The Way Forward:

Pathways to hope, recovery, and wellness with insights from lived experience

Prepared by the
Suicide Attempt Survivors Task Force
of the National Action Alliance for Suicide Prevention
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This report advances Objective 10.3 of the
National Strategy for Suicide Prevention:
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.

To download a copy of the NSSP, please visit
www.actionallianceforsuicideprevention.org/NSSP.

Message from the Suicide Attempt Survivors Task Force Co-Leads

The newly revised *National Strategy for Suicide Prevention*, advanced through the National Action Alliance for Suicide Prevention, calls for a new conversation to reduce suicidal actions and death. That conversation is being given a new voice and a new tone by inviting suicide attempt survivors to share their insights on both staying alive and finding hope.

The mission of the Suicide Attempt Survivors Task Force of the Action Alliance is to create a resource that would convey the voice of suicide attempt survivors. The untold stories of hope and recovery that belong to attempt survivors are the stories of suicide prevention; what they learned is what we all must learn. With these new voices come new ideas, new questions, and new insights. *The Way Forward* emerges from those new voices.

For far too many years suicide prevention has not engaged the perspectives of those who have lived through suicidal experiences. Because of social stigma and fear, as well as personal shame, a culture of silence prevailed. *The Way Forward* represents a seminal moment in this field's history; it is an opportunity to benefit from the lived experience of suicide attempt survivors. Many of its recommendations are derived from evidence-based practices, and several are aspirational. All are grounded in the evidence of recovery and resiliency that is clear in the lives of our Task Force members. Viewing suicide prevention through the lens of the eight core values presented in *The Way Forward* can help us enhance safety while also bringing hope and meaning to those in suicidal despair.

It is our hope that *The Way Forward* will also help serve as a bridge to developing a conversation about suicide prevention between mental health policy makers and consumer advocates. Often, many mental health professionals have narrowly focused on 'identifying persons at risk and getting them into treatment.' Conversely, many mental health consumer advocates either avoid or react negatively to suicide prevention discussions, at times due to traumas associated with historically coercive practices and policies. This resource may enable these two powerful forces for change to come together and develop new, more effective approaches to reducing suicide attempts and deaths.

Like the Task Force itself, we, its co-leads, bring a range of personal and professional perspectives to these efforts. Through our work together over years, one a survivor of suicide attempts and mental health advocate, the other a psychologist with years of experience working with people in suicidal crisis, we have come to believe that collaboration and understanding are critical. Like all of the partners, colleagues, and supporters that helped to develop this resource, we feel deeply that suicide is preventable. It will be the spirit of collaboration – from policy-makers and advocates to clinicians and clients – that will make suicide prevention possible.

We greatly hope that *The Way Forward* will serve as a model for your new collaborations with others, aligned around a new vision for a world free of the tragedy of suicide.

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Acknowledgements

The Suicide Attempt Survivors Task Force of the National Action Alliance for Suicide Prevention (Action Alliance) would like to acknowledge the significant contributions of many individuals in the development of this unprecedented document, which recommends suicide prevention practices, programs, and policies for saving lives from the perspective of those who have lived through experiences of suicidal feeling, thinking, and acting.

First, we would like to thank the primary writer for *The Way Forward*, Dr. DeQuincy Lezine of Prevention Communities, for his outstanding skills, energy, and thoughtfulness in consolidating vast research along with a wide array of inputs from many stakeholders into this cohesive, highly-readable work. Dr. Lezine has been a leader in advocating for the inclusion of suicide attempt survivors in our field since 1996, and his stewardship in developing this resource has emerged through a combination of his own experience as a suicide attempt survivor and his years of experience as a well-respected professional in suicide prevention.

We would also like to acknowledge the important feedback we received from the many insightful experts who were interviewed to provide input about this resource and others who reviewed it (See Appendix E). They helped us prepare *The Way Forward* for a broad audience including researchers, clinicians, policy makers, advocates, and persons who have lived—or are living—with experiences of suicidal thoughts, feelings and behaviors.

In addition, we would like to recognize the extraordinary efforts of the National Action Alliance of Suicide Prevention's Secretariat, specifically, David Litts, former Executive Secretary, for his support and insightful feedback throughout the process, and Jason H. Padgett, Manager of Operations and Technical Assistance, for his dedicated support, patience and organizational skills in helping our Task Force accomplish responsibilities/activities in more efficient ways. Angela Mark, a Public Health Advisor in SAMHSA's Suicide Prevention Branch, also lent her valuable time and expertise to this effort in organizing, documenting, and resourcing Task Force meetings. We are also extremely grateful to staff from the Mental Health Association of San Francisco, Center for Dignity, Recovery, and Empowerment, particularly Melodee Jarvis, Suicide Prevention Specialist, and Anita Hegedus, (former) Executive Associate, for support with coordination and communication that aided Task Force efforts in many ways.

Finally, we would like to thank our Task Force members (See Appendix B for more detail), whose collective intelligence and passion made this possible. Their individual discoveries of hope and meaning following their suicidal experiences provided the heart and soul of this effort, and now provide a pathway for disseminating hope and meaning for all who read *The Way Forward*.

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Table of Contents

Executive Summary 8

Introduction 14

Section I: Core Values for Supporting Attempt Survivors 16

- Part 1: The Core Values 16
  - Foster hope and help people find meaning and purpose in life 16
  - Preserve dignity and counter negative stereotypes, shame, and discrimination 17
  - Connect people to peer supports 17
  - Promote community connectedness 17
  - Engage and support family and friends 18
  - Respect and support cultural, ethnic, and/or spiritual beliefs and traditions 18
  - Promote choice and collaboration in care 19
  - Provide timely access to care and support 19
- Part 2: Core Values in Relation to Recovery and the National Strategy 20

Section II: Task Force Recommendations – Practices, Programs, and Policies for Effective Suicide Prevention 21

Part 1: Attempt Survivors as Helpers: Self-Help, Peer Support, and Inclusion 23

- Self-Help 23
- Supported Self-Help 26
- Peer Supports 26
- Warm Lines 27
- Peer Specialists 28
- Hiring and Supporting Peer Providers in the Workplace 29
- Including Attempt Survivors as Partners in Suicide Prevention 30

Part 2: Family, Friends, and Support Network 33

- Support for The Family and Friends of Attempt Survivors 35

Part 3: Clinical Services and Supports 36

- General Medical Services 36
- Health Professionals 38
- Behavioral Health Systems and Supports 40
  - Behavioral Health Systems 40
  - Behavioral Health Professionals 41

Behavioral Health Treatment 42
Prescribing practices / medication 46
Part 4: Crisis and Emergency Services 48
Help During a Crisis: Crisis Centers, Hotlines, and Crisis Respite Care 48
Crisis Hotlines 48
Crisis Respite Care 50
Emergency Department (ED) 51
On-Site Interventions 53
Mobile Crisis Teams 53
Public Safety and Crisis Intervention Teams (CIT) 54
Part 5: Systems Linkages and Continuity of Care 55
Systems Linkages 55
Connecting the education system with suicide prevention 55
Connecting hospital and community-based supports 56
Coordinated Care 57
Follow-up to Ensure Continuity of Care 58
Technology to Extend Services and Supports 59
Part 6: Community Outreach and Education 61
Communications Campaigns 61
Research 63
Section 3: Appendices, Glossary, and References 65
Appendix A: Recommendations 66
Recommendations by Part 66
Recommendations by Type of Activity 69
Appendix B: Task Force Member Bios and Perspectives 73
Appendix C: Resources 77
Appendix D: Task Force Response to National Institute of Mental Health (NIMH) Request For Information (RFI) on Suicide Research 90
Appendix E: Expert Interviewees, Reviewers, Funding Organizations 97
Glossary 99
References 103

Executive Summary

Purpose and Goals: Who Should Read *The Way Forward*

The Way Forward is, first and foremost, about preventing suicide and bringing new wisdom to that challenge. Until now, suicide prevention efforts have predominately relied on information from suicide research and clinical observation. The field of suicide prevention has rarely tapped the first-person knowledge of suicidal behavior and real-world wisdom that suicide attempt survivors bring to the table. **This long-neglected "lived experience" can help save lives and provide hope to millions of people who survive a suicidal crisis each year.**

The people with the most intimate information about suicidal thoughts, feelings, and actions are those who have lived through such experiences. For decades, people have combined experiential knowledge with professional training to guide research, treatment, prevention efforts, teaching, and advocacy across a range of public health and social issues. However, *The Way Forward* is the first to specifically bring ideas and insights from lived experience into focus for suicide prevention research and practice.

In 2012, 11.5 million people in the U.S. seriously considered suicide

4.8 million made a suicide plan

2.5 million made a suicide attempt

National Survey on Drug Use and Health (2012) and Youth Risk Behavior Surveillance System (2011)

The overarching goal of *The Way Forward* is to inspire better resources, and far more support for the person experiencing suicidal thoughts and feelings, with the hope of saving lives and preventing future suicide attempts. An overview of its recommendations is included in this Executive Summary.

The Way Forward is designed to be of value to:

- policy- and decision-makers
- public and private agencies that fund suicide prevention research and programs
- program developers working in suicide prevention
- clinicians and other professionals working with people who are, or have been, suicidal
- family members, friends, and support persons

Finally, it is hoped that anyone using this resource who has ever had thoughts or feelings of suicide may gain hope and a sense of empowerment through connection to the strength and experience of those who have "been there."

"I am tired of hiding, tired of misspent and knotted energies, tired of the hypocrisy, and tired of acting as though I have something to hide."
– Jamison in *An Unquiet Mind,* 1997.

In an effort to limit the length of *The Way Forward,* it focuses on approaches that should be promoted. Negative and inappropriate practices and policies are often noted, but not discussed in extensive detail. The brevity of those discussions should not be taken to indicate that such occurrences are unimportant. Ideally, such issues would be covered in greater detail, and more extensive work in the future to elaborate on this dialogue is highly anticipated.

Attempt Survivors and Lived Experience of Suicide

While *The Way Forward* reflects widely shared perspectives from individuals who have lived through a suicidal crisis, it cannot represent the full diversity of viewpoints that exist. In addition to differences associated with racial, ethnic, cultural, gender, spiritual, geographic, and other influences, it is important to recognize that suicidal experiences exist on a continuum. Some people have seriously considered suicide, some have made plans that were not carried out, and some have attempted suicide. Of the millions of people who have lived through a suicidal crisis, the vast majority recover. However, the degree of recovery varies, particularly for people who have lived through an experience of self-injury with some intent to die (i.e., suicide attempt survivors – also referred to as attempt survivors).

Attempt survivors' perspectives encompass the entire range of suicide prevention and intervention activities, so this resource focuses on their point of view. Nonetheless, it is hoped that many of the recommendations that are offered will benefit people throughout the continuum of suicidal experiences.

How *The Way Forward* Was Developed

The clinical and research communities have long recognized that important knowledge could be gained from people who have lived through a suicidal crisis. However, most endeavors to acquire that knowledge came in the form of using those people as research subjects or clinical case examples. Such efforts, while generally beneficial, filtered information through assessment instruments designed by clinicians and research scientists.

For decades, the real "voices" from lived experience were missing from the table where suicide prevention stakeholders met to discuss and create solutions.

In 2010, former U.S. Health and Human Services Secretary Kathleen Sebelius and former U.S. Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention (Action Alliance), which envisions "a nation free from the tragic event of suicide with a goal of saving 20,000 lives in five years." The Action Alliance is the public-private partnership advancing the *National Strategy for Suicide Prevention* (NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority NSSP objectives, and cultivating the resources needed to sustain progress.

Over time, a few attempt survivors publicly disclosed that they had lived through a suicidal crisis, and some became advocates and spokespersons in suicide prevention. As a result of advocacy by both attempt survivors and suicide loss survivors, attempt survivors are emerging as important partners in suicide prevention efforts. In 2012, the Action Alliance[a] identified support for attempt survivors as a priority for focus in the revised *National Strategy for Suicide Prevention* (NSSP).[b]

In 2011, the Action Alliance co-chairs established a Suicide Attempt Survivors Task Force (the Task Force) led by

[a] http://www.actionallianceforsuicideprevention.org
[b] http://actionallianceforsuicideprevention.org/NSSP

attempt survivor advocates. The major goal of the Task Force was to help forge a path for stopping suicide attempts and deaths by engaging and supporting people with lived experience of a suicidal crisis. **The initial objective of the Task Force was to support implementation of the NSSP by creating a framework for national, state, and local stakeholders to use when developing resources and initiatives to prevent suicide. These resources and initiatives necessarily seek to engage and empower attempt survivors.**

The Task Force includes people with lived experience of suicide from nearly every region of the U.S., several professional perspectives, and a broad range of racial, ethnic, and cultural backgrounds. The group was convened many times over a three-year period in the development of *The Way Forward*. Task Force members contributed significantly through their time to the form and content herein.

By thoroughly delineating recommendations, *The Way Forward* fulfills the Task Force's principal objective. Guided by the wisdom of people who have "been there," the ideas presented here have the potential to significantly shift the status quo, save lives, and foster hope.

"Core Values" from the Perspective of Lived Experience

> "Our best route to understanding suicide is … directly through the study of human emotions described in plain English, in the words of the suicidal person."
> – Shneidman in *The Suicidal Mind, 1996.*

The Way Forward seeks to filter the evidence base used for suicide prevention through the core values shared by many attempt survivors (the Core Values). These Core Values were generated through extensive dialogue of the Task Force membership. Many are based in the tenets of mental health recovery developed through decades of work by peer advocates, behavioral health professionals, and community feedback. They reflect the consensus perspectives that emerged and were clarified through Task Force discussions, and correspond with many protective factors that counter risk for suicidal thinking and behavior.

All activities designed to help attempt survivors, or anyone who has been suicidal, should be consistent with one or more of the following Core Values:

- Foster hope and help people find meaning and purpose in life
- Preserve dignity and counter stigma, shame, and discrimination
- Connect people to peer supports
- Promote community connectedness
- Engage and support family and friends
- Respect and support cultural, ethnic, and/or spiritual beliefs and traditions
- Promote choice and collaboration in care
- Provide timely access to care and support

Summary of Task Force Recommendations

The Recommendations in *The Way Forward* follow a path consistent with an ecological framework. Approaches start at the individual level and move progressively through relationships, community-based supports and services, and broad community and social change.

Attempt survivors as helpers: self-help, peer support, and inclusion

Every form of help and support for someone who has been suicidal depends on that person's willingness and capability to seek and accept help. Further, given that the suicidal crisis is predominately internal, all changes, regardless of where they are initiated, must ultimately occur within individuals. Beginning with the individual attempt survivor is consistent with mental health recovery practices, person-centered care practices, and the Core Values.

The journey to recovery often begins with self-help practices (e.g., self-advocacy, community involvement, religious/spiritual activity, exercise) which can be supported by family, friends, and professionals. An additional approach to extend support is the peer-operated warm line, which can provide non-crisis assistance at times when traditional services are unavailable. After surviving a suicidal crisis and successfully navigating available systems and supports, peers can model self-care practices, and provide unique and powerful contributions to another's recovery.

The Task Force recommends that suicide prevention and behavioral healthcare organizations engage, hire, and/or collaborate with peer support professionals. Beyond work as peer support professionals, attempt survivors should be included as key partners in a wide range of suicide prevention efforts.

Family, friends, and support network

Community connectedness is one of the Core Values and an established protective factor against suicide. An essential part of that is the assistance provided by family and friends. Each attempt survivor should define a support network, and the people in that network should be offered educational and other resources. It is important to establish who those supportive persons are and how they can assist before, during, and after a crisis.

Family and friends also need support for themselves. Unfortunately, there are very few support resources that have been developed to fulfill this need.

The Task Force recommends developing, evaluating, and promoting programs specifically intended to help the family and friends of attempt survivors.

Clinical services and supports

Behavioral healthcare organizations can enhance care and support for individuals experiencing, or recovering from, a suicidal crisis in multiple ways. At the leadership level, organizations should make suicide prevention a core component of care. Individual professionals should begin care with clear discussions about how they approach crisis situations. Beyond a focus on the suicidal crisis, however, professionals should conduct a comprehensive assessment that recognizes the strengths and challenges in multiple dimensions of life whenever possible. Similarly, all treatment, including use of medication, should take place within a collaborative approach

that discusses multiple options, respects informed choices, and engages a wide range of supports.

While most of the professional care for suicidal persons takes place within behavioral healthcare settings, many key services are provided in general healthcare offices, clinics, and hospitals. In every setting and situation, care for someone who is in, or recovering from, a suicidal crisis would be greatly improved by addressing negative stereotypes, prejudice, and discrimination around suicide and mental health issues among medical professionals. Treating people with dignity and respect can help ease tensions and facilitate the type of collaborative care relationships that are most effective in addressing suicide risk.

The Task Force recommends that medical and behavioral health providers integrate principles of collaborative assessment and treatment planning into their practices.

Crisis and emergency services

Many crises can be addressed before emergency services are needed through the use of key crisis supports such as hotlines and crisis respite centers. In support of the Core Value emphasizing timely access to care, developing and/or sustaining supports and services that can be available 24/7/365 is critical. Yet, many people are wary of hotline services because they fear police involvement or inpatient commitment, based on prior experience or stories from others. Crisis hotlines can do much to alleviate such concerns by following protocols like those established by the National Suicide Prevention Lifeline for active engagement of callers and the use of least invasive approaches, with active rescue being a "last resort." As an additional resource, more crisis respite centers (particularly ones that employ peer providers) should be developed and promoted.

In cases where active rescue, or non-medical on-site intervention, is required, it would be ideal to call a mobile crisis team that includes a peer support professional. When such a team is unavailable, first responders with training about behavioral health emergencies should be engaged.

The recommendations for professionals in emergency departments mirror those for general medical and behavioral healthcare professionals in many ways. Improvements in care should begin with shifting attitudes toward collaborative, respectful, and dignified treatment of persons undergoing a suicidal crisis. The person in crisis can also benefit greatly from the expanded support available from family, friends, and peers, who should be offered relevant information and resources. Peer professionals could provide additional support during on-site crisis intervention, follow-up after a crisis, or emergency department visit and/or discharge.

The Task Force recommends that providers of crisis or emergency services develop formal partnerships with organizations which offer peer support services and especially organizations that are operated or driven by people with lived experience.

Systems linkages and continuity of care

Long-term connections between educational, social, healthcare, and behavioral healthcare settings are solidified through formal agreements and partnerships. As one example, both educational systems and hospitals can establish formal ties with peer support programs or organizations to enhance services. Connecting attempt survivors to peer specialists provides an additional source of support, connection to the community, and a means to facilitate access to other services.

Continuity of care can be furthered through follow-up and/or innovative approaches with technology. Follow-up practices or programs can demonstrate compassion and caring while encouraging help-seeking. Innovative approaches such as online self-help tools and mobile applications can be used to facilitate timely access to care.

The Task Force recommends that hospitals and providers of crisis services establish formal strategies for ensuring continuity of care by helping people transition to community supports.

Community outreach and education

At the broadest level of support, community organizations often use communications and/or social marketing campaigns. The Action Alliance *Framework for Successful Messagi*ng[c] encourages campaign developers and champions to have a clear strategy, convey a hopeful message, and follow relevant guidelines including maintaining safety. Those messages could be effectively promoted by individuals who have lived through a suicidal crisis.

Many recommended programs and practices in *The Way Forward* can be seen as promising, often having evidence for supporting Core Values but lacking formally measured evidence of effects on suicidal thinking or behavior. Research and evaluation efforts are needed to strengthen the evidence base for such approaches, adding science-based knowledge to the insights from lived experience. Developing a network of professionals with lived experience related to suicide to initiate and implement such research and evaluation projects would be a major catalyst for this work.

As a key message in this section, and overall, the Task Force recommends that suicide prevention and behavioral health groups engage attempt survivors as partners in developing, implementing, and evaluating efforts.

A Call to Action

Each year, millions of people in the U.S. seriously consider suicide. Some who survive suicide attempts have recurring or ongoing suicidal thoughts and feelings, and a substantial number of people attempt suicide again. It is imperative to develop and disseminate effective supports that are critically needed. Confronting and abolishing the fear, discrimination, and misunderstanding that have blocked these efforts is long overdue.

With *The Way Forward*, the Task Force aims to begin a new and more inclusive chapter in suicide prevention, sparking the development of innovative programs and projects, altering public policy, and promoting much-needed social change. The recommendations in this resource combine research and practice with lived experience from attempt survivors to help put the NSSP into action. They provide a blueprint for a newly-invigorated community effort to reduce suicide attempts and deaths.

Achieving these goals requires social and political support from attempt survivors, families, friends, and allies. To translate the collective vision of *The Way Forward* into reality, the Task Force recommends developing a national center focused on helping attempt survivors and including attempt survivor peer specialists in current mental health technical assistance centers.

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[c] http://www.suicidepreventionmessaging.org

Introduction

In 2012, approximately 11.5 million people in the U.S. seriously considered suicide, 4.8 million made a plan for suicide, and 2.5 million made a suicide attempt[d].[1,2] Of the millions of people who have lived through the experience of a suicidal crisis, the vast majority recover. However, the degree of recovery varies, particularly as one moves closer to potentially deadly behavior (i.e., suicide attempts). A suicide attempt survivor – hereafter referred to as an attempt survivor – is a person who has lived through an experience of self-injury with some intent to die. Although a suicide attempt is the strongest predictor of future death by suicide, 90% of attempt survivors avoid death by suicide.[3] Nevertheless, many of them have recurring or ongoing suicidal thoughts and feelings, and some attempt suicide again.[4,5] Thus it is imperative to develop and disseminate effective supports.

The overarching goal of *The Way Forward* is to inspire better resources, and far more support for the person experiencing suicidal thoughts and feelings, with the hope of saving lives and preventing future suicide attempts.

The Way Forward is designed to be of value to:

- policy- and decision-makers
- public and private agencies that fund suicide prevention research and programs
- program developers working in suicide prevention
- clinicians and other professionals working with people who are, or have been, suicidal
- family members, friends, and support persons

> The people with the most intimate information about suicidal acts are those who have lived through such experiences.

Ideally, anyone using this resource who has ever had thoughts or feelings of suicide may gain hope and a sense of empowerment through connection to the strength and experience of those who have "been there." Indeed, many of the ideas being promoted hold the potential to create more caring systems and more supportive communities in general. However, specific focus is given to attempt survivors as the ones at highest risk for future injury or death by suicidal acts.

Because suicide is an individual act, the people with the most intimate information about suicidal thoughts, feelings, and actions are those who have lived through such experiences – attempt survivors. Yet, the experiential knowledge of suicidal behavior and real-world wisdom that attempt survivors can contribute about what might help stop suicide has rarely been tapped, and has never been broadly documented. Nonetheless, attempt survivors, whether publicly known or undisclosed, have made many contributions to suicide prevention.

