Suicide Prevention Treatment and Support

Contents

Preface from the Surgeon General

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

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

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

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

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

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

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

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

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

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

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Surgeon General

Introduction

Suicide is a serious public health problem that causes immeasurable pain, suffering, and loss to individuals, families, and communities nationwide. Many people may be surprised to learn that suicide was one of the top 10 causes of death in the United States in 2009.[1] And death is only the tip of the iceberg. For every person who dies by suicide, more than 30 others attempt suicide.[2] Every suicide attempt and death affects countless other individuals. Family members, friends, coworkers, and others in the community all suffer the long-lasting consequences of suicidal behaviors.

Key Facts:

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

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

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

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

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

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

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

To assess progress made to date and identify remaining challenges, the Substance Abuse and Mental Health Services Administration (SAMHSA) commissioned the report *Charting the Future of Suicide Prevention*.[7] Published in 2010, the report identified substantial achievements in suicide prevention in the years following the release of the National Strategy. Examples include the enactment of the Garrett Lee Smith Memorial Act, the creation of the National Suicide Prevention Lifeline (800–273–TALK/8255) and its partnership with the Veterans Crisis Line, and the establishment of the Suicide Prevention Resource Center (SPRC). Other areas of progress include the increased training of clinicians

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

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

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

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

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

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

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

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

A Comprehensive Approach to Suicide Prevention

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

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

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

At the primary care provider or emergency department:

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

In the community, while receiving care:

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

In the community, after the person recovers:

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

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

Understanding Suicide

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

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

Risk and Protective Factors

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

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

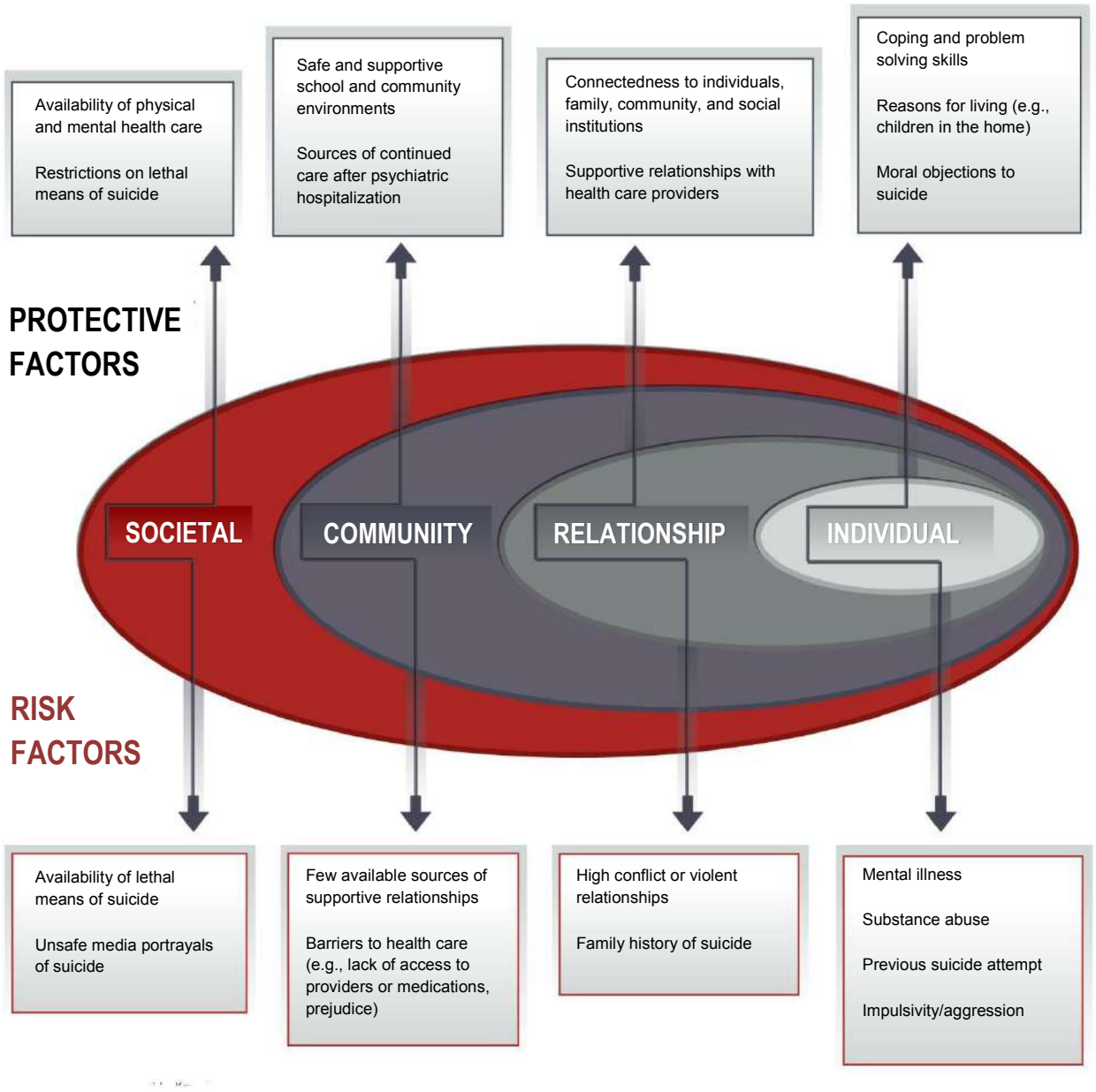
Risk and protective factors for suicidal behaviors can be found at many levels, from the individual to the community and society at large. The social ecological model (see figure on page 15) provides a useful framework for viewing these factors along four levels of influence: individual, relationship,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

