan for implementation can propose the most suitable type and combination of effective evidence-based interventions – universal, selective, and indicated (see also WHO, 2014). Universal interventions target the



general population with coverage of the population as a whole. Selective interventions focus on subpopulations that have an elevated risk and can be employed on the basis of sociodemographic characteristics, geographical distribution, or prevalence of mental and substance use disorders (e.g. according to the contribution of these factors to the overall burden of suicide). Indicated interventions are aimed at persons who are already known to be vulnerable to suicide or who have attempted suicide. A comprehensive suicide prevention program typically employs a combination of universal, selective, and indicated interventions.

Improve case registration and conduct research

As suicide often remains misclassified, un- or under-reported, surveillance systems are needed to improve the availability and quality of data. Suicide attempt data are equally important as presented in the Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm (WHO, 2016), as a prior suicide attempt is the strongest predictor of subsequent suicide in the general population. A systematic approach for gathering data in a sustained manner is key (see also WHO, 2014). Research is important for understanding the risk and protective factors and vulnerable persons for a given context and can be used to identify the link between

intermediate outcomes of a strategy's action plan e.g. enhanced practice of health workers, and the primary outcomes of interest, i.e. suicide and suicide attempts.

Conduct monitoring and evaluation

Monitoring and evaluation need to be planned and agreed upon in advance to ensure the involvement of all relevant stakeholders, including inputs from key personnel involved in the implementation of interventions as well as feedback from community members. Evaluations are important for indicating whether changes need to be made to an intervention or whether it can be scaled up. While evaluating the strategy as a whole, the evaluation of individual interventions that are being implemented offers opportunities to examine critically the outcome and impact of these interventions in terms of the stated objectives. Intermediate outcomes, which are influenced by suicide prevention efforts in the short term, provide evidence of the impact of the strategy and action plan with regard to achieving the goal of reducing the rate of suicide and suicide attempts in the long term, which is the key primary outcome. Examples of intermediate outcomes include more responsible reporting of suicide in the media; enhanced knowledge, attitude, and practice of health workers towards people who engage in suicidal behaviors; an increased number of people utilizing and accessing support and services; and increased awareness and understanding of suicidal behaviors. The emphasis remains clear on the primary outcomes of reducing suicides and suicide attempts. Intermediate outcomes can be useful only if a clear and direct relationship with the primary outcomes can be established. Monitoring the quality of the implementation of the action plan through intermediate outcomes and their impact on primary outcomes can indicate which aspects of the implementation plan have the largest impact on the primary outcomes of suicide and suicide attempts and which aspects of the implementation plan require further improvement. This can also facilitate an understanding of changes that may affect implementation, such as reduced funding or lack of commitment to the process by stakeholders (see also WHO, 2014).

Monitoring and evaluation should be seen as part of a continuous feedback loop that is designed to allow refinements to be made to improve the strategy as it progresses.

More information about approaches to monitoring and evaluation are provided in the next section.

Measuring the success of national suicide prevention strategies

Measuring the success of a national strategy not always easy but there are ways to ensure that evaluations of national strategies are as robust as possible. One of the main concerns is that, by design, national strategies have multiple components and are rolled out on a large scale. Another concern is that a variety of factors influence a country's suicide rates and there will be fluctuations over time. Both of these factors mean that it may be difficult to detect changes in suicide rates that could be attributed to the national strategy. The best evaluations address
these issues by adopting a "program logic" approach and using multiple indicators of success.

A program logic approach is a way to systematize the theory of action of the given national strategy. The approach usually involves developing a hierarchy of objectives that operationalize the stated objectives of the strategy. Typically, the lowest-level objectives relate to ensuring that the structures and processes are in place for the strategy to achieve its aims, the next level relates to immediate and intermediate outcomes, and the highest level relates to the ultimate, longer-term primary outcomes. The logic asserts that, if the lowest-level objectives are met, then this augurs well for the intermediate objectives, and if these are met then this stands the strategy in good stead for meeting its highest-level objectives. Often the hierarchy is arranged in streams that align with the action areas of the strategy, and different indicators will be used to assess whether the objectives within each stream have been achieved. Thus, for example, if one of the key components of a given national strategy is about improving media reporting of suicide, the lowest-level objectives might relate to guidelines being developed and journalists being trained in good reporting practices, the next level might relate to improved reporting of suicide, and the higher levels might relate to reductions in suicide and suicide attempts. Similarly, if another key component was to improve access to and quality of care for suicidal persons, the lowest-level objectives might

relate to resourcing and equipping the general health workforce to assess and manage suicidal behavior, the intermediate-level objectives might relate to increased uptake of and satisfaction with care by suicidal individuals, and the higher levels might relate to reductions in suicide and suicide attempts. The streams will often converge at the higher points on the hierarchy because the ultimate aim will be to reduce rates of suicide and suicide attempts.

Assessment of the extent to which the various objectives are achieved relies on using indicators that are clear and measurable. Ideally, multiple data sources and multiple methods will be used to gauge the strategy's success against these indicators. Some data will come from routine sources, such as death registers or hospital admissions data; other data will be collected in a purpose-designed way, possibly through surveys or interviews. Wherever possible, the full range of perspectives on the success of the strategy should be sought, including the views of those who have engaged in suicidal behavior themselves, as well as those who have been bereaved by suicide. The collection and analysis of data from these various sources will involve qualitative and quantitative approaches.

The benefits of taking a program logic approach and using multiple data sources and methods to evaluate national strategies are manifold. First, this approach ensures that key stakeholders agree on what the strategy is trying to achieve and how it will get there. Second, it provides a framework for evaluating not only the strategy as a whole but also its component parts. And third, it provides a clear picture of the pathways by which the strategy's overarching goals will be achieved, providing early insights into structures and processes that might need to be re-addressed and strengthening the conclusions that can be drawn about causality, including the relationship between intermediate and ultimate primary outcomes.

LIVE LIFE

The elements of a strategic approach for suicide prevention (WHO, 2012) along with core effective interventions (WHO, 2014) are embodied by LIVE LIFE for preventing suicide. LIVE stands for leadership, interventions, vision, and evaluation and builds the pillars of LIFE – i.e. the core interventions, which are: less means (i.e. restricting access to means of suicide), interaction with the media for responsible reporting, the formation of the young in their life skills, and early identification, management and follow-up (Figure 1). LIVE LIFE establishes the key ingredients on which the formulation of a national suicide prevention strategy should be based. The components of LIVE LIFE are as follows:

Leadership. National governments are instrumental in providing leadership through the mobilization and coordination of multiple stakeholders, including governmental and non-governmental sectors, civil society, and communities. Governments are in a position to define a culturally adapted response through a national suicide prevention strategy which aims for a reduction in suicide and suicide attempts. Leadership is essential for conducting a situation analysis, raising awareness, and developing, adapting, and enacting policies across sectors relevant to suicide prevention, such as those on mental health, pesticides, and alcohol.

Intervention. The core effective evidence-based interventions for implementation are described in LIFE (see below). This also means providing services and care for persons in need, including suicide attempters and family, friends, and colleagues around them and after bereavement.

Vision. Having a vision is essential to keep steering towards the goal of reducing suicide and suicide attempts while overcoming changes and barriers. A vision is needed for financing and resource allocation as well as for identifying new funding opportunities and partnerships. A champion in suicide prevention may help drive the process forward. A vision is also important for introducing innovations and for creativity in testing new delivery platforms.

Evaluation. Strategies and interventions must be continuously monitored and evaluated to ensure that suicide prevention goals and objectives are met with interventions that have the desired impact. Monitoring and evaluation are assured by functioning and high-quality case registration and surveillance systems that allow for evaluation, provide feedback to inform improvements (including in effectiveness and efficiency), and are ultimately the cornerstone of research activities.

LIFE

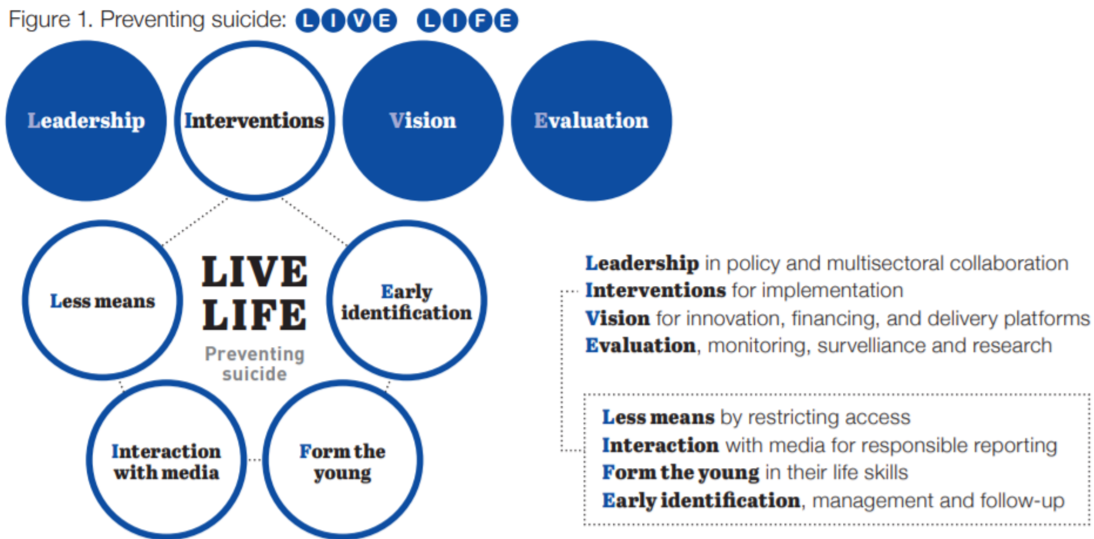
Less means. Restricting access to means (e.g. pesticides, firearms) is the key universal intervention for suicide prevention. Well-established surveillance systems are important to identify and target the most common means in a country or specific context.

Interaction with media. Responsible reporting by the media is an essential component of suicide prevention. Media professionals should not only refrain from the glamorized presentation of cases of suicide and thereby avoid imitation by vulnerable people but should also communicate stories of someone coping successfully, seeking and receiving help. In addition, the media can play a role in raising awareness about suicide, its prevention, and mental health more generally, as well as about stigma reduction.

Form the young. Enhancing young people's problem-solving, coping and life skills has been shown to be an effective intervention for suicide prevention among the

young. Corresponding sessions can be delivered through different platforms (e.g. school-based programs).

Early identification. Early identification, assessment, management, and follow-up ensure that people who may be at risk of suicide, or who have attempted suicide, receive the support and care that they need. Health-care systems need to incorporate suicide prevention as a core component, and health workers, including those at the community level, need to be trained and equipped to deliver these services. As vulnerable people are often at the heart of suicide prevention strategies, universal health coverage needs to ensure that all people are able to access care.



Box 2. National suicide prevention strategy success stories: Scotland

Over the past 17 years the Scottish Government, working in liaison with a range of partners – including the National Health Service, NHS Health Scotland, social services, Police Scotland and the third (voluntary and community organizations) – has prioritized efforts to reduce and prevent suicide through the Choose Life strategy and action plan (2002–2013) 1 and the Suicide prevention strategy (2013–2016).2 The Scottish Government's new Suicide Prevention Action

Plan Every life matters was published in August 2018, setting out ambitious actions for a major change in how services and communities respond to suicide.

Between 2002–2006 and 2013–2017 the Scottish suicide rate fell by 20%. Over much of the last
30 years the suicide rate in Scotland has been consistently lower than the average across the 53
countries of the WHO European Region. Key ingredients of success include:

- a 10-year national strategy and action plan (Choose Life), (partially) evaluated and refreshed, generating a sustained focus on suicide prevention actions and outcomes;
- a devolved government, with key national partners having ease of access to the suicide prevention policy team and Government ministers; and the creation of a new post of Minister for Mental Health in 2016;
- dedicated leadership and a common vision from the Scottish Government and national agencies, which have positively influenced suicide prevention action involving public and third-sector agencies at local government level;
- commitment to a broad public health approach to suicide prevention, combining population-based action and a focus on equity with interventions targeted at high-risk groups and individuals, incorporating but going beyond traditional (mental) health service responses;
- improvement of the capability of the health and social care system to respond effectively and compassionately to individuals in emotional distress/at risk of suicide, via the provision of training (STORM, ASIST, safeTALK, and Scottish Mental Health First Aid) and other learning materials;
- collaborative working across national agencies in gathering, analyzing, disseminating and acting on research and experiential evidence about what works in suicide prevention;
- raising awareness in the general population through agreed branding (Choose

Life), national campaigns, and national and local activities for Suicide Prevention Week;

- tackling problem drinking, especially through alcohol brief interventions delivered in primary care, accident, and emergency services and antenatal care settings, and increased attention to the identification and treatment of depression in primary care;
- improvements in local patient safety introduced on the basis of evidence developed by the United Kingdom-wide National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (in particular the work on discharge planning).

Elements that could be improved, or that remain to be achieved in the future include:

- further reach into communities in order to improve support to those in emotional distress/at risk of suicide and those with direct and indirect experience of suicide, via a range of channels, including face-to-face and digital technology;
- improvement of capacity and capability to deliver trauma-informed practice (which addresses the barriers often experienced by those affected by trauma when accessing the care, support and treatment they need to live a healthy life); and incorporation of this into new learning resources proposed under the recently published Action Plan;
- incorporation of suicide prevention action into local (community) planning and other strategic documents;
- improvement of the access of suicide prevention agencies to data (both real-time and historical) on the epidemiology and characteristics of suicidal behavior at local level;
- development of appropriate reviews/audits into all deaths by suicide (i.e. those occurring in the community as well those in-service settings) and ensuring that findings are shared and acted upon;

- undertaking more sophisticated evaluation studies in order to identify the essential components of complex national multilevel suicide prevention interventions such as Choose Life.

C. Barriers to implementing national suicide prevention strategies

Even with a well-designed suicide prevention strategy, barriers (see examples in Table 1) can arise that threaten its success and sustainability. Overcoming barriers is vital. Actions need to be well-defined and structured, taking into account the stakeholders involved, the resources available and the characteristics of the national and local contexts. Considering this in advance may help to avoid barriers and reduce their consequences.

Identifying barriers

Without the early identification of their potential setbacks or barriers, prevention strategies are likely to be harder to implement or will fail altogether. When planning the implementation of each strategic action, possible barriers should be considered and preparation should include additional strategies for addressing identified barriers.

Overcoming barriers

It is important to understand the factors that create a barrier in order to overcome or circumvent it. The problem generated by the barrier needs to be defined, discussed among stakeholders, and potential solutions need to be proposed. Once actions are taken to overcome a barrier, an assessment is needed of whether the problem was successfully resolved.

Table 1. Barriers to consider when implementing national suicide prevention strategies

Barrier	Description of the barrier	How to overcome the barrier
Management and logistics		
Understanding the problem	A poor understanding of suicide in the national or local context makes it difficult to develop clear goals and actions adjusted to the communities' needs.	Gain a thorough understanding of the problem by recording the means, number and rate of suicides and suicide attempts; identify relevant risk and protective factors and vulnerable groups; assess the health-care infrastructure and resources available for services and care; define the problem properly to allow for efficient implementation with adequate timelines and use of resources.
Actions and interventions	A poor description of actions and interventions – including, for instance, objectives, resources required, responsibility for implementation, and timeline – can leave the strategy disorganized and	Define clear objectives for each action and intervention, expected results, persons in charge of implementation, resources allocated, infrastructure, and timeline.

	ineffective.	
Stakeholders		
Leadership and management	Suicide-relevant stakeholders should be well versed in working with a wide range of government leaders with whom they may be involved. Absent or ineffective leadership, particularly leadership that is not accepted by stakeholders, can make it difficult to achieve goals.	Learn how to communicate and work with a range of stakeholders; adapt to contexts where there is frequent turnover in leadership; understand the traits of ineffective leadership, thus helping to avoid pitfalls and strengthen leadership abilities; government leadership with good management skills needs to be put in place.