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[d] Data combines results from the National Survey on Drug Use and Health (2012) for adults with Youth Risk Behavior Surveillance System (2011) for high school students

By combining professional training and skills with insights from lived experience (i.e., lived expertise) many have contributed to research, behavioral health[e] and prevention programs, clinical services, and advocacy.

A recent review of national suicide prevention efforts acknowledged that addressing attempt survivor needs has been a challenge for the field thus far.[6] The Action Alliance released the revised *National Strategy for Suicide Prevention* (NSSP)[f] in 2012, which reaffirmed that supportive communities and appropriate services for attempt survivors can have a major impact in reducing future attempts and suicides. The NSSP also clearly identifies the need to engage attempt survivors in the development of new approaches to suicide prevention[g]. *The Way Forward* aims to support and build on the NSSP, and highlights connections to it throughout the text. Advancing the social dialogue about suicide and behavioral health can help counter shame and discrimination, encouraging people to seek help and support.

With *The Way Forward*, the Task Force combines information from research and practice with lived experience from attempt survivors. The resulting recommendations are intended to spark the development of innovative programs and projects, alter public policy, and promote social change. The end goal is to generate better support for the person experiencing suicidal thoughts and feelings, with the hope of saving lives and preventing future suicide attempts. The recommendations and information in *The Way Forward*, written with the perspective and insights of attempt survivors, offer guidance for efforts to put the NSSP into action. They provide a blueprint for a newly invigorated community effort to reduce suicide attempts and deaths. Guided by the wisdom of people who have "been there," the ideas have the potential to significantly shift the status quo, save lives, and foster hope. Achieving these goals requires social and political support from attempt survivors, families, friends, professionals, and allies.

"Our mandate for future action is clear… dramatically improve how we incorporate the perspectives and needs of attempt survivors into our suicide prevention and aftercare efforts."

-First National Conference for Survivors of Suicide Attempts, Health Care Professionals, and Clergy and Laity. Summary of workgroup reports, 2008

[e] Note: As in the NSSP, the term behavioral health is used here for "mental and emotional well-being and/or choices and actions that affect wellness. Behavioral health problems include mental and substance use disorders and suicide."
[f] National Strategy for Suicide Prevention: http://actionallianceforsuicideprevention.org/NSSP
[g] Please see Objective 10.3 and Appendix D: Groups with Increased Suicide Risk. Suicide Attempt Survivors.

Section I: Core Values for Supporting Attempt Survivors

Part 1: The Core Values

The Task Force initiated the development of its core values (Core Values) by examining the tenets used in the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Recovery Framework.[7] Those tenets reflect the combined contributions of peer advocates, mental health professionals, and community feedback over three decades. Many also echo the values and principles outlined in "*Practice Guidelines: Core Elements for Responding to Mental Health Crises*[8]." Through group discussions that took place over email, telephone conference calls, and in-person meetings, the Task Force identified principles that could be further specified, enhanced, or added to fit the context of suicide prevention. The Core Values represent the group consensus on the values that attempt survivors want suicide prevention professionals and organizations to consider when developing or implementing suicide prevention supports. Research has indicated that promoting protective factors and addressing risk factors for suicide can prevent suicidal behavior.[9] Therefore, it is reasonable to believe that activities that support the Core Values have the potential to prevent future suicide attempts, and improve the quality of life for people who have survived a suicide attempt.

The purpose of adhering to the values is to identify actions that would be both helpful and preferable for attempt survivors. Each Core Value is linked to protective and/or risk factors, or best practices in behavioral health care. Please note that to reinforce the intent of the Core Values and to communicate the voice and perspective of the Task Force each value in this section is written in first person.

All activities designed to help suicide attempt survivors should be consistent with one or more of the following values:

- Foster hope and help people find meaning and purpose in life
- Preserve dignity and counter stigma, shame, and discrimination
- Connect people to peer supports
- Promote community connectedness
- Engage and support family and friends
- Respect and support cultural, ethnic, and/or spiritual beliefs and traditions
- Promote choice and collaboration in care
- Provide timely access to care and support

Foster hope and help people find meaning and purpose in life

It has long been recognized that the absence of hope (i.e., hopelessness) is a major risk factor for suicidal thinking and behavior.[10] More recently, studies have found that hope and optimism can help guard against suicide.[11-14] Hope is also linked to self-esteem and self-efficacy, as well as improved problem-solving.[15,16] The pursuit of meaning can help a person cope with pain and suffering.[17] Similarly, research on reasons for living has demonstrated that meaning and purpose are keys to recovery in many different groups of people who have lived through a suicidal crisis.[18,19]

When we find hope, we are less suicidal. Hope is a key protective factor against suicidal behavior, and it is a catalyst for the recovery process. Hope is nurtured by finding meaning and purpose in life. If we can see our lives as having meaning and purpose, then we can picture a hopeful future.

Preserve dignity and counter negative stereotypes, shame, and discrimination

The negative perceptions of behavioral health issues and subsequent discrimination pose major barriers to help-seeking.[20] Use of negative stereotypes and discriminatory actions robs people of their dignity, stifles compassion, and crushes hope.[20] Social rejection and discrimination have negative effects on life satisfaction and well-being.[21]

Stigma, negative stereotypes, and discrimination (overt or subtle) are particularly damaging when we are already suffering from depression, hopelessness, damaged self-image, trauma, self-doubt, and shame - thoughts and feelings common during a suicidal crisis. In contrast, when we are treated with dignity and compassion it reaffirms our sense of worth and value. On a larger scale, direct and implied messages about hope, recovery, and genuine concern can encourage us to seek out help and support when needed.

Connect people to peer supports

The meaning of "peer" depends on context, applying to fellow students or military veterans, for example. For the purposes of *The Way Forward,* a peer is someone who has lived experience with a similar mental health condition or issue (i.e., suicidal feelings or past suicide attempt).

Research indicates that people engaged in peer support tend to have positive mental and behavioral health outcomes along with general psychological and social benefits.[22,23] Recent practice guidelines recommend that peer supports be available in response to mental health crises because peers are in a unique position to "convey a sense of hopefulness."[8(p8)] Thus, providing and receiving help from peers counteracts risk factors for suicidal behavior such as hopelessness, impulsiveness, isolation, shame, and symptoms of mental health disorders.[24-26]

As peers, we can provide social support and a sense of community while also sharing experiential knowledge and practical advice about coping skills, serving as positive role models for others. Furthermore, when we enter the role of helper we also experience benefits.

Promote community connectedness

The report *Promoting Individual, Family, and Community Connectedness to Prevention of Suicidal Behavior* notes that "Connectedness is a common thread that weaves together many of the influences of suicidal behavior and has direct relevance for prevention."[27(p3)] The report indicates that connectedness includes relationships between individuals and between organizations. Through social connections, risk factors of loneliness and isolation are countered, while protective factors of belongingness and social integration are enhanced. Benefits also come from access to resources through social capital and networking. Some studies have found that social connections help people cope with stress (i.e., psychological, physiological, and neurological responses to stress) and enhance general health.[28,29]

Connections between community organizations facilitate access to care and continuity of care, enabling services like follow-up programs to help many people after a crisis.[27,30] Furthermore, as noted in the report *Suicide Care in Systems Framework* from the Action Alliance Clinical Care and Intervention Task Force (CCI Report),

connections between professionals eases fears about providing services, and equips them with additional resources.[31] Additionally, both personal connections and organizational ties can be used to encourage community groups and organizations to contribute tangible supports (e.g., funds, meeting space, use of equipment or supplies, availability of volunteers) to suicide prevention efforts.

In the first type of connectedness, we benefit from maintaining or (re)building social connections and support networks in the community. As a second form of connectedness, it is easier to get quality care when healthcare organizations (i.e., medical, mental health, behavioral health, and insurance groups) and social services have formal relationships that allow them to work together.

Engage and support family and friends

Research indicates that people often turn to family and friends for help[19], even when they do not seek help from mental health or medical professionals, emphasizing the critical role of support networks. A strong support network can serve as a safety net in times of crisis and a trusted resource during recovery. This core value is also consistent with NSSP Objective 9.4 to engage a person's support network throughout the course of care. The CCI Report recommended that "families and significant others should be engaged and empowered" in care plans whenever "appropriate and practical."[31(p8)] It is also clear from research that it is extremely stressful to care for someone else, especially in life-or-death situations.[32] Family and friends need additional support. Moreover, a robust literature exists describing the risk for suicide in family members and friends of an attempt survivor or person who has died by suicide.[33] Similar research points to the higher-than-average chance of risk behaviors in friends of a suicidal person.[34] Thus, support for family and friends may have direct benefits to all involved, even if the focus is primarily on helping the attempt survivor.

We have to decide which family, friends, and/or significant persons to engage in our care or support. This agreed-upon support network should be included in informed care decisions, treatment, follow-up, and other forms of help. However, the family members, friends, and peers in our support network also need education, assistance, and resources for themselves.

Respect and support cultural, ethnic, and/or spiritual beliefs and traditions

Differences in suicide rates by gender, race, ethnicity, sexual orientation, geography, and community point to the potential role of social and cultural factors in risk and resilience.[35,36] Such differences form the basis for ongoing research that seeks to understand how human diversity affects suicidal behavior and the practical implications that it has on prevention or intervention efforts.[36] Additionally, many people turn to cultural or spiritual leaders as trusted sources of support, and religion or spirituality often serves as a protective factor.[37] Incorporating such potential strengths into plans for recovery can open the door to many non-clinical options for support.[38] Both contemporary and traditional healing practices can contribute to recovery and wellness. Further, the CCI Report specifically noted that a productive clinical relationship "should respect the cultural preferences and values of the individual as much as possible."[31(p11)]

We want programs and services to: (a) acknowledge and respect our beliefs and traditions (cultural, ethnic, spiritual); (b) incorporate them into our recovery plans; and (c) assess how they might interact with care and identify ways for the traditions, healing practices, beliefs, and/or communities to help keep us well.

Promote choice and collaboration in care

Many calls for mental health system transformation recommend consumer-driven or person-centered care.[39-41] The CCI report recommended that "care for persons at risk for suicide should be person centered, where their personal needs, wishes, values, and resources should be the foundation for continuing care and safety plan."[31(p8)] This value is consistent with the practice of shared decision-making (SDM). In SDM, "providers and consumers of health care come together as collaborators in determining the course of care."[42(p2)] Research indicates that SDM grants the person seeking care lower stress, a greater sense of control, and better functional outcomes.[42] Becoming a partner in care directly counters ideas of helplessness, powerlessness, and hopelessness. Treatment outcomes are generally better when the person has the opportunity to be a partner in the process.[43]

Programs, policies, and initiatives should preserve our autonomy, promote hope, build from our strengths, and empower us to pursue the goals we identify. Professionals should consider all dimensions of wellness when developing plans for care. We need to be informed about care and support choices in language and terms that we can easily understand. Respect our decisions. Provide us with diverse opportunities for involvement in our own care and in broader suicide prevention and mental health promotion activities.

Provide timely access to care and support

Objective 8.3 of the NSSP is to "promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide" as something that is "critically important."[(p54)] With more timely access to care, someone might be able to get help before attempting suicide. Similarly, the CCI Report recommended "immediate access to care for all persons in suicidal crisis," with "effective treatment and support services … how and when they need them."[31(p4,5)] Early intervention is likely to have a meaningful and long-lasting impact. Recent practice guidelines note that expedient support can reduce the intensity and duration of a crisis and allow the person to choose from a wider variety of options.[8] In defining timely access, the guidelines encourage "24-hour/7-days-a-week availability and a capacity for outreach when an individual is unable or unwilling to come to a traditional service site."[8(p7)]

> "Many a suicide might be averted if the person contemplating it could find the proper assistance when such a crisis impends." – Clifford Beers, 1908, *A Mind That Found Itself*

We should have the opportunity to access care and supports that fit our needs, are acceptable and are appropriate 24/7/365. A full range of supports should be available, including crisis alternatives to hospitalization such as peer respite, call or text lines, and mobile crisis teams. When the ideal form of support is not immediately accessible, we should have timely and expedient access to an alternative and/or get a referral. Professional services should continually assess the quality and accessibility of care and support to identify and remedy any gaps. These reviews should be carried out by a group that includes both professionals and peers.

Part 2: Core Values in Relation to Recovery and the National Strategy

In creating the Core Values, the Task Force identified values and tenets that have been used in mental health recovery, the mental health consumer movement, and personal experiences. The Task Force modified the concepts to make them more applicable to the suicide prevention context. The NSSP was a key resource. As a result, the Core Values are consistent with recognized principles of recovery and concepts used throughout the NSSP (see Table 1).

Table 1. Core Values compared to recovery principles and NSSP concepts

Core Value	Recovery Principles[7]	NSSP Concepts
Foster hope and help people find meaning and purpose in life	"Recovery emerges from hope." "Hope is the catalyst of the recovery process."	"Positive messages of recovery and hope" "Recovery-oriented services"
Preserve dignity and counter stigma, shame, and discrimination	"Recovery is based on respect."	"Foster positive dialogue, counter shame, prejudice, and silence."
Connect people to peer supports	"Recovery is supported by peers and allies."	"Appropriate peer support … holds a similar potential for helping those at risk for suicide." "Providers should develop linkages with … peer support services."
Promote community connectedness	"Recovery is supported through relationship and social networks"	"Connectedness to others is another key protective factor" "Increasing collaboration among providers"
Engage and support family and friends	"Recovery involves individuals, family, and community strengths and responsibility."	"Effectively engage families and concerned others" "Provide appropriate clinical care to individuals affected by a suicide attempt…"
Respect and support cultural, ethnic, and/or spiritual beliefs and traditions	"Recovery is culturally-based and influenced." "Recovery is holistic."	"Be tailored to the cultural and situational contexts" "Grounded in a full understanding of and respect for the cultural context"
Promote choice and collaboration in care	"Recovery occurs via many pathways" "Recovery is person-driven"	"Person- and relationship-centered care …" "Patient is actively engaged in making choices"
Provide timely access to care and support	<not addressed>	"Increase access to and delivery of effective programs and services" "Promote timely access …"

Section II: Task Force Recommendations – Practices, Programs, and Policies for Effective Suicide Prevention

Through reviews of published literature and web-based resources, as well as expert opinion, the Task Force identified approaches to supporting recovery from a suicidal crisis that are consistent with the Core Values. The approaches could be described by three types of activities: practices, programs, and policies. To more clearly delineate Task Force recommendations, each one will be labeled as a practice, program, or policy.

An example may help to introduce the differences between these activities, which are further clarified below. If a crisis support volunteer at a call center generally calls someone back for follow-up, then that would be considered a practice. When the crisis center establishes a separate phone line, designated times, procedures, outcomes and/or funding for follow-up calls, then that would be a follow-up program. If the crisis call center clarified in writing that follow-up practices should always happen and made it part of their training and oversight, then the practice would become a formal policy.

Practices

A practice is a process, method, technique, approach, procedure, or other behavior that occurs on a regular basis. Practices describe *how* people and organizations interact with a person seeking support or services. Generally, practices are consistent, sometimes default, responses to situations.

Programs

A program is a specific intervention, therapy, treatment, campaign, course, workshop, seminar, or other activity designed to support or help someone. In many ways, programs are systematic and well-defined uses of practices and resources.

Policies

A policy is a written statement intended to guide governments, organizations, or individuals. Most large organizations, for instance, have manuals that cover a range of topics such as policies, standard procedures, protocols, grant requirements, or general practice guidelines. Public policy generally entails legislation, statute, regulation or ordinance that clarifies, limits, or prescribes individual, governmental or organizational behaviors.

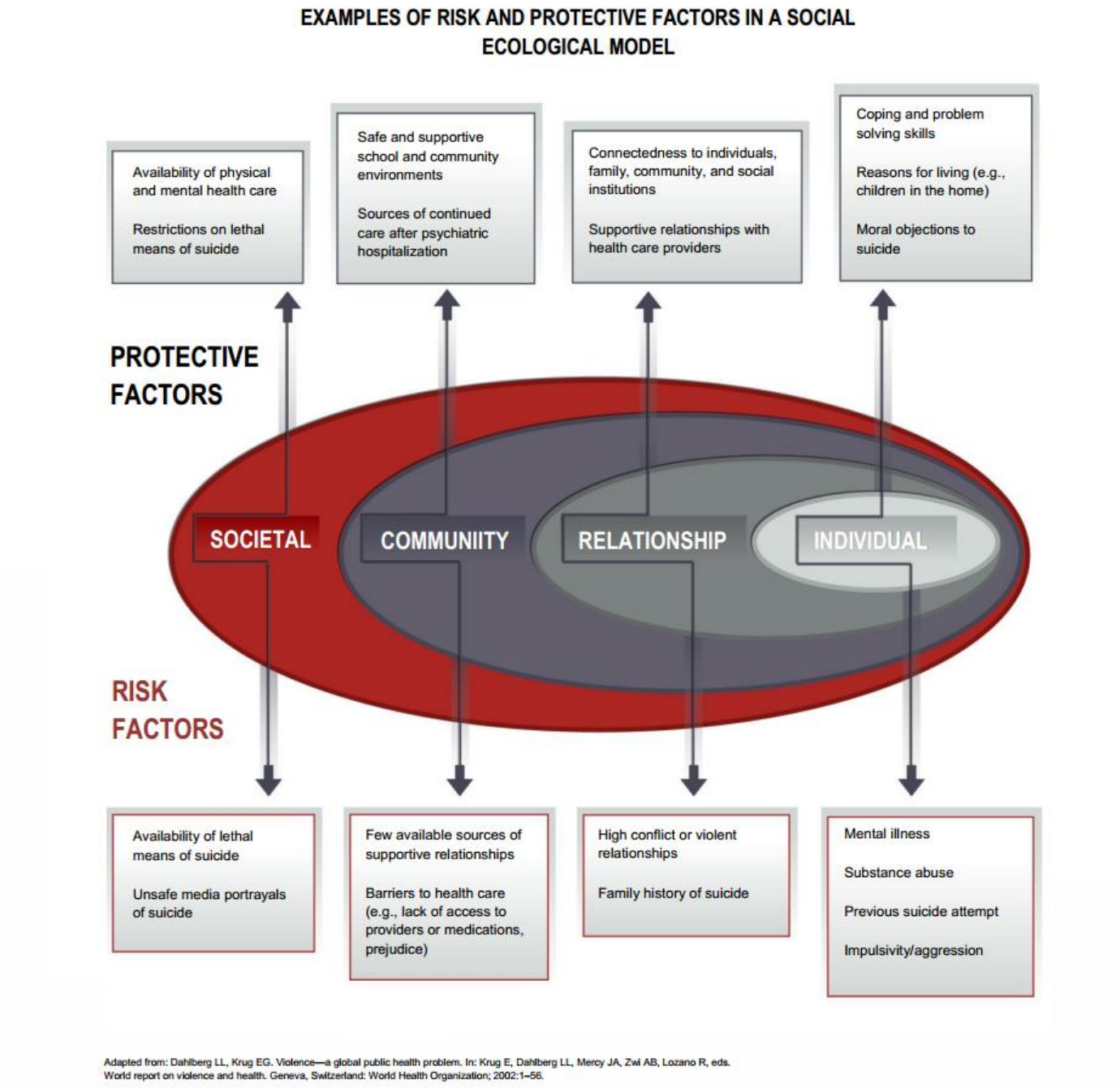
Categories of supports and services

Approaches were sorted into six categories:

1. Attempt Survivors As Helpers: Self-Help, Peer Support, and Inclusion
2. Family, Friends, and Support Network
3. Clinical Services and Supports
4. Crisis and Emergency Services
5. Systems Linkages and Continuity of Care
6. Community Outreach and Education

The presentation order of the categories maintains the framework in the Ecological Model used in the NSSP (see Figure 1). Approaches start at the individual level (i.e., self-help) and move progressively through relationships, community-based supports and services, and broad community and social change.

Figure 1. Protective Factors and Risk Factors for Suicide, as presented in NSSP



This section describes the approach categories, highlights the Core Values supported, discusses needs and challenges from an attempt survivor perspective, and provides specific recommendations for action.

Each section begins with a brief vignette that illustrates a possible path to recovery and hope after surviving a suicide attempt. The stories follow the main character, Jamie, in a world that matches the ideals and recommendations described in The Way Forward.

Part 1: Attempt Survivors as Helpers: Self-Help, Peer Support, and Inclusion

In the aftermath of the suicide attempt, Jamie reflected on past activities that were helpful. It seemed reasonable to think that what worked before could work again. However, Jamie had some trouble coming up with positive activities. Fortunately, family and friends recommended some books and guides that could help nurture hope, support recovery, and enhance self-advocacy skills. They also suggested checking out the new attempt survivor support group being hosted by a local crisis center. Jamie not only joined the group, but became a peer co-facilitator for the group. Having enjoyed the experience of helping others, Jamie trained to become a peer specialist. The idea was to get certified and look for a job at one of the organizations looking to hire people "with lived experience from a suicidal crisis." Ideally there would be a central and specific resource that promoted attempt survivor supports and engagement, like a National Technical Assistance Center on Lived Experience in Suicide Prevention. In the meantime, the search could include organizations or centers looking for the combination of professional and lived experience that Jamie brought to the table.

Self-Help

Recommendation 1.1 – Practice: Develop, evaluate, and disseminate self-help materials for persons who have lived through a suicidal crisis.

Self-help is a way for a person to improve his or her health and welfare by changing thinking and/or behavior without the assistance of others (especially without professional intervention). This may include both ways to help oneself directly, or through improved interactions with others (including health or mental health professionals). Such resources may be particularly important supports in rural or tribal communities that have few traditional services. Empowering a person with self-help options supports his or her **dignity** and enhances **hope** by countering perceptions of helplessness. At the same time, providing people with self-help resources gives them the **opportunity to choose** supports that are almost always **accessible**. Self-help practices can also be used for self-care by any person or professional. Some specific resources are included in Appendix C.

Approaches to self-help

Self-help guides or bibliotherapy

Bibliotherapy uses self-help materials, or recommended readings, to assist people in coping with mental or emotional distress. Study results[44,45] indicate that as an adjunct to therapy, bibliotherapy is associated with increased resilience, decreased psychological distress, and decreased hopelessness when added to therapy. In a study that used an unguided online self-help curriculum, results indicated that participants experienced less suicidal ideation and hopelessness.[46]

Guidance or advice

There are different forms of advice from peers, professionals, or both, that are written for the benefit of people looking to help themselves. These readings often provide stories of recovery that offer **hope** and guidance for combating **shame** or seeking **collaborative care**. Two resources that gather self-help material of this kind are the National Mental Health Consumer Self-Help Clearinghouse[h] and the National Empowerment Center[i]. An additional upcoming resource is the booklet "*A Journey Toward Help and Hope*."[j] Several helpful practices can also be found in the self-help guides from SAMHSA[k]. One should also note that some autobiographical books or materials include advice or guidance.