Key Terms

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

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

EXAMPLES OF RISK AND PROTECTIVE FACTORS IN A SOCIAL ECOLOGICAL MODEL



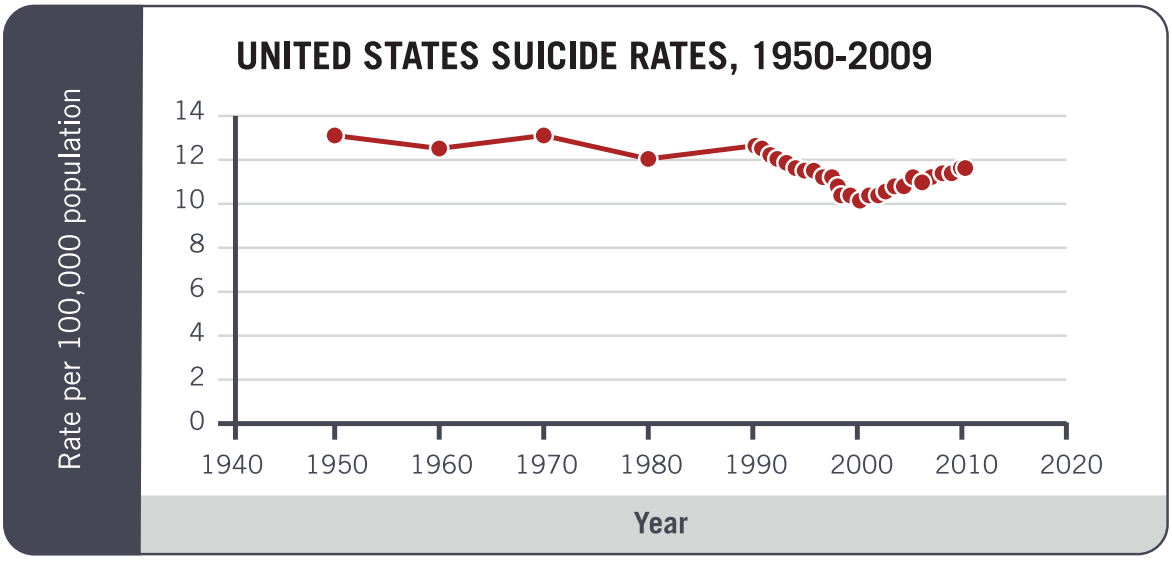
Adapted from: Dahlberg LL, Krug EG. Violence—a global public health problem. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World report on violence and health. Geneva, Switzerland: World Health Organization; 2002:1–56.