Barrier	Description of the barrier	How to overcome the barrier
Teamwork and collaboration	Poor teamwork and lack of cohesion and collaboration result in following one's own interests or approaches, rather than working towards common	Clearly identify each stakeholder's role; establish channels of communication among different stakeholders; share information in a

	objectives in a unified manner.	timely manner and create synergies among different agents; these can serve to unite individuals for the joint achievement of the objectives; designate a national resource center for suicide prevention to provide briefings and reports and to engage internationally.
Legislation and policies	Legislation and policies that are not in line with suicide prevention efforts can hinder implementation.	Increase awareness about suicide and its prevention, helping to align legislation and policies with suicide prevention efforts.
Financial resources		
Budget for implementing the action plan	Lack of political support can result in a lack of funding. Inadequate estimation of funding required can hinder the full implementation of interventions.	Estimate the full cost of the interventions and monitor the funding as this can help to keep implementation sustainable over time; maintain a reserve fund as this can provide stability and reduce uncertainty; clearly demarcate the funding allocation because, without this, interventions are less

		likely to be implemented or evaluated.
Human resources		
Training	Health workers may not be prepared or competent to identify and manage suicidal behaviors. Additionally, the quality of care provided may be inadequate and inconsistent.	Train specialized and non-specialized health workers in the assessment and management of suicidal behaviors and mental, neurological and substance use disorders and ensure these workers meet competency requirements; involving health workers in the adaptation of the training to the local context can enhance motivation and the effectiveness of interventions; understand the context-specific factors which hinder the implementation of evidence-based interventions, thus enabling training to be modified so that staff can be prepared to manage such challenges.

Multisectoral involvement		
Restricting access to means	One of the key methods of suicide involves self-ingestion of pesticides; however, in many contexts, this remains unacknowledged and little or no action is taken.	Monitoring the use of pesticides in suicide or attempted suicide facilitates an understanding of the problem; engage regulatory bodies and relevant government sectors (e.g. agriculture) in the national regulation of access to pesticides.

Barrier	How to overcome the barrier	How to overcome the barrier
Responsible media reporting	Ongoing sensationalizing of suicide in the media.	Actively monitor media reports in order to intervene promptly if there are sensationalist articles; provide ongoing training and awareness sessions for media professionals; work with media regulatory bodies to manage the reporting of suicide;

		include the media in positive reporting (e.g. success or resilience stories and anti-stigma and awareness campaigns).
School-based interventions	Reluctance to address mental health among other topics at school; reluctance (of leaders, schools, or parents/caregivers) to discuss mental health issues, emotional distress, and suicidal behaviors with young people.	Work closely with the educational sector on the need for prevention activities and emotional and life-skills training, given the risk of suicide in younger age groups; provide gatekeeper training for teachers; provide awareness-raising and/or training for parent/caregiver representatives in the community; including young people in the design of any prevention program.
Access to services	Limited health or social care coverage reduces the ability to implement the interventions or follow-up needed for those who have attempted suicide, or for those bereaved by suicide.	Train community workers; establish self-help groups and peer support; explore digital platforms.
Continuity of care in the	Different services and	Promote follow-up, referral,

health-care system	health workers who are not linked and not in communication with each other cannot keep track of persons seeking help and therefore continuity of care may be interrupted.	exchange, meetings and joint training, which can strengthen the care provided; promote integration of services and multidisciplinary treatment as this can promote the continuity of care.
Data		
Data collection	Lack of data and information hinders prioritization and resource allocation by decision-makers. Inadequate data collection throughout the implementation process can lead to resources being wasted on ineffective interventions.	Establish and strengthen surveillance systems for suicide and suicide attempts; surveillance should be considered a core element of suicide prevention; monitor the effectiveness on primary outcomes with accurate data collection, enabling subsequent adjustments to enhance effectiveness.
Stigma		
Stigma	Persons who attempted suicide, their families, and those who are left behind after a suicide are all stigmatized. Stigma negatively influences the	Conducting awareness campaigns and providing information are important elements in fighting stigma, discrimination, and other inequities, such as the lack

	willingness to utilize health-care resources, it affects the quality of care provided by health-care workers, and it may have an impact on the effectiveness of national strategies, if not addressed.	of access to care associated with suicidal behaviors.

Box 3. National suicide prevention strategy success stories: Sweden

In 2008, the Swedish parliament decided on a National Action Program for Suicide Prevention, the "Vision Zero Policy". The vision of the program is that no one should be in a situation of such vulnerability that suicide is seen as the only way out.

The first national suicide preventive program in Sweden, described in the report Support in suicidal crisis was established in 1995 by the Swedish National Council for Suicide Prevention, guided by the National Institute of Public Health, the Swedish National Board of Health and Welfare and the National Centre for Suicide Research and Prevention of Mental Ill-Health (NASP). This program was never presented to the Swedish parliament for ratification, and this fact could be seen as a drawback for implementation since the preventive activities had to rely on the goodwill of public authorities and various organizations and individuals.

The second national suicide preventive program was created by the National Institute of Public Health (now called the Public Health Agency of Sweden) and the National Board of Health and Welfare with the support of experts from NASP. This program was ratified by the Swedish Parliament in 2008 and put in force by the Swedish Government which announced the Vision Zero policy for suicide. The policy sends a

strong signal to the whole population that the topic is important and, for the first time, suicidal persons and their families felt that priority was finally being given to them.

Parliamentary ratification not only gave legal status to the national action program for suicide prevention but also contributed to the implementation of the following nine areas of action:

1. Promote good life opportunities for less privileged groups
2. Reduce alcohol consumption in the population and in groups at high risk for suicide
3. Reduce access to means and methods of suicide
4. View suicide as a psychological mistake
5. Improve medical, psychological and psychosocial initiatives
6. Distribute knowledge about evidence-based methods for reducing suicide
7. Raise skill levels among staff and other key individuals in the care services
8. Perform “root cause” or event analyses after a suicide
9. Support voluntary organizations

The Public Health Agency of Sweden received a mandate from the government in 2015 to
coordinate suicide prevention at a national level. Accordingly, the agency developed the
coordination and cooperation between relevant government agencies and stakeholders in order
to monitor the implementation of suicide prevention activities throughout the country.

Since it was approved, the second national suicide prevention program has been a success in terms of increased awareness within Swedish society and among bodies in the health-care and public mental health systems. Because of the increased awareness in society, attitudes to suicidal persons have changed. When the stigma

surrounding suicide is lifted, it becomes less of a taboo subject. There is a deeper understanding of the risk factors that prompt suicidal behaviors and how they can be reduced by social, medical/psychiatric, and psychological measures.

Moreover, there is a greater understanding of protective factors which help individuals cope with suicidal behaviors and improve their mental health. Subsequently, over time, the view that suicidal behaviors are impossible to prevent and treat has diminished. The idea that most suicidal acts arise in situations in which life is unbearable and everything seems out of the individual's control is emphasized, as opposed to the view that suicidal acts represent control over one's life situation and freedom.

Similarly, a Vision Zero policy was introduced for road accidents in Sweden in 1997. This led to increased public awareness and a substantial increase in funding for the relevant parties. Road safety improvements and changes to the traffic laws resulted in a 50% reduction in deaths due to motor vehicle accidents over a 20-year time period. It is hoped that the Vision Zero policy for suicide will have a similar effect.

Following the ratification of the Vision Zero policy for suicide, financial resources were provided for some time-limited projects. However, financial support to the Vision Zero policy for suicide has been greatly insufficient compared to the Vision Zero policy for traffic accidents. More funding is needed for permanent activities. To ensure that the best possible prevention and treatment are provided, there needs to be an increase in adequately trained human resources in the health-care and public mental health systems, backed by continuous development and dissemination of evidence-based methods which reduce suicidal behaviors. The Vision Zero policy may sometimes be misinterpreted. However, this policy does not mean that suicide is forbidden. The policy's goal is to ensure that everybody does everything within their power to provide the best prevention, care, treatment, and rehabilitation to at-risk and suicidal persons. This should be feasible as research shows that suicidal behaviors are preventable.

D. Country examples

In recent decades, and particularly since 2000, many national suicide prevention strategies have been developed. As of 2017, almost 40 countries were known to have a stand-alone national strategy that had been adopted by the government (WHO, 2018c), demonstrating commitment to suicide prevention. The number of national strategies is increasing steadily. Close to 10% of low-income and lower-middle-income countries have a national strategy, while approximately one-third of upper-middle-income and high-income countries report having such a strategy. In addition, some countries have a national suicide prevention framework, national programs for specific subpopulations, or the integration of suicide prevention into national plans for mental health or other health areas (WHO, 2018c).

This section aims to provide examples of national suicide prevention strategies in order to help countries that are in the process of developing or revising their own strategy. The descriptions and indicators below have not been subject to peer review; rather, they are intended to provide examples across a range of geographical regions. The country examples have been summarized directly from the national strategy documents and indicators to which they pertain. In total, 10 country examples are described (Table 2). Sociodemographic information and suicide estimates by country can be found in the country profiles of the Mental health atlas 2017 and WHO's suicide prevention webpages.

The country examples are structured in several sections: first, the context for suicide prevention is provided; second, the key components of the strategy, such as the vision, mission, time frame, annual budget, goals, objectives and guiding principles are presented; and, third, the implementation of the strategy and its monitoring/evaluation are described.

The vision that the strategies have in common is usually less or no suicide (e.g. a country free of suicide) and/or improved mental health and well-being.

Among the typical components that can be found in national suicide prevention strategies are means restriction, responsible media reporting, access to services, treatment, crisis intervention, training, postvention, surveillance, awareness raising, stigma reduction, and oversight and coordination (WHO, 2014), all of which should reflect universal, selective and indicated interventions.

Table 2. Overview of country examples

1. Bhutan (South-East Asia Region)	**6. Namibia (African Region)**
2. Guyana (Region of the Americas)	**7. Republic of Korea (Western Pacific Region)**
3. Iran, Islamic Republic of (Eastern Mediterranean Region)	**8. Switzerland (European Region)**
4. Ireland (European Region)	**9. USA (Region of the Americas)**
5. Japan (Western Pacific Region)	**10. Uruguay (Region of the Americas)**

Example 1. Bhutan (South-East Asia Region)

The following information was summarized from the National Suicide Prevention Strategy of the Royal Government of Bhutan, called “Suicide prevention in Bhutan”. For further details and references please refer to the original source.
Source: http://www.mindbank.info/item/6176

Context for suicide prevention

Before the three-year action plan was formulated in 2015 by the Royal Government of Bhutan, there had been no stand-alone comprehensive suicide prevention program in Bhutan. However, some forms of integrated services were available through primary care mental health services, domestic violence prevention and de-addiction strategies for alcohol and drugs. Mental health screening or suicide risk identification was not routine practice and most rehabilitation services were concentrated in a few districts. Consequently, many people were unable to access crucial resources.

Key components of the strategy

Vision	A nation with zero deaths by suicide
Mission	Promoting, coordinating and supporting appropriate intersectoral action plans and programs for the prevention of suicidal behaviors at national, dzongkhags (district), gewogs (group of villages) and community levels
Time frame	2015–2018
Annual budget	BTN 9.6 million

Goal	Preventing premature deaths due to suicide across the lifespan, among the Bhutanese population.

Objectives

Specific objectives

1. Improving leadership, multisectoral engagement, and partnerships for suicide prevention in these communities.

2. Strengthening governance and institutional arrangements to effectively implement comprehensive suicide prevention plans.
3. Improving access to suicide prevention services and support for individuals in psychosocial crisis and those most at risk for suicide (including those with suicidal ideation, history of self-harm or a non-fatal suicide attempt).
4. Improving the capacity of health services and gatekeepers to provide suicide prevention services.
5. Improving community resilience and societal support for suicide prevention in communities, including schools and institutions.
6. Improving data, evidence, and information for suicide prevention planning, and programming.

Guiding principles

- Suicide prevention is to be a broad and coordinated system working with a wide range of partners, organizations, and sectors, including people who have been affected by suicide.
- Suicide prevention will address a wide range of factors related to suicidal behavior, including social support, mental illness, substance abuse, economic factors, and community and personal risk and resilience.
- Suicide prevention will be a comprehensive targeting of the population, building supportive community systems, and focusing on individual-level risks for suicide.
- Suicide prevention will employ a combination of public health and individual clinical approaches focusing on risk identification and the provision of individually tailored services.

Strategies

The action plan proposes three levels of interventions: universal suicide prevention strategies, designed to reach an entire population; selected suicide prevention strategies, specifically targeting vulnerable individuals within the population; and indicated suicide prevention strategies, targeting those who have engaged in non-fatal suicidal behavior or are left behind.

Universal strategies: promoting responsible media reporting on suicide; religious beliefs and cultural practices; schools providing parenting education and awareness programs, guidance counselors, etc.; mental health services by training of health workforce, the infrastructure of the hospitals and psychiatric wards, etc.; and means restriction, limiting the availability and supply of pesticides.

Selective strategies: for vulnerable women and children; addiction and substance abuse prevention, established programs, drop-in centers, outreach centers, rehabilitation services; community resilience and support programs; and counseling, such as peer counsellors, health and social counsellors.

Indicated strategies: access to services and care for individuals at higher risk of suicide such as crisis helplines, health information services, etc.; survivor postvention services that include reducing further risk of suicidal behavior, prevent suicide contagion by identifying other members at high risk of suicide etc.; and referral services and standardization of health services.

Implementation

The Government of Bhutan recognized that the action plan had to be realistic and implemented it through a financially sustainable model. Each activity was graded on a 10-point scale in five domains – effectiveness, cost, feasibility, public health benefits and cultural acceptability of the action – in order to ensure an effective cross-sectoral implementation and governance. A Suicide Prevention Steering Committee was established, comprising Ministry of Health representatives and other key stakeholders to advise on the national suicide prevention response. The committee meets every six months and its main function is to provide thrust to the multisectoral response in suicide prevention.

Implementation of the suicide prevention workplans was designed to take place in the dzonkhakgs (districts) and local governments, ensuring that suicide prevention activities

were embedded within the Government Performance Management System. The Dzongdag Suicide Prevention Response Team is composed of appropriate representatives of relevant agencies with the Royal Bhutan Police (RBP) and health representatives, is also established in all 20 dzongkhags (districts). The team's key function is to ensure effective rescue responses to suicide attempts and deliberate self-harm incidents occurring in communities.

Monitoring and evaluation

The monitoring and evaluation are conducted under the direction of the Suicide Prevention Steering Committee. The Committee and the Ministry of Health are responsible for evaluation and management, including the appointing of teams and coordination during the field work.

The monitoring and evaluation framework follows a set of input and output indicators to show accomplishments or progress in the strategy (Annex 2.1). The implementing partners will submit six-monthly implementation reports, using standard reporting forms. The overall trend of the suicide reduction will be monitored through national data on suicide collected through the national registry for suicide and deliberate self-harm. Finally, an annual progress report will be published.

Example 2. Guyana (Region of the Americas)

The following information was summarized from the National Suicide Prevention Strategy of the government of Guyana, called the "National Suicide Prevention Plan: A National Suicide Prevention Strategy for Guyana". For further details and references please refer to the original source.
Source: https://www.mindbank.info/item/6321

Context for suicide prevention
Guyana is facing high suicide rates, and conclusions from situation analyses have indicated that there were not enough primary health care centers with adequately trained personnel. Moreover, similar gaps existed in other sectors. The media, for instance, presented sensationalized reports on cases of suicide and suicide attempts, potentially enhancing the "copycat" phenomenon. Also, the quality of data on suicide attempts and suicide was depicted as poor. To tackle these challenges, a National Suicide Prevention Plan was developed in 2014.

Key components of the strategy

Vision	Improving and contributing to the mental and social well-being of all peoples in Guyana
Mission	Addressing the health determinants and constraints in the health system to achieve mental health for all in Guyana, which reflects the experience gained in the country and expresses the government's commitment to the establishment of priorities and management to prevent and control suicide in Guyana
Time frame	2015–2020
Annual budget	The health budget is GYD 23 455 957 000; of this, the mental health budget was GYD 105 550 000 in 2018

Goal	To reduce the incidence of suicide mortality and attempted suicide (by 20%), thereby preventing premature death from suicide or disability from attempted suicide, across the life span from 2015–2020.

Objectives

General objectives

1. To promote a healthy lifestyle and implement culturally-sensitive approaches, to reduce the risk of suicidal behavior, especially in high-risk groups.
2. To reduce the availability, accessibility, and attractiveness of the means to suicide (e.g. pesticides, medications, firearms).
3. To develop multidisciplinary effective interventions and actions to prevent suicidal behavior and implement new initiatives to help those affected by suicide.
4. To promote the use of mental health services and services for the prevention of substance abuse and suicide.
5. To promote the quality and timeliness of national data on suicide and suicide attempts and support the establishment of an integrated data collection system.

Strategies

1. Risk factor reduction, health promotion and prevention to develop comprehensive interventions for the promotion of healthy lifestyles and prevention of suicidal behavior, especially in high-risk groups.

Specific objectives:

- Provide evidence-based information about the magnitude, risks and consequences of suicidal behavior.

- Promote healthy lifestyles within the general population including the reduction of substance abuse and alcohol intake as a component of suicide prevention.
- Communication through a specialized social communication strategy focused on suicidal behavior.
- Reduce the risk of suicide in key high-risk groups.