Autobiographical accounts from peers

Stories, encouragement, and advice **from peers** can be found in multiple formats that include books, booklets, brochures, blogs, and videos (see Appendix C). Most of the accounts offer **hope** by demonstrating how peers have overcome personal crises and challenges. For example, many books and blogs by suicide attempt survivors are primarily written to help other individuals who may be suicidal.

General self-care

Additionally, individuals often use one or more self-help practices as part of their overall plan for recovery and wellness. Some of the most common or useful techniques used to cope with suicidal thoughts or feelings include[47,48]:

- Spirituality: religious attendance, prayer and meditation
- Family and social support: receiving and providing help, time with family or support persons
- Talking to someone: phone call, hotlines, peer warm lines that offer supportive listening or advice
- Positive thinking: positive self-talk, believing in oneself, positive affirmations
- Effective treatment / having a trusted therapist
- Self-care or distraction: listening to music, having a hobby, movies, humor, exercise, resting

A few self-help practices merit additional consideration because they relate to multiple Core Values and/or encompass both benefits and challenges. These are: (a) advocacy, (b) community involvement, (c) religion and spirituality, and (d) exercise.

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[h] http://www.mhselfhelp.org/techasst/index.php
[i] http://www.power2u.org/articles.html
[j] SAMHSA, in press.
[k] See for example, *Action Planning for Prevention and Recovery: A Self-Help Guide* (http://store.samhsa.gov/product/Action-Planning-for-Prevention-and-Recovery-A-Self-Help-Guide/SMA-3720); and *Recovering Your Mental Health: A Self-Help Guide* (http://store.samhsa.gov/product/Recovering-Your-Mental-Health-A-Self-Help-Guide/SMA-3504)

Recommendation 1.2 – Practice: Provide information about self-advocacy to every attempt survivor.

Advocating for oneself is the direct opposite of considering or attempting self-destruction. To do so, a person must see himself or herself as worth fighting for and hold the **hope** that a better life is possible. One of the most important parts of self-advocacy is actively **collaborating** with professionals and people in a **support network** to plan for safety, recovery, and making life meaningful and enjoyable. Self-advocacy is consistent with practices such as Self-Directed Care, Psychiatric Advance Directives, Wellness Recovery Action Plans (WRAP), and Motivational Interviewing that have demonstrated benefits for enhancing treatment and recovery.[49-52]

Self-advocacy also lays the foundation for someone to offer others peer support or become a partner in suicide prevention efforts. Several mental health advocacy organizations, while not specifically focused on suicide prevention, may be powerful allies for this task.

Recommendation 1.3 – Practice: Encourage attempt survivors to participate in community activities.

When someone is involved in activities outside of medical or mental health systems, he or she establishes or reconnects with community supports that are vital for recovery. As noted in a report on connectedness, "although the influence of such positive attachments on suicidal behavior needs to be better studied, many theoretical reasons support the idea that stronger connections to [community] groups may decrease suicidal behavior."[27(p4)] Through involvement with community groups and projects, someone can establish or solidify an identity outside of the roles of patient or attempt survivor. In support of this idea, the first principle in the *Federal Action Agenda for Transforming Mental Health Care* was to "focus on the desired outcomes of mental health care, which are to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation."[l] Consistent, positive experiences and interactions restore **dignity**, shape quality of life, and give a person **meaning and purpose**.

Recommendation 1.4 – Practice: Explore religion and spirituality as potential resources in collaboration with the attempt survivor and his or her support network.

Religion and/or spirituality deserve particular attention because the practices are widespread and may be the most often-cited individual practices. Many people turn to religion and spirituality as a source of help. Research indicates that several protective factors may be present in religion and spiritual practices.[37,53] In addition to the direct relationship with the Core Value of **respect**, other Core Values that may be supported include finding **hope, meaning, and purpose**; **community connectedness**; and **support from family and friends**.

However, it is also important to note an unresolved conflict. Some research suggests that negative attitudes about suicide, which are supported by some religious beliefs, might protect against suicide. However, the Core Values advocate for working against **shame and discrimination**. Based on reviews of the association between religiosity and suicide, it appears that the outcomes depend on a person's individual perception of the religious or spiritual experience.[37] If the primary experience offers **hope** and provides **meaning and purpose** for life,

[l] Transforming Mental Health Care in America: The Federal Action Agenda. SAMHSA. http://www.samhsa.gov/federalactionagenda/NFC_FMHAA.aspx

connection to others, or a belief that suicidal behavior should be avoided, then someone may be protected from risk. On the other hand, if the primary experiences involve condemnation, judgment, guilt or isolation, then it is unlikely to offer protection and may aggravate risk.

Recommendation 1.5 – Practice: Encourage attempt survivors to participate in exercise and physical activity when it can enhance wellness and recovery.

While it has long been recommended that individuals with depression should consider adding an exercise routine as a way to help, this has rarely been studied for individuals with suicidal thinking or behavior. However, one study in Austria examined mountain hiking as an addition to therapy.[54] In that study, participants experienced less hopelessness, depression, and suicidal thoughts. Additionally, a recent study with veterans found that exercise had direct and indirect effects (i.e., by helping depression or improving sleep) on suicidal thinking and attempts.[55]

Supported Self-Help

Self-help with assistance or advice from others can be called supported self-help or supported self-management. It most commonly refers to self-care recommended as part of therapy or other services. The most structured supports are self-management guides or workbooks that may be completed with coaching from others. A recent and positive review discussed types of support self-management, their effectiveness, safety, and acceptability.[56]

Peer Supports

Approaches in this category are directly related to the Core Value of connecting people to supportive peers. Many of the approaches are also consistent with increasing **hope**, **timely access** to supports, **connectedness,** and **choices** for recovery planning, while empowering persons with lived experience as helpers, which **challenges negative stereotypes**.

Notably, peers work in many types of programs (e.g., professional therapists, crisis workers, emergency department doctors). However, the approach described here specifically relates to areas where having lived experience is an essential part of the job and is included in the qualifications or description of the job. Peer support includes mutual help groups, warm lines for support over the telephone, internet support groups for online support, and mental health services delivered by peers.[22]

Recommendation 1.6 – Program: Develop, evaluate, and promote support groups specifically for persons who have lived through a suicidal crisis; such groups are encouraged to use a peer leader or co-facilitator.

Many successful peer support groups in mental health have been conducted in a structured manner, with closed groups (i.e., a set number of sessions), a manual, and trained peer providers. The content of group sessions usually focuses around concepts of recovery or specific skill-building. These types of groups have been studied extensively, and results have shown increased **hope**, self-esteem, self-efficacy, **connectedness,** knowledge, and social support, as well as decreased symptoms.[26,57-60]

Positive reports from groups for suicidal individuals were published as early as 1968.[61] One study[62] found that groups were beneficial, with only 5% of the 105 attempt survivors having a re-attempt in the one-year follow-up

(compared to approximately 15% in a year in general)[3,63,64]. Currently, there are few groups specifically for suicide attempt survivors (see Appendix C), but the ones that have been evaluated show positive results. An ongoing group for attempt survivors in Toronto, Canada, with a peer co-facilitator has reported improvements in mood, thinking, impulsivity, **connectedness**/belonging, and **hope**.[65] Another attempt survivor group with a peer co-facilitator in Los Angeles, California, has reported increased **connectedness**, decreased suicidal desire, and improved safety planning.[66]

Recommendation 1.7 – Policy: Establish training protocols and core competencies for peer supports around suicidal experiences, and methods for assessing them.

Attempt survivor peer support is building on a long history of support by people with lived experience in mental and behavioral health[26,67]. However, existing behavioral health peer programs can be improved by adding suicide prevention resources. Some practice recommendations that are particularly relevant to peers in suicide prevention are noted here:

- Establish training protocols and core competencies for peer supports around suicidal experiences, and methods for assessing them. Such training can lead to establishing certified attempt survivor peer specialists. Additionally, evaluation and research results will help improve programs and secure funding.
- Establish plans and protocols for support when a peer experiences a mental health crisis.
- Evaluate peer supports and disseminate results to develop an evidence base for program funding and improvement.
- Establish relationships between peer support groups or organizations and local crisis center(s) or hotline(s):
    - For peer specialists, when necessary, they will easily be able to get crisis support for people they are helping.
    - For crisis centers, they can use the partnership to provide follow-up care for callers or people being discharged from the emergency department or hospital.
- Establish mutually beneficial relationships with mental health peer supports (e.g., Depression and Bipolar Support Alliance (DBSA), National Alliance for Mental Illness (NAMI), Mental Health America (MHA), local health (e.g., emergency department) services, and behavioral health care services. Having ongoing relationships will improve continuity of care between services and is an important aspect of community connectedness.

Warm Lines

The warm line is a pre-crisis support service that is usually staffed by peers or paraprofessionals, and provides supportive listening, social support, and, sometimes, advice on coping. The intention is not to replace traditional crisis hotlines, but instead to provide after-hours care that is a source of social support. Research findings indicate that warm lines are associated with decreased loneliness, increased **connectedness**, decreased use of crisis services (e.g., emergency departments, police, and hotlines), and increased recovery.[68]

Recommendation 1.8 – Policy: Provide warm line staff with basic training for working with suicidal callers, including how to refer or transfer callers to crisis services.

Warm lines may receive calls from suicidal individuals, and staff would benefit from knowing how to assist someone with getting to crisis services, or doing a basic assessment of the dangerousness of a situation (e.g., involvement of weapons or lethal substances). The National Empowerment Center (NEC)[m] and the National Mental Health Consumers' Self-Help Clearinghouse (Clearinghouse)[n] offer *A Guide to Developing and Maintaining a Sustainable Warm Line*[o] that provides guidance on developing and running a warm line, including a section on suicide prevention. In addition to a list of warm lines[p], the Clearinghouse also houses warm line training and administrative materials.[q]

Peer Specialists

Recommendation 1.9 – Program: Develop certified peer specialist positions that are specific to lived experience of a suicidal crisis.

One promising model for developing attempt survivor supports is the use of a peer specialist. A certified peer specialist is a person with lived experience who has undergone specialty training and certification in order to provide services to others, often with the benefit of reimbursement from insurers.[69] Research indicates that the peer specialists experience benefits themselves (e.g., increased self-image and self-esteem), while also helping others.[70,71] There appear to be positive, indirect effects on co-workers (e.g., decreased stigma and increased organizational change).[70] Additionally, studies show that the recipients of peer specialist services may have increased quality of life, decreased life problems, and increased engagement with traditional care systems.[70,71]

In most cases, a peer specialist works as part of a group or organization.[69] However, in some circumstances a specialist works with someone in a one-to-one capacity as a mentor or coach.[72] The pairing usually occurs at admission or discharge from a hospital or emergency department and provides support during the early recovery phase. Research indicates that this approach can result in fewer re-admissions to the hospital, fewer hospital days, and increased use of traditional programs.[72]

NSSP Goal 7 addresses the need for all professionals who interact with people at risk for suicide to have knowledge and skills in suicide prevention. Given the heightened risk for suicide with mental health issues, or following a suicide attempt, specific outreach efforts should be made to include peer specialists in the list of groups offered training and support for the prevention of suicide and related behaviors.

Programs and settings seeking to hire peer specialists or to fund peer support programs can look to the Center for Medicaid Services (CMS) and the Veterans Affairs (VA) for some guidance.[73] The CMS allows states to include peer support services in Medicaid programs and has provided specific guidance on requirements for states to follow. Example core competency areas for peer specialists[73] are included here for reference:

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[m] http://power2u.org/index.html
[n] http://www.mhselfhelp.org/
[o] http://www.power2u.org/downloads/Warmline-Guide.pdf
[p] http://www.mhselfhelp.org/warmlines-index/
[q] http://www.mhselfhelp.org/warmline-training-and-administ/

- An understanding of their job and the skills to do that job
- An understanding of the recovery process and how to use one's recovery story to help others
- An understanding of and the ability to establish healing relationships
- An understanding of the importance of and the ability to take care of oneself

Additional peer-run services

Several types of programs, services, or initiatives are operated by people with lived experience of mental or behavioral health challenges. Though not the same as connecting with somebody who has lived through a suicidal crisis, these individuals may also be peers in many instances. Example approaches that may be beneficial for suicide attempt survivors include mutual support groups that focus on mental or emotional distress and peer-operated clubhouses[r] or peer recovery centers[s]. Further discussion about peer- or consumer-operated services, including evidence for their benefits and effectiveness, can be found in the SAMHSA Consumer-Operated Services Evidence-Based Practices (EBP) Kit.[t]

Recommendation 1.10 – Program: Develop a national technical assistance center focused on helping individuals with lived experience of a suicidal crisis.

A Technical Assistance Center would cultivate a support network for peer specialists in suicide prevention to provide training, ongoing development, and leadership support. The center could unify a peer network and partner with other consumer peer support services. Additionally, the center would provide assistance to community organizations or professionals trying to implement peer support programs, or increase supports for suicide attempt survivors more generally. In building up to a specialized center, peer specialists focused on supporting individuals who have lived through a suicidal crisis could be recruited for existing suicide prevention and mental health technical assistance centers.

Hiring and Supporting Peer Providers in The Workplace

Recommendation 1.11 – Policy: Train human resources staff at agencies and organizations that hire disclosed persons with histories of mental health challenges or suicidal experiences in best practices for supporting those employees.

Human Resources (HR) staff may require additional guidance for the hiring and support of people who have attempted suicide or experienced a mental health crisis. In the hiring process, or arranging for reasonable accommodations in accord with the Americans with Disabilities Act (ADA)[u], this type of history should remain completely confidential. In the case of peer specialists, or other positions where lived experience is an integral part of the job, HR should keep specific details about someone's experiences confidential. By protecting an

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[r] See ICCD Clubhouses and Clubhouse Research Outcomes (http://www.iccd.org/images/recent_ch_research_joel_tweet_website_092611.pdf)
[s] From the Ground Up, The Recover Project (http://ftgu.recoverproject.org/)
[t] http://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-KIT/SMA11-4633CD-DVD
[u] Equal Employment Opportunities Commission (http://www.eeoc.gov) and Job Accommodation Network (http://www.askjan.org)

employee's right to privacy, HR can support his or her sense of **dignity**. During the course of employment, someone may experience a mental health crisis. In that case, when properly trained, HR can facilitate arrangements for Family and Medical Leave Act (FMLA)[v] time in a sensitive way, and then help connect people to Employee Assistance Programs (EAP)[w] or other resources when they return. This type of care plays a large role in fostering a "mental health-friendly workplace" as described in *Workplaces That Thrive*.[x]

Recommendation 1.12 – Practice: Train agency/organizational leaders and managers working with persons with lived experience of a suicidal crisis on protecting confidentiality and privacy while also facilitating support for their employees.

Organizational leaders and managers should help protect confidentiality and privacy while also facilitating supports for their employees. As an example, managers could enable people to have flexible schedules to allow for health or mental health appointments, or gradual reentry to full-time employment after a leave that perhaps begins with part-time shifts. For additional practice recommendations, also see general recommendations on hiring and supporting people living with mental health issues at *Workplaces That Thrive*[x].

Including Attempt Survivors as Partners in Suicide Prevention

Recommendation 1.13 – Practice: Engage attempt survivors as partners in behavioral health and suicide prevention efforts.

One of the most important practices that should be widely adopted is the inclusion of suicide attempt survivors and people with lived experience in suicide prevention efforts. Inclusion supports the Core Values of **hope**, **dignity**, and **connectedness**. This is one of the critical aspects of achieving Objective 10.3 of the NSSP: "Promote positive engagement of suicide attempt survivors in support services, treatment, and community suicide prevention education, including the development of guidelines and protocols for suicide attempt survivor support groups." At a 2005 conference for attempt survivors, a key recommendation was to "actively involve suicide attempt survivors and mental health consumers in planning, implementing, and evaluating all suicide prevention efforts."[74(p3)] Outreach efforts may be facilitated by having a suicide attempt survivor as a primary contact or partner in these efforts.

The following examples illustrate ways to increase inclusion, by recruiting attempt survivors:

- to join crisis centers as members of boards of directors, leaders, and staff / volunteers
- to participate in oversight or advising behavioral health systems change
- to review communications campaigns or social marketing endeavors aimed at consumers /suicidal individuals
- to act as spokespersons, advocates, or resources for legislative hearings / testimony

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[v] Department of Labor (http://www.dol.gov/esa)
[w] Employee Assistance Professionals Association (http://www.eapassn.org)
[x] *Workplaces That Thrive* (http://www.promoteacceptance.samhsa.gov/publications/business_resource.aspx)

- to be partners in the development of research / evaluation for suicide prevention initiatives – with Core Values as essential indicators of "effectiveness"

Recommendation 1.14 – Program: The Task Force should work with key partners to assemble a diverse workgroup to develop guidance for meaningful inclusion of attempt survivors in suicide prevention and behavioral health efforts.

It should be noted that while inclusion is generally beneficial for the community, the benefits for the suicide attempt survivor depend on his or her readiness to be open up about the past crisis and use the lived experience as a strength. Some guidance exists for attempt survivors talking to individual family and friends[y], and for being a public speaker talking about lived experiences related to suicide[z]. However, there is a need for specific guidance about public disclosure when becoming a partner in a suicide prevention or mental health effort as an "out" suicide attempt survivor. A specific workgroup could develop such guidance. Ideally, attempt survivors should have easy access to a combined resource that can provide considerations and guidance for a range of activities that require self-disclosure, for example:

1. addressing self-stigma and shame
2. disclosing to family, friends, and support people
3. discussing suicidal thoughts and feelings with a behavioral health professional
4. disclosing to medical providers (e.g., primary care or emergency department)
5. disclosing for peer support
6. disclosing in public speaking
7. becoming a partner or leader in suicide prevention

There are some considerations for disclosure that are shared across multiple types of activities. For example, people should be aware of the potential for others' negative reactions or discrimination. On the other hand, a recent study found that disclosure had beneficial effects, reducing loneliness and countering suicidal feelings.[75] However, there are some topics that are specific to the audience for the disclosure. The workgroup would also have to address the need for wide distribution, availability, and accessibility of the guidance so that attempt survivors are likely to find and use the resource.

The workgroup might address additional considerations for hiring suicide prevention peer specialists:

1. example functions and goals for peer programs
2. clearly written job descriptions and qualifications that value lived experience
3. leadership support at high levels and among immediate supervisors or managers
4. training for staff to prepare them for working alongside peer professionals
5. specific guidance for addressing role conflicts (i.e., the role of patient versus the role of peer specialist) and disclosure practices in the course of providing support

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[y] See Journey Toward Help and Hope, in press from SAMHSA.
[z] See http://www.suicidology.org/c/document_library/get_file?folderId=258&name=DLFE-542.pdf

6. suggested ways to help support peer providers' recovery or post-traumatic growth; specific challenges to be addressed may include stigma, shame, discrimination, and the potential for relapse[76]
7. sources and availability of consultation or technical assistance during the startup process (or ongoing support)

Recommendation 1.15 – Policy: Every Task Force of the Action Alliance should recruit attempt survivors as members. This will demonstrate that the suicide prevention community values them and their expertise.

Beginning with the suicide prevention community, agencies and organizations should move beyond limited representation of attempt survivors into real partnerships. Ideally, inclusion can become significant or meaningful involvement. In the highest forms of inclusion (full integration), attempt survivors are invited as partners in key positions that have decision-making authority (e.g., management, staff, oversight boards) and receive compensation for their time and expertise.[aa] With expert guidance, more agencies and organizations may become prepared to reach out to attempt survivors as partners. In some cases, persons already in leadership or professional positions may have survived a suicidal crisis. When agencies and organizations develop supportive environments, such persons may feel safer with openly using their lived expertise.

Recommendation 1.16 – Policy: Agencies and organizations at all levels (federal, state, community, etc.) should explicitly endorse, or require, inclusion of attempt survivors in suicide prevention efforts.

A policy example that primarily involves a formal shift in practices is the requirement for suicide attempt survivors to be included in suicide prevention efforts. An excellent example of this is legislation in Oklahoma that authorizes a Suicide Prevention Council and requires "survivors of attempted suicide" to be on the Council.[77] In many areas, there are already policies that require people with lived experience, related to mental health and substance abuse issues, to be included in programs or oversight.

[aa] As an example, see Prescott & Harris, *Moving Forward, Together* (http://pathprogram.samhsa.gov/channel/moving-forward-together-integrating-consumers-as-colleagues-603.aspx) - a guide for integrating people with lived experiences related to homelessness into policy, planning, evaluation, and delivery of services.

Part 2: Family, Friends, and Support Network

As part of starting therapy, Vickie asked Jamie about the family or friends who should be included in the support network part of the wellness plan. Who was there throughout Jamie's crisis? Who was around in good times and bad times? When the list was finalized, it had father, sister, close friends Chris and Pat, Prof. Jones, Chaplain Nelson, and Dr. Jamison. Among other resources, Vickie provided a list of times that the local hospital was offering educational programs for community members. Jamie also selected some booklets for them and a flyer for a new group just for family and friends of attempt survivors. There's nothing like having a support group of your own.

Recommendation 2.1 – Practice: Every attempt survivor should define a support network for himself or herself; people can assist in the process but not insist on persons to include or exclude.

Each attempt survivor defines for himself or herself the people who should be consulted and included in care, and in what stage of recovery they are engaged. Helpers can make suggestions or provide ideas in the process of exploring potential supports, but each person should have the opportunity to define his or her own care network. In particular, for youth, the support network usually includes parents or guardians, but someone may feel closer to siblings or another trusted adult in the extended family (e.g., aunt or uncle, grandparent) or the community (e.g., teacher, pastor). As a specific example, a recent study with Latina adolescents found that support from fathers and teachers may be particularly important in protecting against suicidal thinking and attempts.[78] However, individual choice for some (e.g., minors, dependent adults) will need to be balanced with clinical and/or legal needs to involve caretakers.

Getting help from a support network

On multiple occasions, attempt survivors have indicated that simple acts of caring make a major difference in their lives, particularly when they are most vulnerable. The importance of cumulative acts is indicated by research on family-based protective factors and the buffering role of having a network of supportive friends. As an example, a recent study from Taiwan showed that for preventing repeat suicide attempts, social support was just as important as willingness to get professional help.[79] Additionally, a study with U.S. Air Force personnel demonstrated that support that enhanced self-esteem or provided tangible help (e.g., money, transportation) decreased suicidal thinking.[80] Several supportive actions are listed in **Table 2**, and two resources for such actions (Reach Out campaign, and Lifeline E-cards) are highlighted on this page.

Reach Out.
Check In.
Save A Life.