Suicide is closely linked with mental and substance use disorders[13] and shares risk and protective factors with other types of self-directed violence,[14] interpersonal violence,[15] and other related problems. As a result, efforts to reduce the risk factors and to increase the protective factors for suicide are likely to also help prevent or reduce these and other problems. For example, a comprehensive suicide prevention program implemented by the U.S. Air Force (see box on page 21) was found to not only prevent suicide but also to reduce family violence and homicide.[16]

The Prevalence of Suicidal Behaviors

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

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



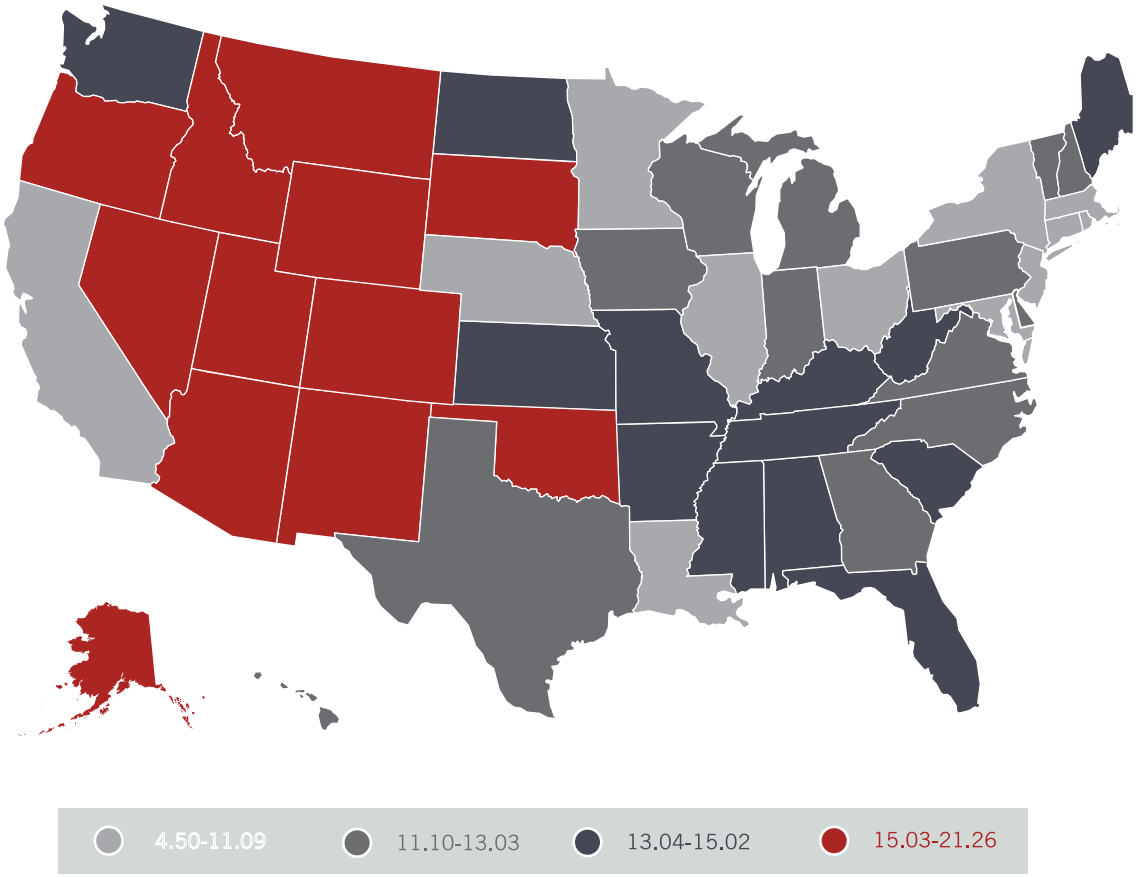
SOURCE: Death data are from the National Vital Statistics System operated by the National Center for Health Statistics, CDC. Age-adjusted rates for 1950–2009 were obtained from WISQARS (www.cdc.gov/injury/wisqars).

