National Council

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Suicide Prevention
Not another life to lose

This special issue is sponsored by
Magellan Health Services

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

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David Litts, Executive Secretary, National Action Alliance for Suicide Prevention

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Jerry Reed, Co-lead, National Strategy for Suicide Prevention Task Force, National Action Alliance on Suicide Prevention

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(look under About Us/National Council Magazine)

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Not Another Life to Lose: Suicide Prevention

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NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

About the National Council

The National Council for Community Behavioral Healthcare (National Council) is the unifying voice of America's behavioral health organizations. Together with our 2,000 member organizations, we serve our nation's most vulnerable citizens — more than 8 million adults and children with mental illnesses and addiction disorders. We are committed to providing comprehensive, high-quality care that affords every opportunity for recovery and inclusion in all aspects of community life.

The National Council advocates for policies that ensure that people who are ill can access comprehensive healthcare services. We also offer state-of-the-science education and practice improvement resources so that services are efficient and effective.

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National Council
MAGAZINE

INTO THE LIGHT: STORIES OF COURAGE AND HOPE

6 The Smoking Gun in Suicides

60
We Owe it to Them: Supporting Our Veterans

72
What Can Colleges and Universities Do to Prevent Suicide?

94
Root Cause Analysis: What Airlines Can Teach Us About Suicide Prevention

National Council MAGAZINE

SUICIDE PREVENTION FROM THE FIELD

128

Don't Be Afraid to Ask:
The Mental Health First Aid
Action Plan

Enabling *your* Technology

TRANSFORMATION

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The Smoking Gun in Suicides

Linda Rosenberg, MSW, President and CEO, National Council for Community Behavioral Healthcare

With a firearm, once the trigger is pulled, there's no turning back

Before this year comes to an end, another one million people around the world will die by suicide. We have all heard what drives people to take their own lives — psychiatric and substance use disorders, stressful life events, and chronic pain are often listed.

But there's another risk factor that's rarely mentioned, even though it accounts for more than half of the suicide deaths in the U.S. each year. That culprit is guns.

Some may argue that guns are merely the *methods* used for suicide, like drowning or suffocation. However, a review of statistics and scientific studies finds that guns are not only a popular means of suicide, but that access to firearms is strongly associated with the increased risk of suicide.

A study in 2007 by researchers at the Harvard School of Public Health found that people who live in areas with high concentrations of guns are more likely to die by suicide. The study, which accounted for factors like poverty, substance use, and mental illness, looked at the 15 states with the highest firearm ownership and found that twice as many people committed suicide compared to those in the six states with the lowest firearm ownership. Published in *The Journal of Trauma*, the study concluded that "the ready availability of firearms is likely to have the greatest effect on suicide rates in groups characterized by more impulsive behavior."

That "impulsive behavior" the researchers referred to is what makes guns a death sentence for people intent on killing themselves. The Harvard study found that while firearms are used in only 5% of suicide attempts, they are responsible for more than 50% of suicide deaths because of their 90% fatality rate. Many of the most widely-used suicide attempt methods have fatality rates below 5%. A 2002 study in the *Journal of Epidemiology and Community* Health found that attempts involving firearms were 2.5 times more lethal than those involving suffocation — the second most lethal form of suicide.

Guns leave little hope for the thousands of people who survive suicide attempts every year and manage to turn around their lives. People who swallow pills, inhale fumes, or slash their wrists have some time to reconsider their desperate actions. Even if they are not rescued, these methods often fail, leaving open the hope that they will seek treatment. But with a firearm, once the trigger is pulled, there's no turning back.

You don't often see "suicide" and "gun control" in the same sentence, but the facts are too overwhelming to ignore. Not only is death by firearms now the fastest growing method of suicide, but guns are even used in more suicides than homicides.

There's no doubt in my mind that people who have less access to guns are less likely to commit suicide. While gun owners reportedly keep a firearm in their home for "protection" or "self-defense," 83% of gun-related deaths in these homes are the result of a suicide, often by someone other than the gun owner.

I encourage you to use World Suicide Prevention Day on September 10 and Suicide Prevention Week, September 9–15, as a time to speak up about guns and suicide. Contact your legislators, inform your members, and issue a statement to the media about the issue of guns and suicide.

Now is indeed the time to bring gun control into our conversations on suicide. Those served by National Council member organizations are often the most likely people to consider suicide and to take their own lives — they are looking to us for leadership, and counting on us to take action.

Linda Rosenberg has more than 30 years of mental health policy and practice experience, focusing on the design, financing, and management of behavioral health services. Since 2004, Rosenberg has been President and CEO of the National Council for Community Behavioral Healthcare, a not-for-profit advocacy and educational association of nearly 2,000 organizations that provide treatment and support services to 8 million adults and children with mental illnesses and addictions. Under Rosenberg's leadership, the National Council has more than doubled its membership; helped to secure the passage of the federal mental health and addiction parity law; expanded financing for integrated behavioral health/primary care services; proved instrumental in bringing behavioral health to the table in federal healthcare reform; and played a key role in introducing the Mental Health First Aid public education program in the United States.

I'll Gladly Pay the Price
Heidi Bryan

On January 7, 1995 my life and world changed forever. That was the day my older brother killed himself. I felt as though someone snuck up behind me with a two-by-four and smacked me on the back of my head and I was leveled. My belief system, my faith, and my foundation cracked and tumbled down inside of me. I wasn't even sure if I still loved my brother when he died and I was devastated. All I could think about was how his wife, children, and friends must feel.

It was then I realized that suicide was no longer an option and now, I had no choice but to live.

I have struggled with suicidal thoughts since childhood and there were many times when I started to prepare myself to die. I even aborted an attempt when I realized I would be found in time and would survive. When my brother died, I had a plan, a back-up plan, and a back-up plan to the back-up plan — I was not going to survive. But now I had to live because I knew that whatever my brother was thinking before he killed himself — like we'd be better off without him or we'd get over it — he was wrong. It was his disease or suicidality talking to him and not the truth.

If it applied to him, it had to apply to me. This forced me to get help and stick with it until I found the right therapist and the right medication. I learned that for me, thinking about suicide was like a drink is to an alcoholic and I had to treat it like a chronic disease. I learned that I have to be vigilant and do my best to maintain a healthy lifestyle. I learned to have a safety plan. Most important, I learned to find someone I trust — my husband — to talk to when I start to feel overwhelmed or suicidal. There's something almost magical about verbalizing the thought without fear of being hospitalized — it takes away the power and intensity of the thought and helps me to see outside myself and seek other options.

As a family member who's lost a loved one to suicide and a survivor myself, I got involved in suicide prevention. I realized I couldn't talk about getting rid of the stigma and shame associated with suicide without self disclosing. We won't start talking about it unless we start talking about it! I've written articles and pamphlets and speak openly about my struggles with suicide and I have no intention of stopping. There are times when I wonder if that's why I can't get that temporary or part-time job or what my neighbors must think if they Google me — but if that's the price I must pay, then I'll gladly pay it.

I pray that by sharing my experience, strength, and hope I am helping others to conquer their suicidality.

Heidi Bryan founded the Feeling Blue Suicide Prevention Council, (www.feelingblue.org) a nonprofit organization based in Pennsylvania, after losing her brother Jeff to suicide. She was awarded SPAN USA's Sandy Martin Grassroots Award in 2005. Heidi was chair of the Pennsylvania Adult/Older Adult Suicide Prevention Coalition (www.PreventSuicidePA.org) with which Feeling Blue Suicide Prevention Council recently merged. She is a QPR Master Trainer and a speaker. Heidi is a member of the National Suicide Prevention Lifeline Consumer Survivor Subcommittee and the National Action Alliance for Suicide Prevention Suicide Attempt Survivor Task Force. She is the author of *Must Be the Witches in the Mountains*, a book about grief after suicide.

Not Another Life to Lose
The Bridge to Zero

David Covington, LPC, MBA, Vice President, Adult & Youth Services, Magellan Health Services and Board Director, National Council for Community Behavioral Healthcare

Michael Hogan, Commissioner, New York State Office of Mental Health

Co-leads, Clinical Care & Intervention Task Force, National Action Alliance on Suicide Prevention

October 2013 marks the 50-year anniversary of President Kennedy's Community Mental Health Act, providing us the opportunity to celebrate the recovery of millions of individuals who have benefited from community care. These individuals have successfully crossed the bridge we've collectively built that leads to a stronger life in community, away from the institutional settings, despair, and disability that could result without our care.

Tragically, our community care "bridge" has seen the suicide deaths of too many seeking an end to their deep pain. Another iconic bridge — the Golden Gate Bridge — marks its 75th year in 2012. It too, must grapple with suicide — 1,500 deaths have occurred from its rails since the first in 1937. Perhaps like the world of community care, the bridge authority has seemed ambivalent about suicide. Intervention was relegated to a niche group of trained security staff, while most leaders focused their attention on their core business.

Attitudes are changing. In 2006, the documentary "The Bridge" included footage of 22 individuals jumping to their deaths over the course of a year and included interviews with family, friends, and bystanders. The film included an interview with Kevin Hines who survived a jump in 2000. In the documentary Kevin intimately describes the last five seconds. In the first second, he would do anything to end the all-consuming despair he felt from his struggle with bipolar disorder — including flinging himself across the rail. In the subsequent 4-second fall, he instantly realized he would do anything to undo what seemed too late to change.

This film — released during a time when knowledge of suicide prevention was emerging — ignited a remarkable change. The bridge authority took responsibility, and voted to install a plastic-coated, steel safety net underneath the entire span of the bridge. Where similar safety interventions have been implemented, the suicide rate has been driven to near zero. We understand that for those who might have died — like Kevin Hines — suicide was not inevitable. Safety precautions could make a difference.

The parallels for community behavioral health are striking. While our nation's suicide prevention efforts have focused on people at high risk for decades, the public's attention has been largely on teens, college students, returning veterans, and people in high-risk minority communities. These groups can face suicide rates 2 to 4 times greater than the general population. By comparison, individuals with serious mental illness die by suicide at rates 6 to 12 times higher (especially those with major depressive disorder, schizophrenia, bipolar disorder, borderline personality disorder, and anorexia) than the general population. Our bridge has not been very safe.

Where similar safety interventions have been implemented, the **suicide rate has been driven to near zero**.

Like the Golden Gate Bridge with its trained security, we have relied on a small group of specialized staff to confront the highest risks. These frontline leaders include crisis interventionists who work in crisis centers, hotlines, or mobile crisis teams. Many may have taken on this mission because someone in their life died by suicide. However, despite the high risk among the people we care for, the bulk of the behavioral healthcare workforce has not received dedicated training in how to help people who are acutely suicidal. We often feel unprepared for the frequent encounters where suicidal thoughts are introduced. We learned that hospitalization was required when people are suicidal. As a result, therapeutic relationships characterized by trust and candor were shaken when individuals were ferried to someone else because they spoke the "S-word," whether to specialized staff, a psychiatrist, an ER employee, or law enforcement officer.

NOW IS THE TIME

In 2010, we were asked to lead a task force on suicide intervention and care for healthcare systems. A statement from SAMHSA's Bureau Chief for Suicide Prevention, Dr. Richard McKeon, set the tone for a different approach: "Over the decades, there have been many instances where individual [mental health] clinicians have made heroic efforts to save lives... but systems of care have done very little."

Over the course of 2011, our task force learned that some systems of care have taken a different path. We studied the results of the US Air Force in the late 90s, the Henry Ford Health System, the National Suicide Prevention Lifeline and the Arizona Programmatic Suicide Deterrent System, and we developed a report, "Suicide Care in Systems Framework."

The fundamental message was that we must do more than offer clinical staff periodic trainings, or vanilla exposure to evidence-based practices. We must take responsibility as leaders. Saving lives starts with culture change, and leverages the resources of our systems. We must commit to safety — both the safety of those we serve and a safe environment for clinical staff, who may experience bad outcomes despite their best efforts. Just as we have committed to change the 25-year

SHIFT IN PERSPECTIVE FROM	TO
Accepting suicide as inevitable	Every suicide is preventable
Stand alone training and tools	Overall systems and culture change
Specialty referral to niche staff	Part of everyone's job
Individual clinician judgment & actions	Standardized screening, assessment, risk stratification, and interventions
Hospitalization during episodes of crisis	Productive interactions throughout, continuity of care
"If we can save one life..."	"How many deaths are acceptable?"

premature death that results from our consumers' medical illnesses, we must commit to helping them stay alive despite the desperation and isolation that can be fatal. We must define suicide intervention and care as a core business competency and expectation for community behavioral health.

The leaders of Henry Ford Health System ignited a fire in our task force, and efforts in Arizona and New York were followed by initiatives in Texas, Kentucky and Pennsylvania. We have a growing learning collaborative of behavioral healthcare leaders who strongly believe suicide represents a worst case failure in mental health care and that we must work to make it a 'never event' in our programs and systems of care.

WHAT CAN YOU DO?

Our task force is working to develop a series of web-based modules that will support your efforts, to be available beginning in spring 2013. These tools and materials will be available through the Suicide Prevention Resource Center website at www.sprc.org:

1. Changing your core business (mission/vision for zero suicide in healthcare)
2. Adopting/leveraging a safety and performance improvement culture
3. Orienting/training the workforce for suicide intervention and care
4. Installing proven suicide prevention practices including screening for risk, pathways to care, interventions that are effective against suicide and follow-up after acute treatment.

We recommend you start with a leadership dialogue and make a commitment and then survey your entire workforce for self-perceptions on skill, training, and support to engage in the important work of suicide prevention. Unless your experience is very different than ours to date, you will likely find that at least half do not feel they are adequately equipped. About one in four behavioral health

professionals have experienced someone under their care ending their life, with resulting concern and possible guilt — or commitment.

The 2010 Forbes magazine article "The Forgotten Patients" chastised the mental health industry for ignoring the over 35,000 people who die by suicide each year. Now is the time for behavioral healthcare to move suicide intervention and care to core business, to equip staff to engage in this important work, and to communicate to those we serve an end to the "don't ask, don't tell" culture around suicide.

In 2001, Henry Ford Health System's behavioral healthcare leaders and staff committed themselves to this new approach with their "Perfect Depression Care" initiative. Within four years, the suicide rate had declined by 75% and more recent results have been stunning. A 2012 national study from the UK published in The Lancet also demonstrated positive declines in suicide for health districts implementing comprehensive reforms.

We are convinced that we must engage in this work and that we can succeed. We know much more than we did just a decade ago—when Surgeon General Dr. David Satcher released the first National Strategy for Suicide Prevention as a follow-up to his pathbreaking report on mental health. We have new tools that can much more accurately predict risk, and clinical interventions as well as systems approaches (e.g. follow-up after Emergency Room visits) that dramatically reduce risks. We have learned from survivors of suicide attempts that the will to live remains strong even after things seemed impossible. Indeed, many survivors are becoming our strongest and most effective advocates.

Now is the time when leadership will make a difference. And no mission is more important than saving lives. Please join with others to make our bridge to recovery safer.

As Vice President for Adult & Youth Services for Magellan of Arizona, David Covington is responsible for the administrative, financial, programmatic, and clinical oversight of the system of care which serves 80,000 actively enrolled individuals who are struggling with mental illness and/or substance abuse issues in central Arizona through a vibrant network of more than 100 specialty behavioral healthcare provider agencies. Covington is a founding Executive Committee member of the National Action Alliance on Suicide Prevention and co-lead of the Clinical Care & Intervention Task Force. He is a member of the Board of Directors of the National Council for Community Behavioral Healthcare, a member of the Magellan of Arizona Community Governance Board, the acting chair for the SAMHSA National Suicide Prevention Lifeline Steering Committee, and Past President for the NAMI Arizona Board of Directors. Previously, Covington was CEO and Partner for Behavioral Health Link, whose groundbreaking Georgia Crisis & Access Line has been recognized for innovation and excellence from SAMHSA, the National Council, CARF's Promising Practices, Council of State Governments, State News magazine, Business Week, and Harvard's Kennedy School of Business.

Dr. Michael Hogan was confirmed in March 2007 as Commissioner of Mental Health in New York. The New York State Office of Mental Health operates 25 accredited psychiatric hospitals and oversees New York's $5 billion public mental health system that serves 650,000 individuals annually. Dr. Hogan served as Director of the Ohio Department of Mental Health (1991-2007) and Commissioner of the Connecticut Department of Mental Health (1987-1991). He chaired the President's New Freedom Commission on Mental Health in 2002-2003 and was appointed as the first behavioral health representative on the board of The Joint Commission in 2007. He served (1994-1998) on the National Institute of Mental Health's National Advisory Mental Health Council, as President of the National Association of State Mental Health Program Directors, and as Board President of NASMHPD's Research Institute. He has received leadership awards from the National Governor's Association, National Alliance on Mental Illness, Campaign for Mental Health Reform, American College of Mental Health Administration, and American Psychiatric Association.

Individuals with serious mental illness (especially those with major depressive disorder, schizophrenia, bipolar disorder, borderline personality disorder, and anorexia) die by suicide at rates 6 to 12 times higher than the general population.

90% of people who die by **suicide** have a **diagnosable and treatable psychiatric disorder** at the time of their death.

(American Foundation For Suicide Prevention)

There Is **HOPE**

When it comes to suicide prevention, EveryDay **Matters**. In recognition of National Suicide Prevention month, we thank those who work in a community that takes action every day.

Visit **www.EveryDayMatters.com** to share your story and help debunk the stigma often associated with mental health.

EveryDay **Matters**
FOUNDATION

NOT ANOTHER LIFE TO LOSE :
SUICIDE IN AMERICA

"Preventing suicide is everyone's business. As members of a family, a school, business, neighborhood, faith communities, friends, and our government, we all need to work together to solve this problem. I ask everyone to help by learning about the symptoms of mental illnesses and substance abuse, the warning signs of suicide, how to stand with and support someone who is in crisis, and how to get someone you care about the help they need."

Surgeon General Dr. Regina Benjamin

SUICIDAL THOUGHTS AND BEHAVIOR AMONG ADULTS AGED 18 OR OLDER

8.7 Million Reported having serious thoughts about suicide

2.5 Million Made Suicide Plans

1.0 Million Made Plans and Attempted Suicide

1.1 Million Attempted Suicide

0.1 Million Made No Plans and Attempte Suicide

Every 15 minutes a person dies by suicide in the US

15

Suicide is the second leading cause of death among 25-34 year olds and the third leading cause of death among 15- to 24-year olds. Almost 16% of students in grades 9 to 12 report having seriously considered suicide.

Among the 1.1 million adults who attempted suicide in the past year, 752,000 (67.2%) received medical attention for their suicide attempt in the past year, and 572,000 (51.1%) stayed overnight or longer in a hospital as a result of their suicide attempt in the past year.

752,000 Received Medical Attention Last Year

67%
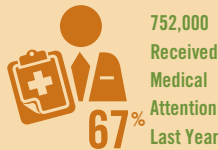
SUICIDE RATES BY AGE, RACE AND GENDER

- White Male
- American Indian/ Alaska Native Male
- Black Male
- White Female
- American Indian/ Alaska Native Female
- Black Female

Rate/100,000 — axis: 0, 5, 10, 15, 20, 25, 30, 35, 40, 45, 50
Age groups: 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+
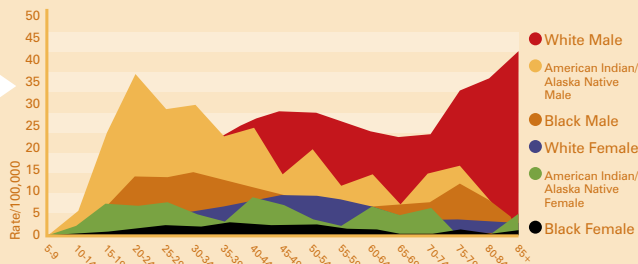
Adults in 2010 who were unemployed in the past year were more likely than those who were employed full time to have serious thoughts of suicide (6.7 vs. 3.0%), make suicide plans (2.6 vs. 0.6%), and attempt suicide (0.9 vs. 0.2%).

Compared with adults with private health insurance, adults with Medicaid or CHIP had higher rates of serious thoughts of suicide (6.7 vs. 3.1%), making suicide plans (2.9 vs. 0.8%), and attempting suicide (1.6 vs. 0.4%).

Suicide is the 2nd most common cause of death in the U.S. military The 154 suicides for active-duty troops in the first 155 days of 2012 outdistance the U.S. forces killed in action in Afghanistan by about 50 percent.

SUICIDE
2nd
3rd

LGBT Youth
Questioning Youth
Non-LGBT

Lesbian, gay, bisexual and trans youth are **4 times more** likely, and questioning youth are **3 times more** likely, to attempt suicide as their non-LGBT peers.

1 out of 6 students nationwide (grades 9-12) seriously considered suicide in the past year.

1/6

700,000 ER VISITS

2 million adolescents attempt suicide annually, resulting in 700,000 ER visits.

Among college students there are a reported 1,100 suicides per year and 50% of college students report suicidal ideation at some time in life.

50% of college students report suicidal thought
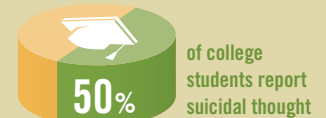
Worldwide, suicide accounts for $26.7 billion in combined medical and work-loss damages yearly and a majority of violence-related injury deaths (64%).

–$26.7 billion

There are **25 attempts for every death by suicide** for the nation; 100-200:1 for the young; 4:1 for the elderly [http://www.suicidology.org/stats-and-tools/suicide-statistics]

SUICIDE RATES PER 100,000 POPULATION
BY COUNTY, UNITED STATES 2000–2006

- Suppressed/undefined
- 4.65–10.14
- 10.15–11.23
- 11.24–12.26
- 12.29–13.64
- 13.65–15.61
- 15.62–71.89
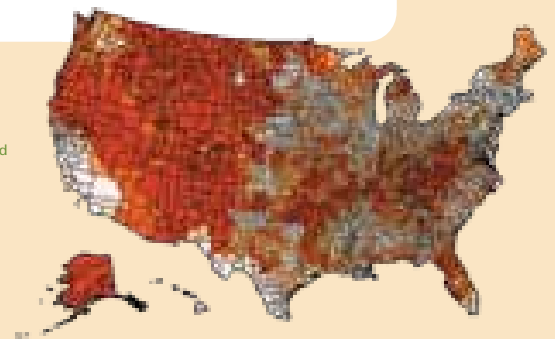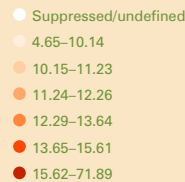
THOSE AT HIGHERST RISK NEED FOCUSED INTERVENTION

White Males 65 +
3-4x

Veterans/Military
2-4x

Alaskan Natives/ American Indians
2-4x

Lesbian, Gay, Bisexual, Transgender(LGBT) Youth
2-3x

Individuals with Serious Mental Illness(SMI)
6-12x

Rates greater than general popultion
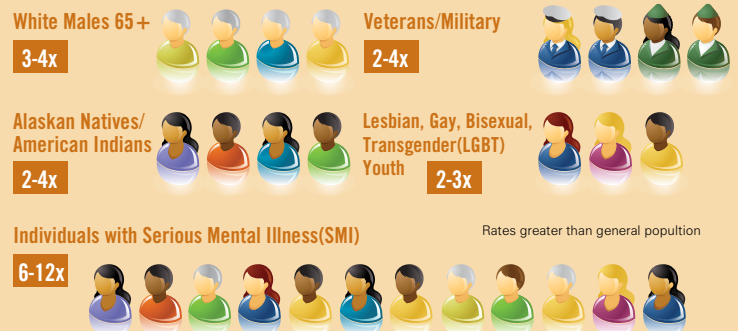
RISK FACTORS FOR SUICIDE

- ☑ Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- ☑ Alcohol and other substance use disorders
- ☑ Hopelessness
- ☑ Impulsive and/or aggressive tendencies
- ☑ History of trauma or abuse
- ☑ Major physical illnesses
- ☑ Previous suicide attempt
- ☑ Family history of suicide
- ☑ Job or financial loss
- ☑ Loss of relationship
- ☑ Easy access to lethal means
- ☑ Local clusters of suicide
- ☑ Lack of social support and sense of isolation
- ☑ Stigma associated with asking for help
- ☑ Lack of health care, especially mental health and substance abuse treatment
- ☑ Cultural and religious beliefs, such as the belief that suicide is a noble resolution of a personal dilemma
- ☑ Exposure to others who have died by suicide (in real life or via the media and Internet)

60% Depression

Untreated Mental Illness

90% of individuals who die by suicide have untreated mental illness — of these, 60% have depression

Under-treatment of mental illness is pervasive — 50-75% of those in need receive no treatment or inadequate treatment; 50-75% of children with depression go undiagnosed and untreated

50-75% untreated
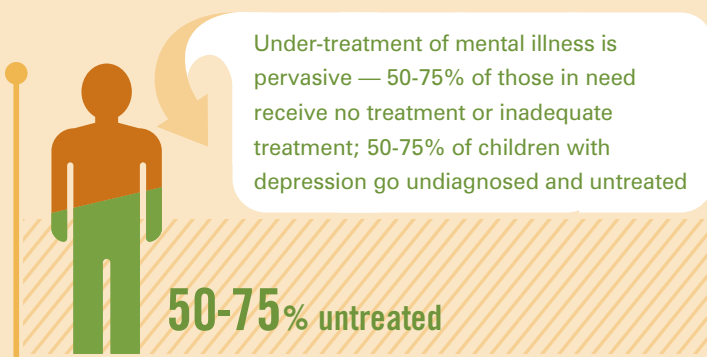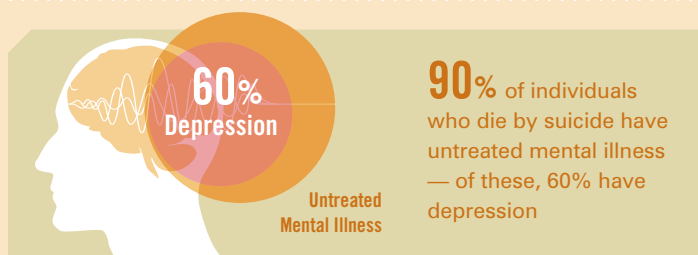
ARE SOME AT GREATER RISK THAN OTHERS?

Of every 100,000 people in each of the following ethnic/racial groups below, the following number died by suicide in 2007.

Per 100,000

Non-Hispanic Whites 13.5
American Indian & Alaska Natives 14.3
Hispanics 6.0
Non-Hispanic Blacks 5.1
Asian and Pacific Islanders 6.2
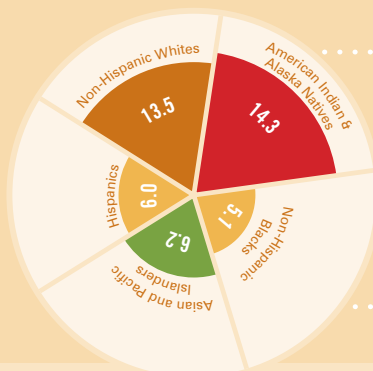
WHEN TO CALL A SUICIDE PREVENTION LIFELINE

- ☑ Feeling like you want to die or to kill yourself.
- ☑ Feeling trapped or like you cannot handle the pain.
- ☑ Feeling hopeless or like you have no reason to live.
- ☑ Looking for a way to kill yourself, such as searching for methods online or buying a gun.
- ☑ Feeling like you can't talk to anyone and would rather be alone.
- ☑ Drinking more alcohol and using drugs.
- ☑ Feeling like you are a burden to others.
- ☑ Sleeping too little or too much.
- ☑ Feeling anxious or agitated.
- ☑ Wanting to seek revenge.
- ☑ Having extreme mood swings.

LIFELINE

National Suicide Prevention Lifeline
1.800.273.TALK(8255)

The Trevor Helpline
1.866.4.U.TREVOR

Veterans Crisis Line
1.800.273.8255 Ext.1

NFL Life Line
1.800.506.0078

facebook
Report Suicidal Content at
www.facebook.com/help/contact/?id=305410456169423

PROTECTIVE FACTORS FOR SUICIDE

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

Nearly one-half of the people who die by suicide have seen a primary care physician within a month of death. Primary care visits may represent an important opportunity for suicide prevention.
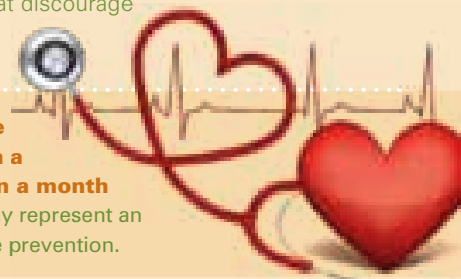
For more information, interviews, and research on suicide check out the National Council's magazine edition on the topic

SOURCES
www.samhsa.gov/data/NSDUH/2k10MH_Findings/2k10MHResults.htm#2.3
www.suicidepreventionlifeline.org/Learn/RiskFactors
www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml#races
www.cdc.gov/ViolencePrevention/suicide/statistics/suicide_map.html
www.thetrevorproject.org/suicide-prevention/facts-about-suicide

They'll Be Glad They Lived
Action Alliance Brings New Focus to Suicide Prevention Efforts

John M. McHugh, Secretary of the Army

The famed French philosopher Voltaire once lamented that "the man who, in a fit of melancholy, kills himself today, would have wished to live had he waited a week." A powerful figure in Europe's Age of Reason, Voltaire's views on suicide today may seem simplistic, even trite. But the point of identifying opportunities to intervene and helping someone choose a different path remains as relevant as ever.

Of all afflictions facing mankind, suicide remains one of the most vexing. There are few, if any, early warnings — no sneezes, coughs, or fevers. It can't be readily diagnosed, x-rayed, or surgically removed. It is not confined to a race, gender, age or socioeconomic status. And perhaps most frustrating of all, its sufferers need do only one thing to keep it from taking hold — absolutely nothing at all. To wait, as Voltaire once advised, just one more week.

For the U.S. military, suicide seems particularly insidious. The Army is an institution that works hard to instill in its members the Warrior Ethos, a code our soldiers live by — never accept defeat, never quit, and never leave a fallen comrade. Yet, for all our effort, we now lose more service members to suicide than to combat.

On average, 95 Americans take their lives each day by suicide. On average, one of them will be a soldier.

It's logical to assume that in the military, the stresses and strains of more than a decade at war — repeated deployments, extended time away from family, and the rigors of combat — are the reason we see so many promising lives lost so early. But like so many of suicide's contradictions, while assumptions are often easy, reality is a far more complicated affair.

A 3-year study by the Department of Defense revealed that 54% of those who took their own lives in 2010 had never deployed to theater. Similarly, 59% of those who had attempted suicide were never sent to war. As Secretary Leon Panetta recently noted, these facts clearly demonstrate that "we're dealing with broader societal issues. Substance abuse, financial distress, relationship problems, the risk factors for suicide that also reflect the problems in the broader society, the risk factors that will endure beyond war."

Secretary Panetta's observations are further supported by statistics from the Center for Disease Control, which show a troubling increase in both the number and rate of suicide deaths across the United States. The CDC's last comprehensive study revealed that between 2001 and 2009, the rate of suicide death increased nearly 10% (from 12.48% to 13.68% per 100,000) while the number of resulting deaths rose more than 20% (from 30,600 to 36,891).

In recent years, the Army has dedicated a great amount of effort and resources into our own suicide studies, prevention, and intervention programs. Nevertheless, we believe that the road to truly meaningful progress lies in collaboration amongst the private sector, public institutions, and experts from all walks of life.
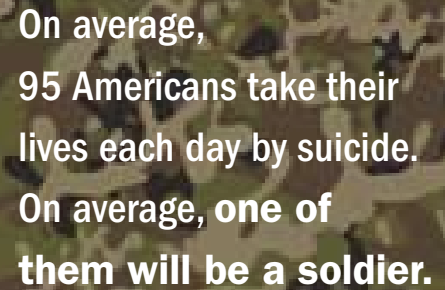
That's why I'm privileged to serve, along with former U.S. Senator Gordon Smith, as co-chair of the National Action Alliance for Suicide Prevention.

Since its inception on World Suicide Prevention Day in 2010, the Alliance has created a unique public-private partnership, with deep and diverse leadership on its executive committee and advisory groups. Alliance members also represent approximately 200 different organizations nationwide, bringing them together in a collaborative effort.

In the short time since its standup, the alliance created fourteen Task Forces. Some will improve research and understanding of suicide within specific demographic groups, while others tackle broader issues facing society as a whole — helping us better define and understand our challenges.

One of the Alliances goals has been the update of the National Strategy for Suicide Prevention, the first revision since its release in 2001. A renewed NSSP will facilitate our efforts to create healthy and empowered individuals and communities; promote clinical and community preventive services; target treatment and support; and improve data collection and analysis.

In our quest to identify new ways to intervene and ultimately prevent suicide, a better understanding

> On average, 95 Americans take their lives each day by suicide. On average, **one of them will be a soldier.**

of the warnings, root causes, and at-risk populations will be essential. For example, while suicide is the third leading cause of death among young people, middle aged women have been identified as the fastest growing at-risk population. In short, we must broaden our thinking, abandon any quest for one-size-fits-all solutions, and recognize a simply reality — while we all face our own challenges, we share a common threat.

With more than a dozen goals and 60 objectives, the NSSP is a substantive and necessary document, encouraging dialogue and sharpening our focus toward solutions.

Suicide is often described as a permanent solution to a temporary problem. Helping those at risk better understand they have options, support, and hope may make them choose to wait, for at least for one more week. Then, as the famed philosopher once noted, they'll be glad they lived.

John M. McHugh was sworn in as the 21st Secretary of the Army on Sept. 21, 2009, following his nomination by President Barack Obama and confirmation by the United States Senate. As Secretary of the Army, he has statutory responsibility for all matters relating to the United States Army. Secretary McHugh is responsible for the Department of the Army's annual budget and supplemental of over $200 billion. He leads a work force of more than 1.1 million active duty, Army National Guard, and Army Reserve soldiers; 221,000 Department of the Army civilian employees; and 213,000 contracted service personnel. At the time of his appointment as Secretary of the Army, McHugh was a sitting member of Congress representing Northern and Central New York. During his nine terms in the U.S. House of Representatives, he earned a reputation as a staunch advocate for soldiers and their families, working tirelessly to ensure they had proper facilities, training, and the quality of life necessary to carry out wartime missions while caring for those at home.
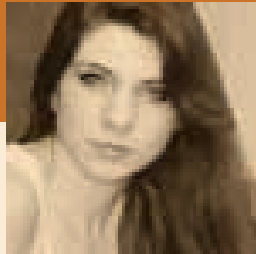
Ally

We Gave More Hugs
Chris Damle

Sunday, March 27, 2011 was going to be a fun day highlighted by my family's (wife and four children) participation in the local NAMI walk to raise mental health recovery awareness. We woke up early to go out for breakfast prior to the event and my wife nervously informed me that Ally, our 15-year-old, was not responding to her best efforts to rouse her. I hurriedly entered Ally's bedroom to find her barely able to make responsive moans and unable to open her eyes. Without thinking, I hoisted her 95-pound frame over my shoulder, ran to the car, and drove faster than I had ever previously dared to the emergency room.

We learned later that Ally had taken a potentially lethal combination of Phentermine – Xanax – Vicodin – Ambien – Ibuprofen in an attempt to end her life. She remained in the hospital for four days in a semi-coma, recovering from a heart attack and short-term neurological damage that prevented her from walking. The doctor told us she was lucky to be live and indicated that it was good to be 15 and healthy, because most other people wouldn't have made it.

Four days is a long time to examine what had just happened. We were confused, angry, frustrated, sad, worried, scared, and lost. How does this happen to parents in the behavioral health field? I have been involved with Magellan's Central Arizona Programmatic Suicide Deterrent System Project. I had been leading a suicide prevention workgroup for two years. This should not be happening to me!

Why would my little girl — who liked to dance, read, watch movies, incessantly text, and hang out with her family — want to end her life? What were we missing? She didn't appear depressed or withdrawn. She wasn't rebellious. She wasn't the type of teenager that wanted to go to parties, the mall, or stay out late.

We decided to admit her into a children's behavioral health inpatient setting after discharge. Our insurance would pay for 10 days of treatment. We were so scared about her being home that we would have preferred for her to stay 10 months. We just wanted her to be safe. These 10 days gave us the opportunity to safely explore the real issues — prescription pain killer abuse; boys/sex/relationships and rejection; sexting, shame, feelings of inadequacy; obsession with "dark, nihilistic" music and movies; the expectation to be perfect in our eyes. Ally would rather end her life than face her parent's rejection. Suicide was a logical option to get her out of her perceived predicament. I was stunned by the "fearlessness" she exhibited when discussing her rationale for attempting suicide.

I was so scared for Ally to come home and worried that she would try again. I read about a woman who was so determined to keep her suicidal daughter alive that she removed all the doors in the house and had the daughter sleep with her, tethered by a string. I didn't want to go that far, but I was willing to take the steps necessary to reduce any risk of suicidal behaviors.

Once we arrived home with Ally, we tried to remove any influences that might increase suicidal thoughts. We took Ally out of public high school and she started taking online classes via home computer. She was only allowed to call friends — no texting or cell phone. Friends could come over to the house and visit, but she was not allowed to go out on her own at first. No social activities without parents/family involved. We limited music to positive selections. Prescription drugs were locked up out of reach. As I write this, it sounds like house arrest, but it allowed Ally to focus on her recovery without distractions.

Ally started counseling — she didn't really want to discuss all of her issues with us and we didn't press her. She joined ballet classes at a studio at least 5 days a week. And she started working out daily with her mother at a gym.

We increased family activities — movie outings, zoo, bowling, etc. — prioritizing this time together and scheduling it like any other appointment. I started spending time with Ally — we hiked Camelback Mountain together. We went to the bookstore and just talked — nothing deep, just about life.

The most important thing we did was be involved. We tried not to play therapist, but offered our unconditional love. Ally needed to hear that we wanted her in our life and that we would be there for her no matter what. We changed, too. We learned how to cope with this force that was trying to take our daughter away from us. We became better listeners and tried not to overreact. We gave more hugs, held more hands, and said more "love you's".

Maybe we were the lucky ones, but Ally started to slowly rebuild herself. She began friendships with those in her dance classes and online program. She started thinking of herself as a dancer and it became a passion. She became best friends with her 13-year old brother. She became so much closer to her family. She is now thinking about what she wants to do after high school this year. Maybe she will be a professional dancer; maybe she will go to college and study to be a physical therapist.

I am hopeful that Ally is headed in the right direction. This experience has changed me in such a profound way, that I am hopeful that I am headed in the right direction as well.

Chris Damle is the Senior Director of Adult Services, Quality of Care for Magellan Health Services of Arizona. He has been serving adults with a serious mental illness for the past 25 years. He is currently leading a suicide prevention workgroup to incorporate social connectedness as a behavioral health treatment practice for adults with a serious mental illness.

America's Doctor Says Connection is Prevention
REGINA M. BENJAMIN, Surgeon General

Exclusive interview by Meena Dayak for National Council Magazine

Dr. Regina M. Benjamin, MD, MBA, is the 18th Surgeon General of the United States. As America's Doctor, she provides the public with the best scientific information available on how to improve their health and the health of the nation. Dr. Benjamin also oversees the operational command of 6,500 uniformed public health officers who serve in locations around the world to promote, and protect the health of the American People. From her early days as the founder of a rural health clinic in Alabama – which she kept in operation despite damage and destruction inflicted by hurricanes Georges (1998) and Katrina (2005) and a devastating fire (2006) – to her leadership role in the worldwide advancement of preventive healthcare, Dr. Benjamin has forged a career that has been recognized by a broad spectrum of organizations and publications.

On September 10, 2012 the National Action Alliance for Suicide Prevention, along with the U.S. Surgeon General, Dr. Regina Benjamin, released the revised National Strategy for Suicide Prevention. The revised strategy emphasizes the role every American can play in protecting their friends, family members, and colleagues from suicide. The Surgeon General talks to National Council Magazine about the highlights.

NATIONAL COUNCIL: Why is suicide prevention a key part of your agenda as surgeon general?

DR. BENJAMIN: Because nearly a hundred Americans die by suicide every single day, and in the past year, more than 8 million Americans had serious thoughts of suicide.

For me, personally, a number of years ago, just as I was about to take over as the first African-American and the first woman president of our county medical society in Alabama, I was speaking on the phone with our executive director on a Friday afternoon, and then we were supposed to speak again on Monday morning. But after I didn't hear from him, I started calling him and calling around, and I learned that on that Friday night he went upstairs, went into the closet, and shot himself. And to this day I ask myself what could I have done and what should I have done? And so if I as a doctor didn't know, I'm not surprised that others don't either.

NATIONAL COUNCIL: What does the revised National Strategy for Suicide Prevention focus on?

DR. BENJAMIN: The revised strategy shows us how individuals and communities can come together to put processes and programs into place that can help people like my former executive director. Ten years ago my predecessor, Dr. Satcher, released the first National Strategy for Suicide Prevention. He started a new conversation about suicide in America, making people aware of the problem.

Since then, the suicide prevention community has been trying to tell everybody who would listen that more than 33,000 people take their lives in the United States every year. And that's one person every 15 minutes! Now it's time for us to turn our conversation to true prevention.

From a national perspective, I guess the biggest advancement that we've had in the field is the launch of that National Action Alliance for Suicide Prevention. And this particular alliance is a public and private coordinating body, and it was called for in the 2001 strategy. It was actually formed two years ago, and prior to that we had multiple groups and organizations spread out trying to address the issue of suicide separately, but this Action Alliance brought us all together and think about suicide in one place. We've had several hundred people who've been involved in the effort of trying to revise the 2001 strategy.

We also wanted to make sure that our suicide prevention strategy aligned well with our overall National Prevention and Health Promotion Strategy that I released in 2011 as U.S. Surgeon General and Chair of the National Prevention, Health Promotion, and Public Health Council.

The revised suicide prevention strategy will guide the nation to prevent the burden of suicide and suicidal behavior. We hope to use it over the next ten years. This strategy captures the progress that we've already made, the knowledge that we've acquired, and the promise that certainly was in our grasp. The promise is that suicide is preventable.

We've had a lot of activity in the field of suicide prevention since that 2001 first report. Government agencies at all levels, schools, nonprofit organizations, and businesses have started to address suicide prevention. We enacted a law, the Garrett Lee Smith Memorial Act, and that law established the National Suicide

The promise is that suicide is preventable.

> We also know that being connected makes a big difference — connected to family, teachers, coworkers, community organizations, and social institutions.

Prevention Lifeline, and we've also established a Suicide Prevention Resource Center. We've started increasing trainings and community awareness programs.

We've had some major developments in research and practice, such as an increased understanding of the link between suicide and other health issues like mental illness and substance abuse and traumatic or violent events. We also know that being connected makes a big difference — connected to family, teachers, coworkers, community organizations, and social institutions. And these things can help protect individuals from a wide range of health problems including suicidal risk. And we have evidence now that certain prevention and intervention strategies like behavior therapy and crisis lines are effective.

We want to foster public dialogue. We want to counter the shame and the prejudice and the silence, and we want to address the needs of certain groups that we know are more vulnerable than others. We want to integrate public health and behavioral health so that we can ensure continuity of care. Basically making system changes.

We also want to reduce the access to lethal means for people at risk of suicide.

The bottom line is that we want people to talk about it. Don't be afraid to ask. When you think somebody may be at risk, ask them, "Are you thinking about hurting yourself? Are you thinking about killing yourself?" We used to be afraid to ask because we thought we'd be giving suggestions, but the research shows now that asking and actually talking about it — communicating — is more important, and that people will at least think someone cares enough to ask.

We also want people to know what the warning signs are — like people talking about wanting to die, talking about feeling trapped, being in unbearable pain, being a burden to others. Have they been looking for a way to kill themselves? Are they becoming withdrawn and isolated with extreme mood swings? And if you see somebody who has these warning signs and you think they may be at risk, it's very important that you don't leave that person alone, that you stay in contact with them or make sure somebody else is in contact with them, and remove any objects that they could use to harm themselves.

Then you can call the National Suicide Prevention Line at 1-800-273-TALK and a professional will tell you what steps to take next. And if all that fails, take them to the emergency room where you can get some help.

It's a simple thing — we're trying to get people to understand that when someone asks for help, you can get them help. You don't have to be trained in it, you don't have to be an expert or a medical person. Basically you just show them that you

care. Many people who are suicide survivors will say, "Somebody cared enough to ask me."

It's not one person that can stop a suicide, it's going to be the whole community — the workplace, schools, teachers — everyone getting together and making it okay to talk about it, making it okay to get rid of the silence, get rid of the prejudice.

NATIONAL COUNCIL: You said being connected is a key prevention strategy — does technology help with that?

DR. BENJAMIN: Technology is sort of a double-edged sword, as you know. Many of our young people, — 16% of high school students — said they had serious thoughts about suicide. They're often on the Internet, on Facebook. And so that's one of the reasons we teamed up with Facebook — to be where the at-risk people are, to reach them where they are. They have a button on the Facebook page, and if you see a posting of a friend that seems to have the warning signs and you're concerned that they may be having suicidal thoughts, you can forward that posting to the National Suicide Prevention Lifeline and a professional will contact that person, either by email or by telephone, and take it from there.

NATIONAL COUNCIL: What can healthcare providers do to support suicide prevention efforts?

DR. BENJAMIN: Linking up medical care with mental health services, and trying to get people into care with good follow up is really important. The Centers for Medicare and Medicaid Services also announced that they're adding reimbursements for clinicians' offices that will do suicide screenings. We're having more funding going toward training of clinicians — physicians and nurses and their office staff — so that we'll have better identification and early treatment. **The main thing now is continuity of care — that we continue the care, that we don't have it piecemeal and separated from regular medical care, that we link the two together.**

I'd just like to say thank you to behavioral health providers for the work that's been done over the years, the awareness. It's hard work. It takes a lot for the providers and clinicians to work with people who are at a point where they consider harming or killing themselves. I'd like to thank them for all the work that they've done over the years and continue to do, and to let them know that they are very much appreciated.

NATIONAL MILESTONES IN SUICIDE PREVENTION

1958: First suicide prevention center opens in Los Angeles, California.

1976: AAS establishes crisis center certification program and certifies its first crisis center.

1989: Suicide Awareness Voices of Education (SAVE) holds its first national suicide awareness memorial in St. Paul, Minnesota.

1989: U.S. Department of Health and Human Services (HHS) publishes *Report of the Secretary's Task Force on Youth Suicide*.

1989: AAS holds its first "Healing After Suicide" conference.

1967: National Institute of Mental Health (NIMH) establishes Center for Studies of Suicide Prevention.

1971: The journal *Suicide and Life Threatening Behavior* publishes its first issue.

| 1958 | 1959 | 1960 | 1961 | 1962 | 1963 | 1964 | 1965 | 1966 | 1967 | 1968 | 1969 | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 | 1977 | 1978 | 1979 | 1980 | 1981 | 1982 | 1983 | 1984 |

1987: American Foundation for Suicide Prevention (AFSP) founded.

1973: NIMH publishes *Suicide Prevention in the 70s*.

1968: First national conference on suicidology held in Chicago, Illinois.
1968: American Association of Suicidology (AAS) founded.

1990: SAVE is incorporated.

1960: International Association for Suicide Prevention founded.

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

1992: Centers for Disease Control and Prevention (CDC) publishes *Youth Suicide Prevention Programs: A Resource Guide*.

1997: The Jason Foundation, Inc. founded.

1997: Congress passes S. Res. 84 and H. Res. 212 recognizing suicide as a national problem; CDC establishes National Center for Injury Prevention and Control.

1997: Organization for Attempters and Survivors of Suicide in Interfaith Services (OASSIS) founded.

2001: Substance Abuse and Mental Health Services Administration (SAMHSA) funds national crisis line.

2001: HHS publishes *National Strategy for Suicide Prevention*.

2010: National Action Alliance for Suicide Prevention established.

2010: SPRC and SPAN USA/AFSP publish Charting the Future of Suicide Prevention: A 2010 Progress Review of the National Strategy and Recommendations for the Decade Ahead.

1999: First National Survivors of Suicide Day held.

1999: National Hopeline Network (1–800–SUICIDE) launched.

1999: HHS publishes *The Surgeon General's Call to Action to Prevent Suicide*.

1999: National Council for Suicide Prevention established.

2005: SAMHSA launches National Suicide Prevention Lifeline (800–273–TALK/8255)

2007: Joshua Omvig Veterans Suicide Prevention Act signed into law.

2007: The Veterans Suicide Prevention Hotline founded.

2007: Joint Commission publishes *Patient Safety Goals on Suicide*, making suicide prevention one of its standards for accreditation.

1995: Lifekeeper Foundation founded.

2003: President's New Freedom Commission on Mental Health publishes *Achieving the Promise: Transforming Mental Health Care in America*.

1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012

2004: Garrett Lee Smith Memorial Act signed into law creating the State, tribal, and campus suicide prevention grant programs.

1998: The Trevor Project founded.

1998: National Organization for People of Color Against Suicide founded.

1998: SPAN USA and CDC partner to host the Reno Consensus Development Conference.

1998: CDC funds Suicide Prevention Research Center at University of Nevada.

1994: Yellow Ribbon Suicide Prevention Program founded.

2009: U.S. Department of Defense (DoD) establishes Task Force on the Prevention of Suicide by Members of the Armed Forces.

2008: Mental Health Parity and Addiction Equity Act signed into law.

2011: The Department of Defense established the Defense Suicide Prevention office (DSPO)

1996: Suicide Prevention Advocacy Network USA (SPAN USA) founded.

1996: World Health Organization and United Nations publish *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies*.

1996: CDC publishes report on suicide among Native Americans.

1996: U.S. Air Force suicide prevention initiative launched.

2000: The Jed Foundation founded.

2000: OASSIS sponsors first National Interfaith Conference on Religion and Suicide.

2002: SAMHSA establishes national Suicide Prevention Resource Center (SPRC).

2002: Institute of Medicine releases *Reducing Suicide: A National Imperative*.

2002: The first Out of the Darkness Overnight walk held.

2006: Federal Working Group on Suicide Prevention formed.

2012: National Strategy for Suicide Prevention revised.

Suicide Prevention IS Everybody's Business
The New National Roadmap to Action

Jerry Reed, PhD, MSW, Vice President, Education Development Center and Director, Suicide Prevention Resource Center

Co-lead, National Strategy for Suicide Prevention Task Force, National Action Alliance on Suicide Prevention

M ore than 15 years ago, the World Health Organization and the United Nations published Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies. This publication called for a national coordinating body to advance suicide prevention in each country. On September 10, 2010, that coordinating body, the National Action Alliance for Suicide Prevention (Action Alliance), was launched in the United States, as a public-private partnership by the U.S. Health and Human Services Secretary, Kathleen Sebelius, and the Defense Secretary, Robert Gates. The Honorable John McHugh, Secretary of the Army, assumed the public sector lead of the Action Alliance, and the Honorable Gordon H. Smith, President and CEO of the National Association of Broadcasters, agreed to serve as the private sector lead. The Action Alliance set out on its mission to champion suicide prevention as a national priority, catalyze efforts to implement high priority objectives of the National Strategy for Suicide Prevention (National Strategy), and cultivate the resources needed to sustain progress.

One of the first concrete steps the Action Alliance took was launching the National Strategy for Suicide Prevention Task Force. The mission of this task force was to update and revise our nation's suicide prevention strategy, which was originally published in 2001. The Surgeon General, Regina Benjamin, and I were nominated to be the task force co-leads.

During the very early stages of this effort, we knew that the first thing we needed to do was to identify stakeholders and take the time to listen to them and benefit from their viewpoints and perspectives. Our task force worked diligently to obtain input from a broad array of stakeholders by stimulating and coordinating dialogue, because our aim was to ensure that the revised strategy would reflect input from as many stakeholders and perspectives as possible and be a document that represented the science, the times, the field, and the many opportunities which exist to advance suicide prevention and save lives.

We came together as a group and reviewed the input thoroughly — it soon became clear that major changes needed to be included, such as the addition of resources for groups with increased suicide risk and the creation of an action oriented approach, conveying what each of us might do to prevent suicide. We also made the decision to align the National Strategy for Suicide Prevention with the National Prevention Strategy: America's Plan for Better Health & Well-

> *We all have a role to play in advancing suicide prevention and the revised National Strategy for Suicide Prevention is our roadmap.*

ness, launched by the Surgeon General Regina Benjamin in June 2011, and organized the document into four strategic directions:

>> Healthy and empowered individuals, families, and communities

>> Community and clinical preventive services

>> Treatment and support services

>> Surveillance, research, and evaluation

We knew early on that we wanted a document that would be strategic in direction and stimulate planning and actions by both public and private sector stakeholders at multiple levels. As we launch the revised National Strategy for Suicide Prevention, I feel we have been able to achieve just that. The new strategy is written to appeal to a broad base, addresses public and mental health, and builds on advances made since 2001. It carries the message that suicide is preventable and, with multi-sectoral engagement, we can:

>> Foster positive public dialogue; counter shame, stigma, and silence; and build public support for suicide prevention.

>> Address the needs of vulnerable groups, be tailored to the cultural and situational contexts in which they are offered, and seek to eliminate disparities.

>> Be coordinated and integrated with existing efforts addressing health and behavioral health, and ensure continuity of care.

>> Promote changes in systems, policies, and environments that will support and facilitate the prevention of suicide and related problems.

>> Bring together public health and behavioral health.

>> Address both risk and protection.

>> Reflect the latest science, as well as evidence-based and best practices/programs.

To ensure an action-oriented approach, the strategy also outlines specific actions that everyone can take to prevent suicide. It calls on businesses and employers, schools, colleges and universities, community, non-profit, and faith-based organizations, as well as individuals and their families. We all have a role to play in advancing suicide prevention and the revised National Strategy for Suicide Prevention is our roadmap.

As we launch the revised National Strategy for Suicide Prevention, I can't help but recall the dedication of our task force members, along with countless others, who gave their honest and open input to create a national strategy that is current, comprehensive, and impactful. The strategy launch on September 10, 2012, is exactly two years after the launch of the Action Alliance and occurring on World Suicide Prevention Day, which is sponsored by the International Association of Suicide Prevention.

It is my hope that you will take the time to read the strategy (see page 22) and identify those objectives where you can take concrete steps to ensure you are providing state of the art care in your behavioral health settings to move suicide prevention forward in the United States. Together, I know, we will continue to make a difference and save lives.

....

Jerry Reed began serving as the Director of the Suicide Prevention Resource Center in U.S. in July 2008. Through this work he provides state and local officials, grantees, policymakers, interested stakeholders and the general public with assistance in developing, implementing and evaluating programs and strategies to prevent suicide. Additionally, Dr. Reed serves as the Director of the Center for the Study and Prevention of Injury, Violence and Suicide overseeing a staff of 40. Prior to this appointment, Dr. Reed served for five years as Executive Director of the Suicide Prevention Action Network USA (SPAN USA) a national non-profit created to raise awareness, build political will, and call for action with regard to advancing, implementing and evaluating a national strategy to address suicide. He spent 15 years as a career civil servant working in both Europe and the United States as a civilian with the Department of the Army developing, implementing and managing a variety of quality of life programs including substance abuse prevention and treatment, family advocacy, child and youth development programs, social services and the range of morale, welfare and recreation programs.

2012 National Strategy for Suicide Prevention Goals and Objectives for Action

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

STRATEGIC DIRECTION 1:
Healthy and Empowered Individuals, Families, and Communities

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

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

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

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

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

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

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

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

Objective 2.2: Reach policymakers with dedicated communication efforts.

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

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

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

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

2012 National Strategy for Suicide Prevention Goals and Objectives for Action *continued*

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

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

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

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

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

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

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

STRATEGIC DIRECTION 2:
Clinical and Community Preventive Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STRATEGIC DIRECTION 3:
Treatment and Support Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STRATEGIC DIRECTION 4:
Surveillance, Research, and Evaluation

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

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

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

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

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

2012 National Strategy for Suicide Prevention Goals and Objectives for Action *continued*

GOAL 12. Promote and support research on suicide prevention.

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

Objective 12.2: Disseminate the national suicide prevention research agenda.

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

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

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

Objective 13.1: Evaluate the effectiveness of suicide prevention interventions.

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

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

Objective 13.4: Evaluate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.
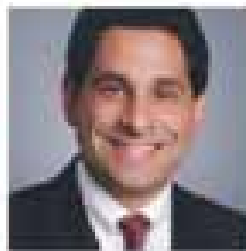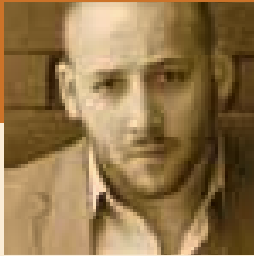
Life Is a Gift
Kevin Hines

I am Kevin Hines, a speaker and advocate of living mentally well. I am also a recovering alcoholic. My struggle with alcoholism began in high school where I would binge drink every weekend until blackout.

In May 1999, in my senior year of high school, I was diagnosed with bipolar disorder, type I, with psychotic features. I had become terribly paranoid, manic, depressed and had horrific auditory and visual hallucinations. At the time, I could barely read, write, speak or function. Extreme paranoia was the first of my symptoms. I believed people followed me in order to hurt or kill me.

The mania presented itself in grandiosity — I felt I could go anywhere, be anyone, and do anything. When I was 17, I believed that Steven Spielberg would, at any minute, show up at my house, contract in hand, offering me the lead in his next major motion picture. I expected his arrival every day.

The hallucinations were voices in my head or visualizations of people or creatures that only existed for me. The depression led me toward complete self-destruction — cutting myself and suicidal thoughts.

One year after my diagnosis of bipolar disorder, I wrote a suicide note, and the following day — September 25, 2000 — I attempted suicide by jumping off of the Golden Gate Bridge. I survived the 220-foot plunge, my body falling at 75 miles per hour, from a height of 25 stories up — two thirds of the height of the Transamerica pyramid building in San Francisco. The impact of hitting the water shattered three of my lower vertebrae lacerating some of my lower organs — yet I lived.

It took me a long time to heal physically and emotionally. I learned all I could about my illness and worked hard to defeat it, eventually winning the battle with alcoholism and bipolar disorder. I had my very last sip of alcohol on my 21st birthday. I stopped cold turkey, knowing how dangerous that was.

Today, I fight every day to stay mentally, physically and emotionally well. I am now winning the battle with only an occasional mental relapse. I work every day to spread the message of living mentally well, the importance of preventing alcohol and drug use, anti-bullying, educating about wellness in the workplace, and teen wellness by way of speaking publicly to domestic and international audiences.

Since my attempt to end my life, I have spoken to more than 300,000 people, and reached and reached millions more in media campaigns.

My struggle is not limited to my experience, it is about all who suffer with mental afflictions. I believe my story can help those who hear it because I have learned that every day we wake up is a good day and every day is a gift.

> "Yesterday is history, tomorrow is a mystery, and today is a gift."
>
> Babatunde Olatunji

TO THOSE WHO GIVE US A FIGHTING CHANCE

I have bipolar disorder. I work diligently to stay mentally well. I take my meds on as prescribed every day. I exercise daily. I eat healthily most days. I also conduct very serene deep breathing drills during panic attacks. I get great sleep nearly every night.

None of this work stops my symptoms from occurring for some unrelenting and unsuspecting moments. I am happy and blessed that my wife, who is a saint, is willing to put up with such a rigorous battle. I sincerely appreciate every second of our time together. She's been with me through five out of seven psychiatric hospital stays in the last nine years.

No matter the stress she is under, my wife recognizes that sometimes she must do what is necessary to keep me safe. Her love for me and mine for her is unmatched and unconditional. There is nothing I could do through the illnesses destruction that would push her away to the point of no return. She simply soldiers on and fights this battle with me. And I thank God for her.

It is important to remember that everything we do in the throes of mental illness affects those around us. Our significant others and family members who love and care for us so very much. The ones who catch us when we fall. The ones who give us a fighting chance when everyone around them tells them to run in the opposite direction. To those with such courage and compassion, I speak for the mental health community when I write that we forever thank you.

PAMELA HYDE
SAMHSA Takes a Public Health Approach to Suicide Prevention

Exclusive interview by Meena Dayak for National Council Magazine

Pamela Hyde was nominated by President Barack Obama and confirmed by the U.S. Senate in November 2009 as Administrator of the Substance Abuse and Mental Health Services Administration, a public health agency within the Department of Health and Human Services. The agency's mission is to reduce the impact of substance abuse and mental illness on America's communities. Hyde is an attorney and comes to SAMHSA with more than 30 years experience in management and consulting for public healthcare and human services agencies. She has served as a state mental health director, state human services director, city housing and human services director, as well as CEO of a private non-profit managed behavioral healthcare firm. In 2003 she was appointed cabinet secretary of the New Mexico Human Services Department by Gov. Bill Richardson, where she worked effectively to provide greater access to quality health services for everyone. She has been recognized by many groups, including the American Medical Association, the National Governor's Association and the Seattle Management Association, for her creativity and leadership in policy and program development and in organizational management issues.

NATIONAL COUNCIL: Can you describe SAMHSA's current focus on suicide prevention — what are your biggest concerns and what kind of programs do you have to address the issue?

HYDE: Well you know that SAMHSA has a number of strategic initiatives and prevention is our number one strategic initiative. And within that prevention initiative, suicide is one of the key focus areas.

Prevention of suicide has been a major effort for us over the last several years but particularly in the last couple of years, we have stepped up the attention. We have grant programs, the National Suicide Prevention Lifeline, and the Suicide Prevention Resource Center. In the last couple of years, we worked to kick off, with Secretary Sebelius and Secretary Gates' help, the National Action Alliance for Suicide Prevention. That has been an incredible public-private partnership and we charged that group with upgrading or revising the ten year-old national strategy on suicide prevention that Surgeon General David Satcher did ten years ago. This Surgeon General, Regina Benjamin, has been the lead to revise that document and it's been an incredible effort.

NATIONAL COUNCIL: Why did we need a revised national strategy? What worked well or what didn't, with the first national strategy for suicide prevention?

HYDE: That was a great effort and it began a lot of work, and much has been done over the last ten years. In that period of time, we've learned a lot more about techniques, about how to assess people, and about awareness issues. We've learned a lot more about who is at risk and how to address some of those high risk populations. We have more research around interventions. So there's a lot more that we know ten years later. There are also some things in the initial strategy which were actually done and it was now time to say okay, what are the next steps.

One of the things that was in the original strategy ten years ago was to create a public-private partnership, an action alliance of sorts, to actually move beyond talking about stuff and get on with actually doing things to prevent suicide across the country. So updating the national strategy was one of the key things that the National Action Alliance was charged with doing. The Alliance was taking a look at that 10 year-old document and asking what's already been done, what needs to be done, what's new in there, what are the issues we need to focus on now for the next decade. So we're very pleased. That's not the only thing the Action Alliance has done. It's been doing a ton of things over the last two years. It was kicked off literally two years ago, on September 10.

NATIONAL COUNCIL: Would you comment on the highlights of the new national strategy from the Action Alliance?

HYDE: Making sure we address access to lethal means — whether that is medications in the medicine cabinet, guns in the house, or a bridge — for someone who is at risk, is down the road. Looking at what those lethal means are for people who are at risk, and seeing what we can do to prevent that is one of the goals.

There are goals on evidence based practices. So for example, we know that a number of people who go into an emergency room, or into a hospital admission because of a suicide attempt, are at very high risk of actually dying by suicide. Making sure that we have coordination and collaboration so that those people get follow-up care is a very high priority.

We've got a fair amount of work in the strategy around populations that are at particularly high risk of either suicide attempts or suicide deaths. So the Action Alliance has particular subgroups or taskforces on Native Americans, on military families, LGBT youth, and other populations like that, and then there are taskforces around particular sectors, like the faith-based sector. And then there are also taskforces around research and taskforces around data issues and things of that nature. I think there are about 200 people that are involved in the taskforce efforts of the Action Alliance at this point.

> We've got to look at the whole thing, we've got to look at it from a preventive point of view, from a universal point of view, from a point of view of not waiting until someone is already in need of treatment before we intervene.

NATIONAL COUNCIL: Is behavioral health cognizant of the suicide risk for people with serious mental illness and do we do enough to address it?

HYDE: I think behavioral health providers know that suicide is an issue for some people, and I think we have strategies and efforts that practitioners use when they identify a person who is suicidal. Unfortunately, I think sometimes we sort of expect that it's going to happen for some people, instead of wanting to ensure that suicide is a "never event."

As we increase awareness of the suicide risk in the general public and ask folks to refer those at risk to a mental health provider or a program, if providers are not really clear on what to do about suicide prevention, then that's a problem. We need to be able to assure that when we make referrals, we have trained and educated practitioners who really know what to do and who can be helpful. So there's training that needs to happen — the workforce can always improve its skills. Practitioners need training and I think want training on what to do about suicide.

NATIONAL COUNCIL: How do you think primary care should address the issue of suicide and what is the role of behavioral health as we work with them?

HYDE: We're doing a lot of work with primary care on universal screening for behavioral health issues. And I think there are good screening tools for individuals who have already screened for depression or we know have depression, who then should be screened for suicidality or suicidal thinking. Those screening techniques and tools are fairly easy to use. So I think it's about raising awareness in primary care.

On the other hand, we have to be sensitive to the fact that primary care physicians right now are being asked to screen for everything and it is hard. So I think more and more, we need to help them know about screening tools that are quick and short and effective, and we also need to help them in multidisciplinary settings and know that not everything has to be done by the physician. Some of the screening can be done by nurse educators, nurse practitioners... and they get the right professionals involved if a person screens positive.

NATIONAL COUNCIL: You've talked often about the public health approach to behavioral health issues. How does suicide factor into that?

HYDE: Suicide is definitely a public health issue and we need to think of it that way. There are more deaths from suicide than there are from HIV/AIDS and traffic accidents combined. We've gotten to the point where we recognize HIV/AIDS as a public health issue that requires universal prevention strategies. We need to look at suicide in that way. We need to look at building emotional health in individuals from children to adults. We need to acknowledge and look at the data about what

populations are most at risk. We need to then intervene early and screen to identify people who may be at risk.

If we just sit and wait for someone who's at risk to come to their physician or come to their behavioral health provider and say "Hey, I don't think I feel very good and I think I'm depressed," that's not going to cut it, because people are generally not going to do that, or at least not until they experience severe symptoms of some sort. So we've got to get up earlier, upstream, and we've got to identify people who may be at risk earlier and we've got to focus on it from a prevention point of view, not from a treatment or reaction point of view once someone is already experiencing symptoms.

We also have to train the general public. The National Council obviously has been great on Mental Health First Aid and efforts like that, to help the general public know what to do.

We have a lot of work to do with the public and with practitioners, as well as just with the culture around behavioral health issues — and not think of them as unspeakable. So one of the things we've got to do is just be willing to talk about suicide. We also have to support survivors and the families or friends of individuals who have died by suicide. That's what I mean by a public health approach. We've got to look at the whole thing, we've got to look at it from a preventive point of view, from a universal point of view, from a point of view of not waiting until someone is already in need of treatment before we intervene.

NATIONAL COUNCIL: What is SAMHSA doing to help address escalating rates of suicide in the military?

HYDE: When we talk about the military, I think it's important to recognize the different populations. For example, the Air Force took on the issue of suicide among their members and they've really made a difference. They've created some techniques that have really let them identify people early and encourage people to get help. So they have seen their numbers reverse a little bit.

The Army, on the other hand, has just begun that process. They've seen their numbers really skyrocket and they have been started reaching out and trying to identify ways that they can build emotional and psychological health.

We have groups like the National Guard, where the numbers for suicide are increasing among individuals who have never been deployed. We don't really know why — we don't have good research about what's going on with that population, and they're a different kettle of fish in terms of what's available to them for treatment and services and outreach. We've been doing a whole lot of policy academies with military families and states, to develop an approach for services to National Guard

> Suicide is definitely a public health issue and we need to think of it that way.
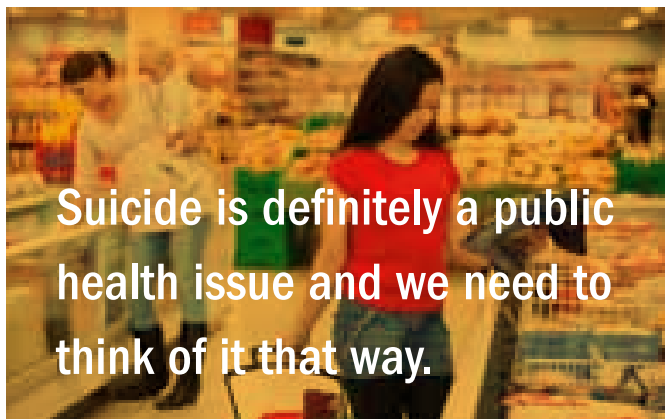
and other current and former members of the military and obviously suicide prevention is a piece of that.

And then there's veterans and the Veterans Administration has very much taken on a couple of major issues for veterans — homelessness and suicide. Access to mental health services is a huge issue they have taken on. They are great partners with us. SAMHSA's National Suicide Prevention Lifeline has an electronic link to the veterans suicide crisis line — so there's no wrong door for a veteran who gets into one of those call centers and can be directed to help they feel comfortable with.

We also have collaborative training and other efforts with the VA. They're very concerned and that's why the National Action Alliance is co-chaired by the Secretary of the Army.

I give the military a lot of credit actually. They have really taken a public health approach and are trying to make sure all their troops are psychologically healthy. They're also trying to make sure that they have treatment and resources available for people who may be experiencing symptoms that need attention. And I think they're trying really hard to overcome the culture of "It's not okay to ask for help."

NATIONAL COUNCIL: As they say, suicide IS everybody's business — so what is the role of the community in suicide prevention?

HYDE: Yeah, well everything about health is community and everything about prevention is at the community level. So I think our role at the federal level is to try to help local communities get the information they need, have the support they need, the resources they need, to do what they need to do.

For one thing, we just have to make sure our communities are educated, whether it's schools or churches or practitioners in the local hospital or the local primary care doctor's office. Part of it is setting some expectations — not in the sense of a hammer but in the sense of saying "Look, there really is a way to make suicide a never event, but it's going to take the whole community to be committed to that outcome."

Certainly, within a school setting or within a particular boundaried system, whatever that system might be, we ought to be able to say let's make a commitment to not have anyone die from suicide in this boundaried system, and how would you do that. It takes leadership at the top.

We also must really help young people understand that it's not violating a confidence if they come and tell an adult when a friend is in distress because it's kids helping kids that are going to make the difference here.

So there's all kinds of things we can do to help communities, but they really have to understand it, embrace it, want to take it on, and want to make a difference in the outcomes. We have for too long, said "Yeah, that's too bad that that many people die from suicide," without asking "How can we actually reduce it?" Instead of just watching the numbers rise, we need to actually say what can we do to make the numbers go the other way.

NATIONAL COUNCIL: Are you doing anything specific to suicide prevention in the population with substance use disorders?

HYDE: Sure. The connection between suicide and substance abuse, I think is just now being talked about a lot. Prescription drugs in particular are a lethal means. If a person is at risk for suicide, we sure don't want to have prescription drugs in the medicine cabinet that are easy to get a hold of and that could be lethal if ingested in inappropriate quantities. So doing sort of that kind of risk assessment is important.

The other issue we know is that almost a third of individuals who die by suicide have a blood alcohol level above the legal limits. I don't think we always know whether or not that is an addiction at play in the suicide itself, or whether it is alcohol used to bolster the courage to actually take the suicidal action. But there is a strong connection. For those who die by suicide and are autopsied, a significant percentage have illicit drugs in their system, whether that be marijuana or heroin or cocaine or methamphetamines.

We also know that people with serious mental illness have higher risk of suicide and also have higher risk of substance use. So these connections are there and we must just recognize that the individual often comes often with multiple issues and prevention efforts have to have multiple approaches as well.
Right now if you screen for depression then you should screen for suicidality, but if you screen for alcohol use, arguably, you should also think about screening for suicidality as well, because we know that those numbers are high correlates.

NATIONAL COUNCIL: Are there other SAMHSA suicide prevention initiatives you want to mention?

HYDE: We do have some pretty major grant programs here. Most recently, 49 or 50 states have received one of the Garrett Lee Smith youth suicide grants, and that means every state is sort of paying attention to this issue.

Our block grant applications, which will be out in December, require states to give us their suicide prevention plan. We've also included some guidance about what should be in those plans. Our goal is to have every state make suicide prevention a priority — to know their data and to know what they're doing with it .

SAMHSA is also providing campus suicide grants. Increasingly, a number of Native American tribes and campuses have received those grants because we know suicide is of high concern to many of the tribes.

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THOMAS INSEL
Where is the Risk?
What the Science Tells Us About Suicide

Exclusive interview by Meena Dayak for National Council Magazine

Thomas Insel, MD, is Director of the National Institute of Mental Health, the component of the National Institutes of Health charged with generating the knowledge needed to understand, treat, and prevent mental disorders. His tenure at NIMH has been distinguished by groundbreaking findings in the areas of practical clinical trials, autism research, and the role of genetics in mental illnesses. Prior to his appointment as NIMH Director in fall 2002, Dr. Insel was Professor of Psychiatry at Emory University. There he was founding director of the Center for Behavioral Neuroscience, one of the largest science and technology centers funded by the National Science Foundation, and, concurrently, director of an NIH-funded Center for Autism Research. He has published more than 250 scientific articles and four books, including the Neurobiology of Parental Care (with Michael Numan) in 2003. Dr. Insel is a member of the Institute of Medicine, a fellow of the American College of Neuropsychopharmacology, and is a recipient of several awards including the Outstanding Service Award from the U.S. Public Health Service.

NATIONAL COUNCIL: What do we know about the science of suicide?

DR. INSEL: Suicide is not a diagnosis, it's a problem. There is a gap here that we're working very hard to fill.

Yes there's an epidemiology of suicide. We know a little bit about some of the risk factors. But suicide has more often been an exclusion criteria — if someone has suicidal ideation, they would have been kept out of studies of bipolar disorder or depression, and the result is we don't have the therapeutic base for suicide prevention that we have in so many other areas. we've categorized mental disorders into silos.

Three things make suicide so compelling. First, suicide covers the whole waterfront of mental health, crossing over everything from eating disorders to bipolar disorder and substance abuse. Second, suicide has such a stubborn epidemiology and we have not moved the dial. The rate of suicide is an extraordinary four per hour! Suicides are about twice the number of homicides in this country and also exceed the number of traffic fatalities. Over the years, the numbers of homicides and the number of traffic fatalities have come down quite significantly, but there's no good indication that there's been any decrease in the suicide numbers for some three decades. There's a slight trending up. And there have been some shifts within the demographics of the groups that are at highest risk, but overall, unlike the numbers for other sources of mortality, this one has really not moved. The third issue about suicide is that there's an opportunity here that we do know something now about risk and about what can be done in the realm of prevention.

NATIONAL COUNCIL: So we haven't really made much progress, but where do we go from here?

DR. INSEL: I want to borrow from the science that we have in another area —

AIDS. About 25 years ago, we measured mortality in months, and now people with HIV infection are expected to live a near normal life span — we can now measure longevity in decades.

So what did they do? What was the difference that allowed that change? They've begun to understand that for HIV and AIDS, treatment is the best prevention. They identify who's at high risk and are then they are very aggressive about treating them — bringing the viral burden down by medication and public health approaches — everything from education to circumcision to microbicides — multi-component intervention programs that allow you to reduce the rate, whatever it takes... It's really worked.

NATIONAL COUNCIL: So what would it take to replicate the AIDS success for suicide?

DR. INSEL: Just like with AIDS, there are the two questions for suicide. How do you identify who's at highest risk? And how do you then intervene a multi-component approach that ensures that people who are at high risk don't die?

We have a research task force that's part of the National Action Alliance for Suicide Prevention and our goal is to develop an agenda that has the potential to reduce morbidity and mortality by at least 20% in five years and 40% or greater in 10 years. That's not quite as ambitious as the AIDS agenda, but it's not too far off. I mean it says we can do this if we simply come up with the right approach and we implement it in the right way. So what is that?

Well, we brought a group of people together to look for the best opportunities for prevention. We did a literature review. Using the Adelphi process, we've asked hundreds of people to help us think about this issue. We asked ourselves, "How do we identify risk? Where should we be looking? There are 36,000 suicides per year — who are those people and where do they concentrate?"

NATIONAL COUNCIL: And what have you learned about high-risk populations?

DR. INSEL: The National Action Alliance for Suicide prevention has a task force for veterans, one for LGBT, for American Indians, for criminal justice, etc. — but all those groups only contribute to a tiny fraction of suicides. The single biggest suicide risk group that we could identify is those who've been to an emergency room because they've made an attempt. In fact, the highest risk factor we have for dying from suicide is having made an attempt. So there are roughly 9,300 emergency room visits each year from people who will ultimately die of suicide. That's a big chunk of the 36,000.

There are about 1 million suicide attempts every year — about half of those who attempt are seen in a hospital and require an overnight stay. So you already had them at some point. They've made contact with the medical system because they've had an overdose or cut their wrist or had a gunshot wound — something that's required medical care. Actually about two thirds of those who attempt suicide require medical care but about half are severe enough that they require an overnight stay. So that takes you to over half a million — that's a lot of people. If you could simply ensure that those people who have made an attempt either never make another one or never make another one that's fatal, you'll bring the suicide rate down in just the way that we're talking about.

So the first part is identifying where the risk is. The second part is the intervention. Capturing that group that's been to the ER and intervening with them to make sure that they don't make another attempt is where we think we have the greatest leverage.

Now getting them engaged and treated is a challenge. The intervention we're looking at is cognitive behavioral therapy because our sense is that works pretty well to reduce suicide risk. We know from work that's already been done in lots of different settings, and in lots of different populations that CBT — if people are engaged and don't drop out — has a pretty good hit rate in terms of the overall response. There's about a 50% reduction in suicide risk in people who go through an evidence-based treatment like CBT. It gets us much closer to the goal.

The science that we're thinking about is identifying the risk group, figuring out how to get them engaged, and making sure there is access so there are people who can deliver the treatments that we think work. Once in treatment, we must demonstrate that we can actually bring down the risk. So I think we've got a plan.

NATIONAL COUNCIL: What about the alarming suicide rate in the military?

DR. INSEL: Since 2009, there have been more suicides than combat deaths in the military. That's not just because combat deaths have come down, which they have, but because suicides have become high and have stayed high. Examining suicide in the military is probably the single biggest project at NIMH these days. Our STARRS — Studies To Assess Risk and Resilience in Soldiers — Project is looking at nearly 80,000 soldiers.

We all went in to this project thinking that we knew what was the driver. We had lots of ideas about this. Some people said it was multiple deployments. Some people said it was personal losses, especially at home. The guy whose girlfriend breaks up with him while he's in Iraq or Afghanistan. There have been all kinds of theories about what's driving the rate.

It's complicated and none of those theories have panned out so far. It turns out that there is not a single explanation for the increasing rate. There are many factors. We've identified some. We've tried very hard to create what we're calling a risk calculator. The idea is based on the way that we brought down the rate of cardiac death with studies like this. With the Framingham Heart Study, it was a whole population identified and followed longitudinally — and we identified the risk factors for cardiac death back in the 60's and 70's. That's where we first learned about the importance of cholesterol and obesity and hypertension and many of the factors that were driving cardiac death.

Most people think that they know what's driving the suicide rate in the Army but all the data we have so far says this really needs to be examined very carefully, that many of our assumptions have been wrong. As we've looked at the first 500 suicides from the past decade, there's not a a single or even two or three factors — it's many factors. But we've gotten an opportunity to look at what would the risk calculator look like for suicide and how can we advise the Army about who's at greatest risk.

We're at a point now with just the factors that we have from our first pass we can identify a four or five-fold increase in risk from the general population. When we've gotten some of the longitudinal data factored in, we think we'll be closer to identifying a ten-fold increase in risk.

> If you could simply ensure that those people who have made an attempt either never make another one or never make another one that's fatal, you'll bring the suicide rate down in just the way that we're talking about.

NATIONAL COUNCIL: Can you at all share what some of those risk factors look like?

DR. INSEL: Well some of them aren't that surprising. Certainly having a history prior to going in to the military of either substance abuse or psychiatric diagnosis and being on medication for that would contribute to the suicide risk.

Just as an example of where the assumptions may have been wrong, it's not entirely clear yet that you can explain all of the risks through multiple deployments. In fact, we've been surprised to find out how many of the suicides occur before there are any deployments.

So you need the data. That really is a scientific question. And as I often say, one of the great things about science is it teaches you that many of your assumptions have been wrong and that's been the case with STARRS. Many of our assumptions have already proven to be incorrect and it's causing us to go back and really redo the fundamentals of understanding risk and resilience.

What we have not done with the Army yet is to link the risk study to interventions. There's another effort within the Army to do just that, and that's the next piece that we have to patch together.

NATIONAL COUNCIL: Do NIMH research projects address suicide resulting from mental illness as well as from other causes?

DR. INSEL: Right. So for both the emergency department and the military projects, while there's no question that mental illness greatly increases your risk, we're not limiting the studies in that way. But the reality is that it's such an overwhelming proportion of people who die have a diagnosis. It's not just any diagnosis, the risks are highest for bipolar disorder, especially in men. We have some data that says the rate of suicide in men with bipolar disorder is about 7 percent which is incredibly high. If you put that together with substance abuse, it goes up to something like 17 percent which puts you in the range of mortality for many forms of cancer. I mean that's really high — almost one in five will die! So definitely the presence of a mental illness is key in thinking about a risk calculator.

And it's important to remember that there are some proportions of suicides, perhaps as many as half, that have not come to anybody's attention previously. So there's no previous attempt, there's no previous visit or diagnosis. And particularly in adolescence. Those are going to be really difficult to prevent. So the important issue is how do you reduce access? What can you do, for instance, to make sure that bridges are safer so people can't jump off of them; that there is limited access to firearms…a whole series of issues that especially play out in youth, but that are important throughout the lifespan.

The single biggest suicide risk group that we could identify is those who've been to an emergency room because they've made an attempt.

NATIONAL COUNCIL: Given the fact that more than 70% of the people who die by suicide have seen their primary care doctor at least a month prior, where is the greatest potential is for prevention?

DR. INSEL: That's right. And particularly relevant for older people. Older Americans comprise about 13% of the US population, yet account for 18% of all suicide deaths. Among adults who attempt suicide, the elderly are most likely to die as a result.

In almost every case of a primary care visit, there was no recognition of suicidal ideation. They didn't go in for depression, they went in for back pain or something that was nonspecific. So it's absolutely critical to do education to make sure that people understand. Very few general practitioners recognize that the highest rate of suicide is in elderly white males. That rate is about six-fold the national average. That's a group that just doesn't come in complaining of sadness. They come in complaining of nonspecific somatic complaints that are often not thought about as a proxy for depression and are not seen as a risk for suicide. So there is an extremely important demographic that needs to be understood as a high risk group.

NATIONAL COUNCIL: What can community behavioral health organizations do to reduce the suicide rate?

DR. INSEL: Well, they do see the people with chronic mental illness and that's a group that's again very, very high risk. For men with bipolar, the suicide risk is about 7.7% and for women with schizophrenia, about 4.2%. That's just extraordinary. I think that's where community mental health folks can help us to think about what to do in the long term.

In schizophrenia, most of the suicides are in the first three years. And people may not realize that the highest rates are often amongst those who are the highest functioning before they got sick. For bipolar, what really adds to the risk is substance abuse. So there are patterns that providers should know about that risk so they can work toward prevention.

NATIONAL COUNCIL: Where are we with finding effective treatments?

DR. INSEL: Yes, we talk a lot about prevention, but if treatment is the best form of prevention, what is that treatment?

There is CBT around the target symptoms of hopelessness and helplessness and that's what seems to work best. There is also some early data that suggests that the rapidly acting antidepressant, Ketamine, is most effective at reducing suicidal ideation within minutes. There are emergency rooms that are beginning to use Ketamine for people who are very aggressively suicidal. We're not yet endorsing this use, but it suggests that maybe we need to begin thinking now about not only behavioral treatments, but potentially about medications that can be used to reduce suicidal ideation — Ketamine as a proof of concept suggests that maybe that's workable. It just popped up because as people began looking at the rapid response to Ketamine, the very first thing to change was suicidal ideation. If it saves lives and if it can be done as an infusion in emergency rooms, it's at least worth considering it in the future as one of the pathways for treatment.

Reach One, Teach One
Tom Kelly

The first time I remember thinking about attempting suicide was when I was about 12 years old. I had this feeling that I just didn't want to be around. I didn't enjoy life the way that most people enjoyed life. I didn't have any friends to speak of. I didn't think that anyone liked me and I didn't know anything about mental illness or the hallucinations that I'd been experiencing since kindergarten.

When I was 17 or 18, I remember falling deeper and deeper into another depression and once again started thinking about suicide. I thought I would be better off dead. When I am in my depressed state, the thought of suicide and taking my own life is part of my daily routine.

A few years after I graduated college and moved to a different city I found myself thinking about suicide once again. That was when I made my first attempt. I put a plastic bag over my head and duct tape around my neck and tried to suffocate myself. I fell asleep and woke up several hours later with the bag ripped open — I guess our body does have some sort of self-preservation mechanism. I was frustrated that I didn't succeed — but I didn't succeed at anything else so why should this be different?

I didn't want to feel anything and here I was feeling again — I was feeling that life was not worth living. I think I was 24 or 25 at the time and living in western Canada. I didn't tell anyone about this at the time; it wasn't until several years later (2000) that I started talking about my experiences in public. Life just kind of went on from that point.

I moved to the U.S. in the mid to late 80's and ended up getting married while I was living in Iowa. Things didn't go well from the start. I ended up once again depressed and found myself curled up in a little ball rocking back and forth in my bed. My wife at the time found me and informed me that I was saying "I need help … I need help … I need help." She brought me to the psychiatric hospital in Waterloo, Iowa. It was the first time I had ever gone into a hospital. I spent a few weeks there and was discharged back home with some medications but no follow-up plan. I was on my own.

A few years later, I tried to overdose — unfortunately I only took enough medication to make me sick. I ended up throwing up all over the bathroom floor. I didn't tell anyone about that episode. Between that time (1992) and my divorce in 1995, I think I went to the hospital two or three other times.

After I left my wife, I remember thinking that the time was near. No one wanted me, everyone had abandoned me, I felt that I was going to be dead within the next few weeks. Who really cared if I were to live or die? Certainly I didn't care!

In April or May 1995, I went to the hospital where I was first admitted as a psychiatric patient and parked as far away from everyone else as I could. No one bothered me.

I spent the next two or three days in that parking lot and no one paid any attention to my being there. I guess I figured it was a safe place to park and move forward with my plan — I wanted to kill myself.

I went to a Goodwill dropoff bin to give ALL my belongings to charity. I opened the trunk of my car and emptied everything that I owned into the Goodwill container. The only thing I had was my sweat-suit, the one on my back. I remember giving away my suit and wishing that I kept it because at least I would have that to wear when I would be laid to rest in my coffin! I had a notebook and about 140 pills — sleeping pills, antidepressants, anti-anxiety… I don't really remember. I drove to the hospital parking lot and went to sleep. I woke up around 10:30 pm — I took one of the pills then a sip of my Coke, another pill and then another sip of Coke. I remember taking the last one and hoping that I had enough medications in my system to take me away.

I woke up in a hospital several days later. I had spent four or five days in a coma. I was restrained. I had my legs, arms, chest and neck strapped down to an ICU hospital gurney. I remember not feeling good because I wanted to be dead.

After a couple of weeks in the hospital, I was transferred to the Iowa State Mental Hospital where I ended up spending the next nine or ten months. I was discharged to the streets in the spring of 1996.

After more hospitalizations and more attempts, I came to Arizona in 1998 and was enrolled into the public mental health system and spent the next couple of years slowly moving forward in my recovery. I made one more attempt in 2001.

I have not had any suicide attempts since then. I can't say that I have not thought about suicide but I am at a place in my life where I understand things a little better and have improved my coping skills and have some support.

People ask me if I am happy to be alive today. My response is that I am where I am by the grace of God. I try to make the best of every day and to help people along the way. I heard someone say "Reach One, Teach One" at a conference several years ago. That is something that I try to do each and every day.

I've met 20-21 people who have gone through times in their life when they believed suicide was the answer. I wish they were not successful. I wish they could have made it through the tough times. I wish they could have waited out the storm. I have lost many great friends to suicide. We've lost many great and talented people to suicide.

It's only when we start talking about suicide like we talk about cancer and HIV — when we break the shame and guilt and address the stigma that is associated with mental health challenges and suicide — that we are going to be able to save that one person who is thinking about taking their life as you read this.

Tom Kelly has twelve years of experience working in public mental health systems. His experience includes educating, coaching, and training staff in recovery principles and the use of strength-based and person-centered planning principles. Tom is employed with Magellan Health Services of Arizona as the Manager for Recovery and Resiliency. He has presented at national, state, and local conferences on topics including homelessness, mental health, and recovery principles.

Type Casting to Save Lives

David Jobes, PhD, ABPP, Professor of Psychology and Associate Director of Clinical Training, Department of Psychology, Catholic University of America

Based on an interview with Heather Cobb for National Council Magazine

Many contemporary clinicians think about suicide broadly: you are suicidal or you are not. However, the Catholic University of America Suicide Prevention Lab has begun to see suicide differently. We have learned a great deal about different kinds of suicidal states, realizing that not all suicidal people are the same.

Many existing interventions assess suicide risk by asking, "Do you have suicidal thoughts?" as if it is a zero/one option. In reality, one person may say that they are suicidal, but have no lethal intent while another hears voices telling saying to kill him- or herself. These are distinct suicidal states.

A series of seven studies clearly show at least three major types of suicidal thinking:

1. A suicidal person who is invested in still living. These people probably have more hope and some sense that things could improve. This group is very treatable and we see resolving or eliminating their suicidal preoccupations rapidly.

2. A suicidal person who is ambivalent about living. These people struggle to find reasons to live or to die. They are in a psychologically tug-of-war, conflicted over their wishes to live or die. This group is pretty treatable.

3. A suicidal person who is death-motivated or even entrenched in their suicidal preoccupations. These people have turned the corner and decided upon suicide. They feel comfort and control in the decision In a certain fashion, they do not want to be talked out of it. This is the toughest group to treat. They can improve with appropriate care, but may need intensive inpatient care for more than the two or three days that is standard, which is very expensive.

We can reliably sort people in those three different lanes. Then, the next step is identifying the best kind of treatment, dosage, and intensity for each of the three types of suicidal states.

We have learned a great deal about different kinds of suicidal states, realizing that not all suicidal people are the same.

FLYING IN THE FACE OF CONVENTIONAL WISDOM

Suicide ideation is a coping behavior, albeit an extreme way of managing things. If you take an empathetic approach, then you climb into the mindset of a suicidal person, which is the highest nature of alliance forming, and we know that any good treatment or regimen relies on a good treatment alliance.

Unfortunately, suicide has this potential to pit patient against clinician, and to introduce a power struggle. In mental health, when a person has suicidal thoughts, we put them into an inpatient setting — the most expensive, most invasive, most controlling, most civil liberties-limiting intervention we've got. Yet, if a patient has chest pains, we try different less invasive interventions while keeping a close eye on the patient to make sure the heart attack does not happen. We don't crack open the chest and do exploratory surgery.

We are trying to disengage in that power struggle through an empathetic approach to suicide assessment. Such an approach enables clinicians to understand how, when, where, and why a person becomes suicidal, putting them in a better position to identify drivers that compel a person to think about suicide (e.g. unemployment, divorce, psychological pain, lifetime of misery). The Collaborative Assessment and Management of Suicidality, which the CUA Suicide Prevention Lab developed and studies, targets and treats these patient-identified drivers. CAMS is meant to connect the clinician with the patient as a treatment partner to understand the suicide risk.

CAMS really flies in the face of conventional wisdom because many clinicians still work within a model where they think a suicidal person needs to be controlled and hospitalized at all costs — and sometimes even shamed or blamed to not feel suicidal. CAMS is largely intended to keep a suicidal person out of the hospital, if possible, so clinicians can work with the patient on an outpatient basis. It aims to delay suicidal behavior in order to engage the person in evidence-based treatment to see if there is a different way to meet their needs without doing something drastic like taking their own life. Clinical trial research shows that when a suicidal person is engaged in this fashion, a strong alliance can form and the patient quickly becomes motivated to want to cope differently. Our studies show that six to eight sessions can reduce or eliminate suicide as a coping option, negating the need for hospitalization. We also have one study in the Air Force showing that CAMS engagement related to decreasing emergency department and primary care visits. So, we are now looking at the causal impact with randomized trials to ensure that CAMS not only reduces ideation more rapidly than treatment as usual, but that it also has non-mental healthcare utilization benefits that realize cost savings.

CAMS really flies in the face of conventional wisdom because many clinicians still work within a model where they think a suicidal person needs to be controlled and hospitalized at all costs — and sometimes even shamed or blamed to not feel suicidal.

Meanwhile, the majority of clinicians still think the best place for a suicidal person is an inpatient setting, and the modal treatment is medication. However, interventions need rigorous scientific support in the form of randomized trials. These conventional interventions, while having quite a bit of clinical intuitive support, enjoy little empirical support.

At CUA, we keep hammering away on the research around CAMS. Developed in the last 15 years, it is a relatively new innovation. So far, six correlational studies show that it works. We have one small randomized trial that shows its effectiveness in a causal way. And now there are two large randomized trials that we hope will put us over the top. Both are showing that CAMS works scientifically better than usual treatment. If the research findings continue, we look forward to showing what actually works, and then clinicians will come around and start using CAMS in a more consistent fashion.

There is not yet a wide embrace of CAMS because we are still working on the model. It takes roughly 17 years for evidence-based practice to become common practice. So, we are realistic about how difficult it is to turn the tide of an established way of working, especially when we think about hundreds of years of hospitalization and of controlling treatments being comforting for the clinician because they feel that they can make a suicidal person do something (e.g., hospitalization, restraint). These days, these approaches do not work: people cannot be hospitalize for long and restraints are used sparingly. In short, a model that a lot of us grew up with is no longer tenable, and what replaces it is still very much in flux.

While it will take a long time to promulgate treatment settings, CAMS is already generating great interest. The military increasingly uses CAMS, and we have a license in the VA system. We also do about 30 or 40 trainings a year in various settings with people who want to learn about and use CAMS.

TEACHING OLD DOGS NEW TRICKS

Clinicians tend to like CAMS because it is not a new psychotherapy — it is a framework. Within that framework, clinicians can realize a lot of flexibility and can retain their experience with interventions they like. There is a lot of room for adaptation and different ways of using the approach. However, it is hard for experienced clinicians to want to try something new. We are creatures of habit. We like what we know and know what we like.

Yet, when clinicians back their way into CAMS, they find that it is not some wild, crazy counter-intuitive thing that does feel unnatural. It is a framework that enables them to do what they already do, but in a way that targets, treats, and stabilizes the patient in an outpatient setting. Clinicians ask a patient about what makes them suicidal, tracks them until the suicidal coping response has been eliminated, and then, in so doing, creates a paper trail that reflects good practice and, therein, decreases malpractice risks. It does require some level of systemic adaptation, especially on the idea of not hospitalizing a suicidal person, but overall is a relatively easy approach to implement.

Our conventional wisdom focuses on the disorder, thinking of suicide as a symptom of the disorder. Yet, so far, the evidence base really shows that independent of the disorder, going after ideation and suicidal behavior is what saves lives. That is a provocative idea — not focusing on the disorder. In CAMS, unless the patient says, "My depression is what makes me want to kill myself," we do not focus on depression, per se, because we target things that our patient says threaten their life. That is hard for a lot of clinicians to handle because we've been raised to think that the way that you treat the symptom of suicide is to go after the depression. And that may well be true, but, so far, the evidence shows that going after the ideation and behavior as the focus or the bulls-eye of the treatment is the way to go.

I'm always impressed that crisis center hotline paraprofessionals are probably better at working with suicidal people than most mental health professionals are because they get training that is suicide-specific, and they expect to deal with suicidal people. We need a shift. We need to train clinicians to be just as — if not more — equipped to treat suicide.

David A. Jobes, PhD, ABPP, is a professor of psychology and associated director of clinical training in the Department of Psychology at the Catholic University of America. The research at the CUA Suicide Prevention Lab, in which Dr. Jobes works, centers on clinical risk assessment (using both quantitative and qualitative methods) with different suicidal populations in different clinical settings. In recent years, they have become particularly focused on clinical interventions for suicidal patients. Dr. Jobes' group at CUA has developed a novel therapeutic approach called the "Collaborative Assessment and Management of Suicidality" (CAMS). They are currently engaged in funded clinical trials to investigate its effectiveness with suicidal patients in the U.S. and other countries. There are various published studies providing solid correlational support for CAMS. A randomized clinical trial demonstrating the causal effectiveness of CAMS with suicidal outpatients has been recently published.
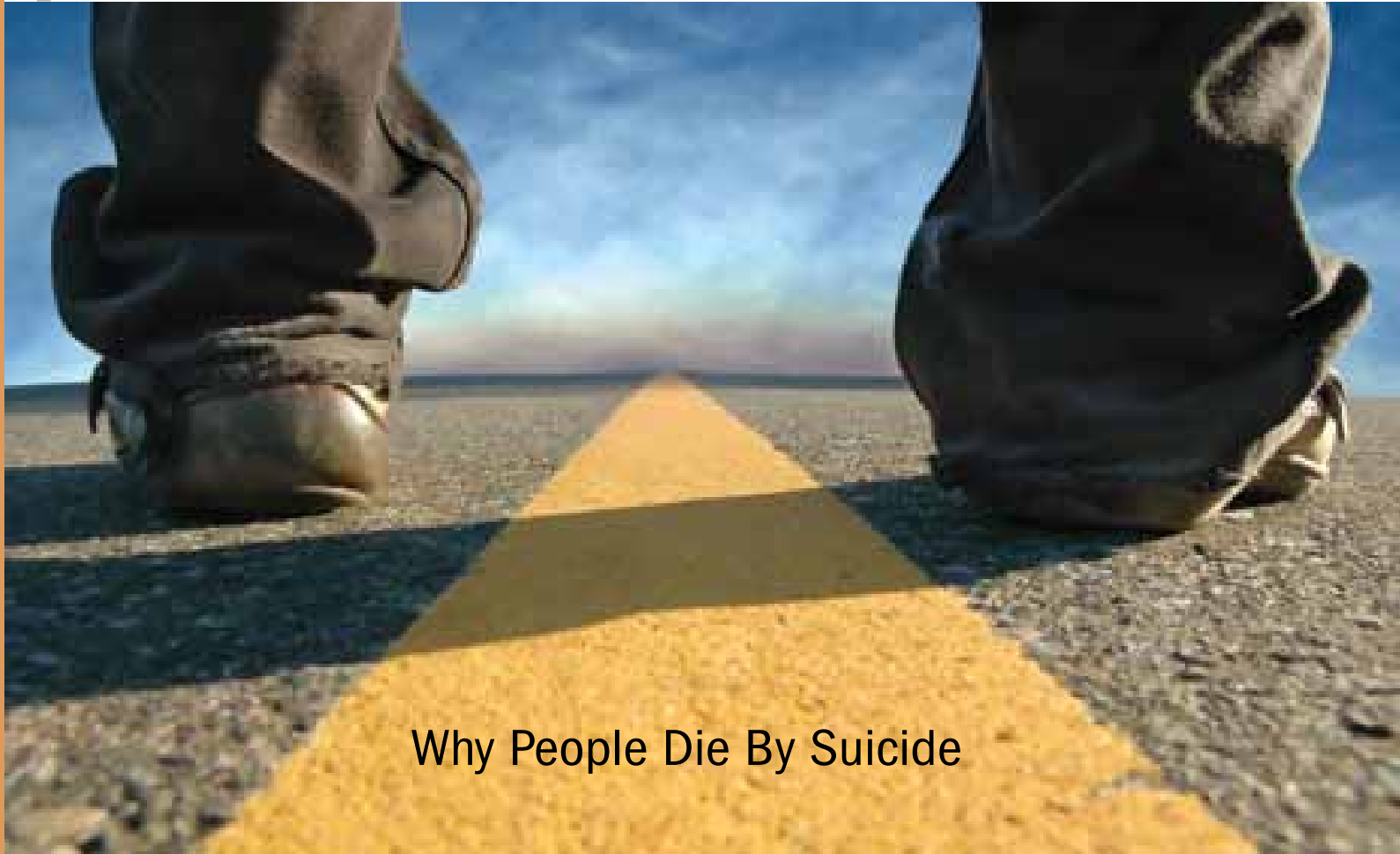
Why People Die By Suicide

Thomas Joiner, Author, *Why People Die By Suicide* and **Robert O. Lawton** Professor of Psychology, Florida State University

In my book *Why People Die By Suicide*, I ambitiously attempt to answer the question in the book's title. The answer begins with two seemingly obvious assumptions: People die by suicide because they can, and because they want to. This would not be much of a theory, if the argument stopped here, because profound questions are begged, like "What differentiates those who can from those cannot?" and "Among those who want to die by suicide, what are the constituents of the desire for death – pain, hopelessness, what?"

What differentiates those who can from those cannot? The theory asserts that lethal self-injury is associated with so much fear and pain that few people are capable of the act. The only ones who are capable of death by suicide are those who have been through enough past pain and provocation (especially involving intentional self-injury) to have habituated to the fear and pain of self-injury. Abundant empirical data are consistent with this view, but clinical and case data are persuasive as well.

For example, in Shneidman's (1996) case study of "Beatrice," she wrote, "I know now that slitting my wrists was not as poetic nor as easy as I imagined. Due to blood clotting and fainting, it is actually difficult to die from such wounds. The evening dragged on with me busy reopening the stubborn veins that insisted upon clotting up. I was patient and persistent, and cut away at myself for over

an hour. The battle with my body to die was unexpected, and after waging a good fight, I passed out." Fighting this battle repeatedly and in different domains instills the capacity to stare down the self-preservation instinct... should an individual want to.

What are the constituents of the desire for death? The theory argues that the constituents of the desire for death are **perceived burdensomeness and failed belongingness.** Here again, although there are compelling empirical data affirming the essential connection of these constructs to desire for death, the anecdotal and case study evidence is at least as persuasive. For example, regarding failed belongingness, in his 2003 New Yorker article on suicide at the Golden Gate Bridge, Tad Friend quoted psychiatrist Jerome Motto on the suicide that affected him most. Motto said, "I went to this guy's apartment afterward with the assistant medical examiner... He'd written a note and left it on his bureau. It said, 'I'm going to walk to the bridge. If one person smiles at me on the way, I will not jump.'"

People die by suicide because they can, and because they want to.

Regarding perceived burdensomeness, as reported on the news website Ananova.com in 2004, an elderly Malaysian couple died by suicide by jumping from the fifteenth floor of their apartment building, specifically because they did not want to be a burden on their family. Their suicide note read "If we had waited for our death due to sickness, we would have caused much inconvenience to all of you." There are dozens of anecdotes like this which, when combined with the empirical evidence, point to perceived burdensomeness and failed belongingness as central components of the desire for death.

So who can die by suicide? Who wants to? The three factors noted above are proposed as answers to these questions.

> Who can? Those who, through habituation, have acquired the capability to enact lethal self-injury.

> Who wants to? Those who perceive that they are a burden on loved ones and that they do not belong to a valued group or relationship.

Any compelling explanation of a clinical condition should have novel and penetrating things to say to clinicians about how to assess, treat, and prevent the condition in question. I believe there are important implications of the theory described above for issues like risk assessment, diagnosis, and implications for treating suicidality. Some very brief examples follow, which are expanded upon in my book.

Suicide risk assessment and involuntary hospitalization. A quick survey of the websites of organizations like the American Association of Suicidology and the American Psychological Association, among many others, shows that over 75 factors are listed as suicide risk factors or warning signs, including things as diverse and questionable as "loss of religious faith," "neurotransmitters," "perfectionism," and "loss of security." Given limited time, clinicians cannot thoroughly assess all of these various factors, and even if they could, how are they to organize the resulting mass of data? Based on the theory described above, the acquired ability to enact lethal self-injury deserves emphasis, as do perceived burdensomeness and low belongingness.

Involuntary hospitalization, both before and after, might be couched in the theory's terms (e.g., a safe haven in which to consider whether conclusions about burdensomeness and belongingness are warranted).

Crisis and management and resolution and alternatives to "no suicide contracts." A main goal of crisis intervention is to take the edge off the pain of the current crisis, so that it is within a tolerable range. In this regard, an under-utilized intervention involves encouraging patients to agree to a duty-to-others role (e.g., volunteer at a hospital, a veterinarian's clinic, teaching English to non-native speakers, etc.). This intervention may take the dangerous edge off of bur-

> Some people think that those who commit suicide are weak. It's actually about fearlessness. You cannot do it unless you are fearless, and this is behavior that is learned.

densomeness self-appraisals, and may also lead to other, belongingness-related outcomes (e.g., positive social contact). In addition, an alternative to "no suicide contracts," the "commitment to treatment" statement, should be considered. This is an agreement between the patient and clinician in which the patient agrees, among other things, to make a commitment to the treatment process and living, by identifying the roles, obligations, and expectations of both the clinician and patient in and outside of treatment. The "commitment to treatment" statement should be couched in terms of enhancing belongingness and reducing feelings of burdensomeness.

Prevention and public health campaigns. In a very intriguing study, researchers studied several thousand people hospitalized because of depression or suicidality (Motto & Bostrom, 2001). Patients who refused follow-up care were randomly divided into 2 groups. People in one group received a letter at least 4 times per year for 5 years. The other group received no further contact. The letters received by the first group were simply brief expressions of care and reminders that the treatment agency was there if needed. Results showed that patients who received the letter had a lower suicide rate in the five years after discharge than did patients in the control group, a finding specifically attributed by the researchers to increased belongingness. In the study just described, the prevention technique was targeted at those previously hospitalized for depression or a suicidal crisis. How might their success be generalized, and presented to the public at large, or to segments thereof?

A public service announcement targeted to older men should be considered, since they are a demographic with high suicide rates. Its gist might be something along the lines of "Keep your friends and make new ones too – it's strong medicine."

Why People Die By Suicide attempts a comprehensive theory of suicidal behavior. Further, the book draws out clinical implications for topics like risk assessment, diagnosis and its implications for treating suicidality, diagnostic feedback with suicidal patients, hospitalization of suicidal patients, the use of and alternatives to "no suicide contracts," crisis management and resolution, between-session contact between patients and therapists, the therapeutic relationship with suicidal patients, various therapies including empirically supported psychotherapy and pharmacotherapy, prevention, and public health campaigns.
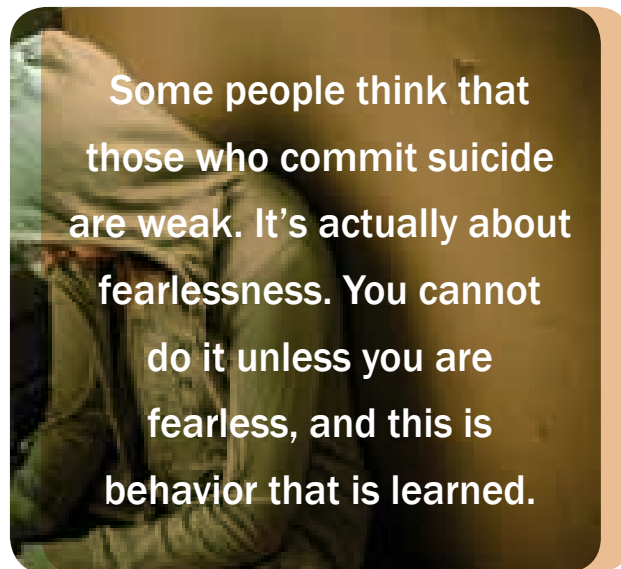
Thomas Joiner is an American academic psychologist and leading expert on suicide. He is presently the Robert O. Lawton Professor of Psychology at Florida State University, where he operates his Laboratory for the Study of the Psychology and Neurobiology of Mood Disorders, Suicide, and Related Conditions. He is author of Why People Die by Suicide (Harvard University Press 2005). In Why People Die by Suicide, Dr. Joiner posits a three-part explanation of suicide, which focuses on ability and desire. Joiner holds a PhD from the University of Texas at Austin.

THE WAR ON SUICIDE

Science, Education, and Advocacy Are Our Weapons

Robert Gebbia, Executive Director, American Foundation for Suicide Prevention
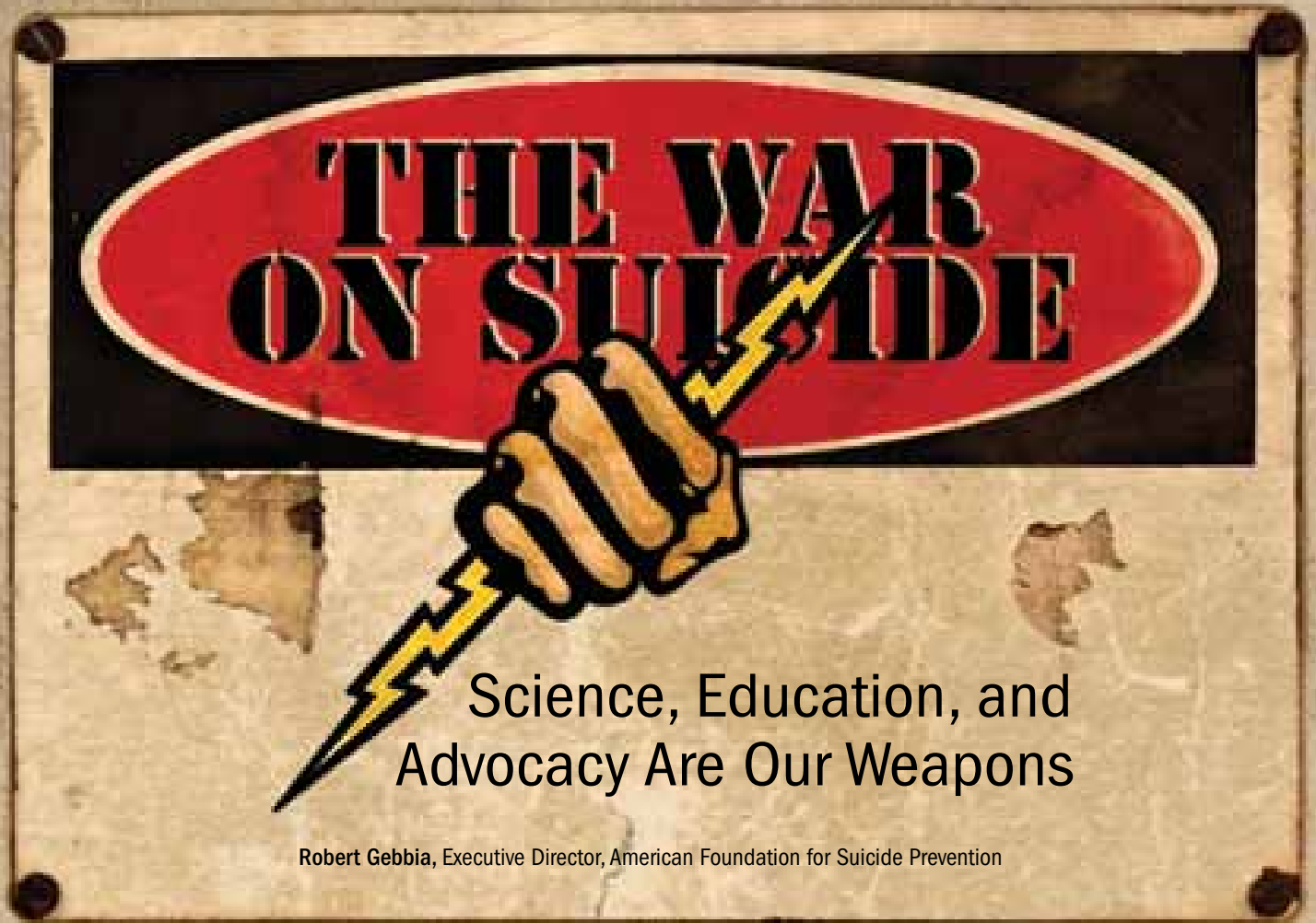
Suicide prevention may finally be getting the attention it needs to reverse the upward trend in the U.S. suicide rate and save lives.

Our organization, the American Foundation for Suicide Prevention, is advancing this goal though its investment in the scientific research, education and grassroots advocacy required to better understand and prevent suicide. From our vantage point, we see growing momentum in the suicide prevention movement, and a new sense of optimism that the time has come for a concerted effort to reduce this leading cause of death.

A report in 2002 by the Institute of Medicine (IOM), *Reducing Suicide: A National Imperative,* set the right tone by calling for a "war on suicide" that would fund research and prevention "at a level commensurate with the severity of the problem." A decade later, having seen this approach reduce mortality from HIV/AIDS and other illnesses, more of us than ever before are asking, "Why not with suicide?"

Research is a critical step toward this goal because what we *do* must be grounded in what we know about why people die by suicide. Historically, the nation's investment in research on suicide has lagged far behind research on other leading causes of death. Stepped-up funding of suicide research in recent years by the National Institute of Mental Health, the Department of Defense, the Substance Abuse and Mental Health Services Administration, and other federal agencies are steps in the right direction. In the private sector, last year's record level of donations to AFSP allowed us to maintain our position as the leading private supporter of suicide research. This momentum is encouraging, but broader public and private research investments are needed if we are to reverse the climbing suicide rate.

We know there are many pathways to suicide. Ninety percent of people who die by suicide have a mental disorder at the time of their death (often undiagnosed). Alcohol and substance use contribute, as do environmental factors, and stressful life events often serve as triggers, especially among already vulnerable individuals. With so many potential areas to investigate, how we apply limited research funds is important. An initiative aimed at focusing suicide research is being undertaken by the Research Prioritization Task Force of the National Alliance for Suicide Prevention. Working in collaboration with NIMH and organizations on the National Council for Suicide Prevention, AFSP is playing a lead role on the Task Force, helping to develop this first-ever national suicide prevention research agenda. The goal is to identify the priority studies that will have the greatest impact on preventing suicide over the next decade.

Research also provides the basis for innovative interventions to prevent suicide. One promising intervention is AFSP's anonymous online Interactive Screening Program, which has been shown effective in bringing at-risk college students into treatment. Listed in the Best Practices Registry for Suicide Prevention, the ISP is now being used by colleges and universities across the country, including many medical schools and all 10 University of California campuses. We recently finished a six-month pilot study with the VA and the National Suicide Prevention Lifeline to adapt the ISP for use with the veterans' online chat service, and we are about to launch the program with a Fortune 500 company and an urban police department.

Another promising trend is the dramatic growth of an engaged, passionate and increasingly vocal constituency for suicide prevention. Individuals and families impacted by suicide are getting involved in numbers not seen before. They are open about how suicide has touched their lives and are becoming more activist – creating the opportunity for greater political will. As we have seen with breast cancer and HIV/AIDS, these champions can be effective in raising awareness, educating the public about prevention, advocating for policies and legislation, and providing the vital resources of time and money.

This growing constituency is evident in the growth of **AFSP's Out of the Darkness Walks.** These walks for suicide prevention, launched 8 years ago in a handful of communities, will take place this year in 260 cities and towns. More than 100,000 people will walk and another 300,000 will sponsor a walker. Most of those who walk have been personally affected by suicide, having lost a loved one or struggled themselves with suicidal ideation or behavior.

Over this same period, AFSP's community-based chapters have grown from 10 to 56, bringing our **prevention and education programs** to tens of thousands of people nationwide. One such program, More Than Sad, teaches high school students about teen depression, anxiety, the dangers of alcohol use, and the negative effects of bullying. More Than Sad encourages young people with problems to seek help for themselves or a friend, and a companion program trains teachers about the role they can play in suicide prevention.

Since the merger of AFSP and SPAN USA (Suicide Prevention Action Network) in 2009, **advocates have been recruited and trained in all 50 states.** In early 2012, 200 volunteers from 33 states participated in our annual Advocacy Forum in Washington, DC, making 270 visits to House and Senate offices. They educated their members of Congress and/or their staff about the need for implementation of mental health parity, which became law over four years ago, but no final regulations have been issued. They also advocated for veteran and military suicide prevention, increased funding for research, and anti-bullying legislation.

In the not so distant past suicide was poorly understood and rarely talked about. Today, we are making progress toward reducing the stigma that has surrounded depression and other mental disorders that can lead to suicide. Then, suicide was a secret; now suicide is seen as a major public health problem and its prevention is becoming a higher priority for our nation.

While we are hopeful about the future, we also recognize the challenges we face and must continue to expand the investment in the science, education, and grassroots involvement that offer hope for preventing this tragic loss of life. This is the time for suicide prevention.

WHAT WE DO MUST BE GROUNDED IN WHAT WE KNOW ABOUT WHY PEOPLE DIE BY SUICIDE.

Robert Gebbia is the Executive Director of the American Foundation for Suicide Prevention. Since joining AFSP, he developed a network of chapters; increased annual revenue to $10 million, and expanded AFSP's mission and programs. He has extensive experience in not-for-profit management, fundraising, program development, and strategic planning. He received his MA in Sociology from the New School for Social Research and completed the Harvard Business School's Human Services Management Executive Program.

Saving Lives, the Forward March

Daniel J. Reidenberg, PsyD, FAPA, BCPC, CMT, Executive Director, Suicide Awareness Voices of Education and Managing Director, National Council for Suicide Prevention

This spring, I was asked to speak at a large, inner city medical examiner's office. I arrived early and was able to listen to the medical examiner present her suicide cases. During her presentation she started with "Case Number..." and gave a very brief case overview (age, gender, location of suicide) and then proceeded to show pictures "of the scene." At the end of an hour and 10 cases, not one time did she ever mention a family member or concerned other that they talked with. In not one case did she talk about what they had learned about the decedents, such as family history, history of mental illness, prior attempts, education, occupation, current family status, or if there was a family pet. Her presentation was void of all emotion and connection to a real person who had a life. Her job of course was to focus on the autopsy findings. But as mental health professionals, we have a chance to do something before someone become a case number.

The mental health continuum can be envisioned as going from very happy (e.g. getting married, having a child, winning a lot of money) to very, very unhappy (e.g. depressed, suicidal) and everything in between. Ultimately, suicide can be the tragic end for some who lives with a psychiatric disorder. In fact, 90% of those we lose to suicide have a psychiatric illness at the time of their death. True, most people who experience mental illness do not venture that far down the continuum, but for those that do — attempters, ideators, and even those who I would call "contemplators"— suicide is too close.

The suicide prevention movement in the U.S. began as an effort to put suicide on the continuum so that it could be seen like other illnesses. In 1998, families who had lost a loved one to suicide raised their voices, joined together, and partnered with the federal government in what became known as The Reno Conference. In the next several years, suicide prevention research was conducted, publications were produced, nonprofit suicide prevention organizations were in operation, international discussion took place, and memorials to those lost to suicide were held. In 1999, Surgeon General David described suicide as a public health crisis, infusing a new energy into the field. The National Council for Suicide Prevention was formed late in 1999 and in 2001 the first National Strategy for Suicide Prevention was released, initiating the first real, coordinated efforts to address suicide in America.

Today, the challenges in suicide prevention are bigger than ever but the hope for saving lives is also greater than at any time in our history. Sadly, a large number of behavioral health professionals know little about suicide. I cannot tell you how many times I present to professionals on this topic and more often than not I hear "I never knew there was so much to learn about suicide; I would

rather refer suicidal patients to others or the hospital; and/or it is too intense for my practice." Instead of realizing the critical role they could play in saving lives, many behavioral health professionals are afraid to tackle suicide but they don't have to be.

Despite the fear and stigma, we're seeing progress in our understanding and awareness about suicide. We have learned about risk and protective factors, about the neurobiology of suicide, and about how the suicidal mind works. Yes, the field of suicidology is on the move!

Over the last decade there have been a number of significant advances in the field of suicide prevention. What began as dreams became real advances, such as:

>> The development of a dozen evidence-based programs in suicide prevention on the National Registry of Effective Programs and Practices.

>> Public policy initiatives such as the Mental Health Parity Act, the Garret Lee Smith Memorial Act, and the Josh Omvig Veterans Suicide Prevention Act have led to millions of dollars in funding for the development of youth suicide prevention programs in states, on college campuses, Tribal communities and VA systems nationwide.

>> Major research findings on medications, treatment programs, cultural variations in suicide and brain imaging have advanced our understanding of the medical diseases that are most commonly associated with suicide.

>> The development of a National Suicide Prevention Lifeline, an inter-connected network of over 150 crisis centers across the country that is accessible 24/7/365 anywhere in the nation free and confidential with connections on Facebook and Google.

Likewise, there have been obstacles that have been challenged, and changed.

The Golden Gate Bridge — where 3 people have completed suicide each month over the last 75 years — was designed to have railings higher than were finally installed. Countless efforts have been made to raise the barrier and all stopped for aesthetic reasons. But this year federal transportation laws were passed that include provisions for bridge barriers require a net to be installed on the Golden Gate Bridge.

The idea that everyone in a system could work together to help to reduce/prevent suicide was taken on by David Litts, Kerry Knox, and others in the development of the Air Force Suicide Prevention Program. Involving all ranks and personnel in the Air Force and focusing on awareness, education, training, resources, referrals, and treatment, the program was able to overcome

As mental health professionals, we have a chance to do something before someone become a case number.

the idea that it couldn't be done and engendered significant reductions in suicides.

A study of the media's impact on suicide in Vienna led to great interest in creating guidelines for how the media reports on suicide. Following 3 years of extensive media coverage of subway suicides, in 1987 a campaign informed journalists of potential effects of reporting on suicide. Within 6 months of the campaign, coverage changed and there was a nearly 80% decline in subway suicides and non-fatal attempts. International guidelines were developed to improve media coverage of suicide, but could the U.S. create something similar that would be used by the media in this country? We did—and with contributions from journalists, experts, scientists and others from around the world, the most recent version of the Recommendations for Media Reporting on Suicide was released in 2011. In 12 months, over 20,000 copies of the guidelines were disseminated and over 7,500 people viewed the website.

So why revitalize and recharge the movement now? Because there are opportunities to do better, to do more, and to do it faster and smarter. A decade into suicide prevention in the U.S., there are more programs and people working in this field than ever before. There are more signs of hope in promising practices that are coming out regularly. For example, the Henry Ford and Magellan's Health Systems work in developing a Zero Suicide initiative in boundaried systems has sparked interest and intrigue worldwide, showing that we can really drive toward zero suicides.

The passion to design better early intervention and recognition of those at risk of suicide is more evident than ever before. Dr. David Jobes' CAMS (Collaborative Assessment and Management of Suicidality) and Dr. Tom Joiner's intelligently conceptualized new theory of suicide (based on thwarted belongingness, perceived burdensomeness and habituation) are examples of new ways of approaching suicide prevention that are showing great promise. The Army STARRS (Study To Assess Risk and Resilience in Service members) is the largest study of mental health risk and resilience ever conducted among military personnel.

Other new initiatives are under way to develop more effective methods of communicating the warning signs of suicide to the public and healthcare professionals. We are working with social networks and the technology industry to analyze "big data" that can help us better understand how those at risk are communicating as they near an attempt or die by suicide. The online world of Facebook, Google, Twitter and other channels is providing new ways of staying connected to those we care about, and new opportunities to help our patients such as with symptom monitoring applications.

The National Action Alliance for Suicide Prevention is bringing together leaders from many industries to partner with federal agencies to catalyze, champion, and cultivate new energy in saving lives. And the new 2012 revised National Strategy for Suicide Prevention will galvanize the nation around new strategic directions for the decade ahead.

Because suicide involves the complex interplay of biology, genetics, environment, psychology and development, suicide prevention requires everyone to be part of the solution. As mental health professionals who see the inner pain manifest in emotions, cognitions, and behaviors that do not truly represent the person, we have a unique opportunity to help where others cannot. For example, studies have

Today, the challenges in suicide prevention are bigger than ever but the hope for saving lives is also greater than at any time in our history.

shown that those who attempt suicide but receive follow up in the weeks and months after a hospitalization — even just a simple card in the mail or phone call — tend to recover and are less likely to attempt again. We in mental health must be part of the follow up care that can save lives.

As we move suicide on the mental health continuum, professionals like us must take note of lessons from cancer. Originally cancer patients and their families were treated in a nonpersonal, cold, sterile, and medical way. But today, cancer treatment is less about the disease and more about the patient — and it is paying off. Similarly, in suicide prevention — and in mental health overall — we need to pay more attention to the person.

Suicide prevention is about saving the lives of our clients and patients. It is also about saving moms and dads, brothers and sisters, aunts, uncles, grandparents, co-workers, neighbors and friends. We must find our role in the national suicide prevention effort and work toward a day when everyone clinician knows the warning signs of suicide and ultimately no one dies by suicide. Now is the time — join the movement to save lives.

Dr. Dan Reidenberg is the Executive Director of SAVE (Suicide Awareness Voices of Education), a national nonprofit agency working to prevent suicide and help suicide survivors. He is on the Steering Committees of the National Suicide Prevention Lifeline and the Suicide Prevention Resource Center. He is also the Chair of the American Psychotherapy Association Advisory Board and the Chair of the Certified Relationship Specialists Board. Dr. Reidenberg has done extensive work with adolescents and adults who have serious and persistent mental illnesses or who are chemically dependent. He has received numerous awards including being named one of the Ten Outstanding Young Minnesotans, the B. Warren Hart Award for service to humanity, Nonprofit Professional of the Year, and he was recognized as a "Champion of Change" at the White House by the Obama Administration.

Greater than the Pull Toward Death
STEPHANIE WEBER

Exclusive interview by Courtney Young for National Council Magazine

NATIONAL COUNCIL: How did the work of suicide prevention come to be so central in your life?

WEBER: My mom, Ellen Weber, took her life in 1979 and there had been one prior attempt about two years before her actual death. From that experience I took the road less traveled.

I have always, at the back in my mind, been interested in talking with an attempt survivor and I finally put it all together and realized that my mother was an attempt survivor and it was never talked about. No doctor, no emergency room, ever told me about the signs to look for. I never knew that the second attempt would prove fatal, which it did, and does in most cases. When she was required to see a psychiatrist after her first attempt, I called him after her second visit and I said, "My sister and I and our husbands would be happy to come and meet with you and with our mom." Today that's called family therapy. I had no idea that even had a label. He was very arrogant and said, "That won't be necessary, I can manage this on my own." My mom was quite pleased and said, "I fooled him. I told him exactly what he needed to know so I didn't have to go back anymore." When I questioned her about that she said, "People of my generation don't tell their problems to strangers."

I had been an elementary school teacher with four small children; and I went back to school to get a degree in counseling. I had seen a grief counselor for about a year after she died and determined that that's what I wanted to do. Part of my internship was actually putting on a suicide education conference in 1982 and that led to forming the Survivors of Suicide Support group (for anyone who has lost a family member or friend to suicide) as well as the Crisis Line of the Fox Valley in 1984. I helped to form the survivors division at the American Association of Suicidology, when there wasn't one and that is now up and going strong. I worked for a large agency running the crisis line for seventeen years and at some point the community came to me and said they needed much more in prevention and training. That's not what I was hired to do so I did trainings on nights and weekends. Eventually I met someone who pulled some task forces together and we formed Suicide Prevention Services and were incorporated in May of 1998.

NATIONAL COUNCIL: Why are people now talking more openly about suicide?

WEBER: I think it's because of the different generations coming along. It's interesting that we're talking right now because my anniversary observance of my mom's death is September 5 and I think at this point my mom would be about 94. I'm a product of the sixties — we loved everybody and we let it all hang out. We started talking about sex at a time when you didn't talk about sex and now we're talking about suicide. Teachers and family members are picking up that the kids are comfortable talking about it.

So many professionals do not get any kind of training in suicide prevention — from psychiatrists all the way down to social workers. It is my hope that one day they will all get a whole semester of training. The more we talk about it, the less stigma there is.

NATIONAL COUNCIL: So the stigma is still there — what needs to be done about that?

WEBER: What needs to be done about it is the talking — it's the identifying as an attempt survivor, or expressing that my loved one died by suicide. This can happen to anyone, it has happened to anyone. These are the things we know that will help people.

It's also about destigmatizing mental illness. No one seeks mental illness. No one seeks diabetes. No one seeks heart problems. In the sixties and seventies, we didn't mention cancer. We whispered the word or we called it "The big C." Using the word suicide and saying that people die by suicide, they die by cancer, they die by heart attacks... is important. Do we like people to be in this much pain and take their lives? No, it's preventable.

NATIONAL COUNCIL: Is that like a 'Front Porch Mentality'

WEBER: Yes, that means not coming in the back door and not being secretive about suicide. It's not whispering it. It's sitting on the front porch and saying, "I have brown hair, I have brown eyes, I'm this tall, I weigh this much, emotionally I suffer from depression but it's treatable and I've had a suicide attempt." It's almost like, look at me.

The pull toward health and living is greater than the pull toward death.

NATIONAL COUNCIL: If we could keep moving on this trajectory of more open expression, what can happen?

WEBER: I think we would have more honesty. I think one of the things that has always perplexed me — and I did the same thing when my mom attempted — is that when someone kills themselves we're great at beating ourselves up, at self-flagellation. The guilt, the anger, the 'if only.' We say, "If only I had another chance I'd do things differently." Why is it, then, that when someone attempts suicide and lives, we get angry and turn our back on them? I believe that's because we're afraid. We don't know what to do.

I think we need to educate people and erase the stigma. It's not about you, it's about the pain that that person is in. They need to be listened to. Take yourself out of the equation and ask them, "What's so painful in your life that you don't want to go on?" And just by asking that question we are offering hope.

NATIONAL COUNCIL: How can we integrate suicide prevention training for social workers, clinicians, and everyone who has the potential to come into contact with attempt survivors?

WEBER: Ideally that could be in every masters level course and in every bachelors level program too. This is a skill you need to know, like first aid or CPR. It's important to know the warning signs and know where people can get help and how to talk to them. To know what three questions to ask. It would be a full semester. If it's a requirement then you get into all the standards that all colleges have to complete. But it can be done; it's not impossible. You know we eat the pizza one piece at a time. So I think it's doable.

The pull toward health and living is greater than the pull toward death. If we listen to people, and open our eyes and ears, and if they're indicating that they are going to attempt, or have attempted, you still have that move toward life as being greater. Try to take yourself out of your shoes and walk in theirs.

Stephanie L. Weber, MS, LCPC, SPS, is Director of Suicide Prevention Services, Inc., a non-profit organization headquartered in Kane County, Illinois. She has a BS in teaching from Northern Illinois University and an MS from Indiana State University in Counseling. She has since secured vast study throughout the United States. Weber founded Survivors of Suicide, a nearly 30-year-old self-help group. As a well-known suicidologist, grief counselor, speaker and crisis coach, her calendar gratifies. She is the founder and former Executive Director of the Crisis Line of the Fox Valley, a 24/7 hotline for all callers who get specialized care from highly trained volunteer paraprofessionals. She is a member of the board of directors of the American Association of Suicidology, the center of the regional 1-800-SUICIDE Crisis Help Line, and a member of the Illinois Counselors Association. In 2000, Stephanie was honored by AAS as "Survivor of the Year" and, in the same year, she accepted the Kane County "Hidden Hero" award. She is the current Survivor Chair of AAS.

Global Classroom
Suicide Prevention Lessons from Around the World

Richard McKeon, PhD, MPH, Branch Chief, Suicide Prevention, Substance Abuse and Mental Health Services Administration

The release of the revised National Strategy for Suicide Prevention represents an important milestone in our national efforts to reduce suicide's tragic toll. Everything we know about suicide suggests that a sustained, comprehensive approach is needed, and the 2012 National Strategy for Suicide Prevention represents the next phase in our intensified, national efforts to prevent suicide in the United States. For national strategies to have their desired impact, they must be living documents that guide national action, and not simply reports on a shelf without meaning or impact. In order to be effective blueprints for national action, such strategies must be able to incorporate new knowledge, and must build upon previous experience.

The 2001 U.S. national strategy provided a critical foundation. Armed with the experience of the last decade and the new knowledge obtained both nationally and internationally, the revised national strategy from the National Action Alliance on Suicide Prevention — the public-private partnership launched to implement the national strategy and reduce suicide in America — builds on that foundation.

Because of the unique nature of national strategies, learning from the experiences of other nations is particularly important, and so it is useful to view the U.S. national strategy within an international context.

Finland in 1992 was the first nation to launch a national suicide prevention strategy. In 1996, the United Nations sought to further encourage such efforts by publishing guidelines to both develop and evaluate national strategies for suicide prevention. Since that time, many nations have developed national strategies, including England, Ireland, Scotland, Norway, Denmark, Sweden, Australia, New Zealand, and Taiwan among others.

Of the nations that have implemented national strategies not all have had sufficient time for both implementation and evaluation, or to redesign their efforts based on their impact. The kind of comprehensive 2-year review process that has been undertaken in the United States by the Office of the Surgeon General in coordination with the National Action Alliance for Suicide Prevention is unique. However England and Norway have both implemented national strategies and attempted to evaluate them and been able to report on their results.

While the effectiveness of national suicide prevention strategies cannot be studied in randomized controlled trials, important evidence for their effectiveness has recently been reported from England and for this reason the revised U.S. strategy highlights these results. The adoption of a range of suicide prevention recommendations by mental health systems across England and Wales was found to greatly reduce suicide rates among patients in those systems that implemented the recommendations. They examined changes in suicide rates as public sector mental health service settings began to implement the following nine suicide prevention recommendations:

>> Providing 24-hour crisis teams

>> Removing ligature points in inpatient facilities

>> Conducting follow-up with patients within 7 days of discharge

>> Conducting assertive community outreach, including providing intensive support for people with severe mental illness

>> Providing regular training to frontline clinical staff on the management of suicide risk

>> Managing patients with co-occurring disorders (mental and substance use disorder)

>> Responding to patients who are not adhering to treatment

>> Coordinating with criminal justice agencies

>> Conducting multidisciplinary reviews and sharing information with families after a suicide

According to While (2012), in 1998, few of the 91 mental health services in the study were carrying out any of these recommendations. By 2004, about half were implementing at least seven recommendations, and by 2006, about 71% were doing so. Over time, as more recommendations were implemented, suicide rates among patients declined. Each year, from 2004 to 2006, mental health services that implemented seven or more recommendations had a lower suicide rate than those implementing six or fewer. Among all recommendations, providing 24-hour crisis care was linked to the largest decrease in suicide rates.

The emphasis on post discharge follow up and proactive outreach that was found to be effective in the English national strategy was also a cardinal feature of the Norwegian strategy which has had as a central goal improving the care for people who made suicide attempts (often referred to as deliberate self-harm in the European nomenclature.) About 25% of the emergency departments in Norway were funded to institute "chain of care" projects so that people at high risk would not fall through the cracks between the Emergency Room and the community.

Similarly, in Taiwan, emphasis is also being given to a national effort to provide post discharge follow up to those who attempt suicide. While no other nation has yet published data in a peer reviewed journal as powerful as the English data, these large scale systematic efforts to improve care for a high risk population can provide significant opportunities for international learning. When combined with the evidence from randomized controlled trials such as the World Health Organization study (Fleischmann et al, 2008) which provided intervention within Emergency Departments and post discharge follow up of people who attempted suicide, large scale efforts provide considerable support for the expansion of emphasis on these areas that is seen in the U.S. strategy. Similarly, the English data on the importance of training of the workforce is mirrored by findings from Norway, and further supports the focus on workforce training in the U.S. strategy.

As the United States works to implement the new national strategy on suicide prevention, and continues to evaluate and assess the impact, the mutual sharing of successes and challenges with other nations can help us all to reduce the estimated one million deaths by suicide that take place worldwide annually.

Richard McKeon has spent most of his career working in community mental health, including 11 years as director of a psychiatric emergency service and 4 years as associate administrator/clinical director of a hospital-based community mental health center in Newton, NJ. He established the first evidence-based treatment program for chronically suicidal borderline patients in New Jersey, using Marsha Linehan's dialectical behavior therapy. In 2001, he was awarded an American Psychological Association Congressional Fellowship and worked for U.S. Senator Paul Wellstone, covering health and mental health policy issues. He spent 5 years on the board of the American Association of Suicidology as clinical division director, and he also has served on the board of the Division of Clinical Psychology of the American Psychological Association. He is currently a special advisor on suicide prevention for the Substance Abuse and Mental Health Services Administration.
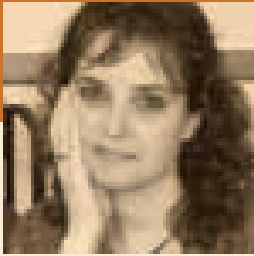
Too Few Years, Too Few Memories
Shauna Moses

My close relative, Michael, was Mr. Popularity — football star, idol and heartthrob — all through high school. All the guys wanted to be him and all the girls wanted to date him. Mike was also Mr. Comedy and cracked me up a million times throughout the too few years that he was with us.

After graduating college, Mike had a few successful careers, including one that allowed him to use his amazing artistic talents. On my 10th birthday, he cheered me up (I was upset about getting braces) by drawing caricatures of popular singers and making jokes.

I have no doubt that, with his talents and terrific personality, Mike would have contributed so much more to our family and to the world. Unfortunately, for reasons I'm unaware of, he did not have consistent treatment for his bipolar disorder. His condition worsened, leading him to take his own life at the young age of 36.

Michael had a long, wonderful life ahead of him. He should be here to celebrate the joys of life with us — joys that are bittersweet now that he is gone. He should be here to help us through the tough times. He should be here to help us create more special memories.

Michael was not able to manage his illness and move on with his life, but I do know that treatment works, especially when it is consistent over a period of time, and that recovery can and does happen, as I know from many members of the New Jersey Association of Mental Health and Addiction Agencies, where I work. Our members' clients achieve many inspiring successes. Men, women, and youth have entered or returned to the workforce; are succeeding in school; and are enjoying stronger relationships as they progress in their recovery from mental illnesses and addictions.

For those who could have a choice of receiving prompt, effective care versus emergency room visits, hospitalizations, homelessness, or incarceration, they would no doubt choose immediate and consistent treatment. However, many people in our state do not have a choice, and due to a lack of insurance or cuts to Medicare and Medicaid, they are forced to endure the more traumatic experiences that cause their health to deteriorate and possibly their families to fall apart.

Millions of dollars are spent on avoidable emergency room visits, hospital admissions, incarceration, and homelessness. By contrast, community-based services require an investment that is a fraction of these preventable expenses. For example, community outpatient services cost less than $600 annually per person, whereas the annual expense for a patient at Ancora Psychiatric Hospital is $178,000. Drug court costs approximately $20,000 to provide six months of residential treatment and outpatient treatment costs significantly less; by contrast, it costs approximately $47,000 to incarcerate one individual for a year.

I urge our government leaders to support community providers and give people opportunities for healthy, successful lives, and at the same time, benefit the state with significant financial savings.

By helping to ensure prompt access to services, the state would help hundreds of thousands of individuals with mental illnesses (nearly 25 percent of New Jersey residents) or addictions (nearly 10 percent of our state's population) and their loved ones.

If all barriers to treatment were dismantled, everyone affected by mental illness and addictions would have a much greater opportunity to enjoy good health, achieve personal goals, and create more special memories — many more than my family and I have been able to do since suicide took Mike away from us.

Shauna Moses is the associate executive director of the New Jersey Association of Mental Health and Addiction Agencies, Inc., a statewide trade association representing 170 hospital-based and freestanding providers of mental health and addiction treatment services. NJAMHAA's mission is to champion opportunities that advance its members' ability to deliver accessible, quality, efficient and effective integrated behavioral healthcare services to consumers who have mental illnesses and/or addictions, and their families.

H³: The New Language of Crisis
High-touch, High-tech, High-volume

Well-meaning public sector crisis services have often lacked credibility. The new-generation crisis center is changing that and Behavioral Health Link is leading the way with a new language of high-touch, high-tech, and high-volume. It is the goal of BHL to introduce a "new language" of crisis services that revolutionizes the expectations of public sector crisis intervention across the industry.

The H³ Methodology

Since 1998, BHL has refined an approach to crisis services we refer to as H^3. This innovative method is *high-touch, high-tech and high-volume.* CARF referred to BHL's approach as a "Promising Practice." NASMHPD spotlighted it in their 2008 Winter Meeting "Brag & Steal" segment. The Council of State Governments awarded it with a 2008 innovations award. More importantly, we believe these services have dramatically improved the lives of Georgians in crisis, and exponentially enhanced outcomes for families, providers, law enforcement, hospitals, family and children's services, courts and judges, and many others.

High Touch (Quality Personal Interactions)

The heart of our crisis intervention is a human interaction, a ministry of presence to engage those who need support. Our clinical professionals have a passion for what can be achieved in these moments. When a person gathers the courage to pick up the "400-pound phone," we give respect and offer a genuine human touch, asking first, "How can we help? How can we work together?"

Engaging and collaborating are our primary tools. Our staff is intently focused on supporting the individual in crisis at that moment and creating a "Quality Personal Interaction" with each and every person served, whether they be to the hotlines or contacts for mobile crisis intervention. The thinking about how to best achieve these outcomes remained relatively unchanged for forty years. However, the last decade has seen an explosion of new dialogue about what works best to optimize recovery and resiliency outcomes and assess accurately for suicidal risk.

High Tech (Innovative Software Solutions)

Over the past decade, BHL has engineered an array of integrated software tools for use with crisis services and the community behavioral healthcare system.

The proprietary *ICS 2008 (Integrated Crisis Services)* software suite includes data tracking and resource information. It also equips Mobile Crisis Teams to be fully equipped and supported while in the community, whether they are in an emergency room, social service agency, home apartment or on the street.

The web-based *BHL Express* application tracks intensive referrals to state hospitals, private psychiatric inpatient programs and community crisis programs.

These high-tech solutions empower staff to provide faster, friendlier and easier services. Our supervisors use support tools to verify quality and improve speed. We report these outcomes, and see transparency as critical in operating as a good steward of public funds.

High Volume (Cost Effective Integrity)

BHL has become one of the nation's largest providers of integrated crisis services. In 2012, BHL received its two millionth crisis and access call. On most business days, we receive more than 1,000 calls and dispatch our mobile crisis teams across the state.

Despite this volume, BHL is continuously improving the quality, consistency, and reliability of its crisis intervention services due to the collective synergies of H3 and its high-touch, high-tech, and high-volume methodology.

The high numbers also create significant savings. BHL provides much more than a professional clinical answering service, with active engagement and collaboration, direct scheduling, linkage and follow-up provided.

There are also the indirect savings created by better coordination with needed services. Diversion from state hospital beds created a cost avoidance in FY2012 exceeding $30 million. Linking callers with the least intrusive services also maximizes self-directed recovery.
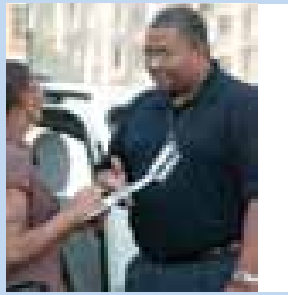
Real Success Stories

Bryan called the night after he attempted to take his life. He saw 800-715-4225 on television and decided to try it. Bryan described to the counselor over the phone that he was facing foreclosure on his house and was jobless. "What is the point of living?" he said. Mobile Crisis was dispatched to his home and they worked with Bryan and a friend to develop a plan, including a brief stay at a crisis unit.

Hector called struggling with thoughts of hanging himself. His English was limited and it was difficult to understand as he was very distraught and sobbing. A Spanish-language clinician continued to engage Hector, who was initially reluctant to give any personal information. Slowly, some trust was established and Hector explained he had received treatment locally. Ultimately, he was transported to a facility for immediate evaluation.

Reggie had been homeless for nearly a year and BHL was contacted by a local social service agency to help. Reggie explained that he felt hopeless and struggles daily with depression. To minimize his psychological pain, Reggie was drinking a case of beer each day. Mobile Crisis was dispatched and helped link him with a detoxification program as a starting point for his recovery. He also received needed medical and mental health care.

Joanne was admitted to a local hospital after an overdose; she had been found in her car several hours earlier and had been unresponsive. Mobile Crisis was contacted and Joanne explained she was determined to end her life and very upset that she had not died. She was linked with an inpatient program. Upon follow-up, Joanne reported she was doing much better and her mood had improved due to a change in her medication.

A school counselor called for help with Bobby, a 10-year-old boy who was expressing bizarre thoughts. The family had no transportation and Mobile Crisis was dispatched. Bobby explained that he was experiencing hallucinations telling him to do "bad stuff" to others. BHL staff worked with the mother to admit him to a crisis stabilization program that day.

After a Suicide
Postvention is Prevention

Joanne Harpel, Senior Director for Public Affairs and Postvention, American Foundation for Suicide Prevention;
Ken Norton, Executive Director, New Hampshire National Alliance On Mental Illness

Based on an interview with Courtney Young for National Council Magazine

The American Association of Suicide Prevention defines suicide postvention as the "Provision of crisis intervention, support and assistance for those affected by a completed suicide."

Postvention is prevention. It's kind of the bumper sticker but it's a mantra. Postvention is a form of prevention and starts with meeting the emotional needs of suicide survivors in the immediate aftermath of suicide loss — providing support, education, information and a sense of community and empowerment for survivors.

And we must remember that survivors are more than just family and include the entire community.

Postvention is also intended to help people recognize that there may be increased risk for more suicides after a suicide death and to understand what the warning signs of suicide are. It's important that people check in with each other and support each other, and particularly important that there isn't blame around a suicide death, because it can be really destructive.

Through postvention, we try hard to help survivors deal with what often can be a sense of guilt, responsibility, and blame by helping to reframe suicide in the context of underlying mental illness. Related to that is an effort to address the stigma that unfortunately persists around suicide. It's a very deeply rooted historical stigma, and the more we are able to help people understand that just as individuals can die as a complication of heart disease or cancer, they can also die as a complication of a serious psychiatric illnesses, the more we hope are able to address some of the stigma that still surrounds suicide.

We encourage people to be honest and tell the truth about suicide. We are often asked about how to explain suicide to children, in language that is age appropriate, and we encourage people to not feel a sense of shame around the fact that suicide happened either in their family or in their circle, that there doesn't need to be anything to feel ashamed about, and that telling the truth about what happened can be a very important step in breaking that cycle of stigma and shame.

We don't want to send a message that's potentially risky to people who are vulnerable, but in terms of the survivor community, it is important to reinforce that they're not alone and that there are a lot of people who have been through the experience of surviving a suicide loss. There is comfort in knowing that there are people out there who really do understand what you're going through. We

try to reinforce that there is a community available and that there are resources available, and that you're not alone.

Suicide loss so often results in people grappling with questions of why and who's responsible. Am I responsible? Who is to blame? How do I assign guilt? It is almost intrinsic to the experience of being a survivor that those kinds of questions come up. There could be a lot of anger and blame directed between family members. There can be very large differences in coping styles and in grieving styles. There could be some family members who want to talk very openly and candidly and frequently about the suicide, and others who don't want to talk about it at all. Suicide can create a lot of conflict between family members who might want to be supportive of one another but in fact, find themselves feeling as if they are at cross purposes with one another.

If we're able to help survivors understand that those feelings not unusual, and can help them look for other coping resources, we can free them to become stronger and to draw on their own resilience, rather than getting locked into this loop of anger and resentment. It can really help them get through, particularly in those early months.

There are several effective postvention programs and a few are described here.

The Connect Program has best practice protocols and training for key service provider groups that have some role in responding to a suicide death — law enforcement, medical examiners, faith leaders, funeral directors, educators, mental health providers, social service agencies — to help promote an integrated community response that promotes healing and resilience and reduces risk for future suicide deaths.

The genesis of the program was the New Hampshire Youth Suicide Prevention Assembly, which had some small dollars to do a survey of service providers in New Hampshire. They concluded that services were fragmented and that, particularly in the area of postvention, there were little to no services. The idea was to develop best practice protocols, and the Connect Program does that by bringing workgroups together from key service provider areas. We conducted research and drafted protocols, then we went through various scenarios and tried to identify where the gaps were and close them. The protocols were converted into the training.

One element of the Connect Program is to provide direct response tools to communities after a suicide death. The other component is to look at postvention as a three-legged stool — prevention, recognizing who's at risk, and intervention.

The program tries to move the postvention response upstream by working with communities, hopefully in advance of suicide deaths, so they are better prepared to respond in an integrated way.

International Survivors of Suicide Day was created by a resolution of the United States Senate, championed by Senator Harry Reid of Nevada, who lost his father to suicide. The resolution declared the Saturday before Thanksgiving to be National Survivors of Suicide Day. There's an event that takes place on that day, which has expanded to over 300 cities around the world. There are local healing conferences for survivors of suicide loss, at which they can not only get information about resources for healing, but also connect with other survivors in their communities. We know that many survivors have the experience of feeling isolated, stigmatized and alone when they lose someone to suicide. Survivors can also access a 90-minute DVD presentation online.

Suicide loss so often results in people grappling with questions of why and who's responsible.

Outreach Programs: One program that is being implemented throughout the country through a chapter structure, trains survivors of suicide loss who are further along on their own to make in-person visits to newly bereaved survivors at the request of the families.

Another program trains both lay people and clinicians to facilitate bereavement support groups for survivors of suicide loss — adult as well as children and teens support groups. That program is offered between 6-10 times a year in different cities. Several thousand people come through to learn the skills they need to run peer support groups for survivors of suicide loss. Although the program is open to mental health professionals and they do attend the program in large numbers, it is really designed to equip survivors to facilitate these bereavement support groups for their fellow survivors. It's a way of reaching out again to those people who are a little further along in their own journey of healing and who want to reach out and be supportive to the newly bereaved survivors.

After a Suicide: A Toolkit for Schools is a new resource for use by schools in the aftermath of suicide. For the most part schools are very concerned about doing the right thing and handling it appropriately, but are often a little bit at sea about exactly what that should look like. The American Foundation for Suicide Prevention has collaborated with the Suicide Prevention Resource Center to develop a free online toolkit for schools to use after there's been a suicide.

We've also partnered with various organizations to develop **"Recommendations for Reporting on Suicide"** for the media. More than 50 research studies worldwide have found that certain types of news coverage can increase the likelihood of suicide in vulnerable individuals. The magnitude of the increase is related to the amount, duration and prominence of coverage. The risk of additional suicides increases when the story explicitly describes the suicide method, uses dramatic/graphic headlines or images, and repeated/extensive coverage sensationalizes or glamorizes a death. Covering suicide carefully, even briefly, can change public misperceptions and correct myths, which can encourage those who are vulnerable or at risk to seek help.

Joanne Harpel joined the American Foundation for Suicide Prevention in 2002 as its first-ever Director of Survivor Initiatives. She is responsible for the full spectrum of AFSP's initiatives relating to the aftermath of suicide. She has collaborated with organizations ranging from the National Institute of Mental Health and World Health Organization to HBO and Sesame Street, and is co-lead of the National Action Alliance for Suicide Prevention 's Survivors of Suicide Loss Task Force. In addition, she oversees all of AFSP's public affairs efforts, including constituency relations, public and media relations, corporate communications, and social media.

Kenneth Norton is the Executive Director of the New Hampshire chapter of the National Alliance on Mental Illness. He led the development of NAMI NH's Connect Suicide Prevention Program which is designated as a national best practice training program in suicide prevention, intervention and postvention. He has been touched by suicide personally and professionally, which fuels his passion for the importance of postvention work.

Shattering the Black Suicide Myth

Donna Holland Barnes, PhD, Co-founder and Executive Director,
National Organization for People of Color Against Suicide

> Young black men who **"put themselves in situations** where it's very likely that they're going to get shot to death are actually committing suicide."

Suicide was once thought of as a "White thing" among people of color, which left several institutions serving communities of color ill-equipped to help those in a suicidal crisis. There was a lack of awareness among the general population that people of color do die by suicide. Suicide is the third leading cause of death for African Americans, behind only homicide and unintentional injury; and American Indians have the highest rate of suicide among all racial and ethnic populations.

The rates of suicide among people of color are much lower than among whites but may be estimates. We have no way of knowing what is not reported accurately.

Younger males between the ages of 15-24 are at a higher risk in the African American and American Indian communities as opposed to older white males who are at highest risk in the white population. Adolescents from these communities may be less likely to report depressive symptoms or suicidal ideation even during a suicidal crisis because of the stigma associated with suicide and the families' lack of awareness in recognizing the signs.

VIOLENT DEATHS

"Instead of committing the act on my own, I'd put myself in situations where someone else would actually do it for me...I would threaten people who were known killers." – Antoine Quichocho

Homicide is defined as a death resulting from the use of physical force or power, threatened or actual, against another person, group, or community when a preponderance of evidence indicates that the use of force was intentional. Suicide is classified as a death resulting from the use of force against oneself when a preponderance of the evidence in-dicates that the use of force was intentional. Within many US Cities with majority African-American populations (>50%), homicide rates are considerably higher than suicide rates. Washington, DC has a homicide rate of 29.1 per 100,000, while the suicide rate is at 6.1; Gary, IN has a 48.3 homicide and 11.2 per 100,000 suicides; Baltimore, MD had a suicide rate of 8.9 per 100,000 and 43.3 per 100,000 homicide; and Detroit's rate of suicide is at 8.9 per 100,000 but is currently with 47.3 murders per 100,000.

Whereas these statistics may be interpreted as African-Americans being more likely to engage in homicidal behavior than suicidal, we must be cautious to consider the social and psychological conditions in which these deaths take place. Due to the cultural stigma regarding suicidal behavior and mental illnesses within African American communities, one may engage in risky, criminal, or even homicidal behavior with ultimate goal of bringing harm to themselves. Dr. Alvin Poussaint, professor of psychiatry at Harvard Medical School, discussed during a 2008 interview on National Public Radio that young black men who "put themselves in situations where it's very likely that they're going to get shot to death are actually committing suicide." He added that the cultural taboo of suicide may cause one to reason that they would "rather have someone else kill them or have it seem like an accident" than to have the shame associated with suicide.

Victim-precipitated homicide is defined as the death in which the victim was the initiator of violence. In effect, this is an "assisted suicide" in which the killer inadvertently carries out the death wish of the victim. "Suicide by cop" is a phrase used to describe a provoked killing at the hands of a law enforcement officer. In such deaths, police officers, who are capable of carrying out lethal responses, are sought out for this very purpose.

In cities, where life is rife with social and economic tension and disparities, people not have to look far beyond their own neighborhood to find potential participants for other assisted suicide scenarios. This same sensitivity to social conditions and cultural stigmas must be considered when examining the occurrence of homicides and suicides within all social groups. With greater awareness of this, the focus of violence in society may be shifted from merely the issue of criminology and law and order, towards the implementation of mental health education and other preventative supports within African American communities.

NOPCAS promotes life-affirming strategies that will help to decrease life-threatening behaviors. It is our aim to develop prevention, intervention, and postvention support services to the families and communities impacted adversely by the effects of violence, depression, and suicide in an effort to decrease life-threatening behavior. We invite the participation and support of all those who wish to assist in the effort to reduce the incidence of suicide in minority communities.

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Donna Holland Barnes lost her son, Marc Jamal Barnes, to suicide in 1990. In 1992 she contacted other families of color who had lost their children to suicide to see if they would join her in conducting a forum in Teaneck, New Jersey for the families and health providers. They agreed. The forum was titled, "Sharing the Pain." Shortly thereafter, many conversations later, Barnes founded the National Organization for People of Color Against Suicide. Since that time, NOPCAS has held two-day conferences in Atlanta, New York, St. Louis, Durham, Denver, Los Angeles, Boston and many more places. Barnes says the nation's minority communities feel the pain and loss of suicide at alarmingly high rates and that it is important to come together and work towards increasing knowledge about suicide and suicide prevention.

Why Are We Whispering?

When Donna Barnes sought help to deal with her son's death two decades ago, there were no services in the African American community for families coping with the suicide of a loved one, she said. The stigma was too great, Barnes said. Also, it has been a popular notion that African Americans do not take their own lives, she added.

It was believed that after dealing with slavery and the attendant legacy of institutionalized racism as well, Black communities blighted by gangs and drugs, there was nothing that African Americans could not handle emotionally, Barnes said.

Barnes co-founded the National Organization for People of Color Against Suicide. She now serves as the organization's executive director. NOPCAS was formed to stop the tragic epidemic of suicide in minority communities.

But it's hard to know exactly why someone would take his own life, Barnes said. "Many times people take their lives, and it's not due to (clinical) depression."

"We do have some of the lowest suicide (rates among the races)," Barnes said. "But suicide of African Americans increased substantially by about 200 percent in some age groups in the 1980's and 1990s."

Perhaps Black males are in jeopardy because they bear the brunt of crime and drugs in the African-American community, according to some researchers. African-American males have a higher rate of joblessness, criminal victimization, and incarceration than other segments of society.

Sean Joe, an associate professor in the School of Social Work and the Department of Psychiatry at the University of Michigan's School of Medicine, has studied the trend of suicide among African American males for the past decade.

And although there is a stigma against suicide in the African-American community as a whole, suicide carries less of a stigma with young adults than with older Blacks, Joe said. Future study should focus on getting mental help resources to Blacks and studying the nature of masculinity among Blacks in order to make the seeking out of such services less stigmatized, he said.

"We need to look at why Black youth do not go to services, and why they drop out when they do," Joe said. "With males in general, you have to deal with this masculinity issue. If you express emotion, this is considered weakness. The idea of masculinity and not emoting has put these young boys in emotional straight jackets. They can't turn to their families because they believe 'our boys should be strong enough,'" Joe said. "You have to allow them a space to emote. You must continue to do health education with families; not just medication, and you have to encourage families to keep them coming (to psychiatric sessions)."

Barnes agrees. "There's a stigma of having a mental illness and a stigma about being treated for it. African Americans believe it's a character flaw to have a mental illness," she said. Or they may even go as far to say, it's a weakness, Barnes said.

"I asked, 'why aren't we discussing this?'" Barnes remembers. "I started talking about suicide. Then, people would talk to me privately. And my position was, why are we whispering?" Today, the organization reaches many people of color and encourages them to find out information about suicide, so that loved ones can pick up on the signs that someone may be contemplating taking his life.

"We're reaching people now, and we're putting it on the minds of families, so they can look out for family members. The people around them need to be able to pick up the signs, like talking negatively about everything; thinking no one cares or isolating themselves," Barnes said.

There are various theories about why suicide has increased among African Americans, Barnes said. "Kids from baby boomer parents didn't practice their religious beliefs," she said. So, these children of boomers were more likely to commit suicide. "Also, we moved our kids out of traditional Black neighborhoods to White neighborhoods, where they were the only Black kids in their classes, and they were often isolated. They didn't have cultural references to help them. That's another theory. And guns became

> I started talking about suicide. Then, people would talk to me privately. And my position was, why are we whispering?

readily available in many communities. It's about 60 percent of completed suicides that happen through gunfire. There are guns everywhere." Suicidal behavior may also present itself in drug use and homicide, Barnes said.

"We're a community that doesn't talk about it. That's the problem. When you do have someone who takes their own life, the family feels they have nowhere to go for the healing process. And it's hard to deal with it, if you won't talk about it. Families should seek out support groups."

In 1999 then-Surgeon General David Satcher began talking about firearm-related suicide among young African-American males and other nonwhites as a public health problem.

"Reports show that the historical gap in suicide rates between African-American males and White males of similar age has been narrowing," according to Joe, who in a published report which analyzed the data, showed that the rate of firearm-related suicides among African-American males age 15 to 19 increased by 133 percent between 1979 and 1997.

"The 1999 Surgeon General's report on suicide highlights the importance of restricting access to firearms in preventing suicide," Joe said in one report. "Our findings underscore the need for all health care professionals to regularly ask whether depressed or suicidal African-American youth have access to firearms. Although this recommendation may seem obvious, several studies of medical practitioners have found that such patients are not asked this question with any kind of regularity."

A Legacy of Strength
Changing the Tide Among American Indians and Alaska Natives

Cortney Yarholar, MSW, Senior Tribal Prevention Specialist; **Petrice Post,** MA, Senior Tribal Prevention Specialist; **Elly Stout,** MA, Prevention Support Program Manager — Suicide Prevention Resource Center and the American Indian/Alaska Native Task Force, National Action Alliance for Suicide Prevention

Rates of suicidal behaviors and ideation among American Indians and Alaska Natives are among the highest of all races in the United States, and death rates are especially high for males age 15 to 24, according to the Centers for Disease Control and Prevention. While suicide rates vary widely among individual tribes, the national rate for American Indians and Alaska Natives of all ages is 1.7 times higher than the U.S. rate, and suicide mortality rates for Alaska Natives are 4 times the national average. Between 14% and 27% of American Indians and Alaska Natives adolescents have attempted suicide, and suicide is the leading cause of death among American Indians and Alaska Natives youth ages 10-34.

Despite these sobering statistics, communities and national leaders are acting to draw on the traditional strengths of American Indians and Alaska Natives communities to turn the tide of suicide and restore hope for future generations.

Many of the stressors contributing to increased risk for suicide among American Indians and Alaska Natives populations stem from the historical experiences of indigenous people since European contact, including:

>> Loss of land

>> Language and cultural traditions

>> Removal of children

>> Disruption of community and family structure.

These experiences have not only fragmented family and community support systems, but also have caused tremendous unresolved collective grief passed across generations, often called 'historical trauma.' At the same time, these historical experiences have led American Indians and Alaska Natives people to develop new ways of retaining and reclaiming culturally-based systems of healing and support. Historical trauma has created both unique stressors and unique resiliencies related to suicidal behaviors in American Indians and Alaska Natives populations.

Relocation is one of the major events contributing to historical trauma and present day conditions that put American Indians and Alaska Natives populations at increased risk for suicide. Today, the majority (at least 67%) of American Indians and Alaska Natives people in the U.S. live in urban settings, largely as a result of past federal policies which encouraged American Indians and Alaska Natives to move to urban areas in an effort to assimilate them into mainstream culture. Native people moving to cities in the hopes of finding employment and opportunity confronted racism, inadequate housing, unemployment, and social and cultural isolation.
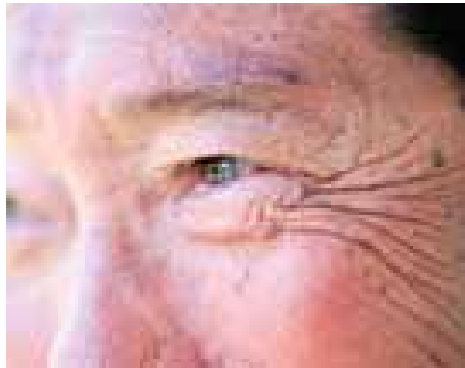
Historical trauma has created both unique stressors and unique resiliencies related to suicidal behaviors in American Indians and Alaska Natives populations.

While these policies have been reversed for many decades, risk factors for urban American Indians and Alaska Natives remain, many of which are believed to be directly related to loss of family and tribal community connections, cultural knowledge and wisdom, and access to tribal resources. Since the relocation program began, American Indians and Alaska Natives in urban areas have mobilized to develop urban Indian centers and urban Indian health centers, which provide culturally influenced social service programs to gain access to mental health supports, and act as a vital link to American Indians and Alaska Natives tribal identity for urban populations.

Research has shown that cultural continuity, high levels of cultural spiritual orientation, and connectedness to family and friends are protective factors that buffer suicide risk for American Indians and Alaska Natives populations. Specific risk factors include alcohol and other substance use, discrimination, limited mental health services access and use, and historical trauma. On reservations, American Indians and Alaska Natives youth have frequent exposure to suicide and other loss, and may be at particular risk for contagion. Much of what is known about American Indians and Alaska Natives racial/ethnic disparities does not include urban areas, where a majority of Native people in the U.S. live. Compared with other racial and ethnic groups, few resources are devoted to the health needs of the urban American Indians and Alaska Natives population.

Several federal initiatives, such as the Substance Abuse and Mental Health Services Administration, Garrett Lee Smith, and Native Aspirations programs, as well as the Indian Health Service Methamphetamine and Suicide Prevention Initiative, support suicide prevention efforts among American Indians and Alaska Natives. With these and other funding sources, rural and urban communities have implemented a range of culturally tailored prevention approaches to strengthen American Indians and Alaska Natives identity and preserve communities. While these efforts include reducing risk factors (substance use, bullying, violence), more emphasis has been placed on promoting strengths (cultural practices, community connectedness and healing, and life skills).

With many American Indians and Alaska Natives populations located in remote settings and with limited resources, crisis response protocols have also been an important focus, to ensure existing services and traditional community supports are connected.

Society and culture play a large role in guiding how American Indians and Alaska Natives people respond to and view mental health and suicide, and thus have been a central focus in prevention efforts. Suicide prevention programs in Indian Country aim to tap the strengths embedded in centuries-old spiritual beliefs, such as the importance of protecting children against harm, traditional child-rearing methods, extended family roles, and systems of clans, bands, or societies. Recent research focusing on protective factors indicate that cultural continuity has a significant protective effect against suicide attempts among American Indians and Alaska Natives, with young people in particular having a valued role in preserving their heritage. By promoting the community's sense of ownership and influence, services can be tailored to the unique local needs of each American Indians and Alaska Natives group, contributing to the community's general well-being.

At the national level, several new initiatives have evolved in recent years for suicide prevention among American Indians and Alaska Natives populations. In 2010 and 2011, IHS, SAMHSA, and the Department of the Interior's Bureau of Indian Affairs and Bureau of Indian Education collaborated to increase communication and cooperation among federal agencies to address the complex issue of American Indians and Alaska Natives suicide. This joint effort began with 10 listening sessions across the country seeking tribal consultation and input, which informed two national summits on suicide prevention in 2011, which focused on priorities identified in the listening sessions. The IHS American Indians and Alaska Natives Suicide Prevention Strategic Plan, created in consultation with Tribes and Villages, was also released during these summits. The plan promotes research, prevention, and behavioral health integration, and is designed to guide IHS suicide prevention efforts from 2011 through 2015. IHS has also been collaborating with the Veterans Administration Suicide Prevention Office and local tribal behavioral health programs to increase outreach activities to American Indians and Alaska Natives veterans and their families and provide community suicide prevention training in tribal communities.

The National Action Alliance for Suicide Prevention, a national public-private partnership advancing the National Strategy for Suicide Prevention, created an American Indians and Alaska Natives Task Force in 2011, which aims to support suicide prevention efforts in Native communities nationwide. Led by the Director of IHS, the Assistant Secretary of Indian Affairs, and the Executive Director of the National Indian Youth Leadership Project, the Task Force is currently exploring how

best practices for American Indians and Alaska Natives suicide prevention can be better documented and shared.

Although SAMHSA's National Registry for Evidence-Based Programs and Practices lists two suicide prevention programs (American Indian Life Skills Development and the Model Adolescent Suicide Prevention Program), the Task Force realizes that these represent only a small fraction of what is being done in the field, and that American Indians and Alaska Natives communities need more examples of culturally appropriate programs that have been successful in similar settings.

Through a partnership with the Suicide Prevention Resource Center and the American Foundation for Suicide Prevention, the Task Force is exploring an expansion of the existing Best Practices Registry for Suicide Prevention to include more promising practices from American Indians and Alaska Natives communities. Additionally, the Task Force is looking for ways to include the more holistic and comprehensive approaches often implemented by American Indians and Alaska Natives communities in existing best practice criteria.

Cortney Yarholar, MSW (Sac & Fox, Creek, Pawnee and Otoe Tribes), Senior Tribal Prevention Specialist, Suicide Prevention Resource Center and Member, American Indian/Alaska Native Task Force, has worked with youth programs in tribal communities for over 10 years, and facilitated state-tribal collaboration for mental health and substance abuse prevention. Mr. Yarholar leads SPRC's collaborative efforts with several national Native organizations, and also provides technical assistance to Garrett Lee Smith Memorial Act Tribal Grantees in implementing strategic suicide prevention initiatives.

Petrice Post, MA, has worked with SPRC since 2008, collaboratively assisting states and tribal organizations to build on community assets to prevent suicide using a public health approach. She has been working in the field of prevention, community mobilization, and development for over 15 years. Ms. Post has spent most of her career working with diverse populations in rural and reservation communities on a broad range of issues, including mental health, substance abuse, family violence, suicide, and family/consumer involvement.

Elly Stout oversees technical support for over 30 tribal suicide prevention programs across the country, and leads an effort to connect SPRC with other technical assistance centers to better serve Indian Country. Ms. Stout has over 11 years of experience working with diverse populations around the world, including 5 years supporting Native communities in the U.S. Ms. Stout maintains active relationships with a number of federal agency and nonprofit partners promoting Native health at the national level. She has expertise in developing, implementing and evaluating communication and social marketing programs in diverse and challenging settings.

The American Indian/Alaska Native Task Force of the Action Alliance has the goal, in partnership with Tribal Communities, to implement suicide prevention strategies to reduce the rate of suicide in American Indians and Alaska Native communities.
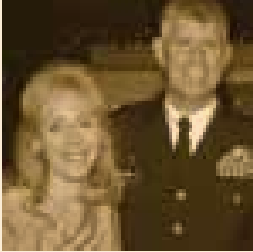
Carol and Mark Graham

Different Kinds of Battles
General Mark Graham and Carol Graham

Based on an interview with Meena Dayak for National Council Magazine

We met in college and we had three wonderful children — we felt like we were one of those Walt Disney families.

In 2003, we were in Korea and our kids were all in college in Kentucky. Our older son Jeffrey graduated with a degree in civil engineering and I had just commissioned him into the army as a second lieutenant. Jeff was over at officer training at Fort Knox, Kentucky. Our younger son Kevin was a pre-med student at the University of Kentucky on an ROTC scholarship — he wanted to be an army doctor. Our daughter Melanie had been there for a whole year. Kevin and Melanie were in an apartment together.

On June 21, 2003 Jeff called to say Kevin had died. He died by hanging himself with a power cord from a ceiling fan. It was a horrible phone call that changed our lives forever.

So we flew back to Kentucky — fragile, broken, in a state of shock, and not knowing what to do. Our son was just so bright and we thought he had so much to live for, but he was suffering from depression, which we now know is an illness that there is treatment for.

Just one month prior to Kevin's death, in May 2003, we had flown back from Korea for Jeff's graduation and commissioning ceremony. We saw Kevin then and he looked the best we've ever seen him look. We said, "Kevin you're in great shape. What are you doing?" He said, "I'm feeling good. I'm working out twice a day." He was getting ready to go to ROTC advanced camp. He was going to be a senior ROTC cadet.

We knew Kevin had depression, but in 2003 you didn't hear much about depression. There weren't ads on the television about it. We had suicide briefings in the army by PowerPoint once a year but we did not understand depression. We knew Kevin was sad but we didn't know you could die from being too sad.

Kevin was working out twice a day because he had been reading and learning about depression on his own and he learned that when you increase your physical activity it increases the serotonin in your body. So he was feeling better and doing well.

Kevin had gone to the university clinic in October of his junior year and had a depression screening. He called and said, "Mom did you know depression is an illness, not just a feeling?" And we remember thinking "Yeah." And he said, "They want me to go on this medicine, this Prozac." We really did not think of it as an illness. We thought "Oh he's going to take those pills and it'll be like erythromycin or something and he'll just get well."

Kevin went on the medication. He actually got better. But he was keeping a secret. He was on a full scholarship and he didn't want the military to know about his depression. He didn't even tell his brother Jeff or his sister Melanie that he was on medication. And sadly we, his parents, were part of the stigma.

Kevin had talked about trying to maybe see a psychiatrist. We reached out through our military insurance to see if we could get a psychiatrist, and they said they would not authorize unless there were extenuating circumstances. They wanted to know if Kevin attempted

suicide and we were like "Oh my God, no. He's going to be an army doctor."

We just didn't see it as a life or death... Like when he said "My brain doesn't work." If our kids had called from college and said, "My heart doesn't work, my kidneys don't work, my lungs don't work..." we'd have been all over it. We'd have had him go to the Mayo Clinic or something.

Kevin said a few weeks before he died "I think guys are just supposed to suck it up." We never said that but by us not doing something, I think he got that impression. He didn't want to let anybody down. He didn't want to let the pre-med advisor down. He didn't want to let ROTC down. He didn't want to let us down. He was a top cadet — he'd been selected to be the cadet commander his senior year.

The last night that we talked to Kevin, I don't think he'd slept for about three days and he did not sound good. He'd been off the medicine. We don't know exactly when he went off it, but he stopped seeing the therapist some time in May. The last conversation we had with him he was quoting Henry David Thoreau and he was saying things like "The mass of men lead lives of quiet desperation."

We knew he was exhausted but we didn't think that he was dying. One of the last things he said was "Mom, I just want to go plow the farm with Jeff and dad, and come home, and you cook all of our favorite foods, and we just read the Bible around a candle, and go to bed, and do the same thing the next day." And you know it was like he was so sad, but again... We don't have a

farm by the way. We never really had the training to see the warning signs that Kevin was spiraling down.

Mark said, "Kevin, if it's the army I'll pay back your scholarship." But he said, "You know dad, I'd be a quitter…because of the soldier's creed and everything."

Actually since Kevin's death, we found out on both sides of our family we have a history of mental illness. Family members had depression but nobody had talked about it.

Anyway, after Kevin's passing, we went to Fort Sill, Oklahoma where Mark became Chief of Staff and we were struggling. Our world was shattered because our kids are our whole world. Frankly, our lives will never be the same. We tell people that happy today is not the same happy it was before we lost our sons.

After Kevin died, Jeff continued to stay in Kentucky and train. He was scheduled to go to Fort Riley, Kansas to the First Infantry Division and then to deploy to Iraq. The army said that he could stay at Fort Knox and work there and not have to deploy because our family had gone through such a tragedy but Jeff came to me and said, "Dad I have to go." The father in me did not want my son to deploy, but the soldier in me understood why he needed to deploy. But it was very hard for all of us that Jeff was deploying to combat right after we lost Kevin.

Jeff was very upbeat about his deployment. We got two phone calls from him while he was deployed and a couple of letters. He sent emails periodically. Jeff was near Fallujah, which in early 2004 was a very dangerous place. Jeff was killed on February 19, 2004 in a town called Kalidiyah just outside Fallujah when he was crossing a bridge leading his platoon on a foot patrol with his men and an IED was detonated by cell phone.

Again, it just shattered our world. After we lost Kevin we had such a hole in our hearts. And then Jeff was killed seven months later so the world as we knew it ended again. But we just have been embraced by so many

wonderful people. Our family has been incredible throughout — our blood family but also our army family.

Our daughter worked her way through nursing school — it took her a long time but she became a nurse. She dropped out of school two or three times at Kentucky because she struggled to continue on with the loss of her brothers. But she is a wonderful, amazing young lady, and she's 28 years old now and married.

So there is hope. We go around and we speak — we tell people that there is hope. We gain a lot of our strength and the way we continue to keep going is by trying to help other people work through this and also to help people know about depression. We did not know, but there is help for people and depression is treatable in many different ways.

We do a lot with an organization called TAPS, the Tragedy Assistance Program for Survivors. They have been a very big source of strength for us through all the others that have lost someone and just bonded together. We often say it's a club you never wanted to be in.

The other thing is we're a family of faith. We've always prayed a lot and we've always been in church. So we were dealing with it spiritually. We did pray. We dealt with it spiritually but we did not deal with it medically. And I think that's what kind of spurs us on to speak out for Kevin.

After Kevin died all we could feel was shame and guilt, and we didn't even know if we should even have a church funeral for him. The stigma was so heavy around us. And when Jeffrey died with the full military honors it was like an opposite kind of tragedy. But today we say our boys died fighting different battles.

Today, the reason we speak out is because we don't want any other families to go through this. We don't want any other family ever to lose a loved one to suicide. We missed it. We were wrong. So we speak out for all the Kevins in the world who have no voice.

As our kids grew up, we talked to them about the dangers of sex, alcohol, drugs, and strangers but we never talked about depression. We never talked about mental illness and suicide prevention. We never did but families need to talk about it. The myth is if you talk about it it'll cause it to occur. That is a myth. Families need to talk about depression especially if they've got a history of it in their families. They don't need to scare their kids, but as they get a little older they need to help them understand that if you start having these feelings then you need to get to a doctor. You need to call your mom or dad or brother or sister. Call someone to get help because it's real and it's serious.

We were part of the stigma and we've got to get rid of that. You've got to be able to go for mental health care like you do for any other care. No one thinks twice about taking a pill every day for high blood pressure or for cholesterol. Some people need counseling or therapy. The key is to get to a medical professional.

It was in 2005 that we were asked to come speak at the National TAPS Conference. But it was really the first time we could openly share Kevin's story because it was like a lot of people could talk to us about Jeff but it was so awkward about Kevin. We could feel their awkwardness. Jeffrey's death was so heroic, purpose driven, but our hearts were just screaming out "What about Kevin; what about Kevin…"

TAPS gave us a chance to connect with other military survivors, to include those that had lost their loved one to suicide, and we just really didn't think it would play out that way. Once we could hug them and hold onto to them, and they could hold on to us, we gave each other strength and help…

It takes a church, a community, a village to overcome the stigma and help those in need. Every door a service member or family goes through needs to be the right door for care, the right answer. They need to be helped — to care and to receive care — and not to be judged.

The Battle Back Home
Overcoming the Reluctance to Ask for Help

Michelle Cornette, Suicide Prevention Subject Matter Expert, Center for Deployment Psychology, Department of Medical and Clinical Psychology, Uniformed Services University of the Health Sciences

Military suicide rates have received much attention in recent years. While research has suggested that military veterans are at risk for suicide, military personnel on active duty have historically demonstrated decreased risk for suicide, relative to their civilian peers. Unit support/camaraderie and the availability of mental health services have been offered as potential protective factors. For the Army, this changed in 2008, when the active duty suicide rate for soldiers exceeded that of civilians for the first time in known history.

To date, more service members have died by suicide than have died in the war in Afghanistan. Although some have speculated the increase may be attributable to combat deployments and/or combat exposure, data suggests otherwise. Between 2008 and 2010, 55% of suicide deaths were among individuals who had never deployed, and 84% had never been exposed to combat. During this same period of time, 80% of suicide deaths occurred in the U.S., while 13% took place in Iraq or Afghanistan. Among active duty personnel, military suicide rates were relatively stable from 1998 – 2005, increased from 2005 – 2009, and decreased mildly through 2011. When adjusting for age, suicide rates from 1998 – 2011 have been highest in the Army and Marine Corps. Recent data indicates the number of monthly Army suicides reported in July 2012 reflected an all-time high.

Some civilian mental health providers work as contractors or General Schedule employees at military treatment clinics where they treat service members on active duty. Other civilian clinicians play an important role in the treatment of former active duty service members, as well as in that of National Guard members and Reservists. While some veterans, Guard members, and Reservists choose to obtain their mental and physical healthcare within the VA system, approximately two-thirds to three-fifths of veterans obtain their health care outside of the system. It is therefore imperative that civilian mental health providers become knowledgeable about military culture, and well-versed in treating military veteran mental health issues, including suicidal ideation and behaviors.

The Center for Deployment Psychology at the Uniformed Services University was created in 2006 in order to address the preparedness of civilian and military mental health providers in meeting the needs of current and former military personnel and their family members. The mission of the CDP is to train licensed mental health providers working in both the civilian and military sectors, who provide psychological services to active duty military and reserve component soldiers, veterans, and their families. The CDP currently offers several training options focused on the etiology, assessment, and treatment of suicidal behavior. In addition, within the coming months, the CDP will launch a new online suicide prevention course, in addition to an intensive live 2-day evidence-focused suicide intervention workshop, as part of its evidence-based psychotherapy program.

> Just as family members and friends play an important role in supporting a military loved one throughout the deployment cycle, they also play a critical role in early identification of risk factors and acute warning signs for suicide and other mental health issues.

The CDP has also been selected to participate in the Pentagon's new Defense Suicide Prevention Office working group, the goal of which is to develop recommendations for training providers in suicide risk assessment, management, and treatment.

Just as family members and friends play an important role in supporting a military loved one throughout the deployment cycle, they also play a critical role in early identification of risk factors and acute warning signs for suicide and other mental health issues. This includes knowing when and how to encourage those who serve or have served in the military and are at risk to pursue professional help. Mental health issues, and suicide in particular, are highly stigmatized problems in civilian culture — a phenomenon which is even more true in the military. The need to encourage help-seeking may therefore be even more necessary, as current and former military personnel may be even more reluctant to seek help.

Veterans Behavioral Health Certificate

★ ★ ★ ★ ★ ★

Jeannie Campbell, Executive Vice President, National Council for Community Behavioral Healthcare

Public memory is short and our veterans returning from Iraq and Afghanistan are less often in the headlines. Yet we know that for the thousands who return with physical and emotional scars, their wounds can present challenges for years to come. An estimated 300,000 veterans of the Iraq and Afghanistan wars have experienced PTSD or major depression. And a 2008 Department of Defense Health Behavior Survey reports increase in prescription drug abuse and heavy alcohol use with one post-deployment study showing that 27% of veterans met criteria for alcohol abuse.

Today civilian practitioners are on the frontlines of our veterans' battlefield back home as more returning veterans and their families are seeking mental health and addiction treatment services outside the VA — in their own communities.

The Substance Abuse and Mental Health Services Administration has issued a Call to Civilian Providers to provide effective services for veterans and their families, understanding their unique culture and needs. As we respond to this call, we're faced with important questions. What do we need to know to effectively serve veterans returning from Operation Iraqi Freedom and Operation Enduring Freedom and their families? What does cultural competency mean with respect to those who have served in the military and their families? What are the unique characteristics of the conflicts in Iraq and Afghanistan that should inform treatment? What lessons can be learned from those who already specialize in treating veterans and family members?

In response, the National Council for Community Behavioral Healthcare has partnered with the U.S. Department of Defense Center for Deployment Psychology and Essential Learning to establish the "Serving Our Veterans Behavioral Health Certificate" (www.TheNationalCouncil.org/Veterans), an online program that helps prepare practitioners to serve veterans. The evidence-informed curriculum offers 14 self-directed, self-paced, online courses for 20+ hours of CE credit. The course content is based on real-life cases and provides applicable knowledge and skills for practitioners to help veterans and their families build a framework of resiliency. It combines knowledge, compassion and perspective, giving clinicians a full picture of what veterans face and the tools to meet their needs. In the first few months since its launch, more than 1,600 people have enrolled in the certificate program.

The only online program of its kind in our field — the Serving Our Veterans: Behavioral Health Certificate— from the U.S. Department of Defense Center for Deployment Psychology, National Council, and Essential Learning — features an evidence-informed curriculum offering 14 self-directed, self-paced, online courses for 20+ hours of CE credit:

>> Cognitive Processing Therapy for PTSD in Veterans and Military Personnel

>> Domestic and Intimate Partner Violence

>> Epidemiology of PTSD in Military Personnel and Veterans

>> Fundamentals of Traumatic Brain Injury

>> Improving Substance Abuse Treatment Compliance

>> Meeting the Behavioral Health Needs of Returning Veterans

>> Military Cultural Sensitivity

>> Overview of Suicide Prevention

>> Prolonged Exposure Therapy for PTSD for Veterans and Military Service Personnel

>> Provider Resiliency and Self-Care: An Ethical Issue

>> PTSD Then and Now, There and Here

>> The Impact of Deployment and Combat Stress on Families and Children

  Part I: Understanding Military Families and the Deployment Cycle

  Part II: Enhancing the Resilience of Military Families

>> Working with the Homeless: An Overview

"GATEKEEPER" TRAINING

The CDP's evidence-based suicide prevention workshop will address the important role of family, friends, and other "gatekeepers" in suicide prevention. Given the challenges inherent in suicide risk prediction, and the relatively limited amount of time service members and veterans spend, if any, with mental health providers (relative to other people in their lives), gatekeeper interventions are a practical strategy for spotting warning signs and risk factors for suicidal behavior, with the hope that at-risk individuals, like veterans, will be identified early, and appropriate referrals can be made. Gatekeeper training is designed for people without formal mental health training and is intended to help individuals:

>> Recognize warning signs/risk factors for suicide.

>> Know to ask questions in a way that helps at-risk individuals feel comfortable coming forward with information.

>> Understand when/how to make referrals.

In addition to family and friends, other "gatekeepers" may include co-workers, military comrades/ commanders, and others with whom individuals may have less close relationships, but with whom they have relatively frequent contact. Mental health providers can play an active role in advocating for gatekeeper training in the family members of their patients, as well as in their clinics, hospitals, and communities more broadly.

WARNING SIGNS AND SUICIDE RISK ASSESSMENT

Suicide risk assessment is a critical component of suicide prevention. Historically there has been a large body of work tying a number of constructs to suicide risk. Yet one of the many challenges in suicide prevention is identifying those points in time when individuals are at greatest risk for serious suicide ideation and attempts. In an attempt to address this critical assessment issue, an important body of literature has been developed, to distinguish between proximal warning signs and more distal risk factors. Both gatekeepers and clinicians may find the following list of warning signs useful in identifying patients who may be at acute risk:

A person in acute (immediate, severe) risk for suicidal behavior most often will show:

Warning signs of acute risk:

>> Threatening to hurt or kill him or herself, or talking of wanting to hurt or kill him/herself; and/or,

>> Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or,

>> Talking or writing about death, dying or suicide, when these actions are out of the ordinary.

Additional warning signs for acute risk:

>> Increased substance (alcohol or drug) use

>> No reason for living; no sense of purpose in life

Approximately two-thirds to three-fifths of veterans obtain their healthcare outside of the system

>> Anxiety, agitation, unable to sleep or sleeping all the time

>> Feeling trapped — like there's no way out

>> Hopelessness

>> Withdrawal from friends, family and society

>> Rage, uncontrolled anger, seeking revenge

>> Acting reckless or engaging in risky activities, seemingly without thinking

>> Dramatic mood changes.

Here's an easy-to-remember mnemonic for warning signs:

IS PATH WARM?

I	Ideation	W	Withdrawal
S	Substance Abuse	A	Anger
		R	Recklessness
P	Purposelessness	M	Mood Changes
A	Anxiety		
T	Trapped		
H	Hopelessness		

In addition to its suicide-specific trainings, the CDP also offers a wide variety of trainings in other critical military mental health content areas to include military culture, deployment cycle, etiology, assessment and treatment of posttraumatic stress disorder, traumatic brain injury, depression, substance abuse, and sleep problems. The CDP also offers — in partnership with the National Council for Community Behavioral Healthcare and Essential Learning — an online veterans behavioral health certificate, which includes a suicide prevention course.

Michelle Cornette, PhD, is a licensed clinical psychologist working as the Suicide Prevention Subject Matter Expert at the Center for Deployment Psychology. She is developing a suicide prevention evidence-based psychotherapy workshop and online suicide prevention courses for military mental health providers. From 2003 to 2011, Dr. Cornette worked at the Zablocki VA Medical Center, where she was Suicide Prevention Team Leader, Mental Health Division Research Lead, and Veterans Integrated Service Network (VISN) 12 Suicide Prevention Director. In the latter capacity, she was responsible for overseeing suicide prevention activities at the 7 VA facilities in VISN 12. She also chaired Zablocki's hospital-wide suicide prevention committee. She holds adjunct faculty appointments in the Departments of Psychology and Nursing at the University of Wisconsin- Milwaukee.

STAND BY THEM

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Veterans
Crisis Line

1-800-273-8255 PRESS ①

Confidential chat at **VeteransCrisisLine.net** or text to **838255**

We Owe it to Them
Supporting Our Veterans

Neal Cash, MS, President and CEO;
Vanessa Seaney, MSW, LCSW,
CPHQ, Chief Clinical Officer; and
Lauryn Bianco, MA, Network
Development Coordinator –
Community Partnership of
Southern Arizona

Every day it seems the news about suicide among veterans and active military can't get any worse — and then it does.

The ebb and flow of deployments in Iraq and Afghanistan and the return of these soldiers has contributed to a spike in behavioral health issues among veterans and an unprecedented number of suicides. The Department of Veterans Affairs estimates that, on average, 18 veterans commit suicide every day.

In light of this and other factors, Community Partnership of Southern Arizona began four years ago to assess and respond to the specific behavioral health needs of veterans in Tucson and Pima County, Arizona, through a community forum, focus groups, and a partnership with the Southern Arizona Veterans Administration Healthcare System – one of the first such partnerships in the United States.

As the locally based Regional Behavioral Health Authority overseeing publicly funded behavioral health services in the county since 1995, Community Partnership of Southern Arizona was the natural lead for a systemic effort to better serve veterans and their families who need mental health and substance use services.

Community Partnership of Southern Arizona's veterans initiative grew out of a public forum held in Tucson by then-Rep. Gabrielle Giffords of Arizona and Rep. Michael Michaud of Maine in September 2008. The forum led to:

>> A strengthening of Community Partnership of Southern Arizona's partnership with SAVAHCS and a new collaboration with the Arizona Coalition for Military Families (ACMF), an acclaimed public/private partnership to strengthen care and support for service members, veterans and families across the state.

>> An increase in veteran-focused peer-support services throughout the Community Partnership of Southern Arizonacare system.

>> Military- and veteran-focused trainings and conferences for behavioral health service providers and the community.

>> Development of Rally Point Tucson, a central point for veterans and family members to find peer support, information and help navigating available services, either in person or online.

About 500 veterans (out of about 35,000 members) already were enrolled in Community Partnership of Southern Arizona's system, many with a serious mental illness. Community Partnership of Southern Arizona began a planning process with other veterans, their families and veteran-serving organizations to eliminate barriers to services by coordinating and creating programs with existing veterans service providers.

Community Partnership of Southern Arizona's veterans services initiative aims to integrate veterans services and behavioral health care, building on our long experience with peer support. Though not termed "suicide prevention," these changes will provide treatment and support that can alleviate

stressors faced by returning veterans and their families, as well as creating a connection to and relationship with resources to recognize and intervene if suicide is a possibility. Community Partnership of Southern Arizona's initiative was featured in a veteran-focused "Road to Recovery" video from the Substance Abuse and Mental Health Services Administration that was shown on cable channels nationwide. We also were asked to share our experiences in a webinar presented by the National Council for Community Behavioral Healthcare, the Department of Defense's Center for Deployment Psychology, and Essential Learning, which had more than 800 participants.

Coordination and communication among existing veteran services was one of the most important needs identified by Community Partnership of Southern Arizona's assessment. As a result, we developed Rally Point Tucson, a starting point for veterans, active-duty military and their families to connect with resources, regardless of discharge status, entitlements or healthcare benefits. The program, staffed by veterans, began operations in August under a grant from the Arizona Department of Veterans Services. It is co-located with Pima County ONESTOP, an employment program familiar to veterans, so veterans need not go to a behavioral health facility – another barrier to obtaining care.

The importance and appropriateness for veterans of service delivery by peers is well-established, and Community Partnership of Southern Arizona has been a leader in peer support for more than a decade. In 2004, Community Partnership of Southern Arizona and the University of Arizona's Recovery thru Integration, Support & Empowerment program established the state's first Recovery Support Specialist Institute to train and certify peer workers. A half-day segment for veterans wishing to provide peer support at SAVAHCS was added to the institute in 2010.

To further strengthen peer support for veterans in its system, Community Partnership of Southern Arizona contracted with Vets4Vets, a nationally known organization that provides peer-led workshops for returning service members, and arranged with HOPE, Inc., a consumer-run agency partially funded by Community Partnership of Southern Arizona, to hire veterans to provide outreach and support.

We also rely on long-established, evidence-based gatekeeper trainings — Applied Suicide Intervention Skills Training (ASIST), safeTALK and Question, Persuade, Refer — to mobilize community members as "eyes and ears" to recognize and intervene when someone may be considering suicide. Community Partnership of Southern Arizona already had provided suicide prevention training to personnel of the local Air Force base before its veterans initiative began and the National Guard.

As the first Regional Behavioral Health Authority in Arizona to offer ASIST and safeTALK, Community Partnership of Southern Arizona was well positioned philosophically and structurally to incorporate training in Mental Health First Aid in 2009, further strengthening the community's awareness and intervention skills and its ability to prevent suicide.

Community Partnership of Southern Arizona and SAVAHCS hosted suicide prevention conferences in 2009 and 2011, each attended by more than 100 people, and in 2011 offered a five-part Community Training Series on topics related to veterans

We mobilize community members as "eyes and ears" to recognize and intervene when someone may be considering suicide.

services. The first series included common behavioral health diagnoses for veterans, suicide prevention and available services for military and veteran families, provided by staff from SAVAHCS, the Department of Defense, and Community Partnership of Southern Arizona service providers. Community Partnership of Southern Arizona has organized another training series to be held in the fall, and we plan to call on ACMF for a Military Immersion Training – two full days for behavioral health staff to increase their understanding of military culture and experiences – and the new, veteran-focused Mental Health First Aid training.

Community Partnership of Southern Arizona's approach of enhancing and coordinating existing services and resources builds in sustainability for its veterans initiative. We look forward to continuing these and creating new partnerships to ensure our returning veterans receive the support and services they need. We owe it to them.

Neal Cash is president and CEO of the Community Partnership of Southern Arizona, the regional behavioral health authority contracted by the state of Arizona for funding and oversight of the public behavioral health system for Pima County, Arizona. He has 35+ years of experience in behavioral health. He is a member of the National Leadership Forum on Behavioral Health/Criminal Justice Services of the National GAINS Center. He is a long-standing board member of the National Council for Community Behavioral Healthcare.

Vanessa Seaney, MSW, LCSW, CPHQ, is the Chief Clinical Officer, Community Partnership of Southern Arizona. She is a licensed clinical social worker and is certified as a professional in healthcare quality. She has 29 years experience working in public behavioral healthcare in Southern Arizona, including 16 years with CPSA, the Regional Behavioral Health Authority that oversees public behavioral healthcare in Pima County, Arizona.

Lauryn Bianco is a Network Development Coordinator for Community Partnership of Southern Arizona, and is the lead on veteran's initiatives. She has worked at CPSA for four years, and focuses primarily on enhancing behavioral health services for special populations.

Older Adults: Changing the Alarming Statistics

Yeates Conwell, MD, Professor, Department of Psychiatry, Geriatric/Psychiatry (SMD), University of Rochester

Based on an interview with Heather Cobb and David Covington for National Council Magazine
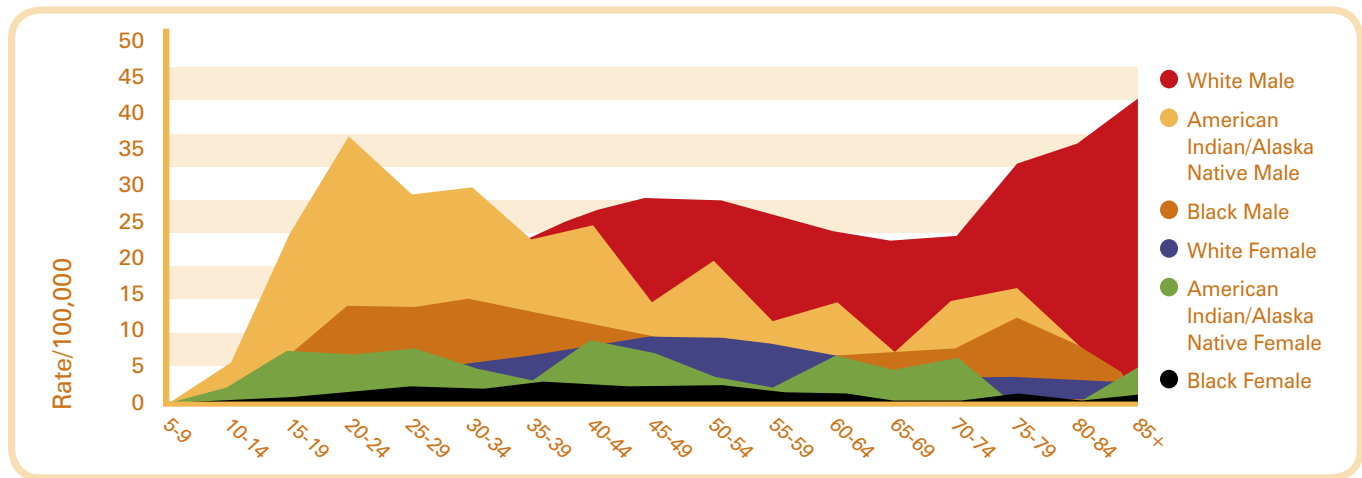
Older adults are a small proportion of community mental health practice. As a cohort, they do not typically go to mental health centers, or even to mental health providers. They get their care in primary care. Our challenge in late-life suicide prevention is figuring out how to provide linkages, through collaborative care models, to primary care practices to facilitate detection and intervention for this population.

When one looks at subgroups of the population, men have a very pronounced peak in older adulthood that begins in the mid-50s and then continues upwards inexorably to an old, old adulthood. For white men aged 85 and over, rates are 4–6 times higher than that of the general population. That's a profound change that one does not see for women, whose risk tends to peak in midlife and then drop somewhat thereafter. What it is about aging, gender, and race that determines those differences is very elusive right now, but there are a number of possibilities.

One characteristic of particular importance is the fact that older people tend to be more lethal in suicidal behavior than is the case for younger and middle-aged people. That is illustrated by the difference in ratios between attempted suicide and completed suicide in the general population. The general population's ration is around 30 attempts per one completed suicide; younger adults' is about 100-200; older adults' 2 to 1 or 4 to 1. There are different reasons for older adults' higher rate of completion. One reason is that older people are frailer so any effort to harm themselves is more likely to result in death. They also tend to be more isolated in our culture so they are less likely to be recognized as at risk or rescued once they've initiated an attempt.

Equally important, however, is that older people tend to use more immediately lethal means: firearms. That's true for both men and women. Where in the general population about 50-55% of suicides are with a firearm in the United States, it is closer to 75% among older adults. It's a very potentially lethal situation when one has an older person who is suicidal, so one needs to be more aggressive in managing that risk, even more so than in younger and middle-aged people. That drives the spectrum of prevention practice more towards primary and secondary prevention because once an older person has become suicidal, the likelihood of them dying in that condition is greater.

DIFFERENTIATING OLDER ADULTS' SUICIDE RISK

In terms of risk factors, older adults' risk factors are analogous to that of younger people, but there are differences. The DSM organizes psychiatric diagnoses into axes, which map closely to what we know to be independent risk factors for suicide in older people.

>> **Axis One:** Research shows that 85-100% of suicides among people in the second half of life are people with a diagnosable psychiatric axis 1 condition (i.e., major psychiatric illness). The difference between older people and younger and middle-aged people is that that condition tends to be an affective disorder. Depression is far and away more common than any other disorder. Another characteristic is that it tends to be less complex than in middle-aged and younger people with regard to comorbidities such as substance misuse. Other psychiatric illnesses are also common in this age group, representing risk factors for suicide. Although the evidence is less developed, substance abuse, when present, is associated with increased risk in most, but not all studies, as are anxiety disorders to some extent. Certainly psychotic disorders, schizophrenia, and delusional disorder in some studies shows increased risk, as well. Somewhat surprisingly, dementia does not appear to increase risks, though there is more research to do on that.

>> **Axis 2:** Older people with high-end neuroticism and low in the major personality domain called openness to experience, tend to be at somewhat higher risk. These are people who you would recognize as being limited in their coping repertoire, rigid, with a constricted range of interests, blunted affective,

and hedonic responses to the world around them. The premise is that these are acceptable characteristics when one is young and has other resources to draw on, but as one becomes older and faces the ubiquitous problems of aging, this kind of personality style limits one's ability to respond in an adequate way and places some increased risk for becoming hopeless, depressed, and suicidal.

>> **Axis 3:** Medical illness increases risk for suicide independent of other factors. Piecing medical illness apart from its effect on mood and even cognition is difficult to do, but it is clear in some studies. For example, record linkage studies that look at registries of people with cancer and link them with mortality data show that some conditions increase the relative risk for suicide by a factor of about two, which is not a lot, but it is real. In addition, some studies show neurological conditions, hedonist conditions — seizure disorders, and in particular temporal lobe epilepsy, which affects the kind of seat of emotions —increase the risk for suicide. Lung disease, heart disease, and pain syndrome have also been shown to increase risk.

>> **Axis 4:** The stressors most closely associated with suicide in older people are social isolation — it's most prominent — and the loss of, or failure to develop, a robust support network. A number of studies have looked at family discord. There is some consistency showing increased risk among older people who do not have intact families or good relationships with others (e.g., social disconnectedness).

>> **Axis 5:** It is clear from some studies that the more comorbidities a person has, the greater the relative risk. Function is not related simply to the medical illness itself, it is also the illness' impact on one's ability to manage independently — the meaning of the illness has on the person's life in terms of their need for instrumental support and symbolic in terms of the illness has on how one sees one's life and derives meaning from life.

Finally, it's worth mentioning that access to legal means — firearms — is a risk factor for suicide. Having a gun in one's home increases the risk for suicide relative to people who do not have handguns in the home in the second half of life.

LOCATION, LOCATION, LOCATION

Relatively few older people who kill themselves have been in mental healthcare. That number continues to increase because of cohort changes. However, virtually all older adults have been in a primary care provider's office, in fact, about half to three-quarters of older adults have been to a primary care office within the last month preceding their death by suicide, and a third to a half within the last week.

Primary care is clearly one important place to look. However, older people having trouble may come to attention in other places in the community. These 'other places' are the basis of our work in community-based aging services agencies — where people might go if they are stressed by inability to pay their electric or heating bill. Then, there's the notion of gatekeepers — if we have sufficient awareness of people in the community, by people in the community, of what an older person who might be at risk is facing — then those gatekeepers may be able to help link at-risk older people to care. Those gatekeepers are postal workers, pharmacists, bank employees, and others in the community.

INDICATED, SELECTIVE, AND UNIVERSAL PREVENTION

The Institute of Medicine terminology talks about (1) indicated, (2) selective, and

Programs & Tools
Depression Screening to Prevent Late Life Suicide

We know that the lifetime risk of suicide among patients with untreated depressive disorder is nearly 20%. A 2002 case control study suggests that risk of serious suicidal behavior is greater among adults age 55 and older with mood disorders. About 60% of elderly patients who take their own lives see their primary physician within a few months of their death. The Fuqua Center for Late-Life Depression has led depression screening trainings using several evidence-based models to educate primary healthcare providers, elder housing providers, and Medicaid program in-home service providers.

IMPACT, PEARLS, and Healthy Ideas are three evidence-based programs with similar components. This provides a good overview of the three evidence-based programs:

● **PEARLS:** In 2008, the Fuqua Center trained resident services providers in senior independent living facilities in the PEARLS (Program to Encourage Active Rewarding Lives for Seniors) model.

● **Healthy Ideas:** In 2002, the Fuqua Center received funding from the American Foundation for Suicide Prevention to teach Georgia Medicaid Community Care Service Program care coordinators how to screen and refer frail older adults living in their homes for depression.

● **IMPACT:** Currently, the Grady Hospital Emma Darnell Geriatric Center has implemented depression screening of all patients using the IMPACT model.

This information was compiled by Jocelyn Chen, LMSW, MPH, Social Worker/ Project Coordinator, Emory University, Fuqua Center for Late-Life Depression, Division of Geriatric Psychiatry

(3) universal preventive interventions, and indicates those that target high-risk individuals.

Indicated Prevention Models

There are interventions to prevent the expression of suicidal behavior in people who are at high or immediate risk for suicide; therefore, this is the standard way to think about suicide prevention in a mental health service setting. With regard to older people, interventions such as detection and aggressive treatment of clinical depression, for example, are helpful given the close association between symptomatic depression and suicide in later life.

Antidepressant interventions are also helpful. The same FDA studies that led to the black box warning about antidepressants use potentially making adolescents and

young adults suicidal also show that antidepressant use in clinical trial circumstances reduced the risk for suicidality and suicidal behavior in people over the age of 50. It's a pronounced effect.

Collaborative care between behavioral health and primary care is another viable intervention. Several large randomized controlled trials showed that detection and systematic treatment of depression among older people in primary care practices using collocated or embedded depression care managers and algorithm-driven treatments reduced suicidal ideation and, therefore, risk, as well as improved depression symptoms more rapidly and in a more sustained way that those who received care as usual.

Selective Prevention Models

Selective prevention is an approach that targets high-risk groups, rather than individuals. It involves identifying groups of people who by virtue of sharing some characteristic have, on average, a higher risk (e.g., older people who recently had stroke and were functionally impaired or who had recently lost a spouse and were more isolated). Not many examples of selective prevention exist, but there are some, and it is an important area to learn more about. Tele-Help/Tele-Check service for the elderly is one helpful selective prevention approach. Over a 10-year period, this model decreases suicide risk for older people at risk by virtue of being socially isolated, functionally impaired, and in need of services to support their independent living in the community. The model links these older people through a telephone service to a bank of social workers who responded when they needed something, checked in, and provide regular support.

Universal Prevention

Universal prevention approaches target the entire population irrespective of the risk status of any individual in it. It's hard to prove that any universal preventive intervention has been effective, in particular, for older people thus far. But there are some indications such as the Brady Handgun Violence Prevention Act in 1994 that compared suicide rates before and after the institution of Brady handgun legislation, and between states that instituted it and those that did not because they already had regulations in place. The study found that while there was not a difference in suicide rates between those two comparative conditions for younger people, that there was a significantly greater reduction in firearm suicides for people over the age of 55 in those states that newly instituted the interventions relative to those that did not.

The bottom line is that when one looks at all of the different things that have been tried, including some that have combined a number of approaches (e.g., screening, detection of depressed people, referral for treatment, engagement of older people in communal activities, volunteer activities to reduce social isolation), it appears that indicated, selective, and universal approaches do reduce suicide. The concern is that that effect seems more prominent for older women than it does for older men. Few prevention studies have shown an impact on older men. It is a big challenge to find what it is needed to crack the tough nut of suicidality in older adult men, which are, after all, the group at highest risk.

A number of observations drive the focus toward connectedness. Several studies that looked at risk factors and social factors hone in on the idea that people who are socially disconnected are at higher risk. That's true parenthetically; not just for suicide death. Social connectedness is associated with all forms of

morality. The observation of several studies mentioned above (e.g., collaborative care in primary care, Tele-Health/Tele-Check) also have seen the effect of social connectedness interventions, at least for women and maybe on men. From the interpersonal theory of suicide perspective, social disconnectedness is a core component that puts a person at risk. There are ways to change that through psychological and social interventions, including psychotherapies, problem-solving therapy, and cognitive behavioral therapy. In particular, one study looking at interpersonal therapy, all with older people who are suicidal, showed that these interventions may reduce risk through giving older people skills and opportunity to improve their connectedness with family members, loved ones, friends, or communities.

WHAT CAN BEHAVIORAL HEALTHCARE PROVIDERS DO?

Obviously, it's important for behavioral healthcare providers to be alert for and sensitive to suicidal ideation and to be aggressive in its detection and management.

>> Routinely use screening tools that include measures or questions about meaning of life and suicidal ideation intent and planning important.

>> Recognize the importance of early and aggressive treatment of mood disorders, and similarly, any major psychiatric illness in the elderly for emergence of suicidality.

>> Understand the community context of older people's lives. We understand this context for people with serious mental illness, and the science of care management and case management has been well developed with regard to the treatment of people with serious and persistent mental illness. In a similar way, it's important among older people to be able to mobilize — to understand the importance of social context, social supports, social integration, and activities that provide meaning in life.

>> Treat the social morbidities in parallel with the axis 1 disorder. Older people at risk for suicide are particularly complex with regard to the social determinants of their risk. We must be able to use social and community-based preventive interventions, aging services, rehabilitation therapies, coordination with primary care, and other community-based social service delivery to mitigate common social problems of aging. These should be available and integrated with our standard psychiatric practice.

In an era that includes health homes, patient-centered medical homes, and other models, the mental health field needs to be part of that game so that it is not simply delivering care independent of other parts of the health system, but rather delivered in an integral way.

Geriatric psychiatrist Yeates Conwell, MD, was chosen as one of 73 "Innovation Advisors"— and the only psychiatrist — in the federal government's Innovation Advisors Program. The IAP encourages Conwell and other "Innovators" in the program to conduct a project that will yield results around each component of three goals: better health, better-quality care, and lower costs. As director of a partnership between University of Rochester Medical Center and a community services provider network called the Senior Health and Research Alliance, Dr. Conwell is developing develop collaborative systems of care integrating primary care, mental health care and — most uniquely — community senior-service agencies in the care of depressed elderly in the community. His first project is a dementia care program that will link memory-disorder specialty services (geriatric psychiatry, psychology, neurology, general medicine, and nursing) with social work and other community-based care to optimize independent functioning and quality of life for people with dementia and their families, while reducing overall costs.

'Boy, Interrupted'

Sharing the Pain through the Lens
Dana Perry

Exclusive interview by Courtney Young for National Council Magazine

National Council: Tell us about your film, 'Boy, Interrupted' and how it came to be.

PERRY: I'm a filmmaker. I'm a survivor of my son's suicide. He killed himself in 2005, when he was 15 years old. Subsequently, I decided to make a film about that experience. I am a filmmaker to begin with and it seemed sort of obvious to begin to deal with what we experienced — his bipolar disorder and his death — through film.

National Council: What was it like to direct and produce a film that was so personal?

PERRY: It was challenging. Obviously, you have this intimate relationship with the material. But it was absolutely necessary for me — whether I wanted to do it or not, it was happening. We had so many images of him, so many home movies, and had inadvertently documented so much of the experience of his illness and death. It seemed like this imperative that I couldn't avoid, it just drove itself forward. It was very challenging to sit in the editing room every day and look at those images. Fortunately, I had a wonderful editor, Geof Bartz, who did not know our family and was able to provide some guidance in terms of balance. It is a very emotional film and it is a film about grief, so I needed that kind of steady hand and objective point of view to keep from disappearing into it.

So as much as it was painful to relive and remember and stir up all these memories, it was also helpful to me to try and make sense of it.

National Council: what were some audience reactions to a film that speaks so openly about suicide?

PERRY: Well, it really does depend on the audience, because the gamut of audiences ranged from viewers of HBO to attendees of the Sundance Film Festival, to various film festivals around the country and the world, and also the psychiatric community and the suicide community. So it was a very different experience. Across the board, I experienced a lot of support from audiences. It was somewhat eye opening for people. The best measure of the response is the two very large binders in my office that are filled with letters I received from viewers of the film — thou-

sands and from all over the world. Invariably they were thank you's for being honest about this experience.

I had also the experience of looking at my husband's brother's suicide within the film, which happened in 1971, and that was a very different world at that time. That tells me something about progress that's being made, but I still feel that people are just amazed and surprised and grateful that anybody would even talk about such a thing. It's such an isolating experience and people don't know what to say. The purpose of the film, to some degree, was to create a dialogue about the subject that is so rarely addressed. You're supposed to whisper in the woods and hide and not talk about it and act as if it didn't happen. Well you know, it happened.

The other thing that's interesting is that people start coming out of the woodwork. It's a painful secret that they can now confess. I think for any type of an audience it's facilitating a dialogue.

National Council: Was your film asking specific questions and offering answers? Or was it simply allowing viewers to experience it as they might?

PERRY: This was not an educational film. It's really a portrait of what can happen in a family with mental illness. If there are questions raised, it was certainly about what is bipolar illness and how do you treat it. We made mistakes along the way. I think that there is a lot to be learned in the medical community about bipolar illness and possible prevention. If anything, it asks those questions, like how can

> I'm often asked,
> "How should I deal with my children,"
> and my answer is invariably,
> "Listen, listen very carefully
> and take it seriously."

we improve that? You know what can we learn about anticipating the behavior of a bipolar person if they are suicidal. Does it provide any answers? No, I don't think it provides answers, but I do want to continue to ask questions.

National Council: What kind of resources, then or now, do you think can be really helpful to parents who have a child with bipolar disorder?

PERRY: There really weren't any resources. We were just completely lost and in the dark. We're educated people, we're upper-middle class, we can afford psychiatric care, and we have health insurance. But, there was very, very little at the time. Our Evan was diagnosed in 1990, and it was said it was just depression, and he was put on Prozac. We only knew later that giving SSRIs to a bipolar patient is about the worst thing you can do and indeed, he did end up, while he was on Prozac, in his first attempt. It wasn't until a hospitalization following that attempt in 1999, that he was actually diagnosed with bipolar. At that time, I didn't even know children could have bipolar. I'd never heard of it. That was an absolute, utter shock. Of all the things I thought could be wrong with him, that was not one of them.

There was one book that we found called, The Bipolar Child, by Demitri Papolos. Now there are many, many more books and it's something that's considered to be real. When we were going through it, it was like, is this even real? Could this even be true? We had a really hard time finding people in the medical establishment who were knowledgeable enough to deal with us. We felt very alone. I can't tell you how lonely it was.

National Council: Why is it that people might feel they should whisper about suicide whereas everyone is talking openly about how someone might have died from cancer?

PERRY: I wish I knew. I wish I could answer that question. There's this giant stigma. I think there is a sense of shame for some people that they couldn't do better to save that person. There's this idea that you somehow control another person's emotions. It doesn't work like that. But there is a sense of embarrassment and shame for people who don't understand how powerful this disease is. People always say what could I have done differently? Why didn't I see this? It's much more complicated than that. I think we're going to be dealing with the stigma.

National Council: What would you want other people to know about suicide?

PERRY: That there is no shame in it. It's not a reflection upon the survivors. So many survivors suffer so terribly from the guilt and wonder what they could have done differently. While I suffer immensely every day and will for the rest of my life, I don't dwell on what did I do wrong, because we did everything we could and there's nothing we could blame. I hope the takeaway is an acknowledgement of how powerful mental illness can be and that it's not a reflection of character and it's not a reflection of the family. The brain is very complex and mental illness is an aberration that is so incredibly powerful — powerful enough to take a life. It's beyond most of our ability to comprehend how powerful that is and how little you can do about it.

I'm often asked, "How should I deal with my children," and my answer is invariably, "Listen, listen very carefully and take it seriously." It's one thing to hear "I'm going to kill myself if you won't let me go to the prom." It's another to hear, "I want to be dead" over and over. That pattern of behavior demands treatment. As far as surviving it, I don't know what to say other than it does get better as years pass, but it's a very terrible thing to survive.

National Council: What was helpful in your own healing process?

PERRY: Well certainly time passing. It's been almost eight years now but not a day goes by when I don't feel a stab in the heart with Evan's loss. Making this film was helpful — sharing with audiences, dialoguing with people, answering those letters, trying to give support back to families like us. There is some satisfaction in that. Spreading the word and building awareness, that's really what's needed. It's really about awareness and about the fact that there is treatment available, that the illness can be treated, and people can have more normal lives. But the treatment has to be received, it has to be paid for, and it has to be adhered to. We hear often that kids, as they grow older, become noncompliant with the medication. That's an issue. So there are a lot of things that could be improved. But again, the takeaway I try to share is to be very observant and really, really listen to your child.

I would emphasize again, that this was not the first suicide in our family and that mental illness tends to be genetic. So it's very important for families who are struggling with this issue to look at their family history and see if there are other instances in the family tree. People can be very surprised by what they find if they look at their genealogy.

Dana Perry is a filmmaker. "Boy Interrupted" a film about the bipolar illness and tragic suicide of her 15-year-old son, Evan, aired on HBO in 2009. The film premiered in competition at the Sundance Film Festival and was featured in many other festivals including Deauville, Vancouver, and Full Frame. The film has aired in more than 30 countries worldwide. "The Drug Years," Perry's 4-hour documentary exploration of illicit drugs and popular culture, was nominated for two IDA awards, received a Cine Golden Eagle, the Telly Award and The High Times "Stony" award, as well as a Prism award nomination. She has produced and directed many other award-winning films and documentaries on music, art, and other topics.

The Psychological Autopsy
What Makes Youth Vulnerable to Suicide?

Madelyn Gould, Professor of Clinical Epidemiology and Professor of Clinical Psychiatry, College of Physicians and Surgeons, Columbia University

Based on an interview by Susan Partain for National Council Magazine

Suicide is the third leading cause of death for young people. Since the early 1990s, the rate of suicide in young people has been decreasing, yet, in 2009, more than 4,300 young people between the ages of 15 and 24 died by suicide, and 13.8% of high school students seriously considered suicide.

Prevalence of suicide in the United States varies dramatically by gender and ethnicity. For any one girl who dies by suicide, there are four or five boys who die by suicide. Suicide rates are highest among American Indian and Alaskan natives, and rates are higher among Whites than Blacks or Hispanics. However, looking at ideation—not dying by suicide, but attempting suicide—in the U.S., Latina girls have the highest rates.

The majority of young people who die by suicide have struggled with a mental illness or substance use disorder. Substance abuse puts individuals at higher risk to attempt and to die by suicide.

Suicide is the leading cause of premature death in people with schizophrenia. Although schizophrenia often doesn't present until early adulthood (18-24), 10-15% of people with schizophrenia will die by suicide within the first ten years of the onset of their illness. They have suicide rates of 50 times greater than the general population.

Adolescents, compared to other age groups, make more non-fatal suicide attempts. For every completed suicide, there are many more suicide attempts in young people. For young people, the rates of attempting suicide really peak at around 15 and 16. One quarter to one third of young people who die by suicide have made a prior suicide attempt, and girls tend to attempt more than boys.

Part of the marked difference between rates of the suicides for males and females is a function of the use of less lethal means for females. For example, females tend to overdose. If you go to countries where they overdose on lethal pesticides, then they die, whereas in the U.S. they can get to an emergency room.

In China, the rates among women — especially in rural areas — were much higher than for men. It's

one of the few countries where the rate of death by suicide was overwhelmingly a female problem compared to males, and they were dying by using lethal pesticides. At the last International Association of Suicide Prevention meetings in Beijing, China reported the results of the prevention strategies that they implemented with regard to decreasing the access to pesticides in rural communities. People couldn't have them in their homes anymore, they had to be in a central repository and have special permission to get to them. The rates of deaths by

> Substance abuse puts individuals at higher risk to attempt and to die by suicide

suicide among women have really plummeted there.

In the U.S., Dr. Gould and colleagues conducted psychological autopsies of youth who had completed suicide, starting in the 1980s, to identify risk factors for youth suicide. A psychological autopsy is conducted by interviewing family and friends and getting school and hospital records. In building the autopsy, they tried to recreate what the lives of those who died by suicide were like, what their problems were, and what stresses they may have experienced. Thanks to their work, we now have an enormous amount of information on how a suicide can occur.

The psychological autopsies found that for a young person to attempt suicide, there needs to be some underlying vulnerability. This underlying vulnerability can range from family characteristics, such as a history of suicide or suicide attempts to sexual or physical abuse and general social adversity. The most common family factors that the psychological autopsy studies have referenced are having a family history of suicidal behavior and parental psychopathology. Parental divorce, once controlled for other problems, isn't significant. Having poor communication in consensual relationships is also a factor.

Biological factors, particularly abnormal serotonin metabolism, can also impact the risk for suicide. Many studies show decreased serotonin activity in suicides. Low serotonin, not necessarily associated with suicides, is associated with excitable and impulsive or violent behavior. And this kind of behavior would put someone at higher risk for dying by suicide.

Being a gay, lesbian, bisexual, or transgender youth does increase the risk of attempting suicide as well. Kids who are gay may get bullied more often. And then that becomes a vicious environment for the young person — a kind of perfect storm — where everything that could possibly work against the health and well-being of a young person actually occurs. Even though the typical media message is, "Bullying causes suicide," this doesn't tell the full story. It's true — but there are other correlated factors which enhance the suicide risk.

The likelihood that a young person will engage in suicidal behavior increases if they have a lethal method handy, or if the media has portrayed a suicide in a sensational way, or someone in their school died by suicide. But not if they don't have these other underlying vulnerabilities. Because someone like Kurt Cobain died by suicide doesn't mean that I'm going to now die by suicide, but if suicide is something that I'm thinking about, or if I've been depressed, then it does significantly increase the likelihood.

There are many people at risk who may not know it, because until a stress event occurs, or something

which exacerbates an underlying vulnerability, they will not contemplate suicide. For youth, the most common stressful life events are breaking up with a girlfriend or boyfriend, and getting into trouble with the law or at school. A stress event can trigger acute mood changes, in terms of anxiety, or dread, or hopelessness, or anger. Even then, if a youth experiences all of these things, they may not attempt suicide if they have support or family cohesion.

Prevention strategies can be classified into two categories — case findings, where you find an at-risk person and then get them into treatment and risk-factor reduction strategies, which are aimed at the general population. Case findings include screening and gatekeeper strategies. Gatekeeper training — comprising programs such as ASIST or QPR — is another way to identify suicidal adolescents by training adults in the community or school to know how to detect signs of suicidal ideation or behavior. But in an ideal world you can really have strategies so that, number one, you never get there.

Risk factor reduction focuses on reducing risks more generally in the population. This may include media education, restriction of firearms or lethal means, resilience development, and skills training. The major aims of these programs are to enhance problem solving, coping and cognitive skills, and help-seeking behaviors; and enhance protective factors. What they're trying to do is immunize young people against having suicidal feelings. So it may prevent the risk factors from even occurring in the first place, such as depression or hopelessness or drug abuse.

Sometimes, effective programs aren't even those that are designed as suicide prevention programs. One example is called the Good Behavior Game, which was actually a program that was designed to reduce disruptive behavior, and involved behavior management and was for elementary school kids. Another very promising program is Sources of Strength. In review of the Good Behavior Game program, they first looked at the actions they were interested in, aggression and disruptive behavior, and found a reduction. But because those are also potential risk factors for suicide, researchers looked at follow up data that they had collected and saw that 15 years later they had an amazing impact on reducing young adults' suicidal ideation. So even though this was a program that wasn't designed to prevent suicide, by changing the trajectory of kids who could potentially have been at risk for suicide and reducing or preventing risk factors for suicide to occur in the first place — it had an impact on suicide.

Madelyn Gould, PhD, MPH, focuses on projects examining the risk factors for teenage suicide, various aspects of cluster suicides, the impact of the media on suicide and youth suicide screening programs, the effect of a peer's suicide on fellow students, and the utility of telephone crisis services. Dr. Gould has received numerous federally funded grants from the National Institutes of Health, the Centers for Disease Control, and Substance Abuse Mental Health Services Administration. She has participated in a number of state and national government commissions, including the 1978 President's Commission on Mental Health, the Secretary of Health and Human Services' Task Force on Youth Suicide (1989), and she authored the chapter on youth suicide prevention, as part of the Surgeon General's 1999 national Suicide Prevention Strategy. The recipient of the Shneidman Award for Research from the American Association of Suicidology (AAS) in 1991, the New York State Office of Mental Health Research Award in 2002, and the 2006 American Foundation for Suicide Prevention (AFSP) Research Award, Dr. Gould has a strong commitment to applying her research to program and policy development.

SAFELINE
814-456-SAFE
A Youth Crisis Hotline

Launched on March 1, 2011, SAFE*Line* is a toll-free 24/7/365 telephone crisis intervention hotline with on-site, clinical counseling services, community education, and outreach programs for pre-teens and teens in Erie, Pa.

Behavioral health professionals from Safe Harbor assist callers with issues such as bullying, teen pregnancy, suicide, dating abuse, rape, peer pressure, and other concerns.

Safe Harbor Behavioral Health, UPMC Health Plan, and Community Care Behavioral Health are proud to collaborate on SAFE*Line* – helping local youth stay healthy, happy, and safe.

COMMUNITY CARE
Behavioral Health Organization

SAFE HARBOR BEHAVIORAL HEALTH
Lighting the Way to Quality Behavioral Health Services

UPMC HEALTH PLAN

A Son's Bequest
What Can Colleges and Universities Do to Prevent Suicide?

Phil Satow, Co-founder and Board President; **John MacPhee,** Executive Director; and **Victor Schwartz,** Medical Director — the Jed Foundation

Based on interviews with Meena Dayak and Susan Partain for National Council Magazine

My son Jed passed away. He took his own life at the end of December '98. I had taken early retirement from my career as a pharmaceutical executive in order to spend time with Jed because I was concerned about him.

Unfortunately, just a few days before my retirement, he committed suicide, so it was just tragic in every way that one can imagine. It left me having left my career and not having my son. At the time, he was a sophomore at the University of Arizona, and so one of the things that I did was visit the president of the university.

We had a very candid discussion, and it led to a broad discussion of mental illness and suicide in a university setting, and he said to me, "Well, I have over 30,000 students on the campus. What is it that you would have me do?"

A very honest, open question. And the reality was that I was not equipped to answer that question. I didn't know. I had recently lost my son — it was just weeks earlier — and he posed the right question to me, and that led me and my family to have a good deal of discussion about Jed and about university settings. And we felt, over time, that we would like to establish a foundation whose mission was to answer that singular question — "What is it that a university should do to deal with the problems of emotional distress, mental illness, and suicide prevention on their campus?"

We established the Jed Foundation in the year 2000, and we've been working for all of these years in developing efforts toward that very concrete, specific mission.

Phil Satow, Founder and Chairman of the Board, Jed Foundation

In the U.S., there are more than 4,000 colleges and universities, and approximately 20 million college students. Between 12-15% of students have had some sort of diagnosed emotional illness before they get to college. College is also a time when many mental illnesses first develop, like depression, bipolar disorder, and schizophrenia.

The Jed Foundation is changing the college mental health landscape through their guidance for how universities can create more emotionally healthy campuses and social marketing campaigns for college age young adults. The foundation develops models that could be adapted for any institution — community college or a large university — to consider what they would need to do to reduce the risk of suicide, and to limit the amount of stress on a campus. Their models are now used with about 1,500 universities.

When the Jed Foundation started, there was no coherent approach to how colleges thought about providing mental healthcare on their campuses.

"College counseling services arose out of the advising centers in the universities," says Victor Schwartz, the Foundation's Medical Director. "In many cases, those programs were focused on helping students adjust developmentally to college and to think about career goals, but really didn't have the clinical framework to see some of the more serious concerns."

Part of the problem, says founder Phil Satow, is that universities often only consider the treatment side of mental health, presuming the issue to be solely the job of the counseling center, rather than a broad community issue that multiple departments collaborate on.

For example, there are issues that relate to campus safety, therefore, the security department might have to be involved. There are legal issues. When do you tell parents? When do you break confidentiality if a student is technically an adult? What is right for you

Universities often only consider the treatment side of mental health, presuming the issue to be solely the job of the counseling center, rather than a broad community issue that multiple departments collaborate on.

to disclose? How do you deal with medical leave? Do you let students come back? The faculty and even the athletic departments could be taught to recognize when students may be having emotional issues. If coaches don't realize that their athletes may be having emotional problems, they could be cutting kids from teams without recognizing that they need a referral to the counseling center.

Many students are afraid to come forward because of stigma or because they think they might be thrown out of school. If they had a broken arm, they'd go straight to the medical center, but that doesn't always happen with mental health. Some universities are having counselors reside in the dorms or spend time in the dorms with students, to break down some of the stigma of interacting with counselors. That's different than being seen going to the fifth floor of the health center — and then everyone is going to know you're going to the counseling center.

For most of these concerns, it is a matter of reviewing and communicating university policies. There should be a formal parental notification policy. When parents bring their kids to college, they should understand when they are going to be notified, and under what circumstances. Does their overall medical leave policy include someone who has severe depression? A student doesn't want to have to reapply and not be able to get back into college.

"Very senior people in universities didn't necessarily have suicide prevention and prevention of emotional distress as one of their highest priorities, but we're beginning to see that things are really starting to change," says Satow. "Unfortunately, what often happens is that universities do make changes after a suicide, rather than doing so in advance in order to prevent it."

The Jed Foundation's **Guide to Campus Mental Health Action Planning (Campus MHAP)** is a diagram of activities and functions that the university needs to use, which was developed in coordination with the Suicide Prevention Resource Center. For example, there must be 24-hour mental health services. Some schools may be small, and they can't have someone available on their campus for 24 hours, but they could have referral services. Each school needs to have adequate full-time equivalents to be prepared when students come to the counseling center. If they don't have a psychiatrist on campus, that needs to be covered somehow. The Campus MHAP also recommends that the health center conduct depression screening — the few colleges that have a screening program have picked up large numbers of students with depression, suicidality, and other concerns. They outline what a rational medical policy may include. They also recommend that there be social marketing programs on wellness.

Another item is **means restriction**. At New York University, some years back there was a group of suicides where students jumped off the top tier of the balcony in the library. They raised the barrier so students couldn't get over it. The closets in the dorm rooms should be made with bars that would break so they can't be used for a suicide vehicle. Many suicides on college campuses used to occur in the chemistry labs, as some of the gases they used were poisonous.

"We don't tell them exactly which barriers because we don't know what barriers. But we do tell them to scrutinize the buildings and their laboratories. People may never think of that if they didn't look in our program materials," noted Satow.

The foundation has **training programs for counseling center staff** to better equip them in serving specialty populations, including student veterans and international students.

"Parents should consider the capability of a college to deal with mental health issues as part of the criteria by which they choose a college," adds Satow. "Parents think about how prestigious the school is, if their kid can get in. But what about if their son has a problem? Are they at all equipped?"

The Designation Program, which will launch at the beginning of 2013, is a detailed online survey for colleges to find out how prepared their campus is for emotional distress and good mental health. The school will receive a confidential detailed report, outlining where their program is strong and where improvements can be made. Schools that have strong programs in place will be recognized with a Jed Foundation seal.

"The idea is to create a national conversation about the importance of these programs, and to give deserved recognition to the schools that do approach mental health support in this holistic way," says John MacPhee, Executive Director of the Jed Foundation.

"No college president is going to want to see that his school is deficient in this area," says Satow, "We'll never achieve our overall objective of safety on all these campuses unless the most senior people in the university are behind it."

Another major area of focus for the Jed Foundation is increasing awareness and help seeking among college age youth.

"Helping students build social skills, basic life skills, and resiliency – all of these things have shown real impact on suicide rates, particularly with young people," says Schwartz.

ULifeline is an online program where students can learn about a wide range of topics related to emotional health, from depression to anxiety, eating disorders, and relationship issues. Students can also access a screening tool (for themselves or for their friends and roommates), and learn about resources on their campus. To date, around 1,400 schools have registered with the website, which receives about 30,000 unique visitors each month.

The screening tool, which was developed by Duke University, is an anonymous questionnaire to allow students to determine whether or not they should go to the counseling center. Approximately 25,000 screens a year have been taken. A version specific to law school students will be launched this year.

The Jed Foundation also manages a campaign called **Half of Us** in partnership with MTV. "The name communicates the fact that half of college students in a given year will experience depression or anxiety and, therefore, is not something that's unusual or to be ashamed about," explains MacPhee.

The Half of Us website features public service announcements, celebrity interviews, and short storytelling videos — on issues such as: depression, drinking, LGBTQ issues, and how technology can be isolating. This fall, they will be launching a new PSA around how young adults can remain emotionally healthy in the context of a relationship breakup. These PSAs are also shown on MTV's University Channel, which is broadcast to students at approximately 750 colleges. The videos may also be used through an educational license by anyone that is doing any kind of education around mental health. The Half of Us campaign website has had more than 200,000 unique visitors.

"In looking to protect the emotional health of college students, we want to make sure that we're working in the ecosystem that surrounds them," notes MacPhee, "and that includes their friends, their siblings, many of whom may not be college students."

Love is Louder is an online campaign that the Jed Foundation began in late 2010 after several high-profile suicides involving bullying. The concept is that love is louder than whatever challenges or internal/external voices may be making somebody feel down or isolated. You can complete the statement: "Love is louder than feeling alone." "Love is louder than hate." The campaign has some 125,000 followers on Facebook, 45,000 on Twitter, and many thousands more visiting the website on a regular basis.

"Our intent through the campaign is to be solution-focused rather than problem-focused, and focus on actions that young people can take to help themselves feel better, to get help, and to best support their friends," notes MacPhee.

The core actions that Love is Louder asks its followers to take are:

>> To dismiss the beliefs that make them feel not good enough.

>> To identify at least one person they can go to if they need someone to talk to or if they need help.

>> To override internal or external negative voices by shifting perspectives to the positive.

>> To practice positive behaviors such as gratitude exercises, doing things to improve the community, or helping others.

> Our intent through the campaign is to be solution-focused rather than problem-focused, and focus on actions that young people can take to help themselves feel better, to get help, and to best support their friends,

>> To think twice before using words or actions in a way that might harm others, and to be empathetic to how others may feel.

"You can't measure the number of lives you've saved, but we get all kinds of anecdotes and letters," says Satow. "I've got to believe that we've saved, or at least we've helped, a lot of kids."

Phil Satow has spent 35 years in the pharmaceutical industry. He has worked for Pfizer, Inc. where his last position was vice president, Pfizer Europe. In 1985 he joined Forest Laboratories and was responsible for founding the marketing and sales organization. He served as executive vice president, president of Forest Laboratories, and a member of the board of directors. After his retirement from Forest Laboratories, Satow and his son founded JDS Pharmaceuticals, LLC, a privately held company that was purchased in 2007 by Noven Pharmaceuticals, Inc. Satow and his family founded The Jed Foundation in 2000 after the loss of their youngest son to suicide. He currently serves as President of the Board.

John MacPhee brings 20 years of leadership and management experience from the business and not-for-profit settings to The Jed Foundation. He most recently served as president of Strativa Pharmaceuticals overseeing functions such as clinical development, medical affairs, alliance management and business development. Previously, he worked at Forest Laboratories and was heavily involved with treatments for depression and anxiety. Well-versed in the challenges faced by college students, MacPhee serves as a board member for Bottom Line, a non-profit organization that provides guidance counseling to disadvantaged urban youth helping them get into college and graduate.

Dr. Victor Schwartz, a psychiatrist who has worked in college mental health for over 20 years, was medical director of NYU's Counseling Service, established a counseling center at Yeshiva University and was most recently University Dean of Students there. He was an original member of the American Psychiatric Association's Presidential Task Force on College Mental Health and co-chair of the APA working group on legal issues in college mental health. He is co-editor with Dr. Jerald Kay, of Mental Health Care in the College Community.

A Life Worth Living
Cheryl Sharp

By the time I reached age 24, I had made 9 attempts to end my life. I was an anguished, overwhelmed, desperate young woman. My journal entries railed against life. I am often struck by the depth of the pain I experienced. I felt so alone in the world.

Most of my suicide attempts were drug overdoses and once the immediate danger was over, I found myself in a psychiatric unit, surrounded by people who felt the same way I did. I often felt some of my loneliness dissipate when I heard others talking about their pain. In the outside world, my thoughts were "crazy" and sent me back into isolation.

It took me many years to understand the difference between thinking dark thoughts and doing dark things.

It took years to stop judging my feelings and thinking of them as "bad" and to recognize that I needed help. It took years to be willing to ask for help when I needed it rather than when it was too late.

I remember some of my suicide attempts clearly but others are shadowy. Not once did I leave a note. My sense is that I did not want to place blame but simply wanted to disappear. I wanted not to feel and death seemed to be the only way to become completely oblivious to pain.

My first suicide attempt was in 1972 – I was a 7th grader and overdosed on aspirin. I had heard that this would kill you. I had no idea how much I needed to take, just to take as much as I could. When I became violently ill, I got scared and called one of my teachers. I talked to him for several hours. There was no ER visit, no report to my parents, and no referral to child guidance. There was no counseling available at this time. The talking helped and I knew that I had someone to go to, but it was a bit of a dangerous game to play.

It took over a year before I finally saw a therapist at my own request. By this time my mother had been hospitalized several times for her own deep sadness and feelings of being overwhelmed. No one ever asked me why I was so distressed, so very sad, and so difficult to handle at home. There was no recognition of me as a person – I was just a difficult and moody teenager.

There were numerous times that I was blamed for the events leading up to my suicide attempts. Many times my parents or I were told, "She's just seeking attention." Yes, I was screaming at the top of my lungs for attention, but I also was screaming that I wanted "out!"

It was upon my final suicide attempt at age 24 that something began to shift. I had a very tough and direct psychiatrist who told me that there was little she could do to help me until I was willing to take responsibility for my own life. Sure, she could keep locking me up and giving me meds but I had to do the work of creating a life worth living.

Step by painful step, over the course of many years, I did begin to take responsibility for my thinking and my behavior. I began to understand that I had to reach out before my thinking became so clouded that death was all I could see.

The thoughts and feelings continued to be there until I had the opportunity to address the multiple traumatic experiences I had in childhood and many that continued into adulthood. I began to realize that when I became overwhelmed by my life, the "go to" thinking process was to escape and escape for me was the sweetness of death, of feeling nothing. I had to learn that there were other ways of thinking and other behaviors that could bring me relief from mental and emotional pain.

The process of overcoming suicidal thinking came through developing a wellness plan in the form of the Wellness Recovery Action Plan. My first WRAP was for suicide prevention and I found that I could shift my thinking from what was wrong with me to proactively working towards reducing stress and engaging in behaviors that contributed to my wellness. It became about looking forward rather than backwards. I began to feel empowered that I could change my life from the inside out.

Over time, I have been able to recognize a series of thoughts that would eventually lead to dire consequences. When the first thought is, "I am overwhelmed and can't do this (whatever "this" is) any more," I know I have to take action. I need to step back and look at my WRAP to determine what would be helpful, such as calling a supporter, taking additional time for self-care, or talking with a professional.

If I reach a point where my thinking moves to "I don't want to be here" (meaning living), I have to take much more assertive action to keep from getting worse. It has been many years since I've had to have my stomach pumped or heard those I love ask me "Why" or tell me, "You have so much to live for."

I am the one who knows what I have to live for. There are still very dark times, scary times, but knowing that I have successfully lived through many difficulties and come back stronger each time has helped in my recovery and understanding of my wholeness. I am a fighter! I am a survivor! I am an active and engaged participant in a life worth living, even when it is hard.

Cheryl Sharp is the special advisor for trauma-informed services at the National Council for Community Behavioral Healthcare. She holds the unique perspective of a person with lived experience as a consumer and family member, as well as a provider of services. As a consultant to the NASMHPD/SAMHSA's Promotion of Alternatives to Seclusion and Restraint, Cheryl trains and speaks nationally on trauma-informed care. She is an advanced level WRAP facilitator, a Mental Health First Aid USA instructor, and a trainer of Intentional Peer Support. Sharp practices as a life coach/mentor and is an ordained minister. She has worked as a hospice/medical social worker and as a director of social services for a skilled nursing facility. She received the Lou Ann Townsend Courage Award for her contributions to persons with psychiatric disabilities.

Best Time of Their Lives?
Sending the Silence Packing on Campus

Alison K. Malmon, Executive Director and Founder, Active Minds

Usually when I share with a college student that more than 10% of students have reported seriously thinking about suicide, I get a simple nod of acknowledgement. Most young adults aren't surprised to hear that stress or a feeling of being overwhelmed pervades the minds of their peers. All too often, it's seen as a normal part of growing up by parents, teachers, and students alike.

While we all deal with our mental health on a daily basis, far too many young adults have all-consuming feelings of hopelessness, worthlessness, and despair. Recent studies from the American College Health Association show that between one-third and one-half of college students report having felt so depressed in the past year that it was difficult to function. Suicide is the second leading cause of death for students, taking the lives of more than 1,100 college students each and every year. As one student recently put it, "That's like half of my sophomore class."

Students impacted by suicide can't be defined by their age, class, gender, socioeconomic status, or the type of school they are attending. While the pressures differ from student to student, and from school to school, everyone feels them in their own way.

I know this firsthand. When I was a freshman in college myself, I lost my big brother, my only sibling, to suicide. Brian had been a star student at his top-ranked university, complete with a 3.8 GPA and with leadership positions as sports editor of his school newspaper and president of his a cappella group. What we didn't know until it was too late is that on the inside Brian had been struggling with intense feelings of hopelessness and helplessness, and psychosis, since his freshman year in college. He was able to mask his struggles from everyone around him for three years. By the time he sought help, it was too late. His depression had spiraled down and despite intensive and top-notch treatment, Brian lost his battle and took his own life when he was just 22 years old.

Brian's story is just one of many that illustrates the problem we are facing in student mental health. Young adults are first experiencing mental health issues in their teens and early twenties. These same young adults may be in college and are probably away from family

Suicide is the second leading cause of death for students, taking the lives of more than 1,100 college students every year.

and friends who know them well and can recognize when something is wrong. Many are on their own for the first time and want to prove to their parents, and themselves, that they can "cut it" away from home. Most have had mandatory health education classes in high school and yet few of them were taught anything about depression, suicide, eating disorders, or any other mental health topics. So, students first experience changes in their moods while not having their typical support system around, and wanting to prove that they are strong and are having "the best time of their lives" in college. And thus, many end up struggling. Alone.

But it doesn't have to be that way. In order to create campus environments that encourage students to get the help they need, a dialogue must be created amongst students that shows the same respect for mental health issues as other physical health issues. Students like my brother Brian, need to know where to seek help. They need to know that there is hope, and understand in their core that it's okay to ask for and get that help.

In order for this change to happen, students must be the change agents. Students listen to students. In fact, statistics show that 67% of suicidal students who do tell someone that they're thinking about suicide, tell a friend first. By arming students with the tools and education they need to speak openly about mental health in order to educate others and encourage help seeking, we can change the conversation about mental health. And by targeting our efforts to the next generation, we are impacting tomorrow's practitioners, teachers, policymakers, and parents – who will change the way society talks about mental health for years to come.

Active Minds, Inc. is the leading national nonprofit addressing student mental health, which I founded as a student at the University of Pennsylvania after my brother's suicide. Now with more than 350 student-led chapters on college and university campuses nationwide, Active Minds works to increase students' awareness of mental health issues by providing information, leadership opportunities, and advocacy training to the next generation. Through campus-wide events and national programming, Active Minds is changing the culture on campuses and in the community by creating a comfortable environment for open conversations about mental health issues. Our award-winning suicide awareness display, Send Silence Packing, publicly displays 1,100 donated backpacks representing the 1,100 college students that die by suicide every year.

Today, mental illness is the most stigmatized and neglected illness and it's really devastating to our nation's young adults. While we can't make it go away tomorrow,

Send Silence Packing

Suicide claims the lives of more than 1,100 college students each year, and each one of those deaths touches us all. Send Silence Packing is an award-winning program by Active Minds Inc. to promote a dialogue about mental health issues on campus and combat the incidence of student suicide. Active Minds hopes that by empowering students and the student voice in mental health awareness, we will see the day when mental health issues are widely discussed, and the number of tragic deaths due to suicide is reduced to zero.

Send Silence Packing is an exhibit of 1,100 backpacks representing the number of college student lives lost to suicide each year. Active Minds Inc. has collected and continues to collect backpacks and personal stories in memory or in honor of loved ones impacted by suicide. By displaying backpacks with personal stories of loved ones that put a "face" to lives lost to suicide, Send Silence Packing carries the message that preventing suicide is not just about lowering statistics, but also about saving the lives of students, daughters, sons, brothers, sisters and friends across the nation. Contributions serve as a meaningful outlet for survivors' grief as well as a powerful way to raise awareness and work towards suicide prevention.

Since the inaugural display in 2008 on the National Mall in Washington, DC, Send Silence Packing has visited over 50 cities in states throughout the U.S. Check out the Send Silence Packing Blog at www.sendsilencepacking.org to learn more or book a tour.

we can empower those who are impacted to share their stories and to get involved. Together, we can all change the conversation about mental health to one with hope, and we can save lives.

....

Alison Malmon is the founder and Executive Director of Active Minds, Inc., the leading national organization that uses students as the driving force to change the perception about mental health on college campuses. For her efforts, Alison has been named one of the "Top 15 Emerging Social Innovators in the World" by Ashoka Changemakers and American Express, Washingtonian of the Year (2007) by Washingtonian Magazine, Citizen of the Year (2008) by the Potomac, Maryland Rotary Club, and a Woman of Distinction by the American Association of University Women. Alison has been profiled as a "Person you Should Know" on CNN, and in stories in the New York Times, Washington Post, Glamour Magazine, and ABC's Good Morning America, among others. Alison is on the National Suicide Prevention Lifeline Consumer/Survivor Subcommittee, Bringing Theory to Practice Project Planning Committee, and Students of AMF Board of Directors.

Coming Out of the Closet Unearthing the Facts on LGBT Suicide

Andrew Lane, Executive Director, Johnson Family Foundation; **Mikel Walters,** PhD, Behavioral Scientist, Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

*Based on Interviews by Courtney Young for National Council Magazine*

Over the course of the last several decades a reasonable body of research has accumulated that would suggest that lesbian, gay, bisexual, and transgender people are at risk for attempted suicides at disproportionate rates relative to non-LGBT people. There is also a robust body of data that's been validated by the Institute of Medicine in their landmark report on LGBT health that would suggest that LGBT people are vulnerable by virtue of some health disparities that we have been tracking over time.

For example, we know that LGBT people are disproportionately likely to suffer from mental health challenges like depression, anxiety, and substance abuse. We also have been able to document ways in which so-called minority stress — by virtue of living in a culture that is not always accepting of homosexuality or gender nonconformity — occurs. There are a range of negative health affects that we think can be explained at least in part by that so called minority stress. This would be anything from the negative mental health consequences like depression, anxiety, and substance abuse. So we know the LGBT population is likely to suffer from mental health disparities that are key drivers for suicidal behavior. We also know that LGBT people are attempting suicide at rates two to six times that of the straight population. We have reason to be concerned.

ROADBLOCKS TO SUICIDE PREVENTION

There is a scarcity of data on LGBT deaths by suicide. Death certificates request basic demographic data — name, age, date or birth/death, occupation if available and if the coroner or medical examiner knows at the time of death — the cause of death. Sexual orientation is not an item listed on death certificates. This is the single biggest issue. It is very difficult to say how many LGBT people are actually dying by suicide. And because of that there can be no conclusions about suicide rates.

When the federal government thinks about its prevention activities, it's really thinking about reducing suicide rates and numbers of deaths. We cannot take part in those conversations because we just do not know what LGBT people die of in this country.
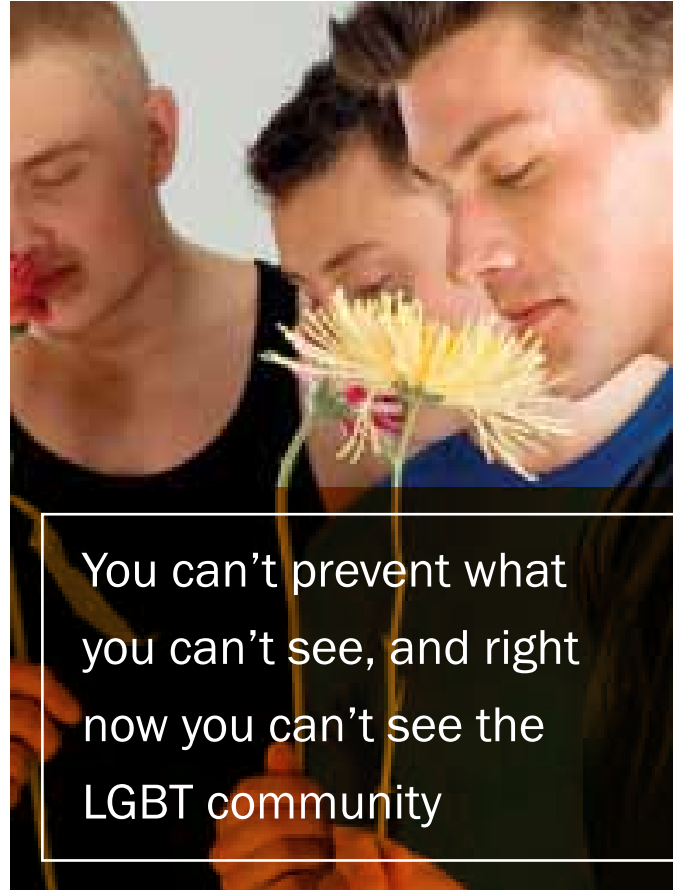
You can't prevent what you can't see, and right now you can't see the LGBT community

The National Violent Death Reporting System began in 2002 and collects data on violent deaths from death certificates, police reports, medical examiner and coroner reports, and crime laboratories. Individually, these sources explain violence only in a narrow context; together, they provide comprehensive answers to the questions that surround violent death: who, what, when, where, and, in many cases, why. The National Violent Death Reporting System provides insight into the potential points for intervention and ways to evaluate and improve violence prevention efforts. However, collecting suicide information on LGBT population is difficult even with the National Violent Death Reporting System as the decedent's sexual orientation and/or gender identity is not routinely recorded in official documents such as on a death certificate, medical examiner, or law enforcement reports.

The National Violent Death Reporting System recognizes the need to have data on LGBT morbidity from violent deaths and scientists are working to determine the best way to have this type of information included in official documents.

The lack of data on mortality is the key barrier to prevention. Prevention strategies are successful or unsuccessful based on whether or not they move the numbers. You can't prevent what you can't see, and right now you can't see the LGBT community.

TRANSGENDER POPULATIONS

There is precious little data on transgender populations across the range of issues and suicide is just one. Any number of other health issues are going to raise

the same concern, which is that it's a population that we believe is quite small and that has not been thoroughly studied and there are methodological issues. "Transgender" is an umbrella term that encompasses many different kinds of identities, behaviors, and physical conditions. It has been methodologically challenging to design research questions that provide useful information.

With respect to transgender populations, suicide attempts and actual suicide deaths are very different phenomena. In fact, we know from many decades of research in the general population that attempts and deaths are not necessarily highly correlated. So if there is a lot of information about one that may or may not reveal something meaningful about the other. The one really good piece of transgender research that was released last year by the National Gay Lesbian Task Force and the National Center for Transgender Equality documented, in a sample of over 6,000 trans people, a 41% lifetime suicide attempt rate.

MENTAL HEALTHCARE WORKS

One thing to cling to, even in the absence of mortality data, is an understanding that intervention and supports for positive mental health, connection to care, and treatment should have efficacy in the LGBT community in the same way that they do in the general population. Everything known about increasing access to mental health services — especially culturally and linguistically competent services — should be completely relevant for the LGBT community too.

FAMILY MATTERS

The place where the data is strongest is on family and the concept of family acceptance and family rejection. When families have an LGBT child and they engage in specific rejecting behaviors, one can measure the negative mental health consequences and the increase in likelihood of a suicide attempt by that child. When families engage in specific accepting behaviors then that actually imparts resilience and measurable protective factors to their LGBT children. It is increasingly possible to document how reducing stressors and reducing stigma — whether bullying in schools, family rejection, or discrimination — have a positive mental health impact. And when people's mental health and psychological well-being improve, then suicide behavior declines.

RISK FACTORS

The existing body of research tells us that the immediate risk factors for suicide are not any different for LGBT people than for straight or gender-conforming people. What is different is what leads to those risk factors. So if what drives this behavior is mental illness or a mental health challenge, the question becomes: What puts you at risk for those mental illnesses and mental health challenges? And that's where it's increasingly clear as to why LGBT people are disproportionately likely to report things like depression, anxiety, and substance abuse – because of the discrimination, the stigma, the bullying, the isolation (particularly in rural areas), and family rejection. That's not meant to imply that straight children don't suffer from family rejection or that the only kids who are bullied are LGBT. But there is this unique set of factors that conspire to put LGBT populations at greater risks than non-LGBT populations by virtue of that discrimination, stigma, bullying, and rejection.

GOVERNMENT SUPPORT

In fall of 2010, the string of suicides by young people who were either LGBT identified or were thought to be LGBT sparked a national conversation on the subject of suicide and bullying and the very complicated relationship between them. It also stirred a lot of action within the LGBT community and outside to try to be responsive to the conversation. Over the course of the last two years, there has been greatly increased attention and probably also resources that have been freed up to better understand what's going on in our community and to begin to develop interventions that would be supportive of LGBT youths and older adults.

But we know that the federal government really has a very long way to go before it is funding research and intervention on LGBT health at a level that is proportionate with both our demographics and also our needs given that we know there are specific health disparities that we struggle with. Large-scale medical and health demographic research requires participation by the federal government.

ACROSS THE LIFESPAN

An additional challenge is encouraging people to understand that suicide is a health issue. Suicide is not the same as bullying, though the two concepts get conflated frequently.

LGBT suicide is not just a concern among young people. There is every reason to believe it's an issue for queer people across the lifespan. In designing interventions — whether social work intervention aimed at rejecting families or passing anti-bullying legislation, or starting gay-straight alliance clubs in schools — it is important to focus on the unique underlying health disparities present across this population. We can't let anyone think "Okay, this is an issue until you turn 21 and then magically snap your fingers and everything is okay."

Andrew Lane is Executive Director of the Johnson Family Foundation, one of the leading supporters of the LGBT movement nationally. He is also Chairman of Funders for LGBT Issues, a philanthropic affinity group, and a past president of The Paul Rapoport Foundation. In 2011 Lane was appointed to the Executive Committee of the National Action Alliance for Suicide Prevention and as co-lead of the Task Force on LGBT Populations.

Mikel L. Walters, PhD, is a Behavioral Scientist in the Division of Violence Prevention at the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention. Dr. Walters received her PhD in sociology from Georgia State University. She joined the CDC in 2009. Her research interests include intimate partner violence, sexual violence, teen dating violence, suicide and many other forms of violence that impact sexual minorities and their communities. Dr. Walters the project lead for the National Intimate Partner and Sexual Violence Survey (NISVS).

Reversing the Culture of Suicide in Rural America Advantage Primary Care

Tamara DeHay, PhD; Mimi McFaul, PsyD, Director, WICHE Mental Health Program; Jeremy Vogt, PhD — Western Interstate Commission for Higher Education

Screening: uncovering suicidality[2]
- Other people with similar problems sometimes lose hope; have you?
- With this much stress, have you thought [are you thinking] of hurting yourself?
- Have you ever thought [are you thinking] about killing yourself?
- Have you ever tried to kill yourself or attempted suicide?

Assess suicide ideation and plans[3]
- Assess suicidal ideation – frequency, duration, and intensity
  - When did you begin having suicidal thoughts?
  - Did any event (stressor) precipitate the suicidal thoughts?
  - How often do you have thoughts of suicide? How long do they last?
  - How strong are the thoughts of suicide?
  - What is the worst they have ever been?
  - What do you do when you have suicidal thoughts?
  - What did you do when they were the strongest ever?
- Assess suicide plans
  - Do you have a plan or have you been planning to end your life? If so, how would you do it? Where would you do it?
  - Do you have the (drugs, gun, rope) that you would use? Where is it right now?
  - Do you have a timeline in mind for ending your life? Is there something (an event) that would trigger the plan?

Assess suicide intent
- What would it accomplish if you were to end your life?
- Do you feel as if you're a burden to others?
- How confident are you that your plan would actually end your life?
- What have you done to begin to carry out the plan? For instance, have you rehearsed what you would do (e.g., held pills or gun, tied the rope)?
- Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?
- What makes you feel better (e.g., contact with family, use of substances)?
- What makes you feel worse (e.g., being alone, thinking about a situation)?
- How likely do you think you are to carry out your plan?
- What stops you from killing yourself?

Endnotes:
[1] SAFE-T pocket card. Suicide Prevention Resource Center & Mental Health Screening. (n/d).
[2] Stovall, J., & Domino, F.J. Approaching the suicidal patient. *American Family Physician*, 68 (2003), 1814-1818.
[3] Gilatto, M.F., & Rai, K.A. Evaluation and treatment of patients with suicidal ideation. *American Family Physician*, 59 (1999), 1500-1506.

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A Pocket Guide for Primary Care Professionals

Assessment and Interventions with Potentially Suicidal Patients

Suicide is a significant issue in the United States and worldwide, and its prevention is a public health imperative. Across the U.S and in many other countries around the globe, suicide rates in rural counties are consistently higher across demographic groups than in urban areas. Research in the U.S. has found that rural suicide rates are 31-43% higher on average in non-metropolitan counties, and that in some areas of the country suicide rates for rural men are up to 80% higher than for their urban counterparts.

Interestingly, the overall prevalence and incidence of mental illness does not significantly differ between rural and urban areas. What does differ in important ways is the experience of individuals with mental illness who reside in rural areas. These individuals face increased challenges related to the availability, accessibility, and acceptability of mental health treatment due to their rural location. This experience too often results in services being initiated after the symptoms have become severe, or in mental health issues going untreated altogether.

Due to cultural and workforce factors in rural areas, primary care providers are frequently the sole providers for many patients with mental health concerns. In fact, more than 90% of all psychologists and psychiatrists and 80% of masters-level social workers work exclusively in metropolitan areas, leaving many rural PCP's with a limited referral network for patients with mental health concerns. Additionally, rural communities often face seemingly intractable stigma related to mental health treatment, which keeps many rural residents from seeking care or even recognizing that the symptoms they are experiencing are related to mental health issues.

Research has shown that, overall, up to 76% of individuals who die by suicide have visited their primary care physician within one month of their death. Although the data is not yet available, logic predicts that this rate is even higher in rural areas due to the increased reliance on primary care and limited availability of mental health professionals. Primary care providers in rural areas are thus uniquely positioned to conduct focused suicide prevention efforts in their practices, and frequently have strong relationships with their communities, which supports their ability to combat stigma associated with mental health treatment.

Yet primary care providers receive little reimbursement, support, and guidance for their suicide prevention efforts and face multiple systemic barriers as described above.

Owing to shortages of mental health providers in rural areas, it is critical that behavioral health organizations develop tools and provide collaboration and guidance to rural primary care providers in order to support their inevitable treatment of patients with serious suicide risk.

The Western Interstate Commission for Higher Education Mental Health Program, in collaboration with the Suicide Prevention Resource Center, has developed a **Suicide Prevention Toolkit for Rural Primary Care** to assist rural PCPs in effectively identifying and intervening with suicidal patients. The purpose of the toolkit is to bring best practices in suicide prevention to rural primary care and to offer physicians, patients, and rural communities the tools and support they need.

The toolkit is presented in six sections:

1. Getting Started
2. Educating Clinicians and Office Staff
3. Developing Mental Health Partnerships
4. Patient Management Tools
5. State Resources, Policy, and Billing
6. Patient Education Tools/Other Resources

A sample of materials included in the Toolkit includes:

>> Quick start guide

>> Suicide prevention primer for providers

>> Suicidal patient Treatment Tracking Log

>> User's guide

>> Suicide risk assessment pocket cards with a treatment decision tree

>> Crisis response planning tools for at-risk patients

>> An office protocol template for coordinating response efforts regarding suicidal patients

>> Tips and strategies for billing

>> Community education materials

The toolkit has been designed to bring cutting-edge suicide prevention tools and techniques into the rural primary care environment in a manner that can be seamlessly integrated regardless of workforce and environmental barriers. These best practices in suicide prevention have been developed as a comprehensive office strategy that empowers each member of the office staff to have an important role in preventing suicide, which will improve physicians' ability to identify and intervene with suicidal patients, while reducing the overall burden on these physicians.

The toolkit has been disseminated across the U.S. and nationally. It is available in hardcopy which may be ordered through the Western Interstate Commission for Higher Education at www.wiche.edu for ordering information. An electronic version is also available for download at no charge on the SPRC website: www.sprc.org/for-providers/primary-care.

A training program based on the toolkit has also been developed and is being administered by WICHE. Trainings have been conducted for primary care clinics, regional healthcare networks, first responders, medical schools, and others.

Tamara DeHay, PhD, is a Senior Project Director at the WICHE Mental Health Program. She is a licensed clinical psychologist and a certified Health Services Provider in Psychology by the National Register. She serves as co-editor of APA's Journal of Rural Mental Health. Dr. DeHay is one of the authors of the Suicide Prevention Toolkit for Rural Primary Care, and has conducted numerous trainings and other presentations based on the toolkit. She leads WICHE's national psychology internship development initiative, and is involved in several other projects addressing rural behavioral health workforce.

Mimi McFaul, PsyD, is a clinical psychologist and the Director of the WICHE Mental Health Program. She is one of the authors of a Suicide Prevention Toolkit for Rural Primary Care and now conducts trainings in rural primary care settings based on this toolkit. Mimi is currently the Managing Editor of the Journal of Rural Mental Health, and serves on the board of the National Rural Mental Health Association and the Colorado Psychological Association. Other areas of focus include rural behavioral health workforce development, the integration of primary care and mental health, forensic psychology, and trauma.

Jeremy Vogt, PhD, is a psychologist candidate and Behavioral Health Research and Technical Assistance Associate with the WICHE Mental Health Program. He received his doctorate degree in clinical psychology from the University of South Dakota and completed his clinical internship at the University of Colorado-Denver School of Medicine with an emphasis in primary care psychology. His professional interests include integrated healthcare and medical education. Dr. Vogt has presented and co-presented several Suicide Prevention Toolkit for Rural Primary Care trainings in his time with WICHE.

Revealing the Colors
Managing Suicide Risk in the Substance Use Population

Ann M. Mitchell, PhD, RN, FAAN, President, American Foundation for Suicide Prevention Pittsburgh Chapter; **Holly Hagle,** PhD; Director, Northeast Addiction Technology Transfer Center; **Kimberly Talcott,** MPA, Project Manager, University of Pittsburgh School of Nursing

Next to depression and mood disorders, substance use disorders are the top factor linked to suicide. Ninety percent of individuals who complete suicide experience a mental or substance use disorder, or both. In fact, a recent study using psychological autopsy to compare individuals who died by suicide with those who died from sudden accidents or medical problems found that those who completed suicide were significantly more likely to have a substance use disorder. In fact, the Center for Substance Abuse Treatment asserts that these disorders are associated with a risk approximately six times greater than average risk for suicide attempts.

The link between suicide and substance abuse has been established, and emerging research confirms that specific substances are associated with suicidal behavior.

>> Inhalant use and cocaine use are especially associated with suicidal behavior.

>> Chronic cocaine use has been cited as a particularly potent substance related to suicide attempts, necessitating enhanced suicide prevention and intervention efforts with the chronic cocaine using population.

>> 67% of those with inhalant use disorders have suicidal ideations and 20% have attempted suicide.

>> Alcohol consumption while sad or depressed increases the risk of suicide attempts among young people not engaging in, planning, or ideating prior to attempt.

Alcohol consumption while sad or depressed increases the risk of suicide attempts among young people not engaging in, planning, or ideating prior to attempt.

VULNERABLE POPULATIONS

Particular groups of people have an increased risk for suicide. Rates are highest among older adults. Of every 100,000 people aged 65 and older, 14.3 die by suicide, and after age 75, the rate is three times higher than average. Substance abuse complicates these statistics because older adults may be more concerned with the stigma associated with mental health and substance abuse treatment than other groups. Suicide rates are also high among young people (ages 15-24 years old), and high rates of substance use put this population of young people at an increased risk for suicidal behavior. Additionally, suicidal ideations at age 11 years are a strong predictor of future substance dependence and depressive symptomatology.

Veterans are another special population with an increased substance abuse and suicide risk. In a 2012 study using data from the National Violent Death Reporting System, male veterans in all age groups (except those aged 65 and older) were found to be at higher risk for suicide than nonveterans. One third of younger veterans showed evidence of acute alcohol use (blood alcohol content ≥ 0.08) at the time of suicide death.

WHAT CAN WE DO?

Identifying substance abuse and other high-risk indicators of suicide greatly assists in suicide prevention. Assessing for suicidal ideation in individuals with depression and/or substance use disorders is extremely important. We must identify those individuals with substance use disorders whose risk for suicide is especially high, including those with co-occurring depression, episodes of interpersonal violence, and serious plans of suicide.

Management of a suicidal patient with substance abuse involves three components

1. Diagnosing and treating substance abuse and other psychiatric disorders.

2. Assessing suicide risk and restricting access to lethal suicide methods.

3. Employing treatments to reduce suicidal inclinations, including abstinence from alcohol and drugs and boosting social supports.

As a society, we cannot afford to look the other way or allow teachable moments to slip by — the suicide rate has been increasing since 2000 and is currently at its highest rate in 15 years. A number of initiatives exist that we can use to help reduce suicidality among those who use substances, including encouraging bonding with family, engagement in school (for school-aged youth), educating vulnerable populations in effectively managing impulsivity and hostility, reducing the number of bars in local neighborhoods, and continuing to eliminate the stigma of mental health issues.
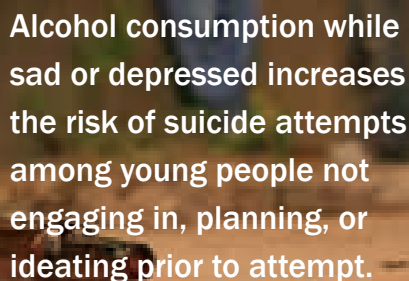
A SEASON OF EDUCATION AND PREVENTION

In September, leaves will begin to reveal their autumnal reds and oranges as the chemical chlorophyll disappears. Chlorophyll disguised these vibrant colors as the leaves worked to make food during summer — the colors were there all along. Likewise, substance abuse can disguise factors that link to increased risk for suicide. As chlorophyll plays a role in the changing of the leaves, alcohol and drug abuse play a role in increasing suicide risk. Awareness, treatment, and prevention activities must move forward. When we break the link between substance abuse and suicide risk, we help individuals reveal their own shades and strength — vibrant colors that were there all along.

Ann M. Mitchell, PhD, RN, FAAN is President of the American Foundation for Suicide Prevention, Pittsburgh Chapter and Project Director for the SBIRT-Emergency Department Registered Nurse grant, funded through the Health Resources Services Administration. She is also an Associate Professor and Fulbright Scholar, 2010-2011, Nursing and Psychiatry, at the University of Pittsburgh School of Nursing.

Holly Hagle, PhD, is the Director of the Northeast Addiction Technology Transfer Center — a Substance Abuse and Mental Health Services Administration funded program at the Institute for Research, Education and Training in Addictions. She is an educator and curriculum developer as well as Adjunct Assistant Professor of Health and Community Systems, University of Pittsburgh School of Nursing.

Kimberly Talcott, MPA, is the Project Manager of three federally-funded grants at the University of Pittsburgh School of Nursing, including two grants on SBIRT implementation in education and healthcare settings. Prior to her work at the University of Pittsburgh, Ms. Talcott received the Nebraska First Lady's Community Service Award serving as an AmeriCorps Member at a nonprofit community services center.

Culture Shock
Latina Teens Face Suicide Risk

Angélica Jiménez

Christmas Eve morning 2009, Giovanna Mendez received the phone call no parent should ever receive. Repeated unanswered calls made from her daughter Tatiana's cell phone and one missed call from the police department caused Giovanna to panic. When the police arrived to Giovanna's home, she learned that her only daughter had hanged herself in the middle of the night.

"You would never know she had depression. She'd keep things to herself," Giovanna explained. "She had a lot of dreams; she was a good daughter."

Tatiana, 20, was smart, determined and focused. She was in a romantic relationship her parents found troubling. After moving out with her boyfriend, she moved home for a time but then went back to him.

Tatiana left a suicide note apologizing to her family and asking that they take care of her niece, whom she adored.

Tatiana's death is only part of a growing national crisis: 11 percent of young Latinas ages 13-21 across nationwide admitted a suicide attempt according to a report from the Center for Disease Control and Prevention. The disparities between Latina teens attempting suicide and their peers is startling: the CDC reported in 2009 that nearly 15% of Latina teens surveyed had attempted suicide the year before compared to 10% of all high school girls.

The idea of Latina teen suicide is perplexing to many because Latino families are known for their close ties and cohesiveness, two known deterrents of teen suicide. But suicide attempts by Latina teens are increasing.

However, the number of Latinas who die by suicide is very small said Samantha Gray, epidemiologist with Cook County Department of Public Health. Gray notes there were fewer than five suicides among Latinas aged 13 to 19 since 2000 in suburban Cook County. But one in six Latina teens have considered attempting suicide, according to the Youth Risk Behavior Survey for Suburban Cook County in 2010. The survey was completed by 1,718 students in 20 public high schools during the fall of 2010.

BI-CULTURAL EFFECT

What is happening to these young women? Some experts point to the culture shock experienced from immigrant Latina teens trying to fit in. There is a disconnect between some immigrant mothers and their U.S. born daughters on how to adapt to American culture while still retaining root cultural values, experts said.

While it is often not just a singular issue that may be troubling teens, the struggle over ethnic identity can be particularly challenging for Latina teens, said Dr. Virginia Quiñonez, faculty chair of the Chicago School of Professional Psychology.

"There's a conflict between 'I want to be independent and I want to be interdependent; I want to feel comfortable in the safety by my family,'" Quiñonez said. "And that is not supported in their peer groups."

Latinas face the pull to be close to family and strike out on their own, Quiñonez said.

"What it means to be a woman in this country may be different than what they bring as Latinas," Quiñonez said. "If one parent or both are not available, it makes it that much more of a critical issue."
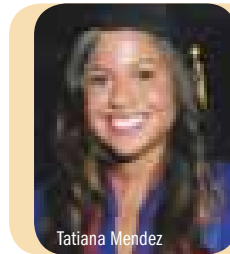
Tatiana Mendez

> "You would never know she had depression. She'd keep things to herself"

CULTURAL STIGMA

Other experts cite a taboo against counseling in immigrant Latino communities is preventing many troubled teens and stressed parents from getting the help they need.

For many teens, it is comfortable to talk about mental health issues but not with their parents, said Mayra Chacon, coordinator of Latino Mental Health Providers Network, which offers support to area mental health providers.

Chacon ran focus groups with teenagers and young adults 14-21 to discuss their thoughts about the mental health system.

"A girl who recently attempted suicide said, 'Even when I was in the bed and the hospital and I was trying to explain to my mom and dad why, they would not listen,' " Chacon said.

The stigma in Latino culture against therapy runs deeps, Chacon said.

"[Teens have] heard it at home from their family, 'You're going to a counselor? Estás loco.' Kids born and raised here in Chicago, but what they heard from their parents impacted them," Chacon said.

SURVIVING A SUICIDE

There is no simple explanation for why her daughter committed suicide.

"They look like they don't have problems at all," Giovanna said wiping her tears. "It's hard to see those signs especially when that person is smiling and not complaining."

Giovanna's faith in God has carried her through such a devastating loss.

"I gave myself to God. I was going to church every single day," Giovanna said tearfully.

Giovanna also started attending support groups for survivors of suicide.

"It's what keeps me strong; I have met beautiful, wonderful people who have given so much support," Giovanna said. "But I've met a lot of women who don't want to go through that [counseling]. They don't go on with their lives."

Photos of Tatiana, a beautiful young woman with long, brown hair and constant smile, are scattered all over their living room.

"I know that through talking [about her], I feel closer to her," Giovanna said solemnly. "I just pray every day for her. I light a candle for her every day."

Lilly salutes the

NATIONAL COUNCIL'S AWARDS OF EXCELLENCE HONOREES.

Congratulations on your achievement!

Lilly

Congratulations

Each year, the National Council for Community Behavioral Healthcare honors those who inspire us to fight against mental illness and addiction. The National Council is also proud to partner with Eli Lilly and Company to offer the Reintegration Awards and Welcome Back Awards. 2012 honorees, now in the National Council Hall of Honor, are profiled here.

Kevin Cleare, CASES, New York, NY

FIRST PRIZE, REINTEGRATION AWARD FOR ACHIEVEMENT

Kevin Cleare is a former prison inmate and tireless advocate for people with serious mental illness in the criminal justice system. After earning his GED in prison, Cleare graduated from a peer specialist training program and started working as a peer specialist. He went on to earn his Credentialed Alcoholism and Substance Abuse Counselor certification to become a professional clinician at CASES, community-based organization that works to increase the understanding and use of community sanctions that are fair, affordable, and consistent with public safety.

"Recovery for me means a return to normalcy and working at CASES has propelled the recovery process I started while in prison. I now have a responsibility to the consumers I serve and the agency where I work. I am rewarded every day when I help someone stay off of drugs and out of jail."

Jessica Lynn Gimeno, Balanced Mind Foundation, Evanston, IL

SECOND PRIZE, REINTEGRATION AWARD FOR ACHIEVEMENT

Advocate Jessica Lynn Gimeno has helped hundreds of young people learn about and cope with behavioral health disorders. Despite immense personal health challenges, she co-founded the depression support network Xapis as a student at Northwestern University and today hosts Flipswitch, a podcast and blog that help teens and 20-somethings understand depression and bipolar disorder.

"I have never let bipolar disorder or physical illnesses prevent me from realizing my dreams. More importantly, I have never let my pain prevent me from helping others."

Fresh AIR Gallery, Columbus, OH

Fresh A.I.R. Gallery

FIRST PRIZE, REINTEGRATION AWARD FOR ADVOCACY

Fresh AIR (Artists In Recovery) Gallery was recognized for challenging the stigma associated with mental illnesses by promoting high-quality artwork by artists affected by psychiatric disorders. Since opening in 2004, the gallery has displayed the work of almost 200 artists in 44 exhibits and sold nearly 200 pieces for more than $45,000. Over 10,000 people have visited the gallery to see the power of recovery in action.

"Unlike most galleries, Fresh AIR does not charge a hanging fee, nor do we accept any commission from the sale of any piece of art. One-hundred percent of whatever is sold goes to the artist to help get their career on track."

Henrico Area Mental Health & Developmental Services, Glen Allen, VA

SECOND PRIZE, REINTEGRATION AWARD FOR ADVOCACY

The Henrico Area Mental Health & Developmental Services' "Voices of Recovery" radio show uses storytelling to amplify the voices of community members with mental health needs. Each episode highlights the struggles and accomplishments of a well-known individual and is read by another with similar lived experience. Together they share a story of recovery.

"'Voices of Recovery' is reaching a large audience. Combating the stigma of mental illness and educating people about the possibility of recovery is slow process. We believe that each person that hears Voices of Recovery is one step closer to understanding. The fact that individuals who have experienced mental illness are the readers for each individual episode adds meaning to the show. It offers the opportunity for the reader to publicly proclaim, 'I'm recovering from a mental illness.'"

Sharon Denise Wise, Washington, DC

FIRST PRIZE, REINTEGRATION AWARD FOR ARTISTIC CONTRIBUTION

A noted national speaker, Sharon Wise has trained more than 2,000 people to help fight the stigma associated with mental illness. A certified peer, whole health specialist, and Wellness Recovery Action Plan (WRAP) facilitator, she operated the first drop-in center in Washington, D.C. solely dedicated to serving people with mental illness and substance use disorders. A certified property manager, she works to make sure that persons with mental illness have adequate housing.

"Compassion isn't just a feeling, it's a force. My trauma and abuse happened pre-verbal, so I had to create a language I understood that could be communicate to the world. At first, that language was dark gray, white, and black. Now, I not only speak with my art in vibrant hues, I dream in color. And I have so many people to thank for that transformation."

Jan Kobe, Wyandot Center, Kansas City, KS

SECOND PRIZE, REINTEGRATION AWARD FOR ARTISTIC CONTRIBUTION

Recovering from her own mental illness and rediscovering the artist within her, Jan Kobe developed a robust arts program for consumers. In the process, she reintegrated into the community while using art as the intervention to reintegrate consumers. Jan meets people where they are on their recovery journeys and helps them develop artistic skills in painting, drawing, quilt-making and other media. People who were symptomatic and didn't know they have artistic talents have found their inner artists and gained self-confidence. Jan has used art to build social skills and self-esteem and has been a mentor and taught consumers to take ownership of projects.

[NOT JAN'S QUOTE] "Her indomitable spirit, and the support and treatment changes she received, led Jan to what she calls an "awakening" and the eventual rekindling of her artistic talent and the subsequent outpouring of her gifts to benefit other persons with mental illness." – Therese Horvat, Communications Director, Wyandot Inc.

Trilogy's Integrated Healthcare Program, Chicago, IL

FIRST PRIZE, REINTEGRATION AWARD FOR CLINICAL MEDICINE, 2012

Trilogy was one of 43 community-based mental health organizations awarded a 4-year SAMHSA grant in 2010 to support and promote better integration of primary and behavioral healthcare services for individuals with mental illnesses and substance use disorders. In 2011, SAMHSA also awarded Trilogy a $200,000 health information technology grant to support of the development of a Trilogy infrastructure to expand the use of electronic health records.

"We are very proud of the work we do here at Trilogy and the innovative Integrated Healthcare Program that we have created by partnering with Heartland International Health Center and Rush University College of Nursing. Through generous funding our clients receive the best coordination of care and have access to quality mental health and primary healthcare."

Asa G. Yancey Health Center, Grady Health System, Atlanta, GA

SECOND PRIZE, REINTEGRATION AWARD FOR CLINICAL MEDICINE

After just a year in business, and with a tight budget, Asa G. Yancey Health Center/Grady Health System began to change the lives of individuals with mental health needs in Atlanta. The center developed strong referral and screening processes and offers weekly supervision of patients via embedded psychiatrists, as well as housing, financial, and employment services.

"Since our start in May 2011, we have made significant progress with limited resources, with a strong commitment from the clinic staff. We have developed a consistent process of securing external referrals for mental health services. We screen all patients for depression and are expanding the training to include screening for bipolar disorder. Weekly group supervision with our embedded psychiatrist has greatly improved the care for patients with schizophrenia and bipolar disorder by prioritizing their needs as part of the primary care visit. We now provide onsite services to facilitate access to resources."

REINTEGRATION AWARDS

Café 54, Community Partnership of Southern Arizona, Tucson, AZ

FIRST PRIZE, REINTEGRATION AWARD FOR EMPLOYMENT

Café 54 assists individuals recovering from mental illnesses by providing a valuable employment experience. The café provides the community with a pool of reliable employees who have had training and firsthand experience working in a quality restaurant setting. Their goal is to reduce and ultimately eliminate the stigma surrounding mental illness by showing that those who suffer can lead fulfilling lives. In addition, the café offers an art scholarship fund to provide individuals recovering from mental illness the opportunity to express themselves through the creative arts.

"Employment is a key element in everyone's life especially in a society that tends to identify people by what they do as being who they are the trainees at Cafe 54 put a face on mental illness for their community in an important way. The point is that people with these diseases — schizoaffective disorder, bipolar, clinical depression — can and do get better."

Recovery Resources' Employment Services, Cleveland, OH

SECOND PRIZE, REINTEGRATION AWARD FOR EMPLOYMENT

Recovery Resources employs the supported employment model and works with the Center for Evidence Based Practices at Case Western Reserve University to maintain fidelity to this model. Recovery Resources' vocational and employment services staff is trained in the core principles and evidence-based best practices of supported employment: zero-exclusion policy, importance of client preferences, rapid job search (employment happens concurrently with treatment and skills training), goal-setting focused on competitive employment, employment integrated with behavioral health services, time-unlimited support, and personalized benefits planning. Recovery Resources has a 65% retention rate, higher than the average retention rate of 50% for other employment models.

"Recovery Resources' Employment Services help clients acquire soft skills, learn to manage the symptoms of one's mental illness and/or recovery in terms of the job environment, and have access to supportive services, including housing. For one client, we offered a better way. With a history of involvement with the criminal justice system and a diagnosis of severe mental illness, Michael could not find a job. We placed him in a temporary position at a local restaurant, which was impressed by his work ethic and dependability. From there, Michael obtained a permanent position with a landscaping company — the kind of work he wanted."

Boley Centers, St. Petersburg, FL

FIRST PRIZE, REINTEGRATION AWARD FOR HOUSING

Boley Centers provide more than 1,000 units of affordable housing to individuals struggling with homelessness, mental illness and substance abuse problems, and poverty. Since 1970, the private, not-for-profit organization has provided some of the community's most vulnerable citizens with the highest quality treatment, rehabilitation, employment, and housing services.

"Over 90% of the people served by Boley's homeless programs maintained permanent housing or moved into equally independent, permanent housing. Over 95% of the people living in the permanent housing programs have remained out of psychiatric hospitals. 99% have maintained permanent housing"

Janian Health Care, Center for Urban Community Services, New York, NY

SECOND PRIZE, REINTEGRATION AWARD FOR HOUSING

At Janian Health Care (formerly Project for Psychiatric Outreach to the Homeless), the results speak for themselves. Since expanding its services in 2007, the project has met and provided evaluation and other services for 1,021 chronically homeless individuals and has provided ongoing treatment to 332 of them. More than 700 of these individuals now have homes.

"The program has developed protocols and delivered trainings to assist the teams in managing the medically vulnerable individuals and has served as liaison to community stakeholders including area hospitals and the FDNY. Each outreach team has 1-2 psychiatrists on their team, providing evaluation and treatment to individuals and training and consultation to the teams."
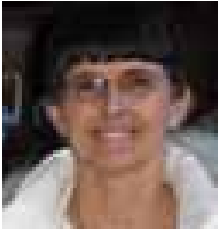
Dr. Tamara Navarro, SARDAA, Houston, TX

FIRST PRIZE, REINTEGRATION AWARD FOR MENTORSHIP

Dr. Tamara Navarro has pushed herself through school and runs a private practice helping those with schizophrenia and their families. She has been a Schizophrenics Anonymous leader and a speaker at national conferences. Navarro also provides support to people with schizophrenia internationally. She has been consistently honored for her work as a leader, including being named Supervisor of the Year at SARDAA. She was also awarded the Self-Help Award of the Year by Yolo County Mental Health Association and the Above & Beyond award from Schizophrenics Anonymous. She's written articles about her illness and recovery and is currently working on a new book.

"My story is about mental illness and it's various faces that, still, in this millennia, is misunderstood and feared by people. [People with mental illness] have a right to pursue happiness just like anyone else in the United States. "

Bill MacPhee, Magpie Media, Ontario, Canada

SECOND PRIZE, REINTEGRATION AWARD FOR MENTORSHIP

Bill MacPhee, CEO and founder of Magpie Media, helps improve the lives of people living with mental illness through his work as an advocate and publisher of SZ Magazine, which he started in 1994 as Schizophrenia Digest. As someone living with schizophrenia, Bill understands all too well the obstacles people with mental illness strive to overcome. He hopes to communicate hope that there is life after schizophrenia through the work he does and by acting as a role model in the fight against stigma.

"As someone living with schizophrenia, some of my most valued achievements are the simple things that most people take for granted – I'm a husband and a father, I own and operate my own business, and I live my life with enthusiasm and optimism. Because I understand how elusive these things can be for those living with mental illness, I see my purpose as being a role model and support for others like me. Above all else, I want people to know that there is hope and there is life after schizophrenia."

Compeer of Greater Buffalo, Older Adult Services, Buffalo, NY

FIRST PRIZE, REINTEGRATION AWARD FOR SOCIAL SUPPORT

Compeer's Older Adult Services recruits, screens, and matches trained volunteers and mentors in one-to-one supportive friendship relationships with older adults who receive mental health treatment. In 2011, Erie County recognized the benefits of Compeer's work for older adults with mental illness by increasing the budget by 100%, even as many other programs' budgets were cut or eliminated.

"This award is important to us for the following reasons: It will help to validate the importance of friendship and social support to reduce the isolation, loneliness, and stigma associated with mental illness. It will further show the community that the power of unified volunteers can change our communities for the better. It will show our funders and other organizations that our Compeer for Seniors is a remarkable program and that more attention and funding is needed to keep our aging seniors as independent, healthy and happy for as long as possible. It will showcase to our community the value of our work, and that friendship can keep our elders safe in the community in the least restrictive environment."

Building Recovery of Individual Dreams and Goals (BRIDGES), Chicago, IL

SECOND PRIZE, REINTEGRATION AWARD FOR SOCIAL SUPPORT

Building Recovery of Individual Dreams and Goals (BRIDGES) is an 8-week, peer-led education course designed to empower mental health consumers by providing them with basic education about the etiology and treatment of mental illness, self-help skills and recovery principles, and peer support. Developed in 1995, BRIDGES is the result of a collaborative effort of mental health consumers, family members, and state administrators to respond to the requests of consumers in Tennessee for peer-provided practical information on the causes and treatment of mental illness.

"The support group component of BRIDGES provides the emotional 'glue' that enables people to ease feelings of helplessness, hopelessness, and guilt. The BRIDGES program has demonstrated to traditional mental health service providers that peers can be effective service deliverers and role models."

WELCOME BACK AWARDS *Lilly*

Kevin Hines, San Francisco, CA

WINNER, WELCOME BACK AWARD FOR LIFETIME ACHIEVEMENT

While suffering from major depression, Kevin Hines survived a jump from the Golden Gate Bridge (one of only 31 in history). He subsequently became a vocal suicide prevention speaker who now addresses tens of thousands of people across the country each year with a message of hope and inspiration. He speaks to all types of people, especially members of the U.S. military, with messages that combat the shame and discrimination associated with mental illness and encourages others to "live well."

"I thank God for such an amazing second chance at life. Every day I awaken is a good day. Today I refuse to sit idly by and do nothing about the problems that brought me and so many others to such a dark and dismal place."

Randy Revelle, Seattle, WA

WINNER, WELCOME BACK AWARD FOR DESTIGMATIZATION

Randy Revelle was recognized for continuously challenging stereotypes about mental illness. His own experiences with insurance discrimination made him a champion in the fight for mental health "parity" in Washington State. As county executive, Revelle has done much to improve mental health services in King County, Washington.

"Although the public understanding of mental illness and their treatment has improved, perceptions and experiences of stigma still exact a heavy toll on individuals, caregivers, and social policy. It is often more difficult to overcome the stigma of mental illness than to recover from the illness itself."
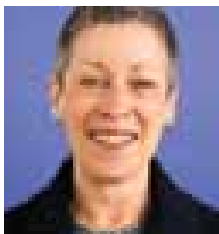
Joanne Jubelier, Los Angeles, CA

WINNER, WELCOME BACK AWARD FOR PRIMARY CARE

Dr. Joanne Jubelier developed the mental health services at Venice Family Clinic out of a labor of love staffed primarily by volunteer clinicians and community members. Today, the clinic is a fully staffed department with a specialized domestic violence component.

"Since my first day at Venice Family Clinic I've seen the importance of social workers and medical staff working alongside each other helping heal the mind and body of those most in need."

Norman Sartorius, Geneva, Switzerland

WINNER, WELCOME BACK AWARD FOR PSYCHIATRY

Professor Norman Sartorius has conducted several major international studies on depression and has found that the misunderstanding attached to mental illness is the main barrier to recovery. He has worked to diminish that misunderstanding through science, education, and social change.

"The main obstacle to any progress in the field of mental illness is the stigma attached to mental illness. It blocks access to facilities that could provide help, jobs, housing, education, and gradually erodes the self-esteem and self-confidence of people with mental illness."

David Fajgenbaum, Philadelphia, PA

FIRST PRIZE, WELCOME BACK AWARD FOR COMMUNITY SERVICE

David Fajgenbaum knows firsthand of the solitary struggle that occurs after the loss of a family member while in college — his mother died from a brain tumor in his transitional college years. He took that grief, however, and created Students of AMF, a campus network to help others that grieved the illness or death of a loved one.

"I felt alone, helpless and guilty. I believed no one could possibly understand what I was going through or relate to my pain. I didn't even share my feelings with my very closest friends."

Central Arizona Programmatic Suicide Deterrent System, Magellan Health Services of Arizona, Phoenix, AZ

WINNER, AWARD OF EXCELLENCE FOR SERVICE INNOVATION, 2012

Central Arizona Programmatic Suicide Deterrent System, a suicide prevention program of Magellan Health Services of Arizona, was recognized for its groundbreaking initiative to reduce to zero the number of suicides among people with serious mental illness enrolled in the region's public health system. Magellan and the Arizona Department of Health Services' Division of Behavioral Health Services led a collaborative with community leaders to change the culture around suicide, arm provider agency staff and families with skills and knowledge to intervene with those most at risk, and create a framework to address this major public health problem.

"The Central Arizona Programmatic Suicide Deterrent System Project is a groundbreaking initiative designed to reduce to zero the number of suicides among individuals enrolled in the region's public health system who face life challenges as a result of serious mental illness. Magellan Health Services of Arizona and the Arizona Department of Health Services' Division of Behavioral Health Services lead a community collaborative with public policy, law enforcement and mental health leaders to change the culture around suicide, arm provider agency staff and families with skills and knowledge to intervene with those most at risk, and create a clinical care and intervention framework to address this major public health problem."

Community Psychiatric Clinic, Seattle, WA

PROGRAM OF SIGNIFICANCE, EXCELLENCE IN SERVICE INNOVATION, 2012

Two years after launching a major program for veterans in the Puget Sound area, the Community Psychiatric Clinic was one of only two agencies in Washington State to receive Department of Veterans Affairs' funding for a rapid rehousing program for 120 homeless veterans and their immediate families annually. Since its inception, the clinic has made contact with 505 women and minority veterans and linked 378 of them to services.

"Two years ago Community Psychiatric Clinic launched a major new and innovative program expansion to create a full continuum of care for veterans that would address previously unmet needs of the significant numbers of veterans in the region with untreated mental illness, substance abuse and homelessness."

Children's Crisis Treatment Center, Philadelphia, PA

WINNER, AWARD OF EXCELLENCE FOR HEALTHCARE MANAGEMENT, 2012

The Treatment Center, devoted to serving the emotional needs of children beginning in early childhood to help them reach their full potential regardless of their challenges, was recognized for its innovative therapeutic nursery program. The novel initiative enables family members to become informed advocates on behalf of their children as they enter schools. Families are encouraged to participate in skill-building workshops that cover topics like anger management, parental self-care, the impact of grief and loss on children, and learning to advocate for special education services.

"This program prides itself on its effectiveness with its client population and expertise of its staff. They know Care Coordination strengthens families and helps parents and caregivers become informed advocates on behalf of their children."

Community Partnership of Southern Arizona, AZ

PROGRAM OF SIGNIFICANCE, EXCELLENCE IN BEHAVIORAL HEALTHCARE MANAGEMENT, 2012

Immediately following the January 8, 2011 Tucson shooting, leaders at the Community Partnership of Southern Arizona went to work planning a mental health forum. The response team helped create lasting, positive changes in the community's commitment to early identification and referral and understanding of mental illness behavioral healthcare.

"The need for a sophisticated, large-scale response was clear within minutes of the January 8, 2011 mass shooting in Tucson, Arizona. Rep. Gabrielle Giffords was gravely wounded in the attack that killed a federal judge, a 9-year-old girl and four others. More than a dozen others were injured, and a city that's home to nearly a million people was traumatized to its core. With speculation about the mental health of the accused shooter already swirling in news reports, the behavioral health needs of the community required immediate action."

IMPACT AWARDS

Midwestern Colorado Mental Health Center, Montrose, CO

WINNER, EXCELLENCE IN HEALTH INFORMATION TECHNOLOGY, 2012

The Midwestern Colorado Mental Health Center was recognized for developing its Patient Tools technology that screens people for behavioral health concerns in a variety of settings. The handheld electronic tablet uses trigger logic, screening metrics, assessment metrics, and key questions in a digital patient-client interview. The assessment results, completed by the client and automatically scored, are produced in seconds. A complete client assessment can be summarized, including highlights of key areas of concern. The innovative tablet has helped the center make tremendous progress in identifying and treating many behavioral health illnesses that would otherwise have gone undiagnosed and untreated.

"As part of its mission 'to be a leader in providing excellent behavioral health services for and with our communities,' Midwestern Colorado Mental Health Center has become a partner in many integrative projects."

David Lawrence Center, Naples, FL

PROGRAM OF SIGNIFICANCE, EXCELLENCE IN HEALTH INFORMATION TECHNOLOGY, 2012

In June of 2010, the David Lawrence Center partnered with ValueOptions®, who manages the Collier County pre-paid Medicaid contract, to launch a pilot project exploring whether telemedicine could provide more timely access and cost-effective mental health and psychiatric services in rural communities. Doctor availability went from twice a month to four days a week, and the small satellite office was able to access clinical staff with many specialties.

"David Lawrence Center's Charter includes a pledge to provide exceptional, compassionate care utilizing innovative healthcare practices. Fulfillment of that pledge has included investment and implementation of health information technology to support delivery of services that promote life-changing wellness."
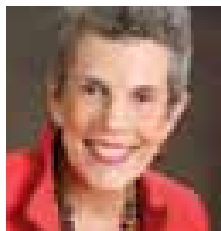
Susan Salasin, SAMHSA Center for Mental Health Services

WINNER, AWARD OF EXCELLENCE FOR PUBLIC SERVICE, 2012

A longtime civil servant at SAMHSA, Susan Salasin's pioneering work on trauma and trauma-informed care throughout her career has been dedicated to recovery and healing for victims of crime and violence. At age 16, she was a victim of a violent crime. She went on to devote her career to improving the lives of people with similar experiences. Among her many accomplishments, she initiated work on women and trauma as co-director of a Harvard collaborative study on women and depression that revealed that women were twice as depressed as men. She also co-authored a respected book on the study, The Mental Health of Women.

"Susan's story of hope and recovery is a testament to anyone struggling to overcome the after effects of experiencing a traumatic event. Her many years of work to shape the thinking around trauma-informed care has helped countless numbers of victims of violence to enjoy happier, healthier lives." — Linda Rosenberg, National Council President and CEO

Clayton Chau, MD, PhD, Orange County Health Care Agency, Orange County, CA

WINNER, VISIONARY LEADERSHIP, 2012

Dr. Clayton Chau has built strong relationships with diverse communities across the county, including refugees, the lesbian, gay, bisexual, transgender population, ethnic minorities, government, and academia. One of the "boat people" from Vietnam who came to the U.S. in the 1970s to escape political persecution, he worked with other Vietnamese refugees in the community to set up an organization to help family members suffering from behavioral health disorders.

"I grew up in an environment where I believe that anyone is capable of generating ideas. But it takes an entire support system to carry out an idea to fruition. I'm fortunate to have colleagues and mentors who have the ultimate wise vision in supporting my works."

Dale K. Klatzker, PhD, MSW, President & CEO
The Providence Center, Providence, RI

WINNER, VISIONARY LEADERSHIP, 2012

Dale Klatzker guides his company with a philosophy that good care equates to clients receiving the right amount of consumer-centered, recovery-focused care at the right time and for right duration; that providing a full continuum of community-based behavioral health services will improve care and decrease costly emergency room visits and unnecessary inpatient admissions; and treating the whole person by providing integrated and coordinated primary and behavioral healthcare. His inspirational leadership has been the catalyst for innovation at The Providence Center and in Rhode Island.

"I view that what I've accomplished over the years, not from the lens of myself, but rather from the lens of what it means for me to be a part of a number of wonderful teams of people. Caring and compassionate individuals working together to improve the lives of many, many others."

Dale Rinard, TERROS, Phoenix, AZ

WINNER, VISIONARY LEADERSHIP, 2012

Dale Rinard, who retired in 2010 as President and CEO of TERROS, successfully steered the community-based behavioral health organization out of financial ruin when he arrived in 1995. In his 16 years at the helm, he expanded the organization from 110 employees and a $5.5 million budget to a company with 450 employees and a $30 million budget. In 2007 and 2008, he demonstrated visionary leadership by helping to form two new behavioral health networks, including the Crisis Response Network, which established a live telephone crisis hotline service 24 hours a day.

"As I reflect on why I did this work, the political difficulties, all the struggles we have, it's because of the purpose. The purpose to help others. The purpose to give to others, no matter what it takes. What we do is so worthy. As someone told me, 'you are doing God's work,' and that is what is so special in keeping me motivated."

Submissions for the 2013 National Council Awards of Excellence are open through October 2012. To apply, visit www.TheNationalCouncil.org/Awards.

Plan now to join us for the celebration in April 2013 at the National Council Mental Health and Addictions Conference.

BHPI congratulates all of the award winners

BHPi 10

Congratulations

to all of the 2012 award recipients!

The Center for Alternative Sentencing and Employment Services (CASES) recognizes the winners of the 2012 Awards of Excellence and Reintegration Awards. A special congratulations to Kevin Cleare for receiving the Reintegration Achievement award. His contributions to his clients and to CASES over the past five years have demonstrated true growth and commitment.

Thank you, Kevin, for all your hard work and dedication.

CASES ▪ ▫ ▫ ▫ ▫

Alan Epstein, Board Chair
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Congratulations
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In gratitude to Randy Revelle and the power of his story in bringing hope to others

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KEVIN HINES

Kevin Hines, your sincere dedication to help those suffering from mental health illnesses is truly remarkable. Congratulations on your achievements and your efforts to give hope to so many.

You have made all of us at SAVE very proud!

SAVE
SUICIDE AWARENESS
VOICES OF EDUCATION

The Trilogy Board of Directors would like to thank the National Council for honoring Trilogy and its outstanding staff by awarding us with the First Place 2012 Reintegration Award for Clinical Medicine in recognition of Trilogy's Integrated Healthcare Program. We are very proud of Trilogy and the outstanding job the organization does to assist adults with serious mental illness in their recovery.

TRILOGY
BEHAVIORAL HEALTHCARE

A Living Legacy
Lessons from America's First Suicide Prevention Center

Kita S. Curry, PhD, President and CEO, Didi Hirsch Mental Health Services, and Director, Board of the National Council for Community Behavioral Healthcare

Imagine being assigned to write a letter of condolence to the family of a veteran who has just died by suicide. Sixty years ago, in the midst of the Korean War, this very assignment ended up inspiring psychologists Norman Farberow and Edwin Shneidman to create the first Suicide Prevention Center in the nation and a new discipline, the study of suicide.

Their drive to understand what caused the veteran to take his life led them to the Los Angeles morgue where they found many suicide notes, including one by the GI. Analysis of the notes, and the lives of the individuals that wrote them, inspired Dr. Farberow and Dr. Shneidman to develop the "psychological autopsy," psychological forensics that are used to assess whether a death has been caused by suicide. Still in use, the method became widely known when Dr. Farberow and his colleagues determined that Marilyn Monroe's death was a suicide.

The founders were open to learning from the experts — those who had attempted or contemplated suicide

With a grant from the National Institute on Mental Health, 1958 marked the launch of the Los Angeles Suicide Prevention Center with Robert Litman, MD, as director. That was 54 years ago. Yet today, many mental health professionals still turn away suicidal clients.

No one at the Suicide Prevention Center shied away from suicide. All shared a common goal: to use what they learned from research to prevent suicide and console the bereaved. Early studies focused on gay Americans, African Americans and youth, to name a few.

Back then, rapid innovation was possible. The founders described their method as trial and error, but that minimizes their psychological acumen and their openness to learning from the experts — those who had attempted or contemplated suicide. They quickly learned that suicide occurs when one is hopeless, isolated, and in terrible psychological pain, but support and treatment can make a difference.

Recognizing that being heard in one's darkest hour can be lifesaving, the Center's therapists began taking calls from home after hours. Several years later, the demand called for expansion to 24 hours, and staff no longer could do it all. As is so often the case, necessity was the mother of invention. SPC developed a training program for volunteer counselors, a radical concept that has been proven effective. Today our volunteers number more than 200.

SPC was ahead of its time in enlisting the community on many fronts. In 1965, it began training the Los Angeles Police Department in crisis response. Today, we also train the FBI, SWAT, hospital personnel and other emergency responders, as well as U.S. military personnel and South Korea's military chaplains. In partnership with the L.A. Mayor's Crisis Response Team, trained survivors offer immediate support at the scene of suicides. We know the training works: after a law enforcement officer talked a suicidal man down from a roof, he attributed his success to his SPC training.

Law enforcement was just one SPC training initiative. In 1981, SPC Project Director, Michael Peck, PhD, wrote a Manual on Suicide Prevention and Education for all California high schools. If only most schools hadn't been afraid of using it; they were deterred by the myth that talking about suicide causes it. But that is changing. We now train thousands of people each year — athletic teams, religious leaders and teachers to name a few. A new audience emerged after the 2008 recession — bankers and mortgage counselors beleaguered by customers' suicidal comments.

No one at the Suicide Prevention Center shied away from suicide.

The therapists that founded SPC were committed to exploring every avenue for preventing suicide. In 1976, they began what surely was one of the first, if not the first, group for chronically suicidal individuals. In 1981, Sam (Mickey) Heilig, LCSW, developed survivor support groups that now are offered throughout Southern California.

The groups bring together people who have suffered the same traumatic loss. They are closed, not drop-in, groups, where members are able to develop the trust needed to share. A survivor who is further along in the grief process co-leads the groups, offering hope that someday it will be possible to smile again.

We have come a long way since Dr. Farberow and Dr. Shneidman set out to understand and prevent suicide. Their unflinching dedication to a cause that was cloaked in silence and shame, helped bring it into the light. Truly pioneers, they paved the way for the 21st century, which promises to dramatically reduce the rate of suicide through both public awareness and scientific advances.

Well into his 90's and the sole surviving founding father, Dr. Norman Farberow has lived to see SPC:

>> Participate in research that proved suicide crisis lines are effective

>> Expand the crisis line's language capacity to serve Spanish, Vietnamese- and Korean-speaking callers

>> Play a vital part in the federally sponsored National Suicide Prevention Lifeline network (1-800-273-TALK)

>> Pilot new technology, such as chat lines and texting, to prevent suicide

>> Offer follow-up care to individuals at highest risk — attempters recently treated at emergency rooms

>> Head a statewide initiative dedicated to coordinating suicide prevention, which is funded by California's voter-approved Mental Health Service's Act (Proposition 63)

Still actively involved with the Suicide Prevention Center, Dr. Farberow serves on its Survivors After Suicide Advisory Board and shares his perspective with each volunteer training class. He joins me in celebrating how far the field has come and how far we all are determined to take it. No one should die of despair.

Psychologist Kita S. Curry, PhD, has been the President and CEO of Didi Hirsch Mental Health Services since 1999. In addition to its Suicide Prevention Center, Didi Hirsch offers a continuum of care that includes low and no-fee outpatient counseling, home and school-based services, residential substance abuse treatment for pregnant and parenting women, and outreach to the homeless. A passionate advocate, Kita has served on California's Advisory Committees on Suicide Prevention and Stigma Reduction and has multiple honors for serving communities where stigma and poverty limit access. From MSN Money to NPR's Morning Edition, from La Opinion to the Los Angeles Times and the new Ricki Lake Show, the media frequently turns to Kita both for her expertise and her candor about her family's history of depression. Currently on the Board of the National Council for Community Behavioral Healthcare, Kita is a past president of Los Angeles' and California's associations of non-profit mental health providers.

Root Cause Analysis

What Airlines Can Teach Us About Suicide Prevention

Paul M. Schyve, MD, Senior Advisor,
Healthcare Improvement, The Joint Commission

Based on an interview by Heather Cobb for National Council Magazine

More than 15 years ago, The Joint Commission became aware of serious adverse events occurring in accredited healthcare organizations, despite their good reputations. The underlying question became "Why do terrible things happen?" The alarming events at the time included cutting off the wrong leg, operating on the wrong side of the brain, giving 10 times the correct dose of chemotherapy — resulting in the patient's death. Then, healthcare tended to assume that somebody made an error and that person wasn't competent or paying attention. The traditional way of addressing these events was to find out who made the error, blame them, and shame them. If you were a physician, you might have your privileges withdrawn; if you were a nurse, you might be fired. Clearly, that approach did nothing to help patient safety.

So The Joint Commission looked at other high-risk industries where if something went wrong, great harm could result. A few such industries include passenger airlines, the nuclear power industry, chemical industry, and aircraft carriers. These are industries where if something goes wrong, people die. We wanted to know how they managed to make themselves so safe despite the inherent risk. We gained a couple of insights.

First, they maintain the policy that if an event occurs, they need to know about it. Then, they talked not only about when the actual event happened, but also if there was a close call or a near miss, or if somebody saw something that may have served as a red flag.

If these industries responded by naming, blaming, and shaming — as the healthcare industry did — it would lead to a culture of secrecy and hidden events. Sharing would be too traumatic for the person involved. Not only had they harmed a person and felt very badly about it, but it could also ruin their career. So, in healthcare, there was a tendency to keep things quiet rather than coming forward to discover how to prevent it in the future. The healthcare culture needed to change into one of trust and reporting instead of naming, blaming, and shaming.

Second, humans make errors. There's no way to stop that. These high-risk industries address the processes that people work to prevent errors from occurring in the first place. That requires shifting focus to the systems and processes that people work within as opposed to trying to figure out how you stop a person from making an error.

In addition, we must look at what we can learn from an event. For example, one technique that's used is called a root cause analysis in which one says, "This nurse may have provided a patient the wrong dose, but what could've been done? What either enabled the nurse to do that or what could've been done to prevent it from occurring?"

Traditionally, most people in healthcare think adverse events are rare, that not much goes wrong, and wonder why time should be spent on looking at rare events. That's how the Institute of Medicine publication, "To Err is Human," came to be published in 2000.

If we look at root causes, we may find ways to reduce these risks and learn from them.

That publication didn't collect new information. It looked at existing research — studies that found that 44,000 to 98,000 people die in hospitals every year from preventable adverse events. That's not a few. It's something we need do something about. This publication encouraged people to start taking learnings from other safe high-risk industries to apply to healthcare. It helped percolate these thoughts into healthcare.

Suicide in healthcare organizations is this type of serious event that caught the attention of The Joint Commission, the Institute of Medicine, and others. Suicide affects not only the person who has taken their life, but also their family, friends, psychiatrist, and those who were involved in their care. If your patient takes their life, you feel very badly about what happened. Just as if you'd given a wrong dose of medication to a patient who then died. Some people have referred to the person who committed the error as the "second victim" because they wanted to do that right thing, but somebody was harmed by what they did or, in the case of suicide, perhaps something they did not do that enabled the tragedy to occur.

If our goal is to reduce suicides, we need to adopt around suicide some of the same kind of additives that we have around other patient safety issues. So, for example, some studies have shown that one breakdown is when a person who is suicidal is discharged from an emergency department and there isn't a careful assurance of follow-up. That increases the risk that the person may take their life. How do you establish systems that ensure that there is a follow-up at the point?

We also need to recognize that this is something we need to talk about. If we look at root causes, we may find ways to reduce these risks and learn from them. If we see these as sentinel events, then we must dig deep into what enabled them to occur, looking at each event to see what happened, what can be learned, and how it might be prevented in the future. This also means thinking about the culture. If people are able to talk about a suicide without being blamed, one would hope that the suicides are infrequent enough — as often as they occur —that one can put effort into doing root cause analysis each time it occurs. And that's part of the attitude around the idea that suicides are events that we can avoid completely.

If an organization is accredited by the Joint Commission, which would mean most hospitals, we require them to treat a suicide as a sentinel event and follow this kind of a policy. Most behavioral healthcare is not provided in organizations that are accredited by the Joint Commission, however. So no one is driving this policy to ensure that every time one of these events occurs, it is investigated. Consequently, everybody needs to say this is the kind of event that we treat as a sentinel event. Behavioral health organizations that have not had any experience with the Joint Commission may not have ever thought using this approach.

The solution to suicide is not that the therapist should work harder, know more, or be more committed. The fact is that no matter how much one tries to keep up with the literature and no matter how much someone is committed, as humans we will make mistakes. Instead, we must try to figure out how to design the way we work with a patient who is suicidal or how we make sure we have determined which

patients are at risk of suicide. It could be the failure to identify the person at risk in the first place, or to provide appropriate intervention, or to successfully transition care to another agency or setting.

There are many different places where failure can occur. The question is how do we address failure without thinking the solution is for people to be smarter and work harder.

At least three barriers stand in the way of doing this:

First, there is a certain degree of denial that something bad is happening. In fact, suicide is not at the margins. It is a serious problem. Acknowledgement leads to recognition and sensitivity. It's not that people haven't recognized that a suicide occurred, but it may be part of culture and belief that we can't prevent them. That attitude leads to thinking nothing can be done. It's giving up.

Second, shame leads to keeping things confidential, rather than leading to discussions and problem solving. We need to, in fact, learn what we can from it the root cause analysis.

Third, the National Action Alliance for Suicide Prevention concluded that many times people even in the behavioral health field feel unsure of what to do to prevent suicide. So, one of suicide's root causes may actually be a lack of confidence because people haven't been provided with the latest information on how to prevent suicide.

Behavioral health providers must accept that they are human, that they will make errors, but by speaking up about suicides and thinking about them in a different way, we can prevent them in the future.

Paul M. Schyve, MD, is senior advisor for healthcare improvement at The Joint Commission. Prior to joining The Joint Commission, Dr. Schyve was the Clinical Director of the State of Illinois Department of Mental Health and Developmental Disabilities. Dr. Schyve is a Distinguished Life Fellow of the American Psychiatric Association. He is a Founding Advisor of Consumers Advancing Patient Safety, the Chair of the Ethical Force Oversight Body of the Institute of Ethics at the American Medical Association, a former trustee of the United States Pharmacopeial Convention, and a former member of the Board of Directors of the National Alliance for Health Information Technology. He has served on numerous advisory panels for the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, and the Institute of Medicine. Dr. Schyve has published in the areas of psychiatric treatment and research, psychopharmacology, quality assurance, continuous quality improvement, health care accreditation, patient safety, healthcare ethics, and cultural and linguistic competence.

Class Is in Session
Research Recommends
Targeting Suicidal Behaviors Directly

Katherine Anne Comtois, PhD, Associate Professor, Department of Psychiatry and Behavioral Sciences, and Clinical Director, Psychotherapy Clinic, Harborview Mental Health Services; Erin Ward-Cieslieski, Graduate Student, Department of Psychology, Behavioral Research & Therapy Clinics; and Marsha M Linehan, Professor, Department of Psychology and Director, Behavioral Research & Therapy Clinics — University of Washington

Suicide is a major national and international public health problem. It is estimated that for every suicide completion, there are 25 attempts and almost one in 20 people in the U.S. general population report attempting suicide at some time in their life. Annually, 250,000 individuals in the U.S. sustain self-inflicted injuries so severe that they are admitted to a medical or surgical service on an acute care hospital floor. In 2005, $2 billion was spent on medical treatment for suicide attempts, while lost productivity accounted for an additional $3.5 billion.

Despite outreach and intervention efforts for those at risk for suicide in the U.S., there has been no change in the suicide rate. In fact, the World Health Organization indicates that the U.S. suicide rate has remained fairly consistent since 1955 at 10.2 to 12.4 suicides per 100,000. In the face of such persistence of suicidal behavior, it is critical to develop and evaluate treatments to help the suicidal individuals that contribute to these statistics.

The problems and despair leading an individual to consider suicide are profound, and suicidal individuals are often hopeless about alternatives to provide relief from their pain. Clinicians must quickly and repeatedly make decisions that have life and death consequences for their patients, as well as professional implications in terms of distress over losing a patient and the prospect of malpractice litigation. The pressure on a suicidal individual and a clinician is enormous and can lead to fear, hostility, frustration, and sadness on both sides.

We have published a number of reviews of interventions to prevent suicide over the past 2 decades, as have others such as the Cochrane and NICE committees; The Clinical Care and Intervention Task Force's report to the National Action Alliance for Suicide Prevention Executive Committee included another. Based on these reviews and our own research at the University of Washington, we have drawn important conclusions about how to treat suicidal individuals effectively.

MODELS OF TREATMENT

There are two models applicable to the treatment of suicidal behaviors. The first is to view suicidal behaviors as symptoms of a mental disorder. For example, suicidal behavior is associated with and viewed as a symptom of depression and, therefore, is expected to decrease when depression is treated. In this example, depression is the disorder believed to cause suicidal behaviors, and these suicidal behaviors are indirectly targeted when depression is directly targeted. Primarily correlational, but not causal, research data supports this model.

Most studies show that mental disorders and suicidal behavior are frequently found together, but have not found that treatments (e.g. antidepressants, mood stabilizers) that affect the mental disorder significantly change the suicidal behavior. Perhaps this model that assumes that the mental disorder causes the suicidal behavior when it often does not, is flawed, especially when additional factors cause both the mental disorder and the suicidal behavior.

This has been addressed in an alternative model that conceptualizes suicidal behavior as disordered behavior that results from any number of environmental and individual characteristics, including but not limited to mental disorders. Rather than relying on

evidence-based treatments designed for mental disorders, this newer model has led to the development and evaluation of evidence-based treatments that target suicidal behaviors specifically — treating whichever characteristics are uniquely related to suicide for that individual. Evidence for these treatments — including dialectic behavioral therapy, cognitive behavioral therapy, and other psychosocial interventions such as sending caring letters or placing phone calls — have strong support in a small but growing number of experimental studies.

More will be known soon as more than 25 randomized clinical trials of treatments targeting suicidality directly are currently in progress.

SMALL INTERVENTIONS YIELD BIG EFFECTS

A review of clinical trials that compared those who included, rather than excluded, high-risk patients found stronger and more positive results — even when these interventions were as 'small' as sending caring letters, placing phone calls, or providing four psychotherapy sessions. Most evidence-based psychotherapies lasting between 10-50 weeks showed stronger effects than inpatient models or expensive pharmacotherapies for suicidal patients. This is particularly important as high-risk patients are often excluded from outpatient treatments, despite the fact that they might strongly benefit from them.

COPING SKILLS REQUIRED

It is critical that providers teach suicidal patients alternative ways to cope with stressful and difficult situations. Research has shown that suicidal individuals have specific deficits in problem-solving, conceptualizing problems, and thinking through their situation, as well as that structured, problem-solving psychotherapies such as dialectic behavioral therapy and cognitive behavioral therapy are effective treatments for suicidal individuals. In thinking of suicidal behaviors as attempts to cope with unbearable circumstances, the individual cannot see how to change. Thus, the provider's role is to teach, model, and practice new ways of managing these circumstances.

LIMITED EVIDENCE FOR INPATIENT AND PHARMACOTHERAPY

Few studies support the efficacy of pharmacotherapy-only treatment for suicidal risk. Similarly, no difference has been found in the few studies of inpatient

Rather than relying on evidence-based treatments designed for mental disorders, this newer model has led to the development and evaluation of evidence-based treatments that target suicidal behaviors specifically.

psychiatric treatment compared to discharge home. It also does not appear that care coordination between inpatient and outpatient providers is helpful at preventing suicide. The Clinical Care and Intervention Task Force of the National Action Alliance for Suicide Prevention "acknowledges that hospitals may provide inpatient psychiatric care for some patients at extremely high risk of suicide (e.g., those with command hallucinations, weapon availability and recent prior attempts). However, hospitals generally should make informed referrals for treatment on the patient's release from hospital care, including emergency departments. The referral would be based on the assessment and needs of the patient. For patients in severe emotional distress, referrals should be to providers or practitioners that can see the patient within 24–72 hours. These providers should have the capability of providing intensive community care, including outpatient care."

OUTREACH AND CRISIS MANAGEMENT IS CRITICAL

There is no question that clinicians should employ outreach strategies as a standard component of any intervention in addition to maintaining availability to their patients. Outreach may play a larger role than the type or size of the intervention that predicts positive results. In two studies, death by suicide was prevented by only sending letters or placing follow-up phone calls. Suicide attempts were reduced in psychotherapies that were provided in the hospital or the patient's home, as well as in psychotherapies that made improving attendance a focus of treatment. Successful treatments for suicidal individuals also incorporate procedures for crisis management. This includes two important stages: generating a plan with a suicidal patient prior to a crisis and enacting that plan in the event of a crisis.

Suicide interventions should target suicidality directly

and use coping strategies more than pharmacotherapy or inpatient admissions to help people have hope and learn to cope effectively with their idiosyncratic set of stressors and make their lives feel worth living. Crisis management and outreach must work together during treatment to firmly connect the provider with the suicidal individual and help him/her through "dark moments." This vision, however, is not the standard of care. It will take dissemination of these research findings, training, and further research to move the field in this direction.

Dr. Katherine Comtois is a University of Washington associate professor in the Department of Psychiatry and Behavioral Sciences and an adjunct associate professor in the Department of Psychology. She is clinical director of the Psychotherapy Clinic at Harborview Mental Health Services, which includes the Dialectical Behavior Therapy program and the University of Washington DBT Residency Training DBT program. She has received numerous awards from the University; from the International Society for Innovation and Training in DBT; and from King County for her DBT clinic as the best direct service mental health or substance abuse program in the county in 2000. Dr. Comtois provides training in DBT and effective suicide management in the United States, Canada, Australia and the United Kingdom.

Erin F. Ward-Ciesielski is a graduate student at the University of Washington Department of Psychology Behavioral Research & Therapy Clinics Seattle, working on her degree in clinical psychology. She got her BA Honors, Magna cum Laude in psychology (major) and Spanish (minor) from Indiana University South Bend.

Marsha Linehan is a Professor of Psychology and adjunct Professor of Psychiatry and Behavioral Sciences at the University of Washington and is Director of the Behavioral Research and Therapy Clinics, a consortium of research projects developing new treatments and evaluating their efficacy for severely disordered and multi-diagnostic and suicidal populations. Her primary research is in the application of behavioral models to suicidal behaviors, drug abuse, and borderline personality disorder. She is also working to develop effective models for transferring science-based treatments to the clinical community. She has received several awards recognizing her clinical and research contributions to the study and treatment of suicidal behaviors, including the Louis I. Dublin Award for Lifetime Achievement in the Field of Suicide and the Distinguished Research in Suicide Award from the American Foundation of Suicide Prevention.

Care Pays
ROI from Better Care Transitions

Tami L. Mark, PhD, MBA, Director, AnalyticStrategies; **John Richardson,** Senior Analyst, Thomson Reuters

In 2009, U.S. community hospital emergency departments and inpatient settings discharged more than 1.3 million people with diagnoses of deliberate self-harm or suicidal ideation. Less than 50% of these patients received behavioral health treatment within the week following discharge. Such a low rate of follow-up is stunning in light of the well-established fact that the period immediately following discharge for a suicide attempt is a time of greatly heightened risk for a subsequent suicide attempt. The need for follow up during this critical period is widely accepted by leading experts, as reflected in the 2001 National Strategy for Suicide Prevention.

Today's health policy environment presents a unique opportunity to address this long-standing problem. Care transitions have received increased attention and are the focus of a number of provisions in the Patient Protection and Affordable Care Act. Many hospital systems are forming Accountable Care Organizations and attempting to reduce readmissions and save costs through improved follow-up, coordination, communication, and care management. This is an opportune time to demonstrate the clinical and economic benefits of improving care transitions for persons at risk of suicide.

Truven Health Analytics and the Substance Abuse and Mental Health Services Administration modeled the costs and economic benefits of care transitions for persons at risk for suicide admitted to hospitals or emergency rooms, and determined how they vary under different assumptions. The model is outlined in Figure 1.

Figure 1. Return on Investment (ROI) Model Schema

Suicidal ideation or deliberate self-harm noted in the ED or Hospital → All patients are discharged and receive transitional care services → Increase in the likelihood of receiving needed follow-up treatment → Decrease in readmission rates

-$ (Cost)   -$ (Cost)   +$ (savings)

Return on Investment (ROI) = +$ / (-$ -$)
Amount Saved for Every $ Spent
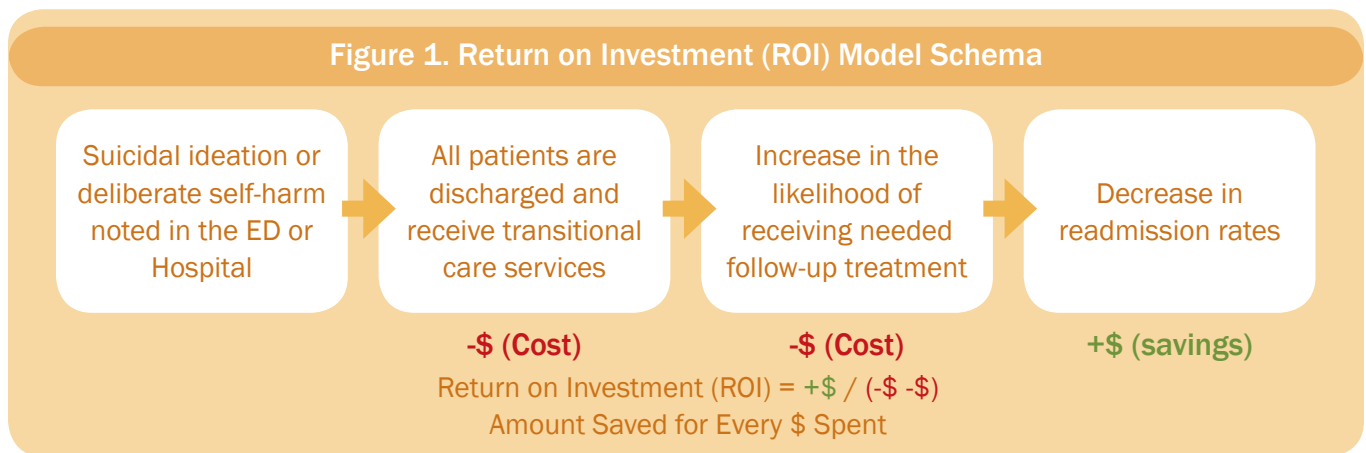
The model inputs are the:

>> Baseline percentage of patients who receive post-discharge treatment/contact

>> Baseline readmission rate among patients discharged with a suicide attempt or ideation diagnosis

>> Increase in treatment/contact following enhanced transition of care services

>> Cost of the enhanced transition of care services

>> Effectiveness of increased post-discharge treatment/contact in reducing readmission rates

>> Cost savings from reduced readmissions

The model is structured so that care transition interventions are assumed to increase post-discharge follow-up treatment, which subsequently reduces readmissions. However, it can also be structured so that care transitions, through minimal contact, are the main intervention.

We used a number of sources for identifying plausible ranges for model inputs. Claims data from the *Truven Health Analytics MarketScan*® Databases indicated that 52% of patients with commercial insurance and 37% with Medicaid received outpatient follow-up care within 7 days of discharge. Additionally, 10% of patients with commercial insurance and 13% of patients with Medicaid who were discharged with a diagnosis of deliberate self-harm or suicidal ideation were readmitted for a behavioral health condition within 30 days.

Based on a review of the scientific literature, we assumed that transitional care can increase post-discharge follow-up by a factor of 43%, and post-discharge follow-up can reduce readmission rates by 50%. We estimated that transitional services would cost approximately $100 per individual, and additional outpatient services within 30 days of discharge would cost $164 for commercial insurance and $109 for Medicaid. Using *Marketscan* data, we estimated that the cost of a readmission following a suicide admission is approximately $8,000 for both commercial insurance and Medicaid.

Starting with these baseline assumptions, we varied the inputs to determine the drivers of the cost effectiveness and return on investment (ROI). Figure 2 shows the sensitivity of our ROI model to various Medicaid inputs.

Figure 2. Sensitivity of Return on Investment (ROI) Results to Medicaid Inputs

Effectiveness of Follow-Up Treatment in Reducing Readmissions: 20% – 52% – 70%

Patients Receiving Follow-Up Treatment After Improving Transitional Care: 40% – 55% – 70%

Baseline Inpatient Readmission Rates: 6% – 14% – 16%

Incremental Cost per Discharge of Improving Transitional Care: $135 – $93 – $65

Cost of Follow-Up Treatment within 30 days of Discharge: $700 – $66 – $50

Return on Investment

Today's health policy environment presents a unique opportunity to demonstrate the clinical and economic benefits of improving care transitions for persons at risk of suicide.

The sensitivity analyses reveal that care transition intervention costs are a key determinant of whether the intervention will result in savings or minimal expenditures, with $93 as the breakeven point under our baseline assumptions for Medicaid. Care transitions can range in complexity and costs. Randomized trials show that minimal follow-up contact such as individually typed letters, brief telephone calls, and brief face-to-face interviews significantly reduce suicide deaths. A recent study by While and colleagues found that while implementing more recommendations for reducing suicide post-discharge lead to reduced suicides, the provision of 24-hour crisis care was associated with the largest reduction in suicide rates. The clinical effectiveness, and cost-effectiveness, of these relatively simple interventions may need to be weighed against more intensive follow-up such as critical time intervention and transition discharge models.

Another key model input is the likelihood of readmission. Under baseline assumptions for the Medicaid population, the break-even point occurs when 14% or more of the population is readmitted. The model suggests that one way to improve the cost effectiveness of care transitions may be to focus on patients at highest risk of another suicide attempt.

Improving care transitions among patients at risk for suicide seems obvious to behavioral health experts. However, in an increasingly constrained fiscal healthcare environment, using empirical models to demonstrate to hospitals and health plans that there are cost-effective ways to pursue this goal may be critical to more widespread adoption of post-discharge interventions to reduce suicide and readmission costs. The current emphasis on reducing readmissions and improving care coordination may provide a unique opportunity for behavioral health providers to make this case to the broader healthcare delivery system.

As a Senior Director at Truven Health Analytics, Tami L. Mark, PhD, leads analytics aimed at improving behavioral health financing and services. Her work has focused on trends in behavioral health financing and services, comparative effectiveness, pharmacotherapy, and care transitions. She has published more than 70 peer review journal articles and has served on a number of expert panels such as for SAMHSA, NIH, AHRQ, and the NQF.

John Richardson, MPH, is a Senior Analyst at Truven Health Analytics. He has experience in healthcare research through performing complex analyses of large national datasets and coding qualitative responses of patients and providers. He recently conducted analyses on the content of state suicide prevention plans and the prevalence and cost of hospital readmissions among those who have deliberately harmed themselves or have suicidal ideation.

I Just Called to Say How Much I Care
Crisis Center Follow Up Bridges the Gap

Manisha Vaze, MSW, Follow-Up Coordinator,
National Suicide Prevention Lifeline

We know the statistics — suicide is the tenth leading cause of death in the United States, with more than 37,000 people lost to suicide each year. Prevention efforts have been directed toward enhancing community awareness, providing education regarding risk factors and assessment, and placing focus on the use of evidence-based treatment within the health and mental health systems.

However, the question remains: How do we reach those individuals at highest risk, those in between or not actively engaged in services, who choose not to reach out during a moment of suicidal crisis? How do we ensure that the methods we use for outreach and support are evidence-based and cost-effective?

According to several groundbreaking studies, people are at highest risk of dying by suicide following discharge from an inpatient or emergency department setting, particularly within the first week after discharge. These studies suggest that an intervention based on supporting those recently discharged could mitigate suicide risk factors and save lives.

In a 2011 SAMHSA-funded report, "Continuity of Care for Suicide Prevention and Research," Dr. David Knesper reviewed the literature regarding suicide risk post discharge from an inpatient or emergency department setting and highlighted the post acute care period as a critical area for suicide prevention efforts. This report emphasized the need to minimize the duplication of services and reduce the unnecessary use of more costly emergency services by diverting consumers to more appropriate care.

Although there are signs of progress in some areas, the mental health system is still largely fragmented in its service delivery. In some cases, patients still do not receive proper suicide risk assessment prior to discharge. One study of more than 350 emergency departments in California in 2006 found that 23% of emergency departments reported they occasionally did not re-assess patients for suicide risk before discharge. Additionally, many institutions are not equipped to provide follow-up services for those they discharge.

Community-based crisis call centers are at the forefront of the move towards continuity of care. "Crisis call centers are an important level of care in this chain. We help patients get through between service appointments, and in many cases, are the only resource for those who choose not to engage in formal treatment environments," said Christine Tabone, Deputy Director of Crisis Contact Center, a crisis center operated by the Mental Health Association of New York City.

Crisis centers have existed since the 1950s, when the Samaritans started in the U.K. and the Los Angeles Suicide Prevention Center opened in the U.S. However, crisis centers have only recently been evaluated for their effectiveness in suicide risk assessment, reducing suicidal thoughts and de-escalating crises. In a SAMHSA-funded evaluation of crisis call centers, Dr. John Kalafat and Dr. Madelyn Gould in 2007 reinforced what the industry already knew — for people at medium to high risk of suicide, crisis centers were effective in reducing emotional distress, hopelessness, psychological pain and suicidal thoughts.

So what is it that crisis centers do? Crisis centers provide free, confidential, 24-hour emotional support for anyone in crisis who calls the hotline. Often centers have a variety of dedicated lines for survivors of rape or bullying, disaster relief, and health and human service referrals. With the already established 24-hour infrastructure, call centers have branched out to provide mobile crisis services,

after-hours services for medical or psychiatric professionals, and employee assistance programs. In many cases, centers operate through a community mental health organization, which provides outpatient services to their callers. To keep in step with the fact that people are constantly connected to their tablets and smart phones, some crisis centers are offering services via chat and SMS text. Furthermore, crisis centers that are part of the National Suicide Prevention Lifeline network are all accredited in their service delivery practices and implement standard policies and evidence-based intervention models.

Given the research on suicide after discharge from an emergency department or inpatient facility, many crisis centers have expanded their service delivery to provide what has come to be known as "follow-up." This service involves crisis workers checking in with previously assessed suicidal callers and recently discharged patients within 48 hours of discharge or call to the crisis line.

Crisis centers are uniquely positioned to administer follow-up services which are cost-effective and, most importantly, have been proven to reduce suicidality among callers and recent discharges. **In one year, a National Suicide Prevention Lifeline crisis center in St. Louis reduced psychiatric hospitalization state-wide by 7%** by referring some callers to more appropriate mobile outreach services and outpatient facilities based on the callers' needs. In a study conducted by the World Health Organization, researchers found that follow-up by phone or face-to-face contact could reduce suicide. In another US based study, follow-up by phone was associated with improved motivation, a reduction in barriers to accessing outpatient services, improved adherence to medication, reduced symptoms of depression and higher attendance rates.

Many crisis centers within the Lifeline network now provide follow-up, but in order to increase the capacity of centers to provide this valuable service, more sustainable funding is needed. Some centers work with their local hospitals to provide follow-up, while others seek private funding or foundation support. Additional staffing and enhanced infrastructures are required to streamline processes and allow for more efficiency in service provision.

More research needs to be done on the efficacy of specific models for service delivery, and in particular on the follow-up programs' ability to divert overuse of emergency department and inpatient hospitalizations. More thorough cost-benefit analyses must be undertaken. A current evaluation led by Dr. Gould at Columbia University/Research Foundation for Mental Hygiene has focused primarily on crisis center follow-up of suicidal callers to the National Suicide Prevention Lifeline. Feedback from callers who have received follow-up has been positive and has confirmed the value to callers of extended care past the initial moment of crisis. Follow-up appears to enhance callers' sense of connectedness and to support their taking the next steps to connect with ongoing mental health treatment. Of 18 centers participating in these follow-up evaluations, at least five have sought to extend the reach of their follow-up services by establishing relationships with emergency departments and/or inpatient facilities that would enable them to offer follow-up to at-risk individuals discharged from these facilities. Patients referred by hospitals to these centers for post-discharge follow-up are being interviewed by evaluation staff an average of eight weeks after discharge, and their current risk status, referral follow-through, and feedback on the experience of follow-up are being assessed.
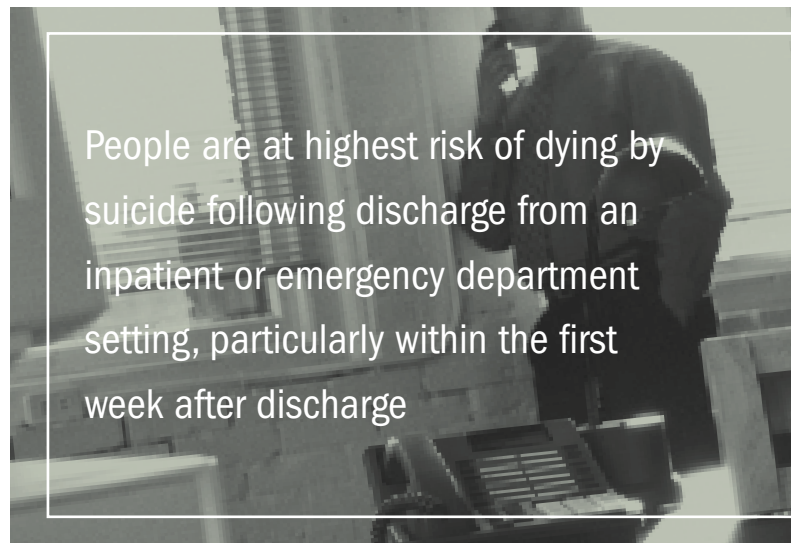
People are at highest risk of dying by suicide following discharge from an inpatient or emergency department setting, particularly within the first week after discharge

An upcoming evaluation by Dr. Gould's team will focus exclusively on crisis center follow-up of patients after hospital discharge. This evaluation will seek to document whether crisis center follow-up of suicidal individuals discharged from hospital emergency departments or inpatient units has the effect of reducing repeat emergency department visits and hospitalizations. To address this question, the evaluation will examine medical records obtained from hospitals on suicidal individuals who do and do not receive crisis center follow-up care. Patterns of subsequent service use, including outpatient treatment (if known), repeat hospitalization, and return visits to the emergency department will be assessed.

Follow-up by crisis centers is an important bridge for continuing the chain of care within the health and mental health systems. Crisis centers provide individuals who are at risk with a resource that reduces the gap in services between emergency or inpatient discharge and outpatient appointments, helping to keep them safe in a cost-efficient, cost-saving manner. These centers are on the frontlines of prevention work, and at the cutting edge of new prevention models. As we continue to advocate for mental health access and continuity of care within the health and mental health systems, we must continue to look to crisis centers for their leadership and expertise in suicide prevention and create sustainable models for their important work.

The National Suicide Prevention Lifeline is a 24-hour, toll-free, confidential suicide prevention hotline available to anyone in suicidal crisis or emotional distress. By dialing 1-800-273-TALK (8255), the call is routed to the nearest crisis center in our national network of more than 150 crisis centers. The Lifeline's national network of local crisis centers provide crisis counseling and mental health referrals day and night.

Manisha Vaze, MSW is the Follow-Up Coordinator for the National Suicide Prevention Lifeline operated by the Mental Health Association of New York City. Manisha promotes follow-up programs throughout the network. She advocates for increased partnerships between crisis centers and emergency department and inpatient facilities by working to build strong relationships with key advocacy groups and associations interested in mental health, suicide prevention, and emergency care. Manisha holds a Bachelor of Arts in Cognitive Science from the University of California at Berkeley and a Master of Science in Social Work from Columbia University.

The Trauma-Suicide Link
An ACE on Coping Strategies

Cheryl Sharp, MSW, ALWF, CPSST, Special Advisor on Trauma-Informed Care,
National Council for Community Behavioral Healthcare
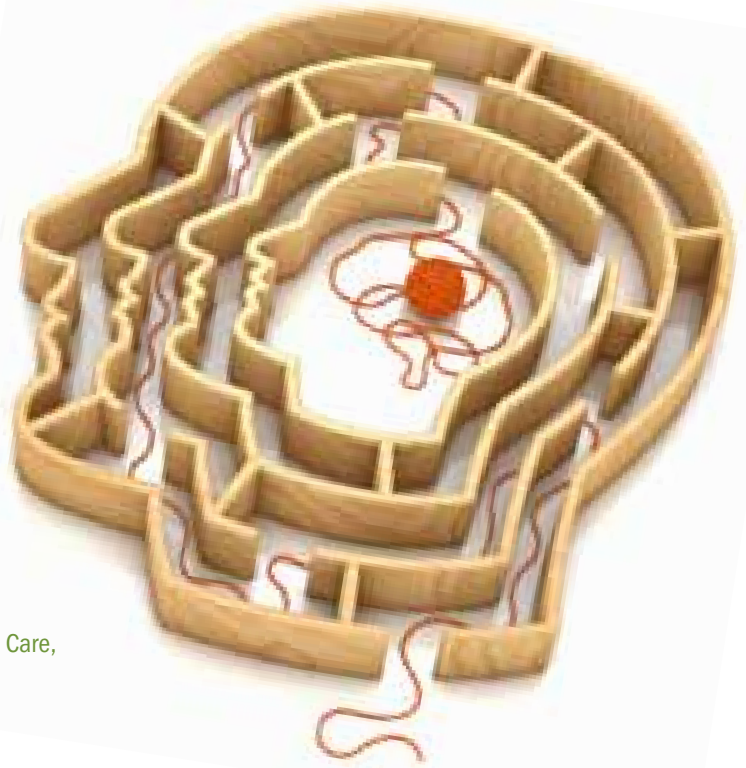
Long before a person even begins to contemplate suicide, other events have occurred. Traumatic events in adulthood such as loss of health and vitality, loss of purpose and meaning at work, and exposure to violence can lead to feelings of hopelessness, helplessness, and powerlessness.

There are often secret and hidden risk factors when a person has a history of adverse childhood experiences, or ACEs. The ACE Study is one of the largest epidemiological studies of its kind and demonstrates a strong, graded relationship between the number of categories of ACEs and participants' lifetime history of depression, but it also demonstrates that "the likelihood of childhood/adolescent and adult suicide attempts increased as ACE Score increased. An ACE Score of at least 7 [categories, not incidents] increased the likelihood of childhood/adolescent suicide attempts 51-fold and adult suicide attempts 30-fold (P<.001)."

The risk for suicidal behavior is associated with changes in brain chemicals called neurotransmitters, including serotonin, that are also associated with depression. Lower levels of serotonin have been found in the brains of people with a history of suicide attempts. Those who have experienced trauma have neurological changes in brain chemistry, as well. Trauma is a stressor and stress leads to higher levels of cortisol in the body. Many people have some of these risk factors, but do not attempt suicide. Suicide is not an average response to stress. It is however, a sign of extreme distress, not a harmless bid for attention. A person who has posttraumatic stress disorder experiences abnormal response to typical life stressors — there is a heightened stress.

When one considers the 10 questions on the ACE Survey and compares them to the National Institute on Mental Illness' risk factors, one can begin to see that suicide doesn't just happen in a vacuum. Suicide has a history and for those who have struggled with the secrecy surrounding many traumatic events, we can begin to understand how a person has difficulty finding the internal resources to cope with present day stressors unless there has been an opportunity to develop new coping strategies along the way.

> ## Long before a person even begins to contemplate suicide, other events have occurred.

What happened to a person in the past correlates to the thoughts, feelings, and behaviors a person exhibits in the present. The ACE Survey does not cover every event that occurs in childhood and it does not take traumatic events after the age of 18 into consideration. However, we know that it is helpful to allow a person to define the meaning of trauma and traumatic experiences for themselves. There is nothing wrong with asking, "Is there anything that has happened in the past that you are thinking about or concerned about?" It may be the first time that they have the opportunity to address the "what happened" question instead of the "what's wrong" one.

If we, as a society, want to address suicide prevention, we must address trauma. The greatest prevention of all would be to prevent child sexual and

physical abuse and neglect. Our society has a long way to go before we have eliminated the greatest risk factors for suicide. We can begin to ameliorate some of those factors by providing trauma sensitive services and trauma specific treatment within behavioral healthcare and throughout all human service systems.

The National Council for Community Behavioral Healthcare stands behind its "Call to Arms" to address trauma, to bring it to the forefront of service delivery, and support our members in creating trauma-informed care environments.

Cheryl Sharp, MSW, ALWF, CPSST, is the special advisor for trauma-informed services at the National Council for Community Behavioral Healthcare. She holds the unique perspective of a person with lived experience as a consumer and family member, as well as a provider of services. As a consultant to the NASMHPD/SAMHSA's Promotion of Alternatives to Seclusion and Restraint, Cheryl trains and speaks nationally on trauma-informed care. She is an advanced level WRAP facilitator, a Mental Health First Aid USA instructor, and a trainer of Intentional Peer Support. Sharp practices as a life coach/mentor and is an ordained minister. She has worked as a hospice/medical social worker and as a director of social services for a skilled nursing facility. She received the Lou Ann Townsend Courage Award for her contributions to persons with psychiatric disabilities.

Got Your ACE Score?

There are 10 types of childhood trauma measured in the ACE Study. Five are personal — physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect. Five are related to other family members: a parent who's an alcoholic, a mother who's a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death or abandonment. Each type of trauma counts as one. So a person who's been physically abused, with one alcoholic parent, and a mother who was beaten up has an ACE score of three.

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   Yes   No   If Yes, enter 1

2. Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   Yes   No   If Yes, enter 1

3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes   No   If Yes, enter 1

4. Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
   Yes   No   If Yes, enter 1

5. Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes   No   If Yes, enter 1

6. Was a biological parent ever lost to you through divorce, abandonment, or other reason ?
   Yes   No   If Yes, enter 1

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes   No   If Yes, enter 1

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   Yes   No   If Yes, enter 1

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes   No   If Yes, enter 1

10. Did a household member go to prison?
    Yes   No   If Yes, enter 1

Now add up your "Yes" answers — This is your ACE Score.

As your ACE score increases, so does the risk of disease, social and emotional problems. With an ACE score of 4 or more, things start getting serious. The likelihood of chronic pulmonary lung disease increases 390 percent; hepatitis, 240 percent; depression 460 percent; suicide, 1,220 percent.

Where Zero Is the Perfect Number

C. Edward Coffey, MD, Vice President, Henry Ford Health System, and Kathleen and Earl Ward Chair of Psychiatry, Henry Ford Hospital

Suicide is an important public health issue and the cause of much personal suffering. Yet only a few large-scale health services interventions have been evaluated or shown to be effective at preventing suicide. The Henry Ford "Perfect Depression Care" Initiative has new data confirming that the initiative was associated with a dramatic (82%) and sustained (over 8 years) reduction in suicide within our HMO network patient population. These results have implications for large-scale quality improvement efforts to reduce suicide.

The Henry Ford "Perfect Depression Care" Initiative was one of 12 national demonstration projects (and the only mental health proposal) selected in 2001 by the Robert Wood Johnson Foundation for its "Pursuing Perfection" Initiative, the goal of which was to demonstrate that the Institute of Medicine's report Crossing the Quality Chasm could serve as a viable roadmap for rapid, dramatic improvement in healthcare.

With the support of the RWJF and the Institute for Healthcare Improvement, we launched an initiative to completely redesign depression care delivery using the Six Aims and Ten Rules from the Chasm Report. We set "perfection" goals for each of the Six Aims (safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity), and then leveraged the Planned Care Model to reengineer our mental healthcare delivery system using multiple Plan-Do-Check-Act cycle tests of improvement within four key domains — partnership with patients, clinical care, access to care, and information flow.

We placed a particular focus on evidenced-based interventions for suicide prevention, including means restriction, as well as rapid access to diagnostic assessment and effective biopsychosocial treatment of underlying mental disorders. At the same time we endeavored to cultivate a "just culture," a culture of dignity and respect in which employees are encouraged to pursue audacious (rather than incremental) goals without fear of retribution should a project come up short of perfection. The key objectives were to learn and get better, and to pursue perfection, even if attaining it may not be possible.

More recently we have continued to build upon these strategies, with a particular focus on immediate access to care (e.g., implementing an "open access" model in our outpatient clinics), simplified screening for suicide risk, leveraging IT to accomplish assessment of suicide risk and weapons availability at every encounter, continuous updating of evidenced-based care protocols, and diligently cultivating a just culture by "walking the walk, not just talking the talk" of pursuing perfection.

Using data from the state of Michigan, we confirmed that implementation of the Henry Ford Health System Perfect Depression Care Initiative was associated with a dramatic reduction (82%) in the suicide rate among patients receiving mental health care in our HMO network. These findings support our original report of a reduction in suicide rate, wherein suicide was determined solely from clinical data, and suggest that if such clinical data are assiduously acquired, then they are valid metrics sufficient to drive real-time quality improvement.

Our Perfect Depression Care Initiative comprised multiple interventions and as such, we are unable to identify the relative impact of the various individual strategies on our patients' suicide rate. The 82% reduction in suicide rate seen in our patients is considerably larger than that estimated for individual interventions, perhaps suggesting that multiple strategies are contributing to the strong results. Controlled studies are required to elucidate this issue. Still, our findings indicate that the Chasm Report is indeed a viable roadmap for dramatic improvements in healthcare quality, particularly when

> **The Henry Ford "Perfect Depression Care" Initiative has new data confirming that the initiative was associated with a dramatic (82%) and sustained (over 8 years) reduction in suicide within our HMO network patient population.**

coupled with a "just culture" that encourages innovation and aggressive improvement.

Our results also indicate that it is possible to sustain dramatic improvements in suicide rate, in this case over eight years. We believe that such sustainability has been achieved at least in part by leveraging a framework for sustainability, which consist of five components — clear goals, infrastructure, incentives, incremental opportunities for participation, and integration within a larger healthcare quality enterprise. Each of these components, especially integration, have proven crucial in our efforts to spread these improvements in mental healthcare processes to the general medical setting, where our Perfect Depression Care Initiative has resulted in newly identified cases of depression in approximately 15% of adults with chronic general medical conditions.

Henry Ford Initiative Prevents Suicide Attempts

By Jessica Zigmond for Modern Healthcare

For the behavioral health services division at the Henry Ford Health System in Detroit, zero is the perfect number. In the past 10 quarters, zero is the number of patient suicides the department has reported, a result of the Perfect Depression Care initiative that it started in 2001.

Equally notable, or maybe even more so, is that the non-profit health system and HMO didn't employ entirely new strategies to produce those results. Instead, staff members changed the way they thought about what a perfect depression-care program would look like — and refused to accept the idea that patient suicide would be a part of that care model.

The concept used at Henry Ford could serve as a model for rural healthcare providers — whether in hospitals or clinics — because the program relies on a shift in thinking, rather than on costly resources or a surge in clinical staff.

"The bigger issue was this culture change that we eventually implemented which simply did not accept the notion that people would kill themselves, the idea that zero would be our goal," says Ed Coffey, a physician who is vice president at the Henry Ford system and CEO of its behavioral health services division. The division has a staff of about 500 and provides mental health and substance abuse services through its integrated delivery system of two hospitals and 10 clinics that serves Southeast Michigan and adjacent states. "That to me was the biggest thing and the key lever that allowed us to accomplish the success we had," he said.

The Perfect Depression Care initiative began as a demonstration project sponsored by the Robert Wood Johnson Foundation, which granted awards for programs that seek to transform health systems. "The idea was to try to get away from incremental improvement and do something 'breakthrough,' " Coffey said. "It was their idea of pursuing perfection. We were very excited about that; what would 'perfect depression care' look like?"

As Coffey explains, the idea that a perfect depression program meant one without any suicides came from a nurse at Henry Ford who suggested the idea at a meeting. At first, a senior clinician in the room dismissed the idea as "crazy," saying there would be no way to prevent patients from killing themselves if that's what they intended to do, especially because clinicians can't be with patients 24 hours a day, seven days a week.

What must our goal be? If it's not zero, is it eight? Does that include your sister or my mother?

"We came to the conclusion that if someone really wants to do it, we can't stop it," Coffey said. "What must our goal be? If it's not zero, is it eight? Does that include your sister or my mother?" And this goal of "zero defects" need not stay confined to mental healthcare services, but apply to other strategic initiatives within the system, Coffey says.

The Perfect Depression Care initiative includes six major tactics: commit to "perfection" (zero suicides) as a goal; develop a clear vision of how each patient's care will change; listen to patients regarding their care redesign; conceptualize, design and test strategies for improving patient partnership, clinical practice, access to care and information systems; implement relevant measures of care quality, assess progress and adjust as needed; and communicate the results.

Within the first four years of the program, the annual rate of patient suicides in the behavioral health services department dropped 75 percent to about 22 per 100,000 — the average rate between 2002 and 2005 — from 89 suicides per 100,000 at the baseline in 2000, according to an April 2007 article in the *Joint Commission Journal on Quality and Patient Safety*. In the past two years, or the last 10 consecutive quarters, the department has not seen one patient suicide.

The program was recognized by the Joint Commission in 2006 when Henry Ford's behavioral services division won the Ernest Amory Codman Award in the behavioral healthcare category.

"There's nothing unique about the strategies," Coffey said. "Everyone would say they're doing the same thing. We assess the risk and do everything we can do to lessen that risk," he adds. "I do think we have developed some unique tactics that have helped," he says, adding that staff members do not spend much time making distinctions between levels of risk because they accept that any patient will be at risk.

For example, Coffey explains, there is a difference between a patient who needs "emergent" intervention — which describes a scenario in which a patient does not leave the office until a plan is established — and one who requires "urgent" intervention, which is for someone who could be seen the next day. "Even that — making that fine a distinction — is difficult to do as well," Coffey said, adding that the real issue is that everyone is at risk, and often assigning "low risk" can lead to a false sense of security.

With that in mind, staff members try several things at one time to address the problem, which often makes it hard to know which "change" is working.

One intervention the team uses relates to the availability of weapons. Because the majority of suicides results from impulsive acts, it is important to make it harder for patients to act on those impulses, Coffey says. For this, patients are asked about the types of weapons they have access to at home and are asked to check again and then call a staff member. If a staff member from the department does not hear back, he or she will follow up. "It's unbelievable what people find that they didn't report," Coffey said. "Sometimes, they really didn't know."

As Coffey explains, the department leaves the definition of weapon to the patient and family. So, while guns would be included for sure, if there are other potential weapons in the home, patients are encouraged to remove those also.

Staff members within the behavioral-health department at Henry Ford complete a course on suicide risk and prevention and must score 100 percent on the follow-up test or receive additional education, according to the article in *JAMA*.

Adequate training for healthcare professionals is an area that needs to be developed, according to Paula Clayton, medical director at the American Foundation for Suicide Prevention in New York. Clayton's previous experience includes serving as chairman of the psychiatry department at the University of Minnesota. At the foundation, which was established in 1987, she oversees research and education.

"I think you need to train the medical community — the nurses, the secretaries in doctors' offices," she said, adding this is because many people who are depressed seek care from their doctors, especially the elderly, of whom 50 percent have seen their doctor in the same month as their suicide.

Something CAN Be Done
Eliminating Suicide Among People With Serious Mental Illness

Richard T. Clarke, PhD, Chief Executive Officer, Magellan Health Services of Arizona

I magine a world where the pain of your existence is unbearable, where you feel trapped and alone. Your deep depression tells you that you're a burden and that you have only one option — suicide. You consider taking your life not because you want to punish someone, or because you have something to prove, or because you just feel like it, but because you want the pain to stop. And if you're an individual with a serious mental illness, you're six to 12 times more likely to feel this pain.

More than 4 years ago, I was introduced to this reality. As CEO for Magellan Health Services of Arizona, the Regional Behavioral Health Authority for central Arizona, one of my duties is to review adverse incident reports. One weekend as I read the latest report, I felt a shock each time I read the word "suicide." The numbers were high, unexpectedly so, and

> *We need to get it into our heads that suicidal behavior... is preventable and treatable. And once we [do], we need to let it lead our hearts.*
>
> *Thomas Joiner*

by the time I finished the report, I was determined that as a system of care, we would do everything we could to reduce the rate of suicide among those challenged with serious mental illness.

Nationally, most public sector behavioral healthcare systems have relegated suicide prevention to secondary status — as the responsibility of a niche group of crisis intervention specialists. Compounding the problem is the fact that many individuals, including some behavioral health professionals, believe that nothing can be done to prevent many suicides.

Through the guidance of experts such as Dr. Thomas Joiner, author of *Why People Die by Suicide* and Robert O. Lawton Distinguished Professor of Psychology at Florida State University, we now recognize that suicide is preventable. We are convinced that accepting suicides as inevitable represents a gross failure to provide safe, effective, and patient-centered care.

COLLABORATING TO FIGHT SUICIDE

Magellan Health Services of Arizona was determined to make suicide intervention and prevention a part of the core business of state-funded behavioral healthcare. We realized that this was not something we could do alone, and joined with the Arizona Department of Health Services/Division of Behavioral Health Services, our service provider partners, as well as suicide attempt survivors, advocacy groups, legislators, police, the probation department, and

other community partners. Leaders from these organizations formed the steering committee for the Programmatic Suicide Deterrent System project, created a charter, and formed workgroups focused on:

>> Suicide intervention and prevention training for all agency staff

>> Attempted survivor support groups to supplement the care plan for those at risk of suicide

>> Family and natural supports as a primary intervention

>> Standardized approaches to clinical care and intervention

>> Community supports and resources to promote belonging and self-worth

>> Culturally appropriate approaches to engaging individuals

BEHAVIORAL HEALTH PROFESSIONALS GET AN 'ASIST'

More than 1,700 behavioral health workers in the Arizona system took a survey on their comfort level with dealing with suicidal behavior. The results showed that the majority of workers felt they didn't have the knowledge and support to identify and directly help people experiencing suicidal thoughts.

In response to this data, the training workgroup conducted research and selected Applied Suicide Intervention Skills Training (ASIST), a model recognized
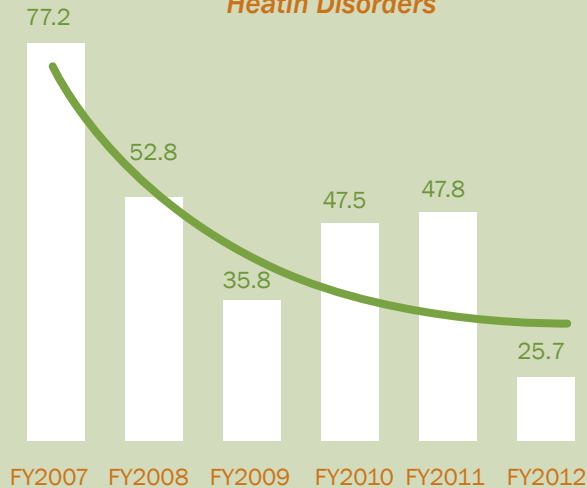
Suicide Rate Per 100,000
Magellan Active Episodes — All Behavioral Heatlh Disorders

77.2 — FY2007
52.8 — FY2008
35.8 — FY2009
47.5 — FY2010
47.8 — FY2011
25.7 — FY2012

Suicide Rate Per 100,000
Magellan Active Episodes — Serious Mental Illness Only

174.8 — FY2007
140.7 — FY2008
82.3 — FY2009
110.9 — FY2010
158.7 — FY2011
101.0 — FY2012
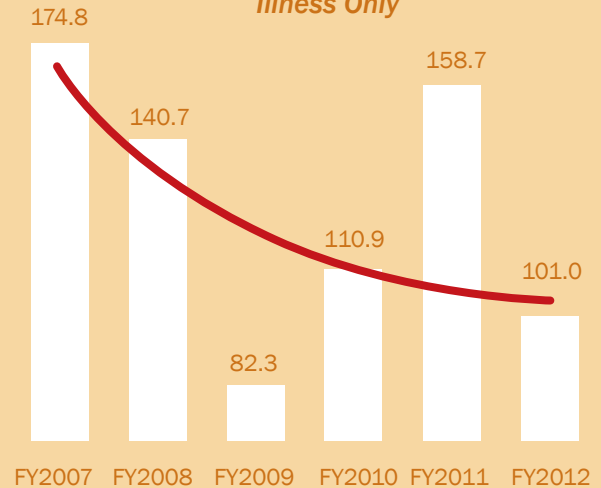
by the Substance Abuse and Mental Health Services Administration as a best practice. Over a year and a half, the largest behavioral health service agencies in central Arizona trained their workforce in ASIST. To date, more than 2,400 provider staff members have completed 2-day ASIST training. Through this training, participants have gained the skills, knowledge, and self-confidence to identify and intervene with those at greatest risk of attempting suicide.

ATTEMPT SURVIVORS GATHER SUPPORT FROM PEERS AND FAMILY

Concurrently with trainings, workgroup leaders developed support groups for those who have survived a suicide attempt or have persistent suicidal thoughts. Launched in 2011, attempt survivor support groups give participants the resources to manage situations when suicidal thoughts occur and to support them in their ongoing recovery. A trained peer in recovery who has previously attempted suicide co-facilitates the group with a licensed clinician.

A workgroup also developed Family Engagement training for service providers in partnership with the National Alliance on Mental Illness. This training is now

a part of employee orientation for all new behavioral health workers in the system. The workgroup also created a Family Engagement packet to help the recipient's "family of choice" better understand the system and effectively support their loved one.

DETERMINING WHO IS AT RISK

In 2011, program leaders began developing a clinical care and intervention model in partnership with the National Action Alliance for Suicide Prevention. The model, which is currently being piloted, focuses on:

>> Screening, assessment, and risk stratification

>> Best practices for intervention

>> Accessibility and follow-up

>> Engagement/education of professionals and recipients

DRIVING SUICIDES TO ZERO

We have seen a 42% reduction in the suicide rate among those with serious mental illnesses and a 67% reduction for the entire behavioral health system of care from 2007 through 2011. We have also achieved a notable reduction in inpatient treatment admissions

by establishing a safety net of well-trained service providers prepared to offer outpatient support in lieu of costly inpatient treatment within self-contained Assertive Community Treatment service-delivery teams. Prior to 2010, the mean monthly rate of ACT team psychiatric hospital admissions was 7.2 admissions per 100 ACT service recipients. Throughout 2010, the mean rate of inpatient admissions declined as staff completed ASIST training. During 2011, that mean rate decreased to 3.5 admissions per 100 ACT service recipients, a 51% reduction.

While we continue to make great strides, we still have much to do. We will pursue ways to integrate individuals into the community, as well as intervene with individuals of different ethnic backgrounds in culturally relevant ways. As the program evolves, we will continue confident in the knowledge that suicides are preventable and that we can — and will — drive suicides to zero.

As chief executive officer for Magellan Health Services of Arizona, Dr. Richard Clarke leads the Magellan team in managing the Regional Behavioral Health Authority contract for central Arizona. He is responsible for the strategic transformation of the system, quality outcomes for recipients, compliance, financial performance, and Magellan's relationships with the Arizona Department of Health Services, the legislature, and the community. Dr. Clarke is committed to delivering superior results through recipient voice and participation, family involvement, a focus on outcomes, community integration of the system of care, culturally appropriate attention to recipient race and equity, and collaborative problem solving with providers.

We have seen a **42% reduction** in the suicide rate among those with serious mental illnesses and a 67% reduction for the entire behavioral health system of care from 2007 through 2011.

Driving Suicides to Zero
New Vistas from the Grand Canyon State

Donald Erickson, MA, Bureau Chief, Adult and Children System of Care, Arizona Department of Health Services; **Karen Chaney,** MD, Adult Medical Director, Magellan Health Services of Arizona; **Gregory Gale,** MD, Vice President of Clinical Services and Chief Medical Officer, Partners in Recovery; **Kent Eller,** MD, Chief Medical Officer, Southwest Network

The seeds that would eventually grow into the Arizona Programmatic Suicide Deterrent System were planted as early as 1999 when an unfunded, grassroots group of concerned people formed a coalition to address Arizona's frighteningly high rates of suicide. By 2001, the Arizona Department of Health Services and its Division of Behavioral Health Services were firmly committed to the coalition's mission and made suicide prevention a health department priority. They created a strategic plan to ensure a sustainable effort throughout the state to reduce the rates of suicide. While this may seem to many an obvious priority of any behavioral health system of care, history suggests that suicide prevention is more frequently addressed as a secondary or even tertiary element of systems of care throughout the United States.

This unfortunate fact is the result of many widely accepted myths as to the nature of suicide, the futility of attempting to prevent suicide, and the belief, even within the behavioral health profession, that only highly trained specialists can effectively engage a suicidal individual.

The state of Arizona created, and implemented a suicide risk assessment in Southern Arizona in 2004. In 2005, the Health Department received its first Garrett Lee Smith grant, which was used in part to fund the initial Applied Suicide Intervention Skills Training (ASIST) and the corresponding train the trainers program. ASIST provides intensive training for caregivers who want or need to feel more comfortable engaging individuals to reduce the likelihood of a suicide attempt. In the year following the full implementation of the Southern Arizona Project, the state's Department of Epidemiology contacted the Division of Behavioral Health to ask if they had any idea why Southern Arizona's suicide rates had declined sharply. It appeared that the project was in fact working.

The success of Arizona's initial strategic plan created a great deal of enthusiasm throughout the state and countered the myth that suicide prevention is ineffective. The fundamental principles developed in those early, seminal projects, including recognition of the indispensable value of a determined and diverse coalition of individuals dedicated to this issue, were fully embraced in the partnership between the Arizona Department of Health Services and Magellan Health Services in the November 2009 creation of the Arizona Programmatic Suicide Deterrent System. It is with great hope and unwavering faith in the power of genuine caring and support for individuals contemplating ending their lives, that we can achieve our goal of zero completed suicides. Acquiescence to anything short of zero is unacceptable.

Targeting all individuals at high risk for suicide is important. Those of us in behavioral health know we must focus on an even higher risk population —those with serious mental illnesses. This population is six to twelve times more likely to commit suicide than the general population. In Central Arizona, we asked ourselves, "What are we going to do about it from a clinical standpoint"?

COLLABORATION

Challenging central Arizona providers with this question brought together a diverse group of roughly 50 professionals representing 20 different provider organizations that serve children, adolescents, and adults with mental illnesses and substance use disorders. The group met weekly to create a strategy to identify suicidal individuals, stratify risk, and apply best practice interventions for specific populations. During the meetings, providers with impressive knowledge of suicide were introduced to a variety of screens and assessments. With our varied populations in mind, the providers began working on an appropriate screen that would ask two to three questions that could single out suicidal ideation and intent. This effort produced three screens — one each for adults, adolescents, and children.

SCREENING AND ASSESSMENT

Collaboration then moved to assessment, which stratified the risk of suicide as acute, moderate, or low. This in turn led to interventions specific to the risk category and population resources. The group designed a map of interventions using

History suggests that suicide prevention is more frequently addressed as a secondary or even tertiary element of systems of care throughout the United States.

resources within clinics, at home, and in the community, while remaining cognizant of interventions available to each population and the fact that these "process maps" were not prescriptive, but that good clinical judgment, creative ideas to keep people engaged, and continual contact were critically important. Each provider and clinic could determine how to do this, meaning this could vary from one clinic or person to another.

The recommendation was to aggressively address those with desire, intent, and capability — that is, to rally the natural supports, identify access to weapons, and intervene with all possible resources prior to consideration of hospitalization. Decreasing hospital admissions when someone is suicidal is a culture change for the behavioral health field, but we do know that identification, stratification of risk, and appropriate interventions based on best practices can reduce hospitalizations and the resulting trauma for the individual.

After collaborative efforts resulted in tools to screen, assess, and intervene, the team developed a manual that focused on the initiative's meaning, while explaining the tools, resources, and related information. The complexity of our system made it necessary to foresee the issues inherent in a diverse system. The manual addresses some of the complexities while reassuring those working with suicidal individuals that zero suicides can be achieved.
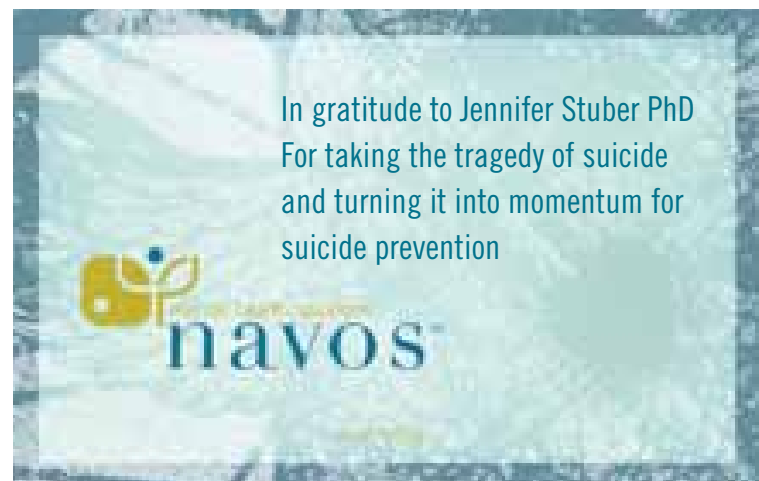
TRAINING

Seven pilot sites were chosen. Training the trainers was the next step. The trainers would be able to train on the tools and interventions and gain experience with the manual and process. It was continuously reiterated that the implementation process would be different for every clinic, even those within the same provider network organization. The intent was not to have the process impede workflow or hamper providers' ability to work with their resources, but rather to determine those who needed intervention rapidly and to utilize the clinics' resources efficiently and effectively while bringing in the natural supports and community resources, when needed, to improving outcomes. While we started with some recommendations, some sites found additional processes that worked better for them. Changes in process were welcomed.

MEASUREMENT

Data was collected in regard to validity and reliability of positive screen scores yielding positive assessments. Data regarding interventions and effects on hospitalization is forthcoming, as the pilot program ended August 31, 2012. The information, suggestions, and creativity that have come out of the pilot sites have been invaluable. Some of the issues and recommended changes have been addressed; others are still pending. Once the information has been incorporated, the initiative will be implemented in phases for the entire provider community after training. We will be better able to anticipate problems, reach for solutions, and encourage the community to actively assist in decreasing suicides.

This initiative demonstrates the importance of a concise screen, an in depth assessment, stratification of risk, and interventions based on best practices, including active follow up. One outcome already realized by this extensive effort that will ultimately touch 80,000 people is evidenced by a system that cares enough to collaborate to drive suicides to zero.

See Driving to Zero case studies on pages 111-112.

Don Erickson worked in behavioral health first as a crisis counselor then as a licensed addiction counselor and finally as a licensed professional counselor. He worked in Montana as a therapist, teacher, and clinical supervisor specializing in co-occurring disorders, suicide prevention, crisis management and program development for 25 years before moving to Arizona. Since moving to Arizona, Erickson has provided clinical supervision, organizational management, program development throughout both the children's and adult's systems of care in Phoenix. He is now the Bureau Chief of Systems of Care for the Arizona Department of Behavioral Health.

Gregory Gale has been a strong advocate, practitioner, and leader in community psychiatry and integrated peer supported behavioral and physical healthcare for the past 15 years. Dr. Gale currently serves as the Vice President of Clinical Services and Chief Medical Officer at Partners in Recovery and is a member of the board of directors at PSA Art Awakenings in Phoenix, Arizona.

Dr. Kent Eller earned his bachelor's degree and attended medical school at Southern Illinois University; then completed his residency at the University of Vermont. Following a 2-year fellowship in consultation-liaison psychiatry at Memorial Sloan Kettering Cancer Center in New York, he moved to Arizona to become the chief psychiatrist and then area medical director for the regional behavioral health authority in Maricopa County. He is now the Chief Medical Officer for Southwest Network.

Dr. Karen Chaney is the Medical Director for Adult Services for Magellan Health Services of Arizona. She has practiced in both the private and public sectors. She served as the Medical Director for two women's programs in Texas specializing in post traumatic stress disorder, and later was the Area Medical Director for the Regional Behavioral Health Authority in Phoenix, Arizona. She is encouraging colleagues to re-examine their approaches to suicide prevention.

Those of us in behavioral health know we must focus on an even higher risk population — persons with serious mental illnesses. This population is **six to twelve times more likely to commit suicide** than the general population.

Driving Suicides to Zero
Partners in Recovery Case Study

We frequently heard that "it is not a matter of if, but when someone will commit suicide on your caseload."

Provider agency staff members across all disciplines including doctors, nurses, and master's level licensed clinicians historically have been trained that suicide was inevitable. During our education and training, we frequently heard that "it is not a matter of if, but when someone will commit suicide on your caseload." We all bought into that philosophical template and accepted it as part of the work we do in behavioral health. Despite scientific advances in medications and other tools, we still struggle with managing someone with suicidal ideation and have not successfully prevented suicides. Although hospitalization has always been a last resort, ultimately it has been ineffective in preventing suicide. As we know, life happens in the community, and it is there that we find the risk factors.

Partners in Recovery launched the Driving Suicides to Zero initiative and embraced the opportunity to utilize new tools and processes to prevent someone from being hospitalized for suicidal thoughts and ultimately from committing suicide. We utilized the basic structure outlined including the screening and assessment tools available to redirect our approach to past perceptions, processes, and interventions when someone presented with risk factors for/or expressed thoughts of suicide.

We developed a person-centered process and protocol to implement this new model, which included screenings and assessments leading to systematic data management. Interventions were focused on more intensive contact with team members, although all available referral and community resources were considered and used based on the individual's preferences and desires. We focused our interventions on more in depth, strengths-based individual relationship building among the key clinical team members who typically included the case manager, psychiatrist, clinical coordinator, nurse, and other team members as necessary. Managing all of this clinical information on almost 250 people required great leadership and organization at the team and campus level. Collecting clinical information was a critical first step followed by the most important second step of interventions.

Everyone screened and assessed to be at risk developed a personalized safety and support plan with support from the clinical team. The plan's key components included the following categories:

>> Warning signs that crisis might be developing

>> Things I can do to take my mind off my problems without contacting others

>> People and social settings that provide distraction

>> People I can ask for help

>> Professionals/agencies I can contact during a crisis

>> Making a safe environment

>> One thing that is most important to "me" and worth living for.

The most common participant responses on "the one thing that is most important to me" included "my children," "my kids," "son," "roommate," "grandchildren," "cat," "my family," "dad", "my future," "friends specifically named," "wife," "mother," "my daughter," "my dog," "my babies," etc. This tells us that relationships with people and pets are important and worth living for. This is a great foundation to use motivational interviewing skills to keep the person hopeful about his/her future and to demonstrate that many people care.

A customized "wallet card" was developed for each participant that included key names and phone numbers of people who are part of his/her safety and support plan. It also includes 24/7 phone numbers for support or crisis lines.

After the initial screening, individuals at risk received a "thinking of you" card signed by each member of their clinical team. The clinical team developed these cards just for this project. This card is sent in addition to the standardized phone call checks and home visits that occurred as part of the interventional protocol practiced. All options were on the table in terms of referrals for services provided by community behavioral health agencies and involvement of natural supports. The most effective intervention seemed to be the increased contact with key team members, particularly the case manager and psychiatrist.

A few participants in the Driving Suicides to Zero initiative were contacted and interviewed to obtain feedback on their experiences with initiative. The most consistent feedback focused on the support from their team members   participants overwhelmingly felt that the team members understood how difficult it was to manage suicidal thoughts recurrently. Most participants interviewed were able to describe the key components of their safety and support plan and appreciated having their own written plan that they could carry with them or post on the refrigerator at home.

A few individuals did not like the protocol, forms, or contact. Each of those situations was carefully reviewed by the psychiatrist and team to determine the best clinical approach regardless of the developed guidelines in the protocol. Interventions and plans were customized to the person's situation and/or requests. The protocols were changed occasionally to meet specific needs. Although a few individuals were challenging to engage, one participant reported that he would never disclose suicidal ideation or triggers. Nonetheless, he did reveal in his

safety and support plan that he would act upon suicidal thoughts if he lost/broke up with his girlfriend. He revealed to his clinical team one day by phone that he split up with his girlfriend, triggering the clinical team to reference his plan to prompt him to put it into action. More importantly, it demonstrated how the participant took the first step to trust his team to say he needed help without actually having to express his thoughts.

Approximately 234 participants received screenings at the East Valley Campus between mid-May and mid- August. Of those, only 31 had a positive screen and thus received a psychiatrist-implemented risk assessment. Those individuals were entered into the protocol for intervention timelines. During this 3 month period, there were NO psychiatric inpatient Level I acute admissions or psychiatric emergency room services at a Level I sub-acute facility.

Although anecdotal, the initial outcomes and overall positive participant satisfaction with the Driving Suicides to Zero initiative does allow for reinforcement that we can change philosophical templates; we can be successful at preventing suicides.

Driving Suicides to Zero
Southwest Networks Case Study

> He reported, "I cannot imagine myself NOT committing suicide, but I have to wait until I can speak with my accountant."

At a well established community mental health clinic, there is a tendency to believe that effective suicide risk assessment is already ingrained in our routine. Unfortunately, our comfort with the old routine has led to an acceptance of suicide's "inevitability" and has permitted more perfunctory risk assessments. Introduction of the Driving Suicides to Zero initiative at Southwest Network enhanced the sensitivity to suicide risk assessment and, consequently, life-saving interventions.

Tom is a 42-year-old Caucasian male who has suffered from chronic mild depression and episodic severe depression since he was 14 years old. He has a strong genetic loading for illness: both his mother and father are diagnosed with depression and his sister and an uncle with schizophrenia.

Tom has received care from our clinic for the past 5 years. He has taken multiple antidepressants with varying degrees of success and is well connected to the clinic's medical and case management staff. He keeps his appointments and takes medication as prescribed. Despite his illness, he remains gainfully employed and has had multiple and varied jobs over the years. The job of which he has been most proud is teaching English as a second language in Japan. He did this for 10 years, returning to the USA 8 years ago.

Tom has chronically expressed suicidal thoughts, which his psychiatrist has documented in virtually every visit. Over the years, "passive suicidal ideation" has been his normal, or baseline, mental status finding and has warranted no further assessment or intervention. In early 2012, Tom was seeing his psychiatrist monthly and was doing fairly well with only mild depression. In May, Tom visited his family out of state. As usual, the visit did not go well. Despite his family's familiarity with mental illness, they are not supportive. Upon his return in June, Tom reported increased depression and the perfunctory mental status exam documented passive suicidal ideation. He was started on an adjunctive medication and told to return in 2 weeks.

By the time Tom came to his next appointment, the Driving Suicides to Zero initiative had started. When Tom entered the clinic he was given a suicide screening questionnaire to complete. He screened "positive" so his psychiatrist performed a full suicide risk assessment. The assessment revealed that Tom was at high risk. We learned that Tom had a plan of suicide "to cut an artery" and that he was "putting his affairs in order" in preparation for his death. He reported, "I cannot imagine myself NOT committing suicide, but I have to wait until I can speak with my accountant."

Tom was immediately assigned a higher level of case management. Medications were rapidly adjusted, and he began weekly visits with his psychiatrist and twice weekly visits with his nurse. His case manager spoke with him by phone or in person daily.

Within a month, Tom's depression began to lift. His suicidal ideation decreased initially to passive suicidal ideation without intent and then to none. His affect returned to full range and he is now future/goal oriented.

In the past month, Tom reconnected with a college friend, a former "frat brother," living in Japan. With his friend's help, Tom has secured another job in Japan and is excited to return to the work that he loves. His team still follows him closely, but now they have the task of helping him arrange mental health services in Japan.

While it is difficult to predict if Tom would have acted upon his strong suicidal ideation, it is clear that a more sensitive and methodical approach identified the risk. A potential crisis was averted, and the outcome clearly justified the additional effort.

They risked life and limb—and mental health—for our country. Now they need our help.

Last year the Veterans Administration (VA) provided services to more than 1.3 million veterans for behavioral issues, including anxiety, post-traumatic stress disorder and depression. And, according to the VA, the demand for these services continues to rise—up 35 percent from 2007 to 2011. What's even more concerning, the suicide rate among active duty soldiers has spiked to almost one suicide per day in the first half of 2012 (U.S. Department of Defense).

A recent RAND study showed that less than half of veterans experiencing mental health issues are getting the help they need. Why? One significant barrier to treatment is the stigma associated with mental illness. Many veterans avoid seeking treatment because of how they feel they will be perceived by loved ones, friends, colleagues and prospective employers.

Veterans, just like others with behavioral health issues, can and do recover and lead productive lives—if they seek help. That's why it's important to reach out to family and friends who are vets. Above all, take the time to educate yourself about mental health issues. If you're a vet who's received help, speak out about your own experiences and encourage your peers to do the same. If you're an employer, consider joining the many companies like Magellan Health Services that are hiring veterans and helping them reintegrate into the community.

Our wounded warriors—those whose injuries are visible as well as hidden—are valuable members of the community, demonstrating dependability, the ability to work as team players and the endurance to triumph over adversity. They've done their duty; now it's time to do ours.

HERO HEALTH ★ HIRE ★ ℠

Companies That Care. Employing Those Who Served.

Our nation's veterans, wounded warriors and military families have made great sacrifices in honor of our country, yet so many remain unemployed when attempting to transition into the civilian workforce.

Hero Health Hire ℠ is a coalition of more than 30 health care companies committed to recruiting, training and supporting these individuals in our workforce. We represent nearly one million employees with work sites in every state, Washington, D.C., Puerto Rico and the U.S. Virgin Islands, and offer programs designed specifically for veterans to help them launch a successful career in health care.

Most importantly, we recognize the value of military experience and skills developed during service. Hiring our veterans and military spouses is good for business *and* good for our communities.

Join us, find careers with our partners, and learn more at HeroHealthHire.com.

MAGELLAN
HEALTH SERVICES

Just One Death is a Failure
The Empire State Takes a Systems Approach to Suicide Prevention

Melanie Puorto Conte, Director, New York State Office of Mental Health, Suicide Prevention Initiative

Although New York has one of the lowest suicide death rates in the U.S., too many persons pass through its health and behavioral healthcare systems and tragically take their lives. Our view is that suicide deaths of persons in care are a system failure. Therefore, as part of its larger Suicide Prevention Initiative, which focuses on preventing suicide across the lifespan and across all communities, New York, led by The New York State Office of Mental Health, developed and is implementing a plan of action to effectively manage suicide risk, eliminate suicide deaths, and reduce suicide attempts by people receiving behavioral healthcare.
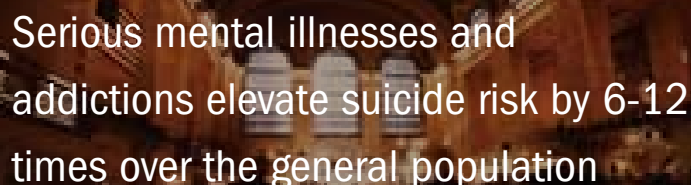
Some may ask why this special focus on people who are receiving behavioral healthcare. First, we know that serious mental illnesses and addictions elevate suicide risk by 6-12 times over the general population's. Second, we must elevate safety as the first responsibility of behavioral health settings. We have learned from many examples that comprehensive suicide care using a systems framework works. The Air Force, Henry Ford Health Service in Michigan, and Magellan Health Services of Arizona have experienced remarkable successes in reducing the number of suicide deaths, suicide attempts, and hospital visits by utilizing a comprehensive care framework.

Our plan is informed by the work of the National Action Alliance for Suicide Prevention. Its Clinical Care Task Force report, Suicide Care in Systems Framework, makes the new point that a systemic approach can comprehensively address suicide risk. The comprehensive framework includes three critical elements:

1. Leadership asserting core organizational values of safety and quality improvement, leading to a commitment that suicide deaths can and will be eliminated for people in care.

2. A management system that structures risk assessment and service protocols to achieve the goal of eliminating suicides.

3. Staff with the knowledge, skills, and confidence to deliver excellent care for patients with suicide risk.

Based on this framework of care, New York has begun employing comprehensive strategies to implement a systems approach in selected communities and systems. Initially, we are focusing on four areas:

>> Taking all needed steps to reduce and hopefully eliminate suicide deaths in four state-operated psychiatric service systems, including both inpatient and outpatient care.

>> Piloting our suicide care model in two county systems: Broome County and St. Lawrence County. In each county, the network will include county leadership, inpatient hospital care, residential providers, and outpatient providers bridging mental health and substance use care.

Serious mental illnesses and addictions elevate suicide risk by 6-12 times over the general population

>> Implementing a comprehensive approach to suicide care with Federated Employed Guidance Services, one of the largest non-profit behavioral healthcare providers in the U.S., which serves New York City and Long Island.

>> Embedding suicide care in four major youth serving organizations across the state. Using federal Garrett Lee Smith Memorial Act funding, OMH has funded each organization to become youth suicide prevention training centers, beginning with their own operational environments and expanding to sister providers within each catchment area.

While New York has made suicide prevention a priority for over a decade, systematizing suicide care reflects an evolution in policy and practice. Our plan comprises a six-point strategy, collectively designed to comprehensively improve suicide care and eliminate suicide deaths in the four aforementioned sites.

We will work with each organization to assist them with setting an organizational vision of zero suicides, leading to "perfect suicide care." This includes helping them raise the level of staff support, and, with the assistance of Magellan Health Services, surveying staff on their knowledge and readiness for providing effective suicide care. Program performance in suicide care will be measured continuously and transparently in a quality improvement environment.

Each organization will receive assistance with creating management practices to achieve the vision of effective suicide care. This includes empowering clinicians to work with patients productively and as a team. It means each organization will create an expectation that suicide care is a shared responsibility delivered through team-based care. Suicide will be treated directly, not as a symptom of underlying mental health and/or substance use disorders. And, suicide care protocols will be incorporated within policies and procedures.

All patients will be screened for suicide risk. Positive screens will lead to specific suicide risk assessments that will trigger appropriate service responses in treatment plans. Staff will be trained in the Columbia Suicide Severity Rating Scale (C-SSRS), an evidence-based screening tool with robust predictive validity for future suicide attempts. Training for staff on C-SSRS will be provided by one of the instrument's developers.

Each patient with identified suicide risk will have a safety plan developed at intake and reviewed regularly. Using the model developed by Drs. Barbara Stanley at Columbia University and Greg Brown with the University of Pennsylvania, staff will receive training on how to develop and effectively use the safety plan. At the same time, OMH is working with Rennssalaer Polytechnic Institute to develop a telephone application safety plan that will allow patients that possess certain cellular phones to have their safety plan on their phones.

Clinical staff will be offered the opportunity to upgrade clinical skills, specifically in cognitive behavioral therapy, an evidence-based treatment modality for managing and treating suicide risk.

Staff will also be trained on appropriate follow-up protocols, including the critical importance of "warm handoffs" for patients with suicide risk — especially from in-patient to outpatient care. New York will also ensure that staff know the community and other resources available for patients with suicide risk, including the National Lifeline and crisis centers.

In addition to the targeted training activities described above, OMH will institutionalize educational opportunities through the development of online learning modules. To be developed in collaboration with Columbia and the New York State Psychiatric Institute, the first two modules (to be completed later this year) will address C-SSRS and safety planning. In early 2013, a third module will focus on follow-up after acute/emergency department care and "warm handoffs." New York will make these modules available nationally through the Suicide Prevention Resource Center

Many of the 1,500 persons who die by suicide each year in New York are not engaged in behavioral healthcare. We must also work to improve basic behavioral healthcare in primary care settings. Therefore, we are working with the New York State Department of Health to implement "collaborative care" in dozens of primary care settings. To reach additional persons at risk, we know expansion of specific suicide prevention competencies will be required in primary care and emergency departments. Yet, we believe that implementing the comprehensive suicide care framework described above in our behavioral health organizations will lead to safer, more effective care, and we believe it is our responsibility to start close to home. In turn, we expect to see fewer lives lost to suicide in New York.

Ms. Puorto Conte is the Director of Suicide Prevention Initiative for the New York State Office of Mental Health in Albany. She has statewide responsibility for planning, funding, and implementing a wide array of suicide prevention, intervention, postvention, and gatekeeper activities throughout the state. She is also an active member of the Statewide Veterans' and Families Advisory Work Group. Mrs. Puorto Conte is the Principal Investigator for New York's SAMHSA Garrett Lee Smith Youth Suicide Prevention grant and an adjunct professor at the Sage Graduate School's Forensic Mental Health program where she teaches a program in Suicide Prevention, Intervention, and Postvention to graduate students in Community Psychology, Forensic Mental Health, and Education.

Bluegrass State Says "Never" to Suicide

Jan Ulrich, State Suicide Prevention Coordinator, Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities

Suicide as a "never event" — as State Suicide Prevention Coordinator for the Commonwealth of Kentucky, this promising, yet daunting phrase completely captured my attention the first time I read it in the groundbreaking report "Suicide Care in Systems Framework" created by the Clinical Care and Intervention Task Force and presented to the National Action Alliance for Suicide Prevention Executive Committee.

The report focused on programs that have received attention for novel approaches and positive outcomes around suicide prevention: Air Force Suicide Prevention Program, Henry Ford Health System's "Perfect Depression Care"; National Suicide Prevention Lifeline "Suicide Risk Assessment Standards;" and Central Arizona Programmatic Suicide Deterrent System Project. Each of these initiatives has astounding successes in their reduction of suicide attempts and deaths and costs associated with unnecessary hospital and emergency department care. The Task Force found the following three critical factors common to all that lead to their successes:

>> **Core Values** — The belief and commitment that suicide can be eliminated in a population under care (boundaried population) by improving service access and quality and through continuous improvement (rendering suicide a "never event" for these populations);

>> **Systems Management** — Taking systematic steps across systems of care to create a culture that no longer finds suicide acceptable, set aggressive but achievable goals to eliminate suicide attempts and deaths among members, and organize service delivery and support accordingly; and

>> **Evidence-Based Clinical Care Practice** — Delivered through the system of care a focus on productive patient/staff interactions. These methods (e.g., standardized risk stratification, targeted evidence-based clinical interventions, accessibility, follow-up and engagement and education of patients, families, and healthcare professionals) achieve results.

I've worked in suicide prevention on the local, state, and national levels for a decade, following the loss

> All of our middle and high school certified staff are now required to have 2 hours of suicide prevention training annually, and all of middle and high school students have to receive some form of suicide prevention awareness materials or program each year.

of my 20-year-old son to suicide. In 2002, U.S. Surgeon General David Satcher proclaimed suicide to be a preventable public health problem. Like many states, Kentucky adopted this notion as part of its suicide prevention mission and vision.

But did we really believe it? Maybe some suicides are preventable, but surely we can't be talking about suicide prevention amongst those at highest risk, those with a diagnosis of severe mental illness?

In Kentucky, we have put a lot of money, time, and effort over the last 10 years toward suicide prevention gatekeeper training, educating our citizens on warning signs, behavioral and situational clues, how to ask a friend or a loved one if they are thinking about suicide, persuade them to get help, and help them connect with the proper resources to save their lives.

But what if the resources to which we refer people in crisis — our behavioral health providers and organizations — aren't required to have any suicide prevention training in suicide risk, assessment, or treatment? Washington State is the only state that requires behavioral health professionals to have any suicide prevention training. What if the prevailing national philosophy in mental health and substance abuse treatment is that suicide is not preventable — perhaps even an expected outcome of those at high risk who are referred to treatment?

Like almost every state in the nation, Kentucky's behavioral health resources are stretched. Yet, we have taken some bold steps in recent years to reduce suicide, particularly among our adolescents. Following a number of high profile youth suicides between 2006 and 2009, in 2010 the Kentucky legislature was one of the first states to pass two laws around school-based suicide prevention. All of our middle and high school certified staff are now required to have 2 hours of suicide prevention training annually,

and all of middle and high school students have to receive some form of suicide prevention awareness materials or program each year. Kentucky was one of the first states to mandate this type of education and awareness for both staff and students.

Kentucky is poised to take another bold step. This fall, partnering with David Covington of the Clinical Care and Intervention Task Force of the National Action Alliance, Kentucky behavioral health providers will participate in a Behavioral Health Workforce Survey. This anonymous survey asks about attitudes, knowledge, skills and support around suicide and prevention. Arizona, Georgia, and Texas have also participated in this study, and the results will be used to inform task force recommendations around improving clinical care and intervention for suicide.

Kentucky hopes to use these survey results to become a state that sees suicide as truly preventable. We are organizing a team to examine how we incorporate strategies to promote suicide as a "never event" within our state health and behavioral health organizations as part of our updated state suicide prevention plan. We are looking at evidence-based and best practices to reduce self-harm and suicide. We recognize that this will take partnerships among public (including primary care, general medical care, emergency services, and medical-surgical care) and behavioral health systems in order to create the change and synergy to make suicide in the Commonwealth of Kentucky a "never event."

Jan Ulrich works for the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities. She is the state suicide prevention coordinator for the Commonwealth of Kentucky with a decade of experience in the field. Ulrich's background is in social marketing, training and awareness. She has been passionate about using these skills to bring social change to the issue of suicide prevention since the loss of her son Nathan to suicide in 2002.

Failure Equals Success
CW Tillman

Failure equals success. This seems counterintuitive to most, but my determination to live after multiple suicide attempts has contributed to my success.

Looking back on my life and my experiences I struggled with depression as early as middle school. By my sophomore year, I made a conscious decision that life wasn't worth living. I wrote a note, leaving it on my desk as I excused myself to go to the restroom. I sat in the window of the bathroom, four stories above the ground and prepared to jump. A classmate came into the bathroom and upon realizing what was happening he exited quickly. My teacher came in, talking to me calmly, convincing me to come down off the ledge. Another student escorted me to the counselor's office. The counselor visited with me for about 30 minutes. As the bell rang for lunch she looked at me and said "you better get to lunch now." The remainder of my day was spent going to class.

After school I walked home as usual and my parents were both home. They sat me down and talked to me for about an hour, though there wasn't much said. They told me they cared about me and didn't want anything to happen to me. This was the last time this incident was discussed. There was no follow-up from the counselor at school or anything that my parents set up.

Years later, when I was suicidal again, I faced the same stigma and lack of resources. Paramedics that I summoned to my home said to me "If we take you anywhere, it could ruin your job and your career. What else can we do? Is there someone else we can call, maybe your pastor?" My pastor came out to my house late that night and helped counsel me. My primary care doctor prescribed some medication for the anxiety that I was experiencing, but I had severe side effects from the medication. A month later I overdosed on that medication and had the first of several hospitalizations to help with depression and suicidal thoughts.

Involvement with groups such as NAMI, Depression and Bipolar Support Alliance, SPAN-USA and now the American Association of Suicidology has given me the knowledge and skills to effectively manage my depression and suicidal thoughts. By knowing that there are services available that I can reach out to at any time – especially our National Suicide Prevention Lifeline – my life has become better.

Even on my best days there might be a fleeting thought of suicide, but that doesn't mean that I will act on it – or even that I will remember it on my darkest days.

The stigma around mental health conditions and suicide gives me pause about sharing my story and speaking out. I have to remind myself is that if sharing my struggle gives one other person the courage to reach out for help and if it saves lives, then it is worth whatever consequences society imposes for me.

Help is available – you simply have to ask for it!

CW Tillman is a student earning dual degrees in American Sign Language Interpreting and Deaf Studies. He works as a job mentor to Deaf individuals and helps to provide access to healthcare to the Deaf and hard-of-hearing community in northern Virginia. He is an advocate within the mental health and suicide prevention community.

Lone Star State Engages the Public in Suicide Prevention

Jenna Heise, MA, NCC, BC-DMT, State Suicide Prevention Coordinator, Texas Department of State Health Services

Based on an interview with Heather Cobb for National Council Magazine

As the legislatively mandated state suicide prevention coordination within the Texas Department of State Health Services, I oversee the work of the local mental health authorities, including the 39 local community behavioral health centers across the state, providing provide policy oversight, programmatic support, and financial support. Each of these centers employs a suicide prevention gatekeeper who is key to ensuring the centers have suicide prevention policies and postvention protocols.

We have and continue to do a great deal of population-based outreach. We have a website hosted through TexasSuicidePrevention.org; we publish English and Spanish suicide prevention and mental health awareness brochures; we have developed a free suicide prevention training akin to QPR; and we developed the first app to go with that training — the first Smartphone app in the world on suicide prevention.

We also developed the online training for high school teachers using gaming technology — it's a one-hour course where they log on at their convenience and go at their own pace through a guided session in which three students have mental health issues, one of which is suicidal thinking, to learn how to discuss suicide and mental health issues. This is the first training using online gaming technology for U.S. high school teachers related to suicide, and we are nearly prepared to release a middle school version, an anticipated resource since there are so few resources and trainings for middle school teachers on suicide prevention.

We are also developing an app for students, called the Virtual Hope Box, where kids can store things that make them feel hopeful and good, like poetry or music. When they start feeling down, they can access it all in one place, at any time.

In addition to our population-based outreach, we are also engaged in systems change — especially since the National Action Alliance for Suicide Prevention's Clinical Care Task Force's groundbreaking report came out last fall. The report points out that people with serious mental illness are 6-12 times likely to die of suicide. Of the people that are dying by suicide, the research now shows that 90% have an underlying mental health or substance abuse issue, either treated or undertreated. That is a nail that we could hang our hats on. These are the people we need to focus on.

The Clinical Care and Interventions Task Force outlined the kinds of changes we need in our healthcare system to eliminate suicides. Our population-based work is impactful, but this report gives us a chance to promulgate these strategies and initiatives through the entire behavioral health system. The Zero Suicide philosophy has become our goal for the entire Texas system.

With this report as our beacon, we are creating transformational change through changing or reinforcing positive cooperation around suicide care. We have the leadership buy-in we need, which is a real paradigm shift.

Our healthcare system by and large has failed the suicidal person. We traditionally assume someone who is suicidal needs to be hospitalized. Research now shows that a person who has made suicide attempts is most at risk of dying by suicide in the immediate days following discharge from the emergency department. The Clinical Care Taskforce Report outlined strategies to address this.

Staff needs to be filled and trained, they need to be confident to intervene once someone is suicidal, and they need to have a sustainable best practice or evidence-based training program in place to ensure all staff speak the same language. We much create an environment that accepts that suicide is everyone's business, everyone's problem. It's an issue for the entire agency — everybody from the van driver to the receptionist, to the clinical team. With the training, the models, the tools, and the agency's support, staff can better meet the needs of individuals at risk of suicide.

We are operationalizing evidence-based trainings and procedures. We follow the person through the evidence-based clinical services they receive. When a person is discharged from a hospital, we focus on proper follow-up. The research shows that people feel safer when receive follow up through texts, phone calls, or postcards — when they know the clinician and the agency cares.

With prior permission, We are creating guidelines for a designation that will become a gold standard in Texas, calling certain centers Suicide Safe Care Centers. They will be able to apply and receive this designation next to their name, like a badge of honor showing that they went through all the trainings and changes to meet the guidelines. This will require some time and financial commitment by the centers, but their suicide attempt rate and complete rates will go down and hospital emergency department and admission utilization will go down. Not only would you be recognized as a suicide safe care site, but ultimately there's a cost savings — better skilled staff, and less staff burnout.

Following what the Clinical Care Taskforce uses to measure the workforce's skills, we have begun pre- and post-testing to ensure staff is confident in intervening with suicidal patients. The tests asks questions to assess knowledge, as well as value-based questions about comfort in openly discussing suicide with patients and whether they believe suicides can be prevented. It only takes participants about 5 minutes to answer. It serves as a needs assessment and is important to any large-scale change. Soon, we hope to have a baseline; we already have received 4,000 surveys back, which is significant.

To have a well thought out system strategy, to implement it and support it, we do national speaking engagements through webinars and conferences, share multimedia information, resources, and tools through www.texassuicideprevention.org, and we talk with centers and stakeholders on the local level to ensure proper implementation and engagement.

Jenna Heise, MA, NCC, BC-DMT, is the Suicide Prevention Coordinator for the Texas Department of State Health Services. Ms. Heise has worked as a therapist, counselor, educator and trainer at public and private mental health facilities in Philadelphia and Austin. As Suicide Prevention Coordinator she provides oversight to suicide prevention programs, serves as a consultant, analyzes policy issues, and works with local and hospital suicide prevention coordinators and the Texas Suicide Prevention Council.

OPTUM™

Building a Culture of Acceptance, Engagement, and Safety to Prevent Suicide

The Institute of Medicine's Crossing the Quality Chasm report has indicated that one of the key elements for a new health system is providing care that is person-centered and safe (IOM, 1999). In medical care this is the remediation of medical errors and a continuously improving quality based culture, which promotes safety. For those with mental and substance use conditions a culture of safety must also address the fundamental issues of suicide prevention.

Suicide is a major public health crisis and must be addressed across all levels of the healthcare system. Optum is committed to building communities that support acceptance and engagement of those with mental and substance abuse conditions. In addition we are committed to providing a full continuum of resources for those we serve. Suicide prevention requires a broad based approach that is continuously available to meet the challenges and needs of those we serve.

Optum is committed to empowering communities, families and friends to foster suicide prevention. Investing and engaging with communities supports a culture that can promote wellness, resiliency, and recovery. Optum has actively committed to working with our members and community-based organizations to create an environment that is aware of the risks and challenges for those who live with mental health and substance use conditions. This includes educating community resources and first responders to better understand the challenges faced by individuals living with mental health and substance use conditions, and promoting a culture of acceptance and safety.

One example of this approach to safety is teaching members of a community the Question, Persuade, and Refer (QPR) model of suicide prevention (see: http://www.qprinstitute.com). This helps to improve the quality of life in the community for our members, and create a recovery-focused culture. When people are trained in the QPR methods of prevention, they learn how to identify and recognize the warning signs of when someone is experiencing a suicide crisis, and how to question, persuade, and refer that person to help. QPR has been successfully used by Optum as a tool to recognize and help individuals at risk for suicidal behavior and actions, and build the necessary supports in their families and communities.

In San Diego, California, Optum has developed a pilot program and partnered with community resources to offer free and open access training for schools, teachers, first responders and other service providers, family members and friends in the community on how to recognize and refer persons who are showing suicidal warning signs. Optum has been able to use the QPR approach to suicide prevention and build a culture that promotes acceptance and safety for our members. Not only do these programs offer hope and save lives, they bring heightened awareness and help reduce the stigma associated with mental illness.

> QPR has been successfully used by Optum as a tool to recognize and help individuals at risk for suicidal behavior and actions, and build the necessary supports in their families and communities.

Optum also promotes the use of suicide hotlines and other resources for our members in educational materials. This includes the suicide prevention hotlines 1-800-237-TALK and the Spanish Language Line 1-888-628-9454. In addition, Optum provides tele-interpreters in our crisis centers that support translation services in over 150 languages. Being available to support a life threatening suicide crisis requires not only 24/7 availability, but also a responsiveness to the needs of the individual and their family.

Recognizing that there are multiple preferences, needs, and approaches to reaching out for help, Optum also makes specialty resources available to our members. For those who prefer to chat online rather than use the phone, we also provide educational referral information for these services. Specialty referral services for youth, military, veterans and other populations are available through the Suicide Prevention Lifeline (see: www.suicidepreventionlifeline.org).

Health Workers as Gatekeepers: Why Training Trumps

April R. Smith, PhD, Assistant Professor, Department of Psychology, Miami University

> Knowledge about suicidal behavior and its assessment and treatment, even among healthcare professionals, has tended to lag behind related research in the field.

In the United States alone someone dies by suicide every 15 minutes. This translates to approximately 101 deaths per day and over 36,000 deaths per year as of 2009. This is more than twice the number of deaths by homicide, making suicide the 10th leading cause of death in the United States. One of the most effective ways to combat serious public health problems, like suicide, is to increase knowledge about risk factors, assessment procedures, and treatment options.

Despite the importance of having health workers well trained on suicide best practices and the Surgeon General's call to action, knowledge about suicidal behavior and its assessment and treatment, even among healthcare professionals, has tended to lag behind related research in the field. Gaps between research and practice may relate to lack of appropriate training.

Recent attempts have been made to improve access to suicide training by offering suicide training programs such as Applied Suicide Intervention Skills Training (ASIST), Question, Persuade, and Refer (QPR), and online suicide prevention programs to healthcare workers. These types of training programs are commonly referred to as gatekeeper training, as they are geared toward people who are likely to have contact with individuals at risk for suicide. Gatekeeper training programs teach trainees to identify risk factors for suicide and aim to increase trainees' knowledge about suicidal behavior and improve skills related to management of suicidal individuals.

A naturalistic and uncontrolled group comparison study of two large groups of community health workers was conducted by having participants complete a brief online survey that assessed suicide related knowledge, as well as confidence in training, skills, and support. One aim of the studies was to examine skilled workers' understanding of suicidal behavior.

Overall, respondents were well attuned to some common misunderstandings about suicidal behavior, but not others. For example, the majority of respondents (82-93%) demonstrated that they knew that an entrenched myth, "Talking about suicide may inadvertently give the person permission to seriously consider it," is just that — a myth. Moreover, approximately 80% of participants understood that suicidal behavior is often predictable, despite the common misunderstanding that many suicides are enacted "on a whim."

However, about half of the respondents incorrectly answered questions pertaining to suicide rates. Specifically, many participants did not know that adults 65 and older are at a greater risk for suicide than adolescents and young adults. Over two-thirds of participants were not aware of the extremely high rate of suicide in people with severe mental illness compared to the general population, and over half of respondents endorsed a common misperception that individuals with borderline personality disorder frequently gesture, but do not really intend to kill themselves.

An additional aim of the study was to evaluate various types of gatekeeper training. Both ASIST and QPR training were associated with higher suicide-related knowledge and confidence in participants' training, skills, and support. Across the two studies, physicians and clinicians tended to score the highest on the questions pertaining to both skills and knowledge. Given this, it may be important to capitalize on medical and clinical leadership in designing and implementing training programs. Further, although there was not a significant interaction between professional group and training type on suicide knowledge, ASIST, QPR, and online training was associated with higher confidence in skills for certain groups such as case managers. Given that many health professionals report significant fears and anxieties regarding working with suicidal individuals, feeling confident in one's skills could be important in increasing case managers' engagement with suicidal clients.

It appears that overall skilled workers are knowledgeable about suicidal behavior, but that there are some specific gaps in their knowledge such as the rates of suicide in special populations. It may be useful for training programs to include a section on at risk populations, which include the elderly, those with serious mental illnesses, and those with borderline personality disorder. Further, it may be helpful for CEOs of community behavioral healthcare providers to assess staff regularly on general knowledge and confidence with regard to suicide, and to make available various training resources to employees who feel lacking in confidence.

Aside from formal training, agency leaders could provide staff with access to current research on suicide risk factors, structured suicide assessments, and prevention strategies. Similarly, it could be useful for company leaders to provide staff with clear protocols, based on research, for dealing with imminent suicide risk. Additionally, easily accessible resources could be provided to at risk clients (e.g., list of therapists, intervention programs in the community specifically geared toward suicidal clients in the community, hotlines). Implementation of these suggestions would help to further answer the Surgeon General's call to action to prevent suicide by broadening awareness of suicide and its risk factors.

Dr. April Smith is the Assistant Professor of Psychology at Miami University. Her research explores the high rates of suicidality and self-injury among individuals with eating disorders. She conducted the first study to examine the influence of genetics and environment on the factors on Joiner's (2005) theory of suicide. She also collaborated on a series of studies that investigated stigma against suicidal individuals (Witte, Smith, & Joiner, 2010). Another set of studies (Smith, et al., 2012) explored mental health care workers' knowledge about suicide and their confidence in their own training, skills, and support. Dr. Smith's research was awarded a pre-doctoral National Research Service Award from the National Institute of Mental Health.

Running to Pole 69
Eduardo Vega

Exercise is crucial medicine for me — training over many years in yoga, martial arts, and running has saved me from the worst effects of the recurring depression that has been part of my life since childhood. Whenever possible, on Tuesday mornings before work, I run to the center of the Golden Gate bridge — the epicenter of world suicide. More people have died by suicide off the Golden Gate Bridge at Pole 69 than at any other single place in the world.

As I run on the bridge, I think about the people who come here in despair, people who feel that death is the best way, or maybe the only way, to wrest power, dignity, or simply relief from a life that seems unendurable. People in a place similar to where I once was.

You get accustomed to it of course but the beauty of the bridge can still strike you on a given day. The dramatic rise of the red towers through shawls of fog, the infinite vista of ocean, the impressive detachment from land and city.

You can see why one would want to leave the world from this place. The promise of a simple quiet solution so readily at hand, the soft wheeling of gulls below you, and dark expansive waters. Who wouldn't want to disappear on a clear day into the huge peace of the ocean below? Or, on one of our many foggy mornings, who wouldn't want to be lost in an oblivion of cool cuddling clouds?

When I get to Pole 69, I spend a quiet moment. I look at the water and feel the rails and try to connect with the many people who have come here seeking a resolution, however tragic, to their sense of utter desolation. I think about the four friends I lost to suicide, or the parents, brothers, and sisters I've known whose lives were devastated in the wake of such deaths.

Sometimes I reflect on my own suicidal moments and attempts. The seemingly endless months where I felt far from hope and comfort, the years in which I yearned daily for death.

I think of the times I took action, the fleeting feeling that I was no longer a victim, that in planning to die I finally had taken the power away from my pain.

On most days, from the center of the bridge, you see Alcatraz Island very clearly. It reminds me of how many people see being identified as mentally ill as worse than being a criminal, and some see it as worse than death. For some people, the first time they go through the doors of a locked psychiatric facility, their sense of self is forever altered. For people who struggle and are hospitalized repeatedly, the undermining messages, the daily challenges to personal dignity, and the sustained cuts at hope can be intensely magnified.

People like me who advocate for mental health services sometimes lose perspective on how powerfully such things as hospitalization can affect those on the receiving end. On how, ironically, one's conception of oneself may be shaken, weakened, even permanently damaged by something designed to support it.

In the United States alone there is a suicide every 15 minutes. So as I stand on the bridge I know that somewhere in the world someone is sitting as I once did with a gun in one hand and a phone in the other. Someone, somewhere, right now, is asking themselves "What is worse — to be a mental patient or to die?"

If we want to reduce death by suicide we have to combat stigma, silence, and shame associated with both suicide and mental health conditions. We need to do this on every front — public policy, the media, and the community. But we must start with ourselves, with our own conceptions and ingrained expectations, with the beliefs that allow us to lower our expectations and hopes for people who receive mental illness diagnoses and treatments. To free our society from the tragedies of suicide, we must make personal dignity more powerful than symptoms or disability, we must foster communities that believe in and support their people. I believe we can make this evolution happen.

The course back from the bridge is tougher. A large part of it is uphill and not too pleasant. Some mornings it can be hard to keep going, even to put one foot in front of another.

I suffer much less now from symptoms of mental illness. But there are still days when getting up, going to work, talking, or even walking down the street can feel unendurable. There are moments, sometimes weeks, when everything real retreats into bleak grey clouds and I feel crushed under a paralyzing weight. Sometimes in those moments, the desire to die returns — a specter of deliverance, emerging like a boat out of the fog.

That's a boat I know well. I also know that it takes me nowhere, that it will help no one. There's just too much work to be done. It is this work I so often come back to on these little journeys.

If we were successful in eliminating stigma, people would not be dying at Pole 69 because we would be able to prevent mental health conditions from becoming debilitating illnesses, we would have the right kind of support from those who know that dignity is more important than medication, that hope is more powerful than pain.

As a consumer of services, an attempt survivor, a provider, and a mental health advocate for over 20 years, I am convinced that preventing death by suicide is crucial and possible. It will require many minds, many hearts, and many hands. As we move forward, I'll take your positive thoughts and good energy with me on the road to Pole 69, where we can all make a difference together.

Eduardo Vega, MA, is the Executive Director of the Mental Health Association of San Francisco and a California Mental Health Services Oversight and Accountability Commissioner. In addition to holding a seat on the Executive Committee of the National Action Alliance for Suicide Prevention, he leads the task force on suicide attempt survivors and is a member of the Steering Committee of the National Suicide Prevention Lifeline.

Training or Tragedy: The Choice is Clear

Paul Quinnett, PhD, President and CEO, The QPR Institute, Inc.

Eighteen of our veterans will take their own lives today. So will someone's daughter, a brother, a co-worker and far too many working men and grandfathers. According the Centers for Disease Control and Prevention, in just one day, more than 101 of our fellow Americans will die by suicide. Too many of these loved ones will have been in the care of mental health professional, but most of them will never have had a single counseling session with a trained professional that might have saved their lives.

WHO DIES BY SUICIDE?

According to the NIMH, over 90% of Americans who die by suicide suffer from a treatable mental illness and/or substance disorder. Suicide is at once preventable and treatment is effective. For the majority of suicide victims, timely, accessible, competent assessment, treatment, and risk management could prevent their deaths.

And yet far too many mental health professionals lack specific training in the detection, assessment, treatment, and management of those at elevated risk of suicide. A task force of the American Association of Suicidology recently published a white paper entitled, *Preventing Suicide through Improved Training in Suicide Risk Assessment and Care: An American Association of Suicidology Task Force Report Addressing Serious Gaps in U.S. Mental Health Training.* This report exposes a persistent, systemic problem with the training and education of mental health professionals in suicide prevention.

With few exceptions, training programs, educators, and healthcare organizations have yet to embrace, implement, and follow the National Strategy for Suicide Prevention 2001 and the Institute of Medicine 2002 recommendations to improve suicidal patient safety through competency-based education and training.

Consider just one of thousands of stories, from Sherry Bryant:

"My son died by suicide in 1993 and in the process of suing the hospital and the doctor, the last professional to see my son for therapy was a PhD in Psychology. When this person was deposed, he reported that he never asked my son if he was suicidal [Todd was two days post discharge from a suicide attempt] and said that "He was a bright young adult, if he was suicidal, he would have told me." Two days later, Todd hung himself. I won the case out of court without going to a jury!"

WHAT IS NEEDED?

Education and training of an entire workforce is needed. Research shows that not only do healthcare providers benefit from continuing education courses, but that such training also improves their clinical practice. Several recent publications show that competency-based suicide prevention training leads to clinician reports of greater confidence and comfort in the assessment and management of their at-risk clients. It is expected that improved knowledge, skills, and practice competencies will save lives.

But this remains an assumption. And yet, the state of Washington is funding research to answer this very important question, as it was raised by a number of groups in objection to a new law mandating suicide prevention education for certain health professionals.

Until this year, no state required mental health professionals to show evidence of training in suicide assessment, treatment, and management. If these skills were needed, they were assumed to have been acquired in graduate school, internships, residencies, or on the job. But as multiple reports have shown, they were not.

Suicide prevention is here and expectations are rising quickly. Following the high profile suicide of a Seattle attorney while in the care of two mental health professionals in 2011, stakeholders gathered to explore the systemic problem of inadequate training among behavioral health specialists. In very short order, a bill was drafted, expert testimony delivered to relevant house and senate health committees, and the Washington State legislature overwhelmingly passed the "2012 House Bill 2366:
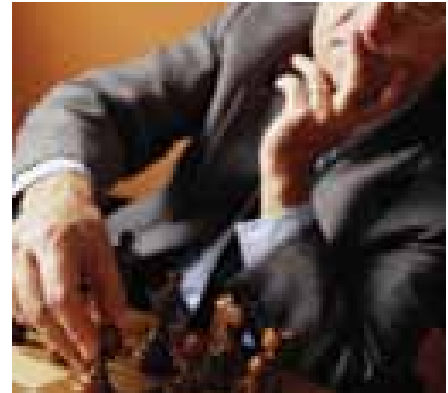
> Far too many mental health professionals lack specific training in the detection, assessment, treatment, and management of those at elevated risk of suicide.

Requiring certain health professionals to complete education in suicide assessment, treatment and management." The bill requires all mental health providers to complete no fewer than six hours of relevant training in each license cycle. (A full report on this bill can be found at http://www.washington-votes.org/2012-HB-2366.)

A MATTER OF PUBLIC TRUST

The public believes their suicidal loved ones are safe once they are seen at a hospital emergency room, or admitted to an inpatient psychiatric unit, seen in a mental health center, counseling agency, or a mental health professional private practice.

Sadly, the public is misinformed.

While specialists exist and many senior mental health professionals are experts at working with suicidal people, to date and by adherence to training standards, only psychiatry residencies focus on this

area of practice. Exceptions exist, but from a national perspective, the vast majority of the mental health workforce is not adequately trained.

Of even more importance, popular citizen-focused gatekeeper training programs (ASIST, QPR, Mental Health First Aid and others) are training thousands of people each month in how to recognize the warning signs of suicide and take their suicidal family members, co-workers, fellow students, and others to mental health professionals, agencies, and community behavioral health organizations.

According to surveys conducted by the Suicide Prevention Action Network, the majority of Americans support suicide prevention and now believe what our former Surgeon General of the United States said in 2001, "Suicide is our most preventable form of death."

The race, now, is between education and tragedy. Every day we delay to implement training, additional lives are lost.

A clinical psychologist and trainer for more than 35 years, Dr. Quinnett developed and managed a suicide prevention hotline, an emergency services department, and a dozen mental health service delivery programs. He has authored seven books, many professional articles and book chapters. He was Director of Training for the Spokane Mental Health APA-approved psychology internship program for more than 20 years and has served on board of the American Association of Suicidology. He was a founding board member of The Kristin Brooks Hope Center (1-800-SUI-CIDE), and The Suicide Prevention Action Network. He serves as Clinical Assistant Professor in the Department of Psychiatry and Behavioral Science at the University of Washington School of Medicine. To help prevent suicide, he donated the French and English electronic editions of his bestseller, Suicide: the Forever Decision to the world in 2005 via the World Wide Web.

Gaps in Suicide Training

"The lack of training available in the institutions that prepare mental health professionals has been documented for decades. Multiple studies have found that only approximately half of psychological trainees had received didactic training on suicide during their graduate education, and the training provided was often very limited (Dexter- Mazza & Freeman, 2003; Kleespies et al.,1993).

It is critical to note that didactic training is not necessarily synonymous with effectively building the skills needed to conduct adequate suicide risk assessments and treat suicidal patients. Providing information to trainees is necessary but not sufficient as trainees must also be given opportunities to translate this information into competent practice by assessing and treating suicidal patients with proper supervision.

Nearly 76% of responding directors of graduate programs in psychology indicated that they wanted to include more suicide-specific training in their programs, but encountered a variety of barriers to doing so (Jahn et al., 2012).

Training has been similarly sporadic in social work education programs. Less than 25% of a national sample of social workers reported receiving any training in suicide prevention, with a majority of the respondents reporting that their training had been inadequate (Feldman & Freedenthal, 2006).

Faculty and deans–directors of graduate social work programs reported that most students receive 4 hours or fewer of suicide-related education (Ruth et al., 2009).
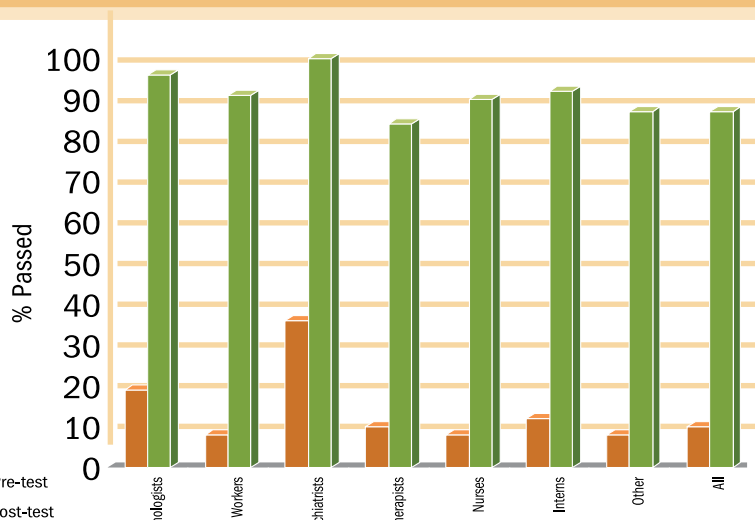
The lack of training is even more pronounced among professional counseling and marriage and family therapy training programs. Wozny (2005) found that suicide-specific courses were present in 6% of accredited marriage and family therapy programs and in 2% of accredited counselor education programs.

Only the field of psychiatry seems to be attempting to ensure that their trainees are, at a minimum, exposed to the skills required to properly conduct a suicide risk assessment and address suicidality in treatment. Ellis, Dickey, and Jones (1998), in a national survey of directors of training in psychiatry, found that 94% of the responding directors reported some form of training in suicide risk assess-

ment and intervention in their residency programs. However, the majority of directors reported that most of the training occurred in passive formats (e.g., therapy supervision, general seminar), and only 27.5% reported training via skill development workshops.

The table below shows the pre and post-training scores of 1,100 mental health professionals practicing in 13 states on a standardized 25-item quiz covering suicide statistics, risk and protective factors, risk management and safety practices in clinical settings. These findings have been twice replicated with more than 5,000 practicing clinicians tested thus far in more 1000 clinical settings.

Results: Component 2 (Cumulative)

Bar chart showing % Passed on the y-axis (0 to 100) for Pre-test and Post-test across categories: Psychologists, Social Workers, Psychiatrists, Therapists, Nurses, Interns, Other, All.

Weaving a Net of Clinicians Trained in Suicide Care

Laurie Davidson, MA, Manager of Provider Initiatives, Suicide Prevention Resource Center; **Anthony R. Pisani,** PhD, Faculty, University of Rochester Center for the Study and Prevention of Suicide and Institute for the Family

We are witnessing a renewed commitment among clinicians, policymakers, and consumers of mental health services to offering responsive and effective care for individuals at risk for suicide. At the policy level, the National Action Alliance for Suicide Prevention Clinical Care & Intervention Task Force has outlined a vision for Suicide Care in Systems Framework, which would transform the way clinical care is delivered. The success of this model in reducing the loss of human life depends on a competent, compassionate, and well-resourced workforce of clinicians. In light of this imperative, individual clinicians and community behavioral healthcare organizations around the country are eagerly searching for new ways to build the specific knowledge, skills, and attitudes required to provide effective care for those at risk of taking their own lives.

NEED FOR CONTINUING EDUCATION

Continuing education for behavioral health professionals is essential to achieving a workforce that can accomplish the goals set by the National Action Alliance. Many practicing professionals were not exposed to specific up-to-date education in this practice area during graduate and pre-professional training. Even for those who were, the daily challenges of working with suicidal patients often reveal areas of practice where additional education is needed in order to provide ethical and competent care.

In recognition of this need, Washington state recently became the first to require continuing education in the assessment and management of suicide risk for licensed mental health professionals. Several other states are considering similar measures. Throughout the country, behavioral health professionals and community mental health agencies are asking what competencies clinicians must have and what educational opportunities are available to enhance them.

Kate Speck is one community leader who recognizes the need to transform suicide care. As senior research manager at the Public Policy Center at the University of Nebraska, Kate has coordinated 16 continuing education workshops in Nebraska this year. "Cultural taboos about suicide and talking about suicide feed clinicians' worries about doing the right thing," she said. "Professionals who are really caring and competent in every other way can be afraid to ask the question 'are you suicidal?'"

CORE COMPETENCIES FOR MENTAL HEALTH PROFESSIONALS

What essential attitudes, approaches, and skills should clinicians and agencies seek to enhance through continuing education? The American Association of Suicidology and the Suicide Prevention Resource Center convened a panel of clinician-researchers that recommended 24 core competencies for mental health professionals. A complete list of these competencies is available from the Suicide Prevention Resource: www.sprc.org/sites/sprc.org/files/AMSRcompetencies.pdf.

In brief, effective suicide care requires that clinicians have:

>> **Knowledge** about suicide, suicide risk factors, and the laws and ethics that govern care of suicidal patients.

>> **Skills** for conducting routine and crisis-driven assessments, synthesizing assessment data to form plans that address short- and long-term suicide risk, and documenting their actions and decisions.

>> **Attitudes** and approaches that promote cordial and collaborative relationships, convey human compassion, and promote dignity and hope.
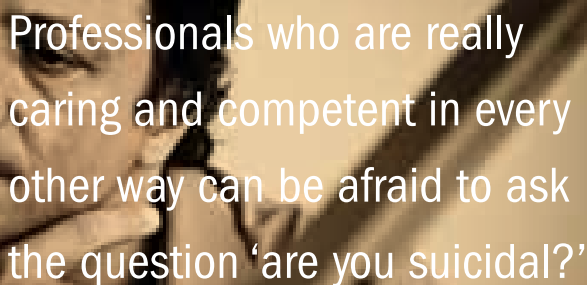
These competencies fall into eight basic domains that behavioral healthcare agencies can use to organize educational and clinical systems planning:

>> Attitudes and approach to suicidal patients

>> Understanding suicide

>> Collecting accurate assessment information

>> Formulation of risk

>> Treatment and services planning

>> Management of care

>> Documentation

>> Legal and regulatory issues

According to Kate Speck, skills in collecting accurate assessment data, formulating risk, and determining a plan of care based on risk are key. "Employing better ways to elicit information from patients, noting the risk factors, and learning how to weigh those risk factors gives the clinician competence and confidence," she said.

CONTINUING EDUCATION WORKSHOPS

Several organizations offer training workshops designed to increase general clinical competence in the assessment or management of suicide risk. Pisani and colleagues (2011) reviewed evidence related to the effectiveness of these workshops and concluded that workshop education in assessment and management of suicide risk is effective for enhancing knowledge, attitudes, and

> Professionals who are really caring and competent in every other way can be afraid to ask the question 'are you suicidal?'

confidence, and that research is needed to demonstrate how the state-of-the-art skills presented in these workshops are generalized into participants' practice patterns and improve patient outcomes.

Speck observes, "In an era of cost-cutting, training is often the first thing to go. For the sake of our patients, this is a trend we're trying to reverse."

WELL-SUPPORTED CLINICIANS CAN MAKE A DIFFERENCE
Community behavioral healthcare systems that have undertaken extensive training and improved policies for assessing and intervening with suicidal patients have shown remarkable results, including dramatic reductions in suicide attempts and deaths. Clinicians, empowered by the right education and healthcare systems, can play an important role in reducing the emotional and economic costs associated with suicide and suicide attempts.

Laurie Davidson, MA, is manager of provider initiatives for the Suicide Prevention Resource Center, the nation's only federally supported resource center devoted to advancing the National Strategy for Suicide Prevention. After working for seven years in community behavioral health centers as a licensed mental health counselor, she joined Education Development Center, Inc. in Waltham, MA, where she has managed projects in alcohol and other drug prevention, mental health promotion, and suicide prevention since 2000.

Anthony R. Pisani, PhD, is on the faculty of the University of Rochester Center for the Study and Prevention of Suicide and Institute for the Family. Dr. Pisani is a nationally recognized expert in clinical education and a member of Workforce Preparedness Taskforce of the National Action Alliance. He publishes a popular blog for clinicians.

Table 1. Workshops for Behavioral Health Professionals: Domains of Competence Addressed in Learning Objectives

Program name	Attitudes & approach	Understanding suicide	Collecting accurate assessment information	Formulation of risk	Treatment & services planning	Management of care	Documentation	Legal/ regulatory
AMSR	X	X	X	X	X	X		
QPRT		X	X		X	X	X	
RRSR	X		X	X	X		X	X
SuicideCare	X	Addressed in ASIST prerequisite		X	X	X		
Unlocking			X	X	X		X	X

Adapted from Pisani, A.D., Cross, W.F., & Gould, M.S. (2011). The assessment and management of suicide risk: State of workshop education. Suicide and Life-Threatening Behavior, 41(3), 255-276.

ASSESSING AND MANAGING SUICIDE RISK: CORE COMPETENCIES FOR SUICIDE PREVENTION
www.sprc.org/training-institute/amsr — 6.5 CE credits
Based on a set of 24 core competencies developed by a clinician-researcher taskforce convened by the American Association of Suicidology (ASA) and the Suicide Prevention Resource Center (SPRC). The 1-day, face-to-face training covers the knowledge, skills, and attitudes required to effectively assess, manage, and treat individuals at risk for suicide in a blend of lecture, exercises, video demonstrations, and journaling activities.

RECOGNIZING AND RESPONDING TO SUICIDE RISK
www.suicidology.org/education-and-training/ recognizing-responding-suicide-risk — 13.25 CE credits
Based on the AAS/SPRC taskforce's core competency recommendations. Prospective participants complete an online qualifying module prior to a 2-day, in-person workshop. RRSR augments the core AMSR content with skill rehearsal and case application exercises.

QUESTION, PERSUADE, REFER, TREAT SUICIDE RISK ASSESSMENT AND MANAGEMENT TRAINING PROGRAM
www.qprinstitute.com —10 CE credits for face-to-face workshop
An 8-10-hour workshop based on QPR, a highly utilized gatekeeper training.

QPRT is offered online and in a face-to-face workshop. Trainees qualify for certification after passing a written 25-item exam and demonstrating competence in a role-play.

SUICIDECARE: AIDING LIFE ALLIANCES
www.livingworks.net
A 1-day workshop for clinicians who have already taken the 2-day ASIST (Applied Suicide Intervention Skills Training) offered by LivingWorks. SuicideCare is a clinically oriented exploration of the challenges presented to and the competencies required of the helper who works with persons at risk of suicide on a longer-term basis. ASIST and SuicideCare together cover immediate first aid and ongoing care issues, including making decisions about management, treatment, and therapy options.

UNLOCKING SUICIDAL SECRETS: NEW THOUGHTS ON OLD PROBLEMS IN SUICIDE PREVENTION
www.suicideassessment.com
A 1-day training that includes an overview of suicide assessment, response, and treatment planning; interviewing techniques for uncovering suicidal ideation; and an introduction to the Chronological Assessment of Suicide Events, approach to interviewing.

Changing Workplace Culture to End the Suicide Standstill

Richard F. Paul, MSW, CEAP, Senior Vice President of
Health and Performance Solutions, ValueOptions;
Sally Spencer-Thomas, PsyD, CEO and Co-founder,
Carson J Spencer Foundation and
Co-founder, Working Minds

Suicide has a dramatic impact on the workplace in both human and financial terms, whether an employee or an employee's family member or friend dies by suicide. In any given year, for every 1,000 employees, 37 will seriously consider suicide, 10 will make a suicide plan, and five will attempt suicide. Suicide can bring the workplace to a standstill.

There is a common perception that suicide rates are greatest among teenagers and the elderly, yet about two-thirds of all suicides occur among Americans ages 25-65 — the nation's workforce. Because the majority of people who die by suicide are working-aged men, the Surgeon General's National Strategy for Suicide Prevention specifically targets employers as critical stakeholders in the prevention of suicide. "It is in the interests of employers to prevent suicide and suicidal behaviors...A suicide in the family of an employee may result in such grief that the employee becomes incapacitated."

Much in the same way that the workplace has been an important venue in creating a culture of health and safety, it can be an equally powerful and influential environment for suicide prevention. Yet, when business leaders envision a healthy workplace, does it typically include a focus on employees' emotional health and wellbeing? Today, 20% of Americans suffer from some type of mental illness. It is important that we address these concerns in the workplace too. When one considers the protective factors that are so critical in the prevention of suicide, productive employment being one of them, the workplace cannot be ignored. Recognizing this, many companies have begun incorporating suicide into their violence prevention policies and expanding their culture of safety and health initiatives to include a focus on a culture of emotional wellness, as well as physical health.

Why are companies often reluctant to take on this issue of suicide in their health and wellness efforts? Is it because suicide still conjures up stigma for some and some believe (mistakenly) that discussing the topic will result in more suicides? The science is clear: increasing help-seeking behaviors by those most distressed can reduce and prevent suicide. The challenge is that many people who die by suicide never sought help.

When a working-age American suffers from the greatest depth of despair and hopelessness — perhaps triggered by a situational crisis such as the end of a relationship or a perceived career failure or perhaps resulting from depression or other mental health issue — how can the workplace support and encourage this person to seek professional help? The answer lies in those areas of his or her life that have provided structure, self-fulfillment, or personal pride. These protective factors may include a loved one, but also often include those with whom the individual spends the greatest amount of time —colleagues, a supervisor, or other leaders.

The workplace's power and influence is great, as is the culture and behaviors of those one interacts with most. Is the workplace a toxic environment that supports and reinforces messages like "win at all costs" or "every man for himself"? Is the work environment one that rewards a dog-eat-dog mentality resulting in feelings, for some, of frustration, fear, and anxiety? Or is the workplace one that supports employees in a meaningful way and reinforces

the best of human behavior such as compassion, empathy, positivity, respect for others, gratitude, optimism, and creativity? While these examples represent two ends of the spectrum related to workplace cultures, clearly one emerges as an environment that is more likely to result in help-seeking behavior.

Senior executives also need to know that suicide prevention programs can be very effective. The U.S. Air Force was experiencing an annual rate of 15.8 suicide deaths per 100,000 of its 350,000-person community, the highest of all U.S. Armed Forces, before developing and implementing its community-based suicide prevention program in 1995. Subsequently, the suicide rate fell 7% to less than 3.5 suicide deaths per 100,000 in 1999. The Air Force program is replicable in communities and corporations. The result can be a demonstrable reduction in the emotional, physical, and financial toll of depression and suicide. Such a program can also impact productivity, absenteeism, and the costs of operations and medical benefits.

Each of us can play a role in impacting this critical public health issue. Business leaders can promote help-seeking behaviors within workplaces, and individuals can take talk of suicide seriously. Suicide warning signs — like giving away material things, expressions of hopelessness and despair, and talk of ending one's life — cannot be ignored. Anyone can suffer from suicidal thoughts, young or elderly, male or female, and no matter what position they hold. But fortunately, suicide can be prevented.

While comprehensive suicide prevention initiative may seem too intensive of an endeavor for workplaces, many prevention strategies do not take much effort and still yield tremendous results. Here are seven simple steps employers can take to promote mental health and prevent suicide:

1. Build a better workplace. Make suicide prevention a part of the overall culture of health and safety. Establish a flexible workplace in which "mental health" days, telecommuting, and flexible scheduling are part of the culture of a mentally healthy workplace; write policies to formalize this support. Develop a proactive, prompt, and consistent approach to work-related problems, as this is essential in helping employees feel safe, protected, and able to do their best work.

2. Develop fully engaged workers. A protective factor for suicide, workers who feel connected to their teammates and feel they belong to something bigger than themselves are also more likely to make sacrifices for the greater good.

3. Reward mental wellness. Just as workplaces offer incentive programs for nutrition and fitness, workplaces can also create opportunities and reward efforts to obtain optimal mental health. For example, employees can earn points (that can be redeemed for cash or other rewards) when they take workshops on how to reduce stress or improve sleep.

4. Change the conversation through social marketing. Develop a multi-media campaign that lets people know they are not alone and that many resources exist to help such as the National Suicide Prevention Lifeline (1-800-273-8255).

5. Offer educational programs on mental illness. Employee assistance professionals or other local mental health service professionals can provide workshops that increase awareness about the mental illnesses that can make individuals more vulnerable to suicide. By sharing stories of successful treatment and recovery, these presentations offer hope and proof that treatment works. Furthermore, misperceptions dissipate when workers interact with providers and are able to ask questions about concerns that may pose barriers to care.

The challenge is that many people who died by suicide **never sought help**

6. Support reintegration and return to work. When people have experienced a suicide crisis — a suicide attempt or the loss of a loved one — their lives are often turned upside down. When a workplace is sensitive to their return-to-work needs, the transition supports their recovery. By empowering survivors to be part of the reintegration plan, workplaces demonstrate respect that builds trust.

7. Support safe bereavement. When a suicide affects a workplace, employers should not underestimate the impact of this event. Vulnerable employees who over-identify with the deceased person may become more at risk for suicidal behavior themselves. At the same time, thwarting bereavement and memorialization efforts can complicate bereavement for those left behind.

The actions of leadership and every individual within an organization can promote a healthy and safe workplace that prevents the tragedy of suicide.

Business leaders are recognizing the problem and getting involved because they see the importance of preventing suicide. Employees are a company's greatest asset. Unrecognized and untreated mental illness costs companies millions of dollars in lost productivity, disability, and worker's compensation claims. And more importantly, it causes an incalculable human toll. That's why it's so important to foster a more emotionally healthy workforce.

Richard Paul, MSW, CEAP serves as senior vice president of health and performance solutions at ValueOptions. He has oversight and development responsibilities over EAP, health and wellness and other employer support services and is responsible for the strategic direction and implementation of company-wide health and productivity customer initiatives.

Sally Spencer-Thomas, PsyD, is chief executive officer and cofounder of the Carson J Spencer Foundation and co-founder of Working Minds, one of the first programs in the country to provide workplaces with a comprehensive approach to suicide prevention. She is also chair of the Survivor of Suicide Loss Division of the American Association for Suicidology and a co-lead of the Workplace Task Force of the National Action Alliance for Suicide Prevention.

Don't Be Afraid to Ask
The Mental Health First Aid Action Plan

Bryan Gibb, Director of Public Education, and **Susan Partain,** Director of Mental Health First Aid Operations — National Council for Community Behavioral Healthcare

Of the more than 70,000 people in the U.S. now certified in Mental Health First Aid, instructor Marie Dudek feels a particular passion when discussing the training's suicide prevention component. In June 2003, Dudek's daughter died by suicide while still in her early 20s, an age group at high risk for suicide.

"Like most people, I never thought suicide would affect my family," says Dudek of Davenport, FL, a founding member of the Central Florida Chapter of the American Foundation for Suicide Prevention. "Even when we can see the signs of mental illness and suicide, we may want to avert our eyes. There's a real fear of doing or saying the wrong thing."

About 87 percent of people who complete suicide have a mental disorder. In the U.S. a death by suicide happens every 15 minutes.

"Mental Health First Aid teaches people that it's OK to talk about mental health issues," says Linda Rosenberg, president and CEO of the National Council for Community Behavioral Healthcare (National Council). The National Council, along with the Maryland Department of Health and Mental Hygiene and the Missouri Department of Mental Health, manages, operates and disseminates the program. "Much of the course focuses on teaching people that mental illnesses are real, common and treatable."

By the year 2020, Mental Health First Aid is expected to be as well known as CPR and First Aid.

Dudek started teaching Mental Health First Aid in 2009, only one year after the course was introduced in the United States from Australia. Participants learn a five-step action plan to assess a situation, select and implement appropriate interventions, and help a person developing signs and symptoms of mental illness or in crisis receive appropriate care. In addition to discussing suicide prevention, participants learn about the risk factors and warning signs of illnesses such as anxiety, depression, psychosis, and addiction.

Mental Health First Aid sheds light on the common signs, symptoms and risk factors for depression and other mood disorders that increase the risk of suicide:

- Threatening to hurt or kill oneself
- Looking for ways to kill oneself, seeking access to pills, weapons or other means
- Talking or writing about death, dying, or suicide
- Expressing hopelessness
- Feeling worthless, no reason for living, no sense of purpose in life
- Feeling rage or anger, seeking revenge
- Acting recklessly or engaging in risky activities, seemingly without thinking
- Feeling trapped, like there is no way out
- Increasing alcohol or drug use
- Withdrawing from family, friends, or society
- Experiencing anxiety or agitation, being unable to sleep or sleeping all the time
- Having dramatic changes in mood

As a Mental Health First Aid instructor, Dudek emphasizes that if people recognize these signs, it is important to directly ask about suicidal thoughts. She suggests asking questions such as "Are you having thoughts of suicide?" or "Are you thinking about killing yourself?"

The Mental Health First Aid manual informs participants that "If you appear confident in the face of a suicide crisis, this can be reassuring for the suicidal person. Although some people think that asking about suicide can put the idea in the person's mind, this is not true. Another myth is that someone who talks about suicide isn't really serious. Remember that talking about suicide may be a way for the person to indicate just how badly they feel."

"This is a time when people simply need to listen. People contemplating suicide are not looking for someone to tell them what to do," concludes Dudek. "They need someone who will listen with an open heart knowing another human being is in pain. For my daughter, she just wanted to end the pain."

Bryan Gibb, director of public education at the National Council for Community Behavioral Healthcare, oversees national dissemination of the Mental Health First Aid program. He is the lead trainer and teaches Mental Health First Aid courses across the country and also trains and certifies instructors to teach the course in their communities. He has taught Mental Health First Aid to first responders, business leaders, faith-based groups, college and university leaders, and many other audiences.

Susan Partain has 7 years of experience in the behavioral health field, and has been with the Mental Health First Aid USA team since the program's inception at the National Council in 2008. As Director of Mental Health First Aid Operations, Partain provides program development, marketing, and training assistance to instructors nationwide; supports curriculum development; and oversees program operations.

Mental Health First Aid is the initial help given to a person showing symptoms of mental illness or in a mental health crisis until appropriate professional, peer or family support can be engaged. Mental Health First Aid USA is disseminated by the National Council for Community Behavioral Healthcare, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health. To find a training program in your community or learn how you can certify as an instructor, visit www.MentalHealthFirstAid.org.

Natalie and Marie

Accepting What Is and What Is Not
Marie Dudek

Peace, love, and joy. How does anyone find them in their own life? All I can tell you is how my journey in life made me aware of each.

Nine years ago, I would have told you it's not possible. I came home and opened the garage door to find that my beautiful, 22-year old daughter hanged herself. For more than two years, Natalie struggled with a disease that ultimately took her life. She fought a valiant battle. As a mother, there's nothing worse than not being able to take away the pain your child is experiencing. And here I was, holding her head on my lap, stroking her hair, coming to the realization that I couldn't change this. As much as I may want to, there is nothing I can do to reverse this. There is no second chance.

As the mother of two, my children mean the world to me. From times spent together on the baseball diamond, to helping with schoolwork, to exploring new places together, we were a family. We certainly had our moments — that's being human. Deep down in our bones, we each know the vast love we have for one another.

A few months after Natalie's death, my son, Javair, and I were talking, no, arguing. The strain on our relationship was palpable. In that moment I told him I see how this experience breaks families apart and that's not what I want for us. We sat quietly for a few minutes. That's not what he wanted either.

Peace came to my daughter when her life ended. Peace came to me when I accepted my daughter's death. Peace comes to my family when we openly and honestly talk, remembering Natalie for who she was as a human being, not the circumstances surrounding her death. Peace is a daily practice.

At Natalie's wake, the line of people went outside and around the block. My family was concerned for me. I knew I needed to hug each and every individual that was there. I did just that.

In the months afterward, I experimented with different classes on body awareness. From sitting meditation, to massage, to riding a stationary bike at the YMCA, I began taking exquisite care of me. One morning in a Feldenkrais class, as I stretched upward, I literally felt my entire heart open up to the world. I began noticing things newly and they were vibrant. At times along the walking trail, I felt at one with the universe. My community and everything surrounding me support me each and every day. Love is a daily practice.

Joy? How could I have joy in my life? I mean my daughter died. My daughter died by suicide. I couldn't imagine joy being in my life whatsoever. Guess what? It is here in my life. It's present in my daily activities because I choose joy. I never thought about that until a seminar leader brought it to the attention of the group. I listened intently. Having joy in my life is accepting what is and what is not. Embracing what it and what is not. And bravely moving forward. I am living that as I bring awareness to mental health conditions. I am living that as I recognize and acknowledge the greatness in others. Imagine a world where each and every human being is fully aware of the difference they make in the universe. Joy is a daily practice.

Marie Dudek, a certified Mental Health First Aid instructor is President of Creating Today, Inc. In 2008, she co-founded the Central Florida Chapter of the American Foundation for Suicide Prevention, and held the position of executive chairperson for two years. In June 2003, Marie experienced the suicide death of her 22-year old daughter, Natalie Gillett. Since that time, her grief journey has brought many gifts her way. Today, Marie provides support to individuals and families after the suicide of a loved one. She works to heighten understanding of the importance of mental health through a multifaceted approach.

Vital Signs
Suicide Attempts
CAN Be Predicted

Kelly Posner, PhD, Director, Center for Suicide Risk Assessment, Columbia University/New York State Psychiatric Institute

Based on an interview with Meena Dayak for National Council Magazine

What if suicide screening was as easy as checking your blood pressure? And what if it could be done by anyone, anywhere?

A universal, easily accessed and administered tool to screen for suicidal risk, the Columbia-Suicide Severity Rating Scale has been proven to predict suicidal behavior and suicide attempts. The tool includes resources to connect people at risk to professional help. The C-SSRS was developed by a team of researchers from Columbia University, the University of Pennsylvania, and the University of Pittsburgh with support from the National Institute for Mental Health and the American Foundation for Suicide Prevention.

The lack of a scientifically validated tool to assess suicidal behavior and suicide risk has been a major obstacle to lower the nation's suicide rate in all age groups. The Institute of Medicine noted in 2002 the lack of definitions and standardization as one of the major impediments to suicide prevention. Subsequently, the Food and Drug Administration requested a standardized assessment tool for suicidal behavior and selected Columbia Psychiatry researchers to lead that initiative.

Prevention depends upon appropriate screening and identification. It's about saving lives and directing limited resources to the people who actually need them.

"Having a proven method to assess suicide risk is a huge step forward in our efforts to save lives," said Office of Mental Health Commissioner Michael Hogan. "Dr. Posner and her colleagues have established the validity of The Columbia–Suicide Severity Rating Scale (C-SSRS). This is a critical step in putting this tool in the hands of healthcare providers and others in a position to take steps for safety. We congratulate them on their efforts."

The screening methods developed through C-SSRS been recommended or mandated across numerous areas of medicine.

HOW IT WORKS

The C-SSRS has shown successful suicide attempt prediction not only in suicidal adolescents, but in non-suicidal adults as well. In the past, typical screening has only identified suicide attempts, omitting some of the most important behaviors that are critical for risk assessment and suicide prevention (e.g. collecting pills, buying a gun). The C-SSRS is the only evidence-based screening tool that assesses the full range of clinically important ideation and behavior, with criteria for next steps – such as referral to mental health. In turn, it streamlines triage and facilitates care delivery to those at highest risk.

The C-SSRS questionnaire asks people whether they have ever wished they were dead or had thoughts of killing themselves. If they say no, that's that. But if they say yes, the test takes them further, asking if they had ever thought about how they might do it, and then probing for details.

The test uses an algorithm, taking the interviewer and the subject along a decision tree until a patient's risk level can be determined.

In a study, the results of which were published in *The American Journal of Psychiatry* in November 2011, Columbia Psychiatry researchers compared the effectiveness of several questionnaires used to assess more than 500 patients. One group was adolescents who had already attempted suicide, the next was a pharmaceutical study of depressed teenagers getting a new medication, and the third was a study of adults who came to an emergency department in mental distress. There was a 24-week follow up to track patients. The C-SSRS demonstrated the unique ability to predict suicide attempts.

In a study utilizing a self-report phone version of the C-SSRS, approximately 35,000 administrations have provided initial evidence that every type of behavior and ideation assessed on the C-SSRS is predictive of future suicidal behaviors. This research has confirmed the notion that every piece of information gathered on the C-SSRS is imperative in quantifying a patient's level of risk.

The test has already been in use a few million times and has been translated into more than 100 languages.

The C-SSRS is available free of charge and no professional mental health training is required to administer it. However, brief training is required for clinical trials (and indicated/preferred for clinical practice) before administering the C-SSRS. Training is available online through a 30-minute interactive slide presentation followed by a question-answer session, or is alternatively available by DVD. Those completing the training are certified to administer the C-SSRS, and receive a training certificate, valid for two years.

To complete the C-SSRS Training for Clinical Practice, visit c-ssrs.trainingcampus.net/.

The C-SSRS not only helps to get the right patients into treatment and save lives, it also keeps money from being wasted on those who did not need such care.

WIDESPREAD USE

The easy-to-use tool has been welcomed by multiple organizations that have suicide prevention on their plate but did not really know how to implement it.

Today, the C-SSRS is used worldwide in intervention studies and clinical trials across a broad range of disorders and diseases, and by institutions from the U.S. and Is-raeli Military to the World Health Organization to local fire departments and public schools. Importantly, the scale has been used extensively to address the Joint Com-mission's National Patient Safety Goals, and is indicated as a best practice.

The C-SSRS is becoming a standard suicide screening tool for hospitals, correctional facilities, health plans, and programs like Medicaid and Medicare. "The use of this scale can be transformative for Rhode Island because it will improve care and allow us to focus resources where they most help people," said Dale K. Klatzker, President/CEO of The Providence Center, a large community behavioral health organization. "The scale is an easy way to save lives," said Deb O'Brien, Providence Center Vice President and Chief Operating Officer. "Our staff have been trained by Dr. Posner, the creator of the C-SSRS, and have found it easy to use and effective. By tying it to our electronic health records, it becomes that much more streamlined into everyday care." At Centerstone, one of the largest behavioral health organizations in the U.S., the C-SSRS is used as a screening tool throughout the system.

The ground swell in use of the C-SSRS over the last 8 years has elicited top-down approaches for dissemination by many systems. Numerous states and countries have moved towards system-wide implementation. For example, New York State's Office of Mental Health's plan is to utilize the C-SSRS in all adult and child behavioral health organizations across the state as a critical element of their systems approach to prevention – implementation has already begun, and the state of Georgia has put the C-SSRS "top-down" approach into policy. Furthermore, multiple nationwide imple-mentation efforts have ensued across many facets of the military. C-SSRS is now the state crisis assessment tool in Tennessee and is being implemented throughout managed care. The C-SSRS is used by general medical and psychiatric emergency departments, hospital systems, managed care organizations, behavioral health orga-nizations, medical homes, community mental health agencies, primary care, clergy, hospices, schools, college campuses, military, frontline responders (police, fire de-partment, EMTs), crisis hotlines, substance abuse treatment centers, prisons, jails, juvenile justice systems, and judges.

Fifty percent of people who die by suicide visited a primary care doctor in the month preceding their death. If they had filled out a simple questionnaire in the waiting room, they could have gotten mental health care point out researchers. "We should be asking these questions the way we monitor for blood pressure," says Posner.

RESULTS

Jeffrey Lieberman, MD, president-elect of the American Psychiatric Association, says about C-SSRS "For the first time in as long as anyone can remember, we may be actu-ally able to make a dent in the rates of suicide that have existed in our population and have remained constant over time..."

A tool like the C-SSRS not only helps to get the right patients into treatment and saves lives, it also keeps money from being wasted on those who do not need such care. With ever shrinking health resources and federal health reform focused on find-ing efficient ways to spend money, the C-SSRS points the way to big savings. For example, the California corrections department estimates spending $20 million on a suicide-watch in half if they had a better system of identify the prisoners at risk.

In the Rhode Island Senate Commission hearing on ER overuse and diversion, state senators discussed use of the C-SSRS by EMS or police in the community to address ER overuse and ER diversion.

Reading Hospital, PA says that the C-SSRS "allowed us to identify those at risk and better direct limited resources in terms of psychiatric consultation services and pa-tient monitoring and it has also given us the unexpected benefit of identification of mental illness in the general hospital population which allows us to better serve our patients and our community."

Crain's NY (2012) recently reported that "[City schools' C-SSRS suicide training] has made more appropriate referrals for students to see support staff in the school and referrals to community agencies as needed." Education departments across many states have started to implement. As explained by the NYC Department of Educa-tion, "The great majority of children and teens referred by schools for psychiatric ER evaluation are not hospitalized and do not require the level of containment, cost and care entailed in ER evaluation." Four hospitals in New York found 61-97% of referrals unnecessary. After training, nurses in 38 NYC middle schools identified many children that would have otherwise been missed while addressing unnecessary referrals. —

For those who make treatment decisions, the C-SSRS provides both better peace of mind and possibly legal protection. "It usually takes some time to become an ac-cepted procedure, but if it does, and a practitioner asked the questions and patients went on to kill themselves anyway, it would provide some legal protection," said Bruce Hillowe, a Long Island-based mental health attorney specializing in malpractice liti-gation. The C-SSRS also has been implemented by medical malpractice insurance companies, such as The Doctor's Company, to protect their insured doctors and fa-cilitate patient safety.

The C-SSRS can also be tailored for population-specific data collection (e.g. a ver-sion has been created that addresses risk factors for suicide specific to the military).

Ultimately, the C-SSRS serves as an effective mobile crisis tool, which gets to the right people at the right time and right place and helps to save lives and save public dollars.

Dr. Kelly Posner, a leading international expert in the areas of suicide and depression, is the founder and Principal Investigator of the Center for Suicide Risk Assessment at Columbia University/New York State Psychiatric Institute. Named one of New York Magazine's "Most Influential" people, Dr. Posner publishes and speaks internationally on the risks, benefits, and public health implications of recent drug safety controversies. In June 2008, she gave the invited presentation on tackling depression and suicide at the first European Union high level conference on mental health. Dr. Posner is the Found-ing Chair of the Board of Turnaround for Children, the groundbreaking model that is the first to fix failing schools in high-poverty communities. She is also co-founder of The Speyer Legacy School and Institute, the first independent school for advanced learners. In 2011, she received The Turnaround Impact Award and was named "Educational Philanthropist of the Year." She will also be the honoree for the Center Law and Economic Justice joining the ranks of Ted Kennedy.

Man to Man: Tackling Suicide Head On

Joseph Conrad, Founder, CEO, and Strategic Director, Cactus Marketing Communications
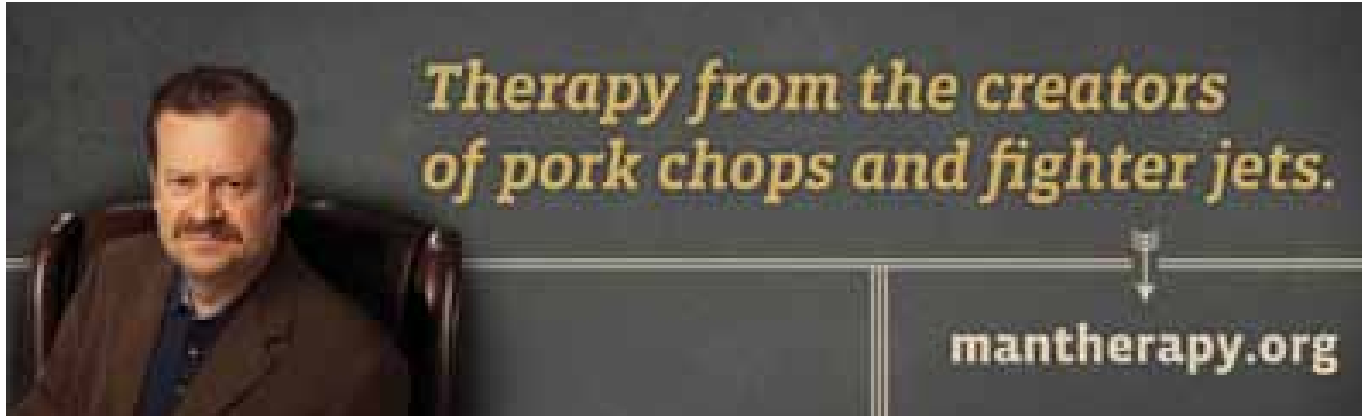
Man Therapy™ is a groundbreaking new marketing approach to suicide prevention and other men's mental health issues. Recently launched in Colorado, the campaign is quickly going national, Man Therapy reshapes the conversation, using humor to cut through stigma and tackle issues like depression, divorce, and even suicidal thoughts head on, the way a man would.

The purpose of Man Therapy is to provide men, and their loved ones, a place to learn more about men's mental health, examine their own situation, and consider a wide array of actions to put them on the path to treatment and recovery. The universal message is that everyone should be aware of their mental health status, treat it like they would any other ailment, and strive to get better.

The campaign features our hero, the good Dr. Rich Mahogany. He is a man's man who is dedicated to cutting through the denial with a fresh approach using his manly charm, odd sense of humor, no BS approach, and practical advice. Some have called him "Hemingway-esque" and others a cross between Ron Burgundy of Anchorman fame and Dr. Phil. But Dr. Rich Mahogany is his own man, and he is dedicated to helping men take charge of their own mental health.

The centerpiece of the campaign is the video-based mantherapy.org website, where men and their loved ones will find they have a virtual appointment with Dr. Mahogany. He greets visitors, makes them feel at ease, and then provides an overview of what they will find and can explore during their visit. People navigate through Dr. Mahogany's office where they can find useful information about men's mental health in the Gentlemental Health™ section. Men can also take an 18-question quiz to evaluate their own mental health status. Based on their answers, they receive one of three different video responses. Respondents are given written advice, recommendations, and actions to consider. They can also access resources and explore a wide range of choices from do-it-yourself tips to professional therapist referrals. Additional resources include links to local support groups and a national suicide crisis line that is highly visible and ever-present on the site.

The strategy behind Man Therapy is to help men and their loved ones recognize early warning signs in their life and do something about it before it reaches a crisis. Since crisis lines already exist, our campaign focuses further upstream, helping men connect the dots between issues they are having and encouraging them to do something about it today. Divorce, unemployment, PTSD, concussions, depression, substance abuse, or other personal and health issues, when unchecked or untreated, can become dangerous. Man Therapy is an invitation for all men to check their mental health status and be more aware of issues they face; the campaign encourages them to consider a wide range of therapeutic options to get better.

## CAMPAIGN HISTORY — A STORY OF DETERMINATION AND PARTNERSHIP

In 2006, as a part of our partnership with the Colorado Department of Public Health and Environment, Cactus Communications was introduced to Jarrod Hindman, Director of the Office of Suicide Prevention. He was running a program to address the critical issue of suicide in Colorado. Like most state agencies, he had a huge challenge and no budget. Cactus agreed to do some pro bono work for the program. Through that process the agency learned a great deal about suicide and was introduced to Dr. Sally Spencer-Thomas, director of the Carson J Spencer Foundation, a local non-profit dedicated to suicide prevention. Together, the three organizations — Cactus, OSP, and CJSF — formed a unique partnership and made a commitment to address this growing public health crisis.

With a $25,000 contribution from the American Foundation for Suicide Prevention and $5,000 allocated from a larger Garrett Lee Smith Suicide Prevention grant, we developed a comprehensive public education plan while conducting some insightful and thrifty research studies. After getting and then losing state funding, the Anschutz Foundation came to the table and helped get the project off the ground with a $200,000 challenge grant.

Over the past 6 years, our partnership has worked diligently to bring Man Therapy to fruition.

IMPRESSIVE RESULTS IN JUST THE FIRST 6 WEEKS

The campaign launched on July 9, 2012 with a feature story in the New York Times. After generating 4,500 web hits in the first day, mantherapy.org has seen
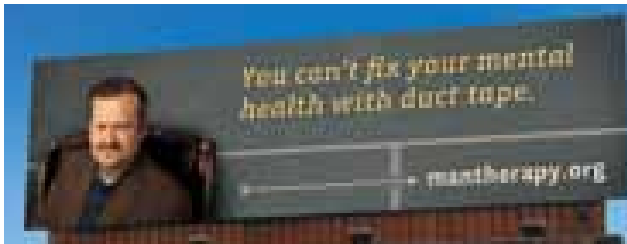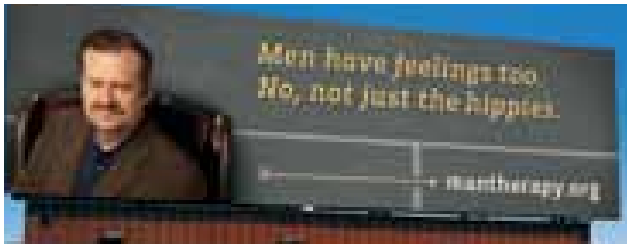
Man Therapy reshapes the conversation, using humor to cut through stigma and tackle issues like depression, divorce, and even suicidal thoughts head on, the way a man would.

an average of 1,000 unique visitors per day and has had 40,000 unique visitors total who have spent an average time of 7 minutes on the site. Roughly 8,000 people have taken the quiz and been given advice and therapy actions to consider. Of the 40,000 visitors, 30,000 are from the U.S. Colorado has seen the most traffic with 8,000 visitors, but other states have seen as many as 3,000 visitors just through word-of-mouth and the campaign's TV PSA. A thorough program evaluation is currently being conducted to obtain more detailed feedback on and analysis of the website experience and the impact it has had on the target audience of working age men.

BRINGING MAN THERAPY TO YOUR STATE

From the outset, Man Therapy was created to be shared with other states and mental health organizations around the U.S. that are working to prevent suicides in their communities. Communities will need to rally together and organize a committed group of partners to implement it locally, but we have tried to make it as easy as possible for partners to band together to quickly and easily launch the campaign locally. Partners who launch the campaign receive a customized page on the website with local resources and links. The integrated campaign toolkit includes implementation playbooks, a 30-second TV public service announcement, three viral videos, public relations and social media programs, billboards, bus shelters, online banner ads, and community outreach materials that include posters, coasters, and Dr. Mahogany's business card.

Joseph Conrad is the Founder, CEO and Strategic Director at Cactus, a full-service branding agency providing innovative solutions for companies and causes. Cactus has extensive experience developing public health communications and social marketing campaigns working on a wide range of issues including tobacco prevention, obesity, mental health literacy, substance abuse recovery and suicide prevention.

Life Savers: That's a WRAP

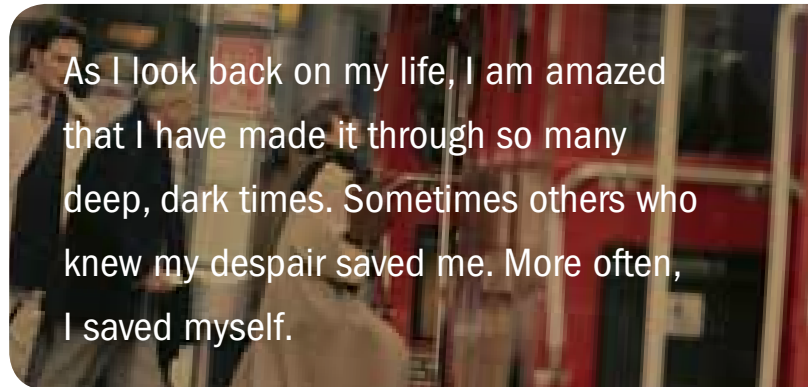Mary Ellen Copeland, PhD, Creator, Wellness Recovery Action Plan

Like many other people, from time to time I feel like I must end my life. These feelings are overwhelming and horrifically painful, more painful than any physical pain I have ever felt. There have been times when these feelings have been so deep and pervasive that I have tried to end my life. I think these feelings are the result of horrific things that happened to me, horrific things that I saw or know happen to other people — and I feel that I just cannot bear it anymore. I can only imagine the horror experienced by people who have been in war, and understand their need to stop the pain any way they can. These feelings are in sharp contrast to my great love of life, to my appreciation of the wonderful things I have experienced, and my feeling that each day of my life is a miracle.

As I look back on my life, I am amazed that I have made it through so many deep, dark times. Sometimes others who knew my despair saved me. More often, I saved myself. Although never simple, this has been much easier to do since I began using WRAP® (Wellness Recovery Action Plan®) as my guide to daily living and as my life plan. Over time, I developed various tools and strategies that were "life savers" for me. WRAP gave me a way to understand, organize, and effectively use those strategies and tools to save my life and to make my life the way I wanted it to be.

The **Wellness Toolbox,** the cornerstone of my WRAP, has become the repository for all of those tools and strategies. Now, I know exactly what those tools are and can easily access this reminder list on my computer or in various strategically placed notebooks. My Wellness Toolbox includes things that I have learned work for me in these darkest of times — things like writing, studying pictures of family and friends, reading beautiful poetry, working hard in my garden, exercising hard, having a long talk with a supporter, working on a creative project, listening to good music, going to a session with my counselor, and even doing eye movement desensitization reprocessing, if my other strategies are not working. I have over 100 tools on this list so I can always find something. I have gathered them from all the groups I have attended, workshops I have facilitated, and self-help books and magazines, and I have gotten more ideas from my supporters. Sometimes they are not easy to use and I find it easier to sink into the depths of despair. But I have learned that to save my life I have to force myself to do these things, even when I don't feel like it.

With WRAP, I have organized these tools into lists and action plans that continue to work for me in all kinds of situations and circumstances. Keeping up with my short, concise **Daily Maintenance Plan** of the basic habits of daily living helps assure me that I will successfully navigate my way through the day. I am familiar with my long list of triggers. I continue to discover more of these triggers as I continue this incredible life journey. When these triggers come up, as they always do, I have my action plan of choices that I can quickly use to navigate these troubled waters until I am once again on the right track.

Sometimes I notice that I am not doing well — interrupted sleep, nightmares, lethargy, sadness, wanting to eat all the time, avoiding friends — and I know

> As I look back on my life, I am amazed that I have made it through so many deep, dark times. Sometimes others who knew my despair saved me. More often, I saved myself.

that I need to refer to my **Early Warning Signs Action Plan**. It is more directive than my **Triggers Action Plan** and has usually been successful in safely guiding me back to a place where I feel well again. But sometimes it gets much, much worse. This used to be the time when my supporters would step in and I would be whisked away for a stay on a psych ward, or when they would guard my every step until they felt the situation had eased. But now, with my very directive "When Things are Breaking Down" Action Plan, which tells me what I absolutely must do with few choices, I have found that I can navigate these rough waters and bring myself safely back to wellness, even though it is difficult.

I have a powerful **Crisis Plan or Advance Directive** that I have distributed to my supporters, which they have not had to use in a very long time. This critical document guides my supporters when my despair is so deep that I cannot get a handle on it myself. I feel the most important parts of this plan are the list of indicators say that others need to step in and take over responsibility for my care because I can no longer take care of myself; my plan for how I can "ride out" this crisis at home or in my community without hospitalization or using medications or invasive treatments of the past; the list of things that others can do or should avoid doing because they make me feel worse — like threatening me, shaming or blaming me, or restraints and seclusion — to help me recover more quickly. I have reviewed the **Post Crisis Plan** and filled in some of sections, and I feel certain that if I have a crisis, the Post Crisis Plan will guide me through the difficult recovery phase.

WRAP has given me life. Whether you also deal with pervasive suicidal ideation, or you support people who are working to save their own lives, WRAP is a simple, safe tool to assist and support you in your good work.

Mary Ellen Copeland, PhD, is the founder of the Copeland Center for Wellness and Recovery and creator of Wellness Recovery Action Plan (WRAP). She is an author, educator, and mental health recovery advocate. She has authored many self help resources including: WRAP: Wellness Recovery Action Plan, The Depression Workbook: A Guide to Living with Depression and Manic Depression, Living Without Depression and Manic Depression: A Guide to Maintaining Mood Stability, The Loneliness Control Workbook, *and* Healing the Trauma of Abuse.

UnWRAPping a Life Worth Living

Carol Bailey Floyd, Mental Health Educator, Advocate, and Advanced Level WRAP Facilitator

"WRAP saved my life!" I have heard that often in the many years that I have been a WRAP (Wellness Recovery Action Plan) facilitator in workshops, trainings, at conferences, and in my personal life. Sometimes people say it as a dramatic statement to indicate that learning to develop a WRAP helped them get out of an abusive relationship, back off from substance abuse issues, manage debilitating physical problems, coordinate a mental health challenge, or even start to heal from the effects of trauma.

But other people literally mean that WRAP has saved their lives. They've learned to interrupt their suicidal thoughts with immediate and specific action plans. Often with the help of supporters, they have started creating a life that is more fulfilling and hopeful.

Every part of WRAP can be significant in suicide prevention. The key concepts are hope, personal responsibility, education, self-advocacy, and support — very powerful ways to take back control in our lives. Wellness tools are the heart of WRAP. They are usually fun, relaxing, and often empowering things that a person can do on a daily basis to help make life more interesting and worth living. Wellness tools are an excellent resource for action planning. Making a list of "What I am like when I am well" is a reference point and a daily goal. Learning to recognize triggers, early warning signs, and when things are getting worse is important, and developing positive action plans to initiate during those times is essential. WRAP also has a crisis and post crisis plan.

Often people with suicidal thoughts or plans feel isolated and hopeless. Once they have developed a system of supporters, which may take time, they never have to be alone again and can have people around them who will encourage them and help them when times get rough.

I met Art in 2005 within a month of his life crashing down around him. He had recently lost his job, marriage, and house. It is a miracle that he survived his suicide attempt and showed up at our laughing club one Saturday. He thought he had nothing to lose and figured that if he could laugh a little, it might make him feel better. Within a month, Art had enrolled in a local WRAP workshop. He took to WRAP as if it was his lifeline, and in many ways, it was.

During his difficult years, Art felt that his darkness was never ending. He was down and out, in a stupor, and drifting. For a year, he watched his life unravel until it became unbearable. The next year brought him to WRAP and the beginning of his recovery.

> **After Art developed a WRAP, he came to believe that suicide was no longer a viable solution.**

Since then, Art and I have become close friends and WRAP supporters to each other. He told me recently, "WRAP empowered me so I could develop tools to manage my highs and lows. Prior to that, there was only medication and no learning process. Becoming proactive and taking responsibility for my life gave me hope that life was actually worth living."

By incorporating WRAP into his daily life, and sharing it with his supporters, Art was able to put his feelings out there and didn't have to hide them anymore. "WRAP is freeing, and by using WRAP language, I could explain my feelings to myself, and to others, and take responsibility for my own wellness," he commented. After Art developed a WRAP, he came to believe that suicide was no longer a viable solution.

At one point, Art gave me a complete copy of his WRAP to take with me to show others at conferences, workshops, and other WRAP activities. He wanted people to understand how WRAP had turned his life around and taken him back from utter despair and the brink of death.

As life got better for Art, he did experience some difficult times of unemployment, but feels strongly that WRAP helped him keep his spirits up so he could apply for jobs with a positive attitude. Now, he happily and gratefully lives with his new wife in a nice house, has an excellent job where he is fully appreciated, and is active in the community. Art still coordinates his WRAP on a daily basis, as well as in rough times, which are much more infrequent now.

WRAP is a powerful and effective way to prevent suicides. Having a WRAP and caring supporters saves lives. Using WRAP makes daily living more manageable with opportunities for hope, possibility, and personal growth.

Carol Bailey Floyd is the director of programs for Mental Health Recovery and WRAP and has facilitated WRAP since 2003. She enjoys training facilitators and has been involved with WRAP in various capacities around the U.S. and Canada. Embracing WRAP wholeheartedly as a way of living has enabled Carol to find balance and wellbeing in ways she never thought possible. As a result, she is always enthusiastic about introducing WRAP to others.

**Austin Travis County
Integral Care**

Tribute

In memory of **Austin Travis County**
residents who lost their lives to suicide.
In honor of the family, friends and
others affected by the tragedy of their loss.

In appreciation of **Austin leaders** who
forged a ground-breaking agreement that
enables the sharing of real time information to
target effective pre- and post-vention efforts.

In dedication to the on-going work of **Austin Travis
County Integral Care's** Mobile Crisis Outreach Team and
24-7 Crisis Hotline professionals, the **Austin Police Department**,
Travis County Crisis Intervention and Victim Services teams, the
Austin Sucidie Prevention Coalition and all the citizens certified
in Mental Health First Aid whose efforts build towards a
healthy community.

24/7 Crisis Hotline 512-472-HELP (4357)
IntegralCare.org

Everyone is Responsible
It Takes a Competent Community to Stop Youth Suicide

Maureen Underwood, LCSW, CGP, Author,
Lifelines: A Suicide Prevention Program, Hazelden

O ne of the most pressing public health problems facing communities today seems to only garner attention when dramatic headlines announce the death of a young person by suicide. Yet, data from the Centers for Disease Control and Prevention's Youth Risk Behavior Survey shows that over 15% of high school students considered suicide in the last year with over 8% attempting suicide. These students are sitting in classrooms, playing on sports teams, and members of a faith community. However, many of these young people have never spoken to anyone about the circumstances in their lives that led them to think about taking their lives. Young people often report that they are reluctant to talk with adults about suicide because they're not sure they will be taken seriously.

Suicide is the third leading cause of death for youth prior to high school graduation. It is the second leading cause of death for young people in college. Most adults do not know how to identify these at-risk youth and are unsure what steps to take if they are concerned about potential suicide risk. In fact, most mental health professionals have never received training to help identify the risk factors, warning signs, or intervention strategies for youth at risk for suicide.

There is good news, however: this lack of awareness is beginning to change. While there is still some degree of stigma attached to acknowledging suicidal behaviors, there appears to be an increasing recognition that suicide *must* be talked about in a context that fosters prevention, not just in the aftermath of a tragic death. Youth suicide prevention programs, like *Lifelines,* are targeting all segments of what is called the *competent community*. Adapting a concept from community psychology, a competent community is described as one in which all members care about each other's welfare and know where and how to get help when a community member is in need. Community members include everyone involved in the lives of youth — family members, educators, and the youth themselves. When everyone takes responsibility for suicide prevention, the protective factors that can help insulate and buffer youth from stress can be multiplied. And there is a much better chance that suicide

> When everyone takes responsibility for suicide prevention, the protective factors that can help insulate and buffer youth from stress can be multiplied. And there is a much better chance that suicide risk will be identified earlier and helpful interventions initiated sooner.

risk will be identified earlier and helpful interventions initiated sooner.

To step up to that responsibility, community members need to learn the most current and accurate information about suicide risk as well as the availability of local treatment resources. Awareness activities include educating everyone in the community about the signs of suicide as well as the importance of encouraging youth to reach out to any trusted adult if they are concerned about themselves or someone in their peer group. The role of trusted adults as helping figures is an essential ingredient in all youth suicide prevention efforts. We know that contact with a caring adult is one of the most important protective factors in the lives of our youth. If that one person is able to understand suicide risk and initiate a conversation about it, think about the difference that could make in the life of a suicidal youth who feels isolated and alone. Talking about suicide can be the critical first step in getting the youth to the necessary behavioral health treatment.

Since youth spend a majority of their time in schools, educational institutions have an essential role to play in this competent community model. Schools are encouraged to develop policies and procedures that clearly delineate their responses to at-risk students, to train their faculty and staff in suicide awareness, and to provide evidence-based curricula that focus on teaching students to reach out to a trusted adult if they are concerned about the risk of suicide for not only a peer, but also themselves. In an active process of empowerment, parents are encouraged to ask questions of mental health professionals to whom their children may be referred for treatment until they receive explanations and information that can help them become a supportive and informed part of their child's treatment plan.

Behavioral health providers are indispensable in this competent youth suicide awareness and responsiveness community. There has been growing recognition on the national level of the importance of increasing training opportunities for frontline mental health professionals in evidence-based assessment and treatment for suicidal youth. It's imperative that treatment providers working with youth, whether they are part of agencies or in private practice settings, recognize that their continuing professional education must include content that addresses these research-based approaches to assessment and management of suicide risk. These resources are available from the Suicide Prevention Resource Center, the national center for the most current information as well as weekly updates on research, online training opportunities, and lists of current programs on the best practices registry and the national registry of evidence-based programs and practices.

When we all recognize our roles as part of that competent prevention community, and share the prevention responsibility, youth suicide doesn't seem so overwhelming.

Maureen Underwood, author of Lifelines: A Suicide Prevention Program; Lifelines Intervention: Helping Students at Risk for Suicide, and Lifelines Postvention: Responding to Suicide and Other Traumatic Death, *is a licensed clinical social worker and certified group psychotherapist with over 35 years of experience in mental health and crisis intervention. From 1985 to 2000, she was the coordinator of the New Jersey Adolescent Suicide Prevention Project. In this role, she initiated collaborative relationships between mental health and educational systems, provided in-service training, provided consultation on policy development, and assisted in the implementation of procedures for school-based crisis management. As clinical director of the Society for the Prevention of Teen Suicide, she has developed an online interactive training program for educators in suicide awareness that has received best practice designation from the Suicide Prevention Resource Center's Clinical Assessment and Management of Suicide Risk Training protocol.*

NFL Kicks Off New Game to Save Lives

John Draper, PhD, Director, National Suicide Prevention Lifeline and President, Link2Health Solutions

While the media has given much attention to concussion-related issues in the lives of former players and family members, this focus has perhaps masked the recognition of behavioral health problems such as anxiety and depression that affect this group as much as they do the general public.

When a person dies by suicide, loved ones are typically plagued with questions such as "Could I have done something more?" This past spring, in the wake of the suicides of former pro football players Dave Duerson and Junior Seau, the National Football League also asked, "What more can we do?" After consulting with prominent suicide prevention experts across the country, the NFL found an answer in the development of a groundbreaking new program.

In partnership with the NFL, Link2Health Solutions and its partners launched the NFL Life Line in July 2012. The NFL Life Line a 24/7 helpline for members of the "NFL Family" to assist them when they are in emotional distress. It is the newest component of the NFL Total Wellness initiative, which builds upon current NFL programs and services that help members of the NFL family deal with pressing matters such as physical and mental health, family safety, lifestyle, and post-career life. Services on the new NFL Life Line target current and former players, NFL staff, and their family members.

While the media has given much attention to concussion-related issues in the lives of former players and family members, this focus has perhaps masked the recognition of behavioral health problems such as anxiety and depression that affect this group as much as they do the general public. Further, transition and adjustment stressors commonly loom large in players' lives from the moment they enter the NFL until the time they leave, typically less than 3 years later. Issues such as changes in their financial status, changes in their social supports (loss of the "locker room culture" and how significant others regard them), changes in their sense of identity ("I am a football player"), and a need for developing new skills to adapt to careers beyond playing football routinely challenge many players in the months and years after leaving the game. For such "tough guys," seeking help — or even talking about feelings — can be hard, creating more challenges for their transition to a different lifestyle. The NFL Life Line provides a confidential service that is one facet of a more extensive education and outreach effort to promote identification of problems and help-seeking behaviors among the NFL family.
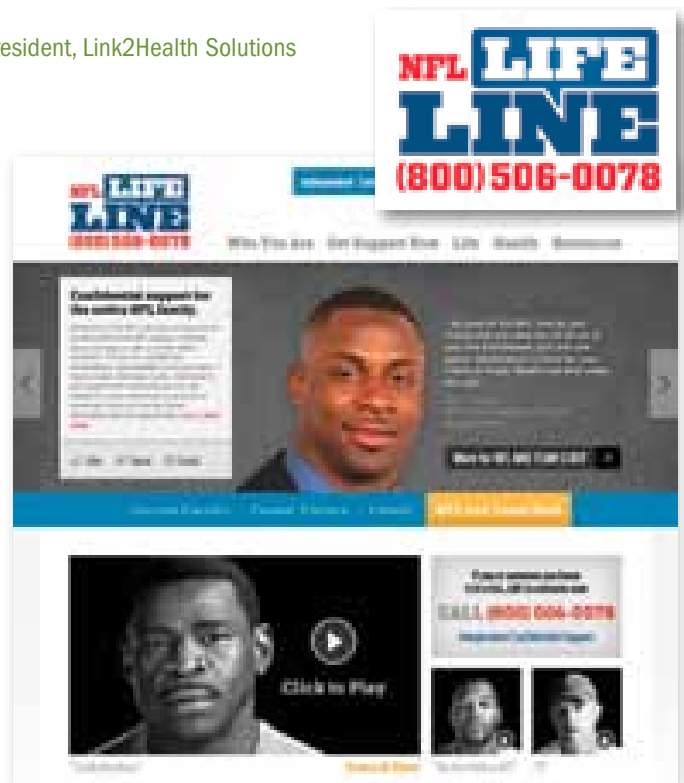
The NFL Life Line project is currently operated through a collaboration of experienced organizations dedicated to suicide prevention work. L2H, which administers both the SAMHSA-funded National Suicide Prevention Lifeline and the NFL Life Line, has employed two crisis centers that respond to NFL callers — Centerstone and the Mental Health Association of New York City's LifeNet — both members of the National Suicide Prevention Lifeline and the National Council for Community Behavioral Healthcare. The JED Foundation and the Educational Development Corporation, which administers the Suicide Prevention Resource Center, provide expert consultation on safe and effective messaging to Reingold Inc., which designs and maintains the NFL Life Line website. In October, the American Foundation for Suicide Prevention will work with Reingold and L2H to adapt its web-based "self-check quiz" (now on the Veterans Crisis Line site) for the NFL Family. The self-check quiz will complement an online chat service that will implemented simultaneously. For more information, visit www.NFLLifeline.org.

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John Draper, PhD, is director of the National Suicide Prevention Lifeline and president of Link2Health Solutions, a subsidiary of MHA-NYC (the Mental Health Association of New York City). Since September 2004, Dr. Draper has overseen all aspects of this service that connects callers to the nearest crisis center within a network of more than 140 crisis centers across the country. Previously, Dr. Draper served as MHA-NYC's Director of Public Education and also oversaw its LifeNet Multicultural Hotline Network. Dr. Draper also worked with Interfaith Medical Center's Mobile Crisis Team in Brooklyn, where for 7 years he conducted and supervised hundreds of home visits to persons in psychiatric crisis of all ages and ethnic backgrounds. He has a private practice in New York City, specializing in family systems and cognitive-behavioral approaches to treatment.

MAGELLAN
HEALTH SERVICES

Journey of Hope
Katie's Story

Katie Ayotte is valued for the many roles she plays — wife, mother, grandmother, friend and behavioral health advocate. But as a survivor of multiple suicide attempts who is in recovery, she also serves as an empathic listener and guide for others who have tried to take their own lives.

Katie's own struggles with mental illness and suicide began at an early age. Over the years, she made multiple attempts to end her life as she battled undiagnosed mental illness. Katie insulated her family and friends from her most painful thoughts and did her best to hide her unsuccessful suicide attempts, fearing she would be a burden to her loved ones. "Keeping my friends and family in the dark about my feelings made me feel even more isolated and fed my suicidal thoughts," she said.

Finally Katie reached out for professional help and began her journey to recovery. Out of this process, she developed a desire to advocate for those with behavioral health issues. In addition to working as a peer group facilitator at behavioral health service provider TERROS, she serves on the Magellan Shared Governance Board as a community member and regularly shares her personal story at behavioral health organizations and conferences and with individuals who are currently undergoing care within the behavioral health system.

In her work at TERROS, Katie co-facilitates the Journey of Hope suicide attempt survivor group with a clinician. "We provide a safe place where people who have tried to kill themselves can begin the healing process and learn how to deal with suicidal thoughts and feelings," she said.

This unique group grew out of the Arizona Programmatic Suicide Deterrent System, a project directed at individuals with serious mental illness and developed by the Arizona Department of Health Services/Division of Behavioral Health Services; Magellan Health Services of Arizona; and a collaborative of behavioral health service providers, governmental agencies, advocacy groups, and other community stakeholders.

"I've been involved with the project since its beginnings in 2009," said Katie. "My experiences —my voice — have helped to shape the work accomplished by the steering committee and work groups."

"It's important to reach out and let others know that they are not alone, that help is available, and that there are other ways to cope with their intense pain," Katie asserts. Through education, tools, processes, support systems, and caring, the Arizona Programmatic Suicide Deterrent System is working to erase the stigma surrounding suicide and break the silence. I truly believe that we will make suicide a 'never event' for those served by the behavioral health system in Arizona."

Excellence in Service Innovation Award

The Central Arizona Programmatic Suicide Deterrent System is the winner of the 2012 National Council Excellence in Service Innovation award supported by Mental Health Weekly.

The relative risk of suicide for individuals with serious mental illness is 12-13 times higher than that of the general population. However, all too often, behavioral health avoids or relegates the issue of suicide prevention to secondary or niche focus. The result is that clinical staff are not adequately trained, many do not feel equipped, and there is a tendency to "pass the hot potato" when the "S-word" is used. The suicide prevention program is recognized for its groundbreaking initiative to reduce to zero the number of suicides among people with serious mental illness enrolled in the region's public health system. Magellan and the Arizona Department of Health Services' Division of Behavioral Health Services led a collaborative with community leaders to change the culture around suicide, arm provider agency staff and families with skills and knowledge to intervene with those most at risk, and create a framework to address this major public health problem. Since 2007, the initiative has succeeded in reducing the suicide death by nearly 50% for those with serious mental illness.

Filling the Adolescent Suicide Ravine with Screening and Prevention

Guy Diamond, PhD, Director, Center for Family Intervention Science and Associate Professor, University of Pennsylvania, School of Medicine; **Joel Fein,** MD, MPH, Professor of Pediatrics and Emergency Medicine, Perelman School of Medicine, University of Pennsylvania at the Children's Hospital of Philadelphia

Suicide is the third leading cause of death among 10 to 19-year-olds in the United States. In a 2011 national survey of high school students, nearly 16% reported seriously considering suicide, 8% reported attempting suicide, and 2% reported receiving treatment from a doctor or nurse because of their suicide attempt. In addition, suicide ideation and attempts are the most common reason for psychiatric hospital admissions, accounting for nearly 500,000 emergency department admissions annually. Even moderate suicide ideation can be disturbing for providers and parents, resulting in distress and utilizing time and resources. Given the severe consequences and cost of youth suicide, it has received surprisingly little prevention and treatment research.

There are many known risk factors for youth suicide. The major domains include: history of ideation and/or attempts, psychiatric disorders, psychological traits, distressed family and social supports, and access to lethal means. Of these, history of attempt and/or ideation has been the strongest predictor of a future attempt. Depression presents in approximately 50% of patients that attempt suicide and 70% of those with suicide ideation. Although 30% of attempters exhibit no depression, they may have problems with conduct disorder and substance use. Family conflict has also been implicated in nearly 50% of suicide attempts. Generally, girls are more likely to make suicide attempts and boys are more likely to complete suicide; girls tend to take pills and boys tend to use

Screening tools can play an important role in the identification of youth at risk for suicide.

guns. In the past, African Americans, like other minority groups, had lower rates of suicide but, unfortunately, the rate of suicide in this group is now comparable to that of Caucasians.

Given suicide's serious impact, there are shockingly few well-developed and tested prevention and intervention models to identify and treat young people. School-based programs for students have often included screening and education. For example, Signs of Suicide (SOS) has been used in over 4,000 schools and has some data to support its effectiveness. Gatekeeper training is another widely used prevention model. These programs train teachers, doctors, and other professionals how to recognize the signs of suicide risk and how to assess and refer these patients. The Yellow Ribbon Suicide Prevention Program (Yellow-Ribbon.org) and Recognizing and Responding to Suicide Risk (suicidology.org)

are increasingly popular gatekeeper training programs. Unfortunately, the research on these methods is sparse and requires more evaluation.

Screening tools can play an important role in the identification of youth at risk for suicide. Brief self-report tools can be handed out in medical waiting rooms, school classrooms, or behavioral health centers. Two popular suicide-screening tools are the Suicide Ideation Questionnaire and the Suicide Risk Screen. Some programs use a depression screens that have suicide items embedded like the Beck Depression Inventory or the Columbia Depression Scale. The Columbia Teen Screen consists of a computer program that screens for suicide and other associated risk factors (Teenscreen.org).

The Behavioral Health Screen is a web-based tool that primary care, emergency rooms, and psychiatric crisis settings have used is a broad-based tool that screens for suicide and psychiatric distress (e.g., depression, anxiety, trauma, eating disorder), risk behaviors (e.g., substance abuse, sexual activity, violence exposure) and patient strengths (e.g., job, school, family). In recognition of the screening's complexity in these contexts, the BHS has been folded into the Behavioral Health-Works project, which provides staff education on suicide risk assessment and strategies for improving collaboration with mental health professionals. The program has been successful in Pennsylvania at identifying patients at risk for suicide and getting them into mental health services.

There are very few empirically tested intervention programs for high-risk youth, or youth who have made a suicide attempt. The existing studies have examined dialectical behavior therapy, cognitive therapy, group therapy, and family therapy. Some studies have added antidepressant medication to these psychotherapy treatments, but none have tested medication alone. A recent study combined cognitive therapy, elements of dialectical behavior therapy, and medication, resulting in some non-conclusive but promising findings. A recent study of attachment-based family therapy demonstrated that 12 weeks of ABFT worked better than 12 weeks of treatment in the community for reducing suicide ideation and depression. These findings held even when patients had co-occurring depression, a history of sexual abuse, or identified as gay or lesbian — characteristics that increase suicide risk.

To assist in disseminating suicide prevention screening, the National Council for Community Behavioral Healthcare is making the Behavioral Health Screen available to members through its Value in Technology program. The screen takes about 7 minutes to complete, is scored automatically, and immediately generates a report for the treating clinician. Behavioral health organizations can easily integrate data into electronic medical records and aggregate it for reports and quality improvement projects. Behavioral health settings also use the Behavioral Health Screen during intake or repeat-measure assessments to track patient outcomes.

To find out how to access the Behavioral Health Screen through the National Council for Community Behavioral Healthcare, contact Michael R. Lardiere, LCSW, Vice President, Health Information Technology & Strategic Development at MikeL@thenationalcouncil.org.
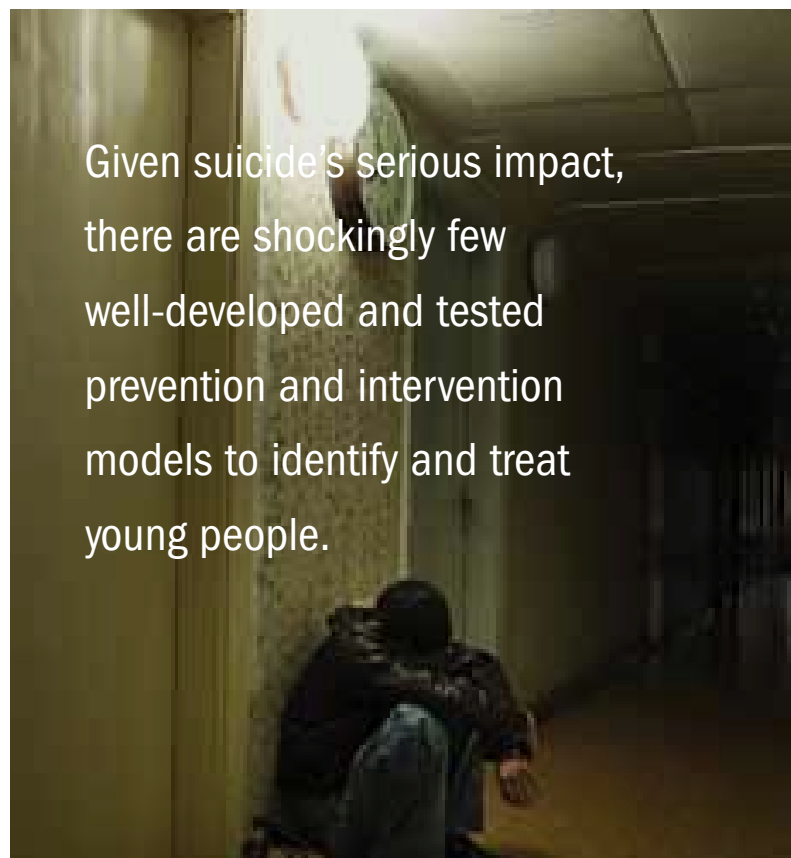
Given suicide's serious impact, there are shockingly few well-developed and tested prevention and intervention models to identify and treat young people.

Guy Diamond, PhD, is an Associate Professor of Psychology in Psychiatry at the University of Pennsylvania, and the Director of The Center for Family Intervention Science at Children's Hospital of Philadelphia. The Center is dedicated to the development, testing, and dissemination of mental health services for adolescents and their families. He has developed Attachment Based Family Therapy, an empirically supported treatment for depressed and suicidal youth. Dr. Diamond is also the primary developer of the Behavioral Health Screen, which is being used in primary care, emergency departments, and mental health facilities across the state of Pennsylvania.

Dr. Joel Fein is a Professor of Pediatrics and Emergency Medicine at the Perelman School of Medicine at the University of Pennsylvania. He also is the Director and Principal Investigator of the Philadelphia Collaborative Violence Prevention Center and the Co-director of the National Network of Hospital-based Violence Intervention Programs. His research focuses on violence prevention, mental health, and procedural pain management.

What's On Your Mind...
Status Update on Social Media and Suicide

Ashley Womble, Online Communications Manager, National Suicide Prevention Lifeline

With more than 500 million users, Facebook is now used by 1 in every 13 people on earth, Almost 500 million tune in to YouTube on a given month (that's more people than live in the United States) and more than 150 million people are active Twitter users.

But it's easy to forget that behind every Facebook picture and Twitter handle is a real live person actively trying to connect with other people. Is it any wonder that people are using their social networks to express feelings of sadness, hopelessness, and suicidal ideation?

Since 2006, the National Suicide Prevention Lifeline has been working with all major social media sites to provide help to at-risk users. The Lifeline helps safety teams at tech companies understand suicidal intent and creates systems that allow users to flag or report others who post concerning messages. In most cases, when people report a potential suicidal user, the person who posted the suicidal content receives an e-mail encouraging them to call the Lifeline. Much like the offline world, it is difficult to gauge someone's intent simply by the language they use, so it isn't possible to create an algorithm that scans social media posts for suicidal phrases. For this reason, social networks rely on individuals to report suicidal behavior.

The Lifeline, a nationwide network of 157 local crisis centers funded by the Substance Abuse and Mental Health Services Administration, answers about 70,000 calls per month. While it is unknown how many people find out about the hotline via social media, one must look no further than the Lifeline's own Facebook page to see that there are many people in crisis who don't feel comfortable picking up the phone.

In an ongoing effort to provide help to people when and where they need it, in December 2011, the Lifeline began offering crisis services to suicidal Facebook users via chat. The new service enables any user to report suicidal comments to Facebook using either the Report Suicidal Content link or the report links found throughout the site. The person who posted the suicidal comment will then receive an email from Facebook encouraging them to call 1-800-273-TALK (8255) or to click on a link to begin a confidential chat session with a trained Lifeline crisis chat specialist. The chat link provided in their e-mail directs the Facebook user to a chat portal where high encryption technology is used to assure security and confidentiality. Lifeline crisis chat specialists are available to answer chats from Facebook users 24/7, giving the user access to help whenever they need it.

This innovative partnership was recognized as a "gold standard" best practice in preventing suicide at the Suicide Prevention Online Summit held in Palo Alto, California in March 2012. Representatives from the Lifeline, SAMHSA, Suicide Awareness Voices of Education, as well as Facebook, Google, Microsoft, Tumblr, Twitter, Wordpress, Yahoo, and YouTube worked to develop consensus for best practices in preventing suicide online.

As the Lifeline continues to harness the power of social media, it is essential to remember that online communication isn't all that different from face-to-face interactions. When someone reaches out for help, whether its takes the form of a tweet or a phone call, the Lifeline is standing by to help.

The National Suicide Prevention Lifeline is a 24-hour, toll-free, confidential suicide prevention hotline available to anyone in suicidal crisis or emotional distress. By dialing 1-800-273-TALK (8255), the call is routed to the nearest crisis center in our national network of more than 150 crisis centers. The Lifeline's national network of local crisis centers provide crisis counseling and mental health referrals day and night.

Ashley Womble is the Online Communications Manager for the National Suicide Prevention Lifeline operated by the Mental Health Association of New York City. With an expertise in digital communications, Ashley works to encourage help-seeking behavior through new media. Prior to joining the Lifeline in 2011, Ashley worked as an editor for Hearst Digital Media and Time, Inc. She received a B.A. in journalism from the University of North Texas. Her essays and articles have been published in Salon, Utne Reader, Cosmopolitan, Austin Monthly, and the Star-Telegram.

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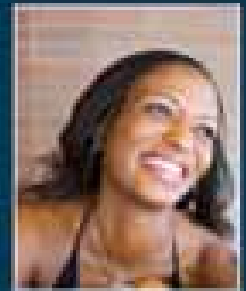
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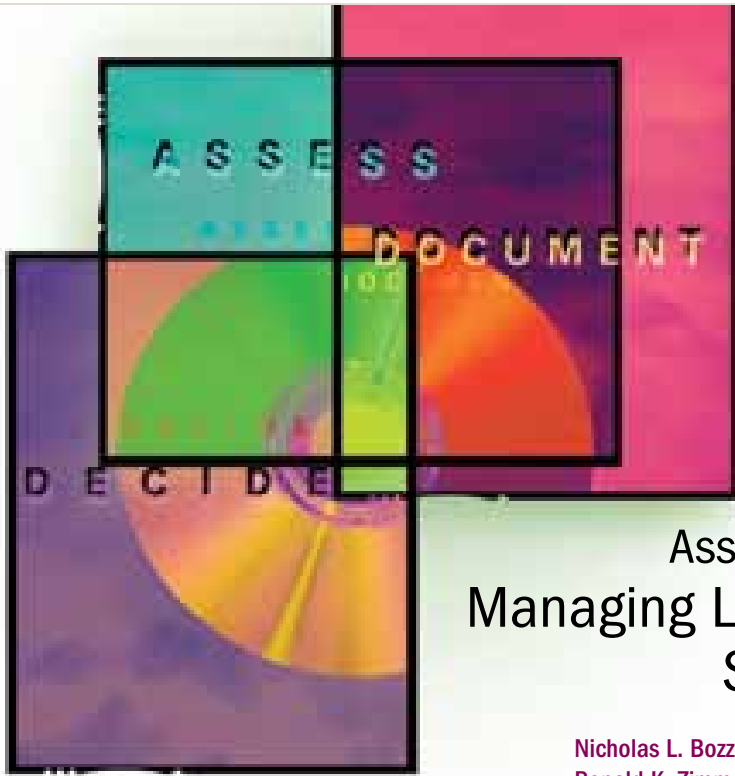
Based on interviews with Meena Dayak and Courtney Young for National Council Magazine

Assess, Document, Decide:
Managing Liability for Suicide Related Claims

Nicholas L. Bozzo, Managing Director, Negley Associates;
Ronald K. Zimmet, JD, General Counsel, Mental Health Risk Retention Group

Individuals with serious mental illness — especially those with major depressive disorder, schizophrenia, bipolar disorder, borderline personality disorder, and anorexia — die by suicide at rates 6 to 12 times higher than the general population.

The risks from suicide related claims are great for behavioral health organizations. Many organizations and professionals believe that if an individual attempts or completes suicide, they are not liable but the claims history suggests otherwise. The potential liabilities can be brought against the professional caregiver, whether it be a physician or other employee, as well as the organization that employs them.

The alleged liabilities that organizations/individual care givers face can be rather broad and include

>> Failure to diagnose that a patient was suicidal

>> Failure to warn

>> Failure to involuntarily commit

>> Failure to consistently and thoroughly evaluate the situation and meet the duty of care threshold

The most significant risk for behavioral health organizations is that of a suicide malpractice — when a client dies by suicide and the family brings a lawsuit for wrongful death. The claim usually is that there was a failure at some point in the process of the care — that the caregiver or behavioral healthcare organization failed to follow the reasonable and ordinary standard of care.

What can be the extent of a suicide malpractice claim? States usually have a statute that defines what can be compensated in a wrongful death case — it's often the amount of support that the deceased person would have provided to the family, funeral expenses, and, depending on the circumstances, the grief and loss of companionship that the family undergoes.

Claims can also result when there's an attempted suicide with serious injuries. For example, a patient was ordered by the doctor to be housed in a secure facility that was locked. However, the door was left unlocked and the patient got out, went up to the top of the building and jumped off, and did not die but had terrible injuries. Injury claims can be very expensive, even more so than when there's an actual death, because the medical expenses can be extraordinary.

Suicide-related claims are usually a question of common law — of whether or not the defendants were negligent and followed the standard of care. Sometimes there are regulations, accrediting body rules, guidelines, or best practices that the plaintiffs might allege were not followed, and that can be proposed as evidence of negligence, but does not necessarily determine negligence. The issues re-volves around whether the plaintiff's expert believes that the standard of care was followed, or whether the defendant's expert believes that the standard of care was not followed. The question is which of those expert opinions makes the most sense under the circumstances.

Today, increasing healthcare integration is leading us to think about new dimensions in suicide risk. As more and more behavioral health organizations provide primary care — either by employing primary care doctors or through partnerships with other organizations — to address the serious health issues of persons with serious mental illness, they need to think about how and where to incorporate at least minimal screening for suicide risk, with appropriate follow up.

ASSESS THE RISK, ASSESS THE RISK, ASSESS THE RISK

The best way to avoid liabilities for suicide related exposures is to utilize a comprehensive suicide risk assessment. The assessment should always be performed, it should be detailed, and it should be very well documented.

Assessment for suicide risk should be conducted thoroughly and consistently multiple times, with many questions asked from different vantage points — and each and every time should be fully documented.

A good risk assessment should obviously include "present situation" questions regarding how the patient is feeling, what is triggering their issues etc. but it should also include finding out about any predisposed factors such as bipolar or other major depression disorders, and whether or not alcoholism or schizophrenia is a contributing factor. A full check into what types of medication the individual is currently taking should be done as part of the comprehensive assessment.

The next step in the assessment should be to determine what other immediate potential factors exist that need to be mitigated such as family history/dynamics, personality variability, presence of firearms or other harmful weapons, as well as a host of other potential issues.

A through assessment needs to include many questions and it is usually a best practice to have questions for the assessment written out and used consistently in all situations. Many times in the moment of a potential crisis, a caregiver can forget some of the questions that should be asked as part of a complete assessment and it can have an adverse impact on determining the appropriate level of care for that specific situation.

In lawsuits, one can generally see a pattern of allegations over a period of time, with the same types of things being alleged as failures. Those are almost always a matter of something that was left out somewhere in the process of the care, as in — did the organization do a thorough risk assessment when a thorough risk assessment was called for? When things don't get done that should have been done, decisions are being made by default rather being made actively.

It's easier to do a thorough risk assessment when somebody is admitted for care into a facility or discharged from care. But what about when the care is ongoing and a person is actually admitted — why don't we do risk assessments when, say, a decision is made to change supervision level from a one-on-one observation to every half hour check? The risk must be assessed and documented to support the decision that's being made.

What if you get new healthcare records from other providers? There may be a need with that new information to rethink the assessment and the risk level.

Often, family members who are very concerned about a patient will call and give the provider new information, which is not adequately addressed. Sometimes

the person who's actually directing the care doesn't end up getting the information — it gets lost somewhere in the process of communication. For example, it may be a situation where there is information about a patient self-medicating; there's a prescription for a particular medication and the patient decides to take twice that amount, or the patient decides to go off the medication entirely. Change in medication definitely calls for a reassessment of risk.

An excellent article by Joiner, Walker, Rudd, and Jobes in the Journal of Professional Psychology: Research & Practice, 1999, Volume 30, Number 5, Pages 447 to 453 provides direction on scientizing and routinizing the assessment of suicidality in outpatient practice. The authors point out is that frequency of thoughts about suicide is not as pernicious as having very resolved plans and being prepared.

What we see with some frequency are allegations by plaintiffs that the actual risk assessment is limited to basically two questions. Those questions are: "Are you having suicidal thoughts, and do you have any plans?" However, assessment of suicide risk is far more complicated than just those two questions. Ironically, whether or not someone is having suicidal thoughts is not in itself a very good discriminator as to whether or not they're actually going to attempt suicide. Some good discriminators are resolved plans and preparations and a history of attempts.

RECOMMENDATIONS

Healthcare providers must have a structured risk assessment with a list of things that must be done to complete the assessment. For instance, the first thing is making sure you get enough information. Plaintiffs frequently allege that information was available, but nobody asked. For instance, the police officer, a family member who comes with the patient, or the emergency room doctor may have information — but those sources weren't consulted and if they had they been, there would have been a different decision because the risk level would have been appreciated differently.

Assessment for suicide risk yields information that is really helpful. If you use a decision tree, and make sure that you have enough information to make your decisions about suicide risk, you're much more likely to make the right decision.

We also recommend offering suicide prevention programs and treatment for staff — case managers, supervisors of supervised apartments, etc. — that may not necessarily have the highest education and training and skill levels. There are some effective treatment programs that don't require psychiatrists or clinical psychologists or a licensed therapists. For instance, Dr. Joiner recommends that patients be given counseling on how to sleep, because if you're not sleeping, you're far more likely to be depressed.

'Behavior Activation' is indicated to be pretty effective in treating depression. You talk to patients and get them to do activities that they will enjoy and that are consistent with their values. Any level of staff can do this.

Basically, utilize your staff in the most efficient, cost-effective way, and give them things to do.

Another technique that has been indicated as pretty effective is 'Caring Letters.' In between actual face-to-face visits, the therapist sends a caring letter or makes a call to say "I just wanted to see how you're doing," and "Don't forget that we have an appointment coming up." Research has shown that those kinds of contacts can be an effective form of suicide prevention.

Nicholas Bozzo has 25 years experience in insurance starting with underwriting at Chubb, Kemper, and Axis and rising to head the Mental Health Risk Retention Group and Negley Associates. He says his proudest achievement is "Taking on the leadership role of an organization with a 20-year track record of success — that's considered by many to be the gold standard of risk retention groups — and continuing to maintain the success without missing a beat." He was named "CEO of the Month" in November 2008 by Risk Retention Reporter. Just before joining Negley, he gained senior management experience as founder and head of the Specialty Lines Business at Beazley, PLC.

Ronald K. Zimmet has been a trial lawyer since 1975. He maintains an active litigation practice and provides risk management consulting services to community mental health centers nationwide. Zimmet helped organize and for over 20 years has served as general counsel to the Mental Health Risk Retention Group, Inc. an insurance company providing professional and general liability and directors and officers insurance to community mental health centers. He is the featured speaker in risk management audio and video presentations presented by the Risk Retention Group that address, among other things, risk management for sexual misconduct, suicide malpractice, violent patients, medication errors and employment related claims. Zimmet has lectured on risk management at many national conferences.

The best way to avoid liabilities for suicide related exposures is **to utilize a comprehensive suicide risk assessment.**

Suicide Prevention Resource Guide

Jerry Reed, PhD, MSW, Vice President, Education Development Center and Director, Suicide Prevention Resource Center

In 2001, the National Strategy for Suicide Prevention called for the development and implementation of community-based suicide prevention programs and laid out a number of objectives to accomplish this goal. One key element of this framework was the development of one or more training and technical resource centers to help states and communities implement and evaluate suicide prevention programs. To that end, the Suicide Prevention Resource Center was established in 2002 as the nation's only federally supported resource center devoted to advancing the national strategy.

The Suicide Prevention Resource Center serves individuals, groups, and organizations that play an important role in suicide prevention, including:

>> Behavioral health organizations that identify and help individuals at risk for suicide

>> Professionals providing social services in their community and organizations that can help reduce suicide rates among the populations they serve

>> State, tribal, campus and community suicide prevention coordinators

SPRC supports the efforts of those who are working to prevent suicide by providing training, publications, and other resources that offer timely, research-based information about suicide prevention. One great way to get started finding resources, information, and tools to assist you in making suicide prevention an integral part of your practice is to visit the SPRC Health & Behavioral Health Care Providers web page at www.sprc.org. The state and community web pages provide state contact information and tell you what's going on in your area related to suicide prevention.

All resources described in this article are available on the SPRC website at www.sprc.org.

The SPRC Training Institute provides high-quality trainings free or at the lowest possible cost to individuals and communities across the country:

>> **Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals:** This one-day program meets providers' needs for research-informed, skills-based training in assessing, treating, and managing suicidal patients or clients. Continuing education credits are available.

>> **Counseling on Access to Lethal Means:** This online course is designed for providers who counsel people at risk for suicide. The first module explains why reducing access to lethal methods of self-harm saves lives. The second module teaches practical skills on when and how to ask suicidal clients about their access to lethal means and how to work with them and their families to reduce their access.

>> **Research to Practice (R2P) Webinars:** These interactive web-based seminars address the science of suicide prevention in practical terms. New webinars are presented on an ongoing basis, and an archive of past webinars is available.

Are you working with LGBT clients? Serving a rural area? Wondering how to better serve the elderly in terms of suicide prevention? The SPRC Library is a searchable collection of authoritative resource materials on suicide and suicide prevention that you can use to find the information that's of greatest interest to you. In addition to SPRC products, the library contains selected materials developed by other organizations and professionals. This collection is maintained by SPRC and items are regularly added by professional librarians.

Two resources focused on healthcare providers may be useful for those involved in behavioral healthcare as well.

>> **The Suicide Prevention Toolkit for Rural Primary Care** was written with rural primary care settings in mind, but contains many tools that are suitable for behavioral health settings. This web-based toolkit contains templates for assessing patients' suicide risk, planning interventions, and creating safety plans. The toolkit also includes posters for display and wallet cards listing warning signs for suicide and the number of the national suicide prevention crisis line.

>> **The "Is Your Patient Suicidal?" Emergency Department Poster and Clinical Guide** can help behavioral health providers who receive referrals from EDs to provide ED practitioners with information on recognizing and responding to acute suicide risk.

For community behavioral health providers who work with high schools, two toolkits offer practical, adaptable resources for suicide prevention and crisis response. :

>> **Preventing Suicide: A Toolkit for High Schools** provides research-based guidelines and resources to help identify teenagers at risk for suicide and take appropriate measures to provide help. The toolkit includes information on screening tools, warning signs and risk factors of suicide, statistics and parent education materials.

>> **After A Suicide: A Toolkit for Schools** is a practical online resource to help schools respond to a suicide or other death in the school community. The toolkit incorporates relevant existing material and research findings as well as references, templates, and links to additional information and assistance.

The suicide prevention field is continually evolving as the research base grows and best practices emerge. SPRC offers several ways to keep up with the latest developments in suicide prevention. One is the Weekly Spark, SPRC's electronic newsletter. The Weekly Spark reaches more than 11,000 subscribers with announcements of webinars and other training opportunities as well as brief summaries of national, state, and international news; analyses of relevant research findings; descriptions of funding opportunities; and links to additional resources. You can also follow SPRC on Facebook and Twitter.

Jerry Reed began serving as the Director of the Suicide Prevention Resource Center in U.S. in July 2008. Through this work he provides state and local officials, grantees, policymakers, interested stakeholders and the general public with assistance in developing, implementing and evaluating programs and strategies to prevent suicide. Additionally, Dr. Reed serves as the Director of the Center for the Study and Prevention of Injury, Violence and Suicide overseeing a staff of 40. Prior to this appointment, Dr. Reed served for five years as Executive Director of the Suicide Prevention Action Network USA (SPAN USA) a national non-profit created to raise awareness, build political will, and call for action with regard to advancing, implementing and evaluating a national strategy to address suicide. He spent 15 years as a career civil servant working in both Europe and the United States as a civilian with the Department of the Army developing, implementing and managing a variety of quality of life programs including substance abuse prevention and treatment, family advocacy, child and youth development programs, social services and the range of morale, welfare and recreation programs.

SUICIDE PREVENTION RESOURCES ONLINE

- SPRC Health & Behavioral Health Care Providers Web page www.sprc.org/for-providers

- SPRC States & Communities Web pages www.sprc.org/states

- SPRC Training Institute www.sprc.org/training-institute

- Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals www.sprc.org/training-institute/amsr

- Counseling on Access to Lethal Means (CALM) www.sprc.org/bpr/section-III/calm-counseling-access-lethal-means

- Research to Practice (R2P) Webinars www.sprc.org/training-institute/r2p-webinars

- SPRC Library www.sprc.org/library_resources/listing

- The Suicide Prevention Toolkit for Rural Primary Care www.sprc.org/for-providers/primary-care-tool-kit

- The "Is Your Patient Suicidal?" Emergency Department Poster and Clinical Guide www.sprc.org/library_resources/items/your-patient-suicidal

- Preventing Suicide: A Toolkit for High Schools www.sprc.org/library_resources/items/preventing-suicide-toolkit-high-schools

- After A Suicide: A Toolkit for Schools www.sprc.org/library_resources/items/after-suicide-toolkit-schools

- The Weekly Spark www.sprc.org/news-events/the-weekly-spark/

- SPRC on Facebook www.facebook.com/SuicidePreventionResourceCenter

- SPRC on Twitter twitter.com/sprctweets

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Thank you for all you do to prevent the tragedy of suicide.

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To get your free course "Overview of Suicide Prevention" and learn more about Essential Learning courses, please go to:

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Suicide Prevention From the Field

Mental health and addiction treatment providers across the USA showcase their suicide prevention initiatives.

Dickinson Teaches Kids to ACT

Jennifer Dippold, Coordinator, Children's Prevention Services, Dickinson Center, Inc., PA / jennifer.dippold@dickinsoncenter.org

Formed in 1958 as the Ridgway Area Psychiatric Center, Dickinson Center, Inc. provides outpatient psychiatric care to rural northwestern Pennsylvania and serves over six counties. DCI is committed to helping individuals reach their full potential by providing a comprehensive spectrum of behavioral health, intellectual disability, and prevention services.

DCI is in its sixth year of providing the Signs of Suicide Prevention Program in two of the counties it services: Elk and Cameron. DCI's Children's Prevention Services division staff facilitates this school-based prevention program that screens for depression and other risk factors associated with suicidal behavior and serves secondary school students ages 13-18. SOS teaches children how to recognize the signs of suicide in themselves as well as others and then teaches them how to respond to a friend who might voice suicidal thoughts. The program teaches students that suicide is directly related to mental illness, typically depression, and that it is not a normal reaction to stress or emotional upset. SOS teaches the acronym "ACT"— Acknowledge, Care, Tell.

SOS teaches the acronym "ACT" Acknowledge, Care, Tell

The SOS's goal is to reduce suicidal behavior among adolescents through two mechanisms. First, the program's educational component is expected to reduce suicidality by increasing students' understanding and recognition of their own depressive symptoms and that of others and by promoting more adaptive attitudes toward depression and suicidal behavior. Second, the program's self-screening component helps students assess and evaluate the depressive symptoms and suicidal thoughts they may be experiencing and prompts them to seek assistance when dealing with these problems.

Creative activities staff has used to educate the community include:

Suicide Symposium: DCI offered the symposium to the Elk County community. The symposium consisted of presenters who have been affected by suicide. The symposium goal was for presenters to provide community awareness of the concerns around suicide's signs and symptoms.

Billboard /Poster Contest: DCI challenged the 8th grade class in Cameron County School District with a poster contest. The students depicted an inspirational message through a poster by using the elements of the SOS Program. For example, one poster elaborated on the ACT acronym. The contest winner had their image placed on a local billboard.

Institute for Family Health Taps Into the Saving Power of EHRs

Neil Calman, MD, President and CEO, and Virna Little, PsyD, LCSW-r, Senior Vice President, Psychosocial Services and Community Affairs — SAP Institute for Family Health, New York, NY / vlittle@institute2000.org

Traditionally, the responsibility of assessing suicide risk has mainly fallen to primary care professionals, as they often actively treat people who are suicidal but not engaged in mental health treatment. Recent research shows that 25-60% of people contemplating suicide seek attention for a medical problem in the weeks before death, and yet as many as 75% do not seek prior psychiatric help. Such evidence speaks to the need for systems to help identify and monitor individuals at risk for suicide in primary care settings.

Electronic health records facilitate immediate feedback to healthcare providers and offer ways to identify and track potentially suicidal patients. Using EHRs, with the involvement of primary care providers, in suicide assessment and prevention may significantly help identify suicidal patients who are not actively seeking mental health treatment and ultimately reduce overall suicide rates. Understanding the major effect that training and EHR decision support can have on suicidality, the Institute for Family Health, a not-for-profit community health center network located in New York, launched a two-prong approach to striving for a zero suicide rate in the populations it serves.

> Now, the Institute requires that all patients who respond positively to the PHQ-9 suicide screening question have "suicide risk" put on their problem list, which means it is visible to all providers who see the patient, regardless of discipline.

The Institute's senior leadership understood that training staff on suicide prevention and awareness is crucial to eliminating completed suicides in its patient population. Partnering with the Mental Health Association of Ulster County and Dr. Max Banilivy, the Institute set upon a mission to train its entire staff using the evidence-based models SAFETALK and ASIST. In 2008, the Institute implemented a policy mandating suicide prevention training for every employee. All staff, regardless of discipline or position, must participate in at least one of the trainings: behavioral health staff participate in the two-day ASIST training and all other staff attend the 3-hour SAFETALK training. The Institute has trained over 700 members of its 900 staff to-date, making this initiative one of the largest employer suicide prevention initiatives in New York. As a training center for family practice and mental health clinicians, the Institute's mandate ensures that over 50 mental health interns and family practice residents are trained each year.
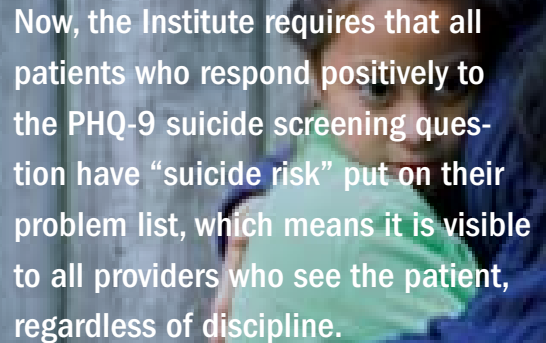
The Institute's second initiative was the implementation of the EHR system Epic (Epic Systems, Verona, Wisconsin) 10 years ago for the identification and assessment of patients at risk for suicide. While the Institute implemented Epic, it simultaneously launched a depression identification and treatment program, making it the first organization to build the PHQ9 depression screening tool into their EHR, scoring it as a lab value. When the PHQ-9 score is a 10 or above, it is added as an abnormal lab value in the EHR, which then alerts providers to the patient's potential risk. Many organizations only flag scores over 10 as an alert; the Institute took it one step further, adding the additional indicator of using a decimal point score for how a patient answers on question 9 (Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead, or of hurting yourself?), which better alerts staff to the patient's thoughts of suicide. While electronic health technology and the use of the PHQ-9 has advanced since that time, the Institute maintains one of the country's highest screening rates at almost 90%.

Now, the Institute requires that all patients who respond positively to the PHQ-9 suicide screening question have "suicide risk" put on their problem list, which means it is visible to all providers who see the patient, regardless of discipline, and it is "blown in" to each provider's note, automatically bringing immediate attention to the patient's risk for suicide. Staff are required to ask the patient if they are at risk. Then, they must develop and review the safety plan and, if necessary, seek mental health support, if they are not a mental health provider.

A safety plan has been built into the EHR that is designed to be completed concurrently with the patient and can be printed individually or as part of an after-visit summary for the patient. As part of a comprehensive suicide prevention program, the Institute developed policies that require direct care staff of any discipline to address suicidality during all interactions.

The Institute also pioneered several decision support tools to alert providers of a patient at risk of suicide. An" FYI" alert is placed in the patient's chart that pops up to notify all providers that the patient needs to be assessed for risk as they open the encounter. The ability to view the FYI alert gives providers immediate information on how to access the patient's safety plan and information regarding the patient's suicidality in order to review it with the patient and further assess risk.

The Institute can run reports for patients with "suicide risk" on their problem lists that have not accessed the organization in 30, 60, or 90 days, prompting staff to review the patients' records and conduct outreach calls or visits. The Institute also utilizes two electronic portals— a physician portal and patient care portal. The patient care portal, or "MyChart," allows patients to view their health records, obtain accurate health related information, and communicate with their providers. The Institute has

recently built the PHQ-9 into the MyChart portal so patients can complete the tool electronically while in the community. In addition, the ability to communicate with their provider through secure electronic mail helps patients because they can reach out to someone with whom they have a relationship for help and support. The physician portal, "InstituteLink," provides access to patients' records. The community providers' ability to see a patient's problem list alerts them to a patient's potential suicide risk and gives them access to the safety plan, allowing them to review and update the plan with the patient and thereby reducing the patient's risk. This increases the opportunities for assessment, risk reduction, and care coordination, as the community organizations can communicate with the patients' health and mental health providers at the Institute, creating a true care network for the at risk patient.

> We will continue to see the high rates of completed suicides for patients known to primary care

The EHRs can play a significant role in identifying patients in community health settings, a common difficulty. Including risk in problem lists, in addition to decision support tools, can dramatically improve the likelihood of assessment for an at-risk patient. However, without proper training, providers in community health settings will feel unprepared to ask patients about suicidality — and we will continue to see the high rates of completed suicides for patients known to primary care. Community health organizations can significantly impact suicide rates by adopting a model that incorporates both the systematic training of providers and the identification and monitoring of at-risk patients through their electronic health records.

Manatee Glens Runs for Hope

Mary Ruiz, President and CEO, Manatee Glens, Bradenton, FL / Sondra.guffey@manateeglens.org

Manatee Glens, Bradenton, Florida's specialty hospital and outpatient practice is celebrating its 10th year of hosting Walk for Life, a 5k run and fun walk to raise awareness about depression and to prevent suicide. Each year, about 1,000 people of all ages and walks of life join the event to support and help raise funds for families in crisis who need mental health and addiction services at Manatee Glens.

Walk for Life helps us make great strides in eliminating the stigma of depression and promoting a message of hope. We also celebrate and honor the lives of those we have lost to suicide. The young people are especially touched by this and leave with a better understanding of the value of each life.

This year, Walk for Life will take place on September 22, 2012 in a large public park and include a scenic walk over the Manatee River. It will be an upbeat, positive event with music, dancing, food, a memory quilt, and an emotional butterfly and bubble release. Schools will compete for prizes for the most participation; families, houses of worship, clubs, businesses, and others will also form teams to make it a friendly competition as they raise funds.

This year, the July kick-off event featured a local celebrity, Bob Delaney, a former decorated trooper with the New Jersey State Police, retired National Basketball Association referee, and author of *Surviving The Shadows: A Journey of Hope into Post-Traumatic Stress.* Delaney is now dedicated to raising awareness of posttraumatic stress, especially among veterans.

Manatee Glens draws in many community members to make it a truly grassroots outreach opportunity. The event committee includes business owners, school board representatives, community volunteers, employees of business partners, and Manatee Glens board members and staff. Business partners contribute cash to cover event costs, food, prizes for top fundraisers, and in-kind donations. Local newspapers and television stations promote the event with public service announcements and news reports, and the local educational station tapes the event and produces a special report that it airs over the next month.

Manatee Glens Walk for Life Chair Patricia Lucas, EdD, said, "This is personally very important to me. It is inspiring to see the crowd — especially the hundreds of teenagers — walking and running for those we have lost and especially for those we hope to save."

> Manatee Glens draws in many community members to make it a truly grassroots outreach opportunity.

More Than One Life
Terry Wise

On the morning of Christmas 2000, I took a massive overdose of narcotics. Two days later, I woke up on the liver transplant floor of a nearby hospital. There is an enzyme in your liver called an ALT. The normal count for a healthy liver is 50. My ALT count was 18,000. Needless to say, my survival still remains a medical mystery.

One year prior to the attempt, my husband died. A few weeks before our wedding, he had been diagnosed with Lou Gehrig's disease, a fatal, untreatable, neurological illness that causes progressive paralysis throughout your entire body. The disease took its course over the next four years and ultimately claimed his life, leaving me a 35-year-old widow.

Most people assume that the reason for my attempt was my husband's death. There is no question that the toll of four years of caregiving, coupled with the anguish of loss, contributed to my steep descent. But as I later learned during treatment with a psychologist, there were many other experiences that contributed to my depression, dating back to childhood. This included, unfortunately, a long history of sexual abuse.

Suicide does not stand alone. It does not just happen out of nowhere. It can be the result of an untreated mental illness, a catastrophic event, or, as in my case, an accumulation of experiences. In essence, my husband's death was a catalyst that revived a lot of the previous turmoil in my life. The work I did in therapy helped me unearth, examine, and learn how to cope with all of these feelings and experiences that led me to have suicidal thoughts.

Overcoming the stigma associated with depression was one of the first turning points for me. As I began to understand that depression was not a weakness and that there was no shame in seeking treatment, the stigma began to lose its "silencing" power. Talking about my feelings was a foreign and terrifying notion, but in therapy I learned how it could lead to new understanding, coping strategies, and pivotal emotional shifts.

I now devote my life to full-time public speaking and writing, sharing all I've learned with others. I consider it a privilege to do this work. Each time someone writes to tell me that something I said or wrote gave them inspiration to continue living or helping others, I receive a priceless gift. The rewards of helping others are immeasurable.

Despite the skepticism I once had about my ability to love and trust again, I am now remarried and able to enjoy a deeply fulfilling relationship. I am truly blessed and I never, not for one moment, forget what it took to get here and how much the journey was worth it.

I often say that every time you prevent a suicide, you save more than one life. Similarly, every time you help someone who is confronted with depression, grief, or the stress of caregiving, you provide the dual benefit of helping them and everyone who loves and cares about them. I continue to tell my story to inspire others to come forward to seek help. I strive to serve as a living example that there is hope and a process that works.

Terry Wise has traveled to all 50 states and hundreds of cities to appear as a keynote speaker and continuing education instructor, speaking to diverse audiences on topics related to depression, suicide, grief, caregiving, and the process of recovery. Her book, *Waking Up: Climbing Through the Darkness*, is in use at universities and crisis clinics nationwide. She serves on numerous boards and steering committees, including the National Suicide Prevention Lifeline, SPRC, and the Public Awareness and Communication Task Force for the National Action Alliance for Suicide Prevention.

Nebraska Says There Is No End Without Means

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The Nebraska State Suicide Prevention Coalition helps communities take action to prevent suicide by letting people know what they can do to make their homes safer. Restricting access to lethal means of suicide at home is an effective way to increase the chances that a suicidal person will receive the assistance they need by buying time and making the most deadly means of suicide harder to access.

Research indicates that firearms are the method most commonly used in completed suicides. Poisoning is also a lethal method of suicide that many people impulsively choose. By working with family members and care providers to reduce a suicidal person's access to guns and medications, we ensure that more people get another chance at life.

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Family members can take two simple actions to make their homes safer:

1. Remove or lock all firearms. Store firearms out of the home, especially if you think someone in your home is impulsive or suicidal. If storing them elsewhere is not an option, store all firearms unloaded and locked, and lock the ammunition in a separate location or remove it. Firearms that must be carried as part of a job should be stored at work if possible.

2. "Suicide-proof" your medicine cabinet. For medicines your family needs, keep only non-lethal quantities on hand and lock up the rest. For medicines your family doesn't need or have expired, empty the medicines into a sealable plastic bag, crush them, or dissolve them with water, add yucky stuff like coffee grounds or kitty litter; then, seal the bag and toss it in the trash. Don't flush or pour medications down the drain unless directed to on the label.

Reproducible means restriction handouts are available for dissemination to families and for emergency providers, emergency rooms, and other healthcare providers as a teaching tool on means restriction education under the resource tab at www.youthsuicideprevention.nebraska.edu and www.suicideprevention.nebraska.edu.

PEMHS Adopts a Well-Rounded Approach to Avert Crises

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Personal Enrichment through Mental Health Services serves over 9,000 clients a year in Pinellas County, Florida, which has a population of one million. Among the agency's offerings is the ongoing emphasis on suicide prevention. The agency has long been identified as the county's suicide prevention line and subsequent intervention, hospitalization, or outpatient referrals resource.

Nearly two decades ago, PEMHS began to obtain certification for its crisis and emergency services through the American Association of Suicidology. The agency has found that AAS certification lifts the level of awareness for staff involved in suicide prevention, and these professionals continue to maintain AAS protocols and risk assessments and attend the annual conference.

PEMHS runs a variety of suicide prevention activities. It has sponsored school-based contests to engage youth to develop suicide prevention posters for countywide distribution and staff have offered system-wide presentations upon the requests of principals. Since PEMHS has a children's crisis unit and children's outreach capacity, this focus on suicide awareness activities has made PEMHS a center of excellence and continuity of care in this crucial area. Additionally, teams are available to support outreach to agencies, businesses, schools, and others, should intervention with supervisors or those affected by suicide be requested following an incident.

Over the years, the agency has instituted a suicide survivor group. Run by a therapist, this group has open-ended membership and accepts referrals from any number of sources, including the local Yellow Ribbon support members, for intervention and support for family members and significant others affected by the loss of a loved one.

As a designated agency in the National Suicide Prevention Lifeline, staff seamlessly field calls from the 24-hour hotline. Also through the Lifeline, PEMHS also received a small SAMSHA grant for additional follow-up services that encourage linkage and connectivity to essential support services for individuals who are suicidal, ensuring them continued access to wellness and recovery after program participation.

PEMHS uses the cornerstone for evidence-based training in suicide awareness, "The Applied Suicide Intervention Skills Training" program (ASIST). The agency has two certified trainers and offers community and staff training quarterly. As CEO, I also serve on the national Lifeline Advisory Committee, offering the unique input of a community behavioral health agency.

PEMHS' standards for suicide prevention activities have grown over many years and now the agency provides a continuum of services over time that includes certification, service fidelity, staff, and community awareness.

Riverside Trauma Center Goes to School for Suicide Prevention

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In late January 2012, a 12-year-old boy in New Bedford, Massachusetts, died by suicide. This was the second suicide death of a New Bedford middle school student in a year. Only about 200 children under the age of 14 die by suicide in the U.S. each year. The community was overwhelmed. The school district asked Riverside Trauma Center to help manage the aftermath and implement a proactive suicide prevention program.

Riverside Trauma Center is a service of the nonprofit organization Riverside Community Care. We help people recover from the overwhelming stress caused by traumatic events by providing community outreach and counseling. In 2006, then State Senator Scott Brown sponsored a bill to ensure the availability of trauma response services to communities in need. This support helped cement the establishment of Riverside Trauma Center, which the Massachusetts Departments of Mental Health and Public Health now primarily funds.

Over the years, Riverside Trauma Center has responded to dozens of situations — a workplace shooting, a bus crash that took the lives of several students, and relocated hurricane Katrina victims who needed "psychological first aid."

The comprehensive suicide prevention plan for New Bedford schools included training students, staff, and parents, as well as clinical support personnel for the middle school at the site of the most recent death. We also hosted two parent meetings to address parents' fears and teach them to recognize the signs of depression and suicide in children and adolescents. More than 300 teachers in three middle schools and three alternative schools were trained to identify and respond to at-risk students.

It is critical to immediately tend to the students after a suicide. A student's suicide death increases the chance of suicide by classmates and raises concerns about the slight risk of suicide contagion. Riverside Trauma Center uses SOS Signs of Suicide® Prevention Program, an evidence-based program developed by Screening for Mental Health. SOS teaches students to identify the symptoms of depression and suicidality and stresses the importance of involving a responsible adult if they are worried about a friend or classmate.

Riverside Trauma Center trained secondary counselors and teachers to utilize SOS with students. The curriculum is composed of a video, a facilitated discussion, and a depression and suicide screening tool. We organized the screenings and trained 30 local mental health clinicians to assess youth who screened positive for depression and suicidality. The trained team ultimately screened over 1,500 6th and 7th graders.

Schools must be proactive to traumatic incidents such as suicides. When we work in schools following a suicide death, we often find that up to 35% of students need to see a clinician following the screening process. The Riverside Trauma Center Postvention Protocols, which are listed in the Best Practices Registry for Suicide Prevention — a collaboration between the Suicide Prevention Resource Center and the American Foundation for Suicide Prevention — are at www.riversidetraumacenter.org.
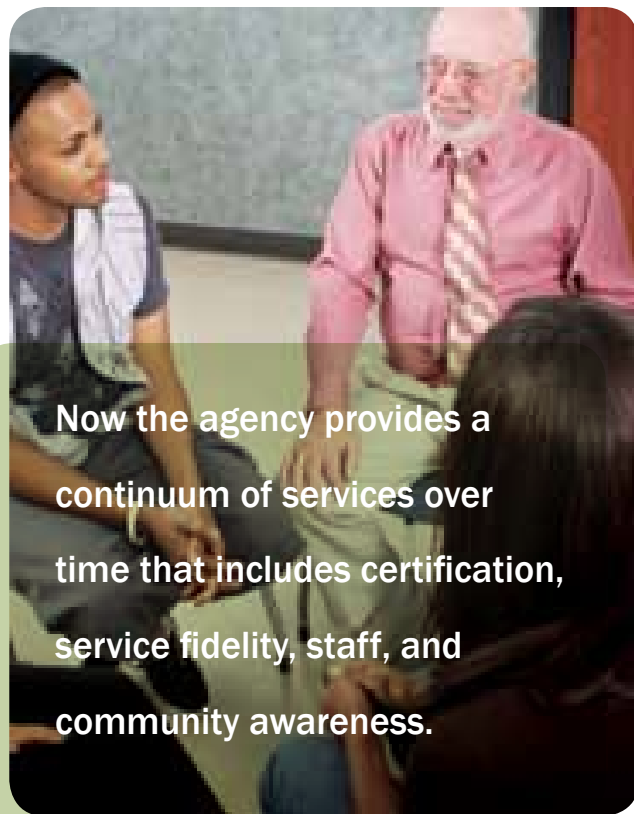
Rushford Ensures SAFE-T for Persons with Substance Abuse

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> Alcoholism is a factor in 30% of all completed suicides.

A common phenomenon in substance abuse treatment is an increased likelihood of past or present suicidal behavior. This correlation has been at the crux of various published research studies — demonstrating just how critical it is to screen all individuals admitted for substance abuse for the presence of suicidal tendencies. Rushford, a leading provider of substance abuse treatment in Connecticut, has created a comprehensive initiative to accomplish this goal in ways traditionally found only in mental health settings.

The cornerstone of this effort is the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T), which was developed by the Educational Development Center and Screening for Mental Health. SAFE-T walks a clinician through a 5-step process to determine an individual's risk level and develop possible interventions. The five steps include:

>> Assessing specific risk factors, including current/past psychiatric diagnoses, key symptoms (e.g., anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, hallucinations), suicidal behavior (e.g., prior attempts, aborted suicide attempts, self-injurious behavior), family history, precipitants/stressors, and access to firearms.

>> Determining internal and external protective factors.

>> Conducting a suicide inquiry comprised of specific questions about suicidal thoughts, plans, behaviors, intent, and homicidal thoughts.

>> Evaluating risk level as high, moderate, or low based on weighing the risk versus protective factors, in conjunction with the level of suicidality. The instrument includes possible interventions for each risk level to serve as guides, but they do not substitute clinical judgment.

>> Documenting both the rationale for the risk level and the treatment interventions that were developed to reduce the client's risk of suicide.

7% of those with alcohol dependence will die by suicide.

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Senior Reach Assesses for Suicidal Ideation in Older Adults

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Senior Reach is an award-winning, evidence-based program that provides care management, mental health treatment, and wellness services at no cost to adults over the age of 60 who are isolated, frail, or need support. The result of a successful collaboration between Jefferson Center for Mental Health, Seniors' Resource Center, and Mental Health Partners of Colorado, this innovative community-based program identifies older adults who need support and/or connection to community services in a contiguous five county area of Colorado. Senior Reach clinicians provide services in either the senior's home or an outpatient office.

In addition to counseling and wellness services, Senior Reach trains individuals and professionals in the community to identify and refer seniors in need. To date, an estimated 26,000 Community Partners have been trained to identify and refer older adults experiencing mental and emotional problems, personality and physical changes, poor health, social isolation, substance abuse, abuse or neglect, and risk factors of suicide. Community Partners include both traditional partners such as doctors, nurses, adult protection, human services workers and non-traditional partners, including bank tellers, bus drivers, postal workers, apartment manager, and others. The Community Partner trainings enhance the community's ability to serve older adults, help reduce stigma associated with seeking care, and improve collaboration between agencies.

Senior Reach utilizes a brief therapy model consisting of an average of eight sessions and individualized treatment plans that are developed in partnership with the consumer. Certified addiction counselors are available for seniors with substance abuse, alcoholism, or co-occurring disorders; geriatric psychiatric services, including assessment, and medication management, are available to seniors with more severe mental health needs; and geriatric wellness classes and individualized coaching are available.

Senior Reach utilizes assessment measures pre- and post-intervention to evaluate effectiveness and demonstrate outcomes. One of the measures, the Geriatric Depression Scale (GDS), measures depression and suicidal ideation. Senior Reach has demonstrated a statistically significant reduction in depression symptoms and suicidal ideation for both males and females that participated in the program during the first 3 years of operation (see table 1). Table 1 shows the percentage of female clients with suicide ideation indicated at baseline to be higher than for males. However, the difference between females and males did not reach a level of statistical significance. Senior Reach will continue to study this area to determine if there are different treatment implications for women and men.

Given older adults' increased risk for depression and suicide, assessing for suicidal ideation among this population is essential and has helped guide Senior Reach's clinical practice. The program uses this data to help educate the community on the risks associated with suicide for older adults and the benefits of treatment.

Geriatric Depression Scores (GDS)	Female	Male	Total
Number of Seniors	89	28	n=117
Percent of Sample	76.1%	23.9%	100%
Baseline GDS Ratings			
GDS Average Score	6.63	6.39	6.57
Suicide Ideation - Yes	83.2%	67.9%	**79.5%**
Follow-up GDS Ratings			
GDS Average Score	c 4.55	c 4.07	c 4.44
Suicide Ideation - Yes	c 57.3%	c 46.4%	c **54.7%**

Statistically significant differences between: a Male and Female Seniors
c Baseline and Follow-up

Suicide prevention is a
Centerstone priority.

At Centerstone, we work to prevent suicide in many ways every day.

Regionally, we serve children and adults through our **outpatient locations and specialty programs** across Indiana and Tennessee. We also help families and individuals in need through our **crisis hotlines** and **Crisis Chat program.**

Nationally, our **Solutions EAP** specialists work hand-in-hand with companies of all sizes to help supervisors recognize employees at risk for suicide. **Not Alone** helps our military, veterans and their families through a network of specialized providers and virtual support and resources. **Advantage Behavioral Health**'s systems of care work with thousands of families to ensure care coordination and timely access to needed resources for at-risk children. Research, analytics and evaluation services at **Centerstone Research Institute** help us speed patient access to effective treatments and interventions to prevent suicide.

We strive to **collaborate with organizations** from across the nation to prevent suicide.

By joining forces, we can save lives.

Learn more at www.centerstone.org.

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Mobile Teams	Community Education	Disaster Outreach
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The National Council for Community Behavioral Healthcare appreciates the support of Behavioral Health Link for the Suicide Prevention issue of National Council Magazine.

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