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ABSTRACT

This guide is designed to be a catalyst for social change, and to transform attitudes, policies, and services concerned with suicide prevention to reflect current knowledge. It involves a comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors in the United States. Representing the combined work of advocates, clinicians, researchers, and survivors, the strategy lays out a framework for action and guides the development of an array of services and programs for the future. It strives to promote and provide direction to efforts to modify the social infrastructure in ways that will affect attitudes about suicide and that will also change judicial, educational, social service, and health care systems. The public health approach is a rational and organized way to direct prevention efforts and ensure that they are effective. This national strategy represents the first attempt to prevent suicide through a coordinated approach between all levels of the government and the private sector. The Goals and Objectives for Action consist of 11 goals and 68 objectives that serve as the blueprint for action. Appendices include the following: "NSSP Goals and Objectives for Action": Summary List;

Evaluation of Suicide Prevention Programs; Suicide Prevention Efforts in Process of Evaluation; NSSP Federal Steering Group Agency Descriptions; and Glossary. (Contains 197 references.) (JDM)

National Strategy for Suicide Prevention: Goals and Objectives for Action

U.S. Department of Health and Human Services

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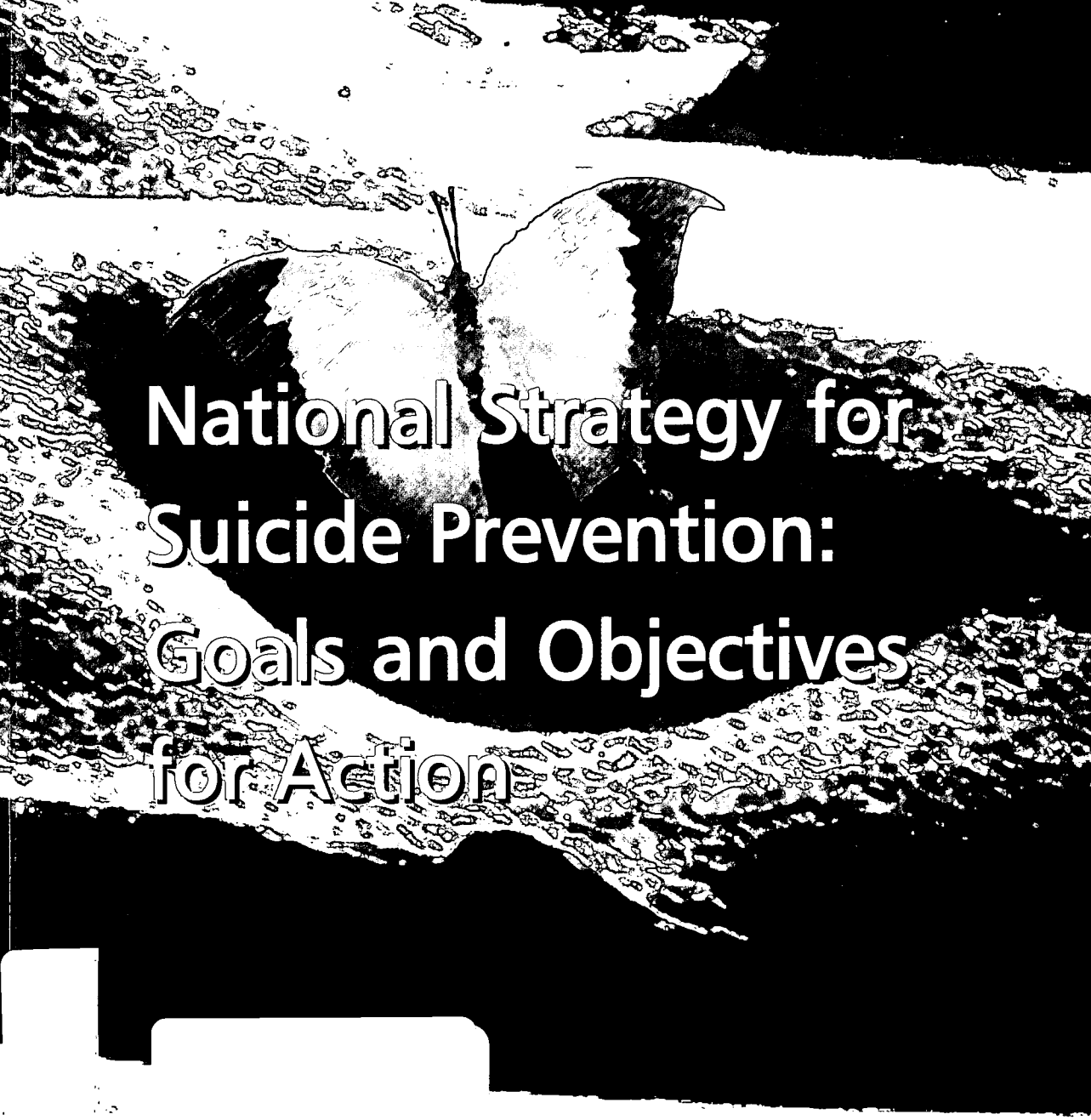

National Strategy for Suicide Prevention: Goals and Objectives for Action

NATIONAL STRATEGY FOR SUICIDE PREVENTION:

Goals and Objectives for Action

2001

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PREFACE FROM THE SURGEON GENERAL:

Suicide exacts an enormous toll from the American people. Our Nation loses 30,000 lives to this tragedy each year, another 650,000 receive emergency care after attempting to take their own lives. The devastating trauma, loss, and suffering is multiplied in the lives of family members and friends. This document, ***National Strategy for Suicide Prevention – Goals and Objectives for Action***, lays the foundation of our Nation's strategy to confront this serious public health problem.

At this document's source are countless dedicated individuals representing every facet of our Nation's communities. They include representatives to a 1993 United Nations/World Health Organization Conference who played key roles in establishing guidelines for national suicide prevention strategies. They include the passionate grassroots activists whose work stimulated Congressional Resolutions declaring suicide prevention a national priority and calling for our own national strategy. They include dedicated public servants and private individuals who jointly organized and participated in the first National Suicide Prevention Conference in 1998 to consolidate a scientific base for this critical endeavor. These people and their efforts led directly to publication of the ***Surgeon General's Call to Action to Prevent Suicide - 1999*** with its most important recommendation, the completion of the ***National Strategy for Suicide Prevention***.

After listening to the concerns of the American people, Government leaders helped bring stakeholders together in a shining example of public-private collaboration to achieve this major milestone in public health. Those who have invested their hearts and minds in this effort believe it effectively points the way for organizations and individuals to curtail the tragedy of suicide and suicidal behavior. Though it does not specify all the details, it provides essential guidance and suggests the fundamental activities that must follow–activities based on the best available science.

Nearly half of the States are engaged in suicide prevention and many have already committed significant resources to implement programs. Their leadership in evaluating the effectiveness of these programs will

help guide the efforts of States that follow in their paths. Most of these plans recognize that much of the work of suicide prevention must occur at the community level, where human relationships breathe life into public policy. American communities are also home to scores of faith-based and secular initiatives that help reduce risk factors and promote protective factors associated with many of our most pressing social problems, including suicide.

As you read further, keep in mind that the ***National Strategy for Suicide Prevention*** is not the Surgeon General's strategy or the Federal government's strategy; rather, it is the strategy of the American people for improving their health and well-being through the prevention of suicide. I congratulate each person who played a role in bringing it to completion. You have served your fellow Americans well.

Sincerely yours,

David Satcher, M.D., Ph.D.
Surgeon General

FROM THE NATIONAL COUNCIL FOR SUICIDE PREVENTION

Dear Surgeon General Satcher:

The members of the National Council for Suicide Prevention are writing to express strong support for this landmark document -- the first ever ***National Strategy for Suicide Prevention (National Strategy)***.

We are particularly grateful to you for bringing needed attention to the problem of suicide in our country, and for your role in the public/private effort that has led to the ***National Strategy***. Further, we applaud the fact that this strategy has been created from the expertise and experience of mental health clinicians, research scientists, suicide survivors, persons who have attempted suicide, prevention advocates and other concerned individuals.

The enormous amount of time and effort that went into the development of the ***National Strategy*** is reflected in its clarity of purpose and its comprehensiveness. From our perspective, the goals and objectives, as articulated and well documented in the strategy, provide a focus for the suicide prevention work of all groups at national, State and local levels.

With this broad agreement on what must be done to prevent suicide, we now face a new challenge, which is how to achieve, to the fullest extent possible, the goals and objectives presented in the strategy and to ensure that it reaches all Americans.

As a council of national not-for-profit organizations whose primary focus is the prevention of suicide, we are dedicated to working with each other and with our colleagues in government and the private sector to do what we can to ensure the timely implementation of the ***National Strategy***. Together, we can and will do more to prevent loss of life from suicide.

Respectfully submitted,

Alan L. Berman, Ph.D.
American Association of Suicidology

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NATIONAL STRATEGY FOR SUICIDE PREVENTION
GOALS AND OBJECTIVES FOR ACTION

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FOREWORD

Suicide is a particularly awful way to die: the mental suffering leading up to it is usually prolonged, intense, and unpalliated. There is no morphine equivalent to ease the acute pain, and death not uncommonly is violent and grisly. The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description.

Kay Redfield Jamison

To most of those who have experienced it, the horror of depression is so overwhelming as to be quite beyond expression, hence the frustrated sense of inadequacy found in the work of even the greatest artists....If our lives had no other configuration but this, we should want, and perhaps deserve, to perish; if depression had no termination, then suicide would, indeed, be the only remedy. But one need not sound the false or inspirational note to stress the truth that depression is not the soul's annihilation; men and women who have recovered from the disease – and they are countless – bear witness to what is probably its only saving grace: it is conquerable.

William Styron

PUBLIC EFFORTS LEADING TO THE GOALS AND OBJECTIVES FOR ACTION

Suicide has stolen lives around the world and across the centuries. Meanings attributed to suicide and notions of what to do about it have varied with time and place, but suicide has continued to exact a relentless toll. Only recently have the knowledge and tools become available to approach suicide as a preventable problem with realistic opportunities to save many lives. The goals and objectives presented here, a cornerstone of our Nation's strategy to prevent suicide, are framed upon these

advances in science and public health. Suicide is a serious public health problem.

The French social scientist, Emile Durkheim (1858-1917) developed a method of study that became the foundation for scientific inquiry about suicide. Instead of basing his conclusions only upon commonalities among people known to have died by suicide, Durkheim originated the scientific exploration of risk factors for suicide by comparing one group with another (Durkheim, 1897/1951). To Durkheim, the differences in rates of suicide could be attributed to distinguishing sociological characteristics among those population groups. Comparing those who are suicidal with those who are not, or groups having high rates of suicide with those having low rates is the incremental process by which risk and protective factors for suicide have been unveiled.

In the United States, large-scale efforts to prevent suicide began in 1958 through funds from the U.S. Public Health Service to establish the first suicide prevention center. Based in Los Angeles, Edwin Shneidman, Norman Farberow, and Robert Litman studied suicide in the context of providing community service and crisis intervention (Shneidman and Farberow, 1965). Other crisis intervention centers were founded across the country to replicate the Los Angeles Suicide Prevention Center's service component.

A more direct Federal role in suicide prevention began in 1966 when the Center for Studies of Suicide Prevention was established at the National Institute of Mental Health (NIMH). In time, this unit became the Suicide Research Unit (no longer existing) that championed the risk factor approach to suicide prevention, a central tenet in the public health model of prevention embodied in this ***National Strategy for Suicide Prevention*** (***National Strategy*** or NSSP). During the next two decades, the American Association of Suicidology and then the American Foundation for Suicide Prevention were established. Among their activities these professional and private voluntary organizations worked to increase the scientific understanding of suicide as a base for effective prevention activities.

In 1983, the Centers for Disease Control and Prevention (CDC) established a violence prevention unit that brought to public attention a disturbing increase in youth suicide rates. In response, the Secretary of Health and Human Services established the multi-year public/private Secretary's Task Force on Youth Suicide to review what was known about risk factors for youth suicide and promising interventions. These reviews and the Task Force's prevention recommendations were published in 1989 (ADAMHA, 1989).

Shortly thereafter an international effort culminated in the United Nations/World Health Organization's 1996 summary, Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies (UN/WHO, 1996). In the U.S., the Suicide Prevention Advocacy Network (SPAN USA), a grassroots advocacy organization including suicide survivors (persons close to someone who completed suicide), suicide attempt survivors, and community activists championed these guidelines as a way to encourage development of a national suicide prevention strategy for the United States. Their work to marshal social will for suicide prevention generated Congressional Resolutions recognizing suicide as a national problem and suicide prevention as a national priority. These resolutions provided further impetus to develop a national suicide prevention strategy.

SPAN propelled the creation of an innovative public/private partnership to jointly sponsor a National Suicide Prevention Conference convened in Reno, Nevada, in October 1998 (Reno Conference). Participating agencies within the U.S. Department of Health and Human Services were the Centers for Disease Control and Prevention, the National Institutes of Health, the Office of the Surgeon General, the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, the Indian Health Service and the Public Health Service Regional Health Administrators. Conference participants, including researchers, health, mental health and substance abuse clinicians, policy makers, suicide survivors, consumers of mental health services, and community activists and leaders discussed eight background papers that were commissioned to summarize the evidence base for suicide prevention (Silverman, Davidson, and Potter, 2001). Working in regional, multi-

disciplinary groups, participants at the Reno Conference offered many recommendations for action that were shaped into a list of 81 by an expert panel.

Moving forward with the work of the Reno Conference, the Surgeon General issued his ***Call to Action to Prevent Suicide*** in July 1999, emphasizing suicide as a serious public health problem. (USPHS, 1999) The Surgeon General's Call introduced a blueprint for addressing suicide prevention through Awareness, Intervention, and Methodology (AIM), which describes 15 broad recommendations, containing goal statements, broad objectives, and recommendations for implementation, consistent with a public health approach to suicide prevention. AIM represents a consolidation of the highest-ranked of the 81 Reno Conference recommendations according to their scientific evidence, feasibility, and community support.

Continuing attention to suicide prevention issues and the significant role of mental health and substance abuse services in suicide prevention is reflected in the landmark ***Mental Health: A Report of the Surgeon General*** (DHHS, 1999) and in the nation's public health agenda, ***Healthy People 2010***, (see Objectives 18-1 and 18-2)(DHHS, 2000). The effective implementation of the ***National Strategy*** will play a critical role in reaching the suicide prevention goals outlined in ***Healthy People 2010***. In early 2000, the Secretary of Health and Human Services officially established the ***National Strategy*** Federal Steering Group (FSG) to, "...ensure resources identified...for the purpose of completing the ***National*** [Suicide Prevention] ***Strategy*** are coordinated to speed its progress." The FSG carefully reviewed the recommendations of both the Reno meeting and the ***Call to Action*** with a view to developing a comprehensive plan outlining national goals and objectives that would stimulate the subsequent development of defined activities for local, State and Federal partners.

The ***National Strategy*** Leadership Consultants (see Acknowledgments) met to identify the scope and priorities for these ***Goals and Objectives for Action***. The Leadership Consultants have continued to refine the goals and objectives as part of a broadly inclusive

process which has invited critical examination by scientific, clinical, and government leaders; other professionals; and the general public. Revised draft goals and objectives were also posted on the World Wide Web inviting comment. During 2000, public hearings on ***Goals and Objectives for Action*** were held in Atlanta, Boston, Kansas City, and Portland to provide a face-to-face forum for additional input and clarification.

Working in collaboration to develop the ***National Strategy*** has been a process that has promoted investment in the goal of suicide prevention and promoted broad collaboration in prevention activities. This volume, the ***National Strategy for Suicide Prevention: Goals and Objectives for Action***, represents a significant milestone and continuing progress towards all of the elements in a planned national strategy.

THE NATIONAL STRATEGY CONCEPT

A national strategy to prevent suicide is a comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors across the life course. It encompasses the promotion, coordination, and support of activities that will be implemented across the country as culturally appropriate, integrated programs for suicide prevention among Americans at national, regional, tribal, and community levels.

A broad public/private partnership is essential for developing and implementing a national strategy. Interwoven within a national strategy are three key ingredients for action to improve suicide prevention: a knowledge base, the public will to support change and generate resources, and a social strategy to accomplish change. Developing a national strategy provides an opportunity to convene public and private partners across many sectors of society – government, public health, education, human services, religion, voluntary organizations, advocacy, and business – to sustain a true, national effort.

BENEFITS OF A NATIONAL STRATEGY

A national strategy for suicide prevention can raise awareness and help make suicide prevention a national priority. This can help direct resources of all kinds to the issue.

A national strategy provides an opportunity to use public-private partnerships and the energy of survivors to engage those who may not have considered suicide prevention within their purview. It supports collaboration across a broad spectrum of agencies, institutions, groups, and community leaders as implementation partners.

A national strategy can link information from many prevention programs to avoid unintentional duplication and disseminate information about successful prevention interventions.

A national strategy can direct attention to measures that benefit the whole population and, by that means, reduce the likelihood of suicide before vulnerable individuals reach the point of danger.

Suicide is an outcome of complex interactions among neurobiological, genetic, psychological, social, cultural, and environmental risk and protective factors. Multiple risk and protective factors interact in suicide prevention. Development of a national strategy can bring together multiple disciplines and perspectives to create an integrated system of interventions across multiple levels, such as the family, the individual, schools, the community, and the health care system.

Collaborating in a national strategy can help develop priorities in an equitable way. Resources are always finite and priorities direct resources to projects that are likely to address the greatest needs and achieve the greatest benefits. Some types of expertise are not available across all communities. A national strategy can provide technical assistance with valuable types of expertise to strengthen community programs.

An evidence-based national strategy can maximize success when recommendations are implemented locally. Sound evaluation of community programs, in turn, builds the evidence base.

KEY ELEMENTS OF A PLANNED NATIONAL STRATEGY

A national strategy for the prevention of suicide has many interrelated elements contributing to success in reducing the toll from suicide.

- A means of engaging a broad and diverse group of partners to develop and implement the national strategy with the support of public and private social policies
- A sustainable and functional operating structure for partners with authority, funding, responsibility, and accountability for national strategy development and implementation
- Agreements among Federal agencies and institutions outlining and coordinating their appropriate segments of the national strategy
- A summary of the scope of the problem and consensus on prevention priorities; for example, The Surgeon General's ***Call to Action to Prevent Suicide 1999*** (USPHS, 1999).
- Specified national strategy aims, goals, and measurable objectives integrated into a conceptual framework for suicide prevention
- Appropriate and evaluable activities for practitioners, policy makers, service providers, communities, families, agencies, and other partners
- A data collection and evaluation system to track information on suicide prevention and benchmarks for national strategy progress

ABOUT THE GOALS AND OBJECTIVES FOR ACTION

The Goals and Objectives for Action represents a synthesis of perspectives from researchers and scientists, practitioners, leaders of non-governmental organizations and groups, Federal agencies, survivors, and community leaders. Because Goals and Objectives for Action is meant to be useful for applications outside the tightly controlled research environment, it builds on and extrapolates from the limited realm of scientific evidence in suicide prevention. While goals and objectives must be consistent with available scientific evidence and support the expansion of the scientific knowledge base, they are also intended for use in other environments: public policy and community action.

Goals and objectives are among many elements needed for a national strategy, not the entire strategy. The blend of evidence represented in the Goals and Objectives for Action helps guide an informed selection of activities for suicide prevention across the spectrum of the nation. The national dialogue to determine specific activities to accomplish each objective will be an extension of the consensus reached on these higher order goals and objectives. In that subsequent step, responsibility and accountability for carrying out activities will be accorded in the details of how each activity should be accomplished, by whom, and with what resources.

Development of specific activities provides the opportunity to address the particular needs of subgroups at high risk for suicide and particular cultural/ethnic/social contexts for implementation. For instance, the objective to "increase the proportion of family, youth, and community service organizations and providers with evidence based suicide prevention programs" can be achieved by different prevention activities appropriate for younger African-American males, the elderly, gay and lesbian youth, persons with major mental illnesses, or American Indians and Alaskan Natives.

Several broad themes for the ***National Strategy for Suicide Prevention*** are interwoven throughout the specific goals and objectives in this volume. These themes are valuable considerations as groups and

individuals across the country move forward in designing and strengthening suicide prevention activities. The major themes are:

- Draw attention to a wide range of actions so that specific activities can be developed to fit the resources and areas of interest of people in everyday community life as well as professionals, groups, and public agencies. As the eighth leading cause (***see Figure 1***) of death among Americans, suicide affects families and communities everywhere across the Nation. Suicide prevention is everyone's business.
- Seek to integrate suicide prevention into existing health, mental health, substance abuse, education, and human services activities. Settings that provide related services, such as schools, workplaces, clinics, medical offices, correctional and detention centers, eldercare facilities, faith-based institutions, and community centers are all important venues for seamless suicide prevention activities.
- Guide the development of activities that will be tailored to the cultural contexts in which they are offered. While universal interventions are applicable without regard to risk status, universal does not mean that one size fits all. The cultural and developmental appropriateness of suicide prevention activities derived from these goals and objectives is a vital design and implementation criteria.
- Seek to eliminate disparities that erode suicide prevention activities. This is an important commitment in the ***National Strategy***. Health care disparities are attributable to differences such as race or ethnicity, gender, education or income, disability, age, stigma, sexual orientation, or geographic location.
- Emphasize early interventions to reduce risk factors for suicide and promote protective factors. As important as it is to recognize and help suicidal individuals, progress depends on measures that address problems early and promote strengths so that fewer people become suicidal.

- Seek to build the Nation's capacity to conduct integrated activities to reduce suicidal behaviors and prevent suicide. Capacity building will ensure the availability of the resources, experience, skills, training, collaboration, evaluation, and monitoring necessary for success.

Moving forward with these ***Goals and Objectives for Action*** can bring suicide prevention into the forefront of the Nation's public commitment to health and well-being. Working together in a coordinated and systematic way towards appropriate activities for each objective will lead to measurable progress.

FIGURE 1:
SUICIDE AMONG LEADING CAUSES OF DEATHS BY AGE GROUP - 1998

	AGE GROUPS							
RANK	5 - 9	10 - 14	15 - 24	25 - 34	35 - 44	45 - 54	55 - 64	TOTAL
1	Unintentional Injuries 1,544	Unintentional Injuries 1,710	Unintentional Injuries 13,349	Unintentional Injuries 12,045	Malignant Neoplasms 17,022	Malignant Neoplasms 45,747	Malignant Neoplasms 87,024	Heart Disease 724, 859
2	Malignant Neoplasms 487	Malignant Neoplasms 526	Homicide 5,506	Suicide 5,365	Unintentional Injuries 15,127	Heart Disease 35,056	Heart Disease 65,068	Malignant Neoplasms 541,532
3	Congential Anonamlies 198	Suicide 317	Suicide 4,135	Homicide 4,565	Heart Disease 13,593	Unintentional Injuries 10,946	Brochitis Emphysema Asthma 10,162	Cerebro-vascular 158,448
4	Homicide 170	Homicide 290	Malignant Neoplasms 1,699	Malignant Neoplasms 4,385	Suicide 6,837	Liver Disease 5,744	Cerebro-vascular 9,653	Brochitis Emphysema Asthma 112,584
5	Heart Disease 166	Congenital Anomalies 173	Heart Disease 1,057	Heart Disease 3,207	HIV 5,746	Cerebro-vascular 5,709	Diabetes 8,705	Unintentional Injuries 97,835
6	Pneumonia & Influenza 70	Heart Disease 170	Congenital Anomalies 450	HIV 2,912	Homicide 3,567	Suicide 5,131	Unintentional Injuries 7,340	Pneumonia & Influenza 91,871
7	Brochitis Emphysema Asthma 54	Brochitis Emphysema Asthma 98	Brochitis Emphysema Asthma 239	Cerebro-vascular 670	Liver Disease 3,370	Diabetes 4,386	Liver Disease 5,279	Diabetes 64,751
8	Benign Neoplasms 52	Pneumonia & Influenza 51	Pneumonia & Influenza 215	Diabetes 636	Cerebro-vascular 2,650	HIV 3,120	Pneumonia & Influenza 3,856	Suicide 30,575
9	Cerebro-vascular 35	Cerebro-vascular 47	HIV 194	Pneumonia & Influenza 531	Diabetes 1,885	Brochitis Emphysema Asthma 2,828	Suicide 2,963	Nephritis 26,182

INTRODUCTION

WHAT IS THE U.S. NATIONAL STRATEGY FOR SUICIDE PREVENTION?

The ***National Strategy for Suicide Prevention*** (***National Strategy*** or NSSP) is designed to be a catalyst for social change with the power to transform attitudes, policies, and services. Representing the combined work of advocates, clinicians, researchers and survivors, the ***National Strategy*** lays out a framework for action and guides development of an array of services and programs yet to be set in motion. It strives to promote and provide direction to efforts to modify the social infrastructure in ways that will affect the most basic attitudes about suicide and its prevention, and that will also change judicial, educational, and health care systems.

As conceived, the Strategy requires a variety of organizations and individuals to become involved in suicide prevention and emphasizes coordination of resources and culturally appropriate services at all levels of government–Federal, State, tribal and community. The NSSP represents the first attempt in the United States to prevent suicide through a coordinated approach by both the public and private sectors.

This document, Goals and Objectives for Action, is a key element in the ***National Strategy***. Its clear articulation of a set of goals and objectives provides a roadmap for action. The next step will be to develop a detailed plan that includes specific activities corresponding to each objective. The Strategy, as represented here, is highly ambitious because the devastation wrought by suicide demands the strongest possible response.

The NSSP is based on existing knowledge about suicidal behavior and suicide prevention. It employs the public health approach, which has helped the nation effectively address problems as diverse as tuberculosis, heart disease, and unintentional injury. This Introduction to Goals and Objectives for Action outlines the components of a comprehensive suicide prevention plan, describes the public health approach as it relates to suicide, and summarizes the knowledge gained from the experience of suicide prevention initiatives in other nations.

AIMS OF THE NATIONAL STRATEGY

- Prevent premature deaths due to suicide across the life span
- Reduce the rates of other suicidal behaviors
- Reduce the harmful after-effects associated with suicidal behaviors and the traumatic impact of suicide on family and friends
- Promote opportunities and settings to enhance resiliency, resourcefulness, respect, and interconnectedness for individuals, families, and communities

A PLAN FOR SUICIDE PREVENTION: GOALS, OBJECTIVES AND ACTIVITIES

This document presents the 11 goals and 68 objectives of this component of the *National Strategy*.

A set of activities will be developed for each objective in the next phase of the NSSP. Goals, objectives and activities are defined as follows:

GOAL: A goal is a broad and high-level statement of general purpose to guide planning around an issue. It is focused on the end result of the work.

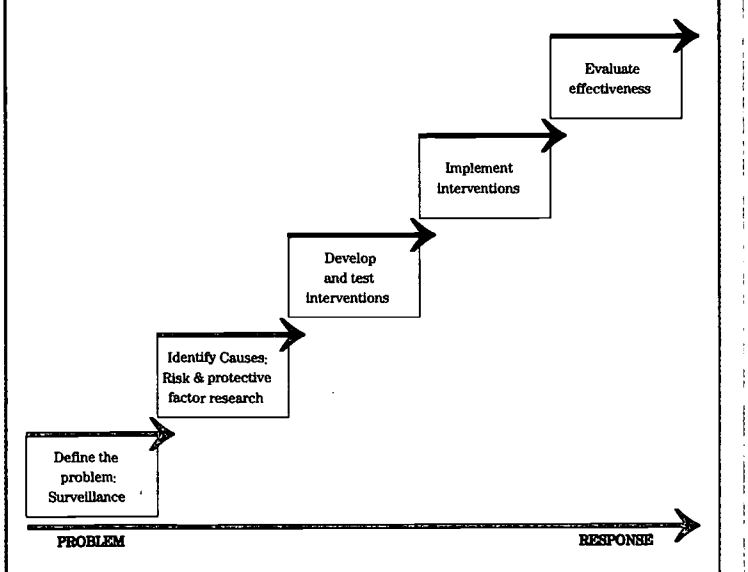
OBJECTIVE: An objective narrows the goal by specifying the who, what, when and where associated with obtaining the goal or clarifies by how much, how many, or how often. Ideally, an objective offers measurable milestones or targets and is very specific–it clearly identifies what is to be achieved. The objectives that appear in the *Goals and Objectives for Action* should be considered "developmental" until all these requisites are established. Until then, the target date of 2005 is used as a place holder on most Objectives to convey a sense of urgency, while considering the time needed for government and private-sector organizations to make progress toward the goal (see also Chapter 12 for the discussion on benchmarks).

ACTIVITIES: Activities specify how objectives will be reached. They are the "things that will be done" to ensure that the goals and objectives are met. A small selection of activities are suggested within *"Ideas for Action"* boxes that are placed throughout this document. These are designed primarily to be illustrative of the types of activities that will be developed in the next phase of the NSSP, and their presence in the ***Goals and Objectives for Action*** is not meant as proof of their effectiveness, but rather as a stimulus to creative thinking in developing suicide prevention activities. The final set of activities for the ***National Strategy*** will occur through a national consensus process designed to fully engage the Nation and assure maximum involvement in its implementation.

THE PUBLIC HEALTH APPROACH

The public health approach to suicide prevention, reflected in the ***National Strategy***, represents a rational and organized way to marshal prevention efforts and ensure that they are effective. In contrast with the clinical medical approach, which explores the history and health conditions that could lead to suicide in a single individual, the public health approach focuses on identifying patterns of suicide and suicidal behavior throughout a group or population. Its five basic steps are shown in (*Figure 2*):

FIGURE 2:
THE PUBLIC HEALTH APPROACH TO PREVENTION



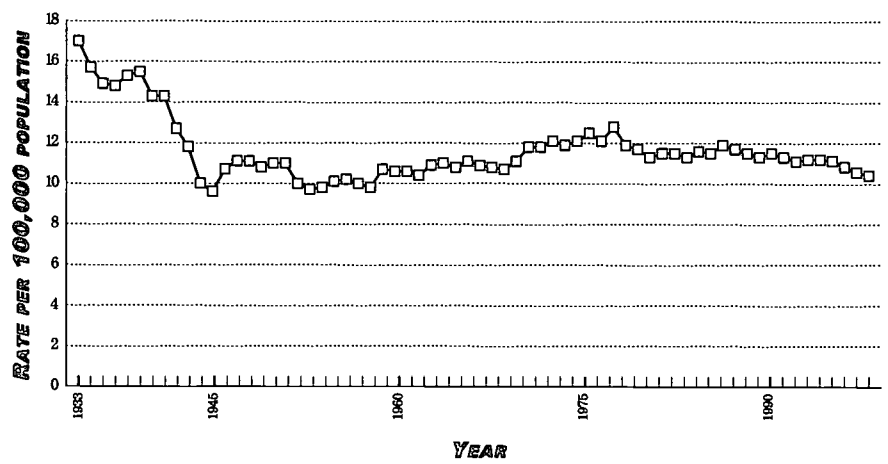
These steps may occur sequentially, but they also sometimes overlap. For example, the techniques used to define the problem, such as determining the frequency with which a particular problem arises in a community, may be used in assessing the overall effectiveness of prevention programs. Information gained from evaluations may lead to new and promising interventions.