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

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

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

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

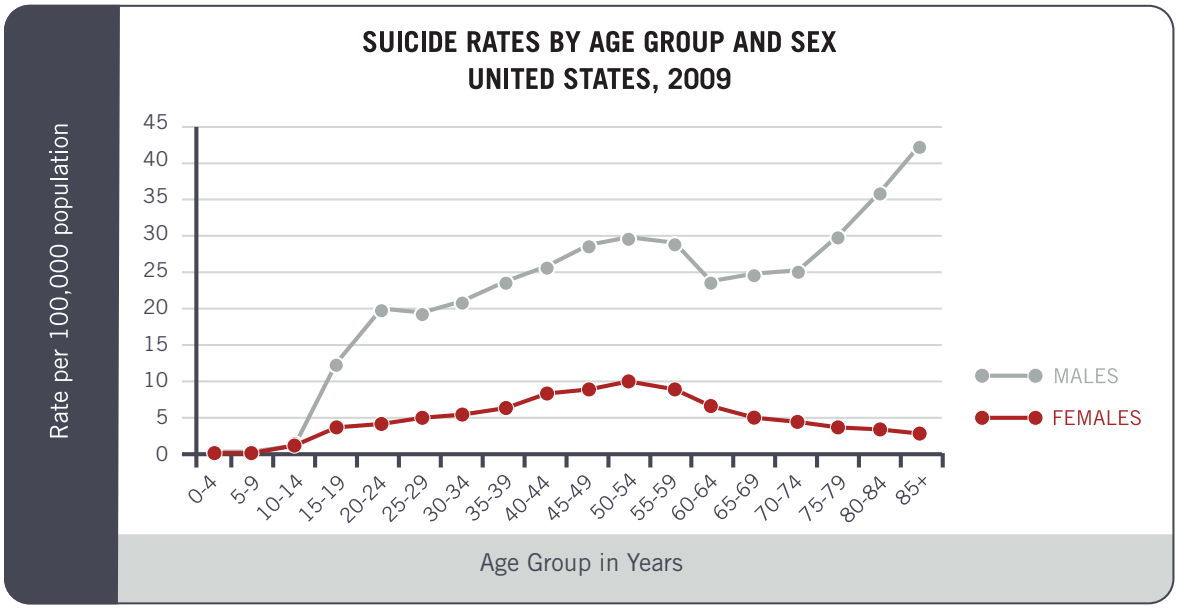


SOURCE: Death data are from the National Vital Statistics System operated by the National Center for Health Statistics, CDC. Age-adjusted rates for 2009 were obtained from WISQARS (www.cdc.gov/injury/wisqars).

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

Differences Among Groups

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



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

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

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

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

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

Warning Signs of Suicide

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

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

What To Do

If someone you know exhibits warning signs of suicide:

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

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

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

Other groups identified as having a higher risk for suicidal thoughts and/or behaviors than the general population include LGBT populations[38] and individuals who have been bereaved by suicide.[39] For more information on these and other groups, see Appendix D.