2. Reduce access to the means of suicide: Develop interventions to reduce access to means of suicide.

Specific objectives:

- Restrict access to means of self-harm/suicide.
- Reduce the number of suicides as a result of self-poisoning.
- Reduce the number of suicides as a result of the overdose of medications.
- Reduce the number of suicides as a result of hanging and strangulation.
- Reduce the number of suicides at high-risk locations.
- Reduce the number of suicides occurring on the road.
- Response to new methods of suicide.

3. Health system response to suicidal behavior: Improve the quality of health services to treat and manage people with mental disorders.

Specific objectives:

- Improve the capacity and quality of the health system response.
- Increase access to the management and interventions for treatment, control, and rehabilitation of persons who attempted suicide.
- Strengthen human resources in the health system and communities to provide care, treatment, and support in cases of suicidal behavior.
- Train gatekeepers to identify individuals at risk, the level of risk, and how to refer at-risk individuals for treatment.

- Mobilize communities and develop interventions to address the factors that influence suicide risks (trauma or abuse, discrimination, and relationship conflict).
- Develop interventions to support survivors.

4. Suicide Surveillance and Research: Improving data collection on the incidence of suicidal behavior, research, and evaluation of effective interventions.

Specific objectives:

- Improve case registration.
- Conduct researches on suicidal behavior.

Implementation

A situation analysis was conducted in order to assess the severity of the problem, resources available and community needs. The development of the action plan took into consideration governance, roles and responsibilities within the Ministry of Public Health, as well as with potential partners. Key stakeholders were made responsible for specific tasks and ways to coordinate these effectively among themselves. The action plan provides leadership and clarity on the main evidence-based suicide prevention interventions and their prioritization. Much is carried out locally, adjusted to local circumstances and building on existing initiatives. The establishment of health and well-being boards supports the setting up of effective local partnerships and helps in the development of creative ways to utilize local resources and assets.

Monitoring and evaluation

Evaluation of the components of the national strategy examines the outcome and impact of interventions vis-à-vis the stated objectives. The monitoring and evaluation plan was planned and agreed upon in advance to ensure the involvement of all relevant stakeholders. The evaluation has a set of specific, measurable, achievable, relevant

and time-bound indicators which can measure the input, process, impact and outcome of individual interventions as well as of the strategy as a whole (Annex 2.2).

The main objectives of the evaluation component of this plan are:

- monitoring the incidence and prevalence of suicidal behavior in the 10 regions of the country, ascertaining and recording the number of attempted suicides and suicides;
- evaluating the catchment, recording and processing of data collected in all levels of the surveillance system through the review of documents and procedures;
- evaluating the management and treatment of suicidal behavior in all levels of the health system (emergency, inpatient and outpatient services, mental health services, communities) and assessing the quality and effectiveness of interventions.

Example 3. Iran, Islamic Republic of (Eastern Mediterranean Region)

The following information was summarized from the National Suicide Prevention Strategy of the Government of the Islamic Republic of Iran, called “National suicide prevention and suicide registration programs”. For further details and references please refer to the original source.
Source: Strategy document shared by WHO Collaborating Centre, Tehran, Islamic Republic of Iran.

Context for suicide prevention
Over the last decade and a half, the Islamic Republic of Iran has implemented a pilot suicide prevention program based on the early identification and treatment of depression in a region called Khoramabad, with successful results. In 2009, the program was piloted in two districts and the rate of suicide was significantly reduced. Based on this, in 2010 a national suicide prevention program was released for implementation in the public health-care system in the Islamic Republic of Iran.

Key components of the strategy

Vision	[not available]
Mission	[not available]
Time frame	2010- [not available]
Annual budget	[not available]

Goal	Reducing suicidal behaviors in populations covered by the primary health care systems.

Objectives

Specific objectives:

1. Improve the accuracy of statistics of suicide and suicide attempts (non-fatal self-harm).
2. Reduce stigma relating to suicidal behavior and mental health, and increase awareness of suicide, attempted suicide, and improve positive mental health promotion.
3. Improve accessibility and consistency in care pathways for the assessment and management of people vulnerable to suicidal behavior.
4. Enhance engagement and collaboration with the media in relation to media guidelines, training and adherence to improve the reporting of suicidal behavior and to disseminate information on positive mental health promotion.
5. Reduce access to frequently used and highly lethal methods of suicide and attempted suicide (non-fatal self-harm), including pesticides and frequently-used drugs, and to address other highly lethal methods such as hanging and self-immolation.
6. Improve and maintain the response to suicidal behavior within the health and community-based services and ensure continuity of care.
7. Improve and maintain the capacity of suicide bereavement support services and specialist interventions for people with prolonged and complicated grief.
8. Reduce the stigma of mental disorders and promote help-seeking behaviors in students.
9. Develop a national monitoring and evaluation system, promote relevant research that supports national innovation, promote the suicide prevention program, and address knowledge gaps.

Strategies

Service strategies: inclusion of suicide prevention programs in the health-care system; reinforcing the referral system by training the staff and gatekeepers; reinforcing the support and treatment services, and providing counseling services in the community.

Research strategies: epidemiologic evaluation of national suicide status; etiological study of suicide in the Islamic Republic of Iran; evaluation of incidence and etiology of suicide; evaluation of the effects of each intervention; evaluation of knowledge and attitude of health-care personnel and of the public towards suicide.

Research strategies: epidemiologic evaluation of national suicide status; etiological study of suicide in the Islamic Republic of Iran; evaluation of incidence and etiology of suicide; evaluation of the effects of each intervention; evaluation of knowledge and attitude of health-care personnel and of the public towards suicide.

Action areas (separated by population level, community level, health systems and services)

- legal status of suicide and attempted suicide;
- registration of suicide and attempted suicide;
- awareness and stigma reduction;
- treatment;
- the media;
- restriction of access to means;
- crisis intervention;
- suicide bereavement/postvention;
- mental health promotion among young people.

Implementation

The first year of implementing the national prevention program was 2010. The action plan adopted across-sectoral approach, with the Ministry of Health being the lead interlocutor but working in collaboration with other relevant government departments

and stakeholders. The implementation of the action plan was divided into three levels: population level, community level, and health systems and services level.

Monitoring and evaluation

For the monitoring of the implementation of the national action plan, both processes and outcomes were evaluated. Alongside the process evaluations, the quality of the implementation of the actions were assessed, the progress of the implementation of actions monitored, and the outcomes measured to help determine whether the strategic actions produced the changes they intended to achieve (Annex 2.3).

Example 4. Ireland (European Region)

The following information is summarized from the government strategy called "Connecting for Life: Ireland`s National Strategy to Reduce Suicide 2015–2020". For further details and references please refer to the original source.
Source: http://www.mindbank.info/item/5640

Context for suicide prevention

Suicide prevention in Ireland was guided by "Reach Out", the first national suicide prevention strategy 2005–2014. This strategy brought a focus on suicide prevention work and guided activities in this area. Reach Out set out a vision and guiding principles for suicide prevention. During that period, 96 actions and identified lead agencies were outlined. Since Reach Out, there have been significant developments in the areas of research, policy, and service delivery relating to suicide prevention. The new strategy 2015-2020 Connecting for Life is very much based on Reach Out.

Key components of the strategy

Vision	An Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and well-being
Mission	[not available]
Time frame	2015-2020
Annual budget	US$ 13 073 535 in 2016

Goal	Reducing suicide and suicide attempts rate in the whole population and among specified priority groups.

Objectives

1. Improving the nation's understanding of, and attitudes to, suicidal behavior, mental health, and well-being: The language relating to suicide and mental health is often stigmatizing or misleading. By working with people and organizations across society, including the media, a greater understanding of suicide can be achieved and stigma reduced.

Specific objectives:

- Improving population-wide understanding of suicidal behavior, mental health and well-being, and associated risk and protective factors.
- Increasing awareness of available suicide prevention and mental health services.
- Reducing stigmatizing attitudes to mental health and suicidal behavior at the population level and within priority groups.
- Engaging and working collaboratively with the media in relation to media guidelines, tools, and training programs to improve the reporting of suicidal behavior within a broadcast, print, and online media.

2. Supporting local communities' capacity to prevent and respond to suicidal behavior: Well-structured and coordinated community-based initiatives can translate into protective benefits for families and individuals, which contribute to a reduced risk of suicidal behavior.

Specific objectives:

- Improving the continuation of community-level responses to suicide through planned, multi-agency approaches.

- Ensuring that accurate information and guidance on effective suicide prevention are provided for community-based organizations (e.g. family resource centers, sporting organizations).
- Ensuring the provision and delivery of training and education programs on suicide prevention to community-based organizations.

3. Targeting approaches to reduce suicidal behavior and improve mental health among priority groups: Considering young people aged 15–24 years, people with mental health problems of all ages, persons with alcohol and drug problems, the bereaved, prisoners and suicide, sex workers, people with chronic illness or disability, etc.

Specific objectives:

- Improving the implementation of effective approaches for reducing suicidal behavior among priority groups.
- Supporting, in relation to suicide prevention, the Substance Misuse Strategy, to address the high rate of alcohol and drug misuse.
- Enhancing supports for young people with mental health problems or vulnerable to suicide.

4. Enhancing accessibility, consistency and care pathways of services for people vulnerable to suicidal behavior: guaranteeing a sustained approach to preventing and reducing suicide, easy access to services, integrating care pathways across both statutory and non-statutory services.

Specific objectives:

- Improving psychosocial and psychiatric assessment and care pathways for people vulnerable to suicidal behavior.
- Improving access to effective therapeutic interventions (e.g. counselling, dialectical behavior therapy, cognitive behavioral therapy) for people vulnerable to suicide.

- Improving the uniformity, effectiveness and timeliness of support services to families and communities bereaved by suicide.

5. Ensuring safe and high-quality services for people vulnerable to suicide: agencies need to have good-practice guidelines, clear care protocols, and appropriate training and supervision mechanisms. All services must promote an ambition for recovery, restoring the individual's independence built on self-worth and self-belief.

   Specific objectives:
   - Develop and implement national standards and guidelines for statutory and non-statutory organizations contributing to suicide prevention.
   - Improve the response to suicidal behavior within health and social care services, with an initial focus on incidents with mental health services. Reduce and prevent suicidal behavior in the criminal justice system.
   - Ensure best practice among health and social care practitioners through the implementation of clinical guidelines on self-harm and the delivery of accredited education programs on suicide prevention.

6. Reducing and restricting access to means of suicidal behavior: implementation of strategies to restrict means can occur at the national level, via legislation and regulations, and at the local level.

   Specific objectives:
   - Reducing access to frequently used drugs in intentional drug overdose.
   - Reducing access to highly lethal methods used in suicidal behavior.

7. Improving surveillance, evaluation and high-quality research relating to suicidal behavior: having real-time and better-integrated data surveillance systems for

suicidal behavior as well as accelerating the transfer of research findings into practice.

Specific objectives:

- Evaluating the effectiveness and cost-effectiveness of Connecting for Life.
- Improving access to timely and high-quality data on suicide and self-harm.
- Reviewing (and, if necessary, revising) current recording procedures for death by suicide.
- Developing a national research and evaluation plan that supports innovation aimed at early identification of suicide risk, assessment, intervention and prevention.

Guiding principles:

- collaborative: achieve together to deliver our goals;
- accountable: clear governance structures and openness in implementing the strategy;
- responsive: providing high-quality service responses;
- evidence-informed and outcome focused: action targeted to identify need and based on international best-practice recommendations;
- adaptive to change: responsive to new and emerging circumstances.

Implementation

In order to develop and implement the strategy, five supporting advisory groups were appointed, covering the areas of research, policy, practice, engagement and communications/media. The strategy was developed through an evidence-based approach and its implementation was based on knowledge of the best practice in terms of policy and services.

For an effective implementation, four incremental stages were created, each requiring different conditions and activities. These were: exploring and preparing, planning and

resourcing, implementing and operationalizing, and full implementation. Multiple evidence-informed interventions were included throughout the strategy. Communication and resource plans were formulated to support the implementation of the strategy.

Connecting for Life depends fundamentally on coordination across government departments and agencies. Formal accountability, budgetary management, capacity development and evaluation structures, with clearly delineated roles and responsibilities, are central requirements for effective implementation. For government strategies with a relatively short time frame, having solid implementation structures in place facilitates monitoring of activities and puts a clear decision-making process in place, thus avoiding decisions being made hastily without clarifying accountability and implications. Five key implementation structures for Connecting for Life represent the different stakeholder groups involved in delivery and provide forums for engagement, facilitate monitoring and clear decision-making, and are designed to make the best use of existing structures to ensure efficient working.

Monitoring and evaluation

Monitoring and evaluation are embedded in the implementation process, with an accompanying outcomes framework in place to allow progress to be tracked and the impact of the strategy to be measured objectively against baseline indicators (Annex 2.4). These indicators measure principal outcomes to assess the achievement of the main goals, and intermediate outcomes to provide preliminary evidence of the effectiveness of the suicide prevention strategy in the shorter term. In addition to the measurement of principal and intermediate outcomes, evaluation of this strategy will include assessment of process variables. This involves assessment of the activities undertaken and of the causal pathways from inputs and activities to outcomes.

Example 5. Japan (Western Pacific Region)

The following information is summarized from a translation of the 2017 Japanese Cabinet Decision called "The general principles of suicide prevention policy: realizing a society in which no one is driven to take their own life". For further details and references please refer to the original source.
Source: http://www.mindbank.info/item/6766

Context for suicide prevention

Suicide began to be viewed as a social problem in Japan around 2005 and this triggered concrete actions. In the symposium on suicide countermeasures held in May 2005, NGOs and some members of the Diet submitted urgent proposals for comprehensive suicide prevention and the Minister of Health, Labour and Welfare vowed to tackle the issue of suicide. Subsequently, Japan's Basic Act for Suicide Prevention was signed into law in June 2006. Following this, the driving force for suicide prevention shifted from the Ministry of Health, Labour and Welfare to the Cabinet Office, and suicide prevention became a multi-ministerial government policy. In 2007, the General principles of suicide prevention policy were enacted, aiming to prevent suicide and provide support to survivors. In 2012 these general principles were revised to emphasize support for young people and for those who had previously attempted suicide.

Key components of the strategy

Vision	Achieving a society in which no one is driven to take their own life.
Mission	Promoting suicide countermeasures as comprehensive support for people's lives; strengthening coordination, with related measures to deal with suicide comprehensively; interconnecting policies and measures at each level tailored to the stage of response; promoting awareness-raising and practical initiatives in parallel to each other; identifying the roles of the national government, local public entities,

	related organizations, private-sector entities, businesses and the people in Japan and promoting cooperation and coordination among them
Time frame	2016–2020
Annual budget	US$ 27.58 million (JPY 3.1 billion)

Goal	Reducing the suicide rate by 2026 to more than 30% below the 2015 level.

Objectives

1. Strengthening support for practical initiatives at the community level: promoting preventive measures based on the contextual conditions of suicide by encouraging research and studies in order to understand the circumstances such as social factors.

   Specific objectives:

   - Preparing profiles of actual local suicide conditions.
   - Preparing policy packages of local suicide countermeasures.
   - Supporting the formulation, etc., of local plans for suicide countermeasures.
   - Drawing up guidelines for formulating local plans for suicide countermeasures.
   - Assisting local support centers for suicide countermeasures.
   - Promoting the establishment of full-time departments for suicide countermeasures and the assignment of full-time staff to them.

2. Encouraging every citizen to be aware of and to monitor potential suicide victims: promoting public awareness.

   Specific objectives:

- Enacting Suicide Prevention Week and Suicide Countermeasures Strengthening Month.
- Implementing education that will contribute to suicide countermeasures among primary and secondary schools.
- Disseminating accurate information about suicide and suicide-related phenomena.
- Promoting public awareness campaigns about depression.

3. Promoting research and studies that will contribute to the promotion of comprehensive suicide countermeasures.

   Specific objectives:

   - Research, studies and verification related to the actual suicide conditions and the state of implementation of suicide countermeasures, etc.
   - Making use of the results of research, studies and verification.
   - Collecting, organizing and providing information on progressive local approaches.
   - Studying suicide among children and young people.
   - Shedding light on actual suicide conditions in conjunction with the system to investigate cause of death.
   - Conducting interdisciplinary research to clarify the pathology of depression and other forms of mental illness, to develop methods of treatment and to make ongoing improvements to community-based care systems;
   - Expediting the use and application of existing data.

4. Recruiting, training and improving the quality of personnel engaged in suicide countermeasures.

   Specific objectives:

   - Providing early detection of and early response to those at high risk for suicide.