THE PUBLIC HEALTH APPROACH AS APPLIED TO SUICIDE PREVENTION

CLEARLY DEFINE THE PROBLEM

Collecting information about the rates of suicide and suicidal behavior is known as surveillance. Surveillance may also include collection of information on the characteristics of individuals who die by suicide, the circumstances surrounding these incidents, possible precipitating events, and the adequacy of social support and health services. Sometimes data

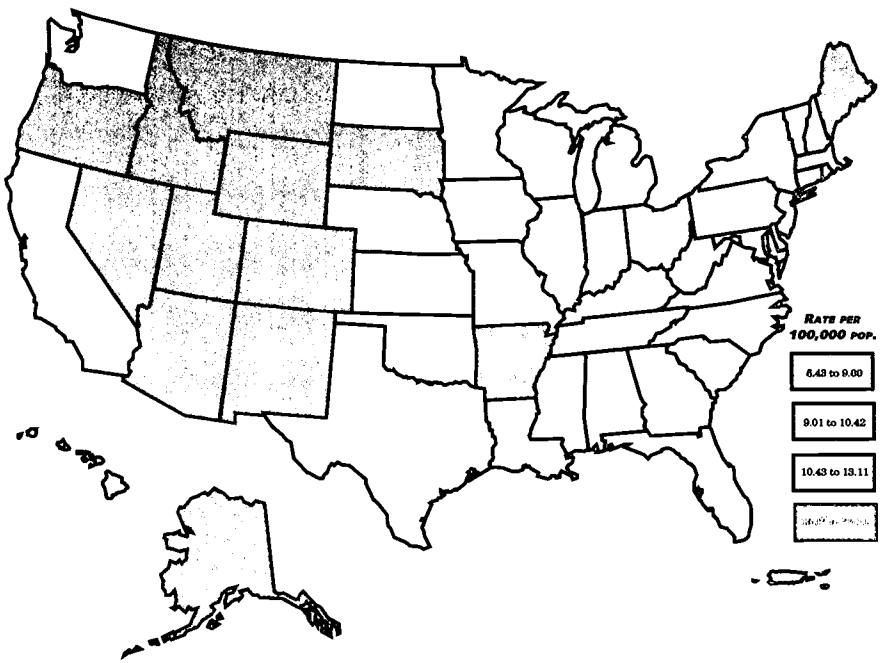
FIGURE 3:
UNITED STATES SUICIDE RATES, 1933–1998



Source: National Center for Health Statistics
Age-adjusted to 1940 U.S. Population

FIGURE 4:
SUICIDE RATES VARY BY GEOGRAPHIC REGION

AGE-ADJUSTED SUICIDE RATES BY STATE
UNITED STATES, 1998

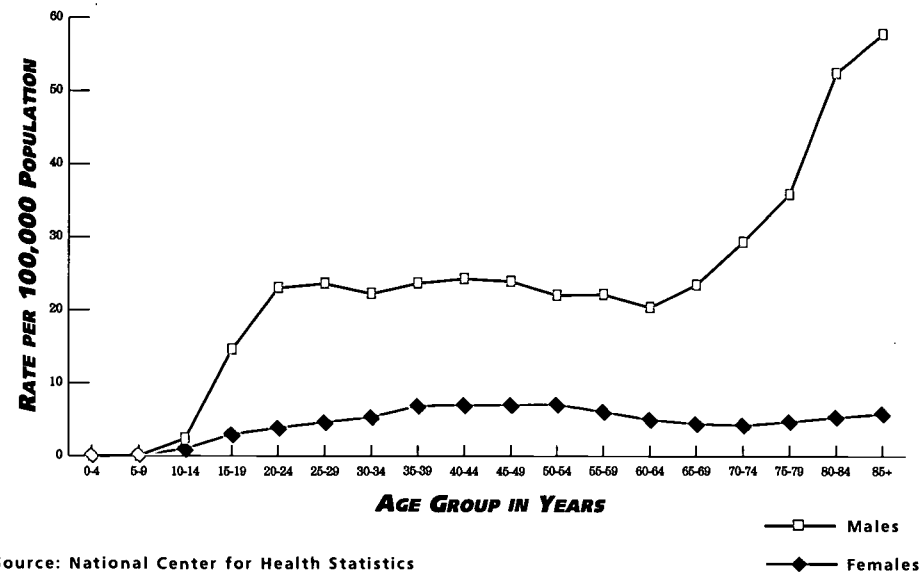


Source: National Center for Health Statistics
Age-adjusted to 1940 U.S. Population

are collected on the cost of injuries related to suicidal behavior. Surveillance helps to define the problem for a community. It documents the extent to which suicide is a burden to a community and how suicide rates vary by time (*see Figure 3*) geographic regions, age groups, or special populations (*see Figure 4*).

While data on suicides are available, data on attempted suicides, particularly among adults, are much less complete. Suicide rates vary by age, gender, and ethnic groups, as shown in the accompanying charts (*see Figures 5 and 6*).

FIGURE 5:
SUICIDE RATES BY AGE GROUP AND SEX
UNITED STATES, 1998



Source: National Center for Health Statistics

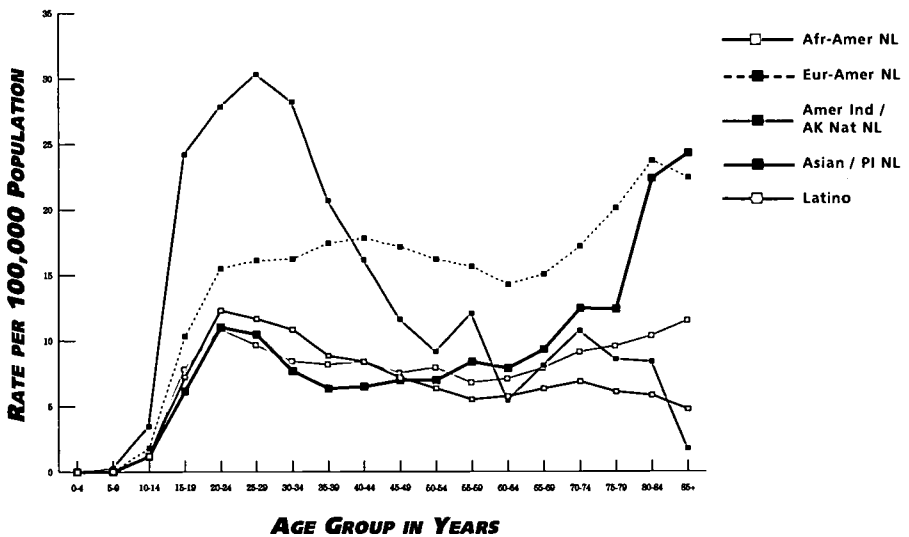
It is generally agreed that not all deaths that are suicides are reported as such. Deaths may be misclassified as homicides or accidents where individuals have intended suicide by putting themselves in harm's way and lack of evidence does not allow for classifying the death as suicide. Other suicides may be misclassified as accidental or undetermined deaths in deference to community or family. Many studies suggest that the actual suicide rate is considerably higher than recorded. (Clark et al., 1992; Gibbs et al., 1988; O'Carroll, 1989).

Suicide rates have changed over time, especially among certain subgroups. For example, from 1980 to 1996, the rate of suicide among children aged 10-14 increased by 100 percent, and among African-American males aged 15-19, the rate increased by 105 percent (Peters et al., 1998).

While no national data base of attempted suicide exists, the Youth Risk Behavior Survey, conducted by the CDC biennially, provides important information on young people (CDC, 1999). This survey consistently finds that a large number of youth in grades 9-12 consider or attempt suicide (Brener, Krug, & Simon, 2000).

Suicide is very costly to the Nation. In addition to the emotional suffering experienced by family members of those who have died by suicide and the physical pain endured by those who have attempted suicide, there are

FIGURE 6:
SUICIDE RATES BY RACE, ETHNICITY AND AGE
UNITED STATES, 1995–1998



Source: National Center for Health Statistics

NL = Non-Latino

financial costs. However, attempts to compute such costs on a national basis are based on incomplete data (e.g., underreporting of suicides and an absence of reliable data on suicide attempts); in addition, such estimates, like economic analyses of other health problems, are of necessity based on certain assumptions, and the accuracy of these cannot always be assured. Consequently, there is no firm consensus on the true dollar costs of suicide. One economic analysis, however, estimated the total economic burden of suicide in the U.S. in 1995 to be $111.3 billion; this includes medical expenses of $3.7 billion, work-related losses of $27.4 billion, and quality of life costs of $80.2 billion (Miller et al., 1999).

While national data provide an overall view of the problem, State and local suicide rates vary considerably from these national rates. Local data are key to effective prevention efforts. It is important to note, however, that local suicide rates, due to the significant fluctuations that occur in small populations, are often not useful in evaluating the effectiveness of suicide prevention programs in the short-run. "Proxy" measures may work better, including changes in risk and protective factors.

IDENTIFY RISK AND PROTECTIVE FACTORS

Risk factors may be thought of as leading to or being associated with suicide; that is, people "possessing" the risk factor are at greater potential for suicidal behavior. Protective factors, on the other hand, reduce the likelihood of suicide. They enhance resilience and may serve to counterbalance risk factors. Risk and protective factors may be biopsychosocial, environmental, or sociocultural in nature. Although this division is somewhat arbitrary, it provides the opportunity to consider these factors from different perspectives.

Understanding the interactive relationship between risk and protective factors in suicidal behavior and how this interaction can be modified are challenges to suicide prevention (Mościcki, 1997). Unfortunately, the scientific studies that demonstrate the suicide prevention effect of altering specific risk or protective factors remain limited in number (***see Appendix C***).

However, the impact of some risk factors can clearly be reduced by certain interventions such as providing lithium for manic depressive illness or strengthening social support in a community (Baldessarini, Tando, Hennen, 1999). Risk factors that cannot be changed (such as a previous suicide attempt) can alert others to the heightened risk of suicide during periods of the recurrence of a mental or substance abuse disorder or following a significant stressful life event (Oquendo et al., 1999). Protective factors are quite varied and include an individual's attitudinal and behavioral characteristics, as well as attributes of the environment and culture (Plutchik & Van Praag, 1994). Some of the most important risk and protective factors are outlined below.

PROTECTIVE FACTORS FOR SUICIDE

- **Effective clinical care for mental, physical, and substance use disorders**
- **Easy access to a variety of clinical interventions and support for help-seeking**
- **Restricted access to highly lethal means of suicide**
- **Strong connections to family and community support**
- **Support through ongoing medical and mental health care relationships**
- **Skills in problem solving, conflict resolution, and nonviolent handling of disputes**
- **Cultural and religious beliefs that discourage suicide and support self-preservation**

Measures that enhance protective factors play an essential role in preventing suicide. However, positive resistance to suicide is not permanent, so programs that support and maintain protection against suicide should be ongoing.

RISK FACTORS FOR SUICIDE

BIOPSYCHOSOCIAL RISK FACTORS

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

ENVIRONMENTAL RISK FACTORS

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

SOCIOCULTURAL RISK FACTORS

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
- Exposure to, including through the media, and influence of others who have died by suicide

Information about risk and protective factors for attempted suicide is more limited than that on suicide. One problem in studying nonlethal suicidal behaviors is a lack of consensus about what actually constitutes suicidal behavior (O'Carroll et al., 1996). Should self-injurious behavior in which there is no intent to die be classified as suicidal behavior? If intent defines suicidal behavior, how is it possible to quantify a person's intent to die? The lack of agreement on such issues makes valid research difficult to conduct. As a result, it is not yet possible to say with certainty that risk and protective factors for suicide and non-lethal forms of self-injury are the same. Some authors argue that they are, whereas others accentuate differences (Duberstein et al., 2000; Linehan, 1986).

DEVELOP AND TEST INTERVENTIONS

Suicide prevention interventions reduce risk or enhance protective factors; some address both. Interventions, like risk and protective factors, may be characterized along biopsychosocial, environmental, and sociocultural dimensions. An intervention might attempt to influence some combination of psychological state, physical environment, or the cultural/subcultural conditions. Alternatively, suicide prevention efforts have been classified as either universal, selective, or indicated: a universal approach is designed for everyone in a defined population regardless of their risk for suicide, such as a health care system, or a county, or a school district; a selective approach is for subgroups at increased risk, for example, due to age, gender, ethnicity or family history of suicide; and an indicated approach is designed for individuals who, on examination, have a risk factor or condition that puts them at very high risk, for example, a recent suicide attempt (Gordon, 1983). The intersections of these dimensions in a matrix shows the intended mechanisms of action and the level of population addressed by interventions. The matrix can identify gaps for development of additional suicide prevention approaches and help match intervention evaluations to the intended outcomes and mechanisms of action.

Rigorous scientific testing of interventions, prior to large scale implementation, is important to ensure that interventions are safe, ethical, and feasible. This testing usually undergoes several stages including small scale, or pilot studies, of efficacy and effectiveness. Efficacy studies test whether

a preventive or treatment intervention works under ideal conditions. The application of the intervention is monitored closely and the question, "Can it work?" is addressed. Only if the answer is "yes" are effectiveness studies undertaken in real world settings. A different question is answered here: "If you do this in the real world, does it prevent suicide?" When interventions have been documented as safe, ethical and feasible, further testing with larger groups can also lead to refinements and enhancements based on important differences among age, gender, geographic, and cultural groups. It is frequently difficult to conduct efficacy studies, although in the absence of such studies, if an intervention does not work, there is no way to know if that is because the program idea was flawed or because the implementation was flawed.

In actuality, definitive pilot studies are frequently missing for many types of social and mental health interventions, including those designed to prevent suicide. By default, program planners may incorporate "promising" interventions into community suicide prevention plans before the evidence base is fully developed. This makes careful evaluation of local outcomes especially important.

IMPLEMENT INTERVENTIONS

State and local organizations will often develop suicide prevention programs that consist of a broad mix of interventions. By selecting interventions from several cells in the "Matrix of Interventions for Suicide Prevention," a more comprehensive program can be developed. Considerations for selecting the elements of a program, i.e., the mix of interventions that will be implemented, include local needs (based on a specific assessment of the problem of suicide in the community) and an analysis of cost vs. potential effectiveness of different interventions. Moreover, program planners will need to consider ways to integrate interventions into existing programs and to strengthen collaboration.

Such comprehensive suicide prevention programs are believed to have a greater likelihood of reducing the suicide rate than are interventions that address only one risk or protective factor, particularly if the program

MATRIX OF INTERVENTIONS FOR SUICIDE PREVENTION
EXAMPLES

	BIOPSYCHOSOCIAL	ENVIRONMENTAL	SOCIOCULTURAL
UNIVERSAL (The intervention is designed to affect everyone in a defined population)	Incorporate depression screening into all primary care practice	Promote safe storage of firearms and ammunition Package drugs in blister packs	Teach conflict resolution skills to elementary school children Provide programs that improve early parent-child relationships
SELECTIVE (The intervention is designed especially for certain sub-groups at particular risk for suicide)	Improve the screening and treatment for depression of the elderly in primary care practices	Reduce access to the means for self-harm in jails and prisons	Develop programs to reduce despair and provide opportunities (increase protective factors) for high risk populations, such as Native American youth
INDICATED (The intervention is designed for specific individuals who, on examination, have a risk factor or condition that puts them at very high risk)	Implement cognitive-behavioral therapy immediately after patients have been evaluated in an emergency department following a suicide attempt	Teach caregivers to remove firearms and old medicines from the home before hospitalized suicidal patients are discharged	Develop and promote honorable pathways for law enforcement officers to receive treatment for mental and substance use disorders and return to full duty without prejudice

incorporates a range of services and providers within a community. Comprehensive programs engage community leaders through coalitions that cut across traditionally separate sectors, such as health and mental health care, public health, justice and law enforcement, education and social services. The coalitions involve a range of groups, including faith communities, civic groups, and business. Suicide prevention programs need to support and reflect the experience of survivors, build on community values and standards, and integrate local cultural and ethnic perspectives (U.S. Department of Health and Human Services, 1999). For example, cultural prohibitions on talking about suicide may have to be

taken into account in the development of certain types of programs. Evaluation can help determine if community interventions are having the desired effect for all groups.

EVALUATE EFFECTIVENESS

It is important to note that most interventions that are assumed to prevent suicide, including some that have been widely implemented, have yet to be evaluated. An ideal, "evidence-based" intervention is one that has been evaluated and found to be safe, ethical, and feasible, as well as effective. Determination of cost effectiveness is another important aspect of evaluation. Evaluation can help determine for whom a particular suicide prevention strategy is best fitted or how it should be modified in order to be maximally effective. Appendix B provides additional information on evaluation.

THE INTERNATIONAL EXPERIENCE BUILDING SUICIDE PREVENTION STRATEGIES

Through the NSSP, the United States has joined the small number of nations that have created a national strategy for the prevention of suicide that is both comprehensive and multifaceted and in which there is a planned integration among different prevention components (Taylor et al., 1997). The U.S. strategy builds on the experience of other nations and also incorporates the recommendations of the 1996 publication ***Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies***, published by the United Nations/World Health Organization (United Nations, 1996).

The first national suicide prevention strategy was initiated in Finland in 1986; the Finnish initiative has provided tremendous amounts of information that have been helpful in the creation of the national suicide prevention strategies of other countries, including the U.S. The U.S. strategy also benefits from the national suicide prevention efforts of Norway, Sweden, New Zealand, Australia, the United Kingdom, The Netherlands, Estonia, and France.

National strategies for suicide prevention share a number of common elements. These include a focus on educational settings as a site of intervention; attempts to change the portrayal of suicidal behavior and mental illness in the media; efforts to increase the detection and treatment of depression and other mental illnesses, including alcohol and substance use disorders; an emphasis on reducing the stigma associated with being a consumer of mental health or substance abuse services; strategies designed to improve access to services; promotion of effective clinical practices; and efforts to reduce access to lethal means of suicide. Not every country with a national suicide prevention strategy, however, includes all of these elements in its strategy, although all current strategies do include plans for increasing research on suicide and suicide prevention (IASP, 1999).

EFFECTIVE SUICIDE PREVENTION PROGRAMS:

- **Clearly identify the population that will benefit from each intervention and from the program as a whole;**
- **Specify the outcomes to be achieved;**
- **Are comprised of interventions known to effect a particular outcome;**
- **Coordinate and organize the community to focus on the issue; and**
- **Are based on a clear plan with goals, objectives and implementation steps.**

Even when nations address the same issue in their strategies, they frequently do so in different ways. For instance, interventions after a suicide has occurred (called postvention) aimed at reducing the impact of suicide on surviving friends and relatives have been proposed by all countries. However, approaches to postvention vary across countries. For example, Norway has proposed outreach services to relatives and friends of those who died by suicide in the community, while other countries that have focused on youth suicide prevention, such as New Zealand, suggest specific postvention efforts to minimize suicide contagion in school settings.

One important difference among nations with respect to their national strategies is the extent to which the community is involved in the creation and implementation of the initiative. The UN/WHO guidelines recommend that no single agency, organization, or governmental body have sole responsibility for suicide prevention (Ramsey & Tanney, 1996). In this regard, a particular strength of the Finnish strategy has been strong community involvement in the process of developing and implementing its strategy. Other countries with different resources, have needed to rely heavily on government agencies to implement their strategies. The development of the ***National Strategy*** in the U.S. has been led by the Federal government, but in collaboration with numerous non-governmental organizations and with advice from hundreds of interested, individual citizens.

National suicide prevention strategies vary in terms of their target audiences. The ***National Strategy*** is aimed at the entire population of the U.S. and in this respect is similar to the strategies of Norway, Sweden, and Finland. In contrast, New Zealand and Australia focus exclusively on youth suicide. Finland has also targeted young men for special attention, given their increasing rate of suicide in that country.

The UN/WHO guidelines recommend that suicide prevention programs be coherent in their approach. Nations take different approaches to ensuring such coherence. For example, the Finnish initiative commenced with a national research study on suicide, using the psychological autopsy method. Data derived from this research were used to help in the development and implementation of suicide prevention programs. In contrast, the New Zealand strategy was guided by a literature review born out of a workshop that included representation from both governmental and non-governmental organizations, including advocacy groups. The development of the U.S. strategy has been based on the public health model, which has proven so effective for approaching other health problems.

The extent to which evaluation is a central component of a nation's suicide prevention strategy varies considerably. The Finnish government commissioned both an internal and external evaluation to assess the out-

come of the strategy (Upanne, 1999). Norway has plans for an external evaluation of its strategy, and Australia requires evaluation for all funded demonstration projects. New Zealand agencies are self-monitoring; in addition, a small steering group convenes annually and reports to the Ministers of Health and Youth Affairs on the progress of the strategy. As recommended by the UN/WHO guidelines, the U.S. strategy includes specific objectives with the potential for measurement. Provision is also made for the evaluation of specific preventive interventions.

SUMMARY

Suicide is a major cause of death in the U.S. and also contributes–through suicide attempts–to disability and suffering. Suicide is a serious public health problem. Persons who experience the loss of someone close as a result of suicide experience tremendous emotional trauma. Suicide is a special burden for certain age, gender, and ethnic groups, as well as particular geographic regions. The public health approach provides a framework for a national strategy to address this serious national problem. The ***Goals and Objectives for Action*** that follow are designed to provide direction to the Nation on ways to prevent suicide and suicidal behavior.

GOAL 1
PROMOTE AWARENESS THAT SUICIDE IS A PUBLIC HEALTH PROBLEM THAT IS PREVENTABLE

WHY IS THIS GOAL IMPORTANT TO THE NATIONAL STRATEGY?

In a democratic society, the stronger and broader the support for a public health initiative, the greater its chance for success. The social and political will can be mobilized when it is believed that suicide is preventable. If the general public understands that suicide and suicidal behaviors can be prevented, and people are made aware of the roles individuals and groups can play in prevention, many lives can be saved.

In order to mobilize social and political will, it is important to first dispel the myths that surround suicide. Many of these myths relate to the causes of suicide, the reasons for suicide, the types of individuals who contemplate suicide, and the consequences associated with suicidal ideation and attempts. Better awareness that suicide is a serious public health problem results in knowledge change, which then influences beliefs and behaviors (Satcher, 1999). Increased awareness coupled with the dispelling of myths about suicide and suicide prevention will result in a decrease in the stigma associated with suicide and life-threatening behaviors. An informed public awareness coupled with a social strategy and focused public will lead to a change in the public policy about the importance of investing in suicide prevention efforts at the local, State, regional, and national level (Mrazek & Haggerty, 1994).

BACKGROUND INFORMATION AND CURRENT STATUS

The factors that contribute to the development, maintenance, and exacerbation of suicidal behaviors are now better understood from a public health perspective (Silverman & Maris, 1995). A public health approach allows suicide to be seen as a preventable problem, because it offers a way of understanding pathways to self-injury that lend them-

selves to the development of testable preventive interventions (Gordon, 1983; Potter, Powell & Kachur, 1995). Although some have criticized the public health model of suicide as being too disease-oriented, it does, in fact, take into account psychological, emotional, cognitive, and social factors that have been shown to contribute to suicidal behaviors (Potter, Rosenberg, & Hammond, 1998).

DID YOU KNOW?

In the 10 years 1989-1998, 307,973 people died as a result of suicide.

Suicide is a major public health problem. It is one of the top ten leading causes of death in the United States, ranking 8th or 9th for the last few decades. For the approximately 31,000 suicide deaths per year, there are an estimated 200,000 additional individuals who will be affected by the loss of a loved one or acquaintance by suicide. The economic and emotional toll on the Nation is profound (Palmer, Revicki, Halpern, & Hatziandreu, 1995).

HOW WILL THE OBJECTIVES FACILITATE ACHIEVEMENT OF THE GOAL?

The objectives established for this goal are focused on increasing the degree of cooperation and collaboration between and among public and private entities that have made a commitment to public awareness of suicide and suicide prevention. To accomplish this goal, support for innovative techniques and approaches is needed to get the message out, as well as support for the organizations and institutions involved.

Objective 1.1: By 2005, increase the number of States in which public information campaigns designed to increase public knowledge of suicide prevention reach at least 50 percent of the State's population.

Suicide has been designated as a serious public health problem by the U.S. Surgeon General, and the 105th U.S. Congress has recognized that this problem deserves increased attention [U.S. Senate Resolution 84 (5/6/97)

and U.S. House Resolution 212 (10/9/98)]. They recognize suicide as a national problem and declare suicide prevention as a national priority, encouraging the development of an effective national strategy for the prevention of suicide. Public and private organizations have developed information campaigns to educate the public that suicide is preventable, as it can be a consequence of other treatable disorders such as depression, schizophrenia, bipolar illness, alcohol and drug abuse, and certain medical conditions. Campaigns alert professional, community, and lay groups about the common signs and symptoms associated with suicidal behavior. Some organizations with existing campaigns include the American Association of Suicidology (AAS), the American Foundation for Suicide Prevention (AFSP), the Suicide Awareness\Voices of Education (SA\VE), the Suicide Prevention Advocacy Network (SPAN USA), and Yellow Ribbon Suicide Prevention Program.

IDEAS FOR ACTION

Work with local media to develop and disseminate public service announcements describing a safe and effective message about suicide and its prevention.

Public information campaigns can take many forms. No single slogan or message works for everyone. For example, the primary purpose of the annual National Depression Screening Day is to identify, in a variety of settings, individuals with symptoms of depression and refer them for treatment (Jacobs, 1999b). However, such a screening program performed at primary care centers, mental health and substance abuse treatment centers, colleges, universities, and places of employment can play an important role in raising awareness and educating large groups of individuals about this mental disorder and its association with suicidal behaviors. Because no one is immune to suicide the challenge is to develop a variety of messages targeting the young and the old, various racial and ethnic populations, individuals of various faiths, those of different sexual orientations, and people from diverse socioeconomic groups and geographical regions.

Objective 1.2: By 2005, establish regular national congresses on suicide prevention designed to foster collaboration with stakeholders on prevention strategies across disciplines and with the public.

Broad-based participation and involvement is needed to ensure progress in reducing the toll of suicide. Open discussion and assessment of suicide prevention programs can only lead to their refinement and better chances for success.

The techniques and tools to create and implement prevention initiatives can be taught and demonstrated. Learning how to develop and disseminate public health messages and to mount public health campaigns is critical to implementing suicide prevention efforts.

A number of organizations have convened annual, national meetings devoted to suicide prevention. Currently, such meetings are sponsored by AAS, AFSP, and biennially by the International Association for Suicide Prevention (IASP). The establishment of regular national congresses on suicide prevention, collaboratively sponsored by more than one organization, will maintain interest and focus on this issue. Ideally, these national congresses should be sponsored by public/private partnerships (see Objective 2.2), and focus on needs and plans for coordinating effective suicide prevention efforts.

IDEAS FOR ACTION

Identify foundations and other stakeholders to contribute to the support of national congresses on suicide prevention.

Objective 1.3: By 2005, convene national forums to focus on issues likely to strongly influence the effectiveness of suicide prevention messages.

National forums increase awareness of the problem of suicide and serve to mobilize social will. Such meetings keep the subject in the forefront of attention and raise concerns to the national level. Such activities increase connectedness between and among key stakeholders, and serve to bring support, consensus and collaboration to suicide prevention efforts.

> ***IDEAS FOR ACTION***
>
> *Incorporate suicide awareness and prevention messages into employee assistance program activities in businesses with greater than 500 employees.*

Focusing on factors that influence the effectiveness of suicide prevention initiatives is critical to an overall strategy. National forums are opportunities to focus on specific issues that affect all efforts to mount suicide prevention initiatives. By highlighting specific areas, consensus can be reached on how best to incorporate elements into a suicide prevention plan and how best to evaluate effectiveness.

Objective 1.4: By 2005, increase the number of both public and private institutions active in suicide prevention that are involved in collaborative, complementary dissemination of information on the World Wide Web.

The World Wide Web offers an unparalleled opportunity to bring public health information to a much broader audience because it can be accessed at home, at work, at schools, at community centers, at libraries, or at any other location where there is access to the Internet. Not only does the World Wide Web offer exciting possibilities for the delivery of public health messages (including promoting awareness and referral

sources for those in need), but it offers an opportunity to develop preventive interventions as well.

> **DID YOU KNOW?**
>
> *Suicide is the eighth leading cause of death for all Americans.*

For example, the World Wide Web offers the potential for interactive dialogue and exchange of accurate information. Clear, concise, and culturally sensitive public health messages are key to assisting individuals to evaluate their at-risk status accurately and to know where and how to get help. It therefore is important that both public and private institutions committed to suicide prevention activities collaborate and cooperate to deliver information that is consistent, comparable, complementary, and not competitive. In addition to several Federal websites (see Appendix D), some of the key national organizations currently disseminating suicide prevention information on the World Wide Web include AAS, AFSP, IASP, SPAN USA, and the American Academy of Pediatrics.

GOAL 2
DEVELOP BROAD-BASED SUPPORT FOR SUICIDE PREVENTION

WHY IS THIS GOAL IMPORTANT TO THE NATIONAL STRATEGY?

Because there are many paths to suicide, prevention must address psychological, biological, and social factors if it is to be effective. Collaboration across a broad spectrum of agencies, institutions, and groups–from schools to faith-based organizations to health care associations–is a way to ensure that prevention efforts are comprehensive. Such collaboration can also generate greater and more effective attention to suicide prevention than can these groups working alone. Public/private partnerships that evolve from collaboration blend resources and build upon each group's strengths. Broad-based support for suicide prevention may also lead to additional funding, through governmental programs as well as private philanthropy and to the incorporation of suicide prevention activities into the mission of organizations that have not previously addressed it. In 1993, the United Nations/World Health Organization identified broad-based collaborative support as a key element in developing and implementing national suicide prevention strategies (UN/WHO, 1996).

BACKGROUND INFORMATION AND CURRENT STATUS

In the last five years, a new collaborative effort has been forged in the fight against suicide. The 1998 National Suicide Prevention Conference brought several Federal agencies together with private groups to focus attention on suicide prevention. This conference engendered renewed enthusiasm for suicide prevention and increased collaboration among public health and mental health agencies on suicide prevention activities (*see Foreword, Public efforts leading to the Goals and Objectives for Action*).

An indication that the Nation has begun to recognize the severity of the

problem of suicide is an increase in the numbers of Members of Congress who have begun to focus attention on the topic. Another is the expansion or formation of organizations focused solely on suicide prevention. For example, the American Association of Suicidology has broadened its membership considerably and now has approximately 900 members. In 1996, the Suicide Prevention Advocacy Network was formed, a grassroots organization made up of survivors of suicide, attempters of suicide, community activists, and health and mental health clinicians. The American Foundation for Suicide Prevention, established in 1987, is a private organization that supports research on suicide prevention and disseminates information on effective strategies. In 2000, the National Council for Suicide Prevention was formed, representing a total of 12 advocacy, survivor and research organizations, each with a primary focus on suicide prevention. In short, support for suicide prevention is growing, but much work still remains to be done to engage the public fully.

HOW WILL THE OBJECTIVES FACILITATE ACHIEVEMENT OF THE GOAL?

The objectives established for this goal are focused on developing collective leadership and on increasing the number of groups working to prevent suicide. They will help ensure that suicide prevention is better understood and that organizational support exists for implementing prevention activities. The objectives also provide a management structure for the NSSP, a key factor in its success.

Objective 2.1: By 2001, expand the Federal Steering Group to appropriate Federal agencies to improve Federal coordination on suicide prevention, to help implement the *National Strategy for Suicide Prevention*, and to coordinate future revisions of the *National Strategy*.

The Federal government has a major role to play in suicide prevention, and several Federal agencies have responsibilities related to suicide prevention, suicidal behavior, and response to suicide attempts, as described in Appendix D.

While several Federal agencies are active in suicide prevention efforts, improved planning and coordination can ensure that resources are used most effectively. Knowledge and resources can also enhance the prevention efforts of each agency. With Federal agencies working together, the goals of the ***National Strategy*** can be embedded in their ongoing work and suicide prevention efforts can become integrated into the spectrum of an agency's mandates and activities. The NSSP Federal Steering Group, established in 2000 by the Secretary of Health and Human Services, is already facilitating such coordination, and thus this objective is to some degree already met. In addition to the Office of the Surgeon General and the U.S. Public Health Service Regional Health Administrators, its membership includes several agencies of the Department of Health and Human Services–the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Indian Health Service, the National Institutes of Health, and the Substance Abuse and Mental Health Services Administration. This membership is augmented by liaisons from eleven other Federal agencies (*see Appendix D*).

> ***DID YOU KNOW?***
>
> *There are now twice as many deaths due to suicide than due to HIV/AIDS*

Objective 2.2: By 2002, establish a public/private partnership(s) (e.g., a national coordinating body) with the purpose of advancing and coordinating the implementation of the National Strategy.

Leadership and collaboration are the keys to success of the ***National Strategy***. The establishment of a public/private coordinating body will stimulate the requisite national attention to the issue. Such a body will help to ensure that suicide prevention is perceived as a national problem and the NSSP as a national plan. The partnership will help establish momentum for the plan and will provide continuity over time and legitimacy through the involvement of key groups. And finally, the coordinating body will oversee the implementation of the ***National Strategy***.

Objective 2.3: By 2005, increase the number of national professional, voluntary, and other groups that integrate suicide prevention activities into their ongoing programs and activities.

> ***IDEAS FOR ACTION***
>
> *Encourage organizations to consider ways that they could integrate suicide prevention into their ongoing work.*

To make suicide prevention efforts more effective and to leverage resources, suicide prevention must be integrated into programs and activities that already exist and included in the agendas of communities and national groups. Some national advocacy groups and some communities attempt to address many problems simultaneously, but have not considered or included suicide among these issues. It is often possible to target several health or social problems with one intervention, particularly since some risk factors put population groups at risk for more than one problem at the same time. Therefore, an intervention that targets one or more risk or protective factors has the potential to effect change in more than one identified problem. For example, the suicide rate has risen steeply over the last two decades for African-American youth, a group with a high risk for other health and social problems. Programs focused on enhancing educational and occupational opportunities for African-American youth may contribute to feelings of hope and self-assurance, and as a by-product reduce suicide. However, by consciously integrating program elements that address suicide prevention more directly (for example, encouraging help-seeking for emotional distress), a program may be even more effective overall.

Objective 2.4: By 2005, increase the number of nationally organized faith communities adopting institutional policies promoting suicide prevention.

While many faith groups have already taken strong stands on suicide prevention, others have not. And yet the statements and positions of faith groups are often key to influencing public opinion. By adopting institutional policies on suicide, faith groups can help to de-stigmatize mental illness and alcohol and substance use problems and change the perception of suicide from something that is shameful to a problem that can be prevented. Faith groups can also assist in suicide prevention by helping their members identify risk factors, encouraging treatment for depression, sustaining protective factors and offering support and guidance to individuals during stressful times. For instance, faith-based organizations are well positioned to provide community guidance on ways to support family members who survive the loss of a loved one to suicide, while avoiding the excessive memorializing of those who have died by suicide that may lead to suicide contagion. A few faith groups have developed statements or "messages" on suicide prevention, which provide guidance to members on the scope of suicide and on how individuals can help prevent it (Evangelical Lutheran Church in America, 1999).

IDEAS FOR ACTION

Encourage local faith-based groups to include suicide prevention as a topic of analysis and discussion.

GOAL 3

DEVELOP AND IMPLEMENT STRATEGIES TO REDUCE THE STIGMA ASSOCIATED WITH BEING A CONSUMER OF MENTAL HEALTH, SUBSTANCE ABUSE, AND SUICIDE PREVENTION SERVICES

WHY IS THIS GOAL IMPORTANT TO THE NATIONAL STRATEGY?

Suicide is closely linked to mental illness and substance abuse and effective treatments exist for both. In fact, 60 to 90 percent of all suicidal behaviors are associated with some form of mental illness and/or substance use disorder (Harris & Barraclough, 1997). Despite the fact that effective treatments exist for these disorders and conditions, the stigma of mental illness and substance abuse prevents many persons from seeking assistance; they fear prejudice and discrimination. About two thirds of people with mental disorders do not seek treatment (Kessler et al.,1996). The stigma of suicide, while deterring some from attempting suicide, is also a barrier to treatment for many persons who have suicidal thoughts or who have attempted suicide.

People who have a substance use disorder also face stigma, because many people believe that abuse and addiction are moral failings and that individuals are fully capable of controlling these behaviors (Murphy, 1992). Rather, many mental health professionals, consider mental disorders, alcohol abuse, and drug abuse disorders not as signs of weakness, but as disorders that require professional assessment and clinically appropriate treatment (U.S. Department of Health and Human Services, 1999).

While the stigma attached to mental illness and addiction prevents persons at risk of suicide from seeking help for treatable problems, the stigma of suicide itself may also reduce the number of people who seek help, while adding to emotional burdens. Family members of suicide attempters often hide the behavior from friends and relatives, since they may believe that it reflects badly on their own relationship with the suicide attempter or that suicidal behavior itself is shameful or sinful.

Persons who attempt suicide may have many of these same feelings. Those who have survived the suicide of a loved one suffer not only the grief of loss, but the pain of isolation from a community that may be perplexed and uninformed about suicide and its risk factors.

Historically, the stigma associated with mental illness, substance use disorders and suicide has contributed to the inadequate funding available for preventive services and to low insurance reimbursements for treatments. Until the stigma is reduced, treatable substance use and mental health problems–including those strongly correlated with suicide–will continue to go untreated, and services tailored to persons in crisis will continue to be limited. As a result, the number of individuals at risk for suicide and suicidal behavior will remain unnecessarily high.

BACKGROUND INFORMATION AND CURRENT STATUS

Stigma has been identified as the most formidable obstacle to future progress in the arena of mental health (U.S. Dept. of Health and Human Services, 1999). It is a key reason that certain ethnic groups are particularly disinclined to seek treatment for mental illness or substance abuse (Sussman et al., 1987; Uba, 1994). Stigma is intense in rural areas (Hoyt et al., 1997) and it is implicated in the low percentages of youth and the elderly with mental disorders–both groups at high risk for suicidal behavior–who receive mental health services (Kazdin et al., 1997; U.S. Department of Health and Human Services, 1999).

Over the past 25 years, a principal goal shared by mental health consumer and family advocacy groups is to overcome the stigma of mental illness. These groups include the National Alliance for the Mentally Ill and the National Mental Health Association. Other mental health advocates, such as the American Psychological Association and the American Psychiatric Association, have also worked to reduce stigma. The publication of *Mental Health: A Report of the Surgeon General* represents a milestone in the Federal government's effort to reduce stigma by dispelling myths about mental illness and by providing accurate knowledge.

HOW WILL THE OBJECTIVES FACILITATE ACHIEVEMENT OF THE GOAL?

The objectives established for this goal are designed to create the conditions that enable persons in need of mental health and substance abuse services to receive them. There are many reasons why individuals may not receive such services, but stigma is an important factor. Stigma dissuades people from seeking mental health or substance abuse services. It is both a contributing cause and a result of society's collective devaluation of mental and substance abuse illness as compared to physical illness, such as heart disease or diabetes. The stigma of mental illness and substance abuse has resulted in the establishment of separate systems for physical health and mental health care; one consequence is that preventive services and treatment for mental illness and substance abuse are much less available than for other health problems. Moreover, this separation has led to bureaucratic and institutional barriers between the two systems that complicate the provision of services and further impede access to care. Destigmatizing mental illness and substance abuse could increase access to treatment by reducing financial barriers, integrating care, and increasing the willingness of individuals to seek treatment.

DID YOU KNOW?

Suicide has ranked among the 10 leading causes of death since 1975.

Objective 3.1: By 2005, increase the proportion of the public that views mental and physical health as equal and inseparable components of overall health.

Due to the historic bias and prejudice against those with mental illnesses, health care, mental health care, and substance abuse treatment have traditionally been viewed as separate types of treatment; persons who need mental health care or substance abuse treatment avoid seeking it, and insurance companies often do not pay for it. As our Nation moves towards viewing mental illness and substance abuse disorders with the same concern and understanding as it views other illnesses, there will be a concomitant change in the importance attached to effective and available care, along with increased political support for "parity" (the financing of mental health care and substance abuse treatment on the same basis as that of other health services).

IDEAS FOR ACTION

Review (and modify, where indicated) school health curricula to ensure that mental health and substance abuse is appropriately addressed.

Objective 3.2: By 2005, increase the proportion of the public that views mental disorders as real illnesses that respond to specific treatments.

Behavior associated with mental disorders is still viewed by many persons as evidence of a character flaw rather than an illness. Consequently, disease that is treatable remains untreated because it is not perceived as disease. When people understand that mental disorders are not the result of moral failings or limited will power, but are legitimate illnesses that are responsive to specific treatments, much of the negative stereotyping may dissipate; more persons will seek treatment and the suicide rate will be reduced.

IDEAS FOR ACTION

Develop public service announcements in which well-known individuals convincingly portray the effectiveness of treatment for mental illnesses and substance use disorders.

Support an educational campaign designed to help the public understand the implications of the brain research conducted over the past decade, with special emphasis on mental illness.

Objective 3.3: By 2005, increase the proportion of the public that views consumers of mental health, substance abuse, and suicide prevention services as pursuing fundamental care and treatment for overall health.

IDEAS FOR ACTION

Develop public service announcements depicting consumers of mental health and substance abuse services as exhibiting responsible and appropriate health care behavior.

When the act of seeking services for mental health concerns is normalized, and when such care is reimbursed, a larger number of persons at risk for suicide will receive treatment. Such a change in perspective might also lead to a better integration of the separate systems of care that now exist–one for mental health, one for substance abuse, the other for primary and specialty health care.

Objective 3.4 By 2005, increase the proportion of those suicidal persons with underlying disorders who receive appropriate mental health treatment.

IDEAS FOR ACTION

Develop a public information campaign describing the role of lithium in the treatment of persons with bipolar disorder.

Research indicates that suicides are more likely early in the course of certain severe mental illnesses and that persons who have required hospitalization for severe mood disorders have a substantially increased lifetime risk of suicide compared to individuals with less severe illnesses. Yet, only a minority of persons with those mental or substance use disorders seek professional help. The literature suggests that up to two-thirds of those who die by suicide are not receiving mental health or substance abuse treatment at the time of their death and that half had never seen a mental health professional (Jamison & Baldessarini, 1999; U.S. Department of Health and Human Services, 1999). Older people, for whom depression is quite prevalent and who

have the highest rates of suicide in the U.S., are especially unlikely to utilize mental health services (Conwell, 1996; Hoyert et al., 1999). They tend to seek and receive health care in primary care settings, where it has been found that depression is frequently undiagnosed and untreated (Caine et al., 1996).

DID YOU KNOW?

Many who make suicide attempts never seek professional care immediately after the attempt.

Members of some ethnic groups may also be reluctant to seek professional mental health care. Few treatment providers in the U.S. are knowledgeable about effective combinations of Western health care and culture-specific remedies that may enhance utilization of mental health services. Moreover, mental health services may not be available from persons who speak the language of individuals from particular ethnic groups or who understand the meaning of mental illness in the culture. Persons from many ethnic and cultural groups encounter additional barriers to access, such as lack of health insurance.

Since effective treatments now exist for the major depressive disorders, and since these disorders are implicated in such a high proportion of suicides, ensuring treatment for these illnesses should reduce the suicide rate. Mood disorders are very prevalent among individuals who complete suicide, with 36-70 percent of individuals having a mood disorder at the time of death (Barraclough, Bunch, Nelson, & Sainsbury, 1974; Henriksson et al., 1993; Foster, Gillespie, McClelland, & Patterson, 1999; Rich, Young, & Fowler, 1986). Schizophrenia, certain personality disorders, and anxiety disorders in combination with other illnesses carry increased risk for suicide (Harris & Barraclough, 1997). An individual who suffers from one of these mental illnesses–especially if he or she has severe symptoms or a co-existing addictive disorder–is at increased risk of suicide (Angst et al., 1999).

Reducing stigma related to mental illness and substance abuse will increase the number of persons from all groups who receive appropriate treatment for mental disorders associated with suicide.

GOAL 4
DEVELOP AND IMPLEMENT COMMUNITY-BASED SUICIDE PREVENTION PROGRAMS

WHY IS THIS GOAL IMPORTANT TO THE NATIONAL STRATEGY?

Research has shown that many suicides are preventable; however, effective suicide prevention programs require commitment and resources. The public health approach, as described in the Introduction, provides a framework for developing preventive intervention programs: clearly define the problem, identify risk and protective factors, develop and test interventions, implement programs that are based on local needs, and evaluate effectiveness. Programs may be specific to one particular organization, such as a university or a community health center, or they may encompass an entire State. While other goals in the ***National Strategy*** address interventions to prevent suicide, a special emphasis of this goal is that of ensuring a range of interventions that in concert represent a comprehensive and coordinated program and of fostering planning and program development work.

BACKGROUND INFORMATION AND CURRENT STATUS

The methodological problems inherent in conducting suicide prevention research have led to the current situation, in which considerably less is known about effective programs than is desirable; nevertheless, some interventions have proven effective and others appear promising but, are in need of evaluation (Silverman & Felner, 1995). The term "evidence-based" is often used to suggest the importance of implementing those interventions that have scientific evidence of effectiveness.

The Introduction presents a matrix that can assist in program planning by clarifying the group(s) targeted for intervention and the focus of interventions–biopsychosocial, environmental, or sociocultural. Appendix C includes information on some interventions currently in progress that are, or could be evaluated.

HOW WILL THE OBJECTIVES FACILITATE ACHIEVEMENT OF THE GOAL?

The objectives established for this goal are designed to foster the implementation of suicide prevention interventions, especially through organizations and agencies that have access to groups of individuals for other purposes. The objectives also address the need for systematic planning at both the State and local levels, the need for technical assistance in the development of suicide prevention programs, and the need for ongoing evaluation.

Objective 4.1: By 2005, increase the proportion of States with comprehensive suicide prevention plans that a) coordinate across government agencies, b) involve the private sector, and c) support plan development, implementation, and evaluation in its communities

Suicide prevention is a complex problem. It intersects public health (especially injury prevention), mental health, and substance abuse; it requires commitment from education, justice, and social services; and it requires the commitment of various private sector groups, including business and labor. Effective programming requires collaboration and coordination of the State and local agencies that deliver services in these three arenas, as well as mobilization of the private sector. The planning process itself can help States and local jurisdictions accomplish a variety of activities that will help to prevent suicide: bring together partners who each play a role in solving the problem; raise awareness of suicide; develop a comprehensive approach to suicide prevention; and ensure that the most current research is employed in developing strategies. At a minimum, the plan should include an assessment of the problem, including a statistical analysis of suicide in the State and its communities; goals, objectives, and timetable; and actions to be taken. State plans may include resources for local communities, such as task force recommendations and screening tools (Children's Safety Network, 2000). It may help communities address the local issues important in suicide prevention; for example, the suicide rate is affected by community norms and cultural values, and suicide rates vary with such factors as percent of the population residing in rural areas and the ethnic composition of the pop-

ulation. A plan implies a locus of responsibility and appropriate resources to carry it out. Both State and local leadership are needed for suicide prevention planning and implementation.

Considerable attention has been devoted to youth suicide prevention. In 1985, a bill was introduced into the House of Representatives to provide funding to States to address youth suicide. Though the bill was not enacted into law, many States did engage in suicide prevention planning. However, during the early 1990s, suicide prevention programs and plans in some States were discontinued and allowed to lapse (Metha et al., 1998). Regional conferences for States were sponsored by the Health Resources and Services Administration in the mid-1990s to encourage renewed State planning for youth suicide prevention, and the National Suicide Prevention Conference held in Reno, Nevada, in 1998 also spurred interest in State-level planning for suicide prevention across the life span. While a number of States currently have suicide prevention plans, few are comprehensive and the plans do not uniformly link public health, mental health and substance abuse programs (Metha et al., 1998; West, 1998). Moreover, not all address the entire life span and few involve all key stakeholders, such as education, justice, social services, and the private sector.

Objective 4.2: By 2005, increase the proportion of school districts and private school associations with evidence-based programs designed to address serious childhood and adolescent distress and prevent suicide.

Most school-based suicide prevention efforts are curriculum-based, with a focus on increasing awareness of the problem of adolescent suicide, identifying adolescents at risk, and teaching referral techniques and resources. In 1996, the New Zealand Department of Education developed and published a guide for schools that summarizes the literature on school-based programs and recommends improving the awareness of teachers and other adults about issues related to youth suicide and suggests a tiered structure of counseling for students identified by these adults as at risk of suicide (Beautrais et al., 1997; Ministry of Education, 1998). Limited evaluation of curriculum-based programs has found min-

imal increases in knowledge, that attitudes towards suicide remain unchanged, or that attitudes have changed in negative ways (Garland & Ziegler, 1993; Hazell & King, 1996). Yet, given the nature of our current knowledge, it is premature to dismiss curriculum-based efforts in suicide prevention, though prudence is clearly indicated.

IDEAS FOR ACTION

Develop criteria by which a State's suicide prevention plan can be described and evaluated.

Efforts concentrating on teaching youth to identify the warning signs of suicide in themselves and their peers may not be effective, since prior research has found that suicidal youth are not likely to self-refer or seek help from school staff, nor do knowledgeable peers request adult help (Kalafat & Elias, 1995). This suggests that schools should screen for youth at risk and that school staff need to be trained and aware of the warning signs for suicidal youth and have a plan of action for helping those at risk.

An alternative approach to school-based efforts that focus on suicide prevention is to target risk and protective factors that occur earlier in the pathways to suicide, and to also consider specific needs and subcultures of the school population (e.g., gay and lesbian youth) (McDaniel et al., 2001). For example, there are many proven prevention programs that reduce substance use and aggressive behavior by teaching techniques in problem solving and building positive peer relations (***see Appendix C***). When implemented effectively, these programs have the potential for reducing risk for suicide simultaneous with other negative outcomes, in this case substance use and aggressive behavior.

Objective 4.3: By 2005, increase the proportion of colleges and universities with evidence-based programs designed to address serious young adult distress and prevent suicide.

Suicide is the third leading cause of death among the U.S. college-aged population. Among adults, those aged 18-24 have the highest incidence of reported suicide ideation (Crosby et al., 1999). One fourth of all persons aged 18-24 years in the U.S. are either full- or part-time college students, suggesting that a large proportion of young adults could be reached through college-based suicide prevention efforts. Colleges and universities are increasingly challenged to identify and manage mental health and substance use problems in students. In part this is because more youth with disorders are able to attend college thanks to effective treatments that improve symptoms of their illness, and the age of onset of a number of psychiatric disorders is in young adulthood (Barrios et al., 2000; Brener et al., 1999; Silverman et al., 1997). Because many of the risk and protective factors for suicide among young adults are similar to those for mental disorders and other problem behaviors, including alcohol, drug abuse and interpersonal violence (Brent et al., 1994; Henriksson et al., 1993), suicide prevention may be best integrated within broad prevention efforts.

IDEAS FOR ACTION

Develop and test "natural- or peer-helper" programs for use with Native Americans attending boarding schools.

Implement and evaluate a program that trains college resident advisors in principles of suicide risk identification, crisis intervention, and referral.

Objective 4.4: By 2005, increase the proportion of employers that ensure the availability of evidence-based prevention strategies for suicide.

Because so many teens and adults are in the workforce, employers have an important role to play in suicide prevention. It is in the interests of employers to prevent suicide and suicidal behaviors; for example, providing mental health treatment, or reducing maladaptive substance use, can improve an employee's functioning. A suicide in the family of an employee may result in such grief that the employee becomes incapacitated.

Employers are a very important player in health insurance in the United States since so many people obtain coverage through their work; employers are the payors of health care and therefore help determine the coverage that workers can obtain. Employers who insist on mental health and substance abuse parity in the insurance policies they offer to workers assure that their workers can obtain treatment for depression and other mental illnesses and substance abuse disorders.

IDEAS FOR ACTION

Work with business associations to provide financial information about the costs and benefits of mental health and substance abuse parity.

Foster cultural changes in organizations that strengthen social support among workers and encourage help-seeking for emotional and health concerns.

Employee Assistance Programs (EAP) are one example of worksite-based programs that employers may use to help prevent suicide. EAPs help employees identify and resolve personal concerns, including mental or physical health, marital, family, financial, alcohol, drug, or other personal issues, that may affect job performance. Some employers provide family services for their workers, and others engage in a variety of activities and programs in their communities designed to foster a higher quality of life for their workers; it is possible to integrate suicide prevention into such programs.

Objective 4.5: By 2005, increase the proportion of correctional institutions, jails and detention centers housing either adult or juvenile offenders, with evidence-based suicide prevention programs.

Jails and juvenile justice facilities have exceptionally high suicide rates, although rates in Federal prisons are relatively low. Suicide rates in jails have been estimated to be approximately nine times higher than that of the general population (Hayes & Rowan, 1988), while suicide rates in some State prisons are at least one and a half times higher (Hayes, 1995). Jail rates are especially high because arrestees may be under the influence of or in withdrawal from alcohol and/or drugs within the first twenty-four hours of arrest (Hayes, 1995).

The suicide rate in the Federal prison system is lower than the rate for the general population of males, and there have been no reported suicides of a female offender in the Federal system since the 1960's. These facts suggest that the experience of the Federal prison system, strategies are available to prevent suicide in correctional settings (Condelli et al., 1997; Cox & Morschauser, 1997). Jail or "lock up" suicides most often occur within 24-48 hours after arrest, suggesting an important role for appropriate medical assessment of substance abuse and administration of standardized suicide assessments. Comprehensive programs include training, screening, effective communication methods, intervention, use of reporting protocols, and mortality review (Hayes, 1997).

IDEAS FOR ACTION

Develop monitoring protocols for alcohol and drug detoxification in jail and detention settings.

Objective 4.6: By 2005, increase the proportion of State Aging Networks that have evidence-based suicide prevention programs designed to identify and refer for treatment of elderly people at risk for suicidal behavior.

Since the elderly have the highest overall suicide rate of all age groups, organizations that have special access to older persons have an important role in suicide prevention. State Aging Networks exist in every State and Territory. They plan, develop and fund a variety of in-home and community-based services for older people. States organize the provision of such services through area agencies on aging, which coordinate a broad range of services for older people in a designated geographic area. In addition, State aging networks or the hundreds of tribal and native organizations that provide services to older American Indians, Alaskan Natives, and Native Hawaiians may also help to maintain protective factors among those elderly at somewhat lower risk for suicide.

IDEAS FOR ACTION

Develop and implement a training program for employees of local aging programs to assist these workers and volunteers in identifying persons at risk of suicide.

Objective 4.7: By 2005, increase the proportion of family, youth and community service providers and organizations with evidence-based suicide prevention programs.

The integration of suicide prevention into existing service-based organizations provides opportunities to expand the numbers of individuals who may be reached by preventive interventions. For example, county extension and 4-H programs have unique access to rural populations, and tribal service organiza-

IDEAS FOR ACTION

Develop resource kits for service organizations that include suggestions for activities designed to strengthen connectedness.

tions may be best positioned to reach Native American youth. Homeless youth and young people who have dropped out of school require special attention by these organizations since school-based programs will not reach them. Faith-based organizations have a special role to play, as do natural community helpers.

Objective 4.8: By 2005, develop one or more training and technical resource centers to build capacity for States and communities to implement and evaluate suicide prevention programs.

Resource centers can serve a number of important functions, such as disseminating information on evidence-based interventions and serving as an information repository; convening meetings; coordinating regional activities; providing technical assistance in planning and program design; and monitoring regional changes in the suicide rate.

While there is now considerable understanding of risk factors for suicide, less progress has been made in the design and evaluation of programs to prevent suicide (Bonnie et al., 1999). A key function of suicide prevention resource centers is evaluation. Useful evaluation is an enormous undertaking for local programs, and measurement at the local level is difficult. Given the need for evaluation of preventive interventions, technical assistance in evaluation is particularly important. Evaluations promoted by the centers can be structured to involve practitioners in evaluations to ensure that the evaluations address questions of particular interest to practitioners and are sensitive to local issues. They may also include a feed-back loop to project staff in programs being evaluated to document findings as they are generated. Moreover, the centers can be given the task of interpreting evaluation findings more widely to the practitioner community. Finally, the resource centers may help to further specify ethnic and culturally-specific risk and protective factors in the implementation of interventions.

DID YOU KNOW?

Suicide takes the lives of more than 30,000 Americans every year

GOAL 5
PROMOTE EFFORTS TO REDUCE ACCESS TO LETHAL MEANS AND METHODS OF SELF-HARM

WHY IS THIS GOAL IMPORTANT TO THE NATIONAL STRATEGY?

Evidence from many countries and cultures shows that limiting access to lethal means and methods of self-harm is an effective strategy to prevent self-destructive behaviors in certain individuals (Brent et al., 1987; Kellerman et al., 1992; Kreitman, 1976). Often referred to as "means restriction," this preventive intervention approach is based on the belief that a small but significant number of suicidal acts are, in fact, impulsive and of the moment (Mann, 1998). A number of suicidal behaviors result from a combination of psychological pain or despair coupled with the availability of the means by which to inflict self-injury (Shneidman, 1999). If intervention is not possible when an individual is in a state of psychological pain, a self-destructive act may be prevented by limiting the individual's access to the means or methods of self-harm. Evidence suggests that there may be a limited time effect for decreasing suicide, as over time, individuals with ongoing suicide intent may substitute a more available for the restricted, less available methods (Marzuk, 1992).

DID YOU KNOW?

For every two victims of homicide in the U.S. there are three deaths from suicide.

Controversy exists about how to accomplish this goal because restricting means can take many forms and signifies different things to different people. Different types of means restrictions may be effective in different settings and for different populations. For some, it may connote redesigning or altering the existing lethal means of self-harm currently available, and to others eliminating or limiting their availability to those at risk for self-harm.

This goal is important and necessary to contribute to an overall effort to reduce the rates of suicide and suicidal behaviors in our population. Means restriction is a key activity in a broader public health approach to reducing intentional injuries.

BACKGROUND INFORMATION AND CURRENT STATUS

In the United States, the focus has been on protecting individuals from access to loaded firearms, lethal doses of prescription medications or illegal substances, illegal access to alcohol by underage youth, and dangerous settings (such as bridges and rooftops of high buildings) (*see Figure 7*) (Birckmayer & Hemenway, 1999; Brent et al., 1993b; ; Marzuk et al., 1992; O'Carroll, Silverman & Berman, 1994).

The majority of suicides and homicides in the U.S. are firearm-related (NCHS, 1997). Between 40-50 percent of all U.S. households have a firearm inside the home. Much focus has been placed on firearm restrictions and safety measures including education, improved storage, and the technology of ensuring that a firearm will not fire unintentionally or be used by those for whom it was not intended. According to recent research (Brent et al., 1988, 1991, 1993a; Kellerman et al., 1992), those who use firearms for suicidal behaviors in the home are not necessarily those who purchase the weapons. Firearms must be safely stored so they are not misappropriated and improperly used.

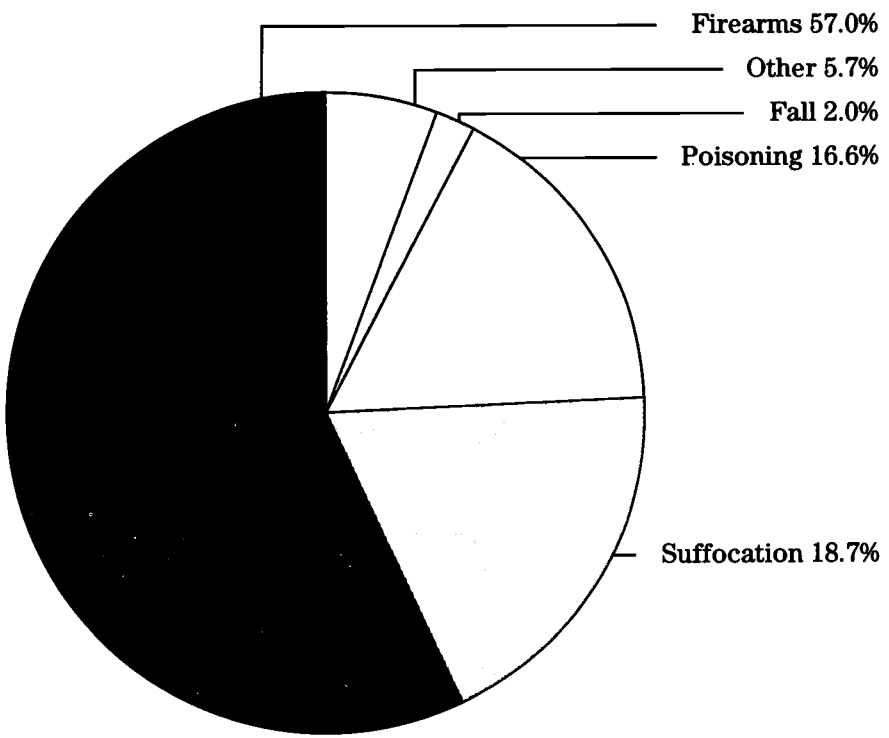
In 1996, the Youth Suicide by Firearms Task Force met to endorse a consensus statement on youth suicide by firearms (Berman, 1998). They concluded that there is clear evidence that intervening in or preventing the immediate accessibility of a lethal weapon can save lives. They identified the safe storage of guns as one preventive intervention approach that would result in the decrease in the number of youth suicides. Close to 40 national organizations endorsed a combination of indicated, selective, and universal preventive interventions addressing this objective.

In addition to efforts related to firearms, activities have been devoted to educating physicians and other prescribing and dispensing professionals about limiting prescriptions of potentially lethal medications to

amounts that are non-lethal. Issues of training related to prescribing and dispensing medications are covered in Goal 6.

Improvements and changes in car exhaust emissions have resulted in a decrease in carbon monoxide poisoning and death by this means. The objectives point to the necessity of collaborating with all stakeholders including, but not limited to, the auto industry, the pharmaceutical industry, gun proponent groups, and gun manufacturers.

FIGURE 7:
SUICIDE BY METHOD
UNITED STATES, 1998



Source: National Center for Health Statistics

HOW WILL THE OBJECTIVES FACILITATE ACHIEVEMENT OF THE GOAL?

Much more needs to be done to reduce the likelihood of the use of lethal means during an impulsive act of self-injury or self-destruction. By eliminating or restricting the easy availability of one particular means of suicide, impulsive individuals often do not substitute another method in the immediate time frame. Current forms of means restriction have meaning over the short-term, but may not over the long-term (Marzuk et al., 1992). Thus, separating in time and space the suicidal impulse from access to lethal means and methods of self-harm has great potential for saving lives.

Objective 5.1: By 2005, increase the proportion of primary care clinicians, other health care providers, and health and safety officials who routinely assess the presence of lethal means (including firearms, drugs, and poisons) in the home and educate about actions to reduce associated risks.

IDEAS FOR ACTION

Develop an emergency department screening tool to assess the presence of lethal means in the home.

Develop standardized practices for law enforcement response to domestic emergencies that assess for the presence of lethal means and advocate their removal or safe storage.

It has been shown that the presence of a lethal means of self-destruction in the home (particularly a firearm) is associated with increased rates of suicide (Brent et al., 1993, Kellerman et al., 1992). Because of their positions, primary care clinicians, other health care providers, and health and safety officials ordinarily inquire about an individual's overall health, safety, and welfare, including their mental health (Goldman, Wise & Brody, 1998). It is incumbent upon them to ask patients, families, and care givers routinely about the presence of lethal means of self harm and to evaluate the risk for their use. This is especially

important when talking with individuals who are in crisis, or who have mental disorders, substance abuse problems, or suicidal thoughts (Goldman, Silverman & Albert, 1998; WHO, 2000c).

Safety officials and health care providers are also in a unique position to educate about firearm storage and access, and about appropriate storage of alcoholic beverages, prescription drugs, over-the-counter medications, and poisons used for household purposes (bleaches, disinfectants, herbicides). To aid in this effort, for example, the American Academy of Pediatrics has developed guidelines on how to talk to parents about the presence of guns in the home (AAP, 1992). Such actions may reduce the likelihood that these lethal means will be used for self-destructive outcomes.

Objective 5.2: By 2005, expose a proportion of households to public information campaign(s) designed to reduce the accessibility of lethal means, including firearms, in the home.

Public information campaigns have been shown to be of great value in changing health behavior and improving public health. Successful campaigns have decreased tobacco use, increased seat belt use, decreased the number of drunk drivers through designated driver campaigns, decreased alcohol use during pregnancy, increased early detection of cancer symptoms, decreased use of illicit drugs (particularly among adolescents and young adults), and increased installation of smoke alarms in homes. The success of these campaigns provides hope that similar efforts will be successful in educating the public about reducing access and availability to lethal means, including firearms, in the home.

> ***IDEAS FOR ACTION***
>
> *Incorporate discussions of firearm risks and safe storage practices as a standard element of well-child care encounters.*

Objective 5.3: By 2005, develop and implement improved firearm safety design using technology where appropriate.

> ***IDEAS FOR ACTION***
>
> *Educate parents about how to appropriately store and secure lethal means of self-harm.*

Efforts are underway to explore the use of technology to improve the safety of firearms. Activities include development of removable firearm pins, computer chips to ensure that only the owner can activate the weapon ("smart guns"), and devices to indicate whether a gun's chamber is loaded. These and other efforts need to be completed so that firearms can be made safer for their intended uses and prevented from being used for self-destructive purposes.

Objective 5.4: By 2005, develop guidelines for safer dispensing of medications for individuals at heightened risk of suicide.

> ***IDEAS FOR ACTION***
>
> *Develop educational materials to make parents aware of safe ways of storing and dispensing common pediatric medications.*

There has been a significant improvement in limiting the potential for lethal overdose with the newer generation of antidepressants currently available (i.e., selective serotonin reuptake inhibitors and other related compounds are less lethal in overdose). Still, some individuals benefit from the use of older antidepressants and there are many other medications that are dangerous in relatively small overdoses. Processes that ensure flexibility in the frequency of prescription refills and regular contact with patients who use these medications need to be developed and supported.

Objective 5.5: By 2005, improve automobile design to impede carbon monoxide-mediated suicide.

Carbon monoxide poisoning and death occurs with prolonged exposure to car exhaust fumes. The redesign of automobile monitoring and exhaust systems would make carbon monoxide poisoning more difficult to accomplish, especially for someone who may be impulsive. Such efforts would also reduce the likelihood of accidental deaths. Cost analyses are needed to determine best approaches.

> **IDEAS FOR ACTION**
>
> *Design reliable ignition shut-off sensors that respond to potentially lethal levels of carbon monoxide.*

Objective 5.6: By 2005, institute incentives for the discovery of new technologies to prevent suicide.

The development of safer drugs and better medical emergency technologies and techniques to intervene in the treatment of overdoses and self-poisonings will result in saving more lives. Better computer technologies will improve the means of educating and communicating messages faster and more precisely. Engineering advances have the potential to influence the design and construction of safer bridges and roof barriers, the design and operation of firearms that function solely for the purposes for which they are intended, and the development of more fuel-efficient and cleaner engines for automobiles. New medical technologies may include the use of blood tests to determine who may be at increased risk for suicide and who might benefit from the use of a particular medication.

> **IDEAS FOR ACTION**
>
> *Provide incentives for the discovery of new technologies such as annual awards and recognition by professional organizations.*

GOAL 6

IMPLEMENT TRAINING FOR RECOGNITION OF AT-RISK BEHAVIOR AND DELIVERY OF EFFECTIVE TREATMENT

WHY IS THIS GOAL IMPORTANT TO THE NATIONAL STRATEGY?

Key gatekeepers, those people who regularly come into contact with individuals or families in distress, must be trained to recognize behavioral patterns and other factors that place individuals at risk for suicide and be equipped with effective strategies to intervene before the behaviors and early signs of risk evolve further. Key gatekeepers interact with people in environments of work, play, and natural community settings, and have the opportunity to interact in other than medical settings.

KEY GATEKEEPERS

- *Teachers and school staff*
- *School health personnel*
- *Clergy*
- *Police officers*
- *Correctional personnel*
- *Supervisors in occupational settings*
- *Natural community helpers*
- *Hospice and nursing home volunteers*
- *Primary health care providers*
- *Mental health care and substance abuse treatment providers*
- *Emergency health care personnel*

Although many textbooks, manuals, handbooks, multimedia presentations, journals, and brochures discuss the assessment and management of suicidal risk, as well as the identification and promotion of protective factors (Hawton & von Herringen, 2000; Jacobs, 1999a; Maris, Berman & Silverman, 2000), there is a need to define minimum course objectives in educating each type of key gatekeeper about his or her special role and perspective. Each has a unique relationship to individuals at risk and a responsibility to intervene in a timely and effective manner.

BACKGROUND INFORMATION AND CURRENT STATUS

With the advent of safer and/or very effective psychotropic medications, many conditions associated with suicidal behaviors can be treated effectively (Montgomery 1997; Tondo, Jamison & Baldessarini, 1997). Furthermore, advances in family, group, and individual therapies (especially cognitive behavioral therapy, dialectical behavioral therapy, and interpersonal psychotherapies) have led to better treatment of at-risk individuals (Linehan, 1997; Linehan, Heard & Armstrong, 1993; Rudd, Joiner & Rajab, 2000; Zimmerman & Asnis, 1995).

About 45 percent of individuals who die by suicide have had some contact with a mental health professional within the year of their death (Pirkis & Burgess, 1998) and as many as 90 percent carry a psychiatric diagnosis at the time of death (Conwell & Brench, 2000). However, only 18 percent of suicide decedents reported suicidal ideation to a health professional prior to their death (Robins, 1981). Thus, at-risk individuals often seek professional help, but may not have their condition adequately recognized and are not likely to report the true severity of their condition.

DID YOU KNOW?

Firearms are by far the most common method of suicide, they are used in about 6 of every 10 suicides.

Studies indicate that many health professionals are not adequately trained to provide proper assessment, treatment, and management of suicidal patients and clients, or know how to refer them properly for specialized assessment and treatment (Bongar, Lomax & Harmatz, 1992; Ellis and Dickey, 1998; Ellis, Dickey & Jones, 1998; Kleespies, 1998). Despite the increased awareness of suicide as a major public health problem, gaps remain in training programs for health professionals and others who often come into contact with patients in need of these specialized assessment techniques and treatment approaches. In addition, many health professionals lack training in the recognition of risk factors often found in grieving family members of loved ones who have died by suicide (suicide survivors).

HOW WILL THE OBJECTIVE FACILITATE ACHIEVEMENT OF THE GOAL?

Much needs to be done to ensure that all key gatekeepers are adequately trained to identify individuals at risk for suicidal behaviors, as well as respond to those expressing self-destructive behaviors. Key gatekeepers also need to identify opportunities for reinforcing protective factors that do exist and help foster protective factors when indicated. Furthermore, gatekeepers need to be educated about the availability and use of effective treatment interventions and when and how to refer to formal treatment settings those identified as being at risk (Hawton, Arensman, Townsend et al., 1998; Rudd, Joiner, Jobes et al., 1998).

As part of the process for designing and implementing training, it would be useful to develop a baseline of professionals' awareness, attitudes and knowledge of risk and protective factors related to suicide. For instance, awareness of the suicide protective effects of lithium for individuals with bipolar disorder is estimated to be low among certain health care personnel. Knowledge of which health care personnel and the extent of their awareness would permit more targeted training efforts.

Consensus about what needs to be taught and how to ensure appropriate training has not been reached; however, with the provision of appropriate and targeted education and training to each key gatekeeper group, it is likely that many suicide attempts and suicides can be prevented.

DID YOU KNOW?

In the month prior to their suicide, 75% of elderly persons had visited a physician.

Objective 6.1: By 2005, define minimum course objectives for providers of nursing care in assessment and management of suicide risk, and identification and promotion of protective factors. Incorporate this material into curricula for nursing care providers at all professional levels.

> **DID YOU KNOW?**
>
> *Suicide rates remain highest among Americans aged 65 and older.*

Nurses deliver health care education and interventions in many different settings, from community health clinics to school settings to private practice offices to occupational settings and hospital settings. They are often the first to see and hear about signs and symptoms of at-risk behavior, and are often in a unique position to intervene effectively when such behaviors are identified. As important members of the health care delivery team their education and training in this subject is critical (WHO, 2000a).

Objective 6.2: By 2005, increase the proportion of physician assistant educational programs and medical residency programs that include training in the assessment and management of suicide risk and identification and promotion of protective factors.

Physicians and physician assistants can benefit from training in the assessment of at-risk behaviors for suicide and in effective treatment interventions (WHO 2000a, WHO 2000c). They should be skilled in talking with patients about the risk for suicide, in providing crisis intervention for those at imminent risk for the expression of suicidal behaviors (Kleespies, 1998), and in referring their patients for expert assessment and treatment.

> **IDEAS FOR ACTION**
>
> *Improve marketing of existing effective community-level educational and support programs through collaboration with faith communities, mental health clinics, public health announcement providers, mass transit advertisers, and community service organizations.*

Many suicidal individuals make contact with their physicians within a few weeks prior to their death (Beautrais et al., 1998; Pirkis & Burgess, 1998). Their imminent risk for suicide may have gone undetected or unappreciated because, in part, the physicians were not appropriately trained to assess and manage suicide. With such training, fewer suicidal patients will go unrecognized and untreated (Shea, 1999).

Objective 6.3: By 2005, increase the proportion of clinical social work, counseling, and psychology graduate programs that include training in the assessment and management of suicide risk, and the identification and promotion of protective factors.

Counselors, clinical psychologists, and clinical social workers are often on the "front line" in assessing and treating individuals who are at increased risk for suicidal behaviors. It is important that these mental health personnel receive appropriate graduate school training on the subject of suicide while preparing for their professions (Neimeyer, 2000). Surveys of clinical psychology training programs (Bongar & Harmatz, 1991) and social work training programs (King et al., 1999), reveal that an insufficient number of training programs provide adequate preparation for the recognition of at-risk suicidal behavior and the delivery of effective treatment.

IDEAS FOR ACTION

Develop and disseminate training modules for all mental health personnel on the subject of suicide.

Objective 6.4: By 2005, increase the proportion of clergy who have received training in identification of and response to suicide risk and behaviors and the differentiation of mental disorders and faith crises.

Clergy often provide counseling and interventions for those in distress, and for some, they may be the first or only professionals to be in a position to provide emotional support. Individuals who are adjusting to and recovering from personal losses may be at increased risk for the expression of self-destructive behaviors (Bailley, Kral & Dunham, 1999). Clergy should be trained to identify and respond to suicidal risk as well as to encourage and support appropriate protective factors to lessen the likelihood of suicidal behaviors.

IDEAS FOR ACTION

Provide seminars at educational conferences for clergy that focus on the interface between faith and mental health.

Objective 6.5: By 2005, increase the proportion of educational faculty and staff who have received training on identifying and responding to children and adolescents at risk for suicide.

Surveys by the Centers for Disease Control (Brener, Krug, & Simon, 2000) indicate that suicidal thoughts and self-reported suicide attempts are prevalent among high school students. It is well known that adolescents and young adults will not seek out interventions or counseling by adults unless they feel that they can trust the adult to maintain respect, confidentiality, and provide knowledge and appropriate information (Eggert et al., 1990; Kalafat & Elias, 1994). Therefore, it makes sense to train those school personnel who are most likely to come in contact with students at risk (see also Objective 4.2). In addition to educational faculty, bus drivers, custodians, and playground supervisors are among those school staff with frequent contact with students. Although efforts have been taken to develop training manuals and handbooks for educators, many school personnel lack the tools and training to intervene effectively on behalf of students at risk (Zenere & Lazarus, 1997).

IDEAS FOR ACTION

Identify which school, teacher and student characteristics predict successful involvement of school staff members in long-term mentoring programs with students at risk.

Implement training for school nurses to identify mental health conditions that contribute to a risk for suicide.

The staff and teachers in these systems need to be better equipped to identify and communicate with students about suicidal behaviors, as well as to communicate among themselves about these issues. School staff and faculty are not expected to make clinical diagnoses, but rather to be able to recognize developing signs and symptoms associated with mental disorders, substance abuse, or suicidal risk. Providing them with the vocabulary, techniques, and skills to be comfortable with these issues will enhance their ability to intervene effectively and make appropriate referrals (Grossman et al., 1995).

Objective 6.6: By 2005, increase the proportion of correctional workers who have received training on identifying and responding to persons at risk for suicide.

Although the Federal prison system has a lower suicide rate than the general population, there is an alarmingly high rate of suicide attempts and suicides in jails and correctional institutions in the United States. Given the often volatile nature of the circumstances that result in someone being placed in a jail or a correctional facility, suicide and suicidal behaviors are much more common than in the general population. The training of correctional workers is an important step to reduce the likelihood of individuals engaging in self-destructive behaviors when placed in correctional settings (Bonner, 2000) (see also Objective 4.5).

Objective 6.7: By 2005, increase the proportion of divorce and family law and criminal defense attorneys who have received training in identifying and responding to persons at risk for suicide.

Attorneys involved in divorce proceedings, custody cases, family law cases, and criminal defense cases, often work with clients who are in heightened emotional states, depressed, hopeless, and who may have lost important social support. Such individuals may be at increased risk for violence and suicide, and attorneys are in a position to identify the increased risk and to refer them for specialized interventions.

> ***IDEAS FOR ACTION***
>
> *Develop and test training modules to help attorneys identify clientele who are at high risk for self-destructive behaviors.*

Objective 6.8: By 2005, increase the proportion of counties (or comparable jurisdictions such as cities or tribes) in which education programs are available to family members and others in close relationships with those at risk for suicide.

It has been shown that educating family members about how to understand, monitor, and intervene with family members at risk for suicide results in better management and treatment of those identified individuals (Richman, 1986).

Organizations such as the National Alliance for the Mentally Ill have conclusively demonstrated the value of family education and support network education to improve the care of individuals who are at risk. 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 are knowledgeable about potential risks for suicide and about how to protect an individual from self-harm.

Objective 6.9: By 2005, increase the number of recertification or licensing programs in relevant professions that require or promote competencies in depression assessment and management and suicide prevention.

The close association between mental disorders, especially depression, and suicidal behaviors warrants ensuring that professionals are competent in applying the tools and techniques of diagnosis, treatment, management, and prevention to those mental disorders associated with suicidal behaviors. In most States, physicians, psychologists, social workers, nurses, and other health professionals must complete licensing examinations or recertification programs in order to maintain active licenses and to ensure ongoing professional certifications. One mechanism to ensure that professionals remain competent to deal with suicidal behaviors is to include the subject area in recertification or licensing programs.

IDEAS FOR ACTION

Incorporate questions on depression and suicide risk assessment on professional recertification examinations.

Encourage private organizations in your community with the capability to provide suicide awareness and prevention education to form community partnerships in suicide prevention training.

GOAL 7
DEVELOP AND PROMOTE EFFECTIVE CLINICAL AND PROFESSIONAL PRACTICES

WHY IS THIS GOAL IMPORTANT TO THE NATIONAL STRATEGY?

As defined by the public health approach, one way to prevent suicide is to identify individuals at risk and to engage them in early and aggressive treatments that are effective in reducing the personal and situational factors associated with suicidal behaviors (e.g., depressed mood, hopelessness, helplessness, agitation, severe anxiety, pervasive insomnia, alcohol and drug abuse, among others). Another way to prevent suicide is to promote and support the presence of protective factors such as skills in problem solving, conflict resolution, and nonviolent handling of disputes.

By promoting effective clinical practices in the assessment, treatment, and referral for individuals at risk for suicide, the chances are greatly improved for preventing those individuals from acting on their despair and distress in self-destructive ways. Moreover, the development and implementation of protective factors for these individuals can contribute importantly to reducing their risk.

DID YOU KNOW?

For every suicide death there are 5 hospitalizations and 22 Emergency Department visits for suicidal behaviors - over 670,000 visits in a year.

BACKGROUND INFORMATION AND CURRENT STATUS

As in illnesses of all types, individuals who are receiving appropriate treatment for mental disorders have the best likelihood of recovery (Jamison & Baldessarini, 1999; Kleespies, 1998; Rudd, 2000; Rudd & Joiner, 1998). It is critical that individuals with psychiatric disorders or otherwise at increased suicidal risk receive adequate assessment, treatment, and follow-up care.

The nature of being in a suicidal crisis can sometimes impede an individual's ability to obtain appropriate medical care for themselves. Some individuals with psychiatric disorders may at times be unable to serve as their own best advocates when their illnesses involve impaired cognitions, emotions or interpersonal skills. Patients with suicidal thoughts report fear of being stigmatized or rejected if they reveal these thoughts to others (see Objective 8.1). Family members and significant others of those who have died by suicide may, as well, be at increased risk for suicide. Appropriate attention and sensitivity to their unique situation is often lacking.

Currently, there are only two psychopharmacological treatments that have been associated with reduced suicide– lithium and clozapine (Baldessarini, Tondo, & Hennen, 1999; Meltzer & Okayli, 1995). The data regarding lithium is extensive—stretching over 28 studies around the world. The 6-8 fold reduction in the suicide rate associated with this particular treatment is dramatic and needs to be more widely publicized. New interventions are being developed and tested for the treatment of disorders associated with suicidal behaviors. Because few studies of treatments for mental disorders have included suicidal individuals (most are excluded from clinical trials), new treatments need to be assessed for their potential to reduce suicide and suicidal behaviors as well as reduce symptoms of the disorder.

HOW WILL THE OBJECTIVES FACILITATE ACHIEVEMENT OF THE GOAL?

A heightened awareness of the presence or absence of risk and protective conditions associated with suicide will result in better triage systems and better allocation of resources for those in need of specialized treatment. Accurate assessment of how individuals respond to significant life events, transitions, and challenges to their mental and physical well-being can lead to appropriate and timely interventions. Health care providers and clergy are often called upon to attend to end of life care issues, including spiritual, religious, and familial reconciliation. Taken together, goals 7 and 8 will ensure that key service personnel are trained

to conduct thorough suicide assessments, deliver appropriate interventions, make appropriate referrals when indicated, and that health systems are appropriately organized to provide patients with needed and effective clinical care.

Objective 7.1: By 2005, increase the proportion of patients treated for self-destructive behavior in hospital emergency departments that pursue the proposed mental health follow-up plan.

Suicide attempts are a significant public health problem, particularly among adolescents and young adults (*see Figure 8*). Without adequate intervention, this population is at increased risk for repeat attempts and death by suicide. Studies have found that fewer than 50 percent of adolescent attempters are referred for treatment following an emergency department (ED) visit (Piacentini et al.; 1995; Spirito et al., 1989), and a large proportion of those fail to attend their initial appointment.

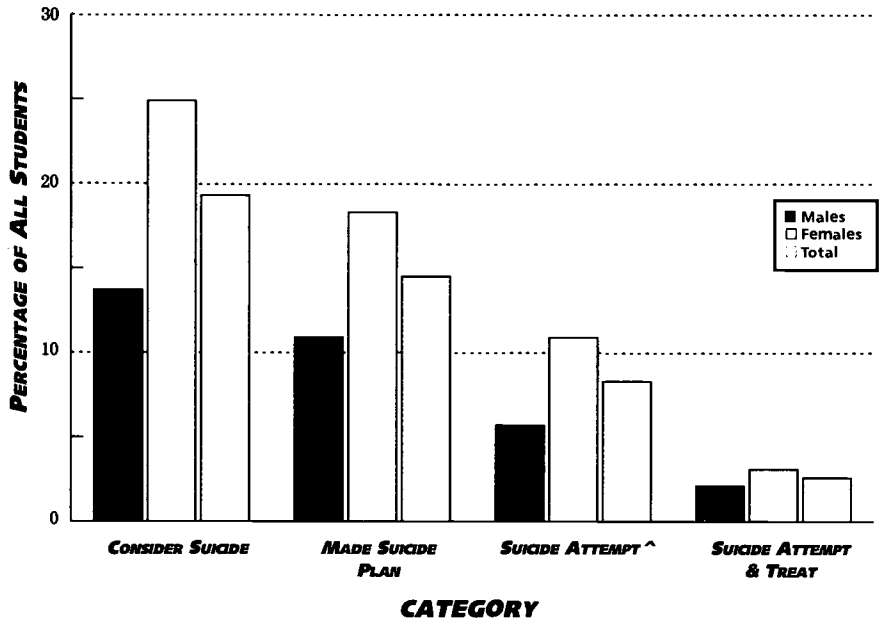
Clinical studies have shown the efficacy of training ED staff to treat suicide attempts with due seriousness, and to emphasize to adolescents' family members the dangers of ignoring suicide attempts and the benefits of follow-up treatment to reduce the reoccurrence of attempted suicide. Such staff training has been associated with greater completion of treatment on the part of persons having sought care in emergency departments (Rotheram-Borus et al., 2000). From a health care perspective, both the patient and the health care delivery system benefit from better linkages between emergency and appropriate follow-care.

IDEAS FOR ACTION

Develop guidelines for hospitals and health delivery systems that ensure adequate resources to implement confirmation of mental health follow-up appointments.

Collaborate locally to establish processes that increase the proportion of patients who keep follow-up mental health appointments after discharge from the emergency department.

FIGURE 8:
SUICIDAL IDEATION AND BEHAVIOR AMONG HIGH SCHOOL STUDENTS BY CATEGORY AND SEX*
UNITED STATES, 1999



* During the 12 months preceding the survey
^ One or more times

Case management is not the usual role of emergency departments, but in facilitating continuity of care they can champion processes that provide the missing link between an emergency evaluation and appropriate mental health treatment. Hospitals should confirm that patients receive appropriate referral and follow-up information through ongoing quality assessment programs while emergency departments identify and develop linkages with mental health and substance abuse follow-up resources for referral and treatment of patients with self-destructive behaviors (see Objective 8.1).

Objective 7.2: By 2005, develop guidelines for assessment of suicidal risk among persons receiving care in primary health care settings, emergency departments, and specialty mental health and substance abuse treatment centers. Implement these guidelines in a proportion of these settings.

> ***IDEAS FOR ACTION***
>
> *Develop standardized suicide assessment guidelines for primary care physicians when assessing elderly patients.*

Persons at risk for suicide arrive in emergency departments and primary health care settings in a variety of circumstances, with a variety of concerns, such as mental and substance use disorders, physical abuse, recent losses, and painful physical illnesses, that can place persons at increased risk for suicide (Harris & Barraclough, 1997; WHO, 2000a, 2000c). Currently, there are no universally accepted guidelines for the assessment of suicidal risk in these patients (Shea, 1999). Such guidelines would assure that these assessments become part of the routine protocol for providing clinical care to all individuals seen in these health care settings and assist in the process of making clinically appropriate referrals for mental health and substance abuse treatment.

Objective 7.3: By 2005, increase the proportion of specialty mental health and substance abuse treatment centers that have policies, procedures, and evaluation programs designed to assess suicide risk and intervene to reduce suicidal behaviors among their patients.

Studies indicate that there is a very high association between some mental (particularly schizophrenia and mood disorders) and substance use (alcohol) disorders and increased risk for suicide (Harris & Barraclough, 1997; Inskip, Harris & Barraclough, 1998; Tanney, 2000). Many patients with such diagnoses are seen in specialty mental health and substance abuse treatment centers, where they receive treatment for their primary psychiatric diagnosis. To provide good clinical care, these

centers must have in place policies, procedures, and evaluation programs designed to identify the level of suicide risk and interventions to reduce suicidal behaviors. Such approaches will likely lead to ensuring that more patients receive the appropriate assessment for suicidal risk and protective factors. Evaluation of these policies and procedures over time will result in more effective and efficient delivery of health care to those at risk.

IDEAS FOR ACTION

Sponsor the development of standardized policy and procedures for assessing suicidal risk in male alcoholics.

Objective 7.4: By 2005, develop guidelines for aftercare treatment programs for individuals exhibiting suicidal behavior (including those discharged from inpatient facilities). Implement these guidelines in a proportion of these settings.

It is well known that one of the highest risk periods for suicide is immediately following discharge from institutional settings (Morgan & Stanton, 1997). Often the investigations of such deaths identify problems in assessing a patient's readiness for discharge or transition to a less restrictive level of care, or with post-discharge planning and communications. The transition from mental health and substance abuse institutional treatment settings to community life can be difficult and challenging for individuals at high risk for suicide. All too often the assumption is that individuals are no longer at risk for suicide once they are discharged from inpatient hospital or institutional settings and placed in after-care treatment programs. Unfortunately, this is not always the case. Thus, it is critical that after-care treatment programs develop guidelines for the appropriate assessment, management, and treatment of individuals exhibiting suicidal behaviors following treatment in emergency settings or in inpatient hospital settings (Bongar et al., 1998). Such programs often incorporate some of the following elements: telephone contact, transportation arrangements to ensure attendance at clinical appointments, appropriate housing arrangements, resources to guaran-

tee purchasing of medications, and family or support group education. It is important to provide education and psychological support to families and significant others of those who have exhibited suicidal behavior.

Objective 7.5: By 2005, increase the proportion of those who provide key services to suicide survivors (e.g., emergency medical technicians, firefighters, law enforcement officers, funeral directors, clergy) who have received training that addresses their own exposure to suicide and the unique needs of suicide survivors.

When suicide occurs it results in shock and disruption for those who may have witnessed the event or arrived on the scene soon thereafter, as well as responding emergency personnel. Often emergency medical technicians and first responders (including law enforcement officers and firefighters) are the individuals to have first contact with suicide survivors. These are emotionally charged situations that leave indelible memories for all those involved. First responders have the opportunity to set the tone for being respectful and sensitive to the needs of survivors and the need to be prepared themselves for the impact such events may have on their own thoughts and emotions.

These personnel are also often the first on the scene when called to assist with a suicide attempt. Here, too, the situation is often emotionally charged, volatile, and unpredictable. The judicial use of tact, patience, sensitivity, authority, judgment, and professional skills can result in a successful assessment and management of the situation. In a similar fashion, other service-oriented professionals (clergy, funeral directors) can provide information about local support services when appropriate.

IDEAS FOR ACTION

Organize suicide survivors in your community to provide seminars on recognizing and managing the personal impact of suicide to first responders.

Objective 7.6: By 2005, increase the proportion of patients with mood disorders who complete a course of treatment or continue maintenance treatment as recommended.

A mood disorder is an alteration in an individual's ability to regulate emotions or feelings. Episodes of depression often recur. A large number of suicidal patients suffer from mood disorders alone or in combination with other mental, substance use or physical disorders (co-morbidity) (Henriksson et al., 1993). Often patients with mood disorders are reluctant to seek treatment because of the stigma associated with having a mental disorder.

The effective treatment of patients with mood disorders (which are often recurrent illnesses, necessitating close monitoring and regular evaluations) may last many months and sometimes even years. For those patients receiving medications, it may take weeks before they are effective and symptoms are significantly reduced. Once symptom relief occurs it is recommended that individuals remain on medication for a minimum of 6-9 additional months and sometimes even longer (Stahl, 2000). Remaining on a therapeutic regimen of medications is an important element in preventing a relapse or recurrence of the illness.

IDEAS FOR ACTION

Improve and disseminate easy to use, web-based tools to aid patients and caregivers in treatment adherence and relapse prevention.

Courses of psychotherapy for mood disorders also are important and curative. Psychotherapy has been found to be as effective as some pharmacologic treatments and some combinations of these two are superior to either alone. Once individuals begin to feel better and their mood disorder is improved, some tend to discontinue regular treatment and do not complete a full course of medication management or psychotherapy. Premature termination of treatment can increase the risk of relapse and return of symptoms, including suicidal behaviors. The available treatment modalities for mood disorder are effective when administered over time

and monitored appropriately. Patients must be educated to understand the need to complete the full course of recommended treatment, continue maintenance treatment as recommended, and learn to recognize and manage risk for relapse.

Objective 7.7: By 2005, increase the proportion of hospital emergency departments that routinely provide immediate post-trauma psychological support and mental health education for all victims of sexual assault and/or physical abuse.

Clinical studies suggest that a high proportion of victims of sexual assault and/or physical abuse are at increased risk for psychiatric disturbances associated with suicidal behavior, and at increased risk for self-destructive behaviors without necessarily developing a psychological disorder (Herman, 1997). It is important for hospital emergency departments to provide immediate post-trauma psychological support and mental health education for victims of violence, recognizing the traumatic nature of their experience and the risk for self-destructive behaviors they may face in the future. Protocols must be developed to assist these patients and to ensure proper follow-up and after-care treatment.

Objective 7.8: By 2005, develop guidelines for providing education to family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide. Implement the guidelines in facilities (including general and mental hospitals, mental health clinics, and substance abuse treatment centers).

This objective is related to Objective 6.8 to increase the availability of programs to educate family members and significant others about understanding, monitoring, and intervening with persons who are at risk of suicide. In combination, these two objectives are intended to ensure that the educational material is available, and that it is appropriately delivered to those who can benefit from the information.

Family members, significant others, and support networks play very important roles in the care of individuals at increased risk for suicide. Personal knowledge and daily proximity means that family members are in the best position to quickly note changes in demeanor and behavior that may signal a deterioration in thier loved one's condition. Educating family members and significant others about how to watch for changes in mood and behavior, and how to access help when needed are important to ensure that a person at risk does not become self-destructive.

Objective 7.9: By 2005, incorporate screening for depression, substance abuse and suicide risk as a minimum standard of care for assessment in primary care settings, hospice, and skilled nursing facilities for all Federally-supported healthcare programs (e.g., Medicaid, CHAMPUS/TRICARE, CHIP, Medicare).

Millions of individuals are treated through Federally-supported health care programs, including military personnel and their dependents and elderly, physically and mentally challenged, and indigent persons. Opportunities exist for these programs to become models for incorporating screening tools and techniques for depression, substance abuse, and suicide risk.

DID YOU KNOW?

Males are four times more likely to die from suicide than are females.

Mental and substance use disorders, as well as suicide risk, are often not assessed in primary care settings because of the time constraints involved and because the staff is not appropriately trained to recognize the presence of these conditions. Incorporating targeted screening tools and techniques into Federally-supported primary care settings, hospices, and skilled nursing facilities is expected to increase the number of individuals identified with symptoms of depression, substance abuse, and suicide risk. Appropriate treatment and follow-up care for these problems, over time, would be expected to prevent suicides.

Objective 7.10: By 2005, include screening for depression, substance abuse and suicide risk as measurable performance items in the Health Plan Employer Data and Information Set (HEDIS).

The Health Plan Employer Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. HEDIS is sponsored, supported and maintained by the National Committee for Quality Assurance (NCQA), a private, not-for-profit organization dedicated to improving the quality of health care.

The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma and diabetes. Screening for depression, substance abuse and suicide should be added to its performance measures for the same reasons outlined in objective 7.9, and would provide similar, expected results contributing to the prevention of suicide.

GOAL 8
IMPROVE ACCESS TO AND COMMUNITY LINKAGES WITH MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

WHY IS THIS GOAL IMPORTANT TO THE NATIONAL STRATEGY?

This goal is designed to prevent suicide by ensuring that individuals who are at high risk due to mental health and substance use problems can receive prevention and treatment services. Barriers to access need to be eliminated and linkages between various community agencies and mental health and substance abuse treatment programs need to be established.

The elimination of health disparities and the improvement of the quality of life for all Americans are central goals for Healthy People 2010 (DHHS, 2000). Some of these health disparities are associated with differences of gender, race or ethnicity, education, income, disability, geographic location, or sexual orientation. Many of these factors place individuals at increased risk for suicidal behaviors, because they limit access to mental health and substance abuse services.

Barriers to equal access and affordability of health care may be influenced by financial, structural, and personal factors. Financial barriers include not having enough health insurance or not having the ability to pay for services outside a health plan or insurance program. Structural barriers include the lack of primary care providers, medical specialists, or other health care professionals to meet special needs or the unavailability of health care facilities. Personal barriers include cultural or spiritual differences, language, not knowing when or how to seek care, or concerns about confidentiality or discrimination (Healthy People 2010). Reducing disparities is a necessary step in ensuring that all Americans receive appropriate physical health, mental health, and substance abuse services.

Improving access will help ensure that at-risk populations receive the services they need, and that all community members receive regular preventive health services. Communities need to take responsibility for preventing suicide and promoting health, but must remain sensitive to the

balance between preserving individual civil liberties and imposing mandatory treatment in those instances where it may be indicated. Developing partnerships with mental health and substance abuse services will enable all components of the community to work together to ensure the overall health and vitality of its members.

BACKGROUND INFORMATION AND CURRENT STATUS

In the last decade, much effort has been put forth to improve community health service delivery systems. It is believed that providing better access and linkages has resulted in a decrease in unnecessary illness and death due to health problems such as unintentional injury, heart attacks, and chronic illnesses. Most communities are proud of their emergency medical services, police and fire emergency services, emergency departments, and available health services.

DID YOU KNOW?

Over half of all suicides occur in adult men, aged 25-65.

Society's view of suicide and suicidal behaviors is evolving from seeing such behavior as an individual act directly affecting a single person, to a societal event in which the suicide of one individual affects many facets of a community — a community that must then accept a leading role in preventing its occurrence. The extent of suicidal behavior is now seen as a reflection of the overall health and welfare of the community, and many communities have made it a priority concern.

As society shifts its attention to addressing public health concerns such as violence, suicide, and other intentional injuries, the courts, schools, churches, social service agencies, correctional institutions, and other community institutions must work with mental health and substance abuse service systems to forge better relationships.

HOW WILL THE OBJECTIVES FACILITATE ACHIEVEMENT OF THE GOAL?

Achieving this goal is dependent on the extent to which community organizations and service delivery systems communicate with each other to facilitate the provision of health services to those in need, and on the extent to which individuals at risk use these services. As activities to achieve objectives are implemented, one outcome will be an initial increase in the number of individuals identified to be in need of mental health and substance abuse services and preventive interventions. This is often the initial result of improved risk identification and referral systems. However, the long-term benefit to identifying those in need of services is that the overall health and well-being of the community is better served by addressing the range of these health problems in the community at an earlier and less debilitating stage. This benefit extends to suicide survivors who are among those for whom linkages with mental health services may be indicated. Not only would there be a long-term reduction in the rate of suicidal behaviors, but also in the morbidity associated with many other disorders (depression, bipolar illness, schizophrenia, alcohol and drug abuse).

Objective 8.1: By 2005, increase the number of States that require health insurance plans to cover mental health and substance abuse services on par with coverage for physical health.

One reason that many mental health problems go untreated in America is that employee benefit plans tend to provide more liberal coverage for physical illness (general medical and surgical services) than for mental illness or substance abuse treatment. This disparity has worsened in recent years due to changes in the nation's health care delivery systems. Without parity, those in need of specialty mental health and substance abuse treatment will be denied adequate access. States and the Federal government have begun to require that mental

IDEAS FOR ACTION

Complete and/or disseminate cost-benefit studies conducted in States that have implemented parity laws.

health and/or substance abuse treatment be covered in the same way as other medical care (parity). Following the passage of the 1996 Mental Health Parity Act, some States have passed mandatory parity laws that to varying degrees require parity in mental health and/or substance abuse benefits. Others have enacted legislation conforming to the Federal mandate. Most State parity laws are limited in scope or application. Few address substance abuse treatment, and many are limited only to treatment for serious mental illnesses. Many parity laws exempt small businesses or only apply to plans for government employees. A necessary first step for States is to require coverage for mental health and substance abuse care on par with coverage for physical health care.

Objective 8.2: By 2005, increase the proportion of counties (or comparable jurisdictions) with health and/or social services outreach programs for at-risk populations that incorporate mental health services and suicide prevention.

It is important to help populations at risk receive needed services. National voluntary organizations such as the American Lung Association, the American Heart Association, and the American Cancer Society have been successful in their outreach efforts. They excel in providing timely and targeted public information, public health messages, and referral recommendations. It is also critical that the services themselves are available in the community, and are able and willing to reach out to populations at risk to offer appropriate health and/or social services that address their needs. At risk populations are not always able to access health services easily or to do it on their own. Often the mental health and substance abuse service provider systems need to provide ways to help individuals access care and to follow up with care over time. Such programs, which include outreach programs for the homeless and street health programs for runaway youth, reach out by contacting these individuals where they congregate.

IDEAS FOR ACTION

Make available more mobile health and mental health clinics (clinics on wheels) for the chronically ill.

Objective 8.3: By 2005, define guidelines for mental health (including substance abuse) screening and referral of students in schools and colleges. Implement those guidelines in a proportion of school districts and colleges.

Suicide in adolescents and young adults (aged 15-24) remains the third leading cause of death for this population. The onset of most major mental and substance use disorders is in this age range. A number of communities have already instituted guidelines for mental health screening and referral of students demonstrating at risk behaviors for suicide (CDC, 1992). These efforts have been shown to reduce the suicide ideation and attempt rates as well as to improve the overall provision of mental health care for the school population (See Objectives 4.2 and 4.3) (Zenere & Lazarus, 1997). Nevertheless, there are no national guidelines for mental health or substance abuse screening and referral for at-risk students. Such guidelines might include assessment tools and criteria, protocols, algorithms for assessing risk status, referral guidelines, and evaluation measures (Grossman & Kruesi, 2000).

DID YOU KNOW?

Persons who desire an early death during a serious or terminal illness are usually suffering from a treatable depressive condition.

Objective 8.4: By 2005, develop guidelines for schools on appropriate linkages with mental health and substance abuse treatment services and implement those guidelines in a proportion of school districts.

It is not sufficient to identify students at risk in public and private school systems without also ensuring that appropriate linkages to receiving services are instituted. The process of effecting a referral for treatment services must be carefully spelled out, tailored to the special circumstances of the school setting, and remain sensitive to the need for adolescents, young adults and their families to feel supported and protected while receiving timely and effective interventions.

IDEAS FOR ACTION

Establish a public/private working group in your community to investigate ways to provide effective mental health support for schools.

Identify model programs currently existing in a wide variety of community settings and showcase them on the World Wide Web.

Objective 8.5: By 2005, increase the proportion of school districts in which school-based clinics incorporate mental health and substance abuse assessment and management into their scope of activities.

Sometimes it is difficult to effect linkages with mental health and substance abuse services when such services are not within close proximity to school districts and colleges, or when they are not readily available in the community. It would be advantageous to increase the proportion of school districts in which school-based clinics incorporate mental health

IDEAS FOR ACTION

Assess availability of mental health and substance abuse treatment services for youth to determine need for school-based clinical services.

and substance abuse assessment and management as part of their mission and scope of activities. When it is in the best interests of all concerned for the student at risk to receive care within the school setting and not be referred elsewhere, school-based clinics need to apply assessment and management techniques appropriate to the age group that they serve.

Objective 8.6: By 2005, for adult and juvenile incarcerated populations, define national guidelines for mental health screening, assessment and treatment of suicidal individuals. Implement the guidelines in correctional institutions, jails and detention centers.

For a variety of reasons, correctional institutions, jails, and detention centers have not been designed to provide mental health assessment and intervention programs and services, nor organized to offer suicide preventive intervention programs (see Objective 4.5) (Hayes, 1997). However, many individuals in these institutional settings are at increased risk for self-destructive behaviors (WHO, 2000). Efforts should focus on providing appropriate assessment and treatment services to those individuals in correctional facilities, particularly juveniles who are in detention centers and holding units (Bonner, 2000).

IDEAS FOR ACTION

Work with professional correctional organizations to identify and promote model suicide assessment guidelines for jails during the acute period of incarceration (first 48 hours).

Objective 8.7: By 2005, define national guidelines for effective comprehensive support programs for suicide survivors. Increase the proportion of counties (or comparable jurisdictions) in which the guidelines are implemented.

Current estimates suggest that for every suicide, there are 6-8 individuals who have been closely associated with the person who has died by suicide. These family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide may be at increased risk

for self-destructive behaviors as well as for a range of adjustment problems, often directly linked to their sudden status as survivors. As these individuals organized into support groups and national advocacy organizations, they have documented the benefit of effective comprehensive support programs (Callahan, 2000). Although such programs exist in many areas, there remain many regions with a dearth of such support groups. Making such programs available to those in need will increase the likelihood of utilization and benefit.

IDEAS FOR ACTION

Develop and offer peer leadership training for facilitators of suicide survivors support groups.

Objective 8.8: By 2005, develop quality care/utilization management guidelines for effective response to suicidal risk or behavior and implement these guidelines in managed care and health insurance plans.

Currently, there are no standardized utilization management guidelines for use by health care provider systems and health insurance plans for the effective response to, and treatment of, individuals at risk for suicide. In part, due to the lack of uniform operational definitions for suicidal risk, suicide attempts, and other suicidal behaviors, such guidelines have been lacking. With better definitions and better surveillance techniques to identify both individuals at risk and those who might benefit from certain types of interventions, standardized utilization management guidelines can be developed, and existing guidelines can be field-tested and refined (Risk Management Foundation of the Harvard Medical Institutions, 1996).

IDEAS FOR ACTION

Work with managed care and insurance providers to develop uniform operational definitions for suicidal behaviors and related terms in utilization management guidelines.

GOAL 9

IMPROVE REPORTING AND PORTRAYALS OF SUICIDAL BEHAVIOR, MENTAL ILLNESS, AND SUBSTANCE ABUSE IN THE ENTERTAINMENT AND NEWS MEDIA

WHY IS THIS GOAL IMPORTANT TO THE NATIONAL STRATEGY?

The media–movies, television, radio, newspapers and magazines–have a powerful impact on perceptions of reality and on behavior. The American Academy of Pediatrics has estimated that American children and adolescents spend 22-28 hours per week viewing television, more than any other activity except sleeping (APA, 1990). The Internet, while not historically considered to be a part of the media, has become quite important in terms of provision of information, and many persons–including youth–spend many hours weekly viewing Web-based presentations on a variety of subjects; however, there is no knowledge currently available that addresses whether the depiction of suicide through the Internet affects those at risk differently than through other media.

Research over many years has found that media representations of suicide may increase suicide rates, especially among youth (Schmidtke & Schaller, 2000; Velting & Gould, 1997). "Cluster suicides" and "suicide contagion" have been documented (CDC, 1988; Gould et al., 1990) and studies have shown that both news reports and fictional accounts of suicide in movies and television can lead to increases in suicide (Davidson & Gould, 1989). It appears that imitation plays a role in certain individuals engaging in suicidal behavior. In particular, suicides increase primarily in the geographic area where a front-page suicide story was published with the effect proportionate to the amount of publicity the suicide receives (Phillips, 1985; Schmidtke & Schaller, 1998). Highly publicized suicides of entertainment celebrities appear to produce imitation suicides most powerfully (Wasserman, 1984).

It is widely acknowledged that the media can play a positive role in suicide prevention, even as they report on suicide or depict suicide and

related issues in movies and on television (Gould, 2001). The way suicide is presented is particularly important. Changing media representation of suicidal behaviors is one of several strategies needed to reduce the suicide rate.

Media portrayals of mental illness and substance abuse may also indirectly affect the suicide rate (Hawton et al., 1999). Negative views of these problems or inaccurate depiction of treatment may lead individuals to deny they have a problem or be reluctant to seek treatment, and untreated mental illness and substance abuse are strongly correlated with suicide.

BACKGROUND INFORMATION AND CURRENT STATUS

There have been several attempts over the last two decades to address the portrayal of suicide in the media. For example, the National Institute of Mental Health and the Association for Media Psychology held a workshop on violence prevention in 1984 in which action steps were developed to address identified problems, but lack of funding precluded follow-through (Berman, 1989). The Health Resources and Services Administration supported a workshop in 1989, convened by the Association of State and Territorial Health Officials and the New Jersey Department of Health, that focused specifically on suicide contagion. This workshop produced a set of recommendations for health professionals in dealing with the media and outlined aspects of news coverage that can promote suicide contagion (O'Carroll & Potter, 1994). These recommendations were published and disseminated. Anecdotal reports suggest that the recommendations have proved to be workable in some communities (Jobes et al., 1996). However, there is no evidence that they have been widely adopted or that they have had a measurable effect on the depiction of suicide or suicidal behaviors. Other organizations have published guidelines on media coverage, including the

DID YOU KNOW?

Between 1952 and 1995, the incidence of suicide among adolescents and young adults nearly tripled.

National Institute of Mental Health, the American Association of Suicidology, the American Psychological Association, and the American Psychiatric Association. The Entertainment Industries Council, founded in 1983 by leaders in the entertainment industry to provide information, awareness and understanding of major public health and social issues among the entertainment industry and to audiences at large, published and disseminated depiction suggestions on mental illness in collaboration with the Carter Center in 1993, updated in 2001 (http://eiconline.org/creative/spotlighton/mentill/depict1.html). Such recommendations and guidelines have been promoted and made available to the media and the public, but again there is no clear evidence that they have changed the portrayal of suicide or suicidal behavior.

HOW WILL THE OBJECTIVES FACILITATE ACHIEVEMENT OF THE GOAL?

The objectives established for this goal are designed to foster consideration among media leaders of the impact of different styles of describing or otherwise depicting suicide and suicidal behavior, to eliminate inflammatory coverage, and to encourage the presentation of content in the media that can help prevent rather than increase suicide. Thus, these objectives incorporate elements of awareness, as well as intervention.

Objective 9.1: By 2005, establish an association of public and private organizations for the purpose of promoting the accurate and responsible representation of suicidal behaviors, mental illness and related issues on television and in movies.

In light of First Amendment issues, there is generally a resistance on the part of the media to "guidelines" or other external attempts to influence artistic expression in entertainment. However, once individuals in the media have a clear understanding of the implications of the ways in which suicide and other issues, including accurate depiction of mental illness and of treatment, are depicted, many see value in modifying their approaches (Knickmeyer, 1996). This understanding is best achieved through collaborative action between the public health sector and media representatives.

Such public/private partnerships have been developed to address other issues, such as interpersonal violence prevention. Monitoring the effects of changes, providing feedback on these effects, conducting research, and ensuring constant communication between media representatives and public health leaders can help sustain progress. An association of media leaders, together with public health professionals, with an organizational mission of responsibly addressing the depiction of suicide, mental illness and substance use disorders could be a key to solidifying an ethic within the television and movie industries that would improve public health without unduly restraining artistic expression.

Objective 9.2: By 2005, increase the proportion of television programs and movies that observe promoting accurate and responsible depiction of suicidal behavior, mental illness and related issues.

Currently, no consensus recommendations have been formulated for entertainment media that specifically address the depiction of suicide and suicidal behaviors. As noted earlier, depiction recommendations do exist for mental illness and substance use disorders (see http://eiconline.org). Once such recommendations are developed, it will be important to work towards their implementation, especially because depictions of suicide are common in the entertainment media. For example, a study conducted in the late 1980s found that by the time adolescents were high school seniors, they had witnessed approximately 800 suicides on television, not all of them realistically portrayed (Radeck, undated). Widespread adherence to depiction recommendations should promote a better public understanding of suicidal behavior and mental illness. Since news reporters are also a part of that public, it is likely they too will have their attitudes changed, which could affect their reporting of suicide.

IDEAS FOR ACTION

Implement a media monitoring process to provide entertainment media and sponsors of television programming informed support of appropriate coverage and constructive critiques of misleading or hurtful depictions of suicide, mental illness, substance use disorders, or mental health and substance abuse treatments.

Objective 9.3: By 2005, increase the proportion of news reports on suicide that observe consensus reporting recommendations.

Public health officials believe that it is not so much the reporting of suicide that may lead to "copy-cat" suicides as it is the manner in which suicide is reported. To minimize the likelihood of suicide contagion, news reports can incorporate recommendations developed at the 1989 New Jersey workshop discussed above. Participants agreed that reporting should be concise and factual. Other suggestions include minimizing repetitive, ongoing or excessive reporting of suicide; limiting morbid details and sensationalism; and avoiding "how-to" descriptions of suicide (O'Carroll & Potter, 1994). Information that can help to reduce suicide can also be inserted in news stories, such as reporting about the complex nature of suicide, listing help resources, explaining how to identify high-risk individuals, and describing available treatment for depression (O'Carroll, 1996).

IDEAS FOR ACTION

Develop and provide press information kits that provide a resource for reporting on suicide and contact information for local spokespersons who may provide additional information.

Objective 9.4: By 2005, increase the number of journalism schools that include in their curricula guidance on the portrayal and reporting of mental illness, suicide and suicidal behaviors.

One way to foster responsible depiction of suicide and mental illness–that is, depictions that do not encourage suicide or stigmatize mental illness–is to encourage discussions of the implications of how news is presented among journalism students. Little is now known about the way suicide, suicidal behaviors, or mental illness and substance use disorders is addressed, if at all, in schools of journalism across the country. It is important to integrate such discussions fully into all journalism schools.

IDEAS FOR ACTION

Develop curriculum materials on reporting of suicide and mental illness for use by professors in schools of journalism.

GOAL 10
PROMOTE AND SUPPORT RESEARCH ON SUICIDE AND SUICIDE PREVENTION

WHY IS THIS GOAL IMPORTANT TO THE NATIONAL STRATEGY?

Much is known about the risk factors associated with suicide, but less about how to modify certain risk factors effectively to reduce the likelihood of suicidal behaviors occurring. Protective factors have been shown to reduce risk for suicide, but little is known about how to enhance these protective factors with individuals already at risk (Felner, Felner, & Silverman 2000). Some good hints are available about what interventions may be effective, but little information about the long term effects of these interventions and about the variables that may influence their effectiveness (Silverman & Felner, 1995). For instance, variables regarding the intervention itself (for whom and for how long, how often, how intensively, and under what circumstances) must be studied to determine which are critical in ensuring that the intervention works.

A great deal about the media and its effect on individuals is known, but little about culturally appropriate messages and how to deliver them to targeted populations to reduce suicide (see Objective 9.1). By advancing a comprehensive research agenda, industry and government, working together, can contribute significantly to the development of a knowledge-base on the causes of suicide and the development of interventions aimed at prevention.

BACKGROUND INFORMATION AND CURRENT STATUS

A good deal of information about individuals at risk for suicide has emerged from epidemiological surveillance studies. Biological and genetic research has begun to identify markers for increased risk for suicide. For example, studies showing decreased 5-hydroxy indoleacetic acid in cerebrospinal fluid along with genetic linkage studies, suggest that certain individuals may be at increased risk for the expression of suicidal behaviors.

All suicides are highly complex. The volume of research on suicide and suicide prevention has increased considerably in the past decade and has generated new questions about why individuals become suicidal or remain suicidal. The important contributions of underlying mental illness, substance abuse, and biological factors, as well as potential risk that comes from certain environmental influences are becoming clearer. Increasing the understanding of how individual and environmental risk and protective factors interact with each other to affect an individual's risk for suicidal behavior is the next challenge.

Like the U.S., other nations are working to build national suicide prevention plans on solid scientific evidence (see Introduction). Evaluation of their efforts are underway and offer the opportunity to learn important lessons from their experiences.

HOW WILL THE OBJECTIVES FACILITATE ACHIEVEMENT OF THE GOAL?

The field of suicidology has significantly advanced as a result of research findings from many related fields including sociology, psychology, psychiatry, biochemistry, neuropharmacology, and epidemiology. These findings have been translated into screening and assessment tools, treatment and resiliency-building interventions, and treatment and symptom monitoring techniques. Continued advancements in the prevention of suicidal behaviors can only come with solid support of a wide range of basic, clinical, and applied research endeavors designed to enhance understanding of the etiology, development, and expression of suicidal behaviors across the life span as well as those factors which enhance resiliency. Such enhanced understanding will lead to better assessment tools, treatments, and preventive interventions. It will also lead to more effective and efficient therapeutic interventions for survivors of suicide attempts.

DID YOU KNOW?

More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease, COMBINED.

Objective 10.1: By 2002, develop a national suicide research agenda with input from survivors, practitioners, researchers, and advocates.

Everyone has a stake in the development and implementation of a national suicide research agenda. Everyone who is touched by suicide has a contribution to make to better understand the individual who has committed suicide and the suicidal process. A coordinated research agenda will benefit everyone affected by suicide and other life-threatening behaviors.

An agenda might address the who, what, when, where, why, how, and how much questions of suicide. The targets for such an agenda might include increased attention to high risk groups, gender and ethnic differences, geographical distribution, means restriction, economic changes, surveillance, genetic contributions, protective factors, and psychotherapy and psychopharmacology as potential treatment and preventive interventions.

Such an agenda might include research on specific aspects of prevention, intervention, or postvention, including basic, applied, clinical, evaluation, community-based intervention, and media-based research.

Objective 10.2: By 2005, increase funding (public and private) for suicide prevention research, for research on translating scientific knowledge into practice, and for training of researchers in suicidology.

IDEAS FOR ACTION

Tie priorities for professional training grants to the inclusion of suicidology in their curriculums.

Scientific knowledge must be translated into practice and general applications, including educational settings, justice, occupational, and elderly programs. Learning more about how to transfer such knowledge effectively will benefit all concerned. Important findings and ideas for implementation must not be over-

looked or lost because their potential for rapid application are not immediately appreciated. A real need exists to improve the translation of basic scientific research findings into recommendations and suggestions for practical application.

Despite the increase in interest in suicide and suicide prevention research, there remains a shortage of researchers trained in the field of suicidology and trained in research methods most applicable to suicide and suicide prevention.

Objective 10.3: By 2005, establish and maintain a registry of prevention activities with demonstrated effectiveness for suicide or suicidal behaviors.

Basic, applied, clinical, and preventive intervention research must focus more on suicide and life-threatening behaviors. Not only is it important to support research in these areas, but also to review existing research to gather those findings that have the most potential for application in community and clinical settings. By comparing and contrasting outcomes and findings, appropriate decisions can be made about which directions to pursue and which approaches are no longer fruitful. Having access to such a registry that identifies evidence-based models or best practices allows individuals or communities to apply them or build upon them in developing local initiatives.

Objective 10.4: By 2005, perform scientific evaluation studies of new or existing suicide prevention interventions.

In promoting better research on suicide and suicide prevention, it is important to develop better evaluation research tools, techniques, and approaches to determine whether interventions do, in fact, work and how effectively and efficiently they achieve the goals stated. Evaluation studies may include measurements of cost-effectiveness, cost-offset, and cost-benefit. It is only through carefully designed, implemented, and evaluated intervention studies that better preventive interventions can be provided to achieve the goal of reducing suicide rates in the nation. (See Objective 4.8).

DID YOU KNOW?

In 1999, approximately 1 out of every 13 U.S. high school students reported making a suicide attempt in the preceding 12 months.

GOAL 11
IMPROVE AND EXPAND SURVEILLANCE SYSTEMS

WHY IS THIS GOAL IMPORTANT TO THE NATIONAL STRATEGY?

Surveillance has been defined as the systematic and ongoing collection of data (Bonnie et al., 1999). Surveillance systems are key to health planning. They are used to track trends in rates, to identify new problems, to provide evidence to support activities and initiatives, to identify risk and protective factors, to target high risk populations for interventions, and to assess the impact of prevention efforts (Thacker & Stroup, 1994).

DID YOU KNOW?

Every 17 minutes another life is lost to suicide. Every day 86 Americans take their own life and over 1500 attempt suicide.

There are an estimated 8 to 25 attempted suicides for every one death by suicide.

Data are needed at national, state and local levels. National data can be used to draw attention to the magnitude of the suicide problem and to examine differences in rates among groups (e.g., ethnic, age groups) (*see Figure 9*) and locales (e.g., rural vs. urban). State and local data help establish local program priorities and are necessary for evaluating the impact of suicide prevention strategies.

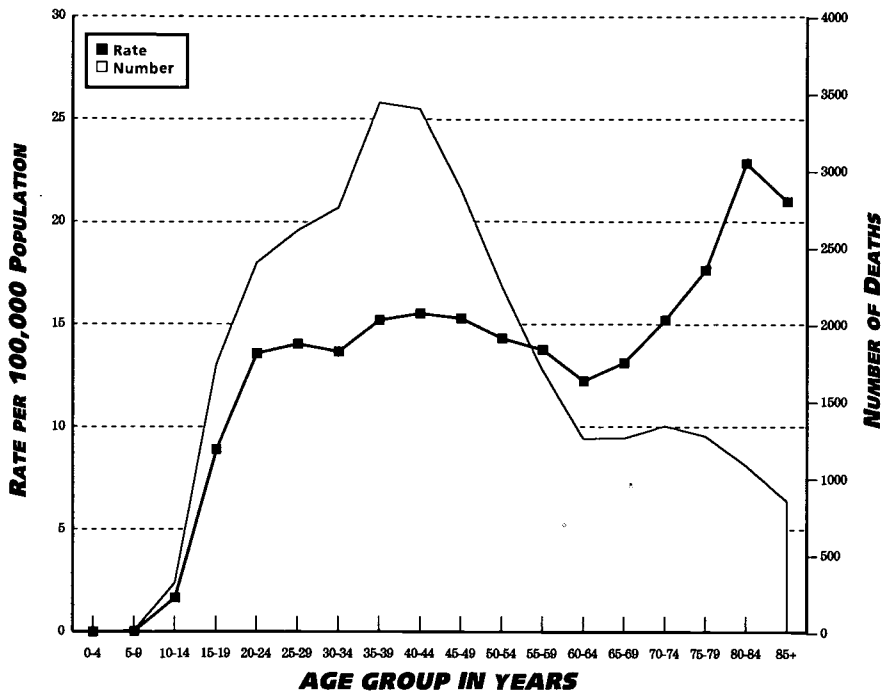
BACKGROUND INFORMATION AND CURRENT STATUS

Nationally, suicide surveillance data come from death certificates. This vital statistics information is available from the National Center for Health Statistics, Centers for Disease Control and Prevention. Medical examiner databases also provide some information related to suicide. The information on rates available from vital statistics databases obviously does not include those deaths misclassified as homicides or accidents, and an unknown number of others misclassified as natural causes, but which

may actually be suicides. Information available from death certificates is limited and is not always complete. Prevention efforts would be enhanced by more comprehensive information. However, such information is not now systematically collected.

FIGURE 9:

SUICIDES AND SUICIDE RATES BY AGE GROUP – UNITED STATES, 1998



Source: National Center for Health Statistics

Data on suicide attempts must come from sources designed for other purposes, such as trauma registries and uniform hospital discharge data sets. Trauma registries provide detailed information about the nature and severity of an injury, the treatment provided, and the status of the

patient on discharge from the hospital. However, most trauma registries include only "major" trauma cases, those that require at least a three-day hospital stay (Bonnie et al., 1999). Moreover, many suicide attempts do not lead to traumatic injuries (e.g., overdoses of medicines). Thus, trauma registries have only limited information on suicide attempts.

A uniform hospital discharge data set is another potential source of information on suicide attempts. As suggested by its name, a hospital discharge data set provides information only about those suicide attempts that resulted in hospital treatment. Not all States require either trauma registries or uniform hospital discharge data.

The State of Oregon is unique in that a 1987 law requires hospitals treating a child under the age of 18 for injuries resulting from a suicide attempt to report the attempt to the Oregon Health Division (Hopkins et al., 1995). This data source provides important information for youth suicide prevention programming in Oregon.

Other possible sources of data on suicide attempts include mental health agencies, psychiatric hospitals, poison control centers, universities and colleges, child death review team reports, emergency departments, and surveys. Limitations exist for all of these data sources, such as lack of detail on the circumstances surrounding the suicide attempt (Children's Safety Network, 2000). Detailed information is important because it may lead to increased knowledge of how suicides can be prevented in the future.

One problem in studying nonlethal suicidal behavior is lack of consensus about what terms should be used to refer to these types of behaviors (O'Carroll et al., 1996). Self-injurious behavior exists on a continuum from actions without conscious intent to die, to actions with lethal intent that do not result in death (suicide attempts), to intentional, self-inflicted death (suicide). Often it is difficult to identify a person's intent to die and thus difficult to differentiate attempted suicide from self-injurious behavior in which there was no intent to die.

HOW WILL THE OBJECTIVES FACILITATE ACHIEVEMENT OF THE GOAL?

The objectives established for this goal are designed to enhance the quality and quantity of data available at national, state and local levels on suicide and attempted suicide and ensure that the data are useful for prevention purposes.

Objective 11.1: By 2005, develop and refine standardized protocols for death scene investigations and implement these protocols in counties (or comparable jurisdictions).

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 data.

The detail and specificity of death scene investigations vary by the training and orientation of those who participate in them. The medical examiner or coroner is seldom the first to arrive at the scene of a suicide; prehospital care providers and fire fighters are more likely to arrive first. The core training curricula for such first responders include little attention to death scene investigation in general or suicide scene preservation specifically. In many jurisdictions, prehospital care providers are required to attempt resuscitative efforts even in the face of overwhelming evidence of death. Such resuscitation and transport efforts disrupt evidence. Protocols defining situations that do not require resuscitation and that specify important evidentiary findings that should be preserved would help to address these problems. While law enforcement officers are trained in death scene investigation, that training is primarily geared towards the confirmation or denial of foul play. Additional training in gathering evidence from a suicide scene

IDEAS FOR ACTION

Review local emergency medical services protocols for suicide scene procedures and revise as needed.

would provide data that should assist in prevention activities (MacKay, 1997). For example, recording the names of witnesses to the death or close personal contacts of the decedent could help uncover essential information about the decedent, e.g., statements and other behaviors prior to the death, as well as personal and family histories. Testimonies of these individuals may reveal insight into the intent, as well as relevant risk and protective factors.

Objective 11.2: By 2005, increase the proportion of jurisdictions that regularly collect and provide information for follow-back studies on suicides.

Follow-back studies consist of the collection of detailed information about the victim, his or her circumstances, the immediate antecedents of the suicide, and other important but less immediate antecedents. Data sources include personal interviews and medical records. Follow-back studies can be used to increase understanding of the causes of suicide and to refine prevention strategies (Berman 1993; Clark & Horton-Deutsch, 1992; Conwell et al., 1996). In some States, child death review teams analyze suicides of young people, and information from these reviews is used to assist in prevention programming.

IDEAS FOR ACTION

Determine if a local jurisdiction regularly completes follow-back studies on completed suicides, and if not, advocate for such studies.

Objective 11.3: By 2005, increase the proportion of hospitals (including emergency departments) that collect uniform and reliable data on suicidal behavior by coding external cause of injuries utilizing the categories included in the International Classification of Diseases.

Consistent use of external cause of injury codes in hospital discharge data and emergency department records would provide an extremely valuable resource for the study and prevention of suicide. Emergency physicians, in particular, have a key role in ensuring that these data are collected. Injury codes include information about the causes and circumstances of injuries (the "how") and, in combination with other information in the medical record, the effect of different injuries on the body. The codes can also be used to obtain information on cost of treatment. External cause of injury codes were developed by the World Health Organization as a part of the International Classification of Diseases. They are standardized internationally and allow consistent comparisons of data among communities, States, and countries (or across time for purposes of evaluation studies). As of January 1997, 17 States had some type of requirement for such coding (Arizona, California, Connecticut, Delaware, Georgia, Maryland, Massachusetts, Missouri, Nebraska, New Jersey, New York, Pennsylvania, Rhode Island, South Carolina, Vermont, Washington, and Wisconsin) (Education Development Center, 1999).

IDEAS FOR ACTION

Advocate for mandated coding of external cause of injury by all hospitals.

Objective 11.4: By 2005, implement a national violent death reporting system that includes suicides and collects information not currently available from death certificates.

A detailed, Federally-supported data system exists to assist policy-making for motor vehicle related deaths, but such a data system does not exist for violent deaths, including those from suicide. As a result, much of the public debate about violent deaths is based on limited rather than comprehensive data. A national reporting system, which might consist of information derived from a combination of sources, including death certificates, medical examiner or coroner's offices, and law enforcement agencies, would fill a gap in current knowledge by providing consistent, comparable data from all States.

Objective 11.5: By 2005, increase the number of States that produce annual reports on suicide and suicide attempts, integrating data from multiple State data management systems.

An annual State report on suicide describes the magnitude of the suicide problem in the State and how suicide differentially affects special populations; thus, the data can be used to identify priorities for planning and programming. The data can also help track trends in the suicide rate over time and identify new problems related to suicide, such as changes in the methods for completing suicide or in the suicide rate among certain groups. And finally, the data can help the State evaluate its suicide prevention efforts.

IDEAS FOR ACTION

Encourage State health agencies to produce annual reports on suicide.

Objective 11.6: By 2005, increase the number of nationally representative surveys that include questions on suicidal behavior.

It is estimated that a far greater number of people attempt suicide than is reflected in statistics based on medical care. Some people are treated in a physician's office from which no reporting is ever made, and others are not treated by medical personnel at all. Studies examining nonfatal suicidal behavior have found that over 70 percent of persons attempting suicide never seek health services (Crosby, Cheltenham, & Sacks, 1999). Even the best of existing data on suicide underestimates the burden it places on society (Rosenberg et al., 1987). The Youth Risk Behavior Survey provides one source of information on youth suicide, but there are no other nationally administered surveys that regularly include questions about suicidal behavior. Such information would be quite useful in understanding the true scope of the problem and in designing interventions.

Objective 11.7: By 2005, implement pilot projects in several States that link and analyze information related to self-destructive behavior derived from separate data systems, including for example law enforcement, emergency medical services, and hospitals.

The utility of data can be enhanced significantly when data sets are linked. 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 mortality and morbidity (Bonnie et al., 1999). The National Highway Traffic Safety Administration, U.S. Department of Transportation has fostered and supported the development of linked data systems in improving knowledge related to traffic injuries. It has found that many important questions can be answered through analyses based on data linkage. However, significant barriers exist with respect to data linkage, including difficulties in obtaining access to various data sets, high costs, limited resources for developing and maintaining databases, technical difficulties, and issues of confidentiality (Bonnie et al., 1999). Some of these problems

are being addressed, however, such as the development of "probabilistic linkage" software that can track individual cases through multiple data sets even in the absence of common identifiers. In short, linking data sets is not a trivial undertaking, but the rewards are often substantial in terms of higher quality data and more complete information.

DID YOU KNOW?

Suicide rates are consistently higher in the western states than in the rest of the U.S.

CHAPTER 12
LOOKING AHEAD

INVESTMENT AND COLLABORATION

Designed to encourage and empower groups and individuals to work together, the ***National Strategy*** **for Suicide Prevention** creates a framework for suicide prevention for the Nation. The stronger and broader the support and collaboration, the greater the chance for the success of this public health initiative. Suicide and suicidal behaviors can be reduced as the general public gains more understanding about the extent to which suicide is a major public health problem, about the ways in which it can be prevented, and about the roles individuals and groups can play in prevention efforts.

The ***National Strategy*** is comprehensive and sufficiently broad so that individuals and groups can select those objectives and activities that best fit their interests, constituencies and resources. The plan's objectives suggest a number of roles for different groups. Individuals representing a variety of occupational fields such as health care, social work, education, law and faith-based care should be involved in implementing the plan. Institutions such as community groups, religious organizations, and schools all have a necessary part to play. Sites for suicide prevention work include jails, emergency departments, and the workplace. The survivors, consumers and the media need to be partners as well. State and local governments are key players, as is the Federal government, whose role is to judiciously provide funding for research and programs that protect and enhance the health and well-being of their citizens.

DID YOU KNOW?

State Suicide Prevention Plans already exist or are in the process of creation in over 20 States.

Ideally, the ***National Strategy*** will motivate and illuminate. But for the NSSP to have any effect, people need to use it as a guideline to develop

their own priorities. The ***National Strategy*** can serve as a model that can be adopted or modified by States, communities, and tribes as they develop their own suicide prevention plan. The information on evidence-based strategies included in this document can help. The ***National Strategy*** articulates the framework for national efforts and provides legitimacy for local groups to make suicide prevention a high priority for action. Taking action will convey a message that we, as a society, do care about supporting our communities.

CHALLENGES TO OVERCOME

The knowledge base about suicide and suicide prevention remains incomplete. Research resulting in the acquisition of new knowledge must continue to contribute by suggesting new strategies and approaches. Evaluation activities must be incorporated into all prevention efforts to ensure ongoing monitoring and refinement.

In the last decade, suicide prevention efforts have received renewed support from Federal and private sources. Most of these efforts have taken the form of educational campaigns and development of health education modules for school systems. The pharmaceutical industry has developed new medications to treat mental and substance use disorders that are often associated with suicidal behavior and there is promising evidence that these medications do reduce suicidal behaviors among those who receive them in therapeutic doses over sufficient time (Jamison & Baldessarini, 1999; Meltzer & Okayli 1995). However, patients may also need non-pharmacologic interventions to reduce their risk for suicidality.

Educational institutions have increased their training in prevention sciences and health promotion. However, the courses offered may not specifically address suicide, suicidal behaviors, mental health services, or the prevention of mental or substance use disorders. New advances in therapeutic modalities such as cognitive behavioral therapy, dialectical behavioral therapy, and interpersonal psychotherapy, hold promise for reducing suicidal behaviors in those individuals at risk (Hawton et al.,

1998). Renewed attention has focused on building social and interpersonal competencies as protective factors against mental disorders (Mrazek & Haggerty, 1994). Systemic interventions, such as the Air Force Suicide Prevention Program, have made an impact (Litts et al., 1999). Nevertheless, access to these quality programs is not universal and not all mental health centers or substance abuse treatment facilities have the available expertise to offer these interventions.

DID YOU KNOW?

A concerted, broadly-supported, community based effort reduced suicide in the US Air Force by over 60% in five years.

Implementing a national suicide prevention strategy successfully requires overcoming some specific obstacles and barriers. Some are well-known to the prevention field in general, such as the real dilemma of allocating scarce human and monetary resources among the many deserving health-related prevention programs. Acquiring and maintaining appropriate levels of public and private funding for suicide prevention efforts can be a challenge. The potential impact on local, state, and federal budgets must be carefully considered.

Another obstacle is the argument that prevention is a luxury and funds should be allocated instead to treatment, which is of the moment. Both are important and necessary and public health efforts work more effectively when these components operate in unison. In an oft-cited metaphor, prevention is likened to the work of posting warnings and constructing protective railings at the river's edge, while treatment is seen as the work of pulling those who have fallen in and cannot swim from the cold waters. There will always remain a role for both kinds of work. One goal of prevention is to prevent those at risk from "drowning," because the treatment programs cannot always keep pace with the demand for services.

Another challenge to overcome is the institutional tendency towards short-term and isolated prevention planning. Because effective prevention efforts may take years to show true benefits, instituting plans in 2-

to 5-year increments may not permit prevention efforts to come to fruition. Additionally, suicide prevention goals and objectives must be woven into the fabric of community and local human services, training, and education. Standing alone, suicide prevention efforts fail to benefit from the resources, experience and community acceptance of established programs and services. There are challenges and complexities surrounding priority setting, data collection, measurement of progress, resource allocation and programmatic refinement over time.

Probably the greatest challenge to the successful implementation of a national suicide prevention strategy comes from the twin nemeses of stigma and disparity: the societal stigma associated with mental illness, substance abuse, and suicidal behaviors, and the current disparity in access to mental health and substance abuse care compared to other forms of health care. Taken together, these two threats–one of psychological and cultural origins, the other due to organizational and economic roadblocks–represent a formidable twin obstacle. Overcoming them must engage the energies, political will and creativity of all members of society.

Collaboration is a keystone of the ***National Strategy***. There is in our Nation a tremendous human resource potential of volunteer and grassroots advocates who are committed to advancing suicide prevention efforts. Many groups and individuals have been involved in developing the plan's goals and objectives and as activities for implementing the plan are developed, many others will be called upon to lend their support. The involvement of a diverse group of participants will lead to the formation of partnerships for successful implementation. Everyone must be involved for the plan to succeed and for the suicide rate to be reduced.

Decisions about which diseases and conditions should receive the most attention are difficult and complex. Opportunities arise only so often to capture the spirit and attention of the public around a particular public health problem. The momentum and activity focused in the last few years on suicide and suicidal behaviors suggest that the time is right for bold and concerted movement forward with suicide prevention efforts.

NEXT STEPS

Beyond the written plan presented in this document, the ***National Strategy for Suicide Prevention*** encompasses the development, promotion and support of programs that will be implemented in communities across the country. These activities are designed to achieve significant, measurable, and sustainable reductions in suicide and suicidal behaviors. This requires a major investment in public health action. For any preventive action to go forward, three ingredients are necessary: a knowledge base, the public support for change, and a social strategy to accomplish change (Atwood, Colditz, & Kawachi, 1997). The next steps for the NSSP recognize that each ingredient is dependent upon the other, and that balance among all three must be achieved to make progress.

A significant step is to develop an operating structure or coordinating body for the ***National Strategy*** that reflects the essential need for a public/private partnership. Public (for instance Federal, State, and local officials) and private sector representation would guide public action. Private sector representatives would include business, voluntary organizations, survivor groups, faith-based groups, professional associations, and the media. The coordinating body, with defined responsibility, funding, authority, and accountability for its work, would be the national focus for prevention activities and would provide a mechanism for engaging public will.

Development of an action agenda, complete with specific activities defined for national, state, and community partners would ideally be shepherded by the coordinating body although to expedite progress, development of a coordinating body and an action agenda may proceed in tandem. When stakeholders participate in the development of prevention activities, political will is generated for the resources to accomplish them. Moreover, bridging the knowledge and practice communities in this way leads to sound prevention activities applicable to specific cultures.

Some activities will be directed towards critical expansion of the knowledge base with, for example, the addition of translational research

connecting advances in neuroscience to "active preventive interventions" (e.g., biological, social, psychological) that lower the risk of suicide, of applied research that carries prevention science into community action, and of research on program evaluation. This knowledge continuum supports development of practice guidelines for all disciplines and sectors engaged in suicide prevention.

Ideally, objectives are measurable; that is, one is able to follow some essential piece of information associated with the stated objective. This information, known as a benchmark, or indicator, permits one to quantify the achievement of a result. For instance, in Objective 3.1 the benchmark (indicator) is the proportion of the public that views mental and physical health as equal and inseparable components of overall health. Thus, to track success in achieving an objective it is required to have identified at least one benchmark, a *baseline* (the measurement of the benchmark from which change will be assessed) and a *target* (the number or percentage change desired in the benchmark). Not all objectives require benchmarks to determine if the Nation has achieved them. Policy and organizational objectives (see Objective 2.2) can often be deemed accomplished simply by the fact of their having been established.

Benchmarks can be a commonsense way to communicate to the public the value of their investment in suicide prevention activities. By measuring the same benchmark over time, one may determine the amount and direction of change towards fulfilling the objective. In this way, benchmark measures can guide decision making by providing information about the success or failure of efforts that are being applied in support of a particular objective.

Each objective in the U.S. ***National Strategy*** is potentially, if not practically, measurable. For some objectives, benchmark data may already exist or its collection will be straightforward. For others, benchmarks have not yet been identified or collecting information on the benchmark may just not be practical at this time. For most of the objectives in ***Goals and Objectives for Action***, no baseline benchmark data has yet been established. Without this baseline information, it is difficult to set a numerical target for change, since it is not clear just how much progress

should be expected by the year 2005. Developing appropriate indicators, determining baseline measures and establishing a benchmarking system for ***National Strategy*** progress is a key next step.

Plans are already underway to launch the ***National Strategy for Suicide Prevention*** website <http://www.mentalhealth.org/suicide-prevention> and document clearinghouse so that the available knowledge can be in the hands of those who will be can use it for effective decision-making in suicide prevention. The website/clearinghouse will provide electronic linkages among partners involved in the NSSP to support their collaboration and progress. It will provide up-to-date information that can help shape public will.

Now is the time for making great strides in suicide prevention. Implementing this ***National Strategy*** for Suicide Prevention provides the means to realize success in reducing the toll of this serious public health problem. The work ahead can extend public and private collaboration to sustain action on behalf of all Americans because suicide prevention is truly everyone's business.

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APPENDIX A

NSSP GOALS AND OBJECTIVES FOR ACTION: SUMMARY LIST

SECTION I: AWARENESS

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

SECTION 2: INTERVENTION

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

SECTION 3: METHODOLOGY

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

SECTION I: AWARENESS

1. PROMOTE AWARENESS THAT SUICIDE IS A PUBLIC HEALTH PROBLEM THAT IS PREVENTABLE

Objective 1.1: By 2005, increase the number of States in which public information campaigns designed to increase public knowledge of suicide prevention reach at least 50 percent of the State's population.

Objective 1.2: By 2005, establish regular national congresses on suicide prevention designed to foster collaboration with stakeholders on prevention strategies across disciplines and with the public.

Objective 1.3: By 2005, convene national forums to focus on issues likely to strongly influence the effectiveness of suicide prevention messages.

Objective 1.4: By 2005, increase the number of both public and private institutions active in suicide prevention that are involved in collaborative, complementary dissemination of information on the World Wide Web.

2. DEVELOP BROAD-BASED SUPPORT FOR SUICIDE PREVENTION

Objective 2.1: By 2001, expand the Federal Steering Group to appropriate Federal agencies to improve Federal coordination on suicide prevention, to help implement the ***National Strategy for Suicide Prevention***, and to coordinate future revisions of the ***National Strategy***

Objective 2.2: By 2002, establish a public/private partnership(s) (e.g., a national coordinating body) with the purpose of advancing and coordinating the implementation of the National Strategy.

Objective 2.3: By 2005, increase the number of national professional, voluntary, and other groups that integrate suicide prevention activities into their ongoing programs and activities.

Objective 2.4: By 2005, increase the number of nationally organized faith communities adopting institutional policies promoting suicide prevention.

3. DEVELOP AND IMPLEMENT STRATEGIES TO REDUCE THE STIGMA ASSOCIATED WITH BEING A CONSUMER OF MENTAL HEALTH, SUBSTANCE ABUSE AND SUICIDE PREVENTION SERVICES.

Objective 3.1: By 2005, increase the proportion of the public that views mental and physical health as equal and inseparable components of overall health.

Objective 3.2: By 2005, increase the proportion of the public that views mental disorders as real illnesses that respond to specific treatments.

Objective 3.3: By 2005, increase the proportion of the public that views consumers of mental health, substance abuse, and suicide prevention services as pursuing fundamental care and treatment for overall health.

Objective 3.4: By 2005, increase the proportion of those suicidal persons with underlying mental disorders who receive appropriate mental health treatment.

SECTION 2: INTERVENTION

4. DEVELOP AND IMPLEMENT COMMUNITY-BASED SUICIDE PREVENTION PROGRAMS

Objective 4.1: By 2005, increase the proportion of States with comprehensive suicide prevention plans that a) coordinate across government agencies, b) involve the private sector, and c) support plan development, implementation, and evaluation in its communities.

Objective 4.2: By 2005, increase the proportion of school districts and private school associations with evidence-based programs designed to address serious childhood and adolescent distress and prevent suicide.

Objective 4.3: By 2005, increase the proportion of colleges and universities with evidence-based programs designed to address serious young adult distress and prevent suicide.

Objective 4.4: By 2005, increase the proportion of employers that ensure the availability of evidence-based prevention strategies for suicide.

Objective 4.5: By 2005, increase the proportion of correctional institutions, jails and detention centers housing either adult or juvenile offenders, with evidence-based suicide prevention programs.

Objective 4.6: By 2005, increase the proportion of State Aging Networks that have evidence-based suicide prevention programs designed to identify and refer for treatment of elderly people at risk for suicidal behavior.

Objective 4.7: By 2005, increase the proportion of family, youth and community service providers and organizations with evidence-based suicide prevention programs.

Objective 4.8: By 2005, develop one or more training and technical resource centers to build capacity for States and communities to implement and evaluate suicide prevention programs.

5. PROMOTE EFFORTS TO REDUCE ACCESS TO LETHAL MEANS AND METHODS OF SELF-HARM

Objective 5.1: By 2005, increase the proportion of primary care clinicians, other health care providers, and health and safety officials who routinely assess the presence of lethal means (including firearms, drugs, and poisons) in the home and educate about actions to reduce associated risks.

Objective 5.2: By 2005, expose a proportion of households to public information campaign(s) designed to reduce the accessibility of lethal means, including firearms, in the home.

Objective 5.3: By 2005, develop and implement improved firearm safety design using technology where appropriate.

Objective 5.4: By 2005, develop guidelines for safer dispensing of medications for individuals at heightened risk of suicide.

Objective 5.5: By 2005, improve automobile design to impede carbon monoxide-mediated suicide.

Objective 5.6:: By 2005, institute incentives for the discovery of new technologies to prevent suicide.

6. IMPLEMENT TRAINING FOR RECOGNITION OF AT-RISK BEHAVIOR AND DELIVERY OF EFFECTIVE TREATMENT

Objective 6.1: By 2005, define minimum course objectives for providers of nursing care in assessment and management of suicide risk, and identification and promotion of protective factors. Incorporate this material into curricula for nursing care providers at all professional levels.

Objective 6.2: By 2005, increase the proportion of physician assistant educational programs and medical residency programs that include training in the assessment and management of suicide risk and identification and promotion of protective factors.

Objective 6.3: By 2005, increase the proportion of clinical social work, counseling, and psychology graduate programs that include training in the assessment and management of suicide risk, and the identification and promotion of protective factors.

Objective 6.4: By 2005, increase the proportion of clergy who have received training in identification of and response to suicide risk and behaviors and the differentiation of mental disorders and faith crises.

Objective 6.5: By 2005, increase the proportion of educational faculty and staff who have received training on identifying and responding to children and adolescents at risk for suicide.

Objective 6.6: By 2005, increase the proportion of correctional workers who have received training on identifying and responding to persons at risk for suicide.

Objective 6.7: By 2005, increase the proportion of divorce and family law and criminal defense attorneys who have received training in identifying and responding to persons at risk for suicide.

Objective 6.8: By 2005, increase the proportion of counties (or comparable jurisdictions such as cities or tribes) in which education programs are available to family members and others in close relationships with those at risk for suicide.

Objective 6.9: By 2005, increase the number of recertification or licensing programs in relevant professions that require or promote competencies in depression assessment and management and suicide prevention.

7. DEVELOP AND PROMOTE EFFECTIVE CLINICAL AND PROFESSIONAL PRACTICES

Objective 7.1: By 2005, increase the proportion of patients treated for self-destructive behavior in hospital emergency departments that pursue the proposed mental health follow-up plan.

Objective 7.2: By 2005, develop guidelines for assessment of suicidal risk among persons receiving care in primary health care settings, emergency departments, and specialty mental health and substance abuse treatment centers. Implement these guidelines in a proportion of these settings.

Objective 7.3: By 2005, increase the proportion of specialty mental health and substance abuse treatment centers that have policies, procedures, and evaluation programs designed to assess suicide risk and intervene to reduce suicidal behaviors among their patients.

Objective 7.4: By 2005, develop guidelines for aftercare treatment programs for individuals exhibiting suicidal behavior (including those discharged from inpatient facilities). Implement these guidelines in a proportion of these settings.

Objective 7.5: By 2005, increase the proportion of those who provide key services to suicide survivors (e.g., emergency medical technicians, firefighters, law enforcement officers, funeral directors, clergy) who have received training that addresses their own exposure to suicide and the unique needs of suicide survivors.

Objective 7.6: By 2005, increase the proportion of patients with mood disorders who complete a course of treatment or continue maintenance treatment as recommended.

Objective 7.7: By 2005, increase the proportion of hospital emergency departments that routinely provide immediate post-trauma psychological support and mental health education for all victims of sexual assault and/or physical abuse.

Objective 7.8: By 2005, develop guidelines for providing education to family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide. Implement the guidelines in facilities (including general and mental hospitals, mental health clinics, and substance abuse treatment centers).

Objective 7.9: By 2005, incorporate screening for depression, substance abuse and suicide risk as a minimum standard of care for assessment in primary care settings, hospice, and skilled nursing facilities for all Federally-supported healthcare programs (e.g., Medicaid, CHAMPUS/TRICARE, CHIP, Medicare).

Objective 7.10: By 2005, include screening for depression, substance abuse and suicide risk as measurable performance items in the Health Plan Employer Data and Information Set (HEDIS).

8. INCREASE ACCESS TO AND COMMUNITY LINKAGES WITH MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Objective 8.1: By 2005, increase the number of States that require health insurance plans to cover mental health and substance abuse services on par with coverage for physical health.

Objective 8.2: By 2005, increase the proportion of counties (or comparable jurisdictions) with health and/or social services outreach programs for at-risk populations that incorporate mental health services and suicide prevention.

Objective 8.3: By 2005, define guidelines for mental health (including substance abuse) screening and referral of students in schools and colleges. Implement those guidelines in a proportion of school districts and colleges.

Objective 8.4: By 2005, develop guidelines for schools on appropriate linkages with mental health and substance abuse treatment services and implement those guidelines in a proportion of school districts.

Objective 8.5: By 2005, increase the proportion of school districts in which school-based clinics incorporate mental health and substance abuse assessment and management into their scope of activities.

Objective 8.6: By 2005, for adult and juvenile incarcerated populations, define national guidelines for mental health screening, assessment and treatment of suicidal individuals. Implement the guidelines in correctional institutions, jails and detention centers.

Objective 8.7: By 2005, define national guidelines for effective comprehensive support programs for suicide survivors. Increase the proportion of counties (or comparable jurisdictions) in which the guidelines are implemented.

Objective 8.8: By 2005, develop quality care/utilization management guidelines for effective response to suicidal risk or behavior and implement these guidelines in managed care and health insurance plans.

9. IMPROVE REPORTING AND PORTRAYALS OF SUICIDAL BEHAVIOR, MENTAL ILLNESS, AND SUBSTANCE ABUSE IN THE ENTERTAINMENT AND NEWS MEDIA

Objective 9.1: By 2005, establish an association of public and private organizations for the purpose of promoting the accurate and responsible representation of suicidal behaviors, mental illness and related issues on television and in movies.

Objective 9.2: By 2005, increase the proportion of television programs and movies that observe promoting accurate and responsible depiction of suicidal behavior, mental illness and related issues.

Objective 9.3: By 2005, increase the proportion of news reports on suicide that observe consensus reporting recommendations.

Objective 9.4: By 2005, increase the number of journalism schools that include in their curricula guidance on the portrayal and reporting of mental illness, suicide and suicidal behaviors.

SECTION 3: METHODOLOGY

10. PROMOTE AND SUPPORT RESEARCH ON SUICIDE AND SUICIDE PREVENTION

Objective 10.1: By 2002, develop a national suicide research agenda with input from survivors, practitioners, researchers, and advocates.

Objective 10.2: By 2005, increase funding (public and private) for suicide prevention research, for research on translating scientific knowledge into practice, and for training of researchers in suicidology.

Objective 10.3: By 2005, establish and maintain a registry of prevention activities with demonstrated effectiveness for suicide or suicidal behaviors.

Objective 10.4: By 2005, perform scientific evaluation studies of new or existing suicide prevention interventions.

11. IMPROVE AND EXPAND SURVEILLANCE SYSTEMS

Objective 11.1: By 2005, develop and refine standardized protocols for death scene investigations and implement these protocols in counties (or comparable jurisdictions).

Objective 11.2: By 2005, increase the proportion of jurisdictions that regularly collect and provide information for follow-back studies on suicides.

Objective 11.3: By 2005, increase the proportion of hospitals (including emergency departments) that collect uniform and reliable data on suicidal behavior by coding external cause of injuries, utilizing the categories included in the International Classification of Diseases.

Objective 11.4: By 2005, implement a national violent death reporting system that includes suicides and collects information not currently available from death certificates.

Objective 11.5: By 2005, increase the number of States that produce annual reports on suicide and suicide attempts, integrating data from multiple State data management systems.

Objective 11.6: By 2005, increase the number of nationally representative surveys that include questions on suicidal behavior.

Objective 11.7: By 2005, implement pilot projects in several States that link and analyze information related to self-destructive behavior derived from separate data systems, including for example law enforcement, emergency medical services, and hospitals.

APPENDIX B

EVALUATION OF SUICIDE PREVENTION PROGRAMS

As not everything can be done, there must be a basis for deciding which things are worth doing. Enter evaluation.

M. Q. Patton (1997)

Evaluation is the tool we use to ensure that programs, such as those that are designed to prevent suicide, accomplish what we intend. Evaluation may answer certain questions that have been taken for granted but that have not been scientifically tested, especially those related to proving the effectiveness of a program. Evaluation may also be used to improve the functioning of a program. Both types of evaluation–sometimes referred to as outcome evaluation and process evaluation–can help to ensure effective use of resources.

Weiss (1998) posits four defining elements of evaluation:

1. Evaluation is concerned with either the operations or the outcomes of a program; a few evaluations may address both.
2. Evaluation compares a program to a set of standards. The standards may be explicit, such as a statement of goals or objectives, or implicit, in which one must deduce the standard. Evaluation implies a judgment.
3. Evaluation is systematic. It is conducted with rigor and thoroughness.
4. Evaluation is purposeful. It is designed to provide information that can improve a program or document the effects of one or more aspects of it.

A process evaluation focuses on implementation. It describes how a program operates, how it delivers services, and how well it carries out its intended functions. By documenting a program's development and oper-

ation, a process evaluation can provide some understanding of the performance of the program and information for potential replication. The goal of a process evaluation may be to ensure that a project stays on course and is faithful to the initial model. It may also be designed to provide the opportunity to make midcourse corrections, to modify aspects of the program that are not working as originally intended, or to identify problems or gaps that need attention. Process evaluation can help a project ensure accountability by comparing its actual performance with expectations and explaining reasons for any differences. Such information can help program administrators understand why some activities were more useful than others, leading to improved services in the future.

An outcome evaluation employs a causal framework; that is, an intervention is assumed to cause a particular outcome. This type of evaluation is used to study the effectiveness of a program. It employs quantifiable data to determine whether or not a program had the desired effects. Examples might include a reduction in the suicide rate or in attempted suicides, changes in knowledge among primary care physicians of treatment resources, or changes in the number of depressed people taking antidepressants. While evaluation is often thought of in terms of measuring overall effectiveness, frequently less comprehensive questions can be asked. For example, an evaluation might address the ability of an outreach program to actually contact people at risk and it might assess the cost of doing so; another might examine the way in which health provider characteristics affect the ability and/or willingness of these individuals to effectively engage persons at risk of suicide.

STEPS IN CONDUCTING AN EVALUATION

The key steps in evaluation are as follows:

- Engaging staff and other potential stakeholders in the evaluation process.
- Focusing the evaluation design.
- Gathering evidence.

- Justifying conclusions.
- Ensuring use and sharing lessons learned.

Engaging Staff and Stakeholders: Involving staff and stakeholders in an evaluation ensures that their perspectives are understood. If they are not engaged, the evaluation might overlook important elements of the program. Stakeholders can also help to implement the evaluation. They can improve its credibility and help the project address any potential ethical concerns.

There are several ways to involve stakeholders in an evaluation. These include consulting with representatives from as many groups as possible; developing an evaluation task force and including representatives of the stakeholder groups; and providing timely feedback on the process of the evaluation. An advisory committee might be formed to function throughout the life of the project.

The provision of feedback to project staff and other relevant stakeholders on the ongoing progress of an evaluation is often overlooked, resulting in missed opportunities to improve the evaluation and ensure that its findings are ultimately used by the field. Examples of ways to provide feedback include weekly meetings with program staff; monthly discussions or roundtables with a larger group; newsletters; and/or biweekly memos from the evaluator(s) on insights and reflections for response and comment. Ongoing dialogue and frequent communication are essential elements in ensuring that providers remain engaged in the project; such communication may also assist the evaluation team to refine the design and interpretations of the study.

Focusing the Evaluation Design: The evaluation question(s) drive the study. There are many potential questions that can be asked in an evaluation. Patton (1997) identifies 57 alternative ways of focusing an evaluation, each type with a different purpose and associated question–and these, he states, are illustrative only. Examples of ways to focus an evaluation and the types of questions relevant to each are shown in Table 1.

TABLE 1
FOCUSING AN EVALUATION

FOCUS OF EVALUATION	DEFINING QUESTION OR APPROACH
Outcome:	
Causal	What is the relationship between an intervention (as a treatment) and outcomes? Can the intervention be shown to have resulted in the observed outcomes? Are other factors which could contribute to an outcome adequately controlled?
Cost-Benefit	What is the relationship between program costs and program outcomes (benefits) expressed in dollars?
Effectiveness	To what extent is the program effective in attaining its goals? How can the program be more effective?
Social and Community Indicators	What social and economic data should be monitored to assess the impacts of the program? What is the connection between program outcomes and larger-scale social indicators, for example, unemployment?
Process:	
Implementation	To what extent was the program implemented as designed? What issues surfaced during implementation that need attention in the future?
Descriptive	What happens in the program? (No "why" questions or cause/effect analysis)
Context	What is the environment within which the program operates politically, socially, economically, culturally and scientifically? How does this context affect the program?

Adapted from Patton, 1997.

After defining one or more important questions, the program and evaluation team must then determine whether or not it is possible to answer them. Perhaps a question cannot be clearly stated or its elements adequately defined. Or perhaps there is not a methodology that can be used to answer the question. Or, while it may be theoretically possible to design an evaluation study to answer a particular question, it may be quite expensive to conduct the study and sufficient funds may be unavailable. Determining whether or not a question can be asked clearly, whether there is a way to study it, and whether there is sufficient money to undertake an appropriate study is sometimes referred to as an "evaluability assessment."

Many people now use a "logic model" as a way to identify evaluation questions. A logic model is simply a diagram (perhaps a flow chart or a table) that shows the relationships between program elements and presumed outcomes; it represents the theory of how and why the program is assumed to work. By developing such a diagram, program stakeholders can sometimes clarify areas of particular interest for evaluation. An example of a completed logic model is included at the end of this discussion.

Once the questions for the evaluation have been determined, the project team must design the methodology. Decisions are made on issues such as the specification of groups that will be studied, the means by which groups will be selected, time intervals for study, the kinds of comparisons that are planned, and the form in which data are to be collected. Either qualitative or quantitative data may be collected, sometimes both. An evaluation question that addresses proving effectiveness, for example, will usually require a formal research design that includes a control group and the development of quantitative measures, but a question that is concerned with understanding a project's responsiveness to cultural issues will most likely employ methods such as interviews and focus groups.

Gathering Evidence: As a part of the study design, the evaluation team will need to decide on the instruments for collecting it. Survey questionnaires, interview protocols, and coding forms are examples of instruments. In some cases, it is possible to use preexisting instruments; in other cases, the evaluator will need to develop a new instrument. An advantage of existing instruments is that they are often (but not always) standardized (i.e., scores on particular items have been rated as "normal" and "non-normal"), and they may have been established as valid and reliable (valid means the instrument measures what it is supposed to measure and reliable means that responses are consistent over time). The disadvantage of using existing instruments is that they may not be appropriate for the particular program being evaluated. For example, an instrument may refer to services not provided through the program, or it may be inappropriate for the cultural or ethnic groups that make up a community.

Justifying Conclusions: In the data analysis phase of evaluation, the information is interpreted and a judgment made about the meaning of the data that has been collected. What are the answers to the questions that have been posed and what do these answers mean?

Generally, some standard will be used to judge the meaning of the findings. For example, if one of the desired outcomes of a program is the institution of or improvement in outreach services, a number by itself will have little relevance in the absence of a standard. Is an outreach program successful that reaches 15 percent of the population? The answer depends on what the program and the community define as adequate and appropriate. When diverse stakeholders have different standards, they may disagree on the conclusions that may be drawn from the data analysis.

Ensuring Use and Sharing Lessons Learned: Evaluation is only worth doing if it leads to improvements in knowledge and program operations. There is both a local and a universal component to utilization of evaluation findings. Evaluation should be important first of all to the stakeholders of the particular program that was evaluated; evaluation findings should inform programmatic decision-making and address questions

that are important to program staff and service recipients. Engaging stakeholders throughout the evaluation process helps to ensure an evaluation that is relevant to the program and that may lead to changes in procedures and policies, if necessary, or to enhanced support for the program.

The second audience for evaluation is outsiders with an interest in the issue. Findings may help to improve the functioning of related projects, convince policy makers of the importance of the program, and generate wider support for the program. Evaluation findings presented in the media can increase public understanding.

Conclusion

This discussion has provided a very brief overview of some issues related to evaluation. It is intended to provoke thought and to suggest the importance of evaluation for suicide prevention. More detailed information on evaluation may be found on the Web sites and in the books listed below.

Useful Web Sites

http://www.cdc.gov/eval

This site, supported by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, provides a description of the public health approach to evaluation in a clear and straightforward manner. It includes links to other Web sites with additional information on program evaluation, including numerous on-line publications that can be downloaded.

http://www.bja.evaluationwebsite.org

This site, supported by the U.S. Department of Justice, Bureau of Justice Assistance, provides a primer on evaluation. While the examples are oriented to projects of the Department of Justice, the text is generic aluation of community-wide programs.

http://www.wkkf.org/publications/evalhdbk

This site includes a downloadable version of the excellent evaluation handbook developed by the W.K. Kellogg Foundation for its grantees. It provides much useful information for evaluating projects that are community-based.

http://ctb.lsi.ukans.edu

This site includes over 3,000 downloadable pages on evaluating community programs. User friendly and comprehensive, it is maintained by the University of Kansas.

USEFUL PUBLICATIONS

Afifi, A.A., Clark, V. (1990). *Computer Aided Multivariate Analysis* (2nd ed.). New York: Chapman and Hall, 1990.

- A text on linear models and regression analysis.

Centers for Disease Control and Prevention. (1999). Framework for program evaluation in public health. *Morbidity and Mortality Weekly Report*, 48, 1-40.

- A description of the elements of a good evaluation for public health programs, including standards for effective evaluation.

Kvale, S. (1996). InterViews: *An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage.

- A comprehensive book written for practitioners but also useful for researchers.

Lunnenberg, C. (1994). *Modeling experimental and observational data*. Boston: PWS-Kent.

- A text on linear models and regression analysis.

Maxwell, J.A. (1996). *Qualitative research methods*. Thousand Oaks, CA: Sage.

- A comprehensive look at qualitative research.

Patton, M.Q. (1997). *Utilization-focused evaluation* (3rd ed.). Thousand Oaks, CA: Sage.
- A clear and readable text providing good guidance on evaluation strategies that can lead to useful–and used–evaluations.

Rossi, P.H., & Freeman, H.E. (1993). *Evaluation: A systematic approach* (5th ed.). Thousand Oaks, CA: Sage.
- A highly regarded text on evaluation.

Weiss, C. H. (1998). *Evaluation methods for studying programs and policies* (2nd ed.). Upper Saddle River, NJ: Prentice Hall.
- An easy-to-read and comprehensive text on evaluation.

Weitzman, E.A., & Miles, M.B. (1995). *A software sourcebook: Computer programs for qualitative data analysis*. Thousand Oaks, CA: Sage.
- A sourcebook addressing the relative advantages of different computer programs for qualitative analysis.

APPENDIX C
EXAMPLES OF RESEARCH EFFORTS THAT MAY YIELD INFORMATION IMPORTANT TO SUICIDE PREVENTION EFFORTS

Preventive efforts to reduce suicide should be grounded in research that provides information about modifiable risk and protective factors, as well as about appropriate target populations on which to focus prevention efforts (see The Public Health Approach as Applied to Suicide, Introduction). Once these are identified, prevention programs must be carefully tested to determine if they are safe, truly effective, and worth the considerable cost and effort needed to implement and sustain them.

Included in this appendix are examples of approaches for delivering preventive interventions aimed at target populations and/or particular settings. In the absence of clear evidence demonstrating that such approaches are effective, ongoing studies are highlighted to show where existing efforts are currently being tested, or approaches which could be evaluated with regard to their potential to reduce suicide. Because completed suicide is a relatively rare event, many programs will be limited to proving effectiveness in reducing suicide attempts and serious suicide ideation, reducing risk factors strongly associated with suicide, or strengthening protective factors.

PREVENTING YOUTH DEPRESSION AND VIOLENCE

Suicide is difficult to predict, but it does not usually "come out of the blue." Many of the factors that put youth at risk for suicide are understood, specifically mental disorders, substance abuse, prior suicide attempt, sexual abuse, impulsive and aggressive behavior, and access to a firearm (USPHS, 1999). Logically, reducing such risk factors should also reduce risk for suicide. While there are effective treatments for many of the risk factors of suicide, including depression (Findling et al., 1999; Lewinsohn & Clarke, 1999), and a growing number of ways to prevent violence and to prevent and treat substance use (USPHS, 2001), the long-

term outcome of these interventions in reducing suicide is not yet known.

Prior research suggests that suicidal youth are not likely to self-refer or seek help from school staff, nor do knowledgeable peers request adult help (Kalafat & Elias, 1995). This suggests that in the absence of effective ways to improve self-or peer-referral, schools would need to screen for youth at risk, and that school staff need to be trained to be aware of the warning signs for suicidal youth, and have a plan of action for helping youth at risk. The U.S. Department of Education recently issued *Early warning, timely response: A guide to safe schools* which offers research-based practices designed to assist school communities in early identification of these warning signs and in developing prevention, intervention and crisis response plans (http://www.ed.gov/offices/OSERS/OSEP/early-wrn.html). Perhaps the greatest challenge for school-based suicide prevention efforts is monitoring and evaluation. A monitoring system has been successfully used by the Dade County Public Schools to assess the prevalence of suicidal behavior, identify the grade level and school classification of those youth most at risk, as well as assess progress of prevention efforts (Zenere & Lazarus, 1997). Screening approaches should be carefully considered with regard to their costs and benefits, such as the problem of over-identifying youth in need of services, lack of adequate and timely referrals, or inadvertently further stigmatizing youth at risk.

Many of the established treatments known to reduce mental and substance use disorders have been tested on youth who typically have come to the attention of care providers (parents, teachers, pediatricians). Because mental disorders and substance use disorders are under-detected and under-treated in youth (U.S. Department of Health and Human Services, 1999; http://www.sg.gov/library/mentalhealth/home.html), another approach to prevention has been the use of school-based screening to identify youth at risk. At least two screening approaches are currently being investigated. One approach identifies youth at risk for dropping out of school through poor attendance and failing grades, further evaluates those youth, and then provides various types of interventions to reduce the potential for suicide and substance use (Thompson &

Eggert, 1999). To date, there is no strong evidence that this approach reduces suicidality, but it has been shown to increase adolescents' sense of personal control, which may have other long-term beneficial effects. In another school-based approach, brief screening instruments are used to identify youths with depressive symptoms and/or suicidal thoughts. They are then evaluated in a more thorough manner and referred to appropriate treatment (Shaffer & Craft, 1999). The effectiveness of this approach has yet to be evaluated. While such screening efforts are more likely to detect youth at risk, they are not precise in their ability to detect only those at risk for suicide. Because of the likelihood of identifying youth with multiple problems, including those not necessarily at risk for suicide, such screening efforts can quickly burden a limited referral or service system. The hazards of labeling and not treating youth detected in such screening efforts must also be considered.

Another approach being promoted to identify at-risk youth who are not yet in treatment is gatekeeper training, involving the education of adults who regularly come in contact with suicidal youth in schools and the community. Some efforts also attempt to train youth so that they can refer other youth at risk to sources of help. The Centers for Disease Control and Prevention (CDC) has described a range of gatekeeper training approaches (O'Carroll et al., 1992; http://www.cdc.gov/ncipc/pub-res/youthsui.htm). Although some evidence suggests increased knowledge and improved attitudes toward helping suicidal youth following gatekeeper training programs, none has been systematically evaluated to determine if more youth at risk are receiving treatment as a result of these programs or if the programs are preventing suicidal behavior.

Universal interventions encompass a broader health-promotion approach. Such interventions are applied to all youth and typically focus on promoting protective factors or halting the development or progression of risk factors. These efforts are applied across home, school, and peer contexts.

Successful universal interventions commonly feature efforts to build one's assets in social, problem solving, and other skills. Many initiated early in a child's life (e.g., improving early parent-child relationships,

enhancing problem solving skills; increasing adaptive social behavior) have been shown effective in reducing aggression and early substance use (e.g., see Catalano et al., 1998; for a review, Olds et al., 1998) Although these programs modify risk and protective factors for suicide, they have not been evaluated specifically for suicide as an outcome in adolescence or young adulthood.

The Surgeon General recently reviewed the effectiveness of violence prevention programs (USPHS, 2001), providing a comprehensive list of model programs (http://www.surgeongeneral.gov/library/youthviolence/report.html).

Safe Schools/Healthy Students, a collaborative effort of the U.S. Departments of Education, Justice, and Health and Human Services is currently funding 77 school-based violence prevention programs across the U.S. that offer opportunities to examine aspects of suicidal behavior in this population (http://www.samhsa.gov/centers/cmhs/cmhs.html). Programs with the goals of promoting healthy development, fostering resilience, and preventing violence and suicidal ideation and behavior have been planned and implemented. Data collection is ongoing and promises to yield important information about the effectiveness of the application of evidence-based practices on a large scale.

While a school setting can be considered a focus for a type of community-based prevention, other prevention approaches have considered geographic areas, such as neighborhoods. Preventive interventions for these contexts include building community assets or "collective efficacy" (Sampson, Raudenbush, & Earls, 1997). Again, whether increased collective efficacy is associated with lower suicidality has yet to be demonstrated. The U.S. Air Force approach to reducing suicide can also be considered a type of community-based intervention for adults in a work setting (see below). Additionally, some universal "policy" interventions suggest that broad-based environmental changes can have an impact on suicide rates (See the example under Individuals with Substance Use Disorders).

IMPROVING FOLLOW-UP TREATMENT FROM EMERGENCY DEPARTMENTS

Because the vast majority of persons do not seek follow-up treatment after attempting suicide (Piacentini et al., 1995), one approach being taken to reduce repeat attempts is to refer individuals to treatment after they have been seen in the emergency department (ED). Since adolescents and young adults are more likely to make nonfatal suicide attempts, a number of studies have focused on these subgroups. One study compared standard care to an intervention in which emergency department staff were taught to recognize the seriousness of suicide attempts, to reinforce the importance of outpatient treatment and to provide for an ED-based initial family education/therapy session. When compared to standard care, this enhanced ED intervention was shown to increase treatment attendance and decrease depression among adolescent Latino suicide attempters. (Rotheram-Borus et al., 2000). However, the sample size was too small to determine whether the intervention had an effect on the number of future suicide attempts. Another study currently being conducted is testing the effectiveness of a cognitive-behavioral therapy intervention implemented immediately after patients have been evaluated in an ED following a suicide attempt (see grant by Aaron Beck; http://www.nimh.nih.gov/research/suiabs.cfm). The targets of the intervention are modifiable risk factors such as substance abuse, depression, hopelessness, and suicidal ideation, which are addressed through problem-solving strategies, utilization of social support, and increasing compliance with adjunctive medical, substance abuse, psychiatric and social interventions.

PRIMARY CARE INTERVENTIONS FOR DEPRESSED ELDERS

Multiple studies have found that elderly are much more likely to have contact with primary care doctors than mental health specialists in the weeks preceeding their death. Follow-back studies have also shown that the most common psychiatric disorder among elderly persons who have died by suicide is a single episode of non-psychotic, unipolar major depression without comorbid illness (Conwell et al., 2001). Because this is the most treatable type of depression, a logical approach to prevention that has been recommended is to improve the screening and treatment of

depression conducted in primary care practices. Improvement could come about with the addition of screening measures, assistants dedicated to the treatment of depression and other mental health issues, or through better prescribing practices. A controlled study, PROSPECT (Prevention of Suicide in Primary Care Elderly Collaborative Trial), is currently testing the effectiveness of using Health Specialists (HS) to collaborate with physicians helping them recognize depression, offer timely and appropriately targeted treatment recommendations, and encourage patients to adhere to treatment. In addition, procedures are implemented to educate patients, families and physicians on depression and suicidal ideation (Bruce & Pearson, 1999).

PRISON/JAIL SUICIDE

Suicide is one of the leading causes of death in our Nation's jails (Bureau of Justice Statistics, 1995). However, very little research or evaluation has been conducted on the success of suicide prevention programs implemented in jail or prison settings. Although no research directly supports any particular prevention approach in jails, guidelines for suicide prevention in jails have been implemented in some settings. Often programs are multidimensional in nature, recommending steps such as adequate mental health treatment, staff training in suicide prevention, intake screening/assessment, increasing communication in detention settings, changes in housing practices, changes in level of supervision/observation, direct intervention after suicide attempts, and adequate reporting and follow-up (Hayes, 1999). Some States have implemented State-wide jail suicide prevention programs. Of these, New York and Texas have seen drops in the rate of jail suicide since the programs were implemented. The American Correctional Association, the National Commission on Correctional Health Care, the National Juvenile Detention Association, and other national organizations have developed guidelines for suicide prevention. However, the effect of these guidelines has not been studied. In addition, Lindsay Hayes has created a comprehensive suicide prevention plan for both adult and child detention facilities that has yet to be evaluated (Hayes, 1999).

SPECIAL POPULATIONS AT RISK

AMERICAN INDIANS AND ALASKA NATIVES

As illustrated in Figure 4, American Indians and Alaska Natives (AIAN) have a 50 percent higher rate of suicide than the general U.S. population, with young males having the highest risk (Indian Health Service, 1997). The most common risk factors for suicide among young male AIANs is alcohol and substance use, and depression. However, there are dramatic differences in suicide rates across tribes. Many tribes, in partnership with the Indian Health Service (IHS) and other government agencies, have designed and implemented programs intended to address suicide prevention and intervention for suicide and related problems (Middlebrook et al., 2001). Prevention efforts include reducing risk behaviors (alcohol and substance use) and promoting protective factors (increasing employment opportunities and promoting positive and encouraging attitudes among adults toward AIAN youth). Unfortunately, too few descriptions and analyses of these efforts have been published, and little is known about their effectiveness (see Middlebrook et al., 2001 for a review).

GAY, LESBIAN, AND BISEXUAL YOUTH

Several State and national studies have reported that high school students who report same-sex sexual behavior or self-identify as gay, lesbian, or bisexual (GLB) have higher rates of suicidal thoughts and attempts in the past year compared to youth who report exclusively heterosexual sexual behavior or self-identify as heterosexual in orientation (McDaniel & Purcell, 2001). Experts do not agree completely about the best way to measure reports of adolescent suicide attempts, or sexual orientation, so the data are subject to question. But they do agree that efforts should focus on how to help GLB youth grow up to be healthy and successful despite the obstacles that they face. Because school-based programs limited to suicide awareness have not proven effective for youth in general, and in some cases have led youth to consider suicide as a normal response to stress or have caused increased distress in vulnera-

ble youth (Vieland et al., 1991), there is reason to belive that they may not be helpful for GLB youth either. Issues of stigma, labeling, privacy, and appropriateness of referrals for youth needing services must be considered to ensure that prevention programs for sexual minority populations are safe and effective.

INDIVIDUALS WITH BORDERLINE PERSONALITY DISORDER

Three to nine percent of those diagnosed with Borderline Personality Disorder (BPD) commit suicide, a rate comparable to that for people diagnosed with mood disorders and schizophrenia (Tanney, 2000). Recurrent suicide attempts, self-injury, and impulsive aggression are often associated with BPD and often result in expensive emergency and inpatient treatment. To date, approaches to the prevention of suicidal behavior among individuals with BPD have focused on treatment to reduce self-injurious behavior with and without intent to die, including certain types of psychotherapy and pharmacotherapy. One psychosocial treatment – dialectical behavior therapy (DBT), a cognitive-behavioral treatment – has been shown to significantly decrease self-injurious behaviors in BPD (Koerner & Linehan, 2000). Although DBT has become increasingly popular as the treatment of choice for suicidal patients with BPD, no replication studies have been done other than those conducted by the developer. One study is evaluating DBT and pharmacological approaches aimed at reducing self-injurious behavior in individuals with BPD (see grant by Barbara Stanley, **http://www.nimh.nih.gov/research/suiabs.cfm**).

INDIVIDUALS WITH SCHIZOPHRENIA

The risk for suicide among individuals with schizophrenia is comparable to the risk for individuals with mood disorder, substance abuse, and BPD. In individuals with schizophrenia, the risk is particularly heightened during the early stages of the illness, and has been found to increase soon after inpatient discharge (Caldwell & Gottesman, 1990; Fenton, 2000). This suggests that adequate aftercare treatments may reduce risk during this phase of disease management. Other approaches to reducing suicide risk among individuals with schizophrenia include investigations of medications that target the key symptoms of the disorder. In industry

sponsored treatment trials, one of the new atypical anti-psychotic medications was observed to have the possible effect of reducing suicidal behavior in persons with schizophrenia. To confirm these findings, the International Clozaril/Leponex Suicide Prevention Trial will compare clozapine and olanzapine in 900 patients with schizophrenia and a history of suicidality (Meltzer, 1999). If these findings indicate that clozapine is effective in reducing suicidality, the makers of the drug clozapine plan to seek FDA approval for this use.

INDIVIDUALS WITH SUBSTANCE USE DISORDERS

Individuals with substance use disorders, including alcoholism, are at increased risk for suicide. Follow-back studies of suicide decedents have shown that 15-56 percent of individuals had diagnoses of alcoholism and/or other substance use and dependence, a rate much higher than that in the population (Murphy, 2000). Alcohol and substance abuse problems contribute to suicidal behavior in several ways. In addition to increasing the risk of suicide directly through lowered inhibitions, people who abuse substances or alcohol also tend to have other risk factors such as depression and social and financial problems. Substance use and abuse are also common among persons prone to be impulsive, and among persons who engage in many types of high risk behaviors that result in self-harm. Fortunately, there are a number of effective prevention efforts that reduce risk for substance abuse in youth, and there are effective treatments for alcohol and substance use problems. While a number of treatments have been found to be effective for the treatment of substance abuse (National Institutes of Drug Abuse, 1999; http://www.nida.nih.gov/podat/podatindex.html) and alcoholism (National Institute on Alcohol Abuse and Alcoholism, 2000; http://silk.nih.gov/silk/niaaa1/publication/aa49.htm), few have measured concurrent effects of treatment on rates of suicide or suicide attempts. Currently, some studies are looking at suicidal behavior among individuals who are abusing substances and are trying to treat substance use, abuse and dependence along with other comorbid psychiatric problems, as well as dealing with stressful life events (see Emergency Departments

above). Some alcohol policies may be effective in reducing suicide deaths. For example, an assessment of minimum legal drinking age (MLDA) found that between 1970 and 1990, the suicide rate of 18- to 20-year-old youths living in States with an 18-year MLDA was 8 percent higher than the suicide rate among 18- to 20-year-old youths in States with a 21-year MLDA (Birckmayer & Hemenway, 1999).

INDIVIDUALS WITH MOOD DISORDERS

Mood disorders are very common among individuals who commit suicide, with 36-70 percent of individuals having a mood disorder at the time of death (Barraclough et al. 1974; Foster et al., 1999; Henriksson et al., 1993; Rich, Young, & Fowler, 1986). A number of long-term follow-up studies of individuals with bipolar disorder found that those who remain on lithium maintenance treatment have a lower risk of suicide than individuals who do not remain in treatment or are non-responsive to lithium (Jamison, 2000). A study in progress is testing whether lithium can prevent suicide attempts among individuals with bipolar disorder who have previously attempted suicide (see grant by Maria Oquendo, http://www.nimh.nih.gov/research/suiabs.cfm). The large, multisite Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) study will track the frequency of suicidal behavior and treatment approaches used to minimize suicidal behavior (http://www.stepbd.org/). Suicide prevention approaches in STEP-BD focus on reducing inclination and minimizing opportunity through medication, psychosocial, and environmental interventions.

With regard to individuals with major depression, retrospective data indicate that many who are at risk for suicide often receive inadequate treatment (Oquendo et al., 1999). The Swedish Island of Gotland study is an uncontrolled study that has inspired efforts to increase primary care providers' abilities to detect and treat depression, and in turn reduce suicide (Rutz et al., 1989). An educational program for all general practitioners on the island to improve recognition and treatment for depression, the program was associated with more appropriate antidepressant

medication prescriptions and fewer inpatient hospitalizations of depressed individuals. The island had fewer adult female suicides in the several years following the intervention (Rutz, 2001). While these results suggest that some suicide deaths may be prevented through improving the diagnosis and ongoing treatment of depression, possibly through the education of providers and the public about depression treatment, controlled studies are needed to determine the effectiveness of these approaches to reduce suicide, particularly among males.

POPULATIONS THAT NEED FURTHER ATTENTION

White males aged 24-55 constitute the greatest numbers of suicide deaths in the U.S., yet this subgroup of individuals is the least likely to have sought mental health treatment prior to death (Pirkis & Burgess, 1998). Currently there are almost no prevention approaches aimed specifically at preventing suicide among males who do not seek mental health treatment. One approach which shows promise is the prevention strategy used by the Air Force (Centers for Disease Control and Prevention, 1999; http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/mm4846a1.htm). This strategy is a multi-faceted approach to suicide prevention that intervened at a community-wide level. Interventions included widespread and repeated suicide awareness and prevention training, gatekeeper training, screening questionnaires, changes in mental health confidentiality policy, and messages from the Air Force Chief of Staff to change community attitudes about seeking and providing help. Surveillance results suggest that the prevention program has been effective in reducing suicide among Air Force personnel, in both majority and minority populations. Because this effort was not experimentally controlled, however, it is not known if certain aspects, or all approaches combined, were effective. Nevertheless, this intervention demonstrates the potential for suicide prevention among late adolescent and adult males in the U.S. through a combination of universal and targeted interventions.

SUMMARY AND FUTURE PROSPECTS

Rates of suicide and suicidal behavior and their risk factors vary across age, gender and ethnic groups. The broad array of prevention strategies described in this appendix reflect the variation in risk factors for different subgroups, as well as the different types of disorders where suicide risk is increased. Testing interventions in different settings are ways to study these diverse risk groups. While the broad range of prevention approaches may seem unsystematic, at the same time it suggests many opportunities for individuals, organizations, and communities to consider who is at most risk for suicide and what are the strategies consistent with our understanding of protective and risk factors to reduce suicide in their communities.

If the costs of this behavior are so great, why is there so little information about what is effective in preventing suicide, suicidal behavior, and suicidal thinking? One reason for the limited number of tested programs is concern among some researchers and academic institutions about possible increased liability when conducting research with individuals at risk for suicide. Many researchers prefer to study problems that do not carry such legal and ethical responsibilities. Efforts are underway to increase the number of federally supported research efforts in this area by providing researchers with guidance and tools to design safe and ethical studies to test approaches to reducing suicidal behaviors (see http://www.nimh.nih.gov/research/highrisksuicide.cfm). In addition, suicide deaths, and even suicidal behaviors, are relatively rare events, making it difficult for researchers to determine if a prevention program was effective, unless administered to a very large population over multiple years. Thus, suicide prevention research requires large numbers of participants and can be very expensive. Nevertheless, because "suicide prevention is everyone's business," communities and organizations can learn more about persons at risk for suicide, consider the financial and social costs of suicide and its risk factors, and work to implement and evaluate prevention efforts appropriate for their communities.

APPENDIX D
NSSP FEDERAL STEERING GROUP AGENCY DESCRIPTIONS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Department of Health and Human Services (DHHS) is the U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. DHHS has 12 operating divisions as well as a number of specialized offices, centers and programs. Among these specialized offices are the 10 DHHS Regional Offices dispersed throughout the U.S. Each Regional Office has a Regional Director, Regional Health Administrator and other HHS components. These offices play a critical role in implementing HHS initiatives, coordinating intra- and inter-agency activities serving as the liaison for the Secretary and agency heads with key constituencies. Through these offices close contact is maintained with State, local, and tribal entities served through HHS programs and policies.

HHS' responsibilities include public health, biomedical research, Medicare and Medicaid, welfare, social services, and more. Several of them conduct and support important work in suicide prevention. These have provided important leadership and effort in the development of this ***National Strategy for Suicide Prevention : Goals and Objectives for Action*** and have been part of the ***National Strategy for Suicide Prevention*** Federal Steering Group (FSG) (see Acknowledgments). A brief description of each of these agencies follows.

Contact information:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
202-619-0257
Toll Free: 1-877-696-6775
e-mail: hhsmail@os.dhhs.gov
Web address: **http://www.hhs.gov**

OFFICE OF THE SURGEON GENERAL

Mission: To protect and advance the health of the nation through educating the public and advocating for effective disease prevention and health promotion activities.

The Surgeon General is a highly recognized symbol of national commitment to protecting and improving the public's health. Administering a force of 6,000 U.S. Public Health Service Commissioned Corps officers, the Surgeon General provides leadership in promoting the quality of public health practice through advancement of appropriate standards and research priorities.

Suicide prevention activities of the Office of the Surgeon General include publication of *The Surgeon General's Call to Action to Prevent Suicide* (DHHS, 1999) and *Mental Health: A Report of the Surgeon General* (DHHS, 1999).

For Additional Information:

Surgeon General
Web address: **http://www.surgeongeneral.gov**

CENTERS FOR DISEASE CONTROL AND PREVENTION

CDC

Mission: To promote health and quality of life by preventing and controlling disease, injury, and disability.

The Centers for Disease Control and Prevention (CDC) provides a system of health surveillance to monitor and prevent outbreak of diseases, maintains national health statistics, and supports research into disease and injury prevention. Through its centers, institutes and offices, the CDC works with partners throughout the nation and the world to monitor health, detect and investigate health problems, develop and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthful environments, and provide leadership and training.

Suicide prevention activities of CDC include efforts in the National Center for Health Statistics, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health, and National Center for Injury Prevention and Control. CDC maintains national data on suicides, Youth Risk Behavior Survey, and publishes reports on self-directed injury at all levels. Additional examples of CDC activities include promoting collaborations in specific communities for suicide prevention and conducting research on suicidal behavior and program evaluation.

For Additional information:

Centers for Disease Control and Prevention
Web address: **http://www.cdc.gov**
http://www.cdc.gov.ncipc
http://www.safeyouth.org

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Mission: To improve the Nation's health by assuring equitable access to comprehensive quality health care for all.

The Health Resources and Services Administration (HRSA) through the activities of its four bureaus and three offices, helps to ensure health resources for medically underserved populations. HRSA works to improve and extend life for people living with HIV/AIDS, provide primary health care to medically underserved people, improve health outcomes for women and children through State programs, and train a health workforce that is both diverse and motivated to work in underserved communities.

Suicide prevention activities of HRSA include programs and activities in the Bureau of Primary Health Care, HIV Aids Bureau, Maternal and Child Health Bureau, and Office of Rural Health Policy. HRSA programs promote integration of primary care and mental health services; develop and implement State suicide prevention plans and programs; ensure access to appropriate screening and services for depression through grants, contracts, technical assistance, and conference sponsorship. Through funding from the Maternal and Child Health Bureau, the Children's Safety Network has developed a Youth Suicide Prevention Fact Sheet packet (http://www.edc.org/HHD/csn).

For additional information:

Health Resources and Services Administration
Web address: **http://www.hrsa.gov**

INDIAN HEALTH SERVICE

Mission: To uphold the Federal government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of tribes.

The Indian Health Service (IHS) is the principal Federal health care provider and health advocate for Indian people, and its goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people. IHS supports network hospitals, health centers, school health centers, health stations, and urban Indian health centers.

Suicide prevention activities of IHS include consultation and technical assistance for tribes related to suicide prevention through 12 Area Offices. Additionally IHS operates 12 regional alcohol and substance abuse treatment centers for youth 12-18 years of age which includes careful assessment of suicidal ideation and suicide prevention education.

For additional information:

Indian Health Service
Web address: **http://www.ihs.gov**

NATIONAL INSTITUTES OF HEALTH

Mission: To uncover new knowledge that will lead to better health for everyone.

The National Institutes of Health (NIH) comprises 25 separate institutes and centers that conduct and support research to acquire new knowledge to help prevent, detect, diagnose, and treat disease and disability, from the rarest genetic disorder to the common cold. As the world's premier medical research organization, these institutes and centers support 35,000 research projects nationwide. Among several institutes that address suicide (National Institutes of Drug Abuse (NIDA), Child Health and Human Development (NICHD), and Alcohol Abuse and Alchoholism (NIAAA)), the National Institute of Mental Health (NIMH) supports the greatest proportion of research related to suicide. NIMH aims to diminish the burden of mental illness through achieving better understanding, treatment, and prevention of mental illness.

Suicide prevention activities of the NIMH include fundamental research in neuroscience, behavioral science, and genetics of mental illnesses and suicidal behavior, as well as research that directly impacts the treatment of individuals with mental disorders and those at high risk for suicidal behavior, including clinical trials and studies of treatment and preventive interventions in "real world" settings. The NIMH Suicide Research Consortium maintains a web site that includes suicide facts, currently funded studies, active NIMH program announcements pertaining to suicide research, a bibliography, reviews of measures of suicidality, and ethical and safety issues to consider in conducting research with persons at high risk for suicidality.

For additional Information:

National Institutes of Health
Web address: **http://www.nih.gov**

National Institute of Mental Health Suicide Research Consortium
Web address: **http://www.nimh.nih.gov/research/suicide.htm**

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Substance Abuse and Mental Health Services Administration

SAMHSA

Mission: To improve the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides funding to the States to support and maintain substance abuse and mental health services through Federal block grants. SAMHSA funds hundreds of programs nationwide to increase the use and improve prevention and treatment methods shown by research to be effective through "Knowledge Development and Application" grants. SAMHSA is comprised of three Centers of which one is the Center for Mental Health Services (CMHS). CMHS focuses on providing leadership in the delivery of mental health services, generating and applying new knowledge, and establishing national mental health policy. The majority of activities directly related to suicide prevention are initiated by CMHS.

Suicide prevention activities of CMHS center on initiating national grant programs to implement and evaluate suicide prevention activities. CMHS is involved in developing suicide prevention guidelines for use in our Nation's schools as well as supporting efforts to identify, through in-school assessment, those children at greatest risk of suicide. In addition, SAMHSA sponsors conferences, workshops and meetings to further national goals for suicide prevention.

For additional information:

Substance Abuse and Mental Health Services Administration
Web address: **http://www.samhsa.gov**

Center for Mental Health Services
Web address: **http://www.samhsa.gov/centers/cmhs/cmhs.html**

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Administration on Aging
Holly Schumann

APPENDIX E

GLOSSARY

Activities – the specific steps that will be undertaken in the implementation of a plan; activities specify the manner in which objectives and goals will be met.

Adolescence – the period of physical and psychological development from the onset of puberty to maturity.

Advocacy groups – organizations that work in a variety of ways to foster change with respect to a societal issue.

Affective disorders – see mood disorders.

Anxiety disorder – an unpleasant feeling of fear or apprehension accompanied by increased physiological arousal, defined according to clinically derived standard psychiatric diagnostic criteria.

Best practices – activities or programs that are in keeping with the best available evidence regarding what is effective.

Biopsychosocial approach – an approach to suicide prevention that focuses on those biological, psychological and social factors that may be causes, correlates, and/or consequences of mental health or mental illness and that may affect suicidal behavior.

Bipolar disorder – a mood disorder characterized by the presence or history of manic episodes, usually, but not necessarily, alternating with depressive episodes.

Causal factor – a condition that alone is sufficient to produce a disorder.

Cognitive/cognition – the general ability to organize, process, and recall information.

Community – a group of people residing in the same locality or sharing a common interest.

Comprehensive suicide prevention plans – plans that use a multifaceted approach to addressing the problem; for example, including interventions targeting biopsychosocial, social and environmental factors.

Comorbidity – the co-occurrence of two or more disorders, such as depressive disorder with substance abuse disorder.

Connectedness – closeness to an individual, group or people within a specific organization; perceived caring by others; satisfaction with relationship to others, or feeling loved and wanted by others.

Consumer – a person using or having used a health service.

Contagion – a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.

Culturally appropriate – a set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures; includes the ability of the program to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.

Culture – the integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, faith or social group.

Depression – a constellation of emotional, cognitive and somatic signs and symptoms, including sustained sad mood or lack of pleasure.

Effective – prevention programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial one in the target group more than in a comparison group.

Elderly – persons aged 65 or more years.

Environmental approach – an approach that attempts to influence either the physical environment (such as reducing access to lethal means) or the social environment (such as providing work or academic opportunities).

Epidemiology – the study of statistics and trends in health and disease across communities.

Evaluation – the systematic investigation of the value and impact of an intervention or program.

Evidence-based – programs that have undergone scientific evaluation and have proven to be effective.

Follow-back study – the collection of detailed information about a deceased individual from a person familiar with the decedent's life history or by other existing records. The information collected supplements that individual's death certificate and details his or her circumstances, the immediate antecedents of the suicide, and other important but less immediate antecedents.

Frequency – the number of occurrences of a disease or injury in a given unit of time; with respect to suicide, frequency applies only to suicidal behaviors which can repeat over time.

Gatekeepers – those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate.

Goal – a broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work.

Health – the complete state of physical, mental, and social well-being, not merely the absence of disease or infirmity.

Health and safety officials – law enforcement officers, fire fighters, emergency medical technicians (EMTs), and outreach workers in community health programs.

Healthy People 2010 – the national prevention initiative that identifies opportunities to improve the health of all Americans, with specific and measurable objectives to be met by 2010.

Indicated prevention intervention – intervention designed for individuals at high risk for a condition or disorder or for those who have already exhibited the condition or disorder.

Intentional – injuries resulting from purposeful human action whether directed at oneself (self-directed) or others (assaultive), sometimes referred to as violent injuries.

Intervention – a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as providing lithium for bipolar disorder or strengthening social support in a community).

Means – the instrument or object whereby a self-destructive act is carried out (i.e., firearm, poison, medication).

Means restriction – techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Methods – actions or techniques which result in an individual inflicting self-harm (i.e., asphyxiation, overdose, jumping).

Mental disorder – a diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional or social abilities; often used interchangeably with mental illness.

Mental health – the capacity of individuals to interact with one another and the environment in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, affective and relational).

Mental health problem – diminished cognitive, social or emotional abilities but not to the extent that the criteria for a mental disorder are met.

Mental health services – health services that are specially designed for the care and treatment of people with mental health problems, including mental illness; includes hospital and other 24-hour services, intensive community services, ambulatory or outpatient services, medical management, case management, intensive psychosocial rehabilitation services, and other intensive outreach approaches to the care of individuals with severe disorders.

Mental illness – see mental disorder.

Mood disorders – a term used to describe all mental disorders that are characterized by a prominent or persistent mood disturbance; disturbances can be in the direction of elevated expansive emotional states, or, if in the opposite direction, depressed emotional states; included are Depressive Disorders, Bipolar Disorders, mood disorders due to a medical condition, and substance-induced mood disorders.

Morbidity – the relative frequency of illness or injury, or the illness or injury rate, in a community or population.

Mortality – the relative frequency of death, or the death rate, in a community or population.

Objective – a specific and measurable statement that clearly identifies what is to be achieved in a plan; it narrows a goal by specifying who, what, when and where or clarifies by how much, how many, or how often.

Outcome – a measurable change in the health of an individual or group of people that is attributable to an intervention.

Outreach programs – programs that send staff into communities to deliver services or recruit participants.

Personality disorders – a class of mental disorders characterized by deeply ingrained, often inflexible, maladaptive patterns of relating, perceiving, and thinking of sufficient severity to cause either impairment in functioning or distress.

Postvention – a strategy or approach that is implemented after a crisis or traumatic event has occurred.

Prevention – a strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors.

Protective factors – factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment.

Psychiatric disorder – see mental disorder.

Psychiatry – the medical science that deals with the origin, diagnosis, prevention, and treatment of mental disorders.

Psychology – the science concerned with the individual behavior of humans, including mental and physiological processes related to behavior.

Public information campaigns – large scale efforts designed to provide facts to the general public through various media such as radio, television, advertisements, newspapers, magazines, and billboards.

Rate – the number per unit of the population with a particular characteristic, for a given unit of time.

Residency programs – postgraduate clinical training programs in special subject areas, such as medicine.

Resilience – capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

Risk factors – those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment.

Screening – administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.

Screening tools – those instruments and techniques (questionnaires, check lists, self-assessments forms) used to evaluate individuals for increased risk of certain health problems.

Selective prevention intervention – intervention targeted to subgroups of the population whose risk of developing a health problem is significantly higher than average.

Self-harm – the various methods by which individuals injure themselves, such as self-laceration, self-battering, taking overdoses or exhibiting deliberate recklessness.

Self-injury – see self-harm.

Sociocultural approach – an approach to suicide prevention that attempts to affect the society at large, or particular subcultures within it, to reduce the likelihood of suicide (such as adult-youth mentoring programs designed to improve the well-being of youth).

Social services – organized efforts to advance human welfare, such as home-delivered meal programs, support groups, and community recreation projects.

Social support – assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services.

Specialty treatment centers (e.g., mental health/substance abuse) – health facilities where the personnel and resources focus on specific aspects of psychological or behavioral well-being.

Stakeholders – entities, including organizations, groups and individuals, that are affected by and contribute to decisions, consultations and policies.

Stigma – an object, idea, or label associated with disgrace or reproach.

Substance abuse – a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use; includes maladaptive use of legal substances such as alcohol; prescription drugs such as analgesics, sedatives, tranquilizers, and stimulants; and illicit drugs such as marijuana, cocaine, inhalants, hallucinogens and heroin.

Suicidal act (also referred to as suicide attempt) – a potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries.

Suicidal behavior – a spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide.

Suicidal ideation – self-reported thoughts of engaging in suicide-related behavior.

Suicidality – a term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide.

Suicide – death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death.

Suicide attempt – a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries.

Suicide attempt survivors – individuals who have survived a prior suicide attempt.

Suicide survivors – family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is also used to mean suicide attempt survivors.

Surveillance – the ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings.

Unintentional – term used for an injury that is unplanned; in many settings these are termed accidental injuries.

Universal preventive intervention – intervention targeted to a defined population, regardless of risk; (this could be an entire school, for example, and not the general population per se).

Utilization management guidelines – policies and procedures that are designed to ensure efficient and effective delivery (utilization) of services in an organization.

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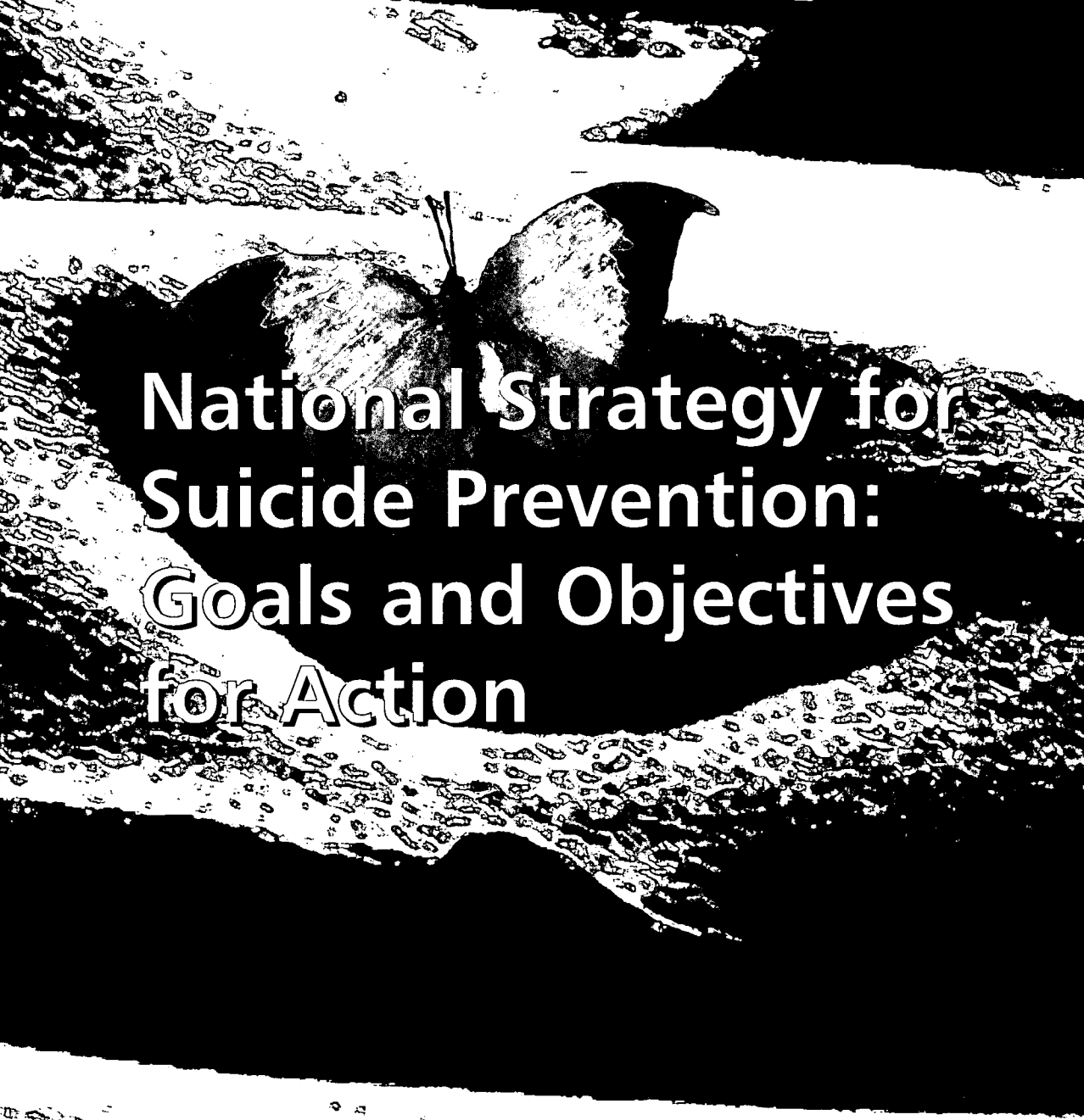

National Strategy for Suicide Prevention: Goals and Objectives for Action

SUMMARY

NATIONAL STRATEGY FOR SUICIDE PREVENTION:

GOALS AND OBJECTIVES FOR ACTION

SUMMARY

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SUMMARY

The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description.

Kay Redfield Jamison

Suicide has stolen lives around the world and across the centuries. Meanings attributed to suicide and notions of what to do about it have varied with time and place, but suicide has continued to exact a relentless toll. In the United States, suicide is the eighth leading cause of death and contributes –through suicide attempts– to disability and suffering for hundreds of thousands of Americans each year. There are few who escape being touched by the tragedy of suicide in their lifetimes; those who lose someone close as a result of suicide experience an emotional trauma that may take leave, but never departs.

Only recently have the knowledge and tools become available to approach suicide as a preventable problem with realistic opportunities to save many lives. The ***National Strategy for Suicide Prevention: Goals and Objectives for Action*** (NSSP or ***National Strategy***) is designed to be a catalyst for social change, with the power to transform attitudes, policies, and services. It reflects a comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors in the United States. The effective implementation of the ***National Strategy*** will play a critical role in reaching the suicide prevention goals outlined in the Nation's public health agenda, ***Healthy People 2010***. Representing the combined work of advocates, clinicians, researchers and survivors, the ***National Strategy*** lays out a framework for action and guides development of an array of services and programs

yet to be set in motion. It strives to promote and provide direction to efforts to modify the social infrastructure in ways that will affect the most basic attitudes about suicide and that will also change judicial, educational, social service, and health care systems. The NSSP is highly ambitious because the devastation wrought by suicide demands the strongest possible response.

SUICIDE: COST TO THE NATION

- **Every 17 minutes another life is lost to suicide. Every day 86 Americans take their own life and over 1500 attempt suicide**
- **Suicide is now the eighth leading cause of death in Americans**
- **For every two victims of homicide in the U.S. there are three deaths from suicide**
- **There are now twice as many deaths due to suicide than due to HIV/AIDS**
- **Between 1952 and 1995, the incidence of suicide among adolescents and young adults nearly tripled**
- **In the month prior to their suicide, 75% of elderly persons had visited a physician**
- **Over half of all suicides occur in adult men, aged 25-65**
- **Many who make suicide attempts never seek professional care immediately after the attempt**
- **Males are four times more likely to die from suicide than are females**
- **More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease, combined**
- **Suicide takes the lives of more than 30,000 Americans every year**

Because suicide is such a serious public health problem, the ***National Strategy*** proposes public health methods to address it. The public health approach to suicide prevention represents a rational and organized way to marshal prevention efforts and ensure that they are effective. Only within the last few decades has a public health approach to suicide prevention emerged with good understanding of the biological and psychosocial factors that contribute to suicidal behaviors. Its five basic steps are to clearly define the problem; identify risk and protective factors; develop and test interventions; implement interventions; and evaluate effectiveness.

As conceived, the ***National Strategy*** requires a variety of organizations and individuals to become involved in suicide prevention and emphasizes coordination of resources and culturally appropriate services at all levels of government–Federal, State, tribal and community–and with the private sector. The NSSP represents the first attempt in the United States to prevent suicide through such a coordinated approach.

The ***Goals and Objectives for Action*** articulates a set of 11 goals and 68 objectives, and provides a blueprint for action. The next step for the ***National Strategy*** will be to prepare a detailed plan that includes specific activities corresponding to each of the 68 objectives.

AIMS OF THE NATIONAL STRATEGY

- **Prevent premature deaths due to suicide across the life span**
- **Reduce the rates of other suicidal behaviors**
- **Reduce the harmful after-effects associated with suicidal behaviors and the traumatic impact of suicide on family and friends**
- **Promote opportunities and settings to enhance resiliency, resourcefulness, respect, and interconnectedness for individuals, families, and communities**

GOAL 1: PROMOTE AWARENESS THAT SUICIDE IS A PUBLIC HEALTH PROBLEM THAT IS PREVENTABLE

In a democratic society, the stronger and broader the support for a public health initiative, the greater its chance for success. If the general public understands that suicide and suicidal behaviors can be prevented, and people are made aware of the roles individuals and groups can play in prevention, the suicide rate can be reduced.

The objectives established for this goal are focused on increasing the degree of cooperation and collaboration between and among public and private entities that have made a commitment to public awareness of suicide and suicide prevention. They include:

- Developing public education campaigns
- Sponsoring national conferences on suicide and suicide prevention
- Organizing special-issue forums, and
- Disseminating information through the Internet.

GOAL 2: DEVELOP BROAD-BASED SUPPORT FOR SUICIDE PREVENTION

Because there are many paths to suicide, prevention must address psychological, biological, and social factors if it is to be effective. Collaboration across a broad spectrum of agencies, institutions, and groups–from schools to faith-based organizations to health care associations–is a way to ensure that prevention efforts are comprehensive. Such collaboration can also generate greater and more effective attention to suicide prevention than can these groups working alone. Public/private partnerships that evolve from collaboration are able to blend resources and build upon each group's strengths. Broad-based support for suicide prevention may also lead to additional funding, through governmental

programs as well as private philanthropy, and to the incorporation of suicide prevention activities into the mission of organizations that have not previously addressed it.

The objectives established for this goal are focused on developing collective leadership and on increasing the number of groups working to prevent suicide. They will help ensure that suicide prevention is better understood and that organizational support exists for implementing prevention activities. The objectives include:

- Organizing a Federal interagency committee to improve coordination and to ensure implementation of the *National Strategy*
- Establishing public/private partnerships dedicated to implementing the *National Strategy*
- Increasing the number of professional, volunteer, and other groups that integrate suicide prevention activities into their ongoing activities, and
- Increasing the number of faith communities that adopt policies designed to prevent suicide.

GOAL 3: DEVELOP AND IMPLEMENT STRATEGIES TO REDUCE THE STIGMA ASSOCIATED WITH BEING A CONSUMER OF MENTAL HEALTH, SUBSTANCE ABUSE, AND SUICIDE PREVENTION SERVICES

Suicide is closely linked to mental illness and to substance abuse, and effective treatments exist for both. However, the stigma of mental illness and substance abuse prevents many persons from seeking assistance; they fear prejudice and discrimination. The stigma of suicide itself--the view that suicide is shameful and/or sinful--is also a barrier to treatment for persons who have suicidal thoughts or who have attempted suicide. Family members of suicide attempters often hide the behavior from friends and relatives, and those who have survived the suicide of a loved

one suffer not only the grief of loss but often the added pain stemming from stigma.

Historically, the stigma associated with mental illness, substance abuse, and suicide has contributed to inadequate funding for preventive services and to low insurance reimbursements for treatments. It has also resulted in the establishment of separate systems for physical health and mental health care. One consequence is that preventive services and treatment for mental illness and substance abuse are much less available than for other health problems. Moreover, this separation has led to bureaucratic and institutional barriers between the two systems that complicate the provision of services and further impede access to care. Destigmatizing mental illness and substance use disorders could increase access to treatment by reducing financial barriers, integrating care, and increasing the willingness of individuals to seek treatment.

The objectives established for this goal are designed to create the conditions that enable persons in need of mental health and substance abuse services to receive them. They include:

- Increasing the number of suicidal persons with underlying mental disorders who receive appropriate mental health treatment, and
- Transforming public attitudes to view mental and substance use disorders as real illnesses, equal to physical illness, that respond to specific treatments and to view persons who obtain treatment as pursuing basic health care.

GOAL 4: DEVELOP AND IMPLEMENT SUICIDE PREVENTION PROGRAMS

Research has shown that many suicides are preventable; however, effective suicide prevention programs require commitment and resources. The public health approach provides a framework for devel-

oping preventive interventions. Programs may be specific to one particular organization, such as a university or a community health center, or they may encompass an entire State. While other goals in the NSSP address interventions to prevent suicide, a special emphasis of this goal is that of ensuring a range of interventions that in concert represent a comprehensive and coordinated program.

The objectives established for this goal are designed to foster planning and program development work and to ensure the integration of suicide prevention into organizations and agencies that have access to groups of individuals for other purposes. The objectives also address the need for systematic planning at both the State and local levels, the need for technical assistance in the development of suicide prevention programs, and the need for ongoing evaluation. Objectives include:

- Increasing the proportion of States with comprehensive suicide prevention plans
- Increasing the number of evidence-based suicide prevention programs in schools, colleges and universities, work sites, correctional institutions, aging programs, and family, youth, and community service programs, and
- Developing technical support centers to build the capacity across the States to implement and evaluate suicide prevention programs.

GOAL 5: PROMOTE EFFORTS TO REDUCE ACCESS TO LETHAL MEANS AND METHODS OF SELF-HARM

Evidence from many countries and cultures shows that limiting access to lethal means of self-harm may be an effective strategy to prevent self-destructive behaviors. Often referred to as "means restriction," this approach is based on the belief that a small but significant minority of

suicidal acts are, in fact, impulsive and of the moment; they result from a combination of psychological pain or despair coupled with the easy availability of the means by which to inflict self-injury. Thus, a self-destructive act may be prevented by limiting the individual's access to the means of self-harm. Evidence suggests that there may be a limited time effect for decreasing self-destructive behaviors in susceptible and impulsive individuals when access to the means for self-harm is restricted. Controversy exists about how to accomplish this goal because restricting means can take many forms and signifies different things to different people. For some, means restriction may connote redesigning or altering the existing lethal means of self-harm currently available, while to others it means eliminating or limiting their availability.

The objectives established for this goal are designed to separate in time and space the suicidal impulse from access to lethal means of self-harm. They include:

- Educating health care providers and health and safety officials on the assessment of lethal means in the home and actions to reduce suicide risk
- Implementing a public information campaign designed to reduce accessibility of lethal means
- Improving firearm safety design, establishing safer methods for dispensing potentially lethal quantities of medications and seeking methods for reducing carbon monoxide poisoning from automobile exhaust systems, and
- Supporting the discovery of new technologies to prevent suicide.

GOAL 6: IMPLEMENT TRAINING FOR RECOGNITION OF AT-RISK BEHAVIOR AND DELIVERY OF EFFECTIVE TREATMENT

Studies indicate that many health professionals are not adequately trained to provide proper assessment, treatment, and management of suicidal patients, nor do they know how to refer clients properly for specialized assessment and treatment. Despite the increased awareness of suicide as a major public health problem, gaps remain in training programs for health professionals and others who often come into contact with patients in need of these specialized assessment techniques and treatment approaches. In addition, many health professionals lack training in the recognition of risk factors often found in grieving family members of loved ones who have died by suicide (suicide survivors).

Key gatekeepers–people who regularly come into contact with individuals or families in distress– need training in order to be able to recognize factors that place individuals at risk for suicide, and to learn appropriate interventions. Key gatekeepers include teachers and school personnel, clergy, police officers, primary health care providers, mental health care providers, correctional personnel, and emergency health care personnel.

The objectives established for this goal are designed to ensure that health professionals and key community gatekeepers obtain the training that will help them prevent suicide. They include:

- Improving education for nurses, physician assistants, physicians, social workers, psychologists, and other counselors
- Providing training for clergy, teachers and other educational staff, correctional workers, and attorneys on how to identify and respond to persons at risk for suicide, and
- Providing educational programs for family members of persons at elevated risk.

GOAL 7: DEVELOP AND PROMOTE EFFECTIVE CLINICAL AND PROFESSIONAL PRACTICES

One way to prevent suicide is to identify individuals at risk and to engage them in treatments that are effective in reducing the personal and situational factors associated with suicidal behaviors (e.g., depressed mood, hopelessness, helplessness, alcohol and other drug abuse, among others). Another way to prevent suicide is to promote and support the presence of protective factors, such as learning skills in problem solving, conflict resolution, and nonviolent handling of disputes. By improving clinical practices in the assessment, management, and treatment for individuals at risk for suicide, the chances for preventing those individuals from acting on their despair and distress in self-destructive ways are greatly improved. Moreover, promoting the presence of protective factors for these individuals can contribute importantly to reducing their risk.

The objectives established for this goal are designed to heighten awareness of the presence or absence of risk and protective conditions associated with suicide, leading to better triage systems and better allocation of resources for those in need of specialized treatment. They include:

- Changing procedures and/or policies in certain settings, including hospital emergency departments, substance abuse treatment centers, specialty mental health treatment centers, and various institutional treatment settings, designed to assess suicide risk
- Incorporating suicide-risk screening in primary care
- Ensuring that individuals who typically provide services to suicide survivors have been trained to understand and respond appropriately to their unique needs (e.g., emergency medical technicians, firefighters, police, funeral directors)
- Increasing the numbers of persons with mood disorders who receive and maintain treatment

- Ensuring that persons treated for trauma, sexual assault, or physical abuse in emergency departments receive mental health services
- Fostering the education of family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide.

GOAL 8: IMPROVE ACCESS TO AND COMMUNITY LINKAGES WITH MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

The elimination of health disparities and the improvement of the quality of life for all Americans are central goals of ***Healthy People 2010***. Some of these health disparities are attributable to differences of gender, race or ethnicity, education, income, disability, stigma, geographic location, or sexual orientation. Many of these factors place individuals at increased risk for suicidal behaviors.

Barriers to equal access and affordability of health care may be influenced by financial, structural, and personal factors. Financial barriers include not having enough health insurance or not having the financial capacity to pay for services outside a health plan or insurance program. Structural barriers include the lack of primary care providers, medical specialists or other health care professionals to meet special needs or the lack of health care facilities. Personal barriers include cultural or spiritual differences, language, not knowing when or how to seek care, or concerns about confidentiality or discrimination. Reducing disparities is a necessary step in ensuring that all Americans receive appropriate physical health, mental health, and substance abuse services. One aspect of improving access is to better coordinate the services of a variety of community institutions. This will help ensure that at-risk populations receive the services they need, and that all community members receive regular preventive health services.

The objectives established for this goal are designed to enhance inter-organizational communication to facilitate the provision of health services to those in need of them. They include:

- Increasing the number of States that require health insurance plans to cover mental health and substance abuse care on par with coverage for physical health care
- Implementing utilization management guidelines for suicidal risk in managed care and insurance plans
- Integrating mental health and suicide prevention into health and social services outreach programs for at-risk populations
- Defining and implementing screening guidelines for schools, colleges, and correctional institutions, along with guidelines on linkages with service providers, and
- Implementing support programs for persons who have survived the suicide of someone close.

GOAL 9: IMPROVE REPORTING AND PORTRAYALS OF SUICIDAL BEHAVIOR, MENTAL ILLNESS, AND SUBSTANCE ABUSE IN THE ENTERTAINMENT AND NEWS MEDIA

The media–movies, television, radio, newspapers, and magazines–have a powerful impact on perceptions of reality and on behavior. Research over many years has found that media representations of suicide may increase suicide rates, especially among youth. "Cluster suicides" and "suicide contagion" have been documented, and studies have shown that both news reports and fictional accounts of suicide in movies and on television can lead to increases in suicide. It appears that imitation plays a role in certain individuals engaging in suicidal behavior.

On the other hand, it is widely acknowledged that the media can play a positive role in suicide prevention, even as they report on suicide or depict it and related issues in movies and on television. The ***way*** suicide is presented is particularly important. Changing media representation of suicidal behaviors is one of several strategies needed to reduce the suicide rate.

Media portrayals of mental illness and substance abuse may also affect the suicide rate. Negative views of these problems may lead individuals to deny they have a problem or be reluctant to seek treatment—and untreated mental illness and substance abuse are strongly correlated with suicide.

The objectives established for this goal are designed to foster consideration among media leaders of the impact of different styles of describing or otherwise depicting suicide and suicidal behavior, mental illness, and substance abuse, and to encourage media representations of suicide that can help prevent rather than increase suicide. They include:

- Establishing a public/private group designed to promote the responsible representation of suicidal behaviors and mental illness on television and in movies
- Increasing the number of television programs, movies, and news reports that observe recommended guidelines in the depiction of suicide and mental illness, and
- Increasing the number of journalism schools that adequately address reporting of mental illness and suicide in their curricula.

GOAL 10: PROMOTE AND SUPPORT RESEARCH ON SUICIDE AND SUICIDE PREVENTION

All suicides are highly complex. The volume of research on suicide and its risk factors has increased considerably in the past decade and has generated new questions about why individuals become suicidal or remain suicidal. The important contributions of underlying mental illness, substance use, and biological factors, as well as potential risk that comes from certain environmental influences are becoming clearer. Increasing the understanding of how individual and environmental risk and protective factors interact with each other to affect an individual's risk for suicidal behavior is the next challenge. This understanding can contribute to the limited but growing information about how modifying risk and protective factors change outcomes pertaining to suicidal behavior.

The objectives established for this goal are designed to support a wide range of research endeavors focused on the etiology, expression, and maintenance of suicidal behaviors across the lifespan. The enhanced understanding to be derived from this research will lead to better assessment tools, treatments, and preventive interventions. The objectives include:

- Developing a national suicide research agenda
- Increasing funds for suicide prevention research
- Evaluating preventive interventions, and
- Establishing a registry of interventions with demonstrated effectiveness for prevention of suicide or suicidal behavior.

GOAL 11: IMPROVE AND EXPAND SURVEILLANCE SYSTEMS

Surveillance has been defined as the systematic and ongoing collection of data. Surveillance systems are key to health planning. They are used to

track trends in rates, to identify new problems, to provide evidence to support activities and initiatives, to identify risk and protective factors, to target high risk populations for interventions, and to assess the impact of prevention efforts.

Data on suicide and suicidal behavior are needed at national, State and local levels. National data can be used to draw attention to the magnitude of the suicide problem and to examine differences in rates among groups (e.g., ethnic groups), locales (e.g., rural vs. urban) and whether suicidal individuals were cared for in certain settings (e.g., primary care, emergency departments). State and local data help establish local program priorities and are necessary for evaluating the impact of suicide prevention strategies.

The objectives established for this goal are designed to enhance the quality and quantity of data available on suicide and suicidal behaviors and ensure that the data are useful for prevention purposes. They include:

- Developing and implementing standardized protocols for death scene investigations
- Increasing the number of follow-back studies of suicides
- Increasing the number of hospitals that code for external cause of injuries
- Increasing the number of nationally representative surveys with questions on suicidal behavior
- Implementing a national violent death reporting system that includes suicide
- Increasing the number of States that produce annual reports on suicide, and
- Supporting pilot projects to link and analyze information on self-destructive behavior from various, distinct data systems.

LOOKING AHEAD

The ***National Strategy for Suicide Prevention*** creates a framework for suicide prevention for the Nation. It is designed to encourage and empower groups and individuals to work together. The stronger and broader the support and collaboration on suicide prevention, the greater the chance for the success of this public health initiative. Suicide and suicidal behaviors can be reduced as the general public gains more understanding about the extent to which suicide is a problem, about the ways in which it can be prevented, and about the roles individuals and groups can play in prevention efforts.

The ***National Strategy*** is comprehensive and sufficiently broad so that individuals and groups can select those objectives and activities that best correspond to their responsibilities and resources. The plan's objectives suggest a number of roles for different groups. Individuals from a variety of occupations need to be involved in implementing the plan, such as health care professionals, police, attorneys, educators, and clergy. Institutions such as community groups, faith-based organizations, and schools all have a necessary part to play. Sites for suicide prevention work include jails, emergency departments and the workplace. Survivors, consumers and the media need to be partners as well, and governments at the Federal, State, and local levels are key in providing funding for public health and safety issues.

Ideally, the ***National Strategy*** will motivate and illuminate. It can serve as a model and be adopted or modified by States, communities, and tribes as they develop their own, local suicide prevention plans. The NSSP articulates the framework for national efforts and provides legitimacy for local groups to make suicide prevention a high priority for action.

The ***National Strategy*** encompasses the development, promotion and support of programs that will be implemented in communities across the country designed to achieve significant, measurable, and sustainable reductions in suicide and suicidal behaviors. This requires a major investment in public health action.

Now is the time for making great strides in suicide prevention. Implementing the ***National Strategy for Suicide Prevention*** provides the means to realize success in reducing the toll from this important public health problem. Sustaining action on behalf of all Americans will depend on effective public and private collaboration–because suicide prevention is truly everyone's business.

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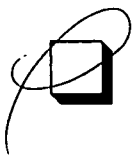

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