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

Preventing Suicide

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

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

Evidence-Based and Promising Practices

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

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

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

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

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

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

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

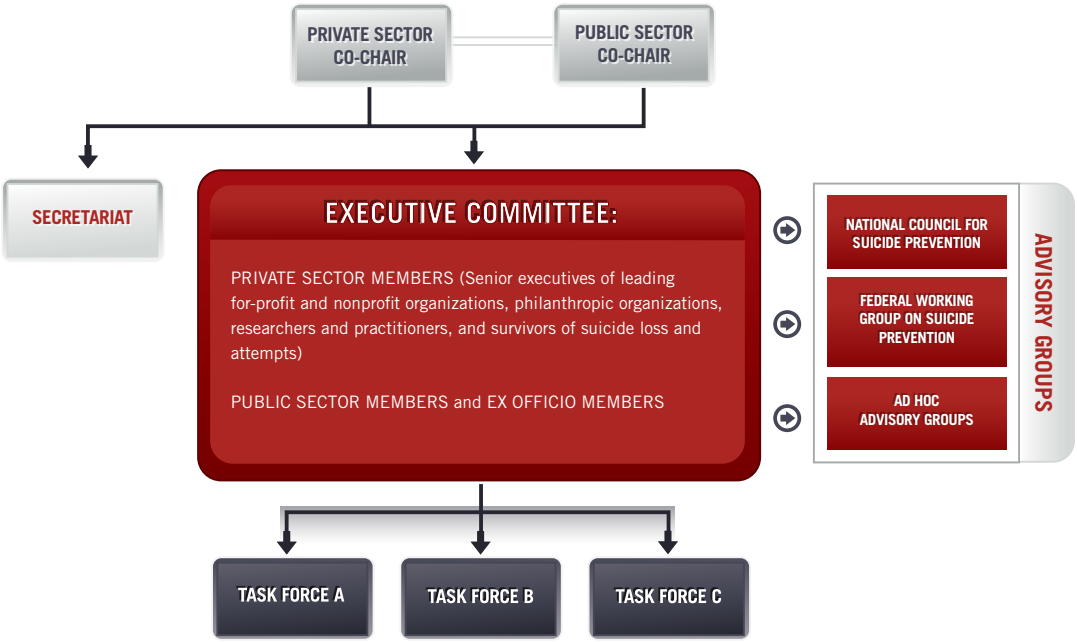
Two online resources—the National Registry of Evidence-Based Programs and Practices (NREPP) and the Best Practices Registry (BPR)—are helping to disseminate these findings so they may be more widely used. NREPP, a searchable online registry maintained by the Substance Abuse and Mental Health Services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

The 2012 National Strategy for Suicide Prevention

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

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

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION
ORGANIZATIONAL CHART



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

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

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

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

Key Documents Informing the Revision

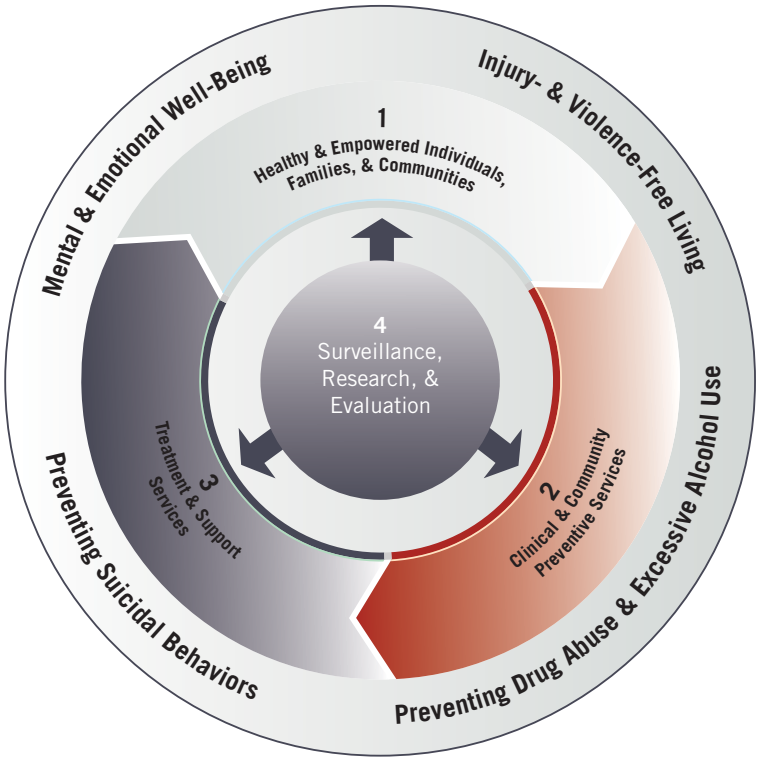
- *National Prevention Strategy,* National Prevention, Health Promotion, and Public Health Council, 2011
- *HealthyPeople 2020*, U.S. Department of Health and Human Services, 2010
- *Charting the Future of Suicide Prevention,* SPRC and SPAN USA, 2010
- *Preventing Mental, Emotional, and Behavioral Disorders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

Organization of the 2012 National Strategy for Suicide Prevention

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

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

ORGANIZATION OF GOALS AND OBJECTIVES



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

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

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

Themes Shared Across Strategic Directions

Suicide prevention efforts should:

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

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

Looking Ahead

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

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

Identifying Priority Areas for Action

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

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

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

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

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

Several considerations helped guide the development of this action agenda.

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

Existing opportunities for action. In selecting areas for action, it is important to take advantage of existing programs, opportunities, and resources, including initiatives that are already underway and that could be expanded or brought to scale in the short term. Examples include expanding the NVDRS system to additional states and territories and promoting the adoption of system-level approaches to suicide prevention and major depression that have been implemented by the U.S. Air Force[16] and the Henry Ford Health System,[49] among others.

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

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

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

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

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

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

Lessons From the United Kingdom

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Objective 2.2: Reach policymakers with dedicated communication efforts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Federal Government Can:

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

State, Territorial, Tribal, and Local Governments Can:

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

Businesses and Employers Can:

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

Health Care Systems, Insurers, and Clinicians Can:

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

Schools, Colleges, and Universities Can:

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

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

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

Individuals and Families Can:

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

Strategic Direction 2: Clinical and Community Preventive Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Federal Government Can:

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

State, Territorial, Tribal, and Local Governments Can:

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

Businesses and Employers Can:

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

Health Care Systems, Insurers, and Clinicians Can:

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

Schools, Colleges, and Universities Can:

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

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

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

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

Individuals and Families Can:

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

Strategic Direction 3: Treatment and Support Services

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

Evidence-based and promising approaches for caring for high-risk patients include safety planning (i.e., working collaboratively with each patient to develop an action plan for times of crises) and specific forms of psychotherapy that can be used to support treatment for underlying mental health conditions. Addressing suicide risk may be particularly important when treating individuals who have survived a suicide attempt. There is now substantial evidence that interventions such as dialectical behavior therapy (DBT) and cognitive behavior therapy for suicide prevention (CBT-SP) can help reduce suicidal behaviors among these patients. In addition, clozapine has been found to be effective in reducing suicidal behaviors among patients with schizophrenia[86] and lithium shows promise in patients with mood disorders.[87]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Federal Government Can:

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

State, Territorial, Tribal, and Local Governments Can:

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

Businesses and Employers Can:

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

Health Care Systems, Insurers, and Clinicians Can:

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

Schools, Colleges, and Universities Can:

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

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

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

Individuals and Families Can:

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

Strategic Direction 4: Surveillance, Research, and Evaluation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Goal 12. Promote and support research on suicide prevention.

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

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

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

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

Objective 12.2: Disseminate the national suicide prevention research agenda.

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

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

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

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

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

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

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

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

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

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

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

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

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

Objective 13.1: Evaluate the effectiveness of suicide prevention interventions.

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

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

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

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

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

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

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

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

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

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

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

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

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

The Federal Government Can:

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

State, Territorial, Tribal, and Local Governments Can:

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

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

Businesses and Employers Can:

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

Health Care Systems, Insurers, and Clinicians Can:

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

Schools, Colleges, and Universities Can:

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

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

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

Individuals and Families Can:

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

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