- Promoting education about suicide countermeasures in coordination with universities and special vocational schools.
- Training personnel in charge of coordinating suicide countermeasures.
- Improving the skills of family doctors and other primary care providers to evaluate and respond to suicide risks.
- Awareness-raising for school staff.
- Improving the quality of care provided by community health staff and occupational health staff.
- Providing training for long-term care support specialists and others.
- Providing training for district welfare commissioners, commissioned child welfare volunteers and others.
- Improving the quality of counsellors with reference to social factors.
- Improving the quality of personnel at public agencies who deal with bereaved family members and others.
- Training gatekeepers in various fields.
- Promoting mental health care for persons engaged in suicide countermeasures.
- Assisting those who provide support, including family and friends.
- Developing training materials.

5. Advancing the promotion of mental health and providing a supportive environment for it.

    Specific objectives:

    - Promoting mental health measures in the workplace.
    - Improving the system for furthering mental health promotion in the community.
    - Improving the system for furthering mental health promotion in the schools.

- Promoting mental care for, and rebuilding the lives of, victims of large-scale disasters.

6. Ensuring that the appropriate mental health, medical care and welfare services are received.

    Specific objectives:

    - Improving the interconnectedness of each program, psychiatric care, health care, welfare, etc.
    - Enhancing the psychiatric care system by training personnel responsible for mental health, medical care and welfare services.
    - Assigning specialists to increase the interconnectedness of mental health, medical care and welfare services.
    - Improving the skills of family doctors and other primary care providers to evaluate and respond to suicide risk.
    - Improving the system to provide mental health, medical care and welfare services to children.
    - Implementing screening for depression and other mental illnesses.
    - Promoting measures for those at high risk for psychiatric illnesses other than depression.
    - Supporting cancer patients and the chronically ill.

7. Lowering the risk of suicide in society as a whole.

    Specific objectives:

    - Extending a helping hand of social support.
    - Improving counselling systems in the community and transmitting easily understandable information on support policies, counselling services, etc.
    - Improving counselling services related to multiple debts and increasing safety-net loans.
    - Improving counselling services for the unemployed.
    - Implementing counselling programs for business owners.

- Improving the provision of information to resolve legal problems.
- Regulating dangerous places, drugs, etc.
- Strengthening suicide countermeasures that make use of information and communications technology (ICT).
- Promoting measures to deal with suicide-related information on the Internet.
- Dealing with suicide notices on the Internet.
- Improving support for caregivers.
- Improving support for hikikomori (social recluses).
- Improving support for victims of child abuse, sex crimes and sexual violence.
- Improving support for the poor and needy.
- Improving counselling services for single-parent families.
- Improving support for expectant and nursing mothers.
- Improving support for sexual minorities.
- Strengthening outreach and ensuring a diversity of counselling methods.
- Making well-known information-sharing mechanisms necessary for coordination between related organizations.
- Promoting the creation of places to go to that contribute to suicide countermeasures.
- Making the WHO guidelines known to the news media.

8. Preventing repeated suicide attempts.

Specific objectives:

- Strengthening measures to prevent repeat suicide attempts.
- Equipping medical facilities that are responsible for the core functions of supporting individuals in the community who have survived a suicide attempt.

- Upgrading the medical care system provided by psychiatrists at emergency medical facilities.
- Strengthening comprehensive support for those who have attempted suicide by promoting coordination between medical care and the community.
- Providing support through interconnectedness with measures to create places to go to.
- Providing assistance to family members and other close supporters.
- Encouraging a post-crisis response in schools and workplaces.

9. Improving support for the bereaved.

    Specific objectives:

    - Providing care for the bereaved immediately after a suicide or attempted suicide in the family.
    - Supporting the operations of self-help groups for the bereaved.
    - Encouraging a post-crisis response in schools and workplaces.
    - Promoting the provision of information to the bereaved.
    - Improving the quality of personnel at public agencies who deal with bereaved family members and others.
    - Supporting bereaved children.

10. Strengthening coordination with private-sector entities.

    Specific objectives:

    - Promoting suicide prevention measures.
    - Supporting human resource development at private-sector entities.
    - Establishing a community coordination system.
    - Supporting counselling programs by private-sector entities.

- Supporting pioneering and experimental approaches by private-sector entities as well as their efforts in places where multiple suicides have occurred.

11. Promoting suicide countermeasures among children and young people even further.

    Specific objectives:
    - Preventing suicide in children who are victims of bullying.
    - Improving support for elementary school children and junior and senior high school students.
    - Promoting instruction on how to raise an SOS.
    - Improving support for children.
    - Improving support for young people.
    - Improving support for young people tailored to their special traits.
    - Supporting their friends and acquaintances.

12. Promoting suicide countermeasures for work-related problems even further.

    Specific objectives:
    - Rectifying the practice of long working hours.
    - Promoting mental health measures in the workplace.
    - Measures to prevent harassment.

Goals

- Promote systems at the national level: encourage and support measures carried out by the relevant ministries and agencies to implement comprehensive suicide prevention measures, and establish a mechanism under which the national government, local authorities, related organizations, NGOs and others coordinate and cooperate so that suicide prevention measures can be promoted by the nation as a whole.

- Ensure coordination and cooperation at community level: work actively to promote the setting up of a forum to study measures formulated by committees, composed of relevant groups and agencies in various fields in the prefectures and designated cities, and the planning of such community measures by the said committees, offering appropriate support by providing information, etc.

- Policy evaluation and management: The Council on Suicide Prevention Policy shall review and improve policies on the basis of its evaluation, including verification of the implementation status of policies based on the General Principles and the establishment of new mechanisms to assess the policies' effectiveness.

- Review of the General principles of suicide prevention policy every five years, based on socioeconomic changes, in the circumstances surrounding suicide, the progress made in implementing policies, the status of achieving the policies' goals, etc.

Implementation

Identifying the roles of the national government, local public entities, related organizations, private-sector entities, businesses and the people of Japan, and promoting cooperation and coordination between them.

Monitoring and evaluation

The Japan Support Center for Suicide Countermeasures put suicide countermeasures into practice through encouragement of research into the policy-making process at each step of the planning cycle.

Example 6. Namibia (African Region)

The following information is summarized from the 2011 strategic plan of the Namibian Ministry of Health and Social Services, called "National Strategic Plan on the Prevention of Suicide in Namibia 2012–2016". For further details and references please refer to the original source. Source: https://www.mindbank.info/item/6272

Context for suicide prevention

Before the strategy was implemented, a national SWOT analysis revealed that Namibia was struggling with a lack of qualifications and infrastructure, as well as high levels of stigmatization and governmental fragmentation. This analysis was the core information that guided Namibia to address the problem of suicide and its prevention. Namibia was the first country in the African region to introduce a national suicide prevention strategy. With the introduction of the National Strategic Plan on the Prevention of Suicide in Namibia, multi-professional teams received an opportunity to address the challenges through suicide prevention programs, workshops, training sessions, counselling and other awareness-raising campaigns. The National Strategic Plan was developed in collaboration with all stakeholders in the field of suicide prevention.

Key components of the strategy

Vision	To be a nation free of suicide
Mission	Providing comprehensive, affordable and accessible services by relevant stakeholders pertaining to suicide
Time frame	2012–2016
Annual budget	[not available]

Goal	[not available]

Objectives

1. Objectives regarding constituency/stakeholders

   Specific objectives

   - Ensuring a responsive legislative/ policy framework.
   - Fostering an improved relationship with stakeholders.
   - Ensuring an accountable coordinating body.
   - Ensuring accessibility to support services.
   - Ensuring reduced incidences of suicide.
   - Strengthening the stewardship role of the steering committee.
   - Ensuring strengthened suicide services.
   - Fostering an adequate understanding of the suicide phenomenon.

2. Objectives for internal processes

   Specific objectives

   - Ensuring strengthened suicide services.
   - Ensuring implementation of the national strategic suicide prevention plan.
   - Ensuring decentralized services.
   - Ensuring a functional coordination body.
   - Ensuring efficient coordination of suicide services.
   - Ensuring public awareness of suicide.
   - Ensuring establishment of an accurate database.

3. Objectives on learning and growth

   Specific objectives

   - Ensuring skilled service providers.
   - Building capacity of relevant stakeholders on expertise, knowledge and skills.

- Ensuring a motivated workforce.
- Ensuring positive staff morale.

4. Objectives for budget and finance

Specific objectives

- Ensuring availability of funds.
- Ensuring equitable and efficient allocation of resources among ministries, directorates and stakeholders.
- Ensuring effective financial management.

Implementation

[Not available].

Monitoring/evaluation

[Not available]; see indicators (Annex 2.5)

Example 7. Republic of Korea (Western Pacific Region)

The following information was summarized from the government plan, “Life Love Plan: Third Basic Plan for Suicide Prevention”. For further details and references please refer to the original source. Source: Strategy document shared by the Korea Suicide Prevention Center.

Context for suicide prevention

The Life Love plan for suicide prevention developed by the Republic of Korea was the country’s third national plan for the prevention of suicide, following two earlier national strategies that succeeded in reducing suicide and reversing the trend of an increase in the rates of suicide in the country. After the Act for Prevention of Suicide and the Creation of Culture of Respect for Life was enacted and promulgated in 2011, the Republic of Korea saw a drop in suicide rates from 31.7 per 100 000 people to 27.3 in just three years, despite anticipated and sometimes still existent challenges such as the lack of government-wide cooperation, and the lack of tailored strategies, depression treatment and infrastructure. This reduction of 13.8% in just three years was a huge achievement and illustrated the effectiveness of the national strategy as a whole. It represented the government’s and all the stakeholders’ commitments to reduce suicide in the Republic of Korea.

Key components of the strategy

Vision	Create safe and healthy communities free from suicide, reduce the risk of suicide and strengthen suicide prevention capabilities of people
Mission	[not available]
Time frame	2016–2020
Annual budget	KRW 148.14 billion total for 2016–2020

Goal	Lowering the rates of suicide from 27.3 per 100 000 in 2014 to 20.0 per 100 000 (a reduction of 26.7%)

Objectives

1. Enabling society-wide suicide prevention.

    Specific objectives

    - Improve social awareness of suicide: creating a culture of respect for life and enhancing suicide prevention (with campaigns, supporting groups, improving press releases related to suicide, organizing campaigns during months when suicide rates are high, media coordination).
    - Create a social support system to prevent suicide: enhancement of a social safety net; system of pan-governmental suicide prevention and cooperation with local governments.
    - Improve the environment to reduce the risk of suicide: blocking access to means of suicide (hazardous materials management, improving risk environment); blocking harmful information online.

2. Providing suicide prevention services.

    Specific objectives

    - Pursue suicide prevention measures by life stage: creating specific child and adolescent suicide prevention programs; adolescent and middle-aged adult suicide prevention (e.g. in the workplace, in colleges); suicide prevention among older people (e.g. integration services, early detection systems).
    - Enhance a high-risk group support system: suicide prevention measures to target specific high-risk groups (e.g. bereaved families, those with physical illness, the unemployed and poor); specific suicide prevention guidelines regarding severely ill patients; integration across the welfare system.

- Prepare an emergency response and follow-up management system: 24-hour suicide crisis response system; preparing a follow-up care system for suicide attempters.

3. Enhancing suicide prevention pursuing base.

   Specific objectives

   - Enhance regional response to suicide: improving suicide prevention competency of primary medical institutions (e.g. introduction and improvement of identification and treatment, distribution of guidelines).
   - Strengthen mental health infrastructure: improving regional and national mental health services delivery system (e.g. through gatekeepers); training experts.
   - Secure suicide prevention human resources: expanding cultivation of gatekeepers, enhancing training of experts (e.g. medical and mental health professionals).
   - Prepare an evidence-based suicide prevention research system: pursuing a suicide observatory; conducting evidence-based research (e.g. psychological autopsy).

Implementation

The Republic of Korea's Life Love plan drew upon evidence-based interventions from comprehensive strategies of other nations and tailored these interventions to fit the Korean culture and context. The plan was therefore tailored to the country's specific needs, establishing best practices and evidence-based interventions in a comprehensive approach. It also clearly identified the challenges that the strategy would face. Furthermore, the objectives outlined by the Republic of Korea's national strategy envisaged the accomplishment of both short-to-medium and long-term objectives, which were to be evaluated using indicators which would then feed into future planning. Each of the sub-responsibilities within the three broader strategies were allocated to specific ministries.

Monitoring and evaluation

Suicide services assessment is an integral part of the plan. The plan identified a number of indicators to establish this aim (Annex 2.6).

Example 8. Switzerland (European Region)

The following information was summarized from the government plan called "Suicide prevention in Switzerland. Initial situation, need for action and action plan". For further details and references please refer to the original source.

Source: http://www.mindbank.info/item/6764

Context for suicide prevention

In 2005, the Government of Switzerland published a report called Suicide and suicide prevention in Switzerland ["Suizid und Suizidprävention in der Schweiz"], which described the possibilities of suicide prevention, suicide prevention programmes in other countries and projects. In 2014, the Federal Council received the task of strengthening suicide prevention throughout Switzerland by accepting a motion ["Motion Ingold 11.3973"]. As a result, the Swiss Federal Office of Public Health, the Cantonal Health Directors and the Swiss Foundation for the Promotion of Health have jointly developed a suicide prevention action plan.

Key components of the strategy

Vision	Lower the rate of suicide and suicide attempts further and sustainably
Mission	Reduce the number of suicides
Time frame	2016 - [not available
Annual budget	CHF 100 000 CHF (for knowledge base, coordination, networking and measures)

Goal	Reduce suicide mortality by 25% by the year 2030 (as compared to 2013), achieving a suicide rate of 10 per 100 000 population (men: 15 per 100 000 and women: 5 per 100 000 population); reduce the number of suicides by 300 per year.

Objectives

1. Strengthen personal and social resources in dealing with emotional burdens, as personal and social resources can strengthen psychological resistance.

   Specific objective: Strengthening personal and social resources in the different stages of life through learning life skills (to solve problems, to communicate and to lead relationships, to be empathetic, to exercise critical thinking, etc.).

   Key measure/activity: Implementing interventions that strengthen personal and social resources in children, adolescents, adults and older people.

2. Sensitize and inform: sensitization measures contribute to de-stigmatization of suicidal behavior and provide information on prevention.

   Specific objective: Informing and raising awareness about suicide.
   Key measures/activities:
   1) Designing suicide prevention campaigns which provide information about the phenomenon of suicide and preventive actions, and

   2) implementing awareness-raising campaigns which provide contact information and prevention options

3. Provide easy access to help: people affected by suicidal behaviors and their environment know and use counselling and emergency services

   Specific objective: Providing assistance and promoting its use

   Key measure/activity: Offering consultancy and emergency services for everyone (24-hour services, youth/adult care, etc.).

4. Early detection and intervention: the early detection of suicidal behaviors and interventions can avoid or reduce fatal and non-fatal consequences.

Specific objective: Recognizing suicidal behaviors in their early stages and providing appropriate assistance.

Key measures/activities:

1) Promoting education on suicide prevention for professionals, specifically for addressing target groups in medical and nonmedical settings, and

2) facilitating early detection and early intervention through processes and protocols by health organizations and institutions.

5. Effective management and treatment: people who made a suicide attempt and those suffering after a suicide need to receive prompt follow-up.

Specific objective: Treating and following up the people at risk for suicide quickly and effectively.

Key measures/activities: Applying measures from the report The future of psychiatry in Switzerland, taking into account the specific needs of vulnerable groups and those who attempt suicide.

6. Suicide means and methods: restricting access to means of suicide is effective because people with suicidal behaviors usually prefer a particular method or even a particular place.

Specific objective: Reducing the availability of means and methods through collaboration of different sectors: rail transport sector, sale of firearms, products of the chemical industry, etc.

Key measures/activities:

1) Developing guidelines and norms for the construction of buildings to prevent suicide, as well as sensitizing and informing building construction specialists,

2) reviewing and establishing regulations for selling medical products,

3) controlling the prescribing and dispensing of medications, and

4) restricting the private storage of firearms on a voluntary basis.

7. Survivors and professionals involved: suicide causes great suffering to survivors and to those who are involved in a professional capacity.

Specific objective: Providing support to survivors, families and professionals in accordance with their needs.

Key measure/activity: Establishing services such as self-help groups, individual care, programs for vulnerable groups, etc.

8. Media reporting for suicide prevention and digital communication: the media reporting after suicides can lead to imitation of suicides.

Specific objective: Promote suicide-preventive media reporting as well as suicide-preventive use of digital communication.

Key measure/activity:

1) Supporting journalists and media speakers to report responsibly about suicides, and

3) raising awareness about the proper use of the Internet and other communication channels among young people.

9. Monitoring and research: suicide data allow for evaluating and controlling the actions implemented. Specific objective: Collecting information and data on suicide and using these to assess the effectiveness of interventions and programs.

   Key measures/activities:
   1) Collecting data and evaluating suicide prevention interventions, and
   2) research to fill knowledge gaps about primary, secondary and tertiary suicide prevention.