[The campaign] encourages everyone to take some time out of their day to reach out and connect with someone who might be struggling... People need to feel connected to others, and to feel that someone notices them and cares. You never know who might be feeling alone, and something as simple as a smile or a conversation can go a long way.

reachoutcheckin.org

Lifeline E-cards are a quick way for people to send a brief note with support, sympathy, or well wishes.

suicidepreventionlifeline.org/getinvolved/ecards.aspx

Table 2. Example social supports

General support	● initiate regular, positive contacts (e.g., calls, emails, text messages, etc.) – see Reach Out campaign in box. ● send a letter, postcard, or e-card – see Lifeline e-Cards in box. ● explicitly offer messages of care, affection, pride, love, or concern ● provide encouragement and tangible supports (e.g., transportation, reminders) for seeking additional help ● offer support and encouragement for engaging in self-help practices ● maintain an emotionally supportive home with consistent communication for children
Crisis support	● visit a family or friend in the hospital ● accompany him or her to the emergency department or crisis center ● help arrange for child care and support during a crisis and/or recovery ● offer to take care of his or her pets, plants, or property ● be particularly vigilant just after he or she gets out of the hospital or emergency department, and in the weeks that follow

Information on helping an attempt survivor

Recommendation 2.2 – Practice: Offer training and/or educational materials to people identified by the attempt survivor as supports.

Many programs are designed to assist people in a care network with identifying suicide risk or warning signs, and providing support to a person recovering from a suicide attempt (or at risk for suicidal behavior). Some educational interventions for community members have been included in research studies and found to be effective[81-84], including a specific educational program within the emergency department[85,86]. Participants have demonstrated improved knowledge, attitudes, and skills which help by increasing **reasons for living** and promoting use of both professional and informal supports (i.e., **connectedness**). Some community organizations, including churches and faith-based groups, can better serve their members as local resources by offering such trainings to their leaders and staff.

Other resources (e.g., fact sheets, brochures, booklets, and self-help materials) are also designed to provide information, but no published evaluations were found. Family and friends might also benefit from guidance about talking to an attempt survivor or suicidal person about reducing access to lethal means. Some specific guidance for mental health professionals, seeking to include family or support persons in discharge planning, can be found through the American Association of Suicidology (AAS).[87] In particular, the AAS guidelines recommend scheduling a family session and providing support persons with specific information and resources.

Support for The Family and Friends of Attempt Survivors

The person recovering from a suicide attempt benefits from the support and **connectedness** that comes with having a network of people who care about them. However, the people in the network themselves often require some support and assistance.

Recommendation 2.3 – Program: Develop, evaluate, and promote programs specifically intended to help the family and friends of attempt survivors.

Supporting a person through a suicidal crisis can entail terrifying experiences and even development of secondary trauma symptoms. Yet, there are few programs that have been designed to support the family of attempt survivors, and no programs were identified for friends and other support persons. In related successful programs, trained family members (i.e., peers for family) offer groups that focus on providing education, skills, training, and support. Outcomes have included decreased stress among family members and increased coping abilities.[32,88] There are also some brochures, booklets, and self-help materials designed to help family with behavioral health recovery.

The following practices might be helpful in developing efforts to assist the family and friends of attempt survivors[32,89]:

- Coping strategies to avoid burnout, especially in consideration of their vigilance and help-giving efforts
- Information about the short-term and long-term factors that contribute to suicidal thinking and behavior, including those from the attempt survivor, from the family, from the environment, and from the larger culture
- Consideration of cultural and/or spiritual differences that influence support practices

Recommendation 2.4 – Practice: Expand programs and projects that provide support for families coping with mental health concerns to explicitly address issues related to suicidal crises.

There are few programs that offer support for family or friends of individuals who have been suicidal. Many people gain support from **connecting** with others while attending programs that were originally intended for educational purposes.[88] As a specific point for intervention, it may be helpful to have a structured meeting with family and friends when a person needs to go to a psychiatric hospital during a suicidal crisis. Resources such as groups or online forums that might foster support through connectedness for people who care about attempt survivors are desperately needed. One way to quickly foster wider availability of support is to enhance related behavioral health programs for support persons by including resources and discussion specifically about suicidal crises.

Part 3: Clinical Services and Supports

Vickie's question, "Who referred you here?" brought back memories for Jamie. Most directly, the referral for a therapist came from Dr. Jamison, a psychiatrist. Dr. Jamison worked with all of her patients to develop a care plan that included a wide variety of support, including therapy, so that they could use minimal medication management. Before that, though, the journey really started with a nurse named Dan who told Jamie that he had gone through a suicidal crisis himself. He said that Dr. Carson, the primary care physician Dan worked with, was understanding and supportive. As it turned out, Dr. Carson and Dr. Jamison were at the forefront of an effort to make suicide prevention a core part of the clinic's mission.

Jamie was not sure how Vickie would react to learning about the suicidal crises of the past. She offered a warm and reassuring smile and explained how she would be working side-by-side with Jamie through crises and challenges, always in light of strengths, hopes, and goals. Together they would develop a care plan that had specific steps they would try if a crisis occurred, and which supports and services they might engage for help. Vickie's insistence on working together to see the whole picture and make plans they would both be comfortable with was the start of a wonderful therapeutic relationship.

General Medical Services

Recommendation 3.1 – Practice: Agencies and organizations providing clinical services should consider the Core Values as ways to improve care for all patients, including attempt survivors.

Many individuals who have lived through a suicidal crisis use medical, mental health, or behavioral health services. Professionals offer specialized knowledge and resources that have the potential to enable and support recovery. Working to restore **hope** should be a major goal of treatment for someone who is seriously considering suicide for the first time, someone who has attempted suicide multiple times, and persons with experiences throughout that continuum. However, services tend to work in isolation from each other and focus only on a specific part of the recovery process (e.g., medical stabilization, detoxification from substance use, individual therapy). As noted in several reports,[31,39,40] this approach has led to a fragmented system with many gaps in care. Additionally, "there is substantial evidence that discontinuities in treatment and fragmentation of care can increase the risk for suicide."[9(p52)] Thus, in line with prior recommendations, the Task Force supports a collaborative, person-centered approach that maintains continuity of care and is aligned with the Core Values.

When elements of healthcare align with the Core Values, they can benefit all patients and contribute to the prevention of suicidal behavior. For example, providing collaborative care and **engaging a person's support network** would be universally beneficial. Focusing on enhancing care in ways that align with the Core Values provides an opportunity to partner with many other groups (e.g., domestic violence prevention, substance abuse treatment and prevention, disability rights, etc.) to make and implement policy changes.

Recommendation 3.2 – Policy: Organizations involved in suicide prevention should have formal statements of support for helping attempt survivors.

As an initial step, a relatively simple policy change is a position statement or formal announcement of support for helping suicide attempt survivors. This approach is exemplified by Suicide Prevention Australia (SPA; a national community organization in Australia focused on suicide prevention) that issued a position paper in support of attempt survivors. Through the position paper, the organization officially endorsed concepts such as expanding care beyond clinical systems, collaborative decision-making, alternatives to hospital-based intervention, and attention to the needs of family and friends of attempt survivors. Similar statements can be made by organizations in the U.S. to formally support recommendations from *The Way Forward*.

Health systems change through policy: The role of political will

In a series of papers co-authored by the U.S. Surgeon General in charge of developing the first "Healthy People" initiative, three essential components were identified for successful health policy as (1) knowledge base about the issue; (2) a comprehensive strategy for taking action; and (3) political will.[90,91] Social and political support, i.e., "political will," are needed to change policies in ways that advance public health.[92,93]

Political will is "society's desire and commitment to support or modify old programs or to develop new programs. It may be viewed as the process of generating resources to carry out policies and programs."[90(p388)] Political will is based on "public understanding and support."[91(p451)] Here, "public" refers to both government leadership and the broader community.[92] Public support can influence public health outcomes when economic, social, and intellectual resources are committed to address an issue.[93]

As noted in a report on the state of suicide prevention in the U.S., "the movement's capacity for activism will be central to its future success."[6(p40)] Securing funding is an essential part of health reform efforts. Community support and pressure help ensure that crucial resources are available (i.e., political will). The Mental Health Services Act in California[bb], which has funded many suicide prevention activities, including attempt survivor supports, is probably the best known example of policy change through public support. [see box]

[bb] http://mhsoac.ca.gov/MHSOAC_Publications/docs/Publications/TransformationPolicyPaper_May2011.pdf

Political will in action: The California Mental Health Services Act

Specific funding for mental health in California began with ballot initiative, Proposition 63 (Prop 63; Mental Health Services Act, or MHSA) in the 2004 election cycle. Prop 63 added a 1% extra tax to income over $1 million a year, with the purpose of funding initiatives to reform and enhance the mental health system in California, and it passed with 53.8% of the vote. In part, the MHSA established programs for prevention and early intervention that specifically address suicide. In 2009, in a special election ballot, Proposition 1E sought to shift funds earmarked for the MHSA to help balance the state budget. Prop 1E did not pass, garnering 33.5% of the vote. See official site: http://www.dmh.ca.gov/prop_63/mhsa/

Elements of transformation addressed in MHSA statutes include:

- requirements for significant stakeholder involvement from clients, family members, parents, and caregivers in local planning and services
- services and supports that are comprehensive, integrated and focused on wellness/recovery/resiliency
- promotion of the employment of mental health clients and family members in the mental health system
- promotion of consumer-operated services as a way to support recovery

Health Professionals

Recommendation 3.3 – Practice: Professional clinical education should include training on providing treatment to someone in a suicidal crisis, or recovering from crisis.

Health systems can further support the Core Values by developing a workforce with the knowledge, skills, and resources needed to respond appropriately in a suicidal crisis. The Task Force agrees with recent guidance recommending that quality improvement efforts examine system readiness for assessing suicide risk and responding appropriately.[31,40] Research indicates that some people prefer to get help for mental health challenges through primary care, and many individuals who die by suicide had contact with health care settings before their deaths.[31,94] Some communities may only have access to primary care. Increasing the number of settings and professionals with basic competence in understanding and supporting a suicidal person opens up additional **choices** for seeking care and facilitates **faster access to care**.

As recommended in the CCI Report, evidence-based clinical care for a person at risk of suicide should be person-centered, engage his or her support network, and respect cultural values and preferences. The report identified the four key parts of care: (1) screening and assessing risk for suicidal behavior; (2) collaborating with the person at risk to plan for safety; (3) addressing suicide risk directly, through collaboration with other professionals, and/or appropriate referral to a mental health care provider; (4) follow-up contact.[31] Additional information about developing a competent health care workforce can be found in the Zero Suicide Tool Kit[cc] and guidance

[cc] http://www.zerosuicide.com/developing-competent-workforce

for specific workforce guidelines for professionals in the forthcoming *Suicide Prevention and the Clinical Workforce: Guidelines for Training*[dd].

Health professionals may also benefit from practical discussion guidance like maintaining dignity and supporting autonomy, teaching or encouraging self-advocacy, and addressing access to materials used for suicide (e.g., guns, large quantities of medicine). The NSSP recommends leveraging the power of credentialing and accrediting agencies / organizations to change professional practices.[9]

Beyond competent care, the Task Force urges professionals to practice compassionate care. NSSP Objective 9.3 focuses on promoting safe disclosure; a process that depends on addressing **negative stereotypes, fear, and discrimination** among health care professionals.[89,95,96] A report from the U.K. provided many specific examples for improving "bedside manner." Most reinforce the idea that individuals currently in, or recovering from, a suicidal crisis "have the right to be treated with dignity and respect … and valued as human beings, as do all service users."[97] Research indicates that presentations with or by people with relevant lived experience can have a bigger impact on reducing negative stereotypes and stigmatizing attitudes than presentations that depend solely on sharing information.[98,99] Engaging attempt survivors in planning and delivering training is emerging as a recommended practice.[97,98]

Recommendation 3.4 – Practice: Clinical professionals should collaborate with a person to understand his or her suicidal experience and specifically address suicide risk.

A person living with a mental and/or substance abuse disorder has a greater risk for suicidal behavior. Yet, even when behaviors that appear to be symptoms of a mental disorder are present, they may not be the root cause of suicidal thinking or behavior. Recent practice guidelines for mental health crises reinforce the notion that "established psychiatric disability may be relevant but may – or may not – be immediately paramount"[40(p6)] and recommend that "appropriate interventions seek to understand the individual, his or her unique circumstances and how that individual's personal preferences and goals can be maximally incorporated …"[40(p5)] While acknowledging the increased suicide risk associated with behavioral health issues, Motto observed that "many suicides are not caused by illness, but by psychic pain or anticipation of pain that exceeds an individual's threshold of pain tolerance" and may be due to "stressful life circumstances that do not constitute a disorder."[100(p226)]

Both theoretical[101-103] and empirical studies[10,104,105] have found that the suicidal crisis may have more to do with subjective experiences of emotional pain and hopelessness, and less to do with diagnosis or symptoms. As noted in the CCI Report, "targeting and treating suicidal ideation and behaviors independent of diagnosis holds the greatest promise for care of suicidal risk."[31(piii)]

[dd] National Action Alliance for Suicide Prevention: Clinical Workforce Preparedness Task Force (in press). *The Clinical Workforce: Guidelines for training.* http://actionallianceforsuicideprevention.org/task-force/clinicalworkforce

Behavioral Health Systems and Supports

Behavioral Health Systems

Recommendation 3.5 – Policy: Behavioral health systems should make suicide prevention a core component of care.

There is a need for system transformation that makes suicide prevention a core component of care. A system that believes that suicide is an unacceptable outcome is likely to try new approaches and be open to change existing programs or policies to ensure that people receive quality, **collaborative care**. When addressing suicidal behavior as a core part of care, the negative perception (**stigma**) of a suicidal person as a "waste of time" is replaced by considering him or her a priority. With a value on life, **access to care** and what happens after hospital or emergency department discharge become critically important. The change might also provide an impetus for creating formal connections to aftercare and follow-up services, thus strengthening the type of interagency **connectedness** that is a Core Value.

At the 2007 National Summit on Recovery, participants identified 17 elements of recovery-oriented care[106]:

- Person-centered
- Family and other ally involvement
- Individualized and comprehensive services across the lifespan
- Systems anchored in the community
- Continuity of care
- Partnership-consultant relationships
- Strength-based
- Culturally responsive
- Responsiveness to personal belief systems
- Commitment to peer recovery support services
- Inclusion of the voices and experiences of recovering individuals and their families
- Integrated services
- System-wide education and training
- Ongoing monitoring and outreach
- Outcomes-driven
- Research based; and
- Adequately and flexibly financed

As noted in the NSSP, changes require "leadership support, changing the organizational culture around suicide prevention, and engaging each component of a system to assume its legitimate role in suicide prevention."[9(p52)] Similarly, a review of large-scale transformations to align health systems with the values of recovery-oriented care concluded that "leadership, innovative thinking, flexible planning, and analysis of existing strengths and weaknesses emerged as key elements in each change process."[106(p23)] Such changes have been applied with success in large systems like the VA, the Henry Ford Health System, and the Central Arizona Programmatic Suicide Deterrent Project.[31] Further information, resources, and support can be found at the Action Alliance's Zero Suicide Initiative website.[ee]

[ee] http://www.zerosuicide.com

Behavioral Health Professionals

Recommendation 3.6 – Practice: At the beginning of care, professionals should inform patients about their approach to working through crisis situations.

While some providers clearly specify that they are able and willing to work with suicidal clients (see HelpPRO in box), for most it is unclear how they would approach a suicidal crisis. As part of informed consent, clinical providers should be "up front" about their stance on suicide (e.g., always support life), and their approach to working through a crisis. The delicate balance required for such decisions and discussions was well described by Linehan: "Two factors are important in treatment planning and deciding on how active to be in responding to a suicidal crisis. The first factor is the short-term risk of suicide if the therapist does not actively intervene. The second factor is the long-term risk of suicide, or a life not worth living, if the therapist does actively intervene."[107(p174)] Regardless of a provider's choices about how to approach crisis situations, the person receiving services should be fully informed about the potential benefits and risks of disclosing suicidal thoughts. Involuntary confinement, even if it provides some therapeutic value, could create "extremely serious, negative repercussions both for the patient's therapy and for his or her life."[107(p178)]

HelpPRO Suicide Prevention Therapist Finder

This resource was launched on World Suicide Prevention Day in 2013 (September 10th) as an online referral source of behavioral health providers trained in suicide assessment and support. It is a joint venture of HelpPRO (developers of a comprehensive therapist finder) and partners including the National Suicide Prevention Lifeline, the American Association of Suicidology (AAS), the QPR Institute, The Carson J Spencer Foundation (CJSF), and the Suicide Prevention Resource Center (SPRC) of the Education Development Center, Inc.

The project has two major goals: (1) connect people to qualified professionals who specialize in working with persons in, or recovering from, a suicidal crisis; (2) encourage behavioral health professionals to enhance their suicide prevention skills.

Professionals who specialize in helping suicidal individuals, and are accepting new clients, are encouraged to list their practice information at the site.

http://www.helppro.com/SPTF

Early discussion of issues like potential crisis situations might reduce instances of professional abandonment (actual or perceived). Some attempt survivors have reported being dropped from treatment after a suicidal crisis, at times without a referral to another provider. For the client, when care is abruptly terminated it may feel like professional rejection, deepening the trauma of the crisis experienced and intensifying feelings of shame. The clinician may also experience anxiety and guilt, in addition to ethical and legal ramifications of abandonment, which is considered medical malpractice. If necessary, the appropriate way to end treatment may include providing information, sharing resources, arranging referrals, follow-up contact, and sufficient time for the termination process.[108]

Some guidance about treatment planning, including the development of a crisis plan (also called a safety plan or emergency plan) can be found in the Zero Suicide Toolkit[ff]. While this type of plan can be devised or revisited

[ff] http://www.zerosuicide.com

during the course of treatment, the process should start at the beginning of treatment. This type of plan flows naturally from the process of assessment, and presents an excellent opportunity to start collaborating on care and support.

Behavioral Health Treatment

Recommendation 3.7 – Practice: Behavioral health providers should integrate principles of collaborative assessment and treatment planning into their practices.

An accurate assessment sets up the possibility for appropriate and effective treatment. Additionally, a person's sole interaction with the behavioral health system may be the assessment. There are at least two models that illustrate ways for assessment to adhere to the Core Value supporting **dignity** and **collaborative care**: the internationally recognized Aeschi approach and the empirically supported Collaborative Assessment and Management of Suicidality (CAMS) model.

- The Aeschi Working Group and Conference is "a group of clinicians and researchers dedicated to improving clinical suicide prevention practice by developing and promoting patient-oriented and **collaborative** models of understanding suicidal behavior."[gg] The approach values the therapeutic relationship and focuses on understanding someone's personal narrative of his or her suicidal thoughts or feelings. Attention to the inner experience is a compassionate approach that is inherently supportive of someone's **dignity**. They offer the following guidelines for clinicians:

    1. *The clinician's task is to reach, together with the patient, a shared understanding of the patient's suicidality.*
    2. *The clinician should be aware that most suicidal patients suffer from a state of mental pain or anguish and a total loss of self-respect.*
    3. *The interviewer's attitude should be non-judgmental and supportive.*
    4. *The interview should start with the patient's self-narrative.*
    5. *The ultimate goal must be to engage the patient in a therapeutic relationship.*

Dr. Jobes, a member of the Aeschi group, developed the CAMS model[102] as a framework for collaborative assessment and treatment planning specifically designed for working with suicidal individuals. One of the core aspects of the approach is a **collaborative** assessment of a person's goals or perceived benefits for suicidal thinking. The therapist can then help the person consider alternative coping strategies or supports that can help the person achieve those goals or realize those benefits. The effectiveness of the model has been demonstrated in several studies and ongoing research. The results showed that people engaged in CAMS experience increased **hope and reasons for living**, improved satisfaction with care, and decreased suicidal thoughts and distress.[104]

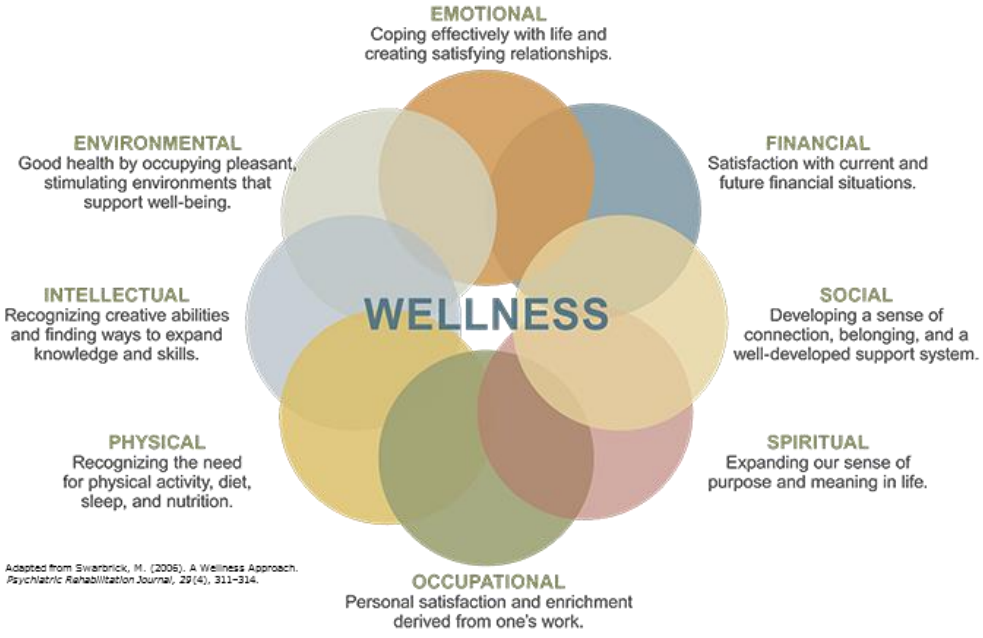
[gg] http://www.aeschiconference.unibe.ch/

Recommendation 3.8 – Practice: Behavioral health professionals should complete a comprehensive assessment that goes beyond suicide risk as soon as it is feasible to do so, acknowledging that a person has a life beyond the crisis.

Everyone should have the chance to receive a comprehensive assessment. Care for someone, beginning with assessment, should address the current crisis, as well as his or her multiple needs. One research report noted (emphasis added) "After a suicide attempt, needs in several different aspects were present. The number of needs and unmet needs was reduced after 1 year, **but a number of needs were still common, especially in health aspects but also in basic needs and social needs**."[109(p362)] Additionally, a study of young attempt survivors found that they often had more health and social problems over time than youth without a history of suicide attempts.[4]

A comprehensive assessment would also examine several life domains, facilitating a discussion of individual strengths and possible community **connections**. Reminding someone that he or she has multiple dimensions (see, for example, Figure 2) that include strengths could help restore a sense of self-respect or **dignity**. One resource on assessment recommended using questions about supports and challenges within both the person and his or her environment.[110] As a specific example, one review recommended that clinicians "be aware of the religious and spiritual activities of their patients, [and] appreciate their value as a resource for healthy mental and social functioning."[37(p289)] For additional information and resources for promoting wellness, please see the SAMHSA Wellness Initiative.[hh]

Figure 2. SAMHSA Wellness Initiative - Eight Dimensions of Wellness



[hh] http://promoteacceptance.samhsa.gov/10by10/

Recommendation 3.9 – Policy: Protocols for addressing safety and crisis planning should be based on principles of informed and collaborative care.

Many people have been sent to involuntary, or coerced, inpatient care when they could have benefited from alternatives. During hospitalization, patients might endure physical and/or psychiatric restraints or solitary confinement. Such practices intensify the crisis, deprive a person of dignity, and substitute potential trauma for treatment while having practically no effect on long-term risk for suicide.[40,107,111,112] As stated by the Bazelon Center for Mental Health Law, "Forced treatment – including forced hospitalization, forced medication, restraint and seclusion, and stripping – is only appropriate in the rare circumstance when there is a serious and immediate safety threat."[ii] The ethical, legal, and scientific consideration of forced treatment available through the Bazelon Center is consistent with the Core Values. Additionally, the practice guidelines for responding to mental health crises remind providers that such interventions carry the risk of physical and psychological harm.[40]

The NSSP recommends that "specialty centers that provide care for mental and substance use disorders should have in place policies, procedures, and programs designed to identify the level of suicide risk and intervene to prevent suicide among their patients."[9(p61)] It was also recommended that "protocols should emphasize patient-centered and stepped approaches that allow relative suicide risk to be assessed and matched with a continuum of services."[9(p62)] It is particularly important to help people find appropriate care for their level of risk. The CCI Report includes further recommendations for assessing and responding to suicide risk in multiple healthcare settings.[31]

Whenever possible, even crisis care should be provided in an environment that maintains **connectedness** to a person's **family and/or peers**, and has as few restrictions as possible. Any restrictions on personal wellness should cease once basic health and safety are attained. For example, at inpatient and partial hospitalization settings, individuals would benefit from having therapeutic contact daily (including weekends) along with a chance to exercise and/or spend time outdoors. Providing care in alternative settings will be greatly facilitated when behavioral health providers follow guidance from the NSSP to "coordinate the services of community-based and peer-support programs with the support available from local providers of mental health and substance abuse services to better serve individuals at risk for suicide."[9(p65)]

Regardless of where care takes place, to make informed decisions, as early as possible, each person should receive a guide to rights and treatment options written in a language and manner that is easily understood. Individuals receiving care would also benefit from ready access to a peer advocate whenever possible.

Recommendation 3.10 – Practice: Consider the Core Values as essential aspects of care and/or outcomes to achieve in all treatment (including outpatient and inpatient) to help in a suicidal crisis.

In many cases someone who is in, or recovering from, a suicidal crisis can benefit from therapy. While there are many types of therapy, generally, for people to cope with suicidal thoughts or recover from a suicide attempt, cognitive and/or behavioral treatment is recommended. As noted in the NSSP, "there is now substantial

[ii] http://www.bazelon.org/Where-We-Stand/Self-Determination/Forced-Treatment.aspx

evidence that interventions such as dialectical behavior therapy (DBT) and cognitive behavior therapy for suicide prevention (CBT-SP) can help reduce suicidal behaviors." Moreover, as noted in the CCI Report and the NSSP, care is most effective when it is specifically designed to counter suicide. [9,31]

A detailed discussion of therapeutic practices is beyond the scope of *The Way Forward*. However, the ideal therapies will value **dignity**, **collaborative care**, and the **engagement and support of family and friends**. Care practices are discussed at length in the CCI Report[31] and Zero Suicide in Healthcare initiative from the Action Alliance.[jj] In addition to the Aeschi and CAMS models (see Recommendation 3.7) a few additional approaches are exemplary in adhering to the Core Values:

Trauma-informed care

Many individuals have histories that include trauma (e.g., physical, sexual, emotional abuse).[113] Thus, past trauma can be a primary factor or a complicating factor to consider in assessment and treatment.[114] Additionally, for some attempt survivors the suicidal event itself (e.g., injury, loss, shame, discrimination, or negative encounters with services) can serve as a traumatic event. Therefore, it may be beneficial for professionals working with attempt survivors to learn from the approaches in trauma-informed care. SAMHSA has developed a National Center for Trauma-Informed Care that provides additional education and assistance regarding these practices.[kk] In brief, this type of approach begins from a basic understanding about how trauma impacts the life and experience of care for the person who survived a trauma. Common principles include the need for **respect**, informed care, **hope**, and **collaboration** that may also **engage family and friends**. Given the increased risk for multiple negative outcomes associated with childhood trauma, early intervention is invaluable.[113]

Connecting with hope

One approach to working with suicidal people was developed based on a review and synthesis of in-depth interviews with attempt survivors.[115] In part, care plans based on the theory might seek to:[116]

- Counter isolation by engaging in treatment and promoting supportive relationships (**connectedness**)
- Validate a person's emotional pain, help them express their feelings (e.g., journaling, art, music) as opposed to attempting to suppress the pain
- Help someone find ways to cope through specific blocks of time and stay connected to **reasons for living** or form a safety alliance during the most suicidal times
- Help someone work through emotional pain in the short term, and in the long term learn to value and use his or her strengths and continue moving toward a **meaningful and hopeful life**

[jj] http://www.zerosuicide.com/using-effective-evidence-based-care
[kk] http://www.samhsa.gov/nctic/

Personalized community-based treatment

The Need Adapted Treatment Model[ll] emphasizes providing **timely access to care** that is flexible in terms of allowing people to choose times and locations for treatment based on individual needs (i.e., **choice**). The person receiving care and the people in their **social support network** are engaged to collaborate with professional support networks in planning and carrying out treatment plans. A particularly important part of this type of care is the spirit of **collaboration** that builds from having the person and her or his support network act as equal partners in seeking solutions and providing care.

The internationally recognized Open Dialogue[mm] model is similar in providing **access to care** within 24 hours of initial contact, organizing treatment meetings at times and locations that accommodate individual needs, and engaging the **family and support network** in care. Research on the model has demonstrated that people can decrease symptoms and return to work while avoiding hospitalization and additional psychiatric medication.[117]

Prescribing practices / medication

Recommendation 3.11 – Practice: Use a collaborative approach to prescribing medication that discusses multiple options, respects informed choices, and is monitored and modified as needed.

Many individuals who have survived a suicidal crisis live with behavioral health challenges and often benefit from ongoing treatment or support, which may include therapy and/or medication. Use of medication may entail both benefits (e.g., decreased symptoms, improved functioning) and costs (e.g., financial expenses, negative side effects that may even increase risk for suicidal behavior[118]). Ongoing research has led to advances in medications[nn] and supplements[oo] with the potential to help a person cope with mental, emotional, or physical health concerns. Thus, someone seeking care depends on the professional to bring knowledge about those options into the treatment planning process. Additionally, the person seeking care, his or her support persons, and/or the professional may have concerns about accidental or intentional overdose, interactions with other medications or supplements, habit-forming or addiction potential, or practical issues such as keeping track of multiple medications. As underscored in the Core Value on choice and collaboration, the Task Force encourages use of a well-informed, shared decision-making approach to address concerns and optimize care.

Treatment that includes medication may be especially beneficial during acute or short-term care, but it is not always required for the long term. Some studies report long-term benefits for medications,[119,120] while others argue that recovery is at least as likely without continuous medication[121,122]. Unfortunately, there is not (yet) enough information about the factors involved in recovery to predict which patients do better with continuous medication, which ones only benefit from acute care with medications, and which ones would be well without medication.[123-125]

[ll] http://recovery.rfmh.org/index.php?id=346
[mm] http://willhall.net/opendialogue/
[nn] See http://druginfo.nlm.nih.gov
[oo] See http://nccam.nih.gov

Research indicates that a treatment approach which focuses on **hope** and uses recovery principles is most likely to be successful.[123] Based on research and consensus among recovery-oriented psychiatrists, guidance for prescription practices[123] would be consistent with the Core Values and include:

- Care must be founded on a strong and **collaborative** therapeutic relationship with mutual **respect** and trust.
- Multiple types of care and supports should be considered, including medication(s). For example, everyone benefits from having a circle of **social supports** and meaningful relationships.
- If treatment is going to be changed, then transitions should be done gradually, with honest communication guiding each step of the process.
- It would often be beneficial to have a "wellness coach" or a **peer supporter** who can advocate for the person receiving care, facilitate communication, and assist the person with making informed decisions that support their long-term goals.

Part 4: Crisis and Emergency Services

Jamie and Vickie had carefully laid out a crisis plan, something they both agreed on. Jamie could call people in the support network list, which now included Vicki as well. Additionally, the National Suicide Prevention Lifeline was a key resource because it was available 24/7/365. The crisis center worked with a mobile outreach team, with a psychiatrist and a peer specialist, who could go out to meet with someone in crisis. Most of the local police officers had completed Crisis Intervention Team training, but it still felt better knowing that a mental health team could respond in an emergency. In spite of a decent experience with a hospital before, Jamie really liked the idea of trying the peer respite house as an alternative in case of a significant crisis. If a trip to the emergency department was required, a peer specialist could be called to the hospital for additional help. As an advocate, the specialist would make sure the treatment was respectful and attentive, while also assisting with the engagement of an ongoing support network.

Recommendation 4.1 – Policy: Crisis and emergency services should be expanded and improved to ensure capacity and competence for helping suicidal individuals.

In some areas, only basic emergency services are available. Other regions devote considerable resources to expensive, and often unnecessary, hospital or public safety interventions. Quality clinical services in the community; peer supports such as warm lines, crisis centers and hotlines; and crisis respite care provide help that is often preferable and less costly.[47,48,68,126] A person may be encouraged to specify his or her preferred type(s) of services through a psychiatric advance directive (see box). Communities should invest in those services. Several effective training programs are available to enhance the competence of professionals, paraprofessionals, and volunteers who provide crisis or emergency care.[82-84,127]

Psychiatric Advance Directives

The directive is a legal document that describes someone's specific instructions and/or preferences regarding treatment if he or she is in an acute mental health crisis. Usually, a specific person(s) is designated as a surrogate decision-maker to address needs that are not specifically noted in the document.

Information and resources can be found at the National Resource Center on Psychiatric Advance Directives. http://www.nrc-pad.org/

Help During a Crisis: Crisis Centers, Hotlines, and Crisis Respite Care

Crisis Hotlines

As noted by the NSSP: "Timely access to care is critically important to individuals in crisis. Crisis hotlines … play an important role in providing **timely care** to patients with high suicide risk."[9(p54)] In most places, crisis centers and/or hotlines are always available and offer brief mental health support and triage to further care. Originally, crisis hotlines operated through local or toll-free telephone numbers; however, an increasing number of centers are also adopting new technologies to provide support (e.g., online chat or SMS text messaging). More details about the use of technology can be found in Part 5: Systems Linkages and Continuity of Care (see page 59).Additionally, some centers work alongside, or even operate, on-site crisis counselors or teams. Finally, many centers are offering follow-up calls to people who have called a hotline or people being discharged from an emergency department. More details about follow-up can also be found in Part 5 (see page 58).

Recommendation 4.2 – Practice: Crisis center and hotline staff should review "Lifeline Service and Outreach Strategies Suggested by Suicide Attempt Survivors."

The National Suicide Prevention Lifeline gathered a group of attempt survivors to discuss crisis center service and outreach strategies. The resulting report, *Lifeline Service and Outreach Strategies Suggested by Suicide Attempt Survivors Final Report of the Attempt Survivor Advisory Summit Meeting and Individual Interviews*,[pp] presented themes for helping attempt survivors within the crisis center and hotline context, including:

- **Peer support** is an invaluable resource. Trust and **connection** is easier when talking to others with lived experience. Centers can engage "open" or "self-disclosed" attempt survivors as crisis line or outreach workers.
- Crisis center staff need to understand that talking about suicide does not necessarily indicate imminent risk. Compassionate listening should always come first.
- Crisis line workers may be able to help by gently engaging a caller in conversation about the **important people in his or her life**, gently pointing out how the caller is cared about or loved.
- **Spirituality and faith are important.** Crisis centers can provide information and outreach to faith-based organizations.
- Follow-up calls from crisis line workers can help callers feel supported and **connected. Follow-up peer to peer outreach is** particularly powerful.

In line with the above points, a recent study with training crisis center staff indicated that helpers should explore reasons for living (i.e., **hope, meaning and purpose**) and informal sources of support (i.e., **engaging family and friends**, **connectedness**). Doing so can help people feel more hopeful, less depressed, less overwhelmed, and less suicidal.[127] Centers are also encouraged to review the National Suicide Prevention Lifeline Imminent Risk Policy (see box on following page) for practices that support the ideals and principles outlined here.

Warm lines are described in Part 1: Attempt Survivors as Helpers (see page 27), and make excellent partners for crisis services, offering one source of peer support and connectedness as suggested by the attempt survivor meeting. Some warm lines have formal relationships with crisis hotlines, and with some training and technology, staff can refer or transfer callers in crisis over to a hotline when necessary. Similarly, crisis hotlines can provide warm line information to callers who might benefit from supportive services. In some communities a single organization or site operates both types of services, providing a seamless connection between the two.

[pp] http://www.sprc.org/library_resources/items/lifeline-service-and-outreach-strategies-suggested-suicide-attempt-survivors

National Suicide Prevention Lifeline (NSPL) Imminent Risk Policy[a]

The policy guidance for working with callers at imminent risk for suicide developed by the NSPL is an excellent resource that is consistent with the Core Values. A few relevant points are included below as examples:

> The NSPL "seeks to instill **hope**, sustain living, and promote the health, safety and well-being" of people. Active engagement is consistent with that mission by "holding **hope** for recovery and empowering the callers."

Centers were directed to "develop formal and informal relationships with community services that can assist in the use of less invasive interventions and/or better ensure optimal continuity of care for callers at imminent risk of suicide." While the policy guidance does not specifically name crisis respite or **peer services**, they could be key partners in shared responsibility, and promoting **interagency connectedness**.

Crisis Respite Care

Recommendation 4.3 – Program: Develop and promote crisis respite care centers, especially ones that employ peer providers.

Respite care offers an alternative to emergency department or hospital services for a person in a mental health or suicidal crisis, when that person is not in immediate danger. Usually, respite centers are located in residential facilities that are designed to feel more like homes than hospitals. Given a relaxed setting that often includes peer staff, this type of care is generally preferred by someone in crisis[126,128-130] and has shown better functional outcomes than acute psychiatric hospitalization.[126,129]

One report specifically examined multiple respite centers as part of an in-depth review.[131] A few suggested practices noted in the report are:

- Assisting with continuity of care and establishing longer-term support resources
- Providing phone/text/online "virtual" supports for a person before and/or after a stay
- Evaluating the development, operation, and outcomes of services provided

Approaches to Crisis Respite Care

Inclusion of peers on staff

While many crisis respite services are operated by mental health professionals, there are also some alternatives that are staffed by peers.[131] This is a very promising model, and initial reports indicate that these respite centers can be cost-effective alternatives to traditional hospitalization.[126,130,132-134] The National Empowerment Center[qq] maintains a directory of peer-run crisis alternatives, as well as evaluation studies for them and resources for operating them. Ideally, all crisis respite centers would include some peer providers as staff.

Limits of stay and exclusion criteria

[qq] http://www.power2u.org/crisis-alternatives.html

Centers vary in the length of care that is provided, as well as limitations on the number of times a person can use its services. In a recent review, one center allowed a one-time only, four-night (five-day) stay, while others allowed stays of 21 days or more.[131]

Some centers have criteria that exclude individuals with active suicidal thoughts or behaviors, and thus not all "crisis respite" centers should be considered alternatives to other emergency services for a suicidal person. Additionally, many exclude individuals who need urgent or complex medical care, with some accepting a person only after he or she is medically stabilized in a hospital or clinic.[131]

Amount of therapeutic care

Some crisis respite centers focus on providing a safe, calm, and peaceful environment (i.e., a sanctuary).[128,131] A person in crisis is allowed to form new relationships with people in a relaxed environment, where others understand his or her experience and offer support and hope. There is some evidence that this approach can be effective in reducing clinical distress, and helping people solve problems or address risks even after leaving the center.[128,131] Other centers provide a supportive environment but also facilitate connections to community resources or agencies, helping to provide continuity of care between crisis services and ongoing care. In addition, some centers have individual therapy, group therapy, and/or psycho-education on-site.[131]

Emergency Department (ED)

Recommendation 4.4 – Practice: Professionals in the emergency department should provide collaborative and compassionate care in response to a suicidal crisis.

As noted in Part 3: Clinical Services and Supports, all health care providers should develop competency in responding to a suicidal crisis. Recent sources[31,135] offer specific guidance for ED professionals including:

- Screening all patients for suicide risk at intake, when feasible
- Collaborating with behavioral health professionals for further assessment if indicated
- Collaborating with a patient to develop a safety plan[136]
- Providing a patient with informed and appropriate referrals for additional care
- Following up with a patient after discharge in support of continuity of care[137,138]

Sometimes interactions with someone who recently tried to end his or her life will be difficult or unpleasant. There are often strong emotions involved. Anger can turn into hostility. Despondency can become desperation. Anxiety can initiate panic. However, every person still desires to be treated with **dignity**, **respect**, and kindness. Yet, research reports indicate that attempt survivors often encounter negative interactions in the ED.[139-141] The most common complaints include derogatory comments, judgmental attitudes, dismissiveness, extended waiting times, and lack of information for the attempt survivor and support persons.

Due to the intensive nature of treatment and emergency and inpatient settings, it may be easy to neglect interpersonal aspects of care. Yet, people are at their most fragile and sensitive state in crisis settings, and they can benefit greatly from compassionate care. Some attempt survivors have felt comforted and relieved when professionals reveal, even briefly, that they have had similar experiences. Each provider, considering

professional guidelines and personal comfort, has to decide whether to disclose personal experience. However, it may be useful to know how much their disclosure may be appreciated. Some additional guidance on professional self-disclosure and its impact on individuals who received mental health services can be found in the SAMHSA monograph on self-disclosure[rr].

Attempt survivors have also expressed appreciation for times when professionals listened, showed respect, and demonstrated care and compassion. In addition to general attitude and demeanor, some tangible supports in the ED are also recommended that would improve the experience of all persons seeking ED services, including attempt survivors:

- Provide written information about what a person can expect (e.g., length of wait), what happens during wait times and interactions with providers, and what his or her rights are.
- Express care for his or her comfort and dignity, such as allowing a person to wear "street clothes" unless it is necessary to disrobe.
- Check in with him or her on a regular basis to see how the ED visit is going.
- Provide information to the person and his or her support persons in the form of take-home materials (booklet, video, brochure, pamphlet – see Self-Help on page 23, Information on Helping the Attempt Survivor on page 34).

Provision of collaborative and compassionate treatment in a suicidal crisis should be incorporated into training and continuing education for health care providers. One study included both staff training and brief therapeutic intervention for adolescent female suicide attempt survivors and their mothers, with positive results.[86] Such training would be consistent with Joint Commission standards on patient-centered communication and suicide prevention (National Patient Safety Goal 15A). Additionally, brief reference materials such as posters, brochures, guides, or reference sheets are also available from the SPRC[ss]. Reference materials usually include things such as warning signs that indicate acute or ongoing risk, potential interview questions or approaches, tips for evaluation and triage, and/or suggestions for discharge instructions.

Recommendation 4.5 – Policy: Emergency departments should form partnerships with peer specialists and organizations that can offer support to patients and their family/friends while they wait for clinical care.

Recommendation 4.6 – Program: Train peer specialists to help support and advocate for patients in emergency departments who are experiencing a suicidal crisis.

ED interventions are brief programs that are completed during the time between initial triage at the ED and discharge. The NSSP states that "many types of motivational counseling and case management can also be used to promote adherence to the recommended treatment."[9(p55)] This type of intervention often involves a single

[rr] http://store.samhsa.gov/product/Self-Disclosure-and-Its-Impact-on-Individuals-Who-Receive-Mental-Health-Services/SMA08-4337

[ss] http://www.sprc.org/for-providers/emergency-departments

therapy session conducted by a mental health professional while a person is in the ED. Self-help materials (see Self-Help on page 23, Information on Helping the Attempt Survivor on page 34) may be used to supplement ED-based programs.

Beyond having a brochure or booklet to take home, there are some programs and materials that are designed to help the patient and/or family while they are in the ED. These enhancements to care may involve an additional staff or volunteer person who can provide assistance ranging from companionship to mental health assessment. One program with positive results, including improved patient satisfaction, used a paid Certified Peer Specialist to provide additional care to patients waiting for treatment in the ED.[70] Some places are starting to offer similar services in the ED, often in concert with either peer support organizations or crisis centers.

On-Site Interventions

When a person is actively suicidal, or initiating a suicide attempt, a person or small group may be sent to intervene. Ideally, the response would be by a Mobile Crisis Team (described below). For policy guidance, agencies and organizations should consider principles like the following from the NSPL guidance on active rescue[142]:

- "The Lifeline promotes the most collaborative, least invasive courses of action to secure the health, safety and well-being of individuals." Centers are required to adhere to this policy to retain network mentorship.
- Emergency intervention should be reserved unless a suicide attempt is in progress, or a person remains at imminent risk and "in spite of the center staff best efforts to engage" a person, he or she is unwilling or unable (e.g., intoxicated or experiencing psychotic symptoms) to get help for himself or herself.
- The NSPL policy notes that the focus on always using the least invasive approach is consistent with federal and state laws in the U.S., and international perspectives as well.

Mobile Crisis Teams

Recommendation 4.7 – Policy: Promote use of mobile crisis teams, including a peer specialist who can use his or her lived experience as an asset during interventions.

These groups specialize in mental or behavioral health care and provide care in the community at the location of the person that is suicidal. Ideally, such teams include peer specialists and multiple professional disciplines (e.g., psychiatry, psychology/counseling, social work/case management). At times, such teams have been dispatched along with law enforcement. Research has shown that mobile outreach can help people address psychiatric symptoms and reduce the number and cost of psychiatric hospitalizations, the need for law enforcement intervention, and the number of ED visits.[143-146] However, mobile outreach services vary in availability and in the extent of connections with law enforcement.[147] Some public safety officials have promoted mobile crisis teams as a beneficial alternative to other crisis responses.[147]

Integrating mobile crisis teams into community services would be consistent with NSSP Objective 8.3 to develop protocols and improve **collaboration** among crisis centers, law enforcement, mobile crisis teams, and social services to ensure **timely access to care** for individuals with suicide risk."[9(p54)]

Public Safety and Crisis Intervention Teams (CIT)

Recommendation 4.8 – Policy: Law enforcement agencies should provide training about behavioral health emergencies to all officers, with a minimum requirement to have a specialized response team that is easily identified by community members.

For someone in crisis, it is best when the group that actually interacts with the person specializes in crisis intervention. However, due to resource and/or time limitations, on-site intervention often includes law enforcement.[147] Dispatchers and organizations that initiate crisis responses should recognize that police presence might increase anxiety, agitation, and/or trauma (or reminders of prior negative experiences) as well as elevate risk for everyone involved.[40,147] As reported by the Center for Public Representation, some communities have a history of public safety officers using extreme, aggressive, and even lethal force in interactions with people experiencing mental or emotional distress.[148] To improve crisis response and community relations, a recent report suggested that "law enforcement agencies should take the lead" on creating local advisory groups involving the justice system, behavioral health, adult and youth peers, families, and advocacy organizations.[147(p14)]

When it is necessary to activate a public safety response, agencies should consider dispatching one or more law enforcement officers with specialized training. It is particularly helpful when those officers can work in concert with a mobile crisis team. Generally, the training encompasses some degree of recognition of a mental health crisis, assessment, and pre-booking diversion to care whenever possible. Employing co-facilitators with lived experience may further the impact of training.[98,147] The topics covered in educational programs should include information about respecting the privacy of the person in crisis, guarding the confidentiality of reports, and treating the cases as protected health information unless a booking offense has been committed. It would be extremely beneficial for entire law enforcement agencies to receive training about behavioral health emergencies.[40,147] It has been recommended that enough officers are trained to enable an appropriate response for all shifts and service areas.[147] Additional information and resources can be found at the University of Memphis CIT Center[tt], or the National Alliance on Mental Illness (NAMI) CIT Center[uu].

[tt] http://cit.memphis.edu/
[uu] https://www.nami.org/template.cfm?section=CIT2

Part 5: Systems Linkages and Continuity of Care

Once, after a brief hospitalization during college, Jamie met with a peer specialist. The school, hospital, crisis center, and peer support organization had formal partnerships to make care more seamless. Within a day of leaving the hospital and returning to campus, Jamie got a follow-up call to set up a meeting with the peer specialist to talk about options for ongoing services and support. There were other signs that people cared as well. Within the first week of being back at school, a short note from the hospital came in the mail – it was a nice touch. One of the college's resident assistants sent a supportive e-card, and included a link for a safety plan mobile app. The peer specialist helped Jamie add contacts and some recommended online resources into the new app once it was installed.

Systems Linkages

Connecting the education system with suicide prevention

Recommendation 5.1 – Policy: Colleges and university should develop policies that promote help-seeking and foster a supportive campus environment.

One non-clinical system that is often connected to health care services is the education system, providing services or referrals for both students and staff. Colleges and universities must balance the needs of a student in crisis with the needs of his or her fellow students and of the institution itself.[149,150] Some campus administrators, though usually well-intentioned, created policies that appear to be more concerned with institutional image or potential liability than for student welfare – policies that use a disciplinary process and/or force students to leave the school.[149,151,152]

As noted by one text on college suicide prevention, requiring a student to leave campus "creates a significant sense of isolation and alienation from the community that may be all that remains of a student's support system … a traumatic experience … this action has momentous impact on their psychological state."[149(p211)] Similarly, the Jed Foundation, an organization that develops mental health tools and guides for campus policymakers, described the policy of forced withdrawal for suicidal students as "clinically questionable and ethically dubious."[150(p16)] Punitive actions may "serve to exacerbate the suicidal state and propel the student more rapidly toward serious suicidal actions."[149(p212)] Such responses can "have the unintended consequence of discouraging students from seeking treatment."[150(p16)] Indeed, they could have a negative effect on the entire student body and expose the college or university to legal risks as well.[150,152,153]

As noted in the NSSP in the discussion about promoting safe disclosure: "Settings that provide care to [persons] with suicide risk must be nonjudgmental and psychologically safe places in which to receive services. [Persons] who have thoughts of suicide may feel embarrassed, guilty, and fearful of disclosing their thoughts and feelings to others … may also fear losing autonomy or the ability to make their own treatment decisions. To address these barriers to treatment, collaborative and non-coercive approaches should be used whenever possible."[9(p59-60)] Schools have been encouraged to develop helpful and caring policies[9,149,151,154,155] that encourage students to use mental health and counseling services and make them more accessible; and train relevant school staff to recognize students at risk, treat them with compassion and sensitivity, and refer them to appropriate services.

Recommendation 5.2 – Program: Develop and promote peer specialist programs to provide students who are coping with suicidal thoughts or behavioral health challenges with support and connections to resources.

Ideally, a student who is struggling with suicidal thinking could meet with a peer specialist. The specialist could assist the student with identifying short-term safety resources, understanding the available support options, and getting connected to care. Such an approach can remove school policies regarding suicide from the disciplinary sphere and place it in the realm of community supports instead. In a recent survey of students living with mental health challenges, peer supports and advocates were cited as programs that would exemplify a supportive campus.[156] Outreach to students in need can engage them in ways that support connectedness[157], and may be effectively implemented by a peer specialist. For example, a study using student leaders to provide peer support in high schools demonstrated increased help-seeking and enhanced protective factors throughout the schools.[81] In addition to clinical services, campus supports might include Student Life or Residential Life and Spiritual Advisors / Chaplains. It would also be useful to provide students with information about their rights[158] and options to get involved with mental health promotion (e.g., Active Minds on Campus[vv]).

Recommendation 5.3 – Practice: Suicide prevention and mental health advocacy groups should use public recognition to highlight exemplary school policies and programs.

When suicide prevention and mental health advocacy groups highlight exemplary school policies, it may put "peer pressure" on others within the district or state to adopt similar policies. Such community support can build the political will needed to change policy or law. Given that most primary and secondary schools are publicly funded, many of the rules, regulations, and policies are consolidated at the state level. Thus, legislation about suicide prevention education for school personnel is usually at the state level. For example, in Texas, a recent bill directs the Department of State Health Services to coordinate with the Texas Educational Agency to identify and implement "early mental health intervention and suicide prevention programs" for schools.[159] Private schools, charter schools, and other independent learning centers can adopt similar positions. Beyond training clinical providers in recognizing and referring youth at risk, some sources also encourage schools to engage a wide range of potential participants (e.g., counselors, nurses, teachers, coaches, school resource officers, administrators).[9,154]

Connecting hospital and community-based supports

Recommendation 5.4 – Policy: Hospitals and clinics should establish formal relationships with community support organizations or groups to facilitate continuity of care.

A recent report by the SPRC and AAS, specifically about continuity of care[ww], provides a succinct description of the concept. The goal is to link "one care provider to another in a timely manner and, in the process, provides all the necessary clinical information required to make the transition smooth and uninterrupted."[94(p8)] This concept is particularly important because "as many as 70 percent of suicide attempters of all ages will never make it to their first outpatient appointment,"[94(p9)] although many suicide attempts and suicide deaths occur soon after

[vv] http://activeminds.org/
[ww] http://www.sprc.org/library_resources/items/continuity-care-suicide-prevention-and-research

discharge from the emergency department or psychiatry inpatient unit. Linking crisis treatment to outpatient care and support is essential.

As noted in the NSSP, "collaborations among EDs and community providers, such as health and mental health centers, crisis centers, hotlines, and outreach teams, can improve the quality and continuity of care … [and] help expand alternatives to EDs, such as the same day scheduling for mental health services and in-home crisis care, and secure rapid and continuous follow-up after discharge."[9(p57)] Collaborating with **faith-based and other community organizations** can enhance **connectedness** and expand the circle of potential supports.

It is possible for continuity of care between the ED and community services to become an established practice. A review study in Norway found that the keys to long-lasting continuity of care were formal collaborative relationships between a coordinator or team at the hospital and community providers; regular training and supervision of staff providing aftercare or follow-up services; and local guidelines for continuous quality improvement.[160] As noted in the NSSP, continuity of care "strategies may include telephone reminders of appointments, providing a 'crisis card' with emergency phone numbers and safety measures, and/or sending a letter of support."[9(p55)] Ideally, such "outreach interventions and bridging strategies that motivate adherence to the recommended treatment plan" could enable individuals to make it to a follow-up appointment within a week of discharge.[94(p16)]

Coordinated Care

Recommendation 5.5 – Program: Develop coordinated care systems that can ensure continuity of care, particularly during high-risk periods for suicide.

Care coordination (also called case management, care management, or systems navigation) is when a professional assesses needs, develops/monitors/adjusts a care plan through regular meetings with a client, and may provide assistance with a wide variety of needs in addition to behavioral health care such as housing, employment, and community connectedness. The NSSP reported that coordinated and collaborative care systems can reduce suicide risk by improving assessment, engagement in treatment, and use of follow-up practices.[9] Enabling multiple services and supports to be available in a central location would significantly reduce the burden of travel and other barriers to **timely access**. A similar option is the use of models like the Network of Care[xx], which provide a virtual central location for care options. Healthcare systems might also consider virtual models such as Health Information Exchanges[yy] that help providers exchange records and coordinate services.

In some cases, like Assertive Community Treatment (ACT), primarily for people with a severe or persistent mental health issues, intensive care may include interventions that range from outreach to involuntary hospitalization. ACT has research support for reducing symptoms, improving quality of life, and decreasing the need for hospital-based care.[161,162] In response to concerns about the potential for ACT to employ control or coercion, some communities are emphasizing choice, collaboration, and including peer supports as ways to be

[xx] http://www.networkofcare.org/
[yy] http://www.healthit.gov/providers-professionals/health-information-exchange/what-hie

more consistent with recovery practices.[163] Using a certified peer specialist on a care coordination team can have benefits for a person receiving care, including role modeling and improved problem solving, as well as indirect benefits through an improved relationship with the primary coordinator.[164]

Follow-up to Ensure Continuity of Care

Recommendation 5.6 – Policy: Hospitals should work with crisis centers, peer professionals, and outpatient healthcare providers to establish formal strategies for transitions from emergency or inpatient services to community supports.

The primary purpose of follow-up is to maintain therapeutic contact with a person after he or she has received some form of primary, emergency, or behavioral health services. As noted in the NSSP, "although referral is necessary, it may not be sufficient. There is increasing evidence that specific outreach programs can be highly effective in increasing the proportion of patients who engage in mental health care after hospitalization."[9(p55)] The time immediately after hospitalization is the period with the highest risk for a (potentially lethal) suicide attempt.[94] Some organizations or groups conduct follow-up as a practice, such as re-contacting someone who called a crisis hotline. At other times, follow-up can involve a "stand-alone" program that is designed to (re-) engage an attempt survivor after he or she received initial services. Specific forms of follow-up[165] may include:

- Brief written contact such as letters or postcards, which increase connectedness and have some evidence for decreasing suicidal behavior.[165-167]
- Enhanced assessment in the hospital, with referral to community supports and additional contact to encourage use of those supports.
- Initial hospital assessment with assistance, preferably from a peer, with understanding and navigating the system of potential supports (sometimes called community or peer bridging).[131]
- Hospital-based assessment and brief therapy with community-based counseling by the same person or organization after discharge.

In the process of increasing continuity of care, one consideration is the costs associated with follow-up care. At least one report indicates that improved continuity of care may decrease hospital costs while increasing community costs.[168] On the other hand, a recent study[169] demonstrated an economic or business case for conducting follow-up calls after someone is discharged from a hospital or emergency department. According to the analysis, for every $1 spent on follow-up services, a single payer/insurer could get $1.70 - $2.43 in savings compared to traditional treatment approaches. While many factors could affect the actual Return On Investment (ROI), it was estimated that if post-discharge follow-up reduced readmissions by 13% or more, it would result in overall cost savings. The study results suggest that continuity of care can reduce overall costs in a system. However, communities should consider which payers or organizations will actually bear the costs, and shift resources accordingly.

Another concern some have about follow-up involves individual privacy and/or confidentiality. Such concerns may be particularly elevated in small communities or other circumstances when a person receiving care may be well-known. Potential loss of social status, employment, housing, or other needs makes strict confidentiality essential. This also highlights the importance of challenging negative stereotypes and discrimination. Another

issue involving privacy and confidentiality is the Health Insurance Portability and Accountability Act (HIPAA)[zz] which is sometimes cited as a barrier to collaboration. When care is planned in collaboration with someone and his or her support network, obtaining necessary consents or authorizations should not be a barrier. However, there may be times when specific authorization is not obtained before someone leaves the hospital. For example, a peer specialist or crisis center might be engaged to offer follow-up assistance after someone has already been discharged. Even in such cases, according to the U.S. Department of Health and Human Services, "the privacy rule allows covered health-care providers to share protected health information for treatment purposes without patient authorization, as long as they use reasonable safeguards when doing so."[aaa] The NSPL policy on helping people at imminent risk for suicide also stressed that HIPAA should not impede people from exchanging information with other professionals when doing so can increase a person's safety.[142]

Technology to Extend Services and Supports

Recommendation 5.7 – Practice: All agencies, organizations, and groups providing support for attempt survivors should consider ways to use technology to facilitate timely access to care.

While technology may be used as a way to present or provide information about existing programs (e.g., telemedicine, telepsychiatry)[170], it is also being used in ways that have created new services or reached new audiences. Technology has the potential to increase **access to support** for new (and, at times, very isolated) individuals. Anecdotal reports show an appreciation for the availability (and privacy) of self-help information provided over the internet, along with opportunities for enhancing **connectedness**. There is a tension between the desire for anonymity on the part of persons seeking support and the desire for tracking information to enhance safety on the part of helpers. As the field moves forward, such challenges are being identified and considered[171-173], with an evolving list of Best Practices for Online Technologies.[bbb]

Older technologies, such as telephone, television, and radio, continue to have the potential to reach many groups, including audiences in rural or isolated communities that have limited internet access. Some research supporting the use of telephone-based outreach and follow-up has come from studies with the NSPL. Results from a large evaluation study of crisis calls showed that while two out of five people had suicidal thoughts since the time of their call, most individuals who received a referral for behavioral health services did not follow through with it.[174,175] A more in-depth study[176] revealed that callers are very likely to follow through with referrals if they are already receiving behavioral health care, but very few without prior care follow through with referrals. While financial concerns played a role for many who did not seek services, perceptions about their behavioral health problems or services also had a major impact on the decision to not seek care. At times expecting a person to seek out care does not produce connect him or her to effective care. In general, and especially in these cases, follow-up or outreach efforts may help. In further research with crisis center callers who received follow-up calls[177], comments from callers who received follow-up overwhelmingly indicated that

[zz] http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html
[aaa] http://www.hhs.gov/hipaafaq/providers/smaller/482.html
[bbb] http://www.preventtheattempt.com/

the calls were helpful, that the caller felt that someone cared, and that the calls help individuals stay safe and feel less suicidal.

Several studies indicate that some individuals prefer to seek help through technology-based or non-traditional channels. A large international study using World Health Organization (WHO) World Mental Health Surveys from 21 countries reported that most participants did not seek clinical treatment often because they did not perceive a need for professional care or they preferred to handle the problem themselves[178] As noted above, many callers to the NSPL do not believe that they need professional help and/or would like to handle concerns on their own.[176] However, as noted by both the NSPL study and a study using follow-up telephone calls after emergency department discharge in France[137], a person may be open to telephone-based assistance even if he or she rejects traditional clinic-based care. Considered together, the research suggests that technology may be able to reach people in crisis even when traditional services cannot, however further study is warranted.

Recommendation 5.8 – Practice: Conduct research and evaluation studies to examine and improve technology-based supports like online forums and self-help resources.

Online (internet-based) groups and forums present a potential alternative to telephone-based services. Anonymous or confidential peer discussions are taking place already. However, the safety and efficacy of such support is unknown. Developing forums moderated by **trained peers** might prove beneficial to many otherwise isolated people. One study combined technology with the use of peer providers, and found that peer coaching improved engagement with an online course and completion rates.[179] Similar practices might be established by training peer providers (e.g., peer specialists and warm line staff) on promising self-help tools. When feasible, sites that offer such tools could then link visitors to the peer services for additional assistance.

One international study[46,180] examined the results of an online self-help curriculum that included elements from several successful therapy models. The curriculum was compared to a waitlist where individuals were offered a website with information links to care. Study safety protocols included screening at the beginning and telephone intervention as necessary. Results indicated that both study groups had fewer suicidal thoughts after the trial, though the decrease was largest for the individuals who had access to the course. Participants who were using the self-help curriculum also experienced less hopelessness and worry. A cost analysis validated the idea that online self-help courses could present a significant cost savings for healthcare systems.[181]

Given the increasing use of smartphones and other mobile devices, some groups are developing mobile applications (apps) that can facilitate **timely access** to care and support. Several groups have developed apps for keeping track of moods and stressors, others allow users to create a virtual “hope box” for pictures, contacts, and messages that could help in a mental health crisis (see Appendix C). Recently, SAMHSA asked groups to submit a “continuity of care suicide prevention app.” The app was specifically aimed at promoting continuity of care and follow-up for a person after discharge from an inpatient unit or emergency department. Many of the apps that were developed have since been offered to the public through marketplaces (e.g., Google Play, iTunes). SAMHSA intends to create or modify a single app that would use promising elements from the various submissions.

Part 6: Community Outreach and Education

Jamie was contacted to help with a new communications campaign that was planning to use the Action Alliance's *Framework for Successful Messaging. Even after years of being a self-disclosed attempt survivor, it was still nerve-racking to get involved in a media effort. It helped Jamie to learn that the producer also had suicidal thoughts earlier in life. Also, it was going to be a campaign strategically focused on a positive narrative and supported by the local community. A local church was providing space for the production. One of the news channels loaned out the filming equipment and donated airtime. Students at the college volunteered to help with editing. The campaign developers planned to keep attempt survivors involved from beginning to end. In addition to being featured in the campaign, Jamie was able to use prior education and training to help with the research and evaluation that followed.*

Communications Campaigns

Recommendation 6.1 – Policy: In accord with the Action Alliance Framework for Successful Messaging[ccc], communications campaigns should focus on successful recovery and hope.

Communication campaigns use tools and channels designed to reach a specific group with the intention of raising awareness, providing information, and especially, encouraging some action. Usually, these campaigns include efforts such as Public Service Announcements (PSAs), posters, flyers, billboards, information tables, advertisements and print materials, or online and/or social media messages. As stated in the NSSP "… the dissemination of positive messages that focus on recovery and hope can help reduce the biases and prejudices associated with mental and substance abuse disorders and with suicide. Using these interventions can increase understanding of the barriers to seeking help and provide information that will empower individuals to take action."[9(p32)]

Recent suicide prevention efforts are focusing on the development of safe messages that promote specific actions and are integrated into a comprehensive plan.[6,9] One of the Action Alliance's priorities aims to change the national narratives around suicide and suicide prevention to ones that promote **hope**, **connectedness**, social support, resilience, treatment, and recovery"[ddd] which reflects the Core Values and is a welcome shift from prior narratives that (unintentionally) focused on darkness, despair, "failure," "committing suicide," death, or graphic details. The voices of attempt survivors are essential for advancing Action Alliance priorities such as promoting Zero Suicide in Health and Behavioral Health Care and changing the public conversation around suicide and suicide prevention. To further support appropriate or recommended practices, it will be helpful for suicide prevention organizations and mental health consumer organizations to publicly recognize and commend media groups that use exemplary policies or practices.

[ccc] http://www.suicidepreventionmessaging.org
[ddd] http://actionallianceforsuicideprevention.org/priorities

Recommendation 6.2 – Policy: Engage attempt survivors throughout the process of developing, implementing, and evaluating suicide prevention communications strategies.

Objective 2.1 of the NSSP is to "develop, implement, and evaluate communication efforts designed to reach defined segments of the population" using evidence-based practices from communications and social marketing.[9(p33)] In accordance with those practices, attempt survivors should be included in the formative research phase of communications efforts, be considered a specific audience to receive messages, be featured messengers in media or materials, and be partners in the evaluation of the campaigns. Additionally, the call to action in campaigns should consider ways to help achieve or support Core Values and further engage attempt survivors in seeking help.

Recommendation 6.3 – Practice: Encourage individuals with personal experience from a suicidal crisis to share their stories of recovery, offering appropriate support and recognition for those who do.

It is understandable that most people do not discuss their past suicidal experiences, often due to the fear of discrimination or interpersonal rejection in both personal and professional settings.[98,182] As noted in one report, it takes "incredible courage and commitment to the well-being of others to share their stories of pain and hope."[74(p8)] Yet, when people stay silent it allows the stereotype of the suicidal person as a severely ill outcast to continue unchallenged, perpetuating stigma, and discrimination. To enhance impact and effectiveness, efforts aimed at training and education should engage people with lived experience of a suicidal crisis, as well as their family and friends, as part of presentations.[98]

The more people speak out, the broader the public image of "suicidal person" becomes, eventually crushing the stereotype.[98,182] Disclosure is not something that should be taken lightly, but it is the most effective way to combat stigma and discrimination. A recent study also found that disclosure had beneficial effects, reducing loneliness and countering suicidal feelings.[75] Additionally, research suggests that telling others about a traumatic experience can have health benefits.[183] As noted under Recommendation 1.14 (page 31), additional guidance about self-disclosure is needed, but new resources are emerging. A promising initiative called "Sound Out for Life" is developing a speakers' bureau of attempt survivors with a particular focus on challenging suicide-related stigma while providing participants with guidance about public disclosure as attempt survivors.[eee] The project builds on prior work with mental health speakers' bureaus including "Sharing Our Lives, Voices and Experiences (SOLVE)"[fff] and "Coming Out Proud."[ggg]

[eee] http://dignityandrecoverycenter.org/center-programs/transforming-suicide-prevention/
[fff] http://dignityandrecoverycenter.org/program/solve-sharing-our-lives-voices-and-experiences-2/
[ggg] http://www.stigmaandempowerment.org/resources

Research

Recommendation 6.4 – Program: Develop a network of professionals with lived experience to conduct research and evaluation studies on supports for individuals who have survived a suicidal crisis.

A network of academic and research professionals with lived experience from a suicidal crisis could develop and advocate for projects and guidelines that follow the Core Values. Developing the research network would support NSSP Objective 12.4 to "increase the amount and quality" of suicide prevention and aftercare research.[9(p70)] It would also help address a key question in the Prioritized Research Agenda for Suicide Prevention (Research Agenda)[hhh] which inquires about needs for "new and existing research infrastructure." Additionally, evaluation of programs and supports, including cost benefit or cost effectiveness, helps further NSSP Goal 13 to "evaluate the impact and effectiveness" of interventions.[9(p71)]

However, more funding is needed for suicide prevention research. While suicide is the 10th leading cause of death in the U.S.[184], only $37 million went to the National Institute for Mental Health (NIMH) grants for suicide studies in fiscal year 2013 ($21 million for suicide prevention)[185]. For comparison, Transmissible Spongiform Encephalopathy (e.g., Creutzfeldt-Jakob or "mad cow" disease) received $35 million in Fiscal Year 2013[185], while having 224 cases reported worldwide between 1996 and 2011[186].

While not specifically focused on suicide, the Lived Experience Research Network (LERN) might be a source of ideas or partners in developing research from an attempt survivor perspective. Among other tasks, LERN seeks to "build research and evaluation capacity among [peers]" and "contribute to the development and evaluation of alternatives to mainstream intervention and mental health services that promote the empowerment, recovery, and community integration of [peers]."[iii]

The Task Force submitted ideas for future research to NIMH as part of a Request for Information (RFI) response (See Appendix D). In brief, the submission focused on four domains, presented in Table 3 (below) alongside relevant questions in the Research Agenda.

[hhh] http://actionallianceforsuicideprevention.org/task-force/research-prioritization
[iii] http://www.lernetwork.org/

Table 3. Task Force Research Interests compared with the National Prioritized Research Agenda

Task Force Research Interests	Prioritized Research Agenda
Examine negative stereotypes, prejudice, discrimination, shame and social exclusion as related to suicide, suicide attempts, diagnoses, seeking services, including emergency care and mental health treatment.	Aspirational Goal 10 is to "increase help-seeking and referrals for at-risk individuals by decreasing stigma."
Investigate the etiology of suicide attempt behaviors and the role of protective factors in preventing both initial attempts and further attempts, as well as avenues for developing and supporting the promotion of protective factors through public education.	Aspirational Goal 1 is to "know what leads to, or protects against, suicidal behavior, and learn how to change those things to prevent suicide."
Explore the experience of attempt survivors with intervention and treatment approaches, and their explanation of the relationship of this intervention/treatment experience to further attempts (or prevention of further attempts). Areas for research and evaluation should include peer-delivered programs, self-help approaches, and technology-based supports.	Key Question 3: "What interventions are effective? What prevents individuals from engaging in suicidal behavior?" Key Question 4: "What services are most effective for treating the suicidal person and preventing suicidal behavior?" Key Question 5: "What other types of preventive interventions (outside health care systems) reduce suicide risk?"
Explore the effects of suicidal crises, as well as the impact of interventions, on family and significant persons after a suicide attempt. Also explore the primary and secondary positive outcomes from interventions as indicators of effectiveness.	<Not specifically addressed in the Research Agenda>

Section 3: Appendices, Glossary, and References

Appendix A: Recommendations

Recommendations by Part

Part 1: Attempt Survivors as Helpers – Self-Help, Peer Support, and Inclusion

Recommendation 1.1 – Practice: Develop, evaluate, and disseminate self-help materials for persons who have lived through a suicidal crisis.

Recommendation 1.2 – Practice: Provide information about self-advocacy to every attempt survivor.

Recommendation 1.3 – Practice: Encourage attempt survivors to participate in community activities.

Recommendation 1.4 – Practice: Explore religion and spirituality as potential resources in collaboration with the attempt survivor and his or her support network.

Recommendation 1.5 – Practice: Encourage attempt survivors to participate in exercise and physical activity when it can enhance wellness and recovery.

Recommendation 1.6 – Program: Develop, evaluate, and promote support groups specifically for persons who have lived through a suicidal crisis; such groups are encouraged to use a peer leader or co-facilitator.

Recommendation 1.7 – Policy: Establish training protocols and core competencies for peer supports around suicidal experiences, and methods for assessing them.

Recommendation 1.8 – Policy: Provide warm line staff with basic training for working with suicidal callers, including how to refer or transfer callers to crisis services.

Recommendation 1.9 – Program: Develop certified peer specialist positions that are specific to lived experience of a suicidal crisis.

Recommendation 1.10 – Program: Develop a national technical assistance center focused on helping individuals with lived experience of a suicidal crisis.

Recommendation 1.11 – Policy: Train human resources staff at agencies and organizations that hire disclosed persons with histories of mental health challenges or suicidal experiences in best practices for supporting those employees.

Recommendation 1.12 – Practice: Train agency/organizational leaders and managers working with persons with lived experience of a suicidal crisis on protecting confidentiality and privacy while also facilitating support for their employees.

Recommendation 1.13 – Practice: Engage attempt survivors as partners in behavioral health and suicide prevention efforts.

Recommendation 1.14 – Program: The Task Force should work with key partners to assemble a diverse workgroup to develop guidance for meaningful inclusion of attempt survivors in suicide prevention and behavioral health efforts.

Recommendation 1.15 – Policy: Every Task Force of the Action Alliance should recruit attempt survivors as members. This will demonstrate that the suicide prevention community values them and their expertise.

Recommendation 1.16 – Policy: Agencies and organizations at all levels (federal, state, community, etc.) should explicitly endorse, or require, inclusion of attempt survivors in suicide prevention efforts.

Part 2: Family, Friends, and Support Network

Recommendation 2.1 – Practice: Every attempt survivor should define a support network for himself or herself; people can assist in the process but not insist on persons to include or exclude.

Recommendation 2.2 – Practice: Offer training and/or educational materials to people identified by the attempt survivor as supports.

Recommendation 2.3 – Program: Develop, evaluate, and promote programs specifically intended to help the family and friends of attempt survivors.

Recommendation 2.4 – Practice: Expand programs and projects that provide support for families coping with mental health concerns to explicitly address issues related to suicidal crises.

Part 3: Clinical Services and Supports

Recommendation 3.1 – Practice: Agencies and organizations providing clinical services should consider the Core Values as ways to improve care for all patients, including attempt survivors.

Recommendation 3.2 – Policy: Organizations involved in suicide prevention should have formal statements of support for helping attempt survivors.

Recommendation 3.3 – Practice: Professional clinical education should include training on providing treatment to someone in a suicidal crisis, or recovering from crisis.

Recommendation 3.4 – Practice: Clinical professionals should collaborate with a person to understand his or her suicidal experience and specifically address suicide risk.

Recommendation 3.5 – Policy: Behavioral health systems should make suicide prevention a core component of care.

Recommendation 3.6 – Practice: At the beginning of care, professionals should inform patients about their approach to working through crisis situations.

Recommendation 3.7 – Practice: Behavioral health providers should integrate principles of collaborative assessment and treatment planning into their practices.

Recommendation 3.8 – Practice: Behavioral health professionals should complete a comprehensive assessment that goes beyond suicide risk as soon as it is feasible to do so, acknowledging that a person has a life beyond the crisis.

Recommendation 3.9 – Policy: Protocols for addressing safety and crisis planning should consider be based on principles of informed and collaborative care.

Recommendation 3.10 – Practice: Consider the Core Values as essential aspects of care and/or outcomes to achieve in all treatment (including outpatient and inpatient) to help in a suicidal crisis.

Recommendation 3.11 – Practice: Use a collaborative approach to prescribing medication that discusses multiple options, respects informed choices, and is monitored and modified as needed.

Part 4: Crisis and Emergency Services

Recommendation 4.1 – Policy: Crisis and emergency services should be expanded and improved to ensure capacity and competence for helping suicidal individuals.

Recommendation 4.2 – Practice: Crisis center and hotline staff should review the “Lifeline service and outreach strategies suggested by suicide attempt survivors”.

Recommendation 4.3 – Program: Develop and promote crisis respite care centers, especially ones that employ peer providers.

Recommendation 4.4 – Practice: Professionals in the emergency department should provide collaborative and compassionate care in response to a suicidal crisis.

Recommendation 4.5 – Policy: Emergency departments should form partnerships with peer specialists and organizations that can offer support to patients and their family/friends while they wait for clinical care.

Recommendation 4.6 – Program: Train peer specialists to help support and advocate for patients in emergency departments who are experiencing a suicidal crisis.

Recommendation 4.7 – Policy: Promote use of mobile crisis teams including a peer specialist who can use his or her lived experience as an asset during interventions.

Recommendation 4.8 – Policy: Law enforcement agencies should provide training about behavioral health emergencies to all officers; with a minimum requirement to have a specialized response team that is easily identified by community members.

Part 5: Systems Linkages and Continuity of Care

Recommendation 5.1 – Policy: Colleges and university should develop policies that promote help-seeking and foster a supportive campus environment.

Recommendation 5.2 – Program: Develop and promote peer specialist programs to provide students who are coping with suicidal thoughts or behavioral health challenges with support and connections to resources.

Recommendation 5.3 – Practice: Suicide prevention and mental health advocacy groups should use public recognition to highlight exemplary school policies and programs.

Recommendation 5.4 – Policy: Hospitals and clinics should establish formal relationship with community support organizations or groups to facilitate continuity of care.

Recommendation 5.5 – Program: Develop coordinated care systems that can ensure continuity of care, particularly during high risk periods for suicide.

Recommendation 5.6 – Policy: Hospitals should work with crisis centers, peer professionals, and outpatient healthcare providers to establish formal strategies for transitions from emergency or inpatient services to community supports.

Recommendation 5.7 – Practice: All agencies, organizations, and groups providing support for attempt survivors should consider ways to use technology to facilitate timely access to care.

Recommendation 5.8 – Practice: Conduct research and evaluation studies to examine and improve technology-based supports like online forums and self-help resources.

Part 6: Community Outreach and Education

Recommendation 6.1 – Policy: In accord with the Action Alliance Framework for Successful Messaging, communications campaigns should focus on successful recovery and hope.

Recommendation 6.2 – Policy: Engage attempt survivors throughout the process of developing, implementing, and evaluating suicide prevention communications strategies.

Recommendation 6.3 – Practice: Encourage individuals with personal experience from a suicidal crisis to share their stories of recovery, offering appropriate support and recognition for those who do.

Recommendation 6.4 – Program: Develop a network of professionals with lived experience to conduct research and evaluation studies on supports for individuals who have survived a suicidal crisis.

Recommendations by Type of Activity

Practices

Recommendation 1.1: Develop, evaluate, and disseminate self-help materials for persons who have lived through a suicidal crisis.

Recommendation 1.2: Provide information about self-advocacy to every attempt survivor.

Recommendation 1.3: Encourage attempt survivors to participate in community activities.

Recommendation 1.4: Explore religion and spirituality as potential resources in collaboration with the attempt survivor and his or her support network.

Recommendation 1.5: Encourage attempt survivors to participate in exercise and physical activity when it can enhance wellness and recovery.

Recommendation 1.12: Train agency/organizational leaders and managers working with persons with lived experience of a suicidal crisis on protecting confidentiality and privacy while also facilitating support for their employees.

Recommendation 1.13: Engage attempt survivors as partners in behavioral health and suicide prevention efforts.

Recommendation 2.1: Every attempt survivor should define a support network for himself or herself; people can assist in the process but not insist on persons to include or exclude.

Recommendation 2.2: Offer training and/or educational materials to people identified by the attempt survivor as supports.

Recommendation 2.4: Expand programs and projects that provide support for families coping with mental health concerns to explicitly address issues related to suicidal crises.

Recommendation 3.1: Agencies and organizations providing clinical services should consider the Core Values as ways to improve care for all patients, including attempt survivors.

Recommendation 3.3: Professional clinical education should include training on providing treatment to someone in a suicidal crisis, or recovering from crisis.

Recommendation 3.4: Clinical professionals should collaborate with a person to understand his or her suicidal experience and specifically address suicide risk.

Recommendation 3.6: At the beginning of care, professionals should inform patients about their approach to working through crisis situations.

Recommendation 3.7: Behavioral health providers should integrate principles of collaborative assessment and treatment planning into their practices.

Recommendation 3.8: Behavioral health professionals should complete a comprehensive assessment that goes beyond suicide risk as soon as it is feasible to do so, acknowledging that a person has a life beyond the crisis.

Recommendation 3.10: Consider the Core Values as essential aspects of care and/or outcomes to achieve in all treatment (including outpatient and inpatient) to help in a suicidal crisis.

Recommendation 3.11: Use a collaborative approach to prescribing medication that discusses multiple options, respects informed choices, and is monitored and modified as needed.

Recommendation 4.2: Crisis center and hotline staff should review the "Lifeline service and outreach strategies suggested by suicide attempt survivors".

Recommendation 4.4: Professionals in the emergency department should provide collaborative and compassionate care in response to a suicidal crisis.

Recommendation 5.3: Suicide prevention and mental health advocacy groups should use public recognition to highlight exemplary school policies and programs.

Recommendation 5.7: All agencies, organizations, and groups providing support for attempt survivors should consider ways to use technology to facilitate timely access to care.

Recommendation 5.8: Conduct research and evaluation studies to examine and improve technology-based supports like online forums and self-help resources.

Recommendation 6.3: Encourage individuals with personal experience from a suicidal crisis to share their stories of recovery, offering appropriate support and recognition for those who do.

Programs

Recommendation 1.6: Develop, evaluate, and promote support groups specifically for persons who have lived through a suicidal crisis; such groups are encouraged to use a peer leader or co-facilitator.

Recommendation 1.9: Develop certified peer specialist positions that are specific to lived experience of a suicidal crisis.

Recommendation 1.10: Develop a national technical assistance center focused on helping individuals with lived experience of a suicidal crisis.

Recommendation 1.14: The Task Force should work with key partners to assemble a diverse workgroup to develop guidance for meaningful inclusion of attempt survivors in suicide prevention and behavioral health efforts.

Recommendation 2.3: Develop, evaluate, and promote programs specifically intended to help the family and friends of attempt survivors.

Recommendation 4.3: Develop and promote crisis respite care centers, especially ones that employ peer providers.

Recommendation 4.6: Train peer specialists to help support and advocate for patients in emergency departments who are experiencing a suicidal crisis.

Recommendation 5.2: Develop and promote peer specialist programs to provide students who are coping with suicidal thoughts or behavioral health challenges with support and connections to resources.

Recommendation 5.5: Develop coordinated care systems that can ensure continuity of care, particularly during high risk periods for suicide.

Recommendation 6.4: Develop a network of professionals with lived experience to conduct research and evaluation studies on supports for individuals who have survived a suicidal crisis.

Policies

Recommendation 1.7: Establish training protocols and core competencies for peer supports around suicidal experiences, and methods for assessing them.

Recommendation 1.8: Provide warm line staff with basic training for working with suicidal callers, including how to refer or transfer callers to crisis services.

Recommendation 1.11: Train human resources staff at agencies and organizations that hire disclosed persons with histories of mental health challenges or suicidal experiences in best practices for supporting those employees.

Recommendation 1.15: Every Task Force of the Action Alliance should recruit attempt survivors as members. This will demonstrate that the suicide prevention community values them and their expertise.

Recommendation 1.16: Agencies and organizations at all levels (federal, state, community, etc.) should explicitly endorse, or require, inclusion of attempt survivors in suicide prevention efforts.

Recommendation 3.2: Organizations involved in suicide prevention should have formal statements of support for helping attempt survivors.

Recommendation 3.5: Behavioral health systems should make suicide prevention a core component of care.

Recommendation 3.9: Protocols for addressing safety and crisis planning should consider be based on principles of informed and collaborative care.

Recommendation 4.1: Crisis and emergency services should be expanded and improved to ensure capacity and competence for helping suicidal individuals.

Recommendation 4.5: Emergency departments should form partnerships with peer specialists and organizations that can offer support to patients and their family/friends while they wait for clinical care.

Recommendation 4.7: Promote use of mobile crisis teams including a peer specialist who can use his or her lived experience as an asset during interventions.

Recommendation 4.8: Law enforcement agencies should provide training about behavioral health emergencies to all officers; with a minimum requirement to have a specialized response team that is easily identified by community members.

Recommendation 5.1: Colleges and university should develop policies that promote help-seeking and foster a supportive campus environment.

Recommendation 5.4: Hospitals and clinics should establish formal relationship with community support organizations or groups to facilitate continuity of care.

Recommendation 5.6: Hospitals should work with crisis centers, peer professionals, and outpatient healthcare providers to establish formal strategies for transitions from emergency or inpatient services to community supports.

Recommendation 6.1: In accord with the Action Alliance Framework for Successful Messaging, communications campaigns should focus on successful recovery and hope.

Recommendation 6.2: Engage attempt survivors throughout the process of developing, implementing, and evaluating suicide prevention communications strategies.

Appendix B: Task Force Member Bios and Perspectives

John Draper, PhD – Co-Lead; Project Director, National Suicide Prevention Lifeline, has nearly 25 years of experience in crisis intervention and suicide prevention work, and is considered one of the nation's leading experts in crisis intervention and hotline practices. Since 2004, he has been the Director of the National Suicide Prevention Lifeline (800-273-TALK). He is also the President of Link2Health Solutions, a wholly owned subsidiary of the Mental Health Association of New York City, and has a private mental health practice.

Eduardo Vega, MA – Co-Lead; Executive Director, Mental Health Association of San Francisco. Over twenty years, Eduardo has worked in five states as a leader in transformative mental health programs and practices, including: national, state and regional technical assistance; research and training projects and major policy initiatives in suicide prevention; stigma and discrimination reduction; consumer rights and empowerment and community integration, self-help and peer support for mental health consumers. He is also Director and Principal Investigator for The Center for Dignity, Recovery, and Empowerment.

Lilly Glass Akoto, LCSW, Looking In ~ Looking Out, LLC, is a passionate advocate for basic human rights and has been involved as a professional in the mental health world since 1989. She has a private mental health practice, and is developing a program to help professionals to work through mental health challenges without threat of losing their employment. She serves on numerous speakers' bureaus and advisory boards, and speaks about depression, suicide, racism, adoption, self-worth, identity issues, advocacy, recovery and healing.

Cara Anna is a journalist and former foreign correspondent, and she edits Talkingaboutsuicide.com and Attemptsurvivors.com. She was co-chair of the task force that established the Attempt Survivor / Lived Experience Division within the American Association of Suicidology (AAS). She looks forward to the day when we ask in amazement, "Why did we ever whisper about this?"

Heidi Bryan is currently the Senior Director of Product Development at Empathos Resources. She has been active in the suicide prevention field since 1999 after losing her brother to suicide and struggling with depression and suicidality herself. Heidi created Feeling Blue Suicide Prevention Council, a nonprofit organization based in Pennsylvania and co-founded the Pennsylvania Adult/Older Adult Suicide Prevention Coalition. She is the author of the booklet, *After an Attempt: The Emotional Impact of a Suicide Attempt on Families* and has been a keynote speaker for numerous national conferences and organizations.

Julie Cerel, PhD, is a licensed clinical psychologist and Associate Professor in the College of Social Work at the University of Kentucky. Her research has focused on suicide bereavement and suicide prevention. She is currently the Principle Investigator (PI) of the Military Suicide Bereavement study funded by the Military Suicide Research Consortium from the U.S. Department of Defense. Dr. Cerel is a Board member and former chair, Kentucky Suicide Prevention Group; and Editorial Board Member, Suicide and Life-

Threatening Behavior. She has served as the Research Division Director and is currently the Board Chair for the American Association of Suicidology.

Mark Davis is the leader of the Pink and Blues GLBT Mental Health Consumer Support group. Mark is Founding President of the Pennsylvania Mental Health Consumers' Association (PMHCA est. in 1987). Mark also serves on the National Suicide Prevention Lifeline (1-800-273-TALK) Consumer Survivor Subcommittee (CSS). Since 2003, he has facilitated Pink & Blues Philadelphia, a weekly peer-run social network and support group and safe space for sexual and gender minority people living with mental health and co-occurring conditions to achieve recovery.

Linda Eakes, CMPS, is a suicide attempt survivor as well as a Certified Missouri Peer Specialist. She manages a Drop-In Center for Truman Medical Center Behavioral Health in Kansas City, MO called New Frontiers.

Barb Gay, MA, is the Executive Director of Foundation 2, Inc., a crisis response non-profit agency located in Cedar Rapids, Iowa. Barb has been able to use her personal experiences to help guide programs that work to save lives and improve access to care. Through this project and other collaborations, Barb has been able to offer her voice as a suicide attempt survivor to help move forward the work of suicide prevention. Barb has her MA degree in Health Education from the University of Northern Iowa. She has been working in human services since 1993.

Leah Harris, MA, writes and speaks nationally about her own experiences of trauma and recovery, as a psychiatric survivor, suicide attempt survivor, and survivor of her mother Gail's death by suicide in 1996. She works to promote peer-developed crisis alternatives at the National Empowerment Center, consults on trauma-informed practice for the National Center for Trauma-Informed Care (NCTIC), and is helping to develop an attempt survivors' speakers' bureau training for the Mental Health Association of San Francisco. Leah is a trainer in Emotional CPR (eCPR), a program that teaches skills for supporting persons in crisis. She is technical director at Madness Radio and is a storyteller in the Washington, DC, area.

Tom Kelly, CRSS, CPS, Former Manager, Recovery and Resiliency, Magellan Health Services of Arizona. Tom Kelly has twelve years of experience working in public mental health. His experience includes coaching and training staff in recovery principles and the use of strength-based and person-centered planning principles. Tom was employed with Magellan as the Manager for Recovery and Resiliency. An attempt survivor and a person who has received services, Tom has presented at national, state, and local conferences on suicide prevention, homelessness, trauma informed care and mental health recovery.

Carmen Lee is a consumer activist who directs and founded, in 1990, Stamp Out Stigma - a well-known speaker's bureau composed of all clients, survivors, and consumers faced with mental health challenges. Since that time, SOS has delivered over 2600 public presentations to local, national and international audiences, directly reaching 400,000 people. The main focus of SOS is to put a human face on mental health problems and dispel the myths that greatly hinder recovery. Carmen is both a suicide attempt survivor and a suicide loss survivor, with her brother having died by suicide at 37 years old.

Stanley Lewy, MBA, MPH, is a survivor of his son David's suicide, several attempts by his wife, and his own passive attempt and suicidal ideation. He is a passionate advocate for suicide prevention at local, state and national levels, and co-authored the State of Illinois' Suicide Prevention, Education, and Treatment Act (PA 093-0907). He founded the Chicago/Midwest Chapter of the American Foundation for Suicide Prevention and the Suicide Prevention Association.

DeQuincy Lezine, PhD, is a suicide attempt survivor who has been active in national suicide prevention efforts since 1996, including roles in the development of national and state suicide prevention plans. Dr. Lezine has worked with organizations including Suicide Prevention Action Network (SPAN) USA, National Alliance for the Mentally Ill (NAMI), Oklahoma Suicide Prevention Council, the National Suicide Prevention Lifeline (NSPL), and the Suicide Prevention Resource Center (SPRC). He is the author of *Eight Stories Up: An Adolescent Chooses Hope Over Suicide* (Oxford University Press, 2008). Dr. Lezine is President & CEO of Prevention Communities, focusing on suicide prevention and mental health promotion. He was the primary wrtier for *The Way Forward* and the inaugural Chair of the Attempt Survivor and Lived Experience Division of the American Association of Suicidology.

Jennifer Randal-Thorpe is CEO of MR Behavior Intervention Center, and has worked in The Juvenile Continuing Education Program(JCEP) in St. Martin Parish. She was also Staff Development Specialist at Our Lady of Lourdes Hospital in Lafayette, Louisiana. Ms. Randal-Thorpe has worked in both mental health services and substance abuse treatment services.

Shari Sinwelski, MS/EdS, is the Associate Director of Quality Improvement for the National Suicide Prevention Lifeline. Working in suicide prevention for 20 years, Shari has served as a director at several crisis centers across the country and trained many populations in suicide assessment and intervention. Shari created one of the nation's first support groups for Suicide Attempt Survivors at the Didi Hirsch Suicide Prevention Center. Shari is an AAS certified crisis counselor and a Training Coach and safeTALK instructor with Living Works Education.

Sabrina Strong, MPH, ADS is the Executive Director of Waking Up Alive, Inc., a nonprofit that provides suicide prevention education and advocacy across the state of New Mexico. She uses her experiences as a mental health consumer and a suicide attempt survivor to help ease the stigma associated with suicidal ideation.

CW Tillman, is a Consumer Advocate that has been active in disability rights advocacy for over 14 years. He has been active as a suicide attempt survivor on the planning committee of the First National Conference for Survivors of Suicide Attempts, Healthcare Professionals, Clergy and Laity held in Memphis, TN in 2005 and as a speaker on the first ever Suicide Attempt Survivor plenary session at the AAS Conference in 2011. He's also spoken at local and state conferences about his experiences as a suicide attempt survivor. CW is the Board President for the disAbility Law Center of Virginia (the designated Protection and Advocacy agency).

Stephanie L. Weber, MS, LCPC, is the Executive Director of Suicide Prevention Services, Inc., a non-profit organization headquartered in Kane County, Illinois. Stephanie founded Survivors of Suicide, a self-help group that has been going for over 30 years. For the past 8 years she has run Survivors of Suicide

Attempts support groups. She is the founder and director of the Crisis Line of the Fox Valley. She is a former member of the AAS board of directors also served as a former Survivor Chair. Ellen Weber, Stephanie's widowed mother, took her own life in 1979. Stephanie has been a featured presenter at forums and meetings held across the United States. She has also appeared on numerous radio, television programs, and talk shows.

Staff Support:

Melodee Jarvis is a suicide prevention specialist at the Mental Health Association of San Francisco, where she promotes and advocates for innovative suicide prevention projects and strategies dedicated to advancing wellness, recovery, and social justice practices. Melodee previously worked at San Francisco Suicide Prevention, where she managed all administrative, development, and training aspects of the crisis line program. As a suicide prevention professional with lived experience of her own suicidal thoughts and actions, Melodee believes that the most effective suicide prevention efforts must directly incorporate lessons learned from the expertise of those who have personal connections to suicide.

Angela Mark is a Public Health Advisor in the Suicide Prevention Branch, Center for Mental Health Services, at the Substance Abuse and Mental Health Services Administration (SAMHSA). Angela serves as a Grant Project Officer and is responsible for managing Garrett Lee Smith Youth Suicide Prevention State/Tribal grants. After losing several close friends to suicide, she uses her personal experiences to help move forward the work of suicide prevention. She believes that reducing stigma as well as engaging and learning from suicide attempt survivors is essential to saving more lives and vital to the suicide prevention movement.

Appendix C: Resources

Disclaimer: The following resources were identified during the process of developing *The Way Forward* and are included here to provide specific examples of approaches described in *The Way Forward*. The list of resources is not intended to be comprehensive and inclusion of specific programs or practices does not constitute an endorsement by the Suicide Attempt Survivors Task Force or the National Action Alliance for Suicide Prevention.

Part 1: Attempt Survivors as Helpers – Self-Help, Peer Support, and Inclusion

Resource	Location	Notes
Blogs / Websites		
Live Through This	http://livethroughthis.org/	"*Live Through This* is a collection of portraits and stories of suicide attempt survivors, as told by those survivors. The intention of *Live Through This* is to show that everyone is susceptible to depression and suicidal thoughts by sharing portraits and stories of real attempt survivors—people who look just like you."
Reasons to Go On Living	http://thereasons.ca/	The group is "collecting the stories of people who have attempted or seriously contemplated suicide but now want to go on living. The Project will study and share these anonymous stories for research, education and inspiration."
Talking About Suicide	http://talkingaboutsuicide.com/	This site features about 60 interviews with attempt survivors about their experience, their recovery and their decision to speak openly.
What Happens Now	http://attemptsurvivors.com/	"This site was launched by the American Association of Suicidology, in the first such effort by a national organization... We want to show that this can happen to anyone and that it's possible to recover, or learn to manage, and move on."

Resource	Location	Notes
Books		
• **Susan Rose Blauner:** ***How I Stayed Alive When My Brain Was Trying to Kill Me*** • **Heidi Bryan:** ***Must Be the Witches in the Mountains*** • **James Clemons (Ed.):** ***Children of Jonah*** • **Richard Heckler:** ***Waking Up Alive*** • **Kevin Hines:** ***Cracked, Not Broken: Surviving and Thriving After a Suicide Attempt*** • **Kay Redfield Jamison:** ***Night Falls Fast: Understanding Suicide*** • **DeQuincy Lezine:** ***Eight Stories Up: An Adolescent Chooses Hope Over Suicide*** • **Craig Miller:** ***This is How it Feels: A Memoir of Attempting Suicide and Finding Life*** • **Joshua Rivedal:** ***The Gospel According to Josh: A 28-Year Gentile Bar Mitzvah*** • **Brent Runyon:** ***The Burn Journals*** • **Kevin Taylor (AKA Ken Tullis):** ***Seduction of Suicide: Understanding and Recovering from Addiction to Suicide*** • **David Webb:** ***Thinking about Suicide: Contemplating and Comprehending the Urge to Die*** • **Terry Wise:** ***Waking Up: Climbing Through the Darkness***		
Peer Mentoring		
ASHA International	http://www.myasha.org/programs/peer-mentoring/	Peer specialists provide support, encouragement, and specialized services
Peer Specialists		
Certified Intentional Peer Support Specialist	http://www.maine.gov/dhhs/samhs/mentalhealth/wellness/pdf/requirements-ipss.pdf	Peer support specialist training used in the state of Maine, and many other warm lines, crisis respites, and peer-operated services

Resource	Location	Notes
Certified peer specialist programs	http://tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/peer_support_consumer_run_services_peer_specialists/Certified_Peer_Specialist_Training_Program_Descriptions.pdf	Compilation of peer specialist training and certification programs
Certified Peer Specialist Whole Health and Resiliency Training	http://www.viahope.org/programs/training-certification	This is used by the state of Texas and other states for peer specialist credentialing
Pillars of Peer Support	http://www.pillarsofpeersupport.org/	Summit meetings and website designed to help foster the use of Medicaid funding to support peer specialists in providing mental health care
Peer Support Groups	http://attemptsurvivors.com/support-groups/	
Alternatives to Suicide	http://www.westernmassrlc.org/alternatives-to-suicide	A peer-led support group program by the Western Massachusetts Recovery Learning Community
Attempters Support Group	http://www.spsamerica.org/services/support-groups/	Suicide Prevention Services of America, Batavia, Ill. - an open, "confidential, educational, self-help group."
Eden Program	http://www.suicideorsurvive.ie/services/the-eden-program	A support group for attempt survivors. The founder is an attempt survivor that has become a therapist, and at least some groups are co-facilitated by peers.
Suicide Anonymous	http://suicideanonymous.net	A peer-run support group, patterned after 12-Step / Anonymous substance abuse recovery meetings

Resource	Location	Notes
Suicide Attempter Support Group	http://www.didihirsch.org/node/32	Didi Hirsch Suicide Prevention Center, Los Angeles, CA - "for people who have had a suicide attempt or who are struggling with chronic thoughts of suicide."
Peer-run organizations		
International Center for Clubhouse Development	http://www.iccd.org/	Clubhouses are "community-based centers that offer opportunities for friendship, employment, housing, education, and access to services through a single caring and safe environment, so members can achieve a sense of belonging and become productive members of society."
Reports		
Suicide Prevention Dialogue with Consumers and Survivors: From Pain to Promise	http://store.samhsa.gov/product/Suicide-Prevention-Dialogue-with-Consumers-and-Survivors-From-Pain-to-Promise/SMA10-458	Report based on a dialogue meeting between SAMHSA representatives, suicide attempt survivors, suicide loss survivors, and representatives of hospital/medical systems.
Self-help		
A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department	http://store.samhsa.gov/product/A-Guide-for-Taking-Care-of-Yourself-After-Your-Treatment-in-the-Emergency-Department/SMA08-4355	Booklet specifically about emergency department care after a suicidal crisis.

Resource	Location	Notes
Finding Your Way Back	http://www.beyondblue.org.au/docs/default-source/default-document-library/bl1160-finding-your-way-back.pdf?sfvrsn=2	A resource for people who have attempted suicide (from Australia)
Stories Of Hope And Recovery: A Video Guide for Suicide Attempt Survivors	http://store.samhsa.gov/product/Stories-Of-Hope-And-Recovery-A-Video-Guide-for-Suicide-Attempt-Survivors/SMA12-4711DVD	DVD with series of video interviews with attempt survivors and resources from the National Suicide Prevention Lifeline.
Wellness Recovery Action Plan (WRAP)®	http://www.mentalhealthrecovery.com	An "evidence-based system that is used worldwide by people who are dealing with mental health and other kinds of health challenges. It was developed by a group of people who have a lived experience of mental health difficulties."
Warm Lines		
National Consumer Self-Help Clearinghouse – Warm Lines	http://www.mhselfhelp.org/	Technical assistance center includes several resources for locating warm lines, or operating them.
National Empowerment Center – Warm Lines	http://www.power2u.org/peer-run-warmlines.html	NEC maintains a resource page on peer-run warm lines.

Part 2: Family, Friends, and Support Network

Resource	Location	Notes
Booklets		
A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department	http://store.samhsa.gov/product/A-Guide-for-Taking-Care-of-Your-Family-Member-After-Treatment-in-the-Emergency-Department/SMA08-4357	A brochure that provides family members with information about the likely assessment, treatment, and follow-up an attempt survivor will receive during and after his or her visit to the emergency department.
After an attempt: The emotional impact of suicide attempt on families	http://www.heidibryan.com/uploads/After_An_Attempt__2013_booklet_download.pdf	This booklet includes information on important do's and don'ts, dealing with a traumatic event, what to say to the attempt survivor, ways the family can communicate their feelings, how an attempt affects family members, and additional resources.
Supporting Someone After a Suicide Attempt	http://www.suicideline.org.au/content/uploads/supporting_someone_after_a_suicide_attempt.pdf	Family resource booklet from Australia.
Educational Programs		
ASIST	https://www.livingworks.net/	Applied Suicide Intervention Skills Training (ASIST) as well as safeTALK are community education programs that teach participants how to recognize signs of emotional distress, provide basic supportive intervention, and make appropriate referrals to additional care.
Families Healing Together	http://family.practicerecovery.com/	Interactive, self-paced classes, and a supportive community focused on recovery.

Resource	Location	Notes
Heidi's Hope for Families	http://www.mhawisconsin.org/heidis-hope.aspx	Support group for families of attempt survivors.
QPR	http://www.qprinstitute.com/	Question. Persuade. Refer. A community education program that teaches participants how to recognize signs of emotional distress, ask about potential suicidal thoughts, and refer someone to get help.

Part 3: Clinical Services and Supports

Resource	Location	Notes
General Resources		
Self-Harm: The Short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care	http://www.nice.org.uk/Guidance/CG16	Guidance from the National Institute for Health and Care Excellence (UK) – describes the type of care that someone who self-harms may want to receive and what types of services might be most beneficial.
Suicide Prevention Resource Center – Providers Section	http://www.sprc.org/for-providers/	Fact sheets, tool kits, trainings, webinars, publications, and research specifically for primary care, emergency department professionals, and outpatient mental health care providers

Resource	Location	Notes
Psychotherapies		
Cognitive Therapy for Suicide Prevention	http://www.behavioralhealth-ctx.org/resources/Suicide_Prevention.pdf	Description and Randomized Controlled Trial for the cognitive therapy approach developed specifically for suicidal thinking and behavior.
Collaborative Assessment and Management of Suicidality	https://sites.google.com/site/cuajsplab/home	CAMS is an approach to suicide risk assessment and therapy that engages a person in a collaborative fashion and specifically works to address suicidal thinking and motivation
Dialectical Behavioral Therapy	http://behavioraltech.org/resources/whatisdbt.cfm	A cognitive behavioral therapy developed to treat chronic or ongoing suicidal thinking and behavior.
Safety Planning Intervention	http://www.suicidesafetyplan.com/	Website supporting the brief intervention using a prioritized list of coping strategies and resources to reduce suicide risk.

Part 4: Crisis and Emergency Services

Resource	Location	Notes
Crisis Respite Care		
A Peer-Run Respite **indicates that peers oversee staff, and operate the respite at all levels and that at least 51% of the Board of Directors identifies as peers.** A directory of peer-run crisis respites currently in operation can be found here: http://www.power2u.org/peer-run-crisis-services.html		

Resource	Location	Notes
Afiya	http://www.westernmassrlc.org/afiya	Afiya strives to provide a safe space in which each person can find the balance and support needed to make meaning out of a crisis and turn it into a growth opportunity. It is available to anyone ages 18 and older who is experiencing distress and could benefit from being in a short-term, 24-hour peer-supported environment.
Rose House	http://www.integration.samhsa.gov/images/res/PDF/PSWRC.pdf	Services are designed to help 'at risk' individuals to break the cycle of learned helplessness and recidivism. In addition, a continuum of crisis services is available, including: warm Line, In-Home Peer Companionship, Social Structure (Nights Out), and peer advocacy.
Hybrid Crisis Respite: A Hybrid indicates that although the respite is attached to a traditional provider organization and/or the Board of Directors is comprised of less than half peers, the director and staff of the respite do identify as peers.		
Leeds Survivor Led Crisis Service	http://www.lslcs.org.uk/	Center provides services which are an alternative to hospital admission and statutory provision for people in acute mental health crisis.
Parachute Program NYC	http://www.nyc.gov/html/doh/html/mental/parachute-respite.shtml	Centers offer voluntary services for individuals in crisis but not at imminent risk of harming self or others, and do not have acute medical needs. The program focuses on helping with acute symptoms of psychosis for stays of one night to two weeks.

Resource	Location	Notes
Provider-run Respite		
Accalmie	www.accalmie.ca	The mission of Accalmie is to help suicidal people in a difficult time by providing transitional housing and allowing them a chance to step back and regain some control over their lives. Meeting and connecting with other resources/agencies is given priority to ensure continuity of services.
Columbia Care	http://www.columbiacare.org	Crisis Resolution Centers are local, home-like environments with 24 hour specialized staff. They promote quick connection and return to home and community services. Strong collaborative relationships exist with local Mental Health Services and hospitals assisting with smooth transitions. They offer crisis respite, diversion, and step down care (transitioning when not safe to go home yet).
Maytree respite centre	www.maytree.org.uk	Maytree offers a sanctuary for people in a suicidal crisis aiming to help through a calm and peaceful environment in which trusting relationships can be developed, and guests can feel listened to and understood. The program reaches people at significant risk and has demonstrated significant reductions in distress levels and longer-term benefits.

Resource	Location	Notes
Crisis Intervention Teams (CIT) and Alternative Crisis Interventions		
CIT International	http://www.citinternational.org/	Organization designed to "facilitate understanding, development and implementation of CIT programs… to create and sustain more effective interactions among law enforcement, mental health care providers, individuals with mental illness, their families and communities and also to reduce the stigma of mental illness.
Emotional CPR (eCPR)	http://www.emotional-cpr.org	This public health education program, developed by persons with lived experience of crisis and distress, teaches how to effectively support persons in crisis. A program that has been successfully paired with CIT training.
NAMI CIT Center	http://www.nami.org/template.cfm?section=cit2	National Alliance on Mental Illness (NAMI) promotes the expansion of the use of crisis intervention teams (CIT) and provides assistance and up-to-date information about implementing CIT programs.
Overcoming The Darkness	http://overcomingthedarkness.com/	Suicide attempt survivor and former police officer, Eric Weaver now trains law enforcement in crisis response through his organization. A possible addition to CIT training.

Part 5: Systems Linkages and Continuity of Care

Resource	Location	Notes
Continuity of care		
The Baerum Model	http://www.biomedcentral.com/1471-2458/11/81	A rapid-response intervention for someone who has attempted suicide and occurs as collaboration between the general hospital, the municipal suicide prevention team, and community health and social services located in the municipality.
NYAPRS Peer Bridger Project	http://www.nyaprs.org/peer-services/peer-bridger/	Persons who are successfully managing their own recovery from a psychiatric disability and have completed the requisite Peer Bridger Training Program help individuals being discharged from psychiatric hospitals to return to community life.
Suicide Prevention Centre of Quebec - CPSQ	http://www.cpsquebec.ca/le-cpsq/services-offerts/ (Website in French)	Integrated Service Liaison, Support and Recovery (SILAR) is a service that is for people who have attempted suicide or who have presented in a hospital emergency center due to a suicidal crisis. This service provides telephone and face-to-face support with individuals and also their relatives.
Vancouver's S.A.F.E.R.	http://www.vch.ca/403/7676/?program_id=78	Suicide Attempt, Follow-up, Education and Research (SAFER) provides a broad range of services associated with suicide prevention, intervention and postvention. SAFER consists of a team of mental health professionals who provide short-term intervention and therapy that is individualized and client centered.

Resource	Location	Notes
Technology-based Supports		
Real Time Crisis	http://www.realtimecrisis.org/	Toronto-based service, a collaboration between a street nurse and a police officer, engages people in crisis on social media in an effort to divert them from the criminal justice system and into proper care.

Part 6: Community Outreach and Education

No additional resources.

Appendix D: Task Force Response to National Institute of Mental Health (NIMH) Request For Information (RFI) on Suicide Research

Suicide Attempt Survivor and Loss Survivor Perspectives on Research Needs in Suicide Prevention

In collaboration with international experts and research faculty the Suicide Attempt Survivor Taskforce has explored recommendations for research in core areas related to attempts, reattempts and suicide death prevention. In addition to the proposed Roadblocks treatment, our recommendations focus on three (3) domains that have the potential to fill crucial information gaps and thereby provide directions for future suicide prevention efforts:

1. Stigma, bias, shame, self-stigma and discrimination as related to suicide itself, surviving an attempt, mental health conditions and mental health treatment generally
2. Etiology of suicide attempt behavior including the role of protective factors and avenues for develop and support of these through educational or other public efforts
3. Interventions and perceptions of treatment as related to re-attempt

Stigma, prejudice, discrimination, self-stigma/shame and social exclusion as related to suicide, suicide attempts, diagnoses, seeking services including emergency care and mental health treatment

- Many studies suggest that stigma decreases help seeking and is related to the continuation or increase of mental health problems, and that stigma is a cross-cultural phenomenon.

- The definition of stigma is often considered separate (or competing) with the effects of stigma, presenting the potential problem, especially in cross-sectional studies, of having multicolllinearity (i.e., several variables from a common construct). For example, stigma is often tested as an independent variable that is competing with concepts such as help-seeking attitudes, trust, confidentiality, fear, loss of esteem, seeing help seeking as weak or failure, reluctance to admit having a mental illness, denial, concerns about disclosure (e.g., Gould, 2012; Bruffaerts, 2011). However, all of the aforementioned variables may be related to stigma, either as part of the construct or as an outcome of stigma.

  It would be useful to determine the joint effects of stigma and related elements as one unified construct, or alternatively to study the downstream effects of stigma. For example, one prospective study showed that self stigma was not predictive of suicidal behavior (Yen, 2009), but more studies are needed to determine whether or not there were moderators involved. For example, do suicide attempt survivors experience more stigma or self-stigma than people with mental illness in general, and could that be related to future behavior? Additionally, there is evidence that many general awareness campaigns are not effective at increasing help seeking or

decreasing suicidal behavior (Dumesnil, 2009). It may be useful to clarify what types and components of stigma targeted by interventions may have significant effects on outcomes such as help-seeking and repeat attempts.

On this topic, one contributor noted that some of the components of stigma could include label avoidance (I don't want to seek out help so I am not labeled mentally ill) and self-stigma. However, one of the barriers to additional research is being able to separate out effects of stigma such as low morale from the symptoms of mental illness such as depression.

- Studies about actual versus perceived public stigma could be helpful in identifying contributors to suicidal behavior or help seeking behavior.

- The notion of access to care is often cited as a barrier to help seeking; however there is less study of the actual accessibility of services. How much of the issue is access to services as opposed to perceived access to services? Is perceived access related to stigma? For example, perhaps people are willing to seek help in private, non-psychiatric settings, in nontraditional hours, or more confidential locations as against other forms of help seeking.

- Studies suggest that the stigma about suicide may be higher than it is for other forms of injury or death (Sveen, 2008), and the effects of that stigma carry-over from the attempt survivor or death by suicide to the family, and perhaps friends of those individuals. The field currently knows little about the effects of that stigma carried over.

- At least one published study has indicated that suicide attempt survivors and their family may experience stigma and discrimination from health care providers (Cerel, 2006). We know less about the effects of this felt stigma and discrimination on subsequent suicidal behavior, continuity of care, or future help seeking. Additionally, even with their advanced training, many healthcare providers avoid mental health care for themselves because of stigma (Wallace, 2010). Do interventions designed to increase awareness, knowledge, and skills have an effect on stigma (for patients and for the healthcare staff themselves)?

- There appears to be little research[1] about the actual and perceived impacts of involuntary rescue, voluntary versus involuntary hospitalization, and self disclosure about being a suicide attempt survivor or having experienced suicidal ideation - particularly as these variables might affect protective factors such as connectedness and risk factors such as social isolation (or burdensomeness, lower belonging) and willingness to seek services in the future.

- There has been little study of the effects of permanent injury or disfigurement that results from a suicide attempt in terms of the effects on self-esteem, self-perception, shame, and re-attempts (or deaths) in the future.

[1] Statements about scarcity of studies reflect the published research known to the members of the Task Force.

- There has been little study of the thought processes related to stigma formation and its effects, which could guide the development of interventions. For example, there is some research that says that suicide attempt survivors may be seen as more responsible for their outcomes than people with other health conditions or issues (Lester, 1996). Additionally, family members have often been considered responsible for suicidal behavior. The assignment of responsibility could be studied in a manner that is consistent with cognitive science and cognitive psychology (e.g., attribution errors, schemas).

- Research that develops a model connecting stigma to suicidal behavior would be useful in determining targets for intervention. Key elements might include, in temporal order, the formation of stigma → level of stigma → stigma effects (as described above) → mental health behaviors (e.g., help-seeking) → suicidal behavior. A critical review could examine and summarize each of those linkages to suggest pathways connecting stigma to suicidal behavior, and identifying intervention points. A stronger evidence base could use a prospective design given the temporal relationships. However, studies conducted in a short timeframe could use of Structural Equation Modeling (SEM) or Mixed Effects Modeling could also strengthen the knowledge about the (potential) role stigma plays in suicidