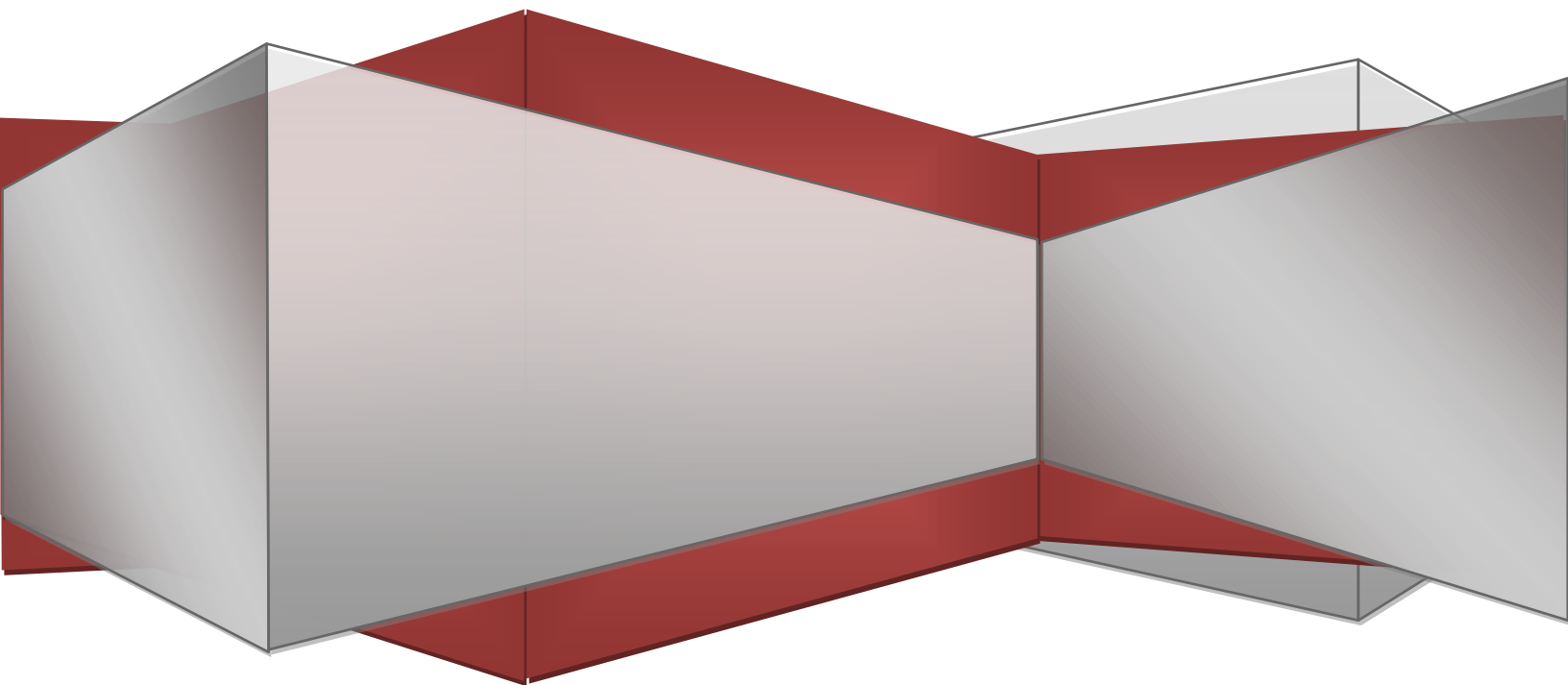# EXPLORING THE ROLE OF THE RAILROAD INDUSTRY
IN PROMOTING SUICIDE PREVENTION

FINAL MEETING REPORT

Tuesday, January 21, 2014
Held in Washington, DC at Education Development Center, Inc.

TABLE OF CONTENTS

**Exploring the Role of the Railroad Industry in
Promoting Suicide Prevention**

ACKNOWLEDGEMENTS

This meeting was a collaborative effort between the suicide prevention field and the railroad industry. It was convened by the National Action Alliance for Suicide Prevention using its model of public-private partnership.

About the National Action Alliance for Suicide Prevention

The National Action Alliance for Suicide Prevention is the public-private partnership working to advance the U.S. *National Strategy for Suicide Prevention* and make suicide prevention a national priority. The Action Alliance was launched in 2010 by U.S. Health and Human Services Secretary Kathleen Sebelius and former U.S. Defense Secretary Robert Gates.

Vision: The National Action Alliance for Suicide Prevention envisions a nation free from the tragic experience of suicide.

Mission: To advance the *National Strategy for Suicide Prevention* (NSSP) by:
- Championing suicide prevention as a national priority
- Catalyzing efforts to implement high priority objectives of the NSSP
- Cultivating the resources needed to sustain progress

Goal: To save 20,000 lives in five years.

Contact: http://actionallianceforsuicideprevention.org
info@ActionAllianceforSuicidePrevention.org

INTRODUCTION

Meeting Purpose

On Tuesday, January 21, 2014, executives from U.S. railroad companies came together with suicide prevention experts to answer the guiding question: "What is known about effective suicide prevention measures, broadly speaking, and what role, if any, can the railroad industry play in supporting and advancing these efforts?" Using the public-private partnership model of the National Action Alliance for Suicide Prevention, the meeting was innovative in exploring whether and how a major industry might contribute to reducing the overall *societal* toll of suicide. Therefore, the focus was on suicide as a broad national problem, rather than on any specific type of suicide. The goal was not to develop an industrywide strategy, but rather for each company to become better educated about suicide prevention and decide its own next steps following the meeting.

Prior to the meeting, we identified at least four ways that railroad companies might potentially facilitate or support efforts to reduce suicide:

- As large employers, they offer health and wellness programs, policies, and benefits for their own employees;
- They are large purchasers of health care and behavioral health services, and thus may have opportunities to influence those systems;
- Because their industry is affected by multiple laws and regulations, they have extensive public policy experience across levels of government; and
- They support an array of initiatives and programs in the communities in which they operate.

Format

The agenda was structured to enable suicide prevention experts to educate railroad industry representatives about best practices in suicide prevention, followed by an opportunity for dialogue and brainstorming about what role the industry might play in promoting these solutions. There were seven sessions in total:

Session 1:	Overview of Suicide Prevention
Session 2:	Clinical Services
Session 3:	Hotlines and Other Crisis Supports
Session 4:	Reducing Access to Lethal Means
Session 5:	Multicomponent Initiatives: Communities and Workplaces
Session 6:	Messaging
Session 7:	National Infrastructure, Legislation, and Priorities

The first session set the stage by providing a general overview of the problem of suicide and basic concepts in prevention. The subsequent six sessions addressed a key area of suicide prevention. Each session began with one or two brief introductory presentations, followed by a discussion period that included generating a list of possible options that railroad companies might pursue to engage in these efforts. This report provides a brief overview of the expert presentations that began each session, and for Sessions 2 through 7, the list of possible opportunities for involvement that were generated by the group.

Exploring the Role of the Railroad Industry in
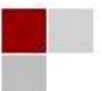Promoting Suicide Prevention

SESSION 1: OVERVIEW OF SUICIDE PREVENTION

Dr. Linda Langford began the day with an introductory presentation describing the problem of suicide in the United States and summarizing basic concepts in suicide prevention.

Langford started by describing a public health approach to prevention. Similar to the way railroad companies approach trespassing, a public health approach to suicide prevention

- is population-focused, addressing patterns of incidents rather than one case at a time;
- aims to prevent new incidents, not just address instances that have occurred;
- considers factors beyond the individual, such as the physical, social, and policy environment; and
- is driven by data and research about patterns of incidents and the factors that cause and contribute to them.

The public health approach consists of the following steps:

1. Define and understand the extent and scope of suicide in the population.
2. Identify factors that increase the likelihood of suicide (risk factors) and those that reduce its likelihood, or buffer that risk (protective factors).
3. Develop interventions to reduce risk and/or enhance protective factors, and test them to evaluate effectiveness.
4. Scale up what works for broader impact.

The public health approach is a cycle, so step 4 leads back into step 1, where the lessons learned from the process help to further refine the problem definition.

Langford used the first three steps in the public health approach to frame the rest of her introduction. To *define the problem*, she provided an overview of national statistics about suicide (see attached slides for all findings). In 2010—the most recent national data—there were 38,364 suicide deaths, or 105 per day on average. Suicide deaths are only the tip of the iceberg; the range of suicidal behaviors also includes nonfatal attempts and seriously thinking about suicide. Suicide was the tenth leading cause of death in the United States in 2010, but the second cause of death for persons aged 25-34 and the third leading cause for those 10-24 years old.

Suicide rates vary by age, race, gender, and geographical location. Males complete suicide at nearly four times the rate of females, but females attempt at a higher rate than males. Working-age males represent 60 percent of total suicides. Groups at higher risk include elderly white males, young- and middle-aged American Indians and Alaskan Natives, and residents of the Mountain States in the western United States. Suicide rates among active duty military and veterans have increased in recent years, causing concern. Attempt rates are higher in adolescence and decline with age. Two groups with concerning attempt rates are Latina youth and lesbian, gay, bisexual, and transgender people. In over half of U.S. suicide deaths, a firearm is the method used. Non-fatal suicide attempts are predominantly poisoning injuries.

Suicide has deep and lasting impacts on families and communities, and its full costs are incalculable. One way of viewing the impact is by looking at who is left behind: the survivors of suicide loss. One study estimated that, for every suicide, there are five family members, 15 extended family members , 20 friends, and 20 co-workers or classmates who are "intimately and directly affected" by the loss. A different perspective is gained through a 2005 estimate of medical and work loss costs of suicide, which calculated the annual costs of suicide deaths to be $34.6 billion and non-fatal attempts at $6.5 billion.

Turning to the second step in the public health model, *identify risk and protective factors*, Langford asserted that there is no simple cause for suicide; it results from a combination of factors. As noted above, these factors extend beyond the individual to include interpersonal factors (e.g., peers, families, co-workers), organizational and community factors, as well as broader societal and public policy factors. Risk factors increase the likelihood of suicide. Examples include mood and substance abuse disorders, a history of suicidal behavior, traumatic experiences in childhood or adulthood, medical conditions and pain, bereavement by suicide, relationship conflict, access to highly lethal means, and unsafe media portrayals. Protective factors serve to reduce or buffer that risk, and include coping skills, social support, connection to schools or other institutions, effective mental health care, and available crisis and follow-up care.

Langford then presented the logic of interventions to introduce step 3, *develop and test interventions*. An "intervention" is any program, policy, or service that changes risk and protective factors and thereby reduces suicide. The newly revised National Strategy for Suicide Prevention (NSSP) was released in 2012 and identifies a broad array of intervention approaches. Interventions can target many goals, for example
- Identify individuals at risk
- Increase help-seeking
- Provide effective mental health services
- Provide crisis supports
- Reduce access to potentially lethal means
- Develop life skills
- Promote social networks

Langford pointed out that there are a number of ways to describe interventions. One attribute of interventions is who is targeted: everyone regardless of risk, groups at high risk, or those with symptoms. Another characteristic is when the intervention occurs in the development of suicidality: before suicidal behavior, during behavior to minimize harm, or follow-up care delivered after suicidal behavior. (An additional category is "postvention," which are interventions for survivors and community members after a death, although these efforts are not within the scope of this meeting.) Langford introduced the concept of "working "upstream," which refers to intervening early in order to keep problems from developing.

Interventions also differ by what risk and protective factors they address. As noted earlier, these factors occur at multiple levels: individual attributes; interpersonal factors (i.e., friends, family, co-workers); how institutions work; community conditions; and broader policy and societal factors. Finally, interventions can be classified by where they happen, for example, in healthcare settings, workplaces, schools, communities, or at a policy level. Langford pointed out that efficiencies often can be realized by working at organizational or
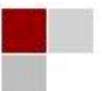
policy levels. For example, rather than trying to change the individual behavior of all healthcare providers in the U.S., it is more efficient to advocate for health systems change or state and federal policy change.

Keys to successful prevention include using the best available data and research, targeting an array of risk and protective factors, employing multiple, coordinated strategies, and working in collaboration with key stakeholders.

Presenter Contact Information:

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E-mail: llangford@edc.org
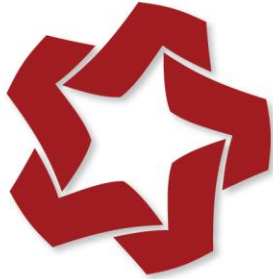
Overview of Suicide Prevention

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention
January 21, 2014

Linda Langford, Sc.D.
Evaluation and Communication Scientist
Suicide Prevention Resource Center
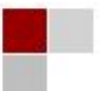llangford@edc.org

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Public Health

✓ Population-focused

✓ Preventing new cases, not just treating

✓ Considers factors beyond the individual

✓ Driven by data/research

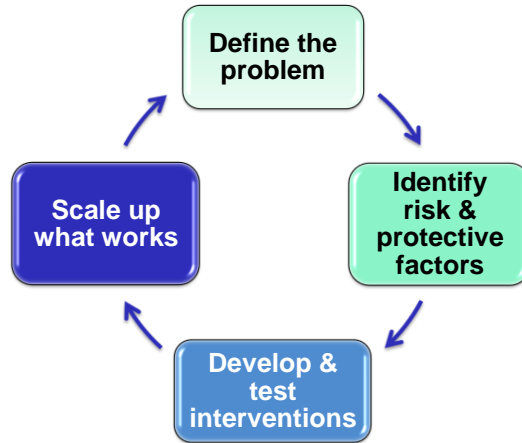**1854 Cholera Outbreak: John Snow's Map**

2

How to Prevent Problems?
Public Health Approach

Define the problem

Identify risk & protective factors

Develop & test interventions

Scale up what works

3

Pyramid of Suicidal Behaviors—U.S. Adults, 2010

Define the problem

All ages: 38,364
105/day (ave.)

37,348
Suicides*

572,000
Hospitalizations**

752,000 Attempts
Requiring Medical Attention**

1,100,000
Suicide Attempts**

8,700,000
Seriously Considered Suicide**
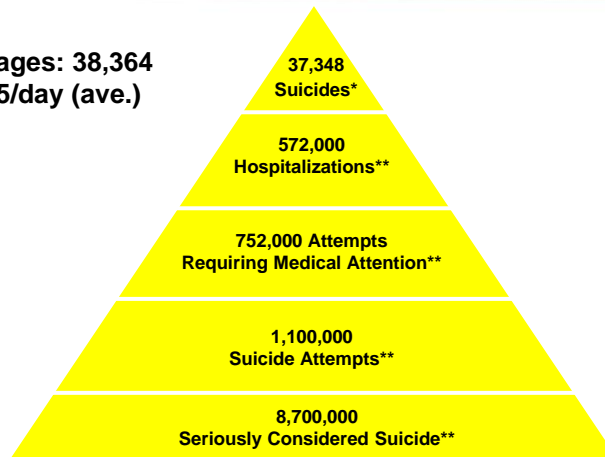
Source:
* Centers for Disease Control and Prevention, *Understanding Suicide: Fact Sheet*. Available from:
http://www.cdc.gov/violenceprevention/pub/suicide_factsheet.html .
**Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2012). *The NSDUH Report: Suicidal Thoughts and Behaviors among Adults*. Rockville, MD.

4

Exploring the Role of the Railroad Industry in
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10 Leading Causes of Death by Age Group, United States – 2010

Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
					Age Groups						
1	Congenital Anomalies 5,107	Unintentional Injury 1,394	Unintentional Injury 758	Unintentional Injury 885	Unintentional Injury 12,341	Unintentional Injury 14,573	Unintentional Injury 14,792	Malignant Neoplasms 50,211	Malignant Neoplasms 109,501	Heart Disease 477,338	Heart Disease 597,689
2	Short Gestation 4,148	Congenital Anomalies 507	Malignant Neoplasms 439	Malignant Neoplasms 477	Homicide 4,678	Suicide 5,735	Malignant Neoplasms 11,809	Heart Disease 36,729	Heart Disease 68,077	Malignant Neoplasms 396,670	Malignant Neoplasms 574,743
3	SIDS 2,063	Homicide 385	Congenital Anomalies 163	Suicide 267	Suicide 4,600	Homicide 4,258	Heart Disease 10,594	Unintentional Injury 19,667	Chronic Low. Respiratory Disease 14,242	Chronic Low Respiratory Disease 118,031	Chronic Low. Respiratory Disease 138,080
4	Maternal Pregnancy Comp. 1,561	Malignant Neoplasms 346	Homicide 111	Homicide 150	Malignant Neoplasms 1,604	Malignant Neoplasms 3,619	Suicide 6,571	Suicide 8,799	Unintentional Injury 14,023	Cerebro-vascular 109,990	Cerebro-vascular 129,476
5	Unintentional Injury 1,110	Heart Disease 159	Heart Disease 68	Congenital Anomalies 135	Heart Disease 1,028	Heart Disease 3,222	Homicide 2,473	Liver Disease 8,651	Diabetes Mellitus 11,677	Alzheimer's Disease 82,616	Unintentional Injury 120,859
6	Placenta Cord. Membranes 1,030	Influenza & Pneumonia 91	Chronic Low Respiratory Disease 60	Heart Disease 117	Congenital Anomalies 412	HIV 741	Liver Disease 2,423	Cerebro-vascular 5,910	Cerebro-vascular 10,693	Diabetes Mellitus 49,191	Alzheimer's Disease 83,494
7	Bacterial Sepsis 583	Septicemia 62	Cerebro-vascular 47	Chronic Low Respiratory Disease 73	Cerebro-vascular 190	Diabetes Mellitus 606	Cerebro-vascular 1,904	Diabetes Mellitus 5,610	Liver Disease 9,764	Influenza & Pneumonia 42,846	Diabetes Mellitus 69,071
8	Respiratory Distress 514	Benign Neoplasms 59	Benign Neoplasms 37	Benign Neoplasms 45	Influenza & Pneumonia 181	Cerebro-vascular 517	HIV 1,898	Chronic Low. Respiratory Disease 4,452	Suicide 6,384	Nephritis 41,994	Nephritis 50,476
9	Circulatory System Disease 507	Perinatal Period 52	Influenza & Pneumonia 37	Cerebro-vascular 43	Diabetes Mellitus 165	Liver Disease 487	Diabetes Mellitus 1,789	HIV 3,123	Nephritis 5,082	Unintentional Injury 41,300	Influenza & Pneumonia 50,097
10	Necrotizing Enterocolitis 472	Chronic Low Respiratory Disease 51	Septicemia 32	Septicemia 35	Complicated Pregnancy 163	Congenital Anomalies 397	Influenza & Pneumonia 773	Viral Hepatitis 2,376	Septicemia 4,604	Septicemia 26,310	Suicide 38,364

Data Source: National Vital Statistics System, National Center for Health Statistics, CDC.
Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC using WISQARS™.

CDC — Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

5

Demographics & Risk Groups

- Suicides:
  - Male : female = 4:1
  - Elderly white males – highest rate
  - Working aged males – ~60% of all suicides
  - Concern:
    - American Indian/Alaskan Natives--youth & middle age
    - Military/Veterans

- Attempts:
  - Female>>male
  - Rates peak in adolescence and decline with age
  - Concern: Latina youth and LGBT

Source:
National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. (2009).
Web-based Injury Statistics Query and Reporting System (WISQARS). Available from: www.cdc.gov/injury/wisqars/index.html.
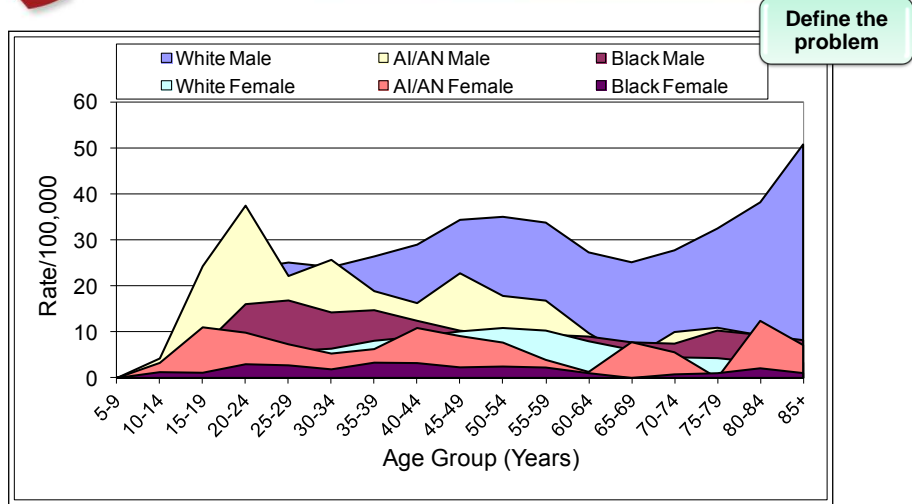
6

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

U.S. Suicide Rates by Age, Race, and Gender, 2010

Legend: White Male · AI/AN Male · Black Male · White Female · AI/AN Female · Black Female

Y-axis: Rate/100,000 (0, 10, 20, 30, 40, 50, 60)

X-axis: Age Group (Years) — 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85+

Source:
National Center for Health Statistics
Note: Non-Hispanic Ethnicity

7

Age-Adjusted Suicide Rates Among All Persons by State -- United States, 2004-2010 (U.S. Avg. 11.4)

Lowest & Highest	Rate (per 100k)
New Jersey	6.7
Alaska	21.8

Legend: 5.80-10.95 · 10.96-12.52 · 12.53-14.74 · 14.75-21.82
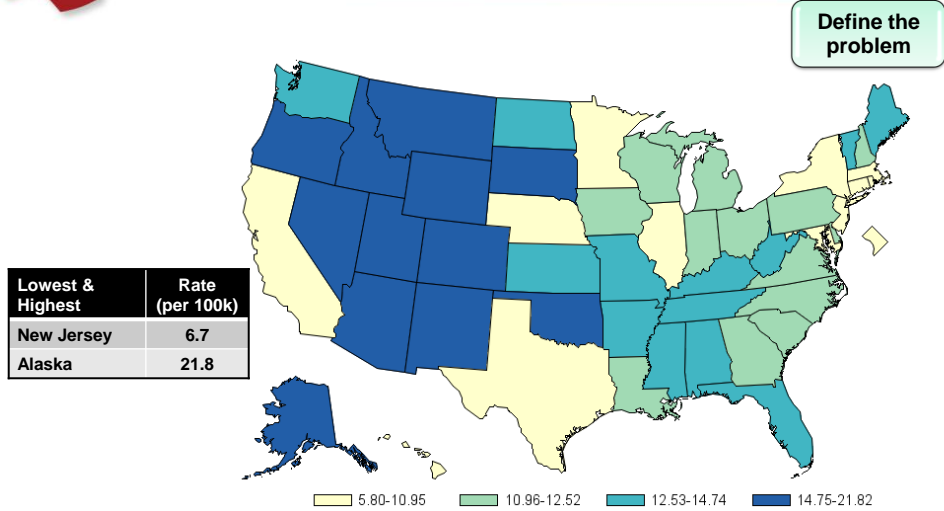
Source: Centers for Disease Control and Prevention (CDC) vital statistics

8

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

Method of Self-Harm: U.S.

Suicide

- Overdose/Poison 17%
- Suffocation 25%
- Firearm 51%
- Jump 2%
- Sharp 2%
- Other 4%

Nonfatal Self-harm

- Overdose/Poison 83%
- Sharp 11%
- Other 4%
- Suffocation 1%
- Firearm 1%

SOURCES Suicide: CDC WISQARS (2010) www.cdc.gov/ncipc/wisqars   Inpatient: HCUP-NIS (2005)

9
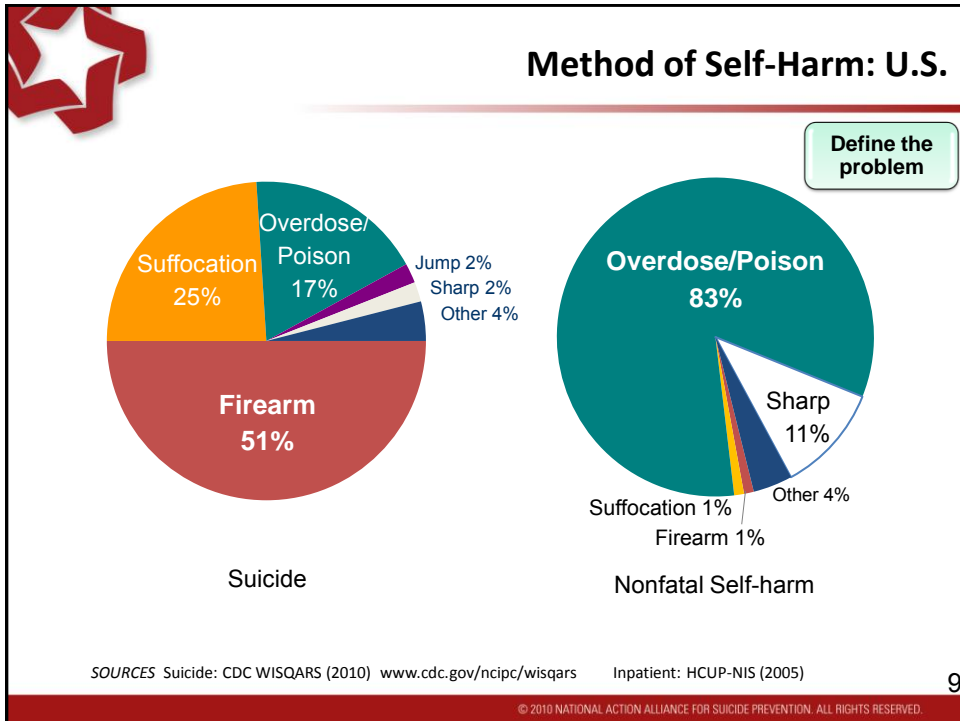
Impacts

Survivors of suicide loss (estimated):

- 5 family members
- 15 extended family members
- 20 friends
- 20 co-workers or classmates
   -- Berman, 2011

Annual Costs (estimated annual medical & work loss, 2005)

- Deaths: $34.6 billion
- Non-fatal: $6.5 billion

10

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

Risk and Protective Factors

Identify risk & protective factors

- Suicide results from a combination of factors

- Risk factors = ↑ likelihood of suicide
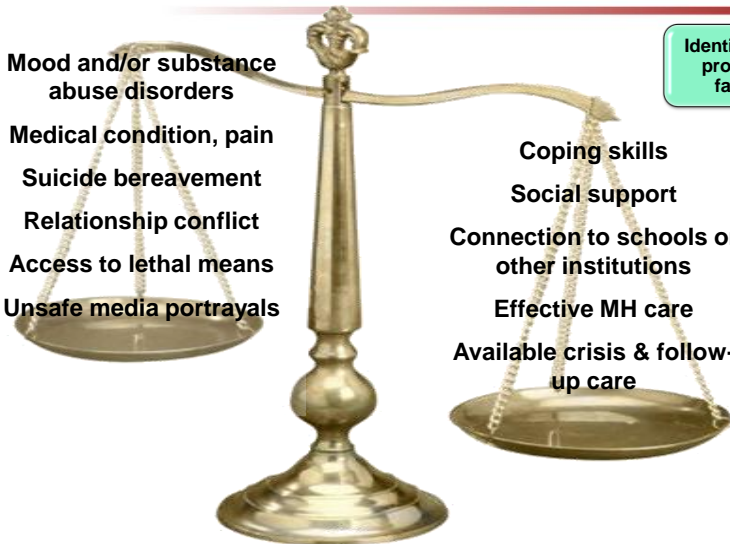- Protective factors = ↓ likelihood of suicide

- Look beyond the individual

Society
Community
Organizational
Interpersonal
Individual

11

Risk and Protective Factors (e.g.)

Identify risk & protective factors

Mood and/or substance abuse disorders

Medical condition, pain

Suicide bereavement

Relationship conflict

Access to lethal means

Unsafe media portrayals

Coping skills

Social support

Connection to schools or other institutions

Effective MH care

Available crisis & follow-up care

12

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

Logic of "Interventions"

Develop & test interventions

Interventions
Programs/
policies/
services/
environments

change

→

Risk & Protective
Factors

to reduce

→

Suicide

13

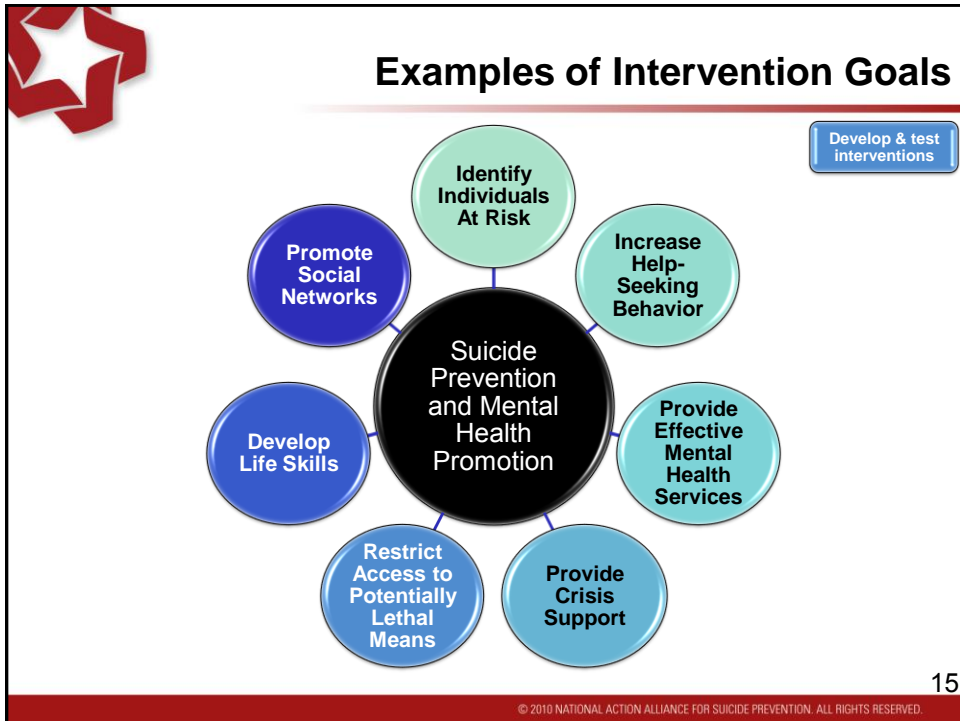## National Strategy for Suicide Prevention

Develop & test interventions

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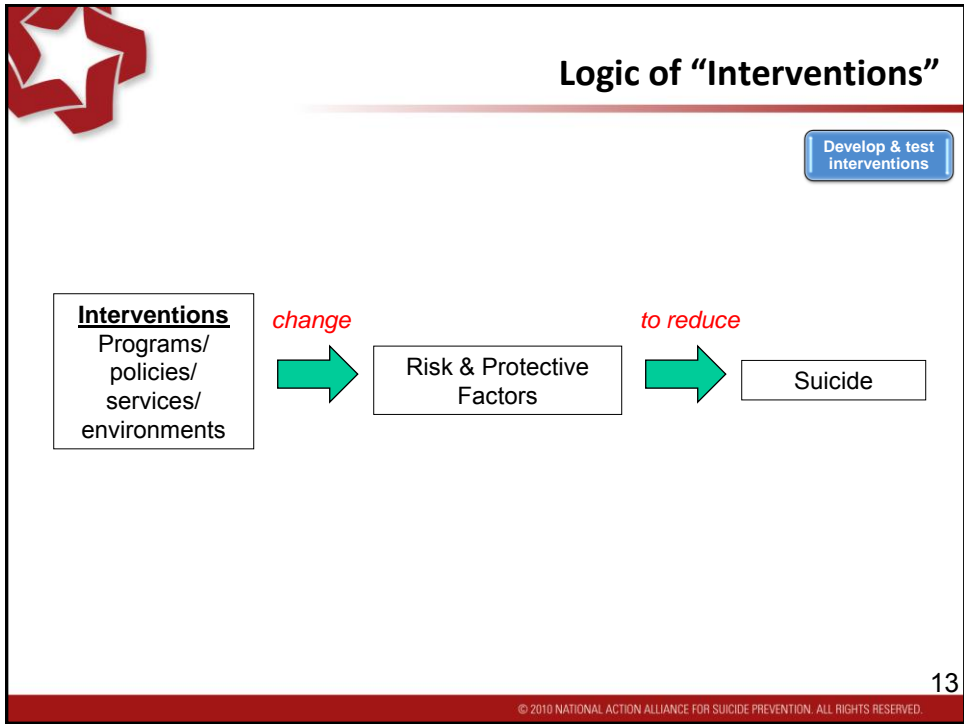
2012 National Strategy for Suicide Prevention:
GOALS AND OBJECTIVES FOR ACTION

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

13 goals, 60 objectives

14

**Exploring the Role of the Railroad Industry in
Promoting Suicide Prevention**

Examples of Intervention Goals

Identify Individuals At Risk

Promote Social Networks

Increase Help-Seeking Behavior

Suicide Prevention and Mental Health Promotion

Develop Life Skills

Provide Effective Mental Health Services

Restrict Access to Potentially Lethal Means

Provide Crisis Support

15

Several Ways to "Slice" Interventions

WHO is it for?

- **Everyone**, regardless of risk
- Groups at **high risk**
- Those with **symptoms**

WHEN do we intervene?

- **Before** suicidal behavior
- **During** behavior
- **After** behavior
- (Also after a death: <u>not</u> today's focus)

WHAT is the focus?

- Individual attributes
- Friends/family/co-workers
- How institutions work
- Community conditions
- Policy/societal factors

WHERE does it happen, e.g.

- Health settings
- Workplaces, schools
- Community-based
- Federal/state/local levels

16

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Develop & test interventions

Working "Upstream"

Everyone | Groups at Higher Risk

<u>Suicidal Thoughts & Behavior</u>

Warning Signs

Ideation/Planning | Attempt | Suicide Death

"UPSTREAM"

"DOWNSTREAM"

Employee Wellness

Trauma Recovery

Effective MH/SA Treatment

Life Skills

Pain Mgmt

Social Networks

Support for Life Transitions

Restrict Access to Means

Identify Indivs at Risk

---------Effective MH Services----

Crisis Support

ID & Refer

Increase Help-Seeking

Lethal Means Counseling

17

Policy/Systems Change: "Working up the food chain"

Provide Effective Mental Health Services

Develop & test interventions

Number of people/orgs you have to reach

Federal laws/regulations

Professional associations

Insurance providers

Health plan policies & practices

Practice-level policies & protocols

Individual providers

18

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

Prevention: Keys to Success

- Use best available **data and research**
  - "Evidence" is on a continuum

- Address **multiple risk and protective** factors

- Use **multiple, coordinated strategies**

- **Collaboration**

19

Today's Meeting

- Our focus is on
  - Suicide as a national problem
  - Prevention and treatment
    - Responding to deaths is an important but separate topic.
  - Interventions with research basis

- Expert presentations, then discussion and brainstorming about possible roles for RR companies
  - Generate a menu of options for each company to consider

Ground rule: DYA!

20

**Exploring the Role of the Railroad Industry in
Promoting Suicide Prevention**

SESSION 2: CLINICAL SERVICES

This session began with two ten-minute presentations highlighting different aspects of suicide prevention in clinical settings. In *Ending Suicide in Healthcare Systems: the Zero Suicide Movement*, Dr. Michael Hogan described the importance of taking a whole-systems approach to suicide prevention in healthcare settings. Dr. Cheryl King then presented *Delivering Optimal Clinical Care: Focus on a Competent, Confident and Caring Behavioral Health Workforce*, which provided additional details about two aspects within a whole-systems approach: clinician training and effective treatment.

Part I: Ending Suicide in Healthcare Systems: the Zero Suicide Movement

Dr. Michael Hogan began his presentation by asserting that "suicide is a largely preventable medical error." He summarized data demonstrating that suicide is a problem among patients in healthcare settings, including primary care practices, emergency departments, and mental health settings. He and other members of the Clinical Care and Intervention (CCI) Task Force of the National Action Alliance for Suicide Prevention undertook the task of finding solutions. They found that there are no simple answers, but there is evidence demonstrating that *systematic efforts* by healthcare systems can reduce suicide.

Currently, most health care organizations do not prioritize suicide prevention. When efforts exist, they are fragmented, which allows suicidal individuals to fall through one or more of the many cracks in the system. However, several organizations have successfully reduced suicide. One example is the Henry Ford Health System (HFHS) in Michigan. HFHS decided to improve their approach to depression by using the same rigorous quality improvement process they employed for inpatient falls and medication errors. This approach led to the HFHS Perfect Depression Care model, a comprehensive approach establishing depression as an institution-wide priority which was realized through the development of an integrated care system. Key elements included information-sharing, care coordination and teamwork, facilitating access to care, and using data to drive continuous improvement. The result: an 80 percent reduction in the suicide rate among plan members.

Based on these findings and other similar initiatives, the CCI Task Force developed the Suicide Care in Systems Framework, which distills the key components of a systemwide approach. To build on the Task Force momentum and disseminate this approach, the Action Alliance selected "transforming health care systems" as one of its four initial priorities. This priority included promoting the adoption of "zero suicides" as an organizing goal for clinical systems.

The Action Alliance's *Zero Suicide initiative* is both a concept and a practice. Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. Its core proposition is that suicide deaths for people under care are preventable, and the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. It represents a commitment to patient safety—the most fundamental responsibility of health care—and also to the safety and support of clinical staff who do the demanding work of treating and supporting suicidal patients.

The elements of Zero Suicide include

1. A leadership commitment to safety, accountability, and transparency that includes creating a safety-oriented culture committed to dramatically reducing suicide among people under care and includes suicide attempt and suicide loss survivors in their leadership and planning;
2. A "planned care" approach, which includes systematically screening for risk, assessing risk levels, and providing access based on need;
3. Excellent access to the right care that is timely and effective, including same-day access if needed and continuing contact and support after acute care;
4. Emphasis on safety and limiting access to means of self harm for those at risk, including development of safety plans and reviewing them at every session for people at high risk;
5. Directly addressing and treating suicidality, rather than just treating mental illness and hoping suicidality abates;
6. Applying a data-driven evaluation and quality improvement approach to inform system changes that will lead to better care and improved patient outcomes.

Hogan briefly described the state of the art in screening, safety planning and means restriction, treatment of suicidality, and crisis lines. In each of these areas, tools and supports exist that have yet to be adopted by clinical settings or integrated into ongoing care. The Zero Suicide initiative has developed a website (www.zerosuicide.com) with this information and is working on version 2.0 with one-click access to tools and other enhancements. There is a learning community for health care organizations that want to embrace Zero Suicide. While some pioneering organizations have adopted this approach, there is a need to influence more top-level leaders of health care systems to embrace the Zero Suicide approach.

Presenter Contact Information:

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> Member, Executive Committee,
> National Action Alliance for Suicide Prevention
> E-mail: dr.m.hogan@gmail.com

Part II: Delivering Optimal Clinical Care: Focus on a Competent, Confident and Caring Behavioral Health Workforce

Dr. Cheryl King presented on two specific aspects of clinical care that are part of an overall systems approach: developing a competent, confident, and caring workforce and delivering effective treatments.

Having a trained workforce is critically important to address suicide in clinical settings. Surprisingly, however, most clinicians who provide health care and behavioral health care (e.g. psychiatrists, psychologists, social workers, counselors, marriage and family therapists, chemical dependency counselors, etc.) receive little or no training in assessing and managing suicide risk during their graduate or continuing education.
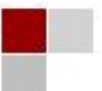
Required competencies include screening for possible suicide risk, assessing risk and protective factors, formulating risk to inform next steps, implementing best-practice interventions, and follow-up to provide continuity of care. King asserted that not only must health care providers be skilled to deliver optimal care (competent), they must also believe they can make a difference and be supported by leadership and teamwork (confident), and work with patients in a way that is calm, collaborative, and sensitive to the client's individual needs (caring).

The first National Strategy for Suicide Prevention (NSSP) released in 2001 set forth objectives to address deficiencies in training, but when the NSSP was revised in 2012, little progress had been made in the adoption of suicide-specific training requirements for clinicians. This gap, however, is not due to a lack of available training programs. In fact, since 2001, numerous education and training programs have been developed for health and behavioral health providers. King described several examples of trainings for clinicians that are listed on the Best Practices Registry for Suicide Prevention (http://www.sprc.org/bpr), which is funded by the Substance Abuse and Mental Health Services Administration to disseminate information about best practices that address specific objectives of the NSSP. King also briefly described the attributes of more effective treatments. Critical features include working collaboratively with the patient, targeting suicide risk directly (rather than solely treating the underlying mental health condition), and providing ongoing care and follow-up.

King suggested several options for promoting broader adoption of these training programs. For example, training could be required by accrediting organizations for graduate programs, state licensing boards, state and federal legislation governing receipt of public funding, accreditation and certification bodies for hospitals and emergency departments, or individual health and mental health systems and settings.

The presentation concluded with a brief description of technology and clinical care. The emerging area of technology-based options for providing care has promise to augment in-person interventions and expand access to care, although issues of privacy, quality control, and technology access must be addressed. King provided examples of care delivered via e-mail, smartphones, text messaging, and apps.

Presenter Contact Information:

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E-mail: kingca@umich.edu
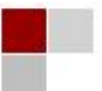
Discussion

Clinical Services: Possible Options for Railroad Company Involvement

During the discussion, the group generated the following opportunities that railroad companies might pursue to support or advance suicide prevention in this area:

- Leverage relationships with United Healthcare and United Behavioral Health to promote adoption of the Zero Suicide Approach for all plan members (not just railroad employees).
- Host workshops for each railroad company's benefits negotiation team to help them understand the problem of suicide and how a systems approach in health and mental health care settings can contribute to the solution.
- Create a Zero Suicide "sales package" for railroad companies to take to large medical facilities.
- Influence health and behavioral health systems to publically report the number of suicides that occur among their patients in order to increase accountability.
- Require healthcare systems and facilities to document that health and mental health care professionals have training in suicide risk recognition, assessment, and care.
- Train Employee Assistance Program (EAP) providers in suicide risk identification.
- Promote Zero Suicide through national EAP networks. One model to draw from might be that used by the BIG Initiative to promote SBIRT—Screening, Brief Intervention and Referral to Treatment (http://bigsbirteducation.webs.com/).
- Advocate for accreditation and certification bodies for hospitals and emergency departments to verity that staff have appropriate training.
- Support state and federal legislation requiring healthcare systems and facilities receiving state/federal funds to show evidence that mental health professionals have training in suicide risk recognition, assessment, and care.
- Support requirements that licensing bodies mandate suicide-specific continuing education for professional mental health licensure renewal.
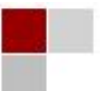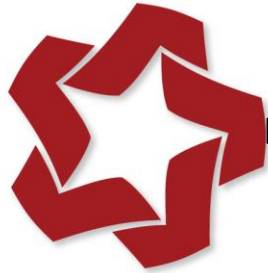
Ending Suicide in Healthcare Systems: The ZeroSuicide Movement

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention
January 21, 2014

Mike Hogan, Ph.D.
Co-Chair, ZeroSuicide Advisory Group
National Action Alliance for Suicide Prevention
dr.m.hogan@gmail.com

Suicide Among Patients In Our Health Care "System" Is A Problem

- Half of the people who die by suicide saw a GP in previous month…70% among older men (where we know the risks are higher)
- South Carolina: 10% of all suicide deaths were people seen in ED in previous month
- People receiving care in public mental health system:
  - Risk among people with depression and other mental health problems are 4-20x general population
  - Kentucky: 20% of all suicides in state among people who got any MH care (claims/deaths crosswalk)
  - NYS: 226 reported suicides in public MH system in 2012 (15% of estimated 1500 suicide deaths in NYS)
- But…solutions are emerging!

2

What Has Worked?
No Simple Solution, But Systematic Efforts

SYSTEMS APPROACHES

- U.S. Air Force
- Henry Ford Health System
- Magellan Maricopa Collaborative
- Veteran's Administration
- National Suicide Prevention Lifeline
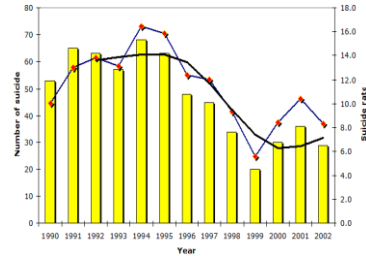
U.S. AIR FORCE

3

Henry Ford Health System

4

Suicide Deaths/100T   HMO Members
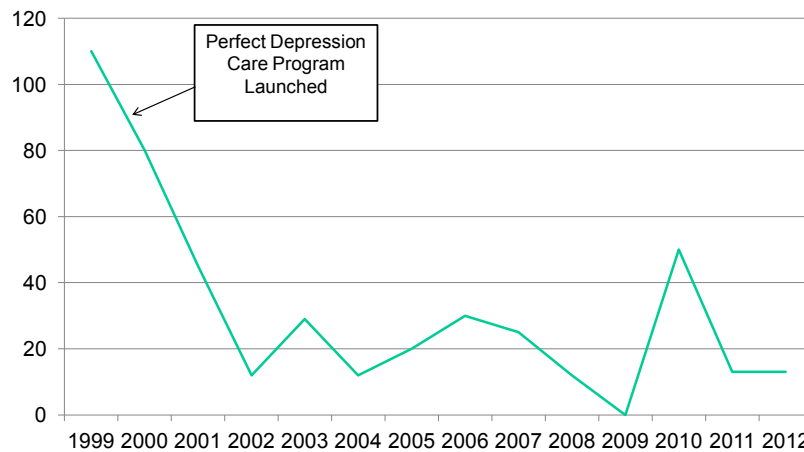
Perfect Depression Care Program Launched

4

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

Preventing Suicide Among People in Care:
No Single Solution is Sufficient

- James Reason's "Swiss Cheese Model" of accidents
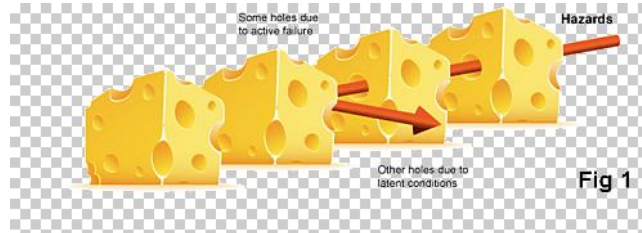
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Suicides Among People in Care:
Currently, An Unsafe Industry
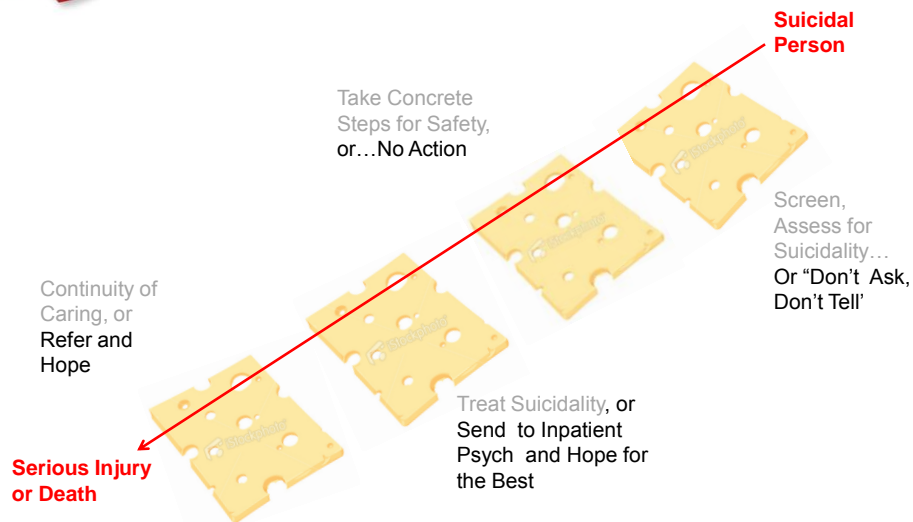
Suicidal Person

Take Concrete Steps for Safety, or…No Action

Screen, Assess for Suicidality… Or "Don't Ask, Don't Tell'

Continuity of Caring, or Refer and Hope

Treat Suicidality, or Send to Inpatient Psych and Hope for the Best

Serious Injury or Death

6

Systematic Suicide Care
Plugs the Holes in Healthcare

Suicidal Person

Collaborative **Safety Plan** Put in Place, Followed

Screen, Assess for Suicidality

Serious Injury or Death Avoided

7

Systematic Suicide Care
Plugs the Holes in Healthcare

Suicidal Person

Collaborative **Safety Plan** Put in Place

Screen, Assess for Suicidality

Treat Suicidality: **Suicide-Informed CBT, Groups/classes on Inpatient, DBT, CAMS**

Serious Injury or Death Avoided

8

Exploring the Role of the Railroad Industry in
Promoting Suicide Prevention
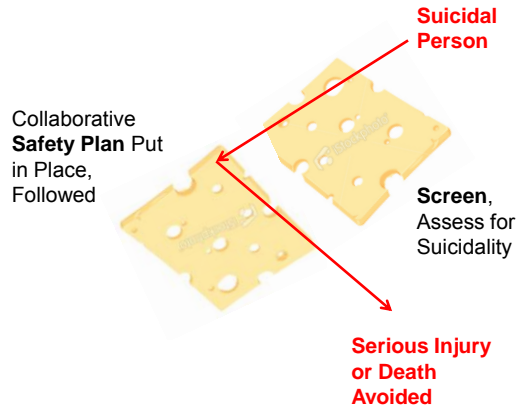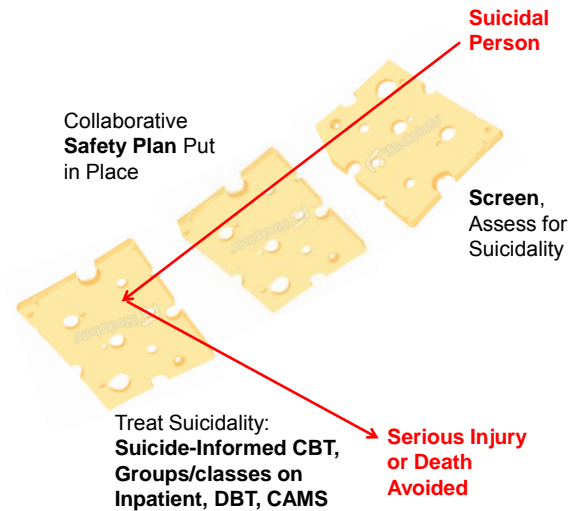
Systematic Suicide Care
Plugs the Holes in Healthcare

- Systematic Suicide Care

Suicidal Person

Serious Injury or Death Avoided

Collaborative **Safety Plan** Put in Place

Screen, Assess for Suicidality

Continuity of Caring: **Follow-up** Calls after ED, Inpatient

Treat Suicidality: **Suicide-Informed CBT, Groups/classes on Inpatient, DBT, CAMS**

9

Systematic Suicide Care:
The Elements of *ZeroSuicide*

- A leadership commitment to safety, accountability, transparency
- "Planned care" approach: Screening for risk, access based on need
- Excellent access to the right care:
  - Same-day access to care if needed
  - Drop-in group medication appointments
  - Email "visits" and follow-up after acute care (inpatient, ED)
- Emphasis on safety, restricting means of self harm for those at risk
  - Development of safety plans, review at every session for people at high risk
- Directly address and treat suicidality, rather than just treating mental illness and hoping suicidality goes away
- Evaluation and quality improvement

10
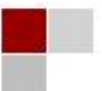
The Elements of **Zero Suicide:**
Where We Are, What We Need to Do NOW

- **SCREENING**
  - For general health settings: PHQ-9
  - For people at elevated risk: C-SSRS
  - Screens can be, not yet embedded in EMR's
- **SAFETY PLANNING, MEANS RESTRICTION**
  - There's an app…not yet a standard of care
  - Technology is developing, not used
- **TREATMENT OF SUICIDALITY**
  - Interventions are available. *Most clinicians don't know them*
- **CRISIS LINES:** 1-800-273-TALK, VETS LINE
  - Follow-up after crises: weak, inconsistent
- **WWW. ZEROSUICIDE.COM, IMPLEMENTATION SUPPORTS**
  - Website has good content, no pizazz
  - Learning Collaborative: helpful, not enough

- **WHERE DO WE GO FROM HERE?**
  - From rugged pioneers to an implementation highway!
    - Zerosuicide 2.0: one-click access to tools
    - Key technology *embedded* in clinical workflow, EMR's
      - Screeners
      - Safety Plans
      - Apps for connectedness, follow-up
    - Implementation by *systems*
      - Health Plans
      - Health, Behavioral Health Centers
      - Integrated Systems
    - Reliable and consistent measurement

11

What Goal Should We Aspire To?
Advice From a Safety Champion

"There are those who say that the human body is much more complicated than our airplanes. There are those that counsel patience and say that these patient safety issues are complicated and they simply take time to fix. But I take a different approach.

I wish we were less patient. Every day, when each of us goes to work…we are choosing individually and collectively how many lives are going to be lost… And the harm is so great, the numbers are so huge, that I don't think we should wait 20 more years until there are 4 million more preventable medical deaths.

We should change the way we do business now. It's not going to be easy, but it is possible."

Chesley "Sully" Sullenberger Healthcare Financial Management, 2013

12
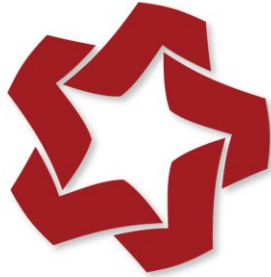
Delivering Optimal Clinical Care:

Focus on a Competent, Confident and Caring Behavioral Health Workforce

Cheryl A. King, Ph.D.
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Developing a <u>Competent</u>, <u>Confident</u>, and <u>Caring</u> Clinical Workforce

- **Competencies**
  - **Screen for possible suicide risk**
    - Knowledge of screening strategies
    - Interviewing skills and screening tools
  - **Assess risk and protective factors**
    - Knowledge of risk and protective factors
    - Interviewing skills and assessment tools
  - **Formulate risk to inform next steps - interventions**
  - **Implement best-practice interventions**
  - **Follow-up – Facilitate continuity of care**

2

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

Defining a Competent, Confident, and Caring Workforce

- **Confident – Comfortable**
  - **Belief that Suicide is Preventable**
  - **Support of Agency Leadership – Organizational Priority**
  - **Competence – Knowledge, Skills, Systematic Strategies**
  - **Teamwork and Available Consultation**
- **Caring**
  - **Direct and Person-Centered – Collaborative**
  - **Sensitive to Individual's Needs and Values**
  - **Calm and Responsive rather than Reactive**

3

Status of Professional Workforce of Behavioral Health Providers

- **National Strategy for Suicide Prevention (NSSP; 2001) put forth objectives to address deficiencies in training;**
- **NSSP Progress Review (2010) summarized current standards for training and progress toward goals;**
  - Among 11 mental health professional groups, one had increased attention to suicide-specific training between 2001 and 2009 (Council for Accreditation of Counseling and Related Educational Programs; SPRC & SPAN, 2010).
  - Few professional training programs voluntarily added suicide-specific training.
  - Some professional organizations began providing members with continuing education programs/materials about suicide prevention.

4

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

Best Practices Registry for Suicide Prevention Program and Strategies

- **Identifies, reviews, and disseminates information about best practices**

- **Funded by SAMHSA**

5

Training for Behavioral Health Providers
Examples of Well-Established Programs

Training Program Name		Program Highlights
AMSR- Assessing & Managing Suicide Risk (Suicide Prevention Resource Center) www.sprc.org/training-institute/amsr	1 day	• Basic Core Competencies • Collaborative and systematic
RRSR- Recognizing & Responding to Suicide Risk (American Association of Suicidology) www.suicidology.org/training-accreditation/recognizing-responding-suicide-risk	2 days	• Core Competencies • Collaborative and systematic • Advanced and interactive

CALM- Counseling on Access to Lethal Means
(Suicide Prevention Resource Center)
www.sprc.org/training-institute/calm
	2 hrs	• Teaches practical skills:
		  - how to ask suicidal clients about access to lethal means
		  - how to work with clients and families to reduce access.

6

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

Training for Behavioral Health Providers
Examples of Well-Established Programs

Training Program Name		Program Highlights
CASE- Chronological Assessment of Suicide Events www.sprc.org/bpr/section-III/experiential-training-chronological-assessment-suicide-events-case-approach	6.5 hrs	• Experiential workshop using Scripted Group Role-Playing • Practice a specific interviewing strategy to uncover suicidal ideation, behaviors, planning, and intent

QPRT- Question, Persuade, Refer or Treat (QPR Institute) http://www.sprc.org/bpr/section-III/qprt-suicide-risk-assessment-and-management-training	7-12 hrs	• Specific course for clinicians
		• Lectures & practice
		  - standardized suicide risk assessment interviews
		  - crisis/safety/treatment plans

7

Treatment and Care Management

- **Immediate Response – Address Safety First**
  - Consider acuity - is hospitalization indicated?
  - Remove accessible lethal means
  - Develop a Safety Plan

- **Acute**
  - Provide external support while building resources
  - Address suicide risk directly – problem-solving and crisis resolution
  - Facilitate acute symptom relief
  - Educate/strengthen support system

8

Exploring the Role of the Railroad Industry in
Promoting Suicide Prevention
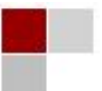
Treatment and Care Management

- **Evidence-Based Psychotherapy/Treatment**
  - Focus on targeting suicide risk DIRECTLY
  - Emphasize COLLABORATION with individual
  - Examples include:
    - Cognitive-Behavioral Therapy – Suicide Prevention (CBT)
    - Dialectical Behavior Therapy (DBT)
    - Collaborative Assessment and Management of Suicidality (CAMS)

- **Continuing Treatment and Care Management**
  - Ongoing Assessment and Follow-Up
  - Evidence-based interventions for modifiable risk and protective factors

9

Recommendations for Improved Training in Suicide Risk Assessment and Care

1. Accrediting organizations include suicide-specific education and skill acquisition as part of requirements for graduate program accreditation;
2. State licensing boards require suicide-specific continuing education as requirement for renewal of mental health professionals' licenses;
3. State and federal legislation require healthcare systems and facilities receiving state/federal funds to show evidence that MH professionals have training in suicide risk recognition, assessment, and care;
4. Accreditation and certification bodies for hospitals and emergency departments verity that staff have appropriate training;
5. Individuals without appropriate graduate or professional training and supervised experience should not be entrusted with the assessment and management of suicidal patients.

Adapted from: Schmitz, W. M., Allen, M. H., Feldman, B. N., et al. (2012). Preventing Suicide through Improved Training in Suicide Risk Assessment and Care: An American Association of Suicidology Task Force Unabridged Report Addressing Serious Gaps in U.S. Mental Health Training. Retrieved December 10, 2013 from: http://www.suicidology.org/resources/multimedia-resources/books-publications/aas-white-papers

10

Exploring the Role of the Railroad Industry in
Promoting Suicide Prevention

Technology and Clinical Care

- Technology can augment recommended interventions, assessment, and case management strategies
- Benefits
  - Access information anytime
  - Larger geographical reach bringing care to underserved and remote communities
  - Increased privacy and anonymity
  - Ideal for mobile populations (military and university students)
- Limitations
  - Some have limited access to internet and other technologies
  - Concerns about privacy
  - Unregulated quality of resources

Luxton, D. D., June, J. D., & Kinn, J. T. (2011). Technology-based suicide prevention: Current applications and future directions. *Telemedicine and e-Health, 17*(1), 50-54.

11

Technology and Clinical Care

- e-Mail - Messaging
  - College students : online suicide risk screening plus brief counseling enhances actual treatment linkage
    (Haas et al, 2008; King et al., 2013)
    - Privacy at beginning stage of assessment & help-seeking
    - May facilitate readiness for professional treatment
  - Inpatient psychiatric patients: periodically sending personalized correspondence via mail reduced suicides (Motto & Bostrom, 2001)

Luxton, D. D., June, J. D., & Kinn, J. T. (2011). Technology-based suicide prevention: Current applications and future directions. *Telemedicine and e-Health, 17*(1), 50-54.

12

Telephone-Based Suicide Prevention

- Smartphones
  - Can provide immediate contact with support systems and providers
- Text messaging
  - Easy to communicate, 50% of adolescents send > 50 text messages a day
  - Mississippi Department of Health implemented text messaging helpline
- Applications (apps) – many free to the public
  - Include hotline links, treatment tools (e.g., relaxation techniques, record therapy homework), and appointment reminders
  - Virtual versions for "Survivor Kit" or "Hope Box"

Luxton, D. D., June, J. D., & Kinn, J. T. (2011). Technology-based suicide prevention: Current applications and future directions. *Telemedicine and e-Health, 17*(1), 50-54.

13

Delivering Optimal Clinical Care

- **Taking Steps to Achieve this Goal**
  - Systematic, Science-Informed and Effective Clinical Care Strategies
  - A Competent, Confident and Caring Behavioral Health Workforce

14

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention
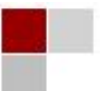
SESSION 3: HOTLINES AND OTHER CRISIS SUPPORTS

Dr. John Draper introduced the third session with a ten-minute overview of suicide hotlines and other crisis supports. Draper explained the essential role crisis hotlines play in the national suicide prevention infrastructure, describing them as the "ground troops and community hubs" of suicide prevention. There are approximately 600 crisis centers in the United States which vary in size, operations, staffing, and funding. Crisis lines embrace the ideal of person-centered healthcare by providing services when and how the client wants them. Access to services is free, and these centers have the ability to link callers with local services.

The Substance Abuse and Mental Health Services Administration (SAMHSA) funds the National Suicide Prevention Lifeline (NSPL) network which links 163 of these crisis centers together under one national phone number, 1-800-273-TALK (8255). Calls are routed to the crisis center closest to the caller. The system provides nationwide coverage through extensive back-up systems that ensure calls are answered quickly by a well-trained crisis worker from a center within the network. A related service is the Veterans Crisis Line (VCL), a national hotline for Veterans, funded by the Department of Veterans Affairs. Callers to the 800 number can press 1 to be connected to a dedicated call center with specially trained counselors at the VA.

Crisis centers that form the national Lifeline network agree to meet accreditation standards and provide suicide prevention services according to nationally-recognized best practices. These centers answer many other types of calls in addition to Lifeline calls. They also conduct community outreach and education and collaborate with other local service providers. Some have added chat and text services, and many systematically reach out to persons at high risk of suicide after the initial contact to provide ongoing support. Both the NSPL and VCL have a large online presence on social media sites. Given the lack of consistent suicide-specific training in "traditional" clinical settings (see previous session), calling the Lifeline often provides the best chance a person in suicide crisis will receive competent crisis care.

It is important to note that the crisis centers comprising the NSPL network are locally funded and staffed. Many rely heavily on trained volunteers, and centers have been forced to close in the past because they lack resources. Draper showed data on annual Lifeline calls since 2005, and the volume has climbed steeply each year, indicating the need for this service. Promotion of the Lifeline number could be more extensive but greater publicity must be balanced against the limits of the system. Previous outreach campaigns have been effective in increasing the number of callers; however, the Lifeline network currently is functioning at or near capacity and would require more operational support before the launch of any major marketing efforts. Resources are also needed to fund existing services, for example, to support online chat and texting services and expand their delivery to more centers and additional hours. Also, there is a need to bring more centers into the network and ensure existing centers are adequately resourced and offer a full range of life-saving services.

Research shows that the Lifeline works. Evaluation studies have found that the Lifeline reaches those most in need of services (i.e., suicidal persons and people not in treatment), reduces emotional distress in callers, and reduces suicidal thinking. Follow-up calls after the initial contact also have been shown to prevent suicide. One study found that 80% of individuals who consented to follow-up calls reported the calls had suicide prevention

effects and over half indicated the calls had stopped them from killing themselves. These services are also cost-effective. A study estimated the return on investment for crisis center follow-up calls after hospital discharge to be $1.76 for commercial insurance and $2.43 for Medicaid.

Presenter Contact Information:

> John Draper, Ph.D.
> Project Director, National Suicide Prevention Lifeline
> President, Link2Health Solutions, Inc.
> E-mail: JohnD@mhaofnyc.org

Discussion

Hotlines and Other Crisis Supports: Possible Options for Railroad Company Involvement

During the discussion, the group generated the following opportunities that railroad companies might pursue to support or advance suicide prevention in this area:

- Direct philanthropic efforts and leverage other means of support to help fund local crisis centers. This assistance could be directed towards
    - Providing support for crisis centers that are already part of the NSPL network to help them stay operational in the network.
    - Sponsoring non-affiliated crisis centers to become accredited and join the NSPL network.
    - Enabling centers to provide services beyond the telephone hotline (e.g. implementing or expanding online chat and texting services; funding local crisis centers to provide follow-up calls to persons at risk).
- Disseminate information and materials promoting the NSPL/VCL phone number, 1-800-273-TALK (8255).
- Incentivize railroad employees to volunteer at local crisis centers (e.g., by undergoing training to staff the phone or assisting with other efforts such as fundraising or other organizational needs).
- Become ambassadors for the crisis centers to other business leaders and philanthropic organizations.
- Partner with local crisis centers to provide postvention support in the workplace for railroad employees affected by suicide.
- Leverage crisis center capacity to provide suicide prevention training and community education, for example, by sponsoring trainings in hospitals, schools, and workplaces.
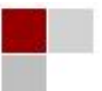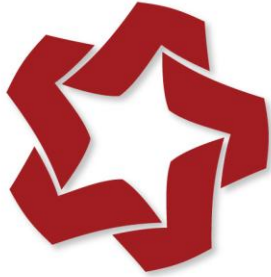
Hotlines and Other Crisis Supports

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention
January 21, 2014

John Draper, Ph.D.
Lifeline Project Director
jdraper@mhaofnyc.org

NSSP Promotes Crisis Center Roles

- Access to care (including online approaches, chat & text)
- Collaborations between care systems to promote safety
- Continuity of care/follow-up (EDs, inpatient, etc.)
- Online/social media outreach, education to promote public health and safety

2

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

The Ideal of "Person-Centered" HealthCare

Overarching aim for an ideal practice that its patients would say of it:

"They give me exactly the help I need and want exactly **when and how** I need and want it."

Dr. Don Berwick
12/2011

3

Crisis Hotlines, or "Contact Centers"

- Over 1200 crisis centers in 61 countries; approx. 600 in USA
- Size, funding, staffing and operations vary
- All: nonjudgmental listening; confidential; assessment; referral
- Many venturing into chat/texting/e-mail help

COMMUNITY HUBS FOR SUICIDE PREVENTION

- **Community Involvement**: Use of volunteers
- **Community-wide Access**: Free access to all, no stigma, no care barriers if have phone
- **Community of providers**: Refer to other services
- **Community outreach**: public education, training, mental health "anti-stigma" promotions

4

With help comes hope

NATIONAL

SUICIDE PREVENTION

LIFELINE™

1-800-273-TALK

www.suicidepreventionlifeline.org

5

About the Lifeline

- Mission: Effectively reach and serve all persons in the United States who are at risk of suicide through a national **network** of **crisis centers**.

- SAMHSA funds the network

- Administered by **Link2Health Solutions**, an independent subsidiary of the Mental Health Association of NYC

  - Partners: NASMHPD, Columbia University and the Department of Veterans Affairs

- Comprised of **163 crisis centers** (and counting) in 50 states

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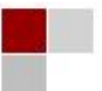
How the Lifeline Works

- Callers dial **800-273-TALK** or **800-SUICIDE**
- Callers are routed to closest center
- Crisis workers listen, assess, and link/refer callers to services, as needed
- Extensive back-up system ensures all calls are answered

Veterans Crisis Line
1-800-273-8255
PRESS ❶

- National suicide hotline for Vets
- Collaborative effort: VA, SAMHSA & L2HS
- Calls routed through 800-273-TALK (press 1 for vets & active military service)
- 24-7 access to trained counselors at VA
  - Lifeline Centers provide back-up call service
- Conduit to VA system of care

7

Lifeline Crisis Centers

FIND YOUR LOCAL LIFELINE CRISIS CENTER:
http://www.suicidepreventionlifeline.org/getinvolved/locator.aspx

8

Exploring the Role of the Railroad Industry in
Promoting Suicide Prevention

Lifeline Call Volume, 2005 – 2013*
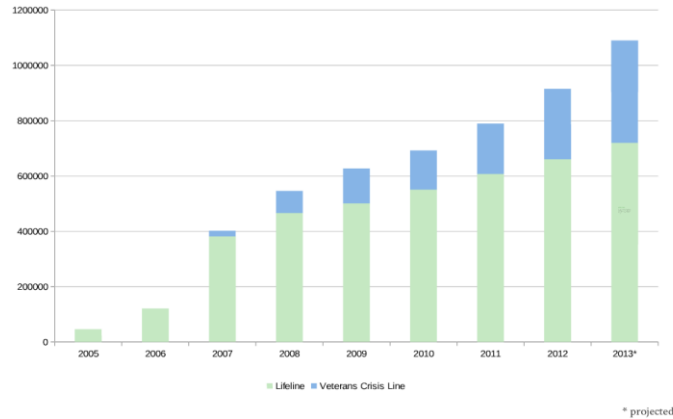
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Network Survey: Ratio of Lifeline Calls to Other Center Calls
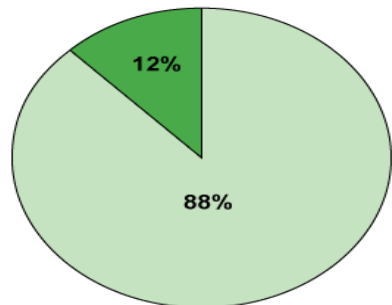
Hotline Call Types
From Crisis Center Network Survey (CY2011)
Sample Size: 103 centers

Lifeline Calls
(1-800-SUICIDE or
1-800-273-TALK)

All Other Hotline Calls

10

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Lifeline Evaluation Findings: Hotlines Work!

Research shows that Lifeline…
- **Reaches suicidal persons**
- **Reaches people not in treatment**
- **Reduces emotional distress in callers**
- **Reduces suicidal thinking**

11

Lifeline ONLINE

- Partnerships with Facebook, Google
- Work with safety teams of Facebook, Youtube, Tumblr, etc.
- Over 70,000 Facebook fans, > 20,000 Twitter followers, etc
- Over 100,000 unique web visitors **suicidepreventionlifeline.org**

- Over 1/3 centers provide **cha**t or online help
- Several providing help via **text**

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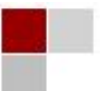
Follow-up: Continuity of Care for Persons at Suicide Risk

- **Many Crisis Centers conduct follow-up calls for persons at high risk**
- **These calls have been shown to prevent suicide**

13

Crisis Center Follow-Up Calls: Reduce Suicidality & Are Cost-Effective

Reductions in suicidality (Gould & Lake, 2011)
- Of 625 suicidal callers consenting to follow-up,
  - 80% reported the calls had suicide prevention effects
  - 53.4% reported the calls stopped them from killing themselves

Cost-Effectiveness (Truven Health Analytics Study)
For every $1 invested, estimated ROI:

	ROI for Commercial Insurance	ROI for Medicaid
Hospital D/C Follow-Up	$1.76	$2.43
ED D/C Follow-Up	$1.70	$2.05

14

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Q & A

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15

**Exploring the Role of the Railroad Industry in
Promoting Suicide Prevention**

SESSION 4: REDUCING ACCESS TO LETHAL MEANS

To begin Session 4, Ms. Catherine Barber provided a ten-minute introduction to the suicide prevention strategy known as "reducing access to lethal means." Traditionally, suicide prevention has focused on *who* takes their life, along with *when*, *where*, and especially *why*. Barber started her presentation, entitled *Means Matter*, by challenging attendees to focus on *how* people attempt suicide. The method used in the attempt—the how—plays a crucial role in whether someone lives or dies. To support her assertion, Barber gave examples of three locations around the world, each with a different leading method of suicide (pesticides in Sri Lanka, domestic gas in the United Kingdom, and military firearms in Israel). In each country, significant declines in suicide deaths were realized by reducing availability of the most commonly used means.

Barber then described why reducing access to means is an effective strategy. First, while people may entertain thoughts of killing themselves over protracted periods, research suggests that suicidal crises—meaning the acute period during which a person is ready to actually attempt—are often relatively brief. Thus, many suicide attempts are undertaken quickly, with little planning. Second, some methods are more deadly than others when used in an attempt. Third, 90 percent who survive an attempt do *not* go on to die by suicide. Taken together, these findings suggest that lives can be saved by minimizing the likelihood that individuals will have access to a highly lethal method at the moment when faced with an acute suicidal crisis.

This strategy will be most effective when focused on commonly used methods that are more deadly. In the United States, firearms are a logical focus because they are both the leading method of suicide and are highly lethal. Data show that gun owners and their families are three times more likely to die from suicide than non-gun owners simply because they're more likely to use a gun in the attempt. "Reducing access" is not a euphemism for gun control. Communities have successfully undertaken an array of actions unrelated to gun control to limit suicidal individuals' access to firearms during a crisis period.

A simple way to increase a suicidal person's safety is to work with them to reduce access to firearms at home until the situation improves. Examples might include having a trusted person outside the home hold onto the guns, storing firearms at a facility (e.g. gun club, police department, gun shop, pawn shop, storage facility), keeping guns and ammunition locked separately, or removing a key component, such as the firing pin. Many times counselors, health care providers, and family members of an at-risk person do not think to take these measures.

These efforts can build upon the safety culture of gun owners, including the Ten Commandments of Firearms Safety. The New Hampshire Gun Project is one example of a means reduction program undertaken by gun shop owners to educate their customers about the "11th Commandment" of responsible firearms safety: "Be alert to signs of suicide or crisis among your loved ones; if at risk of hurting themselves or others, keep firearms from them until the situation has resolved." At present, 48 percent of gun shops in New Hampshire distribute materials about suicide, gun safety, and the 11th Commandment. Project materials are online at www.nhfsc.org.

Barber then described examples of other interventions undertaken to reduce access to lethal means. These efforts target an array of methods (i.e., pills, carbon monoxide, firearms, all possible means) and involve action by various sectors, including employers and health insurance purchasers, communities, clinical settings, and engineers. For example, lethal means counseling could be adopted by EAPs and in clinical settings, at-risk patients could be exempted from mandatory 90-day refill medication policies, and the 11th commandment could be incorporated into firearm safety classes. Barber invited participants to visit the Means Matter website (www.meansmatter.org) for more information about these and other means reduction efforts.

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Discussion
Reducing Access to Lethal Means: Possible Options for Railroad Company Involvement

During the discussion, the group generated the following opportunities that railroad companies might pursue to support or advance suicide prevention in this area:

- Encourage health and mental health care providers to take the Counseling on Access to Lethal Means (CALM) course (available online for free at http://training.sprc.org/).
- Leverage leadership in the EAP community to encourage the adoption of lethal means policies in EAPs, infuse means reduction into EAP services, and encourage EAP providers and other individuals such as peer visitors to take the CALM course.
- Encourage health care systems to require providers to complete a safety plan with each suicidal patient that includes means reduction.
- Reach out to key groups and opinion leaders in the gun owner community, such as gun shop owners, gun rights organizations, and veterans service organizations, and educate them about efforts like the New Hampshire Gun Project.
- Disseminate messages about the 11th commandment during or after other safety campaigns, such as Union Pacific's annual outreach to hunters warning them to stay away from railroad rights-of-way.
- Reach opinion leaders who can encourage firearm safety and/or concealed carry classes to include a suicide awareness module.
- Participate in gunlock, gun safe, or electronic pill-dispensing lockbox giveaways.
- Encourage insurance providers to change prescribing practices so suicidal patients are not prescribed large amounts of lethal medications.
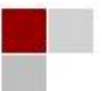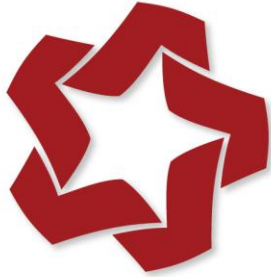
Means Matter

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention
January 21, 2014

Catherine Barber, MPA
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Harvard Injury Control Research Center
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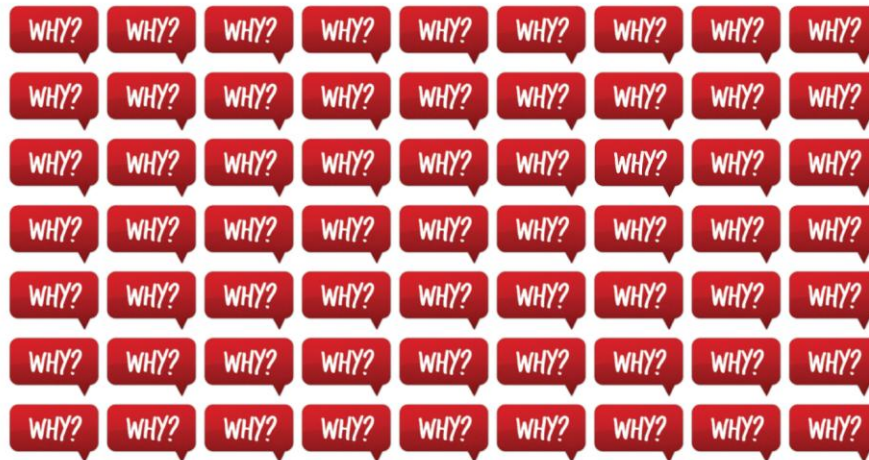
Traditionally suicide prevention has focused on who takes their life, when, where, and especially <u>why</u>.

2

We are beginning to understand that _how_ people attempt suicide plays a crucial role in whether they live or die.

3

Sri Lanka & Pesticides

- Pesticides are the leading suicide method in Sri Lanka.
- Restrictions were placed on sales of the most highly human-toxic pesticides in the mid to late 1990s.
- Suicide rates dropped 50% from 1996 to 2005.
- Nonfatal pesticide attempts, and suicide by other methods, did not drop.

Gunnell 2007. Int'l J of Epidemiology.

4

United Kingdom & Domestic Gas

- Before 1960, domestic gas was the leading method of suicide in the United Kingdom.
- By 1970, almost all domestic gas in the UK was non-toxic.
- Suicide rates dropped by nearly a third.
- The drop was driven by a drop in gas suicides; non-gas suicides increased slightly.

Kreitman 1976, Brit J Prev Soc Med.

5

Israeli Military & Firearms

- In the early 2000s, Israeli Defense Force focused on preventing suicides—most were by firearm, with many occurring on weekends while soldiers were on leave.
- In 2006, IDF required soldiers to leave their weapons on base during weekend leaves.
- The suicide rate decreased by 40%.
- Weekend suicides dropped significantly.
- Weekday suicides did not.

Lubin 2010, Suic & Life-Threat Behavior.

6

Why Does it Work??!!

7
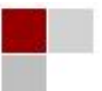
Why Means Matter

1. Suicidal crises—the acute period during which a person is ready to actually attempt—are often relatively brief.

Among people who nearly died in a suicide attempt, 24% said less than FIVE MINUTES elapsed between deciding on suicide and making the attempt.

Another 47% said under an hour.

Only 13% said one day or more.

8

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

Why Means Matter

1. Suicidal crises are often relatively brief. Suicide attempts are often undertaken quickly and with little planning.
2. Some suicide methods are far more deadly than others.

85-90% fatal

1-2% fatal

98% nonfatal, treated in hospital ER

10-15% nonfatal, treated in hospital ER

Firearms

Cutting or Poisoning

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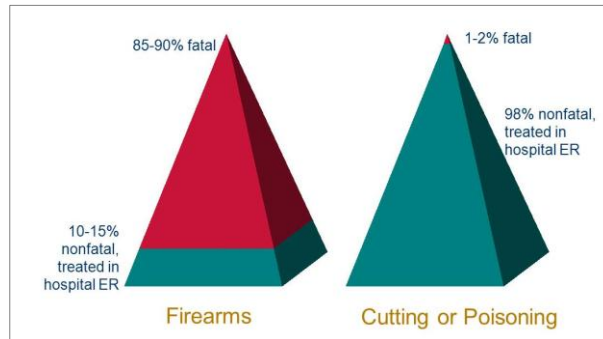
Why Means Matter

1. Suicidal crises are often relatively brief. Suicide attempts are often undertaken quickly and with little planning.

2. Some suicide methods are far more deadly than others.

3. 90% of those who survive even nearly lethal attempts do not go on to later die by suicide.

10

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Why Focus on Firearms

- Firearms are the leading suicide method in the U.S.

- Gun owners and their families are at about 3 times higher risk of suicide than non-gun owners.

- This isn't because they're more suicidal. Gun owners are NOT more likely to be mentally ill, to think about suicide, or to attempt suicide.

- Rather, they're simply more likely to die in a suicide attempt because they're more likely to use a gun.

11

Reducing a Suicidal Person's Access

- A simple step to increase a suicidal person's safety is to work with them to reduce their access to firearms at home.

- Many counselors, providers, and family members of at-risk people don't currently do this.

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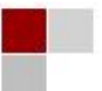
Making a Difference

- Friends and family can help protect a suicidal person by temporarily storing any household firearms away from home.
    - Have a trusted person outside the home hold onto the guns until the situation improves.
    - Or store the guns at a facility—e.g., gun club, police department, gun shop, pawn shop, storage facility.
- Second best option: secure, in-home locking with ammunition out of home or locked separately.
- Or remove a key component of the guns such as the firing pin.

13

11th Commandment

- Spread the "11th Commandment" of responsible firearm ownership:

    - *Be alert to signs of suicide or crisis among your loved ones; if at risk of hurting themselves or others, keep firearms from them until the situation has resolved.*

14

NH Gun Shop Project

15

Examples of Interventions

Sector	Intervention
Employers/Health Insurance Purchasers	• Encourage lethal means counseling (LMC) policies among behavioral health care and medical providers • Institute LMC policies among EAPs • Exempt at-risk patients from mandatory 90-day refill policies
Community	• Firearm safety instructors begin including suicide awareness module in their classes • Firearm advocacy groups, gun shops, hunting groups begin promoting 11th commandment in basic firearm safety brochures, websites, etc. • Gunlock/gun safe giveaways (e.g., NSSF for vets)
Clinical	• Train providers on LMC (and go beyond traditional providers to divorce/defense attorneys, probation/parole, first responders, etc.) • Limit prescription quantity if overdose risk
Engineering	• Carbon monoxide-sensing engine shut-offs in autos • Biometric gun locks • Electronic daily pill-dispensing lockbox

16

Exploring the Role of the Railroad Industry in
Promoting Suicide Prevention

For More Information

- Means Matter website: www.meansmatter.org

- Take CALM-Online—free, online course on Counseling on Access to Lethal Means http://training.sprc.org/

- Download gunshop materials: www.nhfsc.org

- Request technical assistance from Means Matter: cbarber@hsph.harvard.edu

- Request an in-person CALM training: elaine.m.frank@dartmouth.edu

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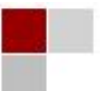
SESSION 5: MULTICOMPONENT INITIATIVES: COMMUNITIES AND WORKPLACES

Session 5 began with two ten-minute presentations focusing on suicide prevention in different settings. Dr. Peter Wyman first presented on community-based prevention programs, which take place outside of treatment settings. Dr. Sally Spencer-Thomas then discussed comprehensive workplace-based suicide prevention efforts. These two presentations were combined into one session because initiatives in these settings typically involve multiple program components and there is some overlap in the types of programs adopted.

Part I: Community-Based Programs

Dr. Peter Wyman discussed the rationale for community-based suicide prevention programs and provided examples. *Prevention programs* are designed to prevent suicidal behavior from occurring, and can be designed to reach everyone, groups at high risk, or those showing early symptoms. Also part of community-based prevention are programs for suicidal individuals aimed at *increasing use of treatment services*.

Two types of programs designed to increase service use among suicidal individuals are screening and gatekeeper training. Screening programs involve administering instruments to proactively assess for suicidality (e.g., in schools or primary care settings) and referring individuals who screen positively for further evaluation and treatment. Gatekeeper training programs teach laypeople to identify warning signs of suicide and encourage help-seeking. While some positive results have been found, Wyman said that these programs are unlikely on their own to reduce suicide rates significantly. These efforts do increase community engagement and have the potential to save some lives, especially when combined with other program components.

Interventions that are implemented for whole populations and target the risk and protective factors that lead to suicide are known as "upstream" prevention programs. These efforts are likely to prevent suicide in addition to impacting other related issues, for example, drug abuse, aggression, positive social relationships, and coping behaviors. In contrast, high risk approaches such as screening aim to have a large effect on the relatively small number of individuals at the most extreme end of the risk continuum. While these efforts are important, they may not have a very large impact on overall rates. Having a small effect on a large population can result in bigger impacts overall. The aim of upstream approaches is to shift the entire population toward a lower risk status. Both high-risk and upstream programs are needed for a comprehensive approach.

Upstream prevention programs can occur across the lifespan. One example of an evidence-based upstream prevention program is the Good Behavior Game (GBG), a school-based intervention for first and second graders that teach positive classroom behaviors through peer group reinforcement. The GBG demonstrated a 50% reduction in self-reported suicide attempts by age 19-21 in addition to reduced substance use and antisocial behavior.
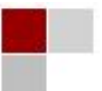
Wyman also described Sources of Strength, a school wide program developed in North Dakota and being disseminated internationally, that includes training student opinion leaders as agents of culture change to encourage other youth to identify how to get through difficult times, enhance connectedness, and change community norms around help-seeking. A study of this program in forty high schools is underway, and it also is being used in middle schools, colleges, and in Alaskan villages and Native American communities. Another example is the United States Air Force Suicide Prevention Program (AFSPP). This program included a spectrum of 11 initiatives aimed at strengthening social support, promoting development of social skills, and changing policies and norms to encourage effective help-seeking behaviors. The AFSPP demonstrated a 33% reduction in suicide deaths and impressive reductions in other violence related outcomes as well.

As discussed earlier, white males over age 65 have the highest suicide rates in the U.S. Some evidence-based programs for reducing suicide risk factors have been identified for this age group. For example, Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) is an outpatient collaborative care model for depression management demonstrated to reduce depression symptoms and improve quality of life and functioning. While this program is focused on treatment and therefore not strictly "upstream," the goal is to reduce depression severity which is a risk factor for suicide. Unfortunately, no studies to date have assessed the effect of IMPACT on suicidal behavior.

This is a common problem. Many programs target risk and protective factors for suicide in various age groups and settings but are not conceptualized as "suicide prevention" programs, and therefore suicidality is not measured as an outcome. This is a major limitation of the existing research. Suicide prevention researchers have begun to encourage scholars in areas such as substance abuse, violence prevention, and other related areas to measure suicidal behavior even when it is not the primary goal of the program.

Other evidence-based programs can be found in Section I of the SPRC/AFSP Best Practices Registry (www.sprc.org/bpr) and in SAMHSA's National Registry of Evidence-Based Programs and Practices (www.nrepp.samhsa.gov).

Presenter Contact Information:

>
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Part II: Workplace Suicide Prevention

Dr. Sally Spencer-Thomas began her presentation by describing how suicide intersects with the workplace. In the United States the working age population comprises about 70% of all suicides. Spencer-Thomas noted that workplaces can be affected by suicide in several ways including the suicide attempt or death of an employee or that of an employee's family member. Employee attempts and deaths can occur either on- or off-site.
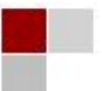
One study estimated that, in a U.S. corporation employing 100,000 people, one employee or family member is lost to suicide every seven days. In another study, surviving partners/spouses estimated that the death of their loved one intimately and directly affected 20 co-workers on average.

Workplaces are natural settings for suicide prevention programs. Among other reasons, they are places of belonging and have existing wellness programs and other built-in methods to disseminate training, information, and referrals for mental health services and other supports.

To assist companies in developing suicide prevention programs that are tailored to their unique contexts and needs, the Workplace Task Force of the National Action Alliance for Suicide Prevention has released the beta version of its Comprehensive Blueprint for Workplace Suicide Prevention, available at http://actionallianceforsuicideprevention.org/task-force/workplace/cspp. The blueprint outlines several possible components, including Screening, Mental Health Services and Resources, Suicide Prevention Training, Life Skills and Social Network Promotion, Crisis Management, Policy & Means Restriction, Education and Advocacy, Social Marketing, and Leadership. The site offers a checklist called "How Mentally Healthy is Your Workplace?" that employers can use to assess their organization's strengths and weaknesses and identify current gaps in a comprehensive approach to suicide prevention and mental health promotion. Organizational leaders can greatly facilitate the adoption of workplace suicide prevention efforts by being vocal in their support for these efforts and providing support for self-assessment, planning, and implementation of workplace initiatives.

Spencer-Thomas then shared several examples of workplace initiatives, including those undertaken by first responder groups, the construction industry in Australia, Walgreens, and the U.S. Department of Energy, among others.

Presenter Contact Information:

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> CEO and Co-Founder
> Carson J Spencer Foundation
> E-mail: Sally@CarsonJSpencer.org
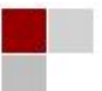
# Discussion

Multicomponent Initiatives⎯Communities and Workplaces: Possible Options for Railroad Company Involvement

During the discussion, the group generated the following opportunities that railroad companies might pursue to support or advance suicide prevention in these two areas:

- Educate the workforce and their families on suicide warning signs and ways to get help, similar to previous efforts addressing fatigue and alertness.
- Ensure educational materials are tailored to the various segments of the railroad workplace (e.g. Native Americans, Spanish-speaking individuals, males who reside in the western U.S.). For example, the NFL found that for their audience it was helpful to frame the issue of suicide prevention around action-oriented messages and "readiness to help others" instead of "getting help for oneself."
- Incorporate suicide prevention content into Union Pacific's Courage to Care program or similar efforts that urge employees to intervene when they see something unsafe.
- Promote the broader cultural value of encouraging and supporting employees to address problems early and take advantage of available supports (similar to the cultural change promoted by the Air Force program: "If you have any sort of problem⎯financial, legal, mental, marital⎯take steps to deal with it and we'll support you.")
- Incorporate suicide prevention into EAP employee meetings.
- Enhance peer support programs such as Operation Redblock for alcohol and drug prevention and psychological first aid with content on (1) suicide prevention; and (2) how to support individuals who have witnessed or are bereaved by suicide.
- Better promote existing programs focused on wellness and personal resiliency, perhaps through developing ambassadors.
- Arrange for a workshop or training at the annual wellness leadership conference in May.
- Engage occupational nurses in identifying individuals at risk for suicide, since they have high credibility with the workforce.
- Designate community-based suicide prevention efforts as a philanthropic priority.
- Support suicide prevention programs for local communities or populations with an elevated risk for suicidality (e.g., Native American communities, programs for young Latinas.)
- Encourage state and community partnerships to undertake community-based suicide prevention activities in a manner that would enable evaluation of impacts (e.g. by delaying the program start in some communities to serve as a comparison). Test programs that could be disseminated systemwide.

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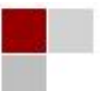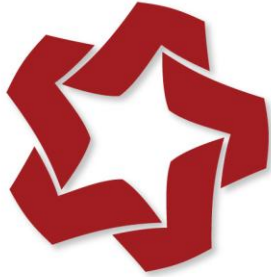
Community-Based Programs

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention
January 21, 2014

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Professor
Department of Psychiatry
University of Rochester School of Medicine
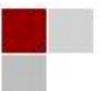peter_wyman@urmc.rochester.edu

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Community-Based Prevention

- Programs outside treatment settings
- Address different points on pathways to suicide
- Developmental stage (children to seniors)
- Social context (military, school)
- Multicomponent to single focus

-Review rationale of different strategies
-Illustrative programs and prevention evidence

2

Population Groups Targeted by Different Suicide Prevention Strategies

Identify Individuals Needing Treatment– increasing service use: major depression, suicidal behavior, etc

_____

Showing Symptoms – those already exhibiting early symptoms (e.g., heavy drinking college students)

Groups at High Risk– group shares characteristic that elevated risk (e.g., teens whose parents have depression)

Everyone– apply to all in population (e.g., classroom behavior programs; resilience skills training for all in military basic training)

Prevention below line

3

Widespread Use of Programs to Increase Treatment Use

- Respond to evidence that suicidal individuals are under-identified and few receiving ongoing services
- Warning signs may be detected by others (CDC study)
- **Gatekeeper training**
  - Question, Persuade, Refer (QPR)
  - Applied Suicide Intervention Skills Training (ASIST)
- **Screening**
  - School
  - Pediatric Care/Primary Care settings
- Often part of larger multicomponent programs

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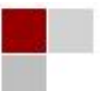
Evidence for Programs Aimed at Increasing Treatment Use

- **Gatekeeper training** increases knowledge of suicide risk factors/warning signs
- Inquiring about suicide mostly increased in those already in helping roles(Wyman et al. 2008)
- **Screening** is safe; modest service use after screening of high school populations (Gould et al. 2012)
- Combined screening/education (**Signs of Suicide**) may reduce short-term suicidal behavior (Aseltine et al. 2007)
- No evidence suicide rates are reduced
- *May save lives and increase community engagement*
- *Unlikely on its own to significantly reduce suicide rates*

5

Upstream Prevention
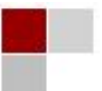
Interventions that Target the Risk Factors for Suicide are also likely to Prevent Suicide

Heart Disease: exercise, diet reduces coronary disease

Mental Health: strengthening emotion regulation, social environments reduces emotional problems

6

Strategies Involving Upstream Interventions for Suicide Prevention

A Small effect on a **large**, low to moderate risk population,

can have a **bigger population level impact** than a

Large effect on a **small** high-risk population

G Rose: The Strategy of Preventive Medicine (1992)

7

High-risk Approach

8

High-risk Approach

Mortality threshold

After treatment

Population

Low   High

Suicide risk

9

Population-based Approach

Mortality threshold

Move population toward less risk

Population

Low   High

Suicide risk

10

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Potential Pathways to Suicide Prevention: The Logic of Moving Upstream

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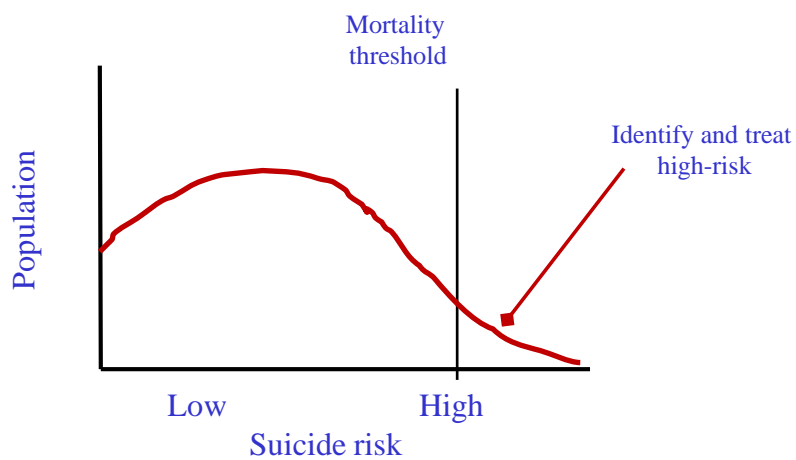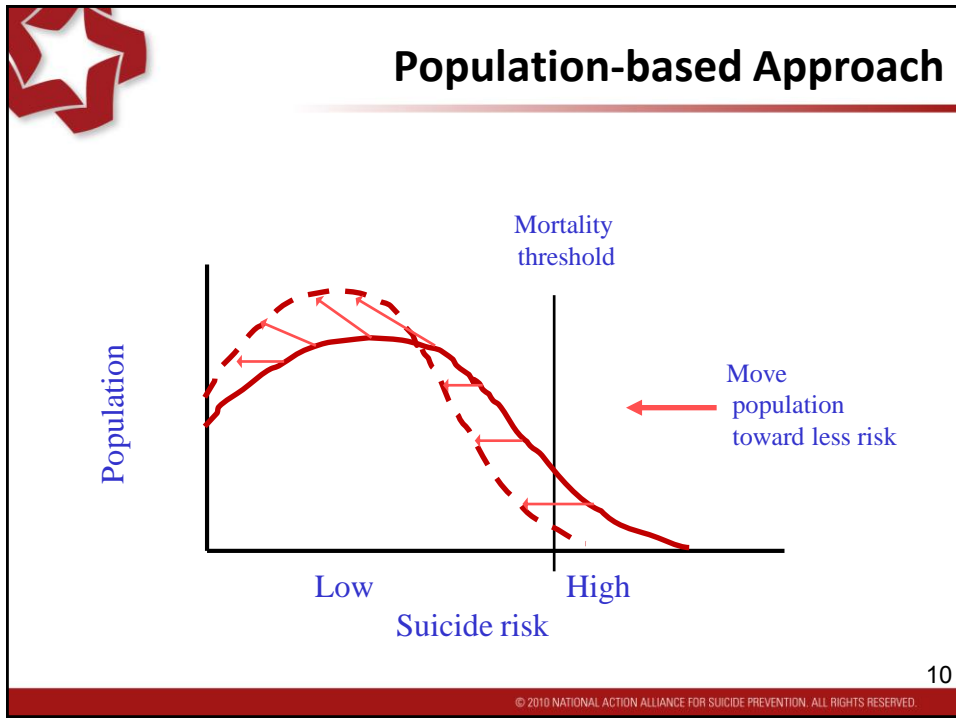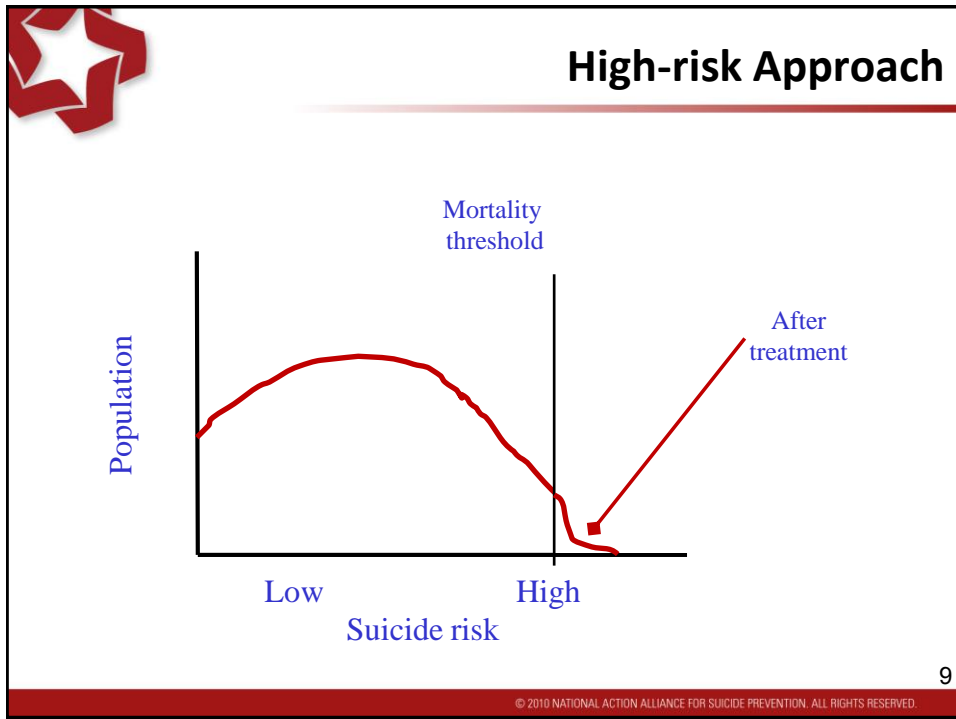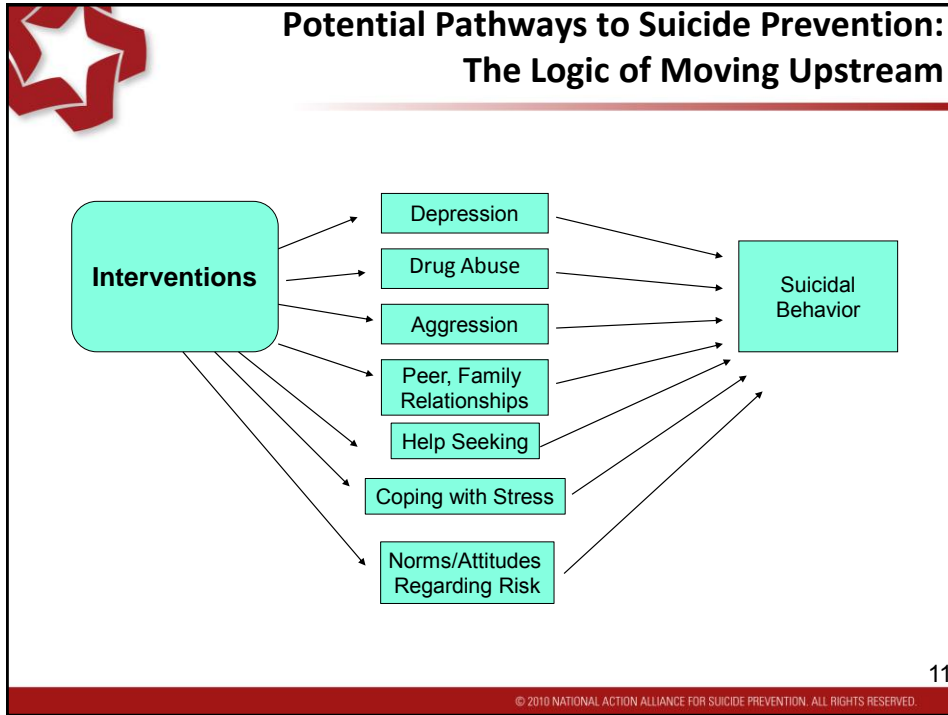
Evidence for Upstream Prevention Beginning in Childhood

Good Behavior Game (GBG)

- 1st-2nd grade teachers promote positive classroom behaviors through peer group reinforcement – urban Baltimore in late 1980s (Kellam et al 2008)
- Reduced substance use, antisocial behavior, high-risk sex behaviors in adolescence
- Improves self-control of behavior, emotions, which can have 'cascading effects'
- **First upstream prevention program to show impact on reducing suicidal behavior later in life (50% reduction in self-reported suicide attempts by age 19-21)**

Second cohort with less stringent implementation quality had reduced effects – importance of implementing programs w/ quality

12

Good Behavior Game (GBG): Prevents Suicide Attempts into Young Adulthood (Wilcox et al 2008)

13

Suicide Prevention Potential of Upstream Programs: Childhood and Adolescence

Figure 1

Illustrative program examples: [1]New Beginnings Program[16]; [2]Good Behavior Game[14]; [3]Iowa Strengthening Families Program[19]; [4]Olweus Bullying Prevention Program[21]; [5]Life Skills[18]; [6]Communities that Care[20]; [7]Sources of Strength[8].

14

Exploring the Role of the Railroad Industry in
Promoting Suicide Prevention
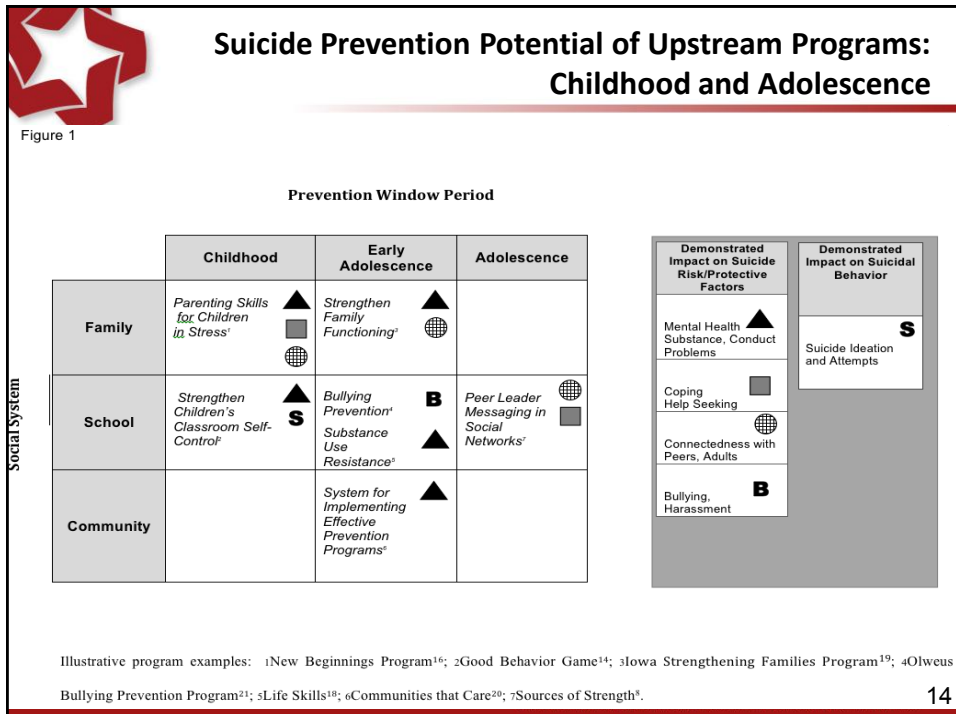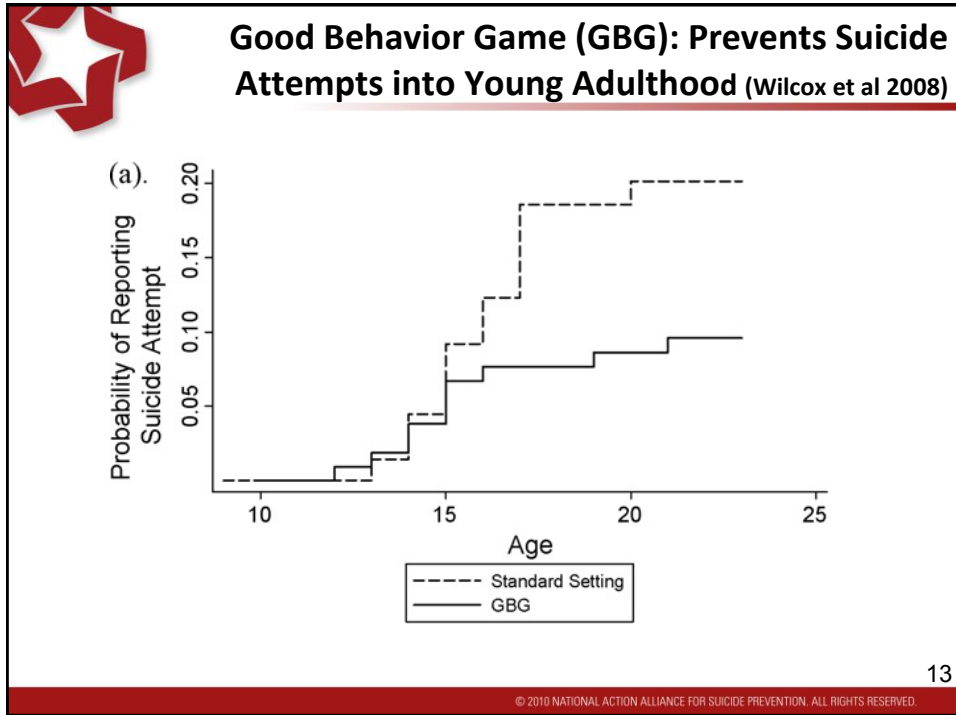
Multicomponent Program (Universal-Indicated)
United States Air Force

- Beginning mid-1990s AF leadership supported spectrum of suicide prevention initiatives:
  - Suicide prevention education in training
  - Policies to encourage mental health services
  - Community preventive services tracking
  - Interviews of high-risk personnel (e.g., after arrest)
  - Trauma stress response
  - Assessment/surveillance

Suicide rate reduced following implementation in 1995-1996, along with violence related outcomes

Knox, Litts, Talcott, Feig, & Caine (2003)

15

AF Quarterly Rate of Suicides
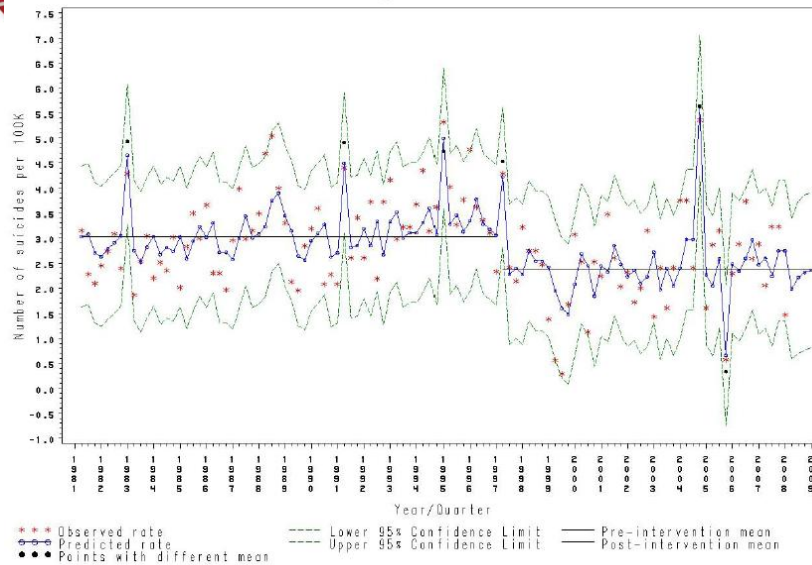
16

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

Significance of US AF Suicide Prevention Program

- Programs addressing needs of low and high risk individuals may have synergy in culture change that reduces suicides and other health problems (e.g., domestic violence)

- **Subsequent increase in AF suicide rates in 2004 suggest that reduced implementation quality erodes program effects**

- How to translate program concepts -- from highly structured military setting -- into effective suicide prevention in civilian communities remains a challenge

17

Seniors: Promising Programs that Reduce Suicide Risk Factors

- Males (white) over 65 have among highest suicide rates in U.S.
- Programs that reduce depression may lower suicides

- **Improving Mood-Promoting Access to Collaborative Treatment (IMPACT)** – collaborative care management for 60+ with elevated depression identified in primary care
  - Reduced depression symptoms, improved quality of life, and functioning

  Suicidal behavior not assessed, as with many other programs targeting suicide risk factors

18
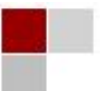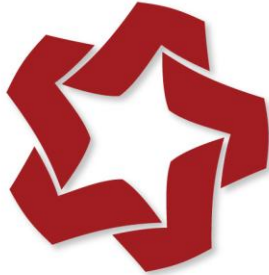
Workplace Suicide Prevention

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

January 21, 2014

Sally Spencer-Thomas, Psy.D., MNM
CEO & Co-Founder, Carson J Spencer Foundation
Co-Lead Workplace Task Force, National Action Alliance
Co-Chair, Workplace Special Interest Group, IASP
Survivor Division Director, American Association for Suicidology
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www.WorkingMinds.org

Suicides and the Workplace

- In the U.S., the working age population comprises about 70% of all suicides
- In the U.S., in a corporation employing 100K people, each with an average of 4 blood relatives, the loss of 1 employee or family member to suicide occurs every 7 days. (ValueOptions)
- On average, surviving partners/spouses estimate that the death of their loved one intimately and directly affected an average of 20 co-workers. (Berman, 2011)

2

Suicidal Behavior and the Workplace

- Employee suicides occur on site
- Employee suicides occur off site
- Recently terminated employees die by suicide
- Suicides by loved ones of employees occur
- Vendors, clients, customers suicides affect workplaces
- Suicidal behavior affects workplaces
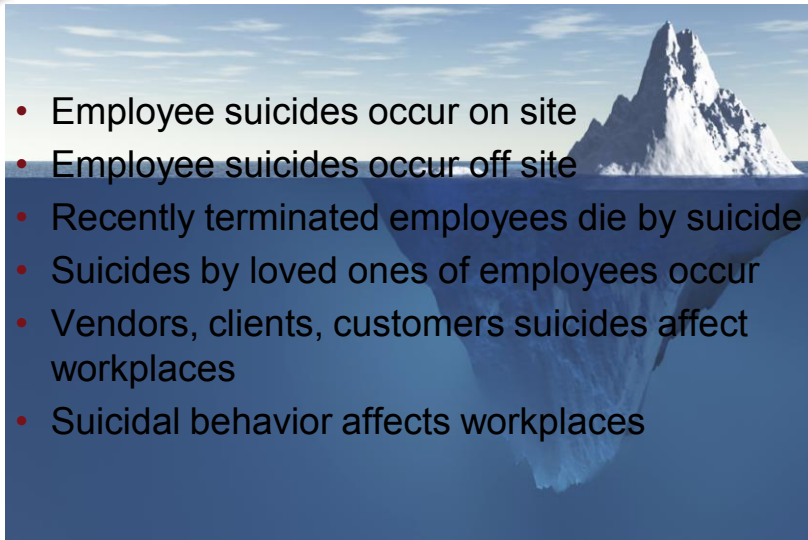
3

Before Work   After Work

4
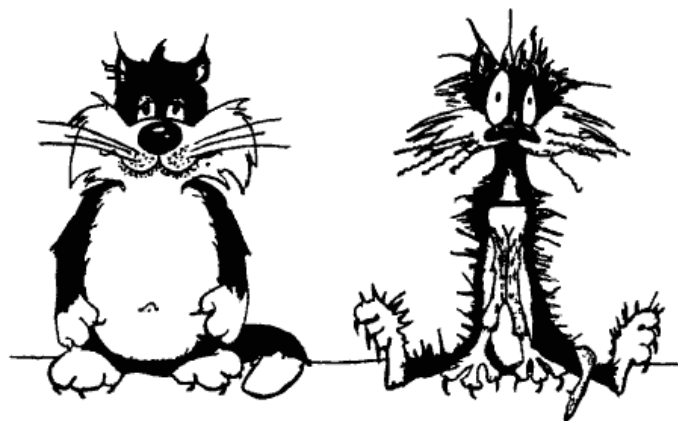
Why the Workplace?

- Another important piece of community-wide prevention
- Place of "belonging"
- Place of "effectiveness"
- Built in methods of dissemination of training and information

5

WHY THE WORKPLACE?

- Built-in referral mechanism for mental health services
- "Social Responsibility" movement (doing the right thing)
- Part of holistic movement
- Workplaces already tuned into "Workplace Violence"

6

COMPREHENSIVE BLUEPRINT FOR WORKPLACE SUICIDE PREVENTION

SCREENING	MENTAL HEALTH SERVICES AND RESOURCES	SUICIDE PREVENTION TRAINING
LIFE SKILLS AND SOCIAL NETWORK PROMOTION	**GOAL: PROMOTE MENTAL HEALTH AND SUICIDE PREVENTION**	CRISIS MANAGEMENT, POLICY & MEANS RESTRICTION
EDUCATION AND ADVOCACY	SOCIAL MARKETING	LEADERSHIP

Comprehensive Blueprint for Workplace Suicide Prevention
adopted from the Air Force Model, the Jed Foundation/Suicide Prevention Resource Center, and Working Minds.

7

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

Session 6: Messaging

Dr. Linda Langford provided a ten-minute overview of the importance of messaging in suicide prevention. Research has shown that some types and methods of messaging can increase the risk of suicide among vulnerable individuals. Unsafe content includes repeated and dramatic media coverage, providing details on method and location, or portraying suicide as more common than it is or a normal response to adversity. Conversely, messaging can be a powerful tool to promote positive behaviors, encourage help-seeking, and frame how the public thinks about suicide and suicide prevention.

"Changing the public conversation around suicide and suicide prevention" is one of the four initial priorities of the National Action Alliance for Suicide Prevention, with the goal of "changing the national narratives around suicide and suicide prevention to ones that promote hope, connectedness, social support, resilience, treatment and recovery." Led by the Public Awareness and Education (PAE) Task Force of the Action Alliance, this priority is being pursued along two pathways: (1) outreach to media and entertainment professionals; and (2) resources for suicide prevention and mental health professionals and others messaging publicly about suicide. Both audiences are important in shaping the national narrative.

Langford showed examples of typical media headlines about suicide to illustrate ways in which this coverage often is unsafe and problem-focused. These types of stories form a negative narrative that portrays suicide as an unstoppable problem without viable solutions. Fortunately, there are research-based Recommendations for Reporting on Suicide (http://reportingonsuicide.org/) that encourage journalists to avoid problematic practices, provide accurate information about suicide, spread the message that there is help and hope for suicidal individuals, and disseminate resources. The media pathway of the Action Alliance's work is focused on promoting these recommendations. For example, the Action Alliance has partnered with Poynter Institute to develop a strategy to improve the accuracy and safety of reporting on suicide. Currently partially funded, the initiative will train journalists in both face-to-face and online formats, with the potential of reaching hundreds of thousands of journalists in the U.S. and around the world.

The gold standard for influencing media and entertainment coverage is Australia's Mindframe project, a comprehensive dissemination strategy for media guidelines. Efforts include tailored materials for multiple sectors (media professionals and organizations, stage and screen, police and courts, and mental health and suicide prevention) and hands-on capacity-building through leadership, resources, organizational change, training, and partnerships. An analysis comparing news coverage before Mindframe and several years into its implementation demonstrated better adherence to guidelines.

The second pathway undertaken by the Action Alliance addresses the messages disseminated by suicide prevention and mental health professionals and others communicating to the public about suicide. "Public messaging" includes any communications released into the public domain that has the potential to shape public perceptions about suicide, including posters, PSAs, social media, websites, newsletters, fundraising appeals, event publicity, press interactions, public talks, and advocacy materials.

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Promoting Suicide Prevention
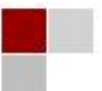
Langford showed examples of public messages that research suggests are unsafe or not likely to be effective because they, for example, depict methods of suicide, emphasize the negative narrative, lack a specific call to action, or are not integrated with other programmatic efforts.

To improve public messaging about suicide, the Action Alliance has created a *Framework for Successful Messaging*. The Framework outlines four considerations for more successful messages: strategy, safety, positive narrative, and guidelines. Strategy includes clearly defining goals, audiences, and desired actions, and integrating communications and other program components into an overall plan. Safety refers to avoiding the unsafe content outlined above. Conveying a Positive Narrative about suicide can take many forms, for example including personal stories of coping and resiliency, describing action steps the audience can take, or emphasizing the availability of resources and supports. The Guidelines component recognizes there are many existing resources outlining best practices for specific types of messaging (e.g., using social media effectively, guidelines for survivors telling their personal stories, etc.). Once launched, the *Framework for Successful Messaging* will be housed at www.SuicidePreventionMessaging.org.

Presenter Contact Information:

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> Evaluation and Communications Scientist
> Suicide Prevention Resource Center
> Education Development Center, Inc.
> E-mail: llangford@edc.org

Discussion

Messaging: Possible Options for Railroad Company Involvement

During the discussion, the group generated the following opportunities that railroad companies might pursue to support or advance suicide prevention in this area:

- Educate reporters about the potential for suicide contagion and make them aware that the way they cover this issue could encourage people at risk to attempt suicide. Provide them with the two-page Recommendations for Reporting on Suicide, available at http://reportingonsuicide.org/.
- Help to support the Action Alliance's initiative with Poynter Institute.
- Partner with crisis centers or other local suicide prevention organizations and refer media inquiries about deaths on rails to them. Without addressing whether or not a particular death was a suicide, these partners can provide information about resources and supports that people might need after a death.
- Partner with crisis centers or suicide prevention organizations to train first responders and/or their Public Information Officers about how to safely respond to media inquiries about suicide deaths.

- Partner with crisis centers or suicide prevention organizations to approach the media proactively, to encourage helpful stories about suicide prevention.
- Support the development of a toolkit for railroad communications departments to use when responding to media inquiries and when partnering with local organizations to proactively approach members of the media about safe reporting.
- Ensure trespassing prevention materials do not portray trains or any other method as an attractive method of suicide (i.e., as highly lethal, quick, painless).
- Tailor trespassing and suicide prevention messages to particular audiences and test them to see how they are interpreted by the general public and individuals at high risk for suicide.
- Help to disseminate the Framework for Successful Messaging, once launched.
- Encourage and support efforts to disseminate personal stories of hope and recovery, e.g., similar to the VA's campaign Make the Connection (www.MakeTheConnection.net).

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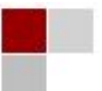
Messaging

**Exploring the Role of the Railroad Industry
in Promoting Suicide Prevention**
January 21, 2014

Linda Langford, Sc.D.
Evaluation and Communication Scientist
Suicide Prevention Resource Center &
National Action Alliance for Suicide Prevention
llangford@edc.org

What's Important About Messaging in Suicide Prevention?

- **Safety:** some messaging associated with *increased risk* of suicide among vulnerable individuals, e.g.
  - Prominent, repeated, dramatic media coverage
  - Providing details of method/location/person
  - Romanticizing suicide
  - "Normalizing" suicide

- Conversely, communications can be a powerful tool if used **effectively**

2

Slide 3

One of the Action Alliance's Initial Priorities:
"Change the Public Conversation"

Change the public conversation around suicide and suicide prevention.

"Leverage the media and national leaders to change the national narratives around suicide and suicide prevention to ones that promote hope, connectedness, social support, resilience, treatment and recovery."

**Media/Entertainment Outreach
(Journalists, Writers)**
NSSP Goal 4

**Public Messaging
(Suicide Prevention & Mental Health Professionals & Other Messengers)**
NSSP Goal 2

3

Slide 4

1st Pathway: Media/Entertainment Coverage:
Often Unsafe, Problem-Focused

Man shoots, **kills himself** outside Littleton hospital | Local News ...
www.wmur.com/news/nh-news/man...**kills-himself**.../-/index.html ▾
4 days ago - Authorities said a 55-year-old man shot and killed himself outside the Littleton Regional Hospital's emergency room on Monday.

Suicide Epidemic Among Veterans - CBS News
Nov 13, 2007 ... A CBS News Investigation Uncovers A **Suicide** Rate For **Veterans** Twice That Of Other Americans.

The Financial Crisis Is Driving Hordes of Americans to Suicide

12 TUESDAY, MAY 15, 2007 MAPLE RIDGE AND PITT MEADOWS TIMES
▸ Community
Mentally ill still face stigma

4

Exploring the Role of the Railroad Industry in
Promoting Suicide Prevention

Solution: Promote Adoption of Research-Based Media Recommendations

Recommendations for Reporting on Suicide (2011)

www.ReportingOnSuicide.org

5

Multi-Layered Dissemination to Media/Entertainment

National Orgs & Standards

Schools of Journalism/ Communications

Organizational Policies: Media, Government, Prevention Orgs

Media/Entertainment Professionals
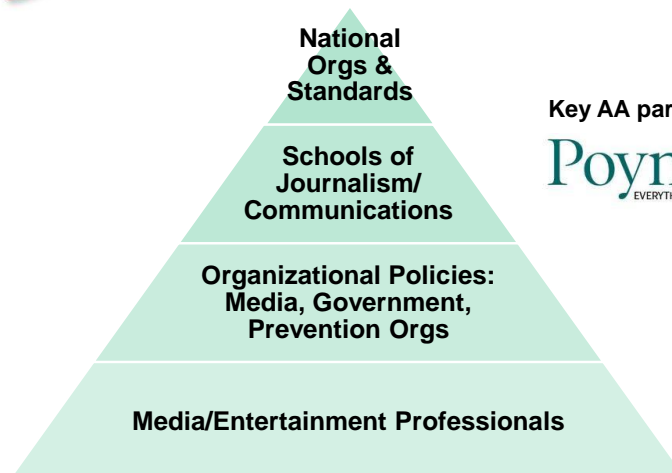
Key AA partnership:

Poynter.
EVERYTHING YOU NEED TO BE A BETTER JOURNALIST

6

Gold Standard: Australia

Mindframe for the mental health & suicide prevention sector

- **Comprehensive dissemination** of media guidelines

- Via multiple **SECTORS:**
  - Media professionals and media organisations
  - Journalism and public relations educators
  - Mental health and suicide prevention sectors
  - Police, courts
  - Stage and screen

- **Capacity-building:** leadership, resources, organizational change, training, partnerships

- **Demonstrated change** in coverage quality from 2000/01 to 2006/07

7

Other Possible Options to Improve Media/Entertainment Coverage

- Encourage adoption of recommendations in **online contexts**

- Organized effort to **monitor & respond** to news, entertainment, social media stories

- **Train media spokespeople**, e.g. government, workplace, organizational PIOs

- **Recognition awards** for accurate and responsible news and entertainment portrayals of suicide

8

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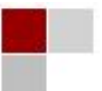
2ⁿᵈ Pathway: Improve "Public Messaging"

Violates safety guidelines

Emphasis on problem (not how to solve it)

Every 16 minutes someone in the US dies from suicide. You can help raise awareness. afsp.donordrive.com/index.cfm?fuse…

9

{SUICIDE} IS 100% PREVENTABLE

SPEAK UP
REACH OUT

• Not targeted
• Vague call to action

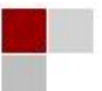**Prevent suicide. Treat depression.** *See your doctor.*

Not integrated with programmatic efforts, e.g. clinical training

Expert Panelist: "It's time to shift from communicating for awareness to communicating for action."

10

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

National Action Alliance for Suicide Prevention
Framework For Successful Messaging

- **Strategy:** Defined goals, audiences & actions, integrate with other efforts, etc.

- **Safety:** Avoid "don'ts"

- **Positive narrative:** e.g. stories of coping & resiliency; programmatic successes; actions audience can take; available resources & services, etc.

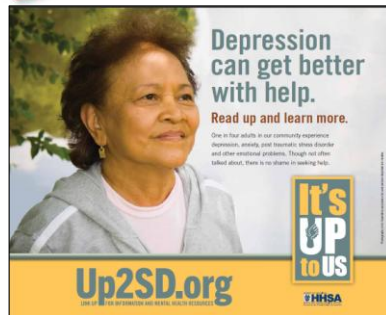- **Guidelines:** Use message-specific best practices

Website Coming Soon! **www.SuicidePreventionMessaging.org**

11

Framework ≠ One-Size-Fits-All Messages

- Target specific goals & audiences
- Action-oriented
- **+** narrative that fits message

12

Exploring the Role of the Railroad Industry in
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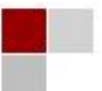
Applies to "Everyday Messaging" Too

AAS Suicidology @AASuicidology   25 Mar
A loved one has attempted suicide. Now what? Attempt
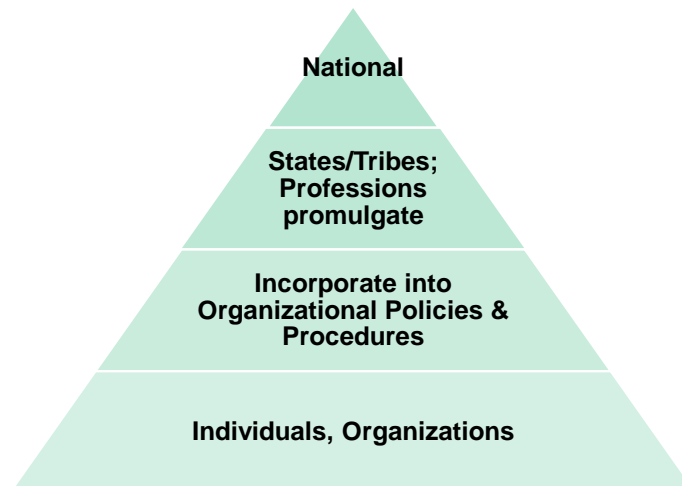survivors explain what family approaches put them more at ease. ow.ly
/ipBMJ

U.S. Army @USArmy
Don't take **suicide training** for granted. It helped the Licciardi
family save a Soldier's life: ow.ly/dl8rf @Military1Source

13

Future Plans: Multi-Layered Dissemination of Framework to <u>Messengers</u>

National

States/Tribes;
Professions
promulgate

Incorporate into
Organizational Policies &
Procedures

Individuals, Organizations

14
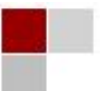
# SESSION 7: NATIONAL INFRASTRUCTURE, LEGISLATION, AND PRIORITIES

Dr. Jerry Reed introduced the seventh and final session with a 20-minute overview of the policy landscape and national infrastructure for suicide prevention. He began by sharing a model for action that can inform suicide prevention efforts. This model posits that three components are needed to advance prevention priorities: a knowledge base, a social strategy, and political will. Reed explained that the suicide prevention field has an ever-growing knowledge base and a social strategy in the form of the 2012 National Strategy for Suicide Prevention (NSSP), but is lacking sufficient political will to make great strides in preventing suicide. Specifically, there is one suicide prevention organization with two staff members dedicated to advancing state and federal policy efforts, including organizing a volunteer network of field advocates and holding an annual advocacy forum. Other scattered efforts have occurred, for example, the Action Alliance has held three Hill briefings and a coalition of prevention organizations periodically advocates for specific policies.

To date, research funding dedicated to suicide has not been commensurate with the burden. For example, in 2010, 38,364 Americans died by suicide and the National Institutes of Health (NIH) spent $44million on suicide research. During that same year, NIH spent roughly the same amount in research ($40 million) on smallpox, a disease that was eradicated in 1980 and has not killed anyone in 30 years. This disparity exists even though a nationally representative telephone survey found that 86% of Americans think that is it somewhat or very important for the United States to invest in suicide prevention.

There has been some progress in passing suicide prevention legislation on both the federal and state levels, and these measures have increased the national and local infrastructure needed for suicide prevention efforts incrementally. Notable federal examples include the Garrett Lee Smith Memorial Act (2004), which funds the Suicide Prevention Resource Center (SPRC) and youth suicide prevention grants for states, campuses, and tribes, and the Joshua Omvig Veterans Suicide Prevention Act (2007), which mandates a suicide prevention coordinator at each Veterans Administration medical facility. These acts target specific populations (i.e. youth and veterans) but there is no legislation to assist other high risk groups, such as the elderly or working-aged adults.

Several states have also passed legislation favorable to suicide prevention. Through the Mental Health Services Act (2004), California imposes a 1% income tax on personal income in excess of $1 million to support county mental health programs. Washington State requires mental health providers to receive training in suicide assessment, treatment, and management through the Matt Adler Act (2012). Both of these acts serve as excellent examples of what can be achieved at the state level to support suicide prevention.

Another example of national infrastructure is the National Action Alliance for Suicide Prevention. The Action Alliance was launched in 2010 as a public-private partnership to advance the NSSP by championing suicide prevention as a national priority, catalyzing efforts to implement high priority objectives of the NSSP, and cultivating the resources needed to sustain progress. During the years between the launch of the first NSSP
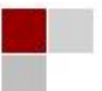
in 2001 and the creation of the Action Alliance, little progress was made on national level initiatives. The Action Alliance has been accelerating progress and currently has four priorities: 1) Integrating suicide prevention into health care reform and encouraging the adoption of similar measures in the private sector; 2) Transforming health care systems to significantly reduce suicide; 3) Changing the public conversation around suicide and suicide prevention; and 4) Increasing the quality, timeliness, and usefulness of surveillance data regarding suicidal behaviors. The Action Alliance has accomplished important work in a short time with modest funding. However, the Action Alliance is not currently authorized in federal legislation, and additional support is needed from both public and private sectors to sustain its catalytic work.

Reed concluded his presentation with examples of policy opportunities that would help to advance the current Action Alliance priorities and other efforts important to suicide prevention (see slides for a full list). For example, the Drug Enforcement Agency (DEA) could fund prescription take-back programs, the National Institute of Mental Health (NIMH) and the Centers for Disease Control and Prevention (CDC) could allocate federal research dollars to speed the implementation of the recently released prioritized research agenda, the Centers for Medicare & Medicaid Services (CMS) could incentivize the use of evidence-based treatments through reimbursement policies, and various federal and state agencies could fund middle and older adult state suicide prevention programs.

Presenter Contact Information:

>   Jerry Reed, Ph.D., MSW
>   Vice President and Director
>   Center for the Study and Prevention of Injury, Violence and Suicide
>   Suicide Prevention Resource Center
>   Education Development Center, Inc.
>   E-mail: jreed@edc.org

Discussion
National Infrastructure, Legislation, and Priorities: Possible Options for Railroad Company Involvement

During the discussion, the group generated the following opportunities that railroad companies might pursue to support or advance suicide prevention in this area:
- Work with the Action Alliance to identify a shortlist of specific policy "asks" that make sense for railroad companies, including what audiences they might influence how best to frame the issues from the railroad perspective (e.g. making the business case for suicide prevention, or alternatively, focusing on overall wellness rather than suicide prevention specifically.)
- Establish credibility and build support for policies by helping to support legislative priorities at the state level.
- Identify key opinion leaders in states and assist in mobilizing their support for suicide prevention.
- Catalyze support for the Action Alliance to have a government relations arm in Washington, D.C.

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Promoting Suicide Prevention
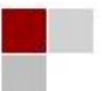
- Support efforts to authorize the Action Alliance in federal legislation and to leverage resources to sustain Action Alliance activities.
- Help to disseminate the business case for being involved in suicide prevention.
- Champion suicide prevention successes and innovative initiatives (e.g. Zero Suicide, local crisis centers/Lifeline, collaborations with gun shop owners, evidence-based prevention programs, partnership with the Poynter Institute to educate journalists, Framework for Successful Messaging, Comprehensive Blueprint for Workplace Suicide Prevention).
- Advance Action Alliance policy priorities through in-kind support of legislative activities.
- Champion suicide prevention policy priorities at state and national levels.
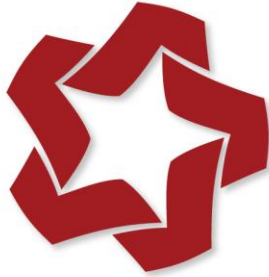
National Infrastructure, Legislation, and Priorities

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

January 21, 2014

Jerry Reed, Ph.D., MSW
Vice President and Director
Suicide Prevention Resource Center
Education Development Center, Inc. (EDC)
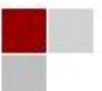jreed@edc.org

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The Model for Action

Richmond and Kotelchuck's Health Policy Model
Found in: Atwood, K, Colditz, G. A., Kawachi, I. (1997). From public health science to prevention policy: Placing science in its social and political context. *American Journal of Public Health, 87(10)*.

2

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

Current Advocacy Efforts

American Foundation for Suicide Prevention (AFSP)
- 2 staff dedicated to policy (state and federal)
- Field Advocates Program, Annual Advocacy Forum

Action Alliance Briefings
- 3 hill briefings: military/veterans, youth, and about the Action Alliance

National Council for Suicide Prevention (NCSP)
- Advocates for specific policies

3

Federal Legislation

Milestones:

- **1997/1998**: Senate Resolution 84, House Resolution 212

- **2002:** Suicide Prevention Resource Center (SPRC) established

- **2004**: Garrett Lee Smith Memorial Act

- **2007:** Joshua Omvig Veterans Suicide Prevention Act

- **2008:** Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act

4

Exploring the Role of the Railroad Industry in
Promoting Suicide Prevention

State Legislation

Key examples:

- **California:** 1% income tax on personal income > $1m to support county mental health programs (2004)

- **Washington State:** Training in suicide assessment, treatment, and management required of mental health professionals, social workers, and occupational therapists (2012)

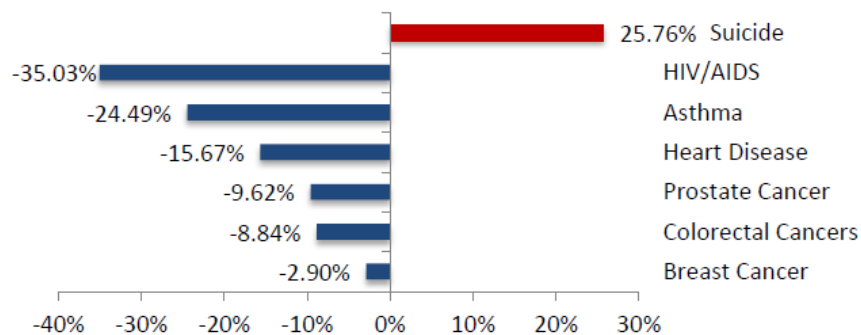- Many states mandate suicide prevention training for school personnel

5

Change in Number of Deaths by Cause: 2000-2009*

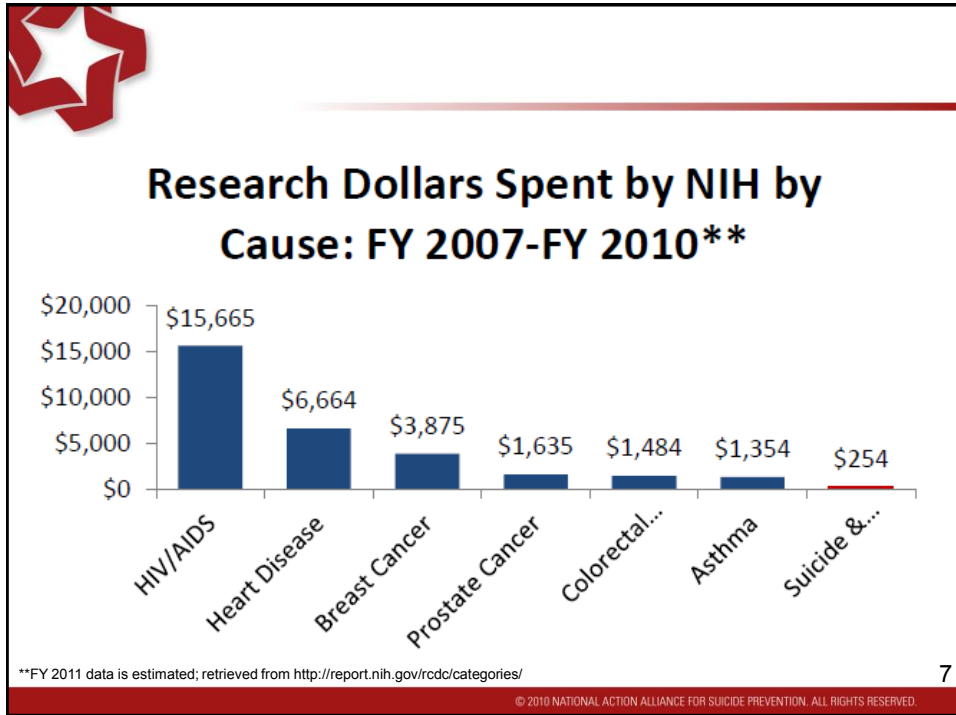| Percentage	Cause
25.76%	Suicide
-35.03%	HIV/AIDS
-24.49%	Asthma
-15.67%	Heart Disease
-9.62%	Prostate Cancer
-8.84%	Colorectal Cancers
-2.90%	Breast Cancer

* Centers for Disease Control and Prevention (CDC)'s actual 2000 data versus preliminary final data from 2009; retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr50/nvsr50_15.pdf and http://www.cdc.gov/nchs/data/dvs/deaths_2009_release.pdf

6

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

Research Dollars Spent by NIH by Cause: FY 2007-FY 2010**

HIV/AIDS	$15,665	
Heart Disease	$6,664	
Breast Cancer	$3,875	
Prostate Cancer	$1,635	
Colorectal...	$1,484	
Asthma	$1,354	
Suicide &...	$254	

**FY 2011 data is estimated; retrieved from http://report.nih.gov/rcdc/categories/

7

	NIH Research Funding in 2010	Deaths in 2010
Suicide	**$44m**	**38,364**
Smallpox	**$40m**	**0**

8

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

Public Opinion

Very Important for the U.S. to Invest in Suicide Prevention

How important do you think it is for the U.S. to invest in the prevention of suicide?

- 50% Very
- 36% Somewhat
- 12% Not
- 2% Don't know
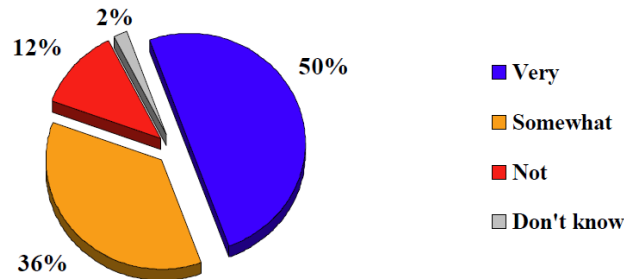
Taking Our Pulse: The PARADE/Research!America Health Poll
Charlton Research Company, 2006

Research!America
AN ALLIANCE FOR DISCOVERIES IN HEALTH

9

President's 2014 Budget Request: Suicide Line Items

- **Substance Abuse and Mental Health Services Administration (SAMHSA)**
  - $50M for Lifeline; GLS state, tribal, and campus; SPRC; AI/AN initiative
  - $2M first time funding to implement NSSP included
- **Centers for Disease Control and Prevention (CDC)**
  - $10M for Gun Violence Prevention Research
  - $20M for NVDRS implementation nationwide

- **National Institute of Mental Health (NIMH)**
  - $15m for Army Study to Assess Risk and Resilience in Service Members (Army STARRS)
- **Department of Defense (DoD)**
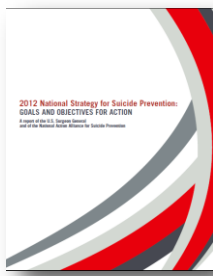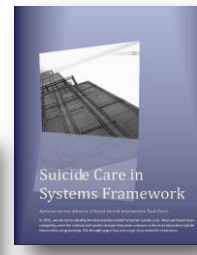 - $7M for Defense Suicide Prevention Office
  - $50m for Army STARRS

10

Exploring the Role of the Railroad Industry in
Promoting Suicide Prevention

Organization of the Action Alliance

11
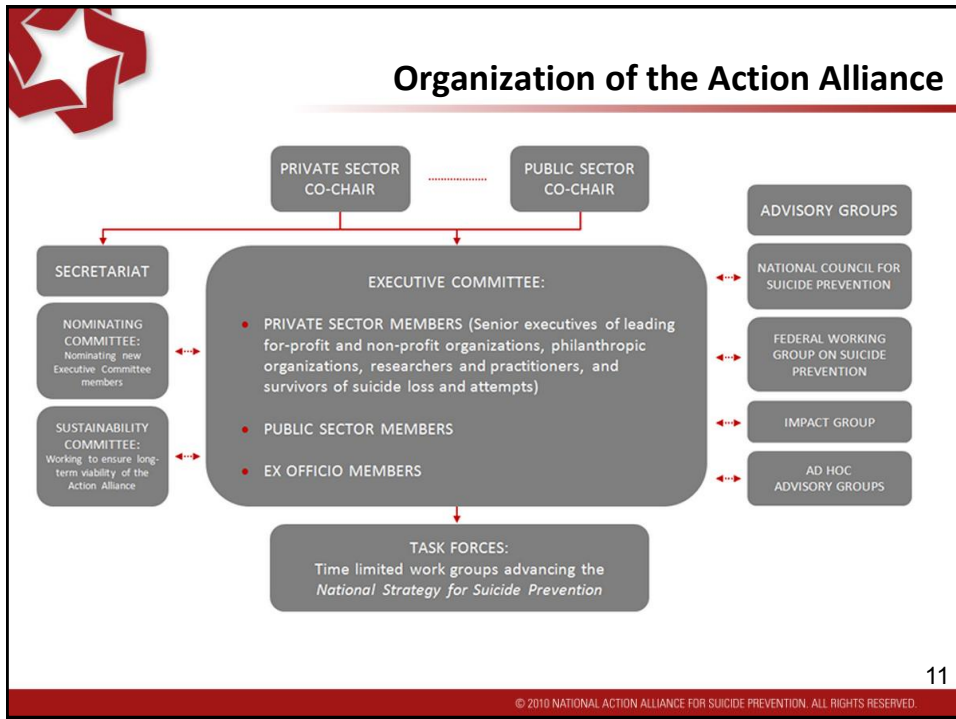
Action Alliance Accomplishments

- Revised National Strategy for Suicide Prevention

- Suicide Care in Systems Framework Report

- Comprehensive Blueprint for Workplace Suicide Prevention

- Manager's Guide to Suicide Postvention

- Videos for CEOs and firefighters

- Juvenile Justice Resources

- Prioritized Research Agenda

12

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention

Action Alliance Priorities: 2012-2014

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

13

"The Action Alliance needs to have a continuous presence on the Hill"

- Rep. Napolitano

Congresswoman Grace Napolitano

14

Exploring the Role of the Railroad Industry in Promoting Suicide Prevention
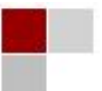
Policy Opportunities

Legislation

- Authorize Action Alliance: SAMHSA or GLS reauthorization
- Establish National Office of Suicide Prevention: coordinate federal efforts
- Use language in authorization/appropriation bills to set expectation that federal departments advance NSSP

Funding

- Middle and older adult state suicide prevention programs (CDC, SAMHSA, ACL)
- Pharmacy prescription take-back programs (DEA)
- Studies addressing gaps in suicide research (NIMH, CDC)
- Supplemental grants to NVDRS states: link to other data systems

15

## Policy Opportunities

Data/Research

- Reporting system to collect data about employee suicides (NIOSH)
- Promote suicide prevention training as part of workplace safety/wellness programs (NIOSH)
- Speed implementation of prioritized research agenda (NIMH, CDC)
- Build evidence for upstream and community-level interventions (CDC)

Licensure/Accreditation/Reimbursement

- Require training for mental health clinician licensure
- Require training for hospital accreditation from Joint Commission
- Reimbursement policies incentivize evidence-based treatments (CMS)

16
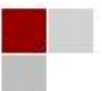
"People need to advocate for whatever they believe in. If you truly believe in something you need to find the chain of command to get bills passed that can be put into action for prevention or treatment."

-Mellisa Millard, North Platte, NE
Lost her brother, Mitch, to suicide 18 years ago

17

APPENDIX: LIST OF SUICIDE PREVENTION EXPERT ATTENDEES

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