10. Examples of good practice: the dissemination of good practice examples enables the actors to make use of synergies and to implement effective suicide prevention.
   Specific objective: Providing good practice examples for suicide prevention to stakeholders.

   Key measures/activities: Reviewing and proposing evidence-based and best practice examples of suicide prevention and making them available to stakeholders.

Implementation

The federal government, specifically the Federal Office of Public Health, coordinates and supports all stakeholders in the implementation of the action plan, establishing networking groups. The main stakeholders who work closely with the federal government are the network of mental health, the cantons and Swiss health promotion institutions.

The action plan provides a common framework for action, with a number of key measures and actions. These are based on national and international examples of evidence and good practice. In particular, the federal government focuses its efforts on

objectives 9) Monitoring and research and 10) Examples of good practice, and supports the implementation of the action plan as a whole through processing of data and providing evidence-based practice. The regional governments (cantons) are also responsible for various important areas of suicide prevention, such as the cantonal health care and welfare systems, the educational institutions, the police and judicial institutions.

Monitoring and evaluation

Evaluation is focused on quantifying the efficiency and effectiveness of past actions for the entire population; people with suicidal behaviors (including those with previous attempts) as a consequence of being exposed to risk factors; the environment; and professionals and other people involved in suicide prevention.

Example 9. USA (Region of the Americas)

The following information was summarized from the government plan, called “2012 National Strategy for Suicide Prevention: Goals and Objectives for Action”. For further details and references please refer to the original source.
Source: https://www.mindbank.info/item/2094

Context for suicide prevention

Suicide became a central issue in the USA in the mid-1990s, when survivors of suicide who were bereaved saw the need to bring the issue to federal attention in politics. Based on this, the first document The Surgeon General's call to action to prevent suicide was developed, introducing a blueprint for addressing suicide prevention and making 15 broad recommendations consistent with public health policy. This then led to the development of the first National Strategy for Suicide Prevention in 2001. Also, in 2001, the Substance Abuse and Mental Health Services Administration (SAMHSA), with the support of many national organizations, established a national network of crisis centers answering a national toll-free suicide hotline number, which has become the national suicide prevention lifeline. The lifeline answered more than two million calls in 2017.

The Suicide Prevention Resource Center was created in 2002 to promote the implementation of the national strategy. In 2005, the Congress passed, and the President signed into law, the Garrett Lee Smith Memorial Act launching a national youth suicide prevention effort based on the national strategy. Evaluations of this effort have shown reduced youth suicides and suicide attempts in counties implementing the grants compared to matched counties that were not. The national suicide prevention strategy also called for the development of comprehensive state suicide prevention plans and a national reporting system for violent deaths. Further milestones include the formation of the National Action Alliance for Suicide Prevention in 2010, and the revision of the national strategy in 2012. The Alliance, a public-private partnership, is fulfilling the role of the coordinating/lead agency

Key components of the strategy

Vision	A nation free from the tragedy of suicide: preventing suicide and promoting health, resilience, recovery and wellness for all
Mission	Reduce suicide through comprehensive implementation of the National Strategy for Suicide Prevention
Time framework	2012–2022 (the revised National Strategy for Suicide Prevention was designed as the nation's blueprint for the next decade and was published in 2012)
Annual budget	US$ 69 million (Congressional appropriation to SAMHSA to implement national suicide prevention efforts, but not the entire federal investment in suicide prevention in the USA)

Goal	Increasing 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; reducing rates of suicide by 20% by 2025.

Objectives

1. Healthy and empowered individuals, families and communities: creating supportive environments that will promote the general health of the population and reduce the risk for suicidal behaviors and related problems.

Specific objectives:

- Integrating and coordinating suicide prevention activities across multiple sectors and settings.
- Implementing research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes and behaviors.
- Increasing knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.

- Promoting responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and safe online content related to suicide.

2. Clinical and community preventive services: developing support systems, services and resources be in place to promote wellness and help individuals successfully navigate challenges.

Specific objectives:

- Developing, implementing, and monitoring effective programs that promote wellness and prevent suicide and related behaviors.
- Promoting efforts to reduce access to lethal means of suicide among individuals with an identified suicide risk.
- Providing training to community and clinical service providers on the prevention of suicide and related behaviors.

3. Treatment and support services: guaranteeing evidence-based approaches for caring for high-risk patients, including safety planning and specific forms of psychotherapy that can be used to support treatment for underlying mental health conditions.

Specific objectives:

- Promoting suicide prevention as a core component of health care services. Promoting the adoption of “zero suicides” as an aspirational goal by health care and community support systems that provide services and support to individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.
- Promoting and implementing effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

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

4. Surveillance, research, and evaluation: promoting public health surveillance through the systematic collection, analysis, interpretation, and timely use of data for public health action to reduce morbidity and mortality.

Specific objectives:

- Improving the timeliness and usefulness of national surveillance systems relevant to suicide prevention as well as the ability to collect, analyze, and use this information for action.
- Promoting and supporting research on suicide prevention.
- Evaluating the impact and effectiveness of suicide prevention interventions and systems and synthesizing and disseminating findings.

Priority areas

- Integrate suicide prevention into health care reform and encourage the adoption of similar measures in the private sector.
- Transform health-care systems to significantly reduce suicide.
- Change the public discourse about suicide and suicide prevention.
- Improve the quality, timeliness, and usefulness of surveillance data regarding suicidal behaviors.
-

Implementation

SAMHSA, in coordination with the National Action Alliance for Suicide Prevention and the Office of the Surgeon General, published an implementation assessment report in 2017.

Monitoring and evaluation

Implementation of the National Strategy for Suicide Prevention is monitored by the National Action Alliance for Suicide Prevention and the Federal Working Group on

Suicide Prevention. Evaluation of national suicide prevention efforts focused on youth were published in the peer-reviewed journals.

Example 10. Uruguay (Region of the Americas)

The following information was summarized from the government plan, called “National Suicide Prevention Plan”. For further details and references please refer to the original source.
Source: https://www.mindbank.info/item/3288

Context for suicide prevention

Relevant activities on suicide prevention had already been developed and implemented before the current plan. In 2006, the Technical Advisory Committee of the National Mental Health Program (NMHP), and specifically its technical group on violence and violent deaths, prepared guidelines and recommendations regarding suicidal behavior. In 2008, the Prevention and detection guide of risk factors for suicidal behavior was published. This document was widely distributed at various events, and in public, private and nonprofit health services in the country. Also, special training workshops based on the guide were carried out for the fire and police department. In 2010, the NMHP published Strategic guidelines for suicide prevention and the following year the first national plan for suicide prevention was developed.

Key components of the strategy

Vision	Improving the quality of life and mental health of the general population, considering the distinctive geographical features
Mission	[not available]
Time frame	2011–2015
Annual budget	[not available]

Goal	Reduce suicide mortality by 10% from 2011 to 2020.

Objectives

1. Organizing comprehensive mental health care: Providing treatment and follow-up for mental disorders is an effective measure to prevent suicide.

Specific objectives:

- Designing a manual to define and organize a network of care for those who attempted suicide, and interdisciplinary teams to ensure comprehensive care to individuals and their families.
- Increasing the coverage of mental health services for those who attempted suicide, as well as their families.
- Developing a regulatory framework for those who attempted suicide and their families

2. Developing an intersectoral network.

Specific objective:

- Strengthening the social, interinstitutional and intersectoral network, promoting a comprehensive approach for the problem of suicide.

3**.** Raising awareness and educating the community about mental health and suicide.

Specific objectives:

- Promoting mental health awareness with timely and meaningful community engagement and working towards the de-stigmatization of mental disorders.
- Promoting the training of trainers for mental health promotion and suicide prevention.
- Incorporating mental health programs on promotion and prevention in the education sector, police force, etc.

4. Educating, training and reorienting human resources for addressing suicide prevention and care for suicide attempters and survivors.

Specific objective:

- Improving human resources training in health promotion, prevention, diagnosis, treatment and the follow-up of people at risk of suicide.

5. Developing and implementing a national surveillance system for fatal and non-fatal suicides.

Specific objectives:

- Improving the national data on suicide attempts and suicides, implementing a national surveillance system with mandatory registration and follow-up of cases.
- Generating evidence on the effectiveness of strategies for suicide prevention and their implementation.

Implementation

A National Commission was assigned to articulate, supervise, evaluate and monitor the national suicide prevention plan. The National Commission is composed of representatives of the Ministry of Public Health, the Ministry of Education and Culture, and the Ministry of Interior. The National Commission coordinates the actions of the plan through different subcommissions and working groups. These groups are responsible for developing the strategies and activities of the plan. The groups are composed of, for instance, members of scientific societies, universities, civil servants, and representatives of NGOs and community health services.

Monitoring and evaluation

Indicators were developed based on the goal and objectives (Annex 2.7).

References for Chapter 5

Cerel J, Brown MM, Maple M, Singleton M, van de Venne J, Moore M et al. (2018). How many people are exposed to suicide? Not six. Suicide Life-Threat Behav. doi: 10.1111/sltb.12450.

Hawton K, Witt KG, Taylor Salisbury TL, Arensman E, Gunnell D, Hazell P et al. (2016). Psychosocial interventions following self-harm in adults: a systematic review and meta-analysis. Lancet. http://dx.doi.org/10.1016/S2215-0366(16)30070-0

Pitman A, Osborn D, King M, Erlangsen A (2014). Effects of suicide bereavement on mental health and suicide risk. Lancet Psychiatry. 1(1):86–94.

UN (1996). Prevention of suicide: guidelines for the formulation and implementation of national strategies. New York (NY): United Nations.

WHO (2012). Public health action for the prevention of suicide: a framework. Geneva: World Health Organization.

WHO (2013). Mental Health Action Plan 2013–2020. Geneva: World Health Organization.

WHO (2014). Preventing suicide: a global imperative. Geneva: World Health Organization.

WHO (2016). Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm. Geneva: World Health Organization.

WHO (2018a). Global health estimates. Geneva: World Health Organization (http://www.who.int/healthinfo/global_burden_disease/en, accessed 8 November 2018).

WHO (2018b). Preventing suicide: a community engagement toolkit. Geneva: World Health Organization.

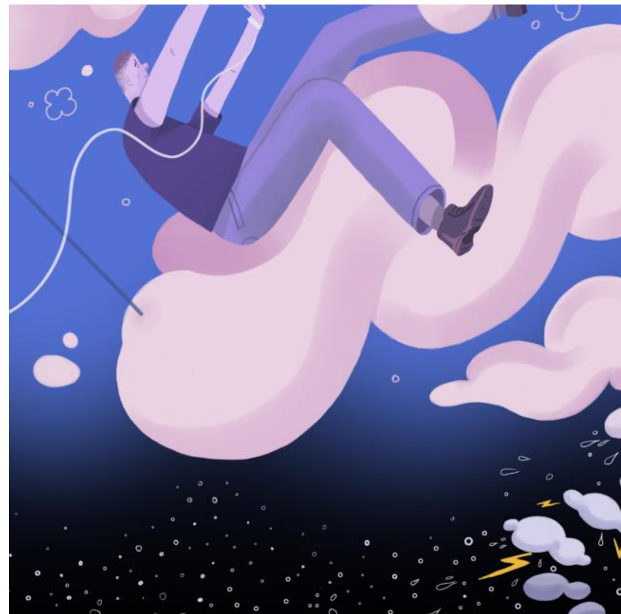
WHO (2018c). Mental Health Atlas 2017. Geneva: World Health Organization.

Zalsman G, Hawton K, Wasserman D, van Heeringen K, Arensman E, Sarchiapone M et al. (2016). Suicide prevention strategies revisited: 10-year systematic review. Lancet. http://dx.doi.org/10.1016/S2215-0366(16)30030-X.

Chapter 6. A Journey Towards Hope

This chapter is sourced from:
A Journey Toward Help and Hope: Your Handbook for Recovery After a Suicide Attempt. HHS Publication No. SMA-15-4419. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2015. Retrieved from: https://suicidology.org/wp-content/uploads/2019/06/HandbookForRecoveryAfterAttemptSAMHSA.pdf

How Did It Get to This Point?



The time right after your suicide attempt can be the most confusing and emotional part of your entire life. In some ways, it may be even more difficult than the time preceding your attempt. Not only are you still facing the thoughts and feelings that led you to consider suicide, but now you may be struggling to figure out what to do since you survived.

It's likely that your decision to try to kill yourself didn't come out of the blue. It probably developed over time, perhaps from overwhelming feelings that seemed too much to bear. Experiencing these emotions might have been especially difficult if you had to deal with them alone. A variety of stressful situations can lead to suicidal feelings, including the loss of a loved one, relationship issues, financial difficulties, health problems, trauma, depression, or other mental health concerns. It's possible that you were experiencing some of these problems when you started to think about suicide.

While the events that lead to a suicide attempt can vary from person to person, a common theme that many suicide-attempt survivors report is the need to feel relief. At desperate moments, when it feels like nothing else is working, suicide may seem like the only way to get relief from unbearable emotional pain.

Just as it took time for the pain that led to your suicide attempt to become unbearable, it may also take some time for it to subside. That's okay. The important thing is that you're still here; you're alive, which means you have time to find healthier and more effective ways to cope with your pain.

Survivor Stories

"Life became like an endurance test. That's really how it felt. It felt like life was an endurance test for me. And making it to the next day and to the next day and to the next day was truly...it was just a fight for survival."

—Terry Wise

"It felt like there was still a hole inside of me, and I couldn't figure out why I had a lack of motivation to get out of bed, why I was randomly crying. So, when I was 16, I was going to school with a mask on my face, acting and pretending as though I was really happy with the things that were going on around me."

—Jordan Burnham

"I could not feel hope; I did not even care if things would get better; I was in pain and I wanted it to stop, period."

—Cathy Singer

"I thought, well yeah, maybe, maybe the family's better off without me. So the entire day this thought began to build and dwell and it escalated very quickly...and when the pain got real bad I was going to do what I needed to do, not thinking that they loved me."

—David Lilley

Terry's Story

On the morning of December 25, 2000, Terry Wise tried to kill herself. She awoke two days later in the intensive care unit. The death of Terry's husband from Lou Gehrig's disease was a trigger for her suicide attempt. But in reality, her attempt was the culmination of years of depression and other problems that started in her childhood. Terry was overwhelmed by an intense emotional pain that had been building for years, and when her husband died, the pain became unbearable. For Terry, suicide felt like a way to end the pain. Terry explains:

> *Suicide doesn't stand alone. It doesn't just happen as the result of nothing out of nowhere; it's the result of something. My husband's illness and death really became the catalysts that brought a lot of other things to the fore front that I had been grappling with my whole life. If you've gone through your life and you've had traumas, or you've had difficulties or you've had things that you think you have buried and then you have a significant loss or a significant trauma occur later in your life as I did with my husband dying, all the things that have been on simmer in your life come to a full boil.*

Right after Terry tried to kill herself, she felt lost. She didn't know what to do. She found no joy in living. Terry went to therapy, and ultimately it changed her life. By working with a counselor, Terry realized that the trauma she experienced when she was younger still affected her emotions as an adult. Her counselor helped her find ways to cope with her feelings. Therapy also allowed her to see how others would have reacted to her death by suicide. Most importantly, Terry's therapist trusted her and respected her, and for Terry, her therapist's compassion made a huge difference.

Terry's recovery was a process. It took time and hard work. Terry recalls:

And that is really the first step, to go from feeling that life is an endurance test to being able to tolerate being alive. And then you hope that the unendurable becomes bearable. Then you hope the bearable becomes manageable. Then you hope the manageable becomes pleasurable. And so, it's a process. It evolved over time.

Now, Terry is a well-known writer and public speaker whose mission is to educate others about suicide prevention. She finds fulfillment in traveling the country to share her story and help others who are struggling with suicide. Terry has learned ways to cope with negative emotions and enjoy life.

What Am I Feeling Right Now?

Right now, you're probably experiencing many conflicting emotions. You may be thinking:

- "Why am I still here? I wish I were dead. I couldn't even do this right."
- "I don't know if I can get through this. I don't even have the energy to try."
- "I can't do this alone."
- "How do I tell anyone about this? What do I say to them? What will they think of me?"
- "Maybe someone will pay attention to me now; maybe someone will help me."
- "Maybe there is a reason I survived. How do I figure out what that reason is?"

Right after a suicide attempt, many survivors have said that the pain that led them to harm themselves was still present. Some felt angry that they survived their attempt.

Others felt embarrassed, ashamed, or guilty that they put their family and friends through a difficult situation. Most felt alone and said they had no idea how to go on living. They didn't know what to expect and even questioned whether they had the strength to stay alive. Still others felt that if they survived their attempt, there must be some reason they were still alive, and they wanted to discover why.

You're probably experiencing some of the same feelings and may be wondering how others have faced these challenges. The next section provides some examples of the steps others found helpful in recovering from a suicide attempt.

My Feelings

You may want to note how you feel today, so you can come back later and see how you are progressing in your recovery.

How am I feeling now?

☐ Afraid ☐ In pain

☐ Angry ☐ Lonely

☐ Ashamed ☐ Numb

☐ Depressed ☐ Overwhelmed

☐ Dread ☐ Relieved

☐ Grateful ☐ Tired

☐ Guilty ☐ Other

☐ Hopeful

It is normal to feel several conflicting emotions after your suicide attempt. Whatever you are feeling is okay, but it's important to find ways to deal with negative emotions so that you are able to stay safe.

What do I need and want?

- Not to return to the hospital
- Relief from depression
- Relief from distressing voices
  - A life without alcohol or other drug problems
- Financial help
- A place to live
- A trusted friend
- Better relationships with:
  - Parents
  - Spouse/partner
  - Friends
  - Sisters and brothers
- Co-workers
- Hope for the future
- Other:

Know that you can have these things.

Am I the Only One Who Feels This Way?

Knowing how others made it through can help you learn new ways to recover from your own suicide attempt.

It’s estimated that more than one million people attempt suicide each year in the United States, from all parts of society. In other words, you’re not alone. However, it can be hard to know how other survivors recovered because suicide is a personal topic that often is not discussed openly and honestly. This can leave those affected feeling like they don’t know where to turn.

Shame, dreading the reaction of others, or fear of being hospitalized are some of the reasons that prevent people from talking about suicide. This is unfortunate, because direct and open communication about suicide can help prevent people from acting on suicidal thoughts. Hopefully, reading about the experiences of other survivors in this booklet will make it easier for you to talk about your own attempt, learn ways to keep yourself safe, know when to ask for help, and most importantly, find hope as you think about what happens next on your journey.

It’s okay if you feel conflicting emotions right now. Other suicide attempt survivors know that what you’re experiencing is normal. They understand that your concerns are real. Going on won’t be easy, and finding a way to ease your emotional pain may be challenging, but this can be a time to start down a new path toward a better life— to start your journey toward help and hope.

Those who have recovered from a suicide attempt want you to know that:

You are not alone. You matter. Life can get better. It may be difficult, but the effort you invest in your recovery will be worth it.

Right now, moving forward may seem impossible. And while it probably won't be easy, many other survivors will tell you that they're glad they held on and worked for a better life. By taking a few steps now, and then a few more when you're ready, you can regain your strength.

Sometimes it can be helpful just to take a few steps forward, even when you don't feel like it. In fact, you might start to remember that others care about you. You might discover that suicide is not the only way to relieve your pain. You may find that your feelings will change, either on your own or by working with a counselor. You could wake up one day surprised to feel less pain than you do today.

Survivor Stories *"After my attempt I needed to be able to talk and be heard—not counseled, not encouraged—to really be listened to, like what I had to say was the most important thing in the world at that moment, for someone to connect to my pain without losing control of themselves."*

—Cathy Singer

(After my attempt) "I felt exhausted. I felt empty: What now? I soon felt angry. As I told a therapist, staying alive means that now I have to rationalize being a loser, a failure. That is the way you can think sometimes."

—Cara Anna

Jordan's Story

Jordan was only 16 when he was diagnosed with depression. He was popular and had almost everything he wanted; yet there was still a hole in his life. Jordan said that he hated himself. As an African-American, he felt that he didn't fit in with the mostly white students in his school, and he felt like a failure if he didn't get the grades, he and his parents wanted him to achieve. He went to therapy for his depression before attempting to kill himself, but he didn't talk honestly with his therapist.

He didn't take his medications consistently and kept his drinking problem a secret. After his suicide attempt, he ended up in a hospital. He was in a coma, and his doctors didn't know if he would survive. When Jordan woke up, he had to heal physically and went through the pain of learning to walk again. He decided to be at peace with the way things were. He knew he had a second chance at life, and he felt he should get better so he could help others.

Jordan saw a psychiatrist who helped him choose treatment options, including medication to treat his depression. They worked together to adjust and manage his medications, talk about his problems, and help him learn how to cope with depression. Jordan explained that therapy taught him more about himself and what he could do to make himself feel better. For Jordan, this meant learning how to have a healthy emotional balance, including being around other people and working out regularly. He is now a motivational speaker, traveling across the country and telling his story to help others. Jordan finds great satisfaction in letting youth know that they're not alone with their problems. He takes pride in helping others speak up when they need help.

> *I have the same depression that I had before, but the way that I cope and deal with it is in a much more positive way than I did before. I don't have thoughts of wanting to*

try and take my own life. Do I question, you know, how I am going to get through this day and why am I here? Yeah, I definitely have thoughts of that. But what I do with those thoughts is different.

An important part of Jordan's recovery was understanding his diagnosis, finding ways to cope with his depression, and learning how to live a healthy, productive life. It can be difficult to open up and accept help in our society, but taking this first step can be very important in your recovery.

Taking the First Steps

Making big changes right now might be out of the question for you. You may not even know where to begin. That's okay. Recovery is a process, and it's important that you move at your own pace. There are a few things you might want to do to ease your transition back to everyday life. Some important steps that others have found helpful are listed below. You'll find additional information about each of these steps on the following pages.

First, it might be less stressful to decide in advance how to deal with others' questions about your suicide attempt. The people around you may be surprised by your suicide attempt and have questions or comments about what happened. Thinking about what you might say in advance can help you prepare for their reactions.

Second, re-establishing connections may help you feel better. Often, the stress or depression that leads to a suicide attempt can cause people to disconnect from others who care about them or the things they used to enjoy doing. Reconnecting with the people and things you love or loved can help instill hope.

Third, because suicidal thoughts might return, you'll want to be prepared with a plan to stay safe. A safety plan is a tool that can help you identify triggers (like events or experiences) that lead to suicidal thoughts and can help you cope if the pain that led to your suicide attempt returns.

Fourth, finding and working with a counselor can help you start to recover. Unlike friends or family, a counselor is an unbiased listener who won't be personally affected by your suicide attempt. The counselor's role is to help you sort through your feelings and find ways to feel better. You may find it helpful to use this booklet with your counselor to begin discussing your experiences and feelings about your suicide attempt. A counselor can be a peer supporter, psychiatrist, social worker, psychologist, or other skilled person. If counseling isn't possible, there are also ways you can help yourself, but please remember that you don't have to go through this alone. (See page 17, Finding a Counselor.)

Survivor Stories

"There are a lot of things that happen in your life that you have no choice over. But the one thing that can never be taken away from you is your ability to choose how to respond."

—Terry Wise

"The hospital was the first place where I felt like I could acknowledge my illness, to myself and to others. Even knowing I had depression, they still saw me as a human with great potential. That led me to understand that seeking help would not lead to me becoming defined by my depression, as I had feared. It inspired me with the most basic conviction that I was inherently worthy of health and happiness, regardless of what others thought of me."

—Misha Kessler

"When I woke up in the hospital, I didn't feel positive about life. But I watched TV a lot and saw stories about people who went through worse than I had. It inspired me to stop focusing on what I couldn't do and start focusing on what I could do."

—Suicide Attempt Survivor

Talking With Others About Your Attempt

One of the most difficult tasks you might face will be responding to the questions people ask about your suicide attempt. The shame, guilt, confusion, and other emotions that might follow an attempt can make it tough to speak about it with others, especially if people respond in a way that doesn't feel supportive.

Often, those closest to you may be feeling lots of emotions about your attempt. They may be scared, confused, or angry about what happened, causing them to focus on their own feelings, rather than being as supportive as you need them to be. Their reactions might hurt you, whether they mean to or not.

To make it easier, here are some suggestions that can be helpful:

It's your story to tell, or not.

The details of your experience are personal, and it's up to you to determine what you want to share and with whom. Sharing what happened with your doctors, nurses, counselor, or peer supporters can help them give you the right kind of support. In most cases, they're required to keep the details of what you share confidential.

You may want share some of the details and your feelings about what happened with other people you trust, such as family or friends. How much you share, or the details you decide to give, are up to you and what you feel comfortable with.

Answering Tough questions

Potential tough questions/reactions to plan for:

- I heard you were in the hospital.
- What was the matter?
- Did you really try to kill yourself?
- How could you do this to me?
- Things could never be that bad.
- How did you do it?

- What happened after you tried it?
- Was it something I did to you?
- Why didn't you trust me and tell me what was going on?

Practice what you want to say when:

You don't want to talk:

- "You're so thoughtful to worry about me, but I'd rather not talk about it right now."
- "Even though I've been through a tough time, I'm getting better."
- "I know you're trying to be helpful, but it's hard to understand if you haven't experienced the kind of pain that led me to attempt suicide."
- "I appreciate your concern, but I'm just not ready to talk about it yet."

You want to reach out:

- "The most important thing for me right now is knowing that people still care about me."
- "You could be really helpful by being there for me as I recover."
- "I just need you to listen to me without judging me for what happened."
- "Right now, I need people to help me stay safe. Can I count on you?"

People don't always say the right things.

It's difficult to predict how people will respond when they learn that you tried to kill yourself. Some people might change the subject or avoid the topic altogether because of their fear of death or suicide. Others who are close to you may be confused, hurt, or angry about what's happened. They may judge or blame you. They may feel betrayed or be wondering what they could have done to prevent you from attempting suicide.

Often, those who care the most about you have the strongest reactions to your suicide attempt because they can't imagine life without you. It's helpful to

remember that a strong reaction may reflect your family's or friends' depth of concern about you.

Sometimes you may feel that they're being overly controlling. It may seem like they're watching everything you do or won't leave you alone because they're afraid you may attempt suicide again. This can be very frustrating when you're trying to recover from an attempt.

It can take time to repair the trust in your relationships. If you can show that you're committed to safety, it might allow those close to you to feel more comfortable giving you the space you need. Completing a safety plan, like the ones on pages 26–29, can help you show those who are worried about you that you want to stay safe.
Learning more about suicide can help the people who care about you be more supportive. If they better understand what led to your suicide attempt, they might be better able to give you what you need, especially if you communicate your needs in a clear and direct way.

Because this booklet contains general information about suicide attempts, you might want to give loved ones their own copies. It may help them understand some of the feelings that led to your suicide attempt and enable them to support you more effectively.

Survivor Stories

"Attempt survivors most want and need someone they can just talk to who will listen and let them mull things over without rushing to intervene. They are looking for someone who can understand and make them feel valued."

—Heidi Bryan

"When I had these suicidal thoughts, I didn't know how to talk to anyone because I figured I was the only one who had those thoughts and emotions and if I told someone, I just figured that the automatic reaction would be I'd have to go to a psych ward."

—Jordan Burnham

Direct communication may help you get what you need.

While it may be hard for you to talk about what happened, it is also important for you to try your best to be direct in communicating what you need. It may seem obvious to you, but others may not understand or know the best way to support you. This period can be challenging because you might want to ask people for help, but you don't want to scare anyone if you're still struggling. This is especially true if you're concerned that people might overreact and insist on care in a hospital when you believe you just need more support and understanding.

A system for monitoring the intensity of your suicidal thoughts, should you have them, can help you notice if things are getting better or worse. It can also help you communicate how much assistance you need from those supporting you. Using a scale from 1 to 5 (with 1 being minimal distress or no thoughts of suicide and 5 being extreme distress and thoughts of imminent suicide) can make it easier to express how you're feeling. The tips on this page provide additional ideas on asking for help.

Take note of not only what's going on around you and through your mind when you're at a "4" or a "5," but also when you're at a "1" or a "2." These may be the situations, people, or strengths that will help you get through the hard days.

Support can make things easier.

It might be hard at first, but having someone you feel comfortable talking to after your attempt is very important. You may face some challenges as you move forward; knowing there is at least one person you can turn to will make the road to recovery less daunting. Being alone with suicidal thoughts can be dangerous. Having supportive people around you and educating them on how to help you can be a crucial part of staying safe.

Ask yourself, "What do I need from a support person?"

Different people need different things after a suicide attempt, so make sure the person you choose meets your unique needs. Maybe you need someone who will listen to you without judgment, or maybe you need someone who will come and be with you when you're feeling alone. Perhaps it would be helpful to have someone close to you who can go with you to appointments, or perhaps you want to schedule regular phone calls with a trusted friend. No matter what kind of assistance you need, it's helpful to have at least one person with whom you can share your thoughts of suicide—someone who will stay calm and help you when you need support. Once you know what you need, it may be easier to find someone to help. And remember, because you might not get everything you need from one person, it can be helpful to have a variety of people available to support you, if possible.

Tips for Asking for Help

When you ask for help, let people know you are dedicated to safety but need their assistance to maintain that commitment. For example:

> "Mom, I want to keep myself safe, but I am feeling really depressed right now. Do you think we can just talk for a while?"

Be direct. It may seem obvious to you that you need support, but others may not understand or know how to help you. Asking for what you need specifically can help others respond appropriately.

> "I've been having a hard time figuring out how to get to my doctor's appointment. Could you help me?"

Know the strengths and limitations of the people in your support system. It's good to know who can help you with what.

Re-establishing Connections

It’s likely that the overwhelming life events, stress, and depression that led to your suicide attempt affected your ability to enjoy life. Struggling with suicidal thoughts can be exhausting and leave you with little energy to do the things you once loved. It also can put stress on your relationships with friends and family. The irony of depression and suicidal thinking is that they may cause you to give up the things in life that help you feel better, just when you need them the most.

Establishing Your Connections

It may be hard to answer some of these questions right now. It’s okay if you can’t answer them immediately.

WHO ARE THE IMPORTANT PEOPLE IN MY LIFE? *(Friends, family, colleagues, counselors, clergy, pets, etc.)*

WHAT ARE MY PLANS FOR THE FUTURE? WHAT THINGS HAVE I ALWAYS WANTED TO DO IN LIFE?

WHAT HAVE I COME TO BELIEVE ABOUT SUICIDE?

WHAT ARE THE THINGS I CHERISH IN LIFE?

WHAT THINGS DO I ENJOY DOING? WHAT DID I USED TO ENJOY?

WHAT GIVES ME A SENSE OF PURPOSE IN LIFE?

WHAT ARE MY OTHER REASONS FOR LIVING?

Even up until the moment of their attempts, many suicide-attempt survivors report that there was an internal struggle going on inside them. One side argued that suicide was the best way to end the pain they were experiencing. The other side struggled to find

another way to feel better. To put it another way, most people with suicidal thoughts had reasons for dying AND reasons for living.

Before your suicide attempt, you might have lost connections to your reasons for living, but it's important to re-establish those connections because they can help instill hope. They can remind you about the things you love in life. The exercise on the previous page will help you consider reasons for living. Personalizing this can help remind you of where you were before you started to feel suicidal and where you would like to be again.

Planning To Stay Safe

You might still have thoughts of suicide after your attempt, even if you've decided that you want to stay alive. Perhaps the pain that led to your suicide attempt is still there. It's okay to have suicidal thoughts. Everyone needs to feel relief from unbearable pain, and suicidal thoughts may be one of the ways you've learned to cope. What's important is that you don't act on those thoughts and that you try to find other, safer ways to ease your pain. A safety plan can help you do this.

What is a safety plan?

In times of trouble, you may not see that you have options other than harming yourself. A safety plan is a written list of coping strategies and resources to help you survive a suicidal crisis. A safety plan can help you discover other ways to ease your pain so you don't feel tempted to act on suicidal thoughts you may experience.

Your plan will be a personalized list of strategies to help you cope. You can use these strategies before or during a suicidal crisis. By writing them down, you'll always know what they are, even if you're upset or not thinking clearly.

You can complete your plan by yourself or with the help of a counselor, peer, family member, or friend. The following pages will help you brainstorm elements of your safety plan.

Things to Think About What Do I Write in My Safety Plan?

- Things that lead to suicidal thoughts
- Things I can do to take my mind off my problems
- People and places that distract me from my problems
- People I can ask for help
- Doctors, counselors, peer specialists, or other professionals to contact in a crisis
- The number for the local crisis line or National Suicide Prevention Lifeline (1-800-273-TALK)
- Items to remove so that I won't use them to hurt myself
- Reminders of hope and reasons for living

Have People Ready to Help

You will feel more secure with someone you can trust as your supporter in times of crisis. It may be a family member, friend, peer support or health professional. Try to select a person you can trust to respect you and stay level-headed in an emergency. To cover all your bases, you may want to ask a second person to serve as a backup contact.

It's important that those you ask to be your primary support person and backup support person feel comfortable in these roles and know what to do. Share your

safety plan with them and keep them aware of how you are feeling. Don't forget to thank them for their help. My primary support person is:

My backup support person is: ________________________________

Developing Your Safety Plan

(Blank Safety Plans can be found on pages 26–29). You can also download a free Safety Plan app—MY3—for your Android or Apple phone or tablet.)

1. WHAT TRIGGERS MY SUICIDAL THOUGHTS?

Many suicide attempt survivors indicate that their suicidal thinking became almost automatic over time. When something negative occurred, they would start to have negative thoughts.

It may have been an event or behavior (called triggers), such as failing a test, not sleeping well, or arguing with a loved one, that led to suicidal thoughts. Some survivors noticed that their suicidal thoughts occurred with a certain mood, such as feeling angry or sad, while others started feeling suicidal when remembering a painful event from the past. No matter what the trigger, many survivors experienced a common theme: When something negative occurred, they would start thinking things like:

- "I'm no good." "I can't do anything right." "I fail at everything I do."
- "I hate myself. I'm worthless." "I don't want to be here anymore."
- "Nobody cares about me."
- "I can't take it anymore. I wish I were dead."

Coping with these types of negative thoughts can be difficult. If you don't talk about how you're feeling with someone, the thoughts might start to escalate. One survivor indicated that it was like having "tunnel vision." Even though her negative thoughts

weren't always true, the feelings they created became so strong that she started to believe them.

It's important to recognize what triggers your suicidal thoughts for several reasons, but the most important reason is to recognize when you're in crisis and that it's time to use your safety plan. The questions below can help you figure out what triggers your suicidal thoughts.

Think about what happened the last time you attempted suicide. ***What events preceded your attempt?*** Examples include: "Argument with a good friend." "Yelling."

What were your thoughts or feelings, memories, or behaviors? This is what is meant by "triggers." The more specific you can be about your triggers, the more likely you'll be able to identify them and prevent another attempt in the future. Examples include: "I'm a failure." "Everybody hates me." "Memories of my mother screaming at me, saying that I couldn't do anything right." "Thoughts of how good it would feel if I could just get rid of the pain."

How Have others Coped With Suicidal Thoughts?

"I journal, I call a friend, I remember what it would do to certain people. I remember how hard it is to recover physically and mentally if I don't succeed. …I keep busy at work; I volunteer my time to others who are in need of support. I take a mood stabilizer; I wait one more minute; I think it through while I wait."

—Cathy Singer

"For me, recognizing automatic thinking was a big thing, challenging my thoughts, thinking of my suicidality as an entity rather than a part of me or who I am. I keep a folder of nice cards and emails I've received that make me feel like I've done something with my life or that I'm valued and cared about/for when I read them."

—Heidi Bryan

2. WHAT CAN I DO TO TAKE MY MIND OFF THESE THOUGHTS?

You learned earlier that it can be common to have suicidal thoughts after an attempt. While these thoughts may be common, it's important to find ways to keep them from escalating into suicidal behaviors. One way is to do something that helps you feel better and takes your mind off your problems. For this step of the safety plan, you should think of internal coping strategies or things you can do when you're by yourself. These strategies vary from person to person. To identify your internal coping strategies, ask yourself:

What can I do when I'm alone and I start to have thoughts of suicide? What can I do to take my mind off my problems? Examples include: reading a book, playing computer games, exercising, playing with my dog, shopping, or writing down my thoughts and feelings in a journal.

3. WHERE CAN I GO OR WITH WHOM CAN I TALK TO FEEL BETTER?

Another way to take your mind off your suicidal thoughts is through external strategies, like talking to certain people or visiting places that improve your mood. Finding places that make you feel better or people who cheer you up are good ways to keep your thoughts from escalating. Ask yourself:

Where can I go to be around other people in a safe environment? Who can I be around that makes me feel positive? Examples include: the coffee shop, the gym, place of worship, neighbors, friends, or family.

4. WHOM CAN I ASK FOR HELP? WHO KNOWS THAT I'M STRUGGLING WITH THOUGHTS OF SUICIDE?

If the ideas above don't seem to be helping, you may need more specific assistance, like talking to someone with whom you feel comfortable sharing your thoughts of suicide. Ideally, this is a support person who already knows about your suicidal thoughts

and is aware of his or her role as a support person in your plan. You may want to have several people listed here, if possible, in case your primary support person is unavailable. If it's difficult for you to ask people for support, you might say, "I'm calling you today because I feel like I might need to use my safety plan." Ask yourself:
Who do I feel comfortable talking to when I'm in crisis? Examples include: a trusted friend, parent, minister, or other family member.

5. WHAT RESOURCES CAN I CONTACT IF I'M IN CRISIS?

The next step of the plan involves contacting professionals who can offer assistance if the other parts of the plan don't seem to be increasing your ability to stay safe. Ideally, you want to have resources that are available 24 hours a day, 7 days a week. The National Suicide Prevention Lifeline (1-800-273-TALK (8255) is a resource that's always available. You might also want to consider:

What professionals have I spoken to who can provide assistance? Who can I contact at any hour of the day or night? You may have a doctor, nurse, or counselor available. Other examples are urgent care centers, crisis hotlines, emergency departments, crisis teams, crisis respite centers, or (if it isn't an immediate crisis) warm lines in your area.

Survivor Stories *"Pain has a beginning and an end. It comes, then it goes. We need to make it to the finish line so we can feel the satisfaction of having made it through. We don't know what we might miss if we don't. It could be something really fantastic; you never know until you live to the next moment."*

—Cathy Singer

"Suicide, for me, had become almost like a coping mechanism, and I learned in therapy that death wasn't the only way to end my pain. There were other ways to end

my pain besides death. And one of them was developing coping skills and learning how to manage my feelings in a different way, which I did."

—Terry Wise

6. ARE THERE ITEMS AROUND ME THAT MAY PUT ME IN DANGER?

As an attempt survivor, it's likely that suicide became one of the strategies you developed to end a painful situation. It's natural for human beings to want to avoid pain. When pain is unbearable, you need relief and you probably want it quickly. While suicide may seem like a quick way to end your pain, it can have devastating consequences for you and the people who care about you
You can use your safety plan to help find alternate ways of relieving your pain that don't involve ending your life. However, if you forget to use your plan, or it doesn't make you feel better, having items close to you that you could use to harm yourself can create a dangerous situation. It's important, then, to remove items that you may use impulsively in a moment of unbearable pain.

Most suicide attempt survivors indicate that their thoughts of suicide changed over time. While they had periods when the pain seemed unbearable, those times didn't last forever. Removing dangerous items gives you time to allow the way you're feeling to change. Ask yourself:

What items am I most likely to use to harm myself? Examples include guns, pills, etc.

How can I safely remove them for the time being? Who can I call to come and get them?

7. INCORPORATING REASONS FOR LIVING AND HOPE INTO YOUR SAFETY PLAN

Earlier, this booklet mentioned that when you're suicidal, you're likely to identify both reasons for dying AND reasons for living. Depression and suicidal thinking tend to make you focus only on your reasons for dying, while not allowing you to appreciate your reasons for living. It can be helpful to add your reasons for living into your safety plan as reminders of the things in life that are important to you, as well as the people whom you care about and who care about you. Reminding yourself of your reasons for living can help build hope and increase your motivation to stay safe.

Turning points for other Survivors

"I think the main difference is the coping abilities that I have now and the honesty that I have in being able to verbalize my thoughts and emotions with my depression."

—Jordan Burnham

"I recognized my value to other people."

—Suicide Attempt Survivor

"I found I could do something for someone else. I could do something useful with my life."

—Suicide Attempt Survivor

"I recognized the value of talking. Talking doesn't change the event, but it can change how I felt about it and can make me feel less alone."

—Suicide Attempt Survivor

"I realized depression was a disease."

—Suicide Attempt Survivor

"I accept that my feelings are not who I am. I am an intelligent, strong, determined woman."

—Cathy Singer

What should you do with your plan?

The exercise you just completed was designed to help you think of items to include in your personalized safety plan. You can find blank safety plans on pages 26–29 of this handbook into which you can transfer your ideas. When your plan is complete, you can tear it out and keep it with you. Be sure to add contact information for the resources and support people you included. You can also find a copy of a safety plan at www.sprc.org/sites/sprc. org/files/SafetyPlanTemplate.pdf or download a free safety plan app—MY3—for your Android or Apple device.

Your plan is for your use, but it's a good idea to share it with a few other people. Your support person and backup person can do a better job in times of crisis if they have your most recent copy. If you're using a paper safety plan, you may want to keep multiple copies in various places so it's nearby whenever you need it. Your safety plan may change over time. You can add information to it in the future as you identify more triggers or want to change the names of contacts. You wouldn't want to search around for information in a crisis situation, so it's a good idea to keep contact information up-to-date.

There's one more thing about your safety plan that's very important—you have to actually use it! It's important to think about ways you can use it when you're afraid your suicidal thoughts might escalate to suicidal actions. For this reason, it should contain items and ideas that work for you, not things you feel others are forcing you to do. If you don't like the options or you feel they're unrealistic, say so. If you can't find options that are right for you, this may indicate that you need more support until you feel comfortable that you can stay safe. You may want to ask yourself:

How likely am I to use this plan when I'm feeling unsafe? What might keep me from using it? Is there anything about the plan that makes me uncomfortable?

With whom might I share my safety plan? Where will I keep my safety plan to make sure it's nearby when I need it?

Survivors Experiences with Safety plans

"You don't realize what to do when you are in that situation (feeling suicidal). Having planned activities, like going to a coffee shop and remembering to breathe, were effective." "It made me feel a little more comfortable knowing that I had a way to defuse the situation." "Having a plan in place was comforting to myself and my spouse."

—Suicide Attempt Survivors

What can I do to make it more likely that I'll use the strategies in my plan to stay safe? Examples include: keeping multiple copies close by, sharing it with others who will encourage you to use it, ensuring that you're comfortable with the contents, practicing using it, and talking with someone about how practicing went.

Tips if You're concerned about affording care

If payment is a problem, there may be ways to get low-cost or free help through various programs in your community.

If you have insurance:

Call your doctor and ask for a recommendation for a counselor/therapist. Your insurance provider should be able to provide a list of people in your area that take your insurance.

If you don't have insurance:

- You may be eligible for insurance coverage through the marketplace. For more information about your coverage options, visit www.healthcare.gov.
- It may not be simple to find a counselor if you don't have coverage, but it's not impossible. Most communities have counselors who provide low-cost or free counseling services.

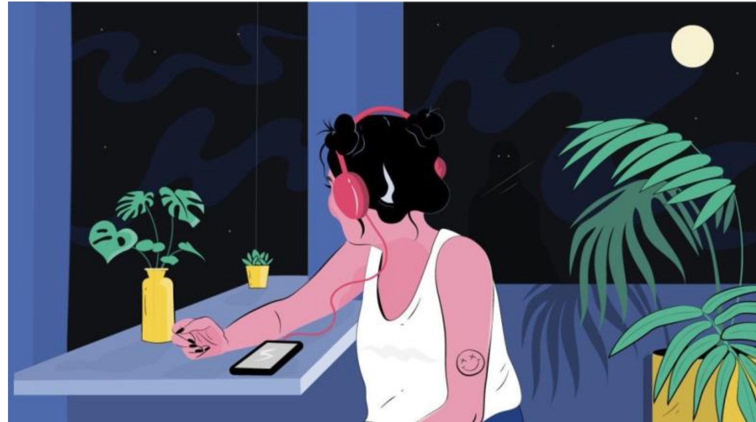
Things to try:

- If you were in the hospital after your attempt, the staff there may be able to refer you to low-cost or free counselors in your area. Additionally, your primary-care doctor may know of options.
- See if your workplace has an Employee Assistance Program (EAP). Many businesses offer an EAP to their staff with access to free and confidential counselors.
- If you're a member of a church or other place of worship, you may want to check there. Sometimes they offer free counseling with clergy or other members of the congregation.
- If you live near a university with a school of psychology, or near a seminary, see if they have free or sliding scale fees for therapy.

Finding a Counselor

Suicide attempt survivors and researchers who study suicide recommend professional help as your best bet for finding long-term strategies to ease the emotional pain that led

to your attempt. And, of course, if you're in less pain, you're much more likely to experience joy and be motivated to keep yourself safe.



Making a decision to go to therapy can be intimidating. You might worry that it will be uncomfortable or that it could lead to hospitalization, but most people who give it a try find it really helps.

When looking for a counselor, it might be difficult to know where to start. It's always smart to ask others which counselors in your area have good reputations. Your doctor or the people that helped you in the emergency room might have suggestions. Here are other ideas:

- Call the National Suicide Prevention Lifeline (1-800- 273-TALK (8255). Lifeline crisis workers know their local communities and may be able to refer you to a counselor or support group in your area. Crisis workers are also available to talk with you about your suicidal thoughts until you find other sources of support.
- Check out the SAMHSA Behavioral Health Treatment Services Locator online at https://findtreatment. samhsa.gov or call them at 1-800-662-HELP (4357).
- In many communities, you can reach an information and referral hotline by dialing three simple digits: 2-1-1. If dialing 2-1-1 doesn't work for you, check out www.211.org for the seven-digit number of your local information and referral hotline.
- Try the Suicide Prevention Therapist Finder: http://www.helppro.com/SPTF/BasicSearch.aspx
- You can also check with a local chapter of a mental health organization, such as the American Psychiatric Association, American Psychological Association,

Anxiety Disorders Association of America, Mental Health America, National Alliance on Mental Illness, or Depression and Bipolar Support Alliance.

Getting What You Need From Counseling

Selecting a counselor is an important decision, and you'll find many options for various types of therapy. When choosing a counselor, it's vital to find someone who is comfortable with and has experience talking about suicide. It's also important to remember that if drugs or alcohol played a part in the problems that led to your suicide attempt, your counselor should have experience in substance abuse treatment.

Medication could be an important part of your path to recovery, especially if you've ever been diagnosed with major depression, bipolar disorder, schizophrenia, or an anxiety disorder, or if your symptoms are so troubling that you're having problems getting through the day. This might include having serious problems sleeping; having no appetite or eating too much; thinking negative thoughts that you can't stop, no matter how hard you try; or hearing voices. If this sounds like you, you'll want to discuss medication with your counselor. Together you can find a doctor or psychiatrist who can work with you to determine whether medication might be helpful.

Different people have different needs, and sometimes it takes time to find a counselor who is right for you. This can be a frustrating process, but if one counselor, doctor, or type of therapy doesn't work, you have the right to keep trying until you find one that does. Think about your preferences in a counselor (or clinician, therapist, doctor, or psychiatrist): a man or a woman, their age range, ethnicity, language, etc. If you have a choice of counselors, call ahead for an interview or use the first session to get to know them better. Ask questions to see if they might be a good match for your style and needs.

The following questions can be helpful when selecting a counselor (Bryan and Cunningham, 2009):

1. What type of education do you have?
2. How long have you been practicing?
3. What types of treatment do you offer?
4. Do you specialize in any particular issues or treatment types?
5. Have you treated clients with problems similar to mine? Have you worked with a person who has survived a suicide attempt?
6. If I need help after regular business hours, how should I get it? Do you take after-hours/emergency calls?
7. What will you expect from me in therapy, and what can I expect from you?
8. How will your treatment help me with thoughts of suicide?
9. If I'm feeling suicidal, do you believe that the first course of action is for me to be in a hospital, or will you work with me on ways to stay safe in my home (or with family or friends)?
10. If I want to try medications, can you help me with that?

Remember, it's crucial that you be persistent. Any important decision requires some research, and sometimes it takes trial and error before you get it right.

While there are many different approaches to therapy, research shows that the following methods are especially helpful for those struggling with suicidal thoughts and attempts:

Cognitive behavioral therapy (CBT) is a short term, goal-oriented counseling approach. The premise behind CBT is that changing your thoughts can change the way you feel and behave. CBT has been used to treat a variety of disorders and issues, including helping people struggling with suicide.

Dialectical behavior therapy (DBT) combines techniques of cognitive behavioral therapy with additional skills of emotion regulation. A goal of DBT is to help you to accept the things you cannot change and change the things you can.

Collaborative Assessment and Management of Suicidality (CAMS) is an approach to suicide risk assessment and therapy that engages a person in a collaborative way and specifically works to address suicidal thinking and motivation.

The Lifeline was mentioned earlier as a source for finding referrals for counselors, but it's also a great place for support if you're in crisis. While not a substitute for ongoing therapy, the Lifeline is a network of confidential crisis hotlines across the country that are staffed by trained crisis workers. This means they won't be shocked or scared by what you say, and, importantly, they won't judge you. Lifeline crisis workers will talk with you about your suicidal feelings and brainstorm ways to help you stay safe. Crisis workers are available 24 hours a day, 7 days a week. Best of all, it's a free service.

If You Don't Go to Counseling

While it might be easier to recover from your suicide attempt with the help of a counselor, you may choose to try to get better on your own. This might be because you don't have insurance and can't afford counseling (if that's the reason, see the tips on page 17 for ideas on how to access affordable counseling services). Maybe you tried counseling, but had difficulty finding a counselor who was right for you. Maybe you don't feel like taking that step right now. It's important to remember that if struggles with a mental illness led to your suicide attempt, it might be difficult to get better and recover on your own. Just as with some physical ailments, you may find it particularly challenging to heal without medications or help from a professional.

Whatever your reason for not seeing a counselor, there are things you can do to get better on your own. The ideas already mentioned in this booklet are a good start. When you're ready, you might find the following options to be helpful as well. And even if you do have a counselor, these ideas can be great resources for additional support.

Call the National Suicide Prevention Lifeline.

The Lifeline can be a great resource for your friends and family as well. If they're having difficulty understanding your struggles with suicide or don't know how to support you, a crisis worker can speak to them about their concerns and give them ideas on how to help. Evaluations of crisis hotlines have shown that they can reduce emotional distress and suicidal thinking in callers (Gould, et al., 2007).

If talking about suicide is difficult for you, you may want to check out the Lifeline Website, www. suicidepreventionlifeline.org. The organization also provides an online chat service with crisis counselors.

Join a support group.

A support group is composed of people who meet regularly to talk about common concerns and look out for each other's wellbeing. Support groups can be helpful because they allow you to meet others who have had experiences similar to yours. It can be a huge relief to learn that you're not alone and that there are others who feel the way you do. It also can be helpful to learn about strategies others have found useful.

Just as there are different types of counselors, there are support groups for a variety of topics, such as:

- Depression
- Anxiety
- Substance abuse
- Self-esteem
- Anger
- Post-traumatic stress, sexual assault, and other traumas
- Hearing voices (e.g., schizophrenia)

A few communities across the country are even beginning to offer support groups **specifically for people who have survived a suicide attempt** or who are struggling with persistent thoughts of suicide.

Many times, support groups are led by an experienced counselor; other times they are peer-led by people who have experienced similar issues. If you don't have insurance to pay for individual counseling, a group may be one way to get help. They are often free of charge or much less expensive than seeing an individual counselor.

The information and referral hotline in your community (dial 2-1-1 or visit www.211.org) or the Lifeline (1-800-273-TALK (8255) or www.suicidepreventionlifeline.org) can give you more information about support groups in your area.

Read books or visit websites.

Sometimes, if you aren't ready or don't have access to a counselor, you can find helpful information on your own. There are many websites and books that address issues related to stress, depression, or other mental health issues. There are even several books written by people who have survived a suicide attempt. A list of recommended websites is available on pages 30–32.

Survivors' Experiences Talking to peers

"(In a support group for survivors) we are in the same club of profound personal pain. And once you assure yourself that you are talking with someone like that, then you know that what you're going to get is understanding, compassion, and sympathy."

—Suicide Attempt Survivor

"There were things that I told complete strangers because I knew that they understood where I was coming from. And I couldn't say that to my therapist, I couldn't say that to my parents, I couldn't say that to my friends because they didn't

truly understand the real Jordan, the real Jordan who hated himself, wondered everyday whether I should be here."

—Jordan Burnham

Moving Toward a Hopeful Future

After you've taken your first steps back into daily life, it might be time to consider taking on a few more challenges. You've already made it through the toughest part. Now it's time to think about doing some things that can give you a greater sense of wellbeing and happiness.

Many survivors talk about a "second chance," or slowly coming to value what would have been lost if their attempt had resulted in their death. Over time, they begin to reclaim a sense of purpose in their lives, a new sense of identity, and real reasons for hope.

Maintaining Hope

When you made your suicide attempt, you felt as if suicide was a way to end your pain. At that moment, in your mind, your reasons for dying outweighed your reasons for living. As you've learned, reconnecting with your reasons for living can help you build hope. Some survivors recommend putting together a "hope box" that can serve as a physical reminder of the things in your life that bring you joy. When you begin to feel bad about yourself or your life and feel depressed, the contents of your hope box can help lift your spirits. It also is a good place to keep your safety plan.

Staying in Control by Being Organized

Dealing with stress or emotional pain can feel overwhelming and lead you to neglect day-to-day tasks and responsibilities. Feeling like life is out of control can make anyone feel anxious. It might help to make a list of the things you have to do each day. That

way, you won’t forget important events or get distracted and not complete things you need to get done.

Checking items off a to-do list can also help you feel a sense of accomplishment. Keep it simple and short to begin with; you can always add more when you have more energy. Keeping a calendar and using a daily planner are great ways to help yourself stay organized and maintain a sense of control over your life.

Things to Think About

Creating a Hope Box

Your hope box can contain anything that might help you put aside painful thoughts or negative emotions and instead remind you of things in life that you enjoy. Decorating the box can be fun, as well. Here are some ideas for things to include:

- Photos or letters from people you care about.
- Poems, books, or scripture passages that lift you up.
- Movies or music you like.
- Note cards with uplifting words or thoughts, things that have kept you going in the past, or memories of happy times.
- Special trinkets or mementos that help you feel grounded.
- Your safety plan.

Your box can contain actual objects or be a collection of links or digital files on your com-puter, cell phone, e-reader, or other device. You can also download a free “Virtual Hope Box” app for your Android or Apple phone or tablet.

What would you put in your hope box?

Getting in Touch With Your Spirituality

Some suicide attempt survivors find comfort in spirituality. Spirituality can mean different things to different people, and for some it can provide a feeling of being connected to something larger than themselves. Some may experience this

by attending churches, temples, synagogues, mosques, and other places of worship. Others discover deeper meanings in nature, philosophy, or music. Would getting in touch with your spirituality bring you comfort and peace? Only you can answer that, but it does help some people.

Maintaining a Healthy Lifestyle

Maintaining a healthy lifestyle can affect the way you feel, not only physically, but emotionally. If you feel depressed or overwhelmed emotionally, it's easy to forget the basics of taking care of yourself physically. It will make a difference if you maintain a healthy lifestyle during your recovery. Of course, this means limiting your use of alcohol and eliminating other drugs, as these can negatively affect your emotions, but it's more than just that. Getting enough sleep, eating well, and exercising are also crucial to your recovery.

Sleep

A link between sleep and depression is well-documented. When depressed, many people find themselves sleeping a lot more than usual, while others are unable to sleep adequately. Poor sleep can lead to fatigue, inactivity, anxiety, and irritability, making depression or other mental health issues even worse. Insomnia can also be associated with suicidal thoughts and actions. If you have depression that includes sleep disturbances, certain kinds of talk

therapy (like CBT) can help, as well as medication. So it is important to discuss sleep problems with your counselor or psychiatrist.

Getting enough sleep is crucial because your body restores itself during sleep. For more information you can read Healthy Sleep Tips from the National Sleep Foundation (http://sleepfoundation.org/sleep-tools-tips/healthy-sleep-tips).

Survivor Story

"I contacted a church and found faith, which gave me a lot of coping skills. And then I started opening up."

—Suicide Attempt Survivor

Diet

Appetite changes—either poor appetite with weight loss or increased appetite with weight gain—also can be symptoms of major depression. If your appetite has changed and you have low, depressed mood, please talk with your psychiatrist or counselor about whether you should consider medication.

While no particular diet has been proven to decrease depression and anxiety or improve emotional health, there does seem to be a correlation between what we eat and how we feel. A healthy diet is recommended as a key part of the overall treatment for depression. Additionally, ensuring that your body has the nutrients it needs can increase your energy level.

Enrolling in a healthy cooking class can help you find ways to eat well and meet new people. You also can find out how to prepare healthy food online.

The United States Department of Agriculture (USDA) has a diet and nutrition website: http://snap.nal.usda.gov/ basic-nutrition-everyone that could be a good starting point.

Exercise

When you exercise, your body releases endorphins, a chemical that affects how people perceive pain. It's believed that the release of endorphins can help people feel more energized and even improve their emotional states, allowing them to be more hopeful about life. In fact, some studies suggest that exercise can be an effective treatment for depression.

Given that exercise can improve your mood, you might want to join a local gym, take a walk every day with a friend, or do exercises at home. Incorporating an exercise plan into your daily life (exercising three or more times each week) is highly recommended. You can find more information about depression and exercise online. The National Alliance on Mental Illness (NAMI) has resources about exercise and mental health at http://www.nami.org/Find-Support/Living-with-a-Mental-Health-Condition/ Taking-Care-of-Your-Body.

For more information about maintaining a healthy lifestyle, see SAMHSA's Wellness Strategies at http://www.samhsa.gov/wellness/strategies.

Survivor Story

"I believe that like treating any other chronic illness, [with depression] I have to be vigilant about maintaining a healthy lifestyle."

—Heidi Bryan

Taking Medication

If you choose to go to counseling, your counselor may recommend taking medication to improve your mood, especially if maintaining a healthy lifestyle and counseling aren't giving you the results you're looking for. You may struggle with the decision to take medication and feel as though it's a sign of weakness. It's important to remember that people take medications for all sorts of illnesses, and there is no reason to be embarrassed if you choose to try medications to alleviate depression, anxiety, or another mental health concern that causes you pain.

Certainly, only you can decide if you want to take medication; however, many people have felt that their depression and anxiety improved after taking medication. Most people (including researchers) indicate that counseling combined with medication provides the best results.

If you do choose to try medication, here are a few important things to remember:

- It can take some time for medication to have an effect. While some medications (for instance, sleep medication) may work immediately, medications for depression may take up to 8 weeks to reach their full effect. Your psychiatrist or doctor can tell you what to expect.
- You must take your medication as directed, without skipping dosages, for it to be effective.

- It’s important to continue taking your medication for the entire period it is prescribed. You may be tempted to stop taking medication when you start to feel better. Stopping too soon can cause a relapse. Always work with your psychiatrist or doctor if you want to stop or change your medication.
- If your thoughts of suicide increase after you start taking medication, be sure to contact your psychiatrist or doctor immediately.

• Different medications work for different people. Be patient; sometimes it can take time to find the medications that work best for you. If one medication doesn’t work, that doesn’t mean none of them will. Finding the right medication can take persistence.

Advocating for Others to Support Your Recovery

When you’re feeling stronger, you may find that helping others who are facing suicide can help you, too. Sharing your experiences and wisdom might save other lives. And saving lives can be a source of pride and accomplishment for you. Speaking about your experience also helps to break the guilt and shame that can be associated with suicide and lets others know they’re not alone.

You should give serious consideration to whether you’re ready to talk openly about your suicide attempt before deciding to advocate for others. It’s important to ensure that you’ve given yourself enough time to heal and learn from your experience before using it to help others. Some questions you might ask yourself include:

- Am I ready to speak? Have I healed enough to speak?
- Am I prepared for my family’s reactions to going public?

- Am I prepared for the possible social effects of going public with my story?
- Am I familiar with the resources available to help others?
- How will I take care of myself?

The American Association of Suicidology has a helpful guide, “Special Considerations for Telling Your Own Story: Best Practices for Presentations by Suicide Loss and Suicide Attempt Survivors.” You may want to read the entire article before making the decision to share your story.

For more information, visit: http://www.suicidology.org/suicide-survivors/suicide-attempt-survivors

Some Ways to Help others When the Time is right include:

- Becoming a member of a national organization that advocates for suicide prevention
- Helping raise funds for suicide prevention
- Participating in a suicide prevention walk
- Volunteering at a crisis hotline
- Organizing an attempt survivors’ support group
- Writing or talking with others about your journey to raise public awareness about suicide and recovery

Hopes for a Safe Journey

The time after your suicide attempt is an important one. It can be a turning point in your life. Often, your suicide attempt can break the silence that surrounded the problems you were experiencing and your suicidal thoughts. Making a choice to be open about how you’re feeling and seeking help, when you’re ready, can be the first step on the path to a more fulfilling life.

As discussed, recovering from your suicide attempt is a process. It will likely have its ups and downs. You may feel overwhelmed or sad at times, and you may experience

suicidal thoughts again. However, it's important to remember that feelings change. Finding ways to cope with those negative feelings while staying alive will give you a chance to enjoy the positive things life has in store for you. The stories and tools in this booklet can help you feel better. They've worked for other people, and they may work for you, too.

The survivors, researchers, SAMHSA and Lifeline staff, and many others who contributed to this booklet sincerely hope it will help you. We ask you always to remember our message:

- You are not alone.
- You matter.
- Life can get better.
- It may be difficult, but the effort you invest in your recovery will be worth it.

There is Hope *"Everything will feel different if we just live long enough to see and be the difference."*

—Cathy Singer

"You may think things will never get better, but you never know. You may think you know, but you don't know. And you may think nobody cares about you or that you're worthless, but that's not true. This is just your disease talking, and you can't listen to it. It will pass and eventually, sometimes longer than other times, it will get better."

—Heidi Bryan

"If I were to sum up my life today, the word that I would use to describe it is fulfilling. I live a very enriched life."

—Terry Wise

"You are not 'crazy' or lessened in any way by your experience. Many more people than you can imagine, even among people you know, have had suicide attempts or

suicidal thinking themselves. You have a lot of company from people of all backgrounds, even if the majority of that company may be too scared to admit it. Be strong. Don't let yourself get pushed around. You can move on."

—Cara Anna

References for Chapter 6

Bryan, H., and Cunningham, A. (2009). Now what do I do? Surviving a suicide attempt. Retrieved from http://www.heidibryan.com/uploads/NOW_WHAT_DO_I_DO_04.2011.pdf.

Gould, M.S., Kalafat, J., Harrismunfakh, J.L., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 2: Suicide callers. Suicide and Life-Threatening Behavior, 37(3), 338–352.

National Suicide Prevention Lifeline (2007). Lifeline service and outreach strategies suggested by suicide attempt survivors: Final report of the attempt survivor advisory summit meeting and individual interviews. http://lifelineforattemptsurvivors.org/connect-to-resources.

Stanley, B., and Brown, G.K. (2011). Safety planning intervention: A brief intervention to mitigate suicide risk. Cognitive and Behavioral Practice, 19, 256–264.

Conclusion

Suicide is becoming an ever-increasing issue throughout the world. Some States, like California, recognizing suicide as "a public health crisis" warranting a response from the State, are forming an "Office of Suicide Prevention." Additionally, the Board of Behavioral Sciences has mandated all Licensed Social Workers, Family Therapists and

Licensed Professional Counselors complete a course, such as this one, in Suicide Risk Assessment and Intervention.

The purpose of this course is to help the healthcare professionals in their efforts to identify, assess and intervene with those at risk for harming themselves. It is also hopeful individual will be encouraged to reach out for treatment services prior to reaching the point of considering suicide. In each case, it is vital we are each prepared with the tools to assist individuals who are suffering.

End of the Course!

References:

California Legislative Information, *AB2112*, (2020) Retrieved from: http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB2112

National Institute of Mental Health (NIMH), *Suicide in America: Frequently Asked Questions*, 2020: Retrieved from https://www.nimh.nih.gov/health/publications/suicide-faq/tr18-6389-suicideinamericafaq_149986.pdf

National Suicide Prevention Lifeline (NCPL), "LGBTQ+" 2020, Retrieved from https://suicidepreventionlifeline.org/help-yourself/lgbtq/

Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., and Wilkins, N. (2017). *Preventing Suicide: A Technical Package of Policies, Programs, and Practices*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from: https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf

Substance Abuse and Mental Health Services Administration, *Preventing Suicide*, (2020) Retrieved from https://www.samhsa.gov/suicide/at-risk

Substance Abuse and Mental Health Services Administration. *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series, No. 50. HHS Publication No. (SMA) 15-4381. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009. Retrieved from https://store.samhsa.gov/product/TIP-50-Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/SMA15-4381

Substance Abuse and Mental Health Services Administration. (2015). *Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Centers*. HHS Publication No. SMA-15-4416. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2015.
Retrieved from: https://store.samhsa.gov/product/Promoting-Emotional-Health-and-Preventing-Suicide/SMA15-4416?referer=from_search_result

Substance Abuse and Mental Health Services Administration. *A Journey Toward Help and Hope: Your Handbook for Recovery After a Suicide Attempt.* HHS Publication No. SMA-15-4419. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2015.
Retrieved from: https://suicidology.org/wp-content/uploads/2019/06/HandbookForRecoveryAfterAttemptSAMHSA.pdf

Suicide in America: Frequently Asked Questions (2018)
https://www.nimh.nih.gov/health/publications/suicide-faq/index.shtml

World Health Organization (WHO); *National suicide prevention strategies: progress, examples and indicators.* Geneva: World Health Organization; 2018. License: CC BY-

NC-SA 3.0 IGO. Retrieved from: https://www.who.int/mental_health/suicide-prevention/national_strategies_2019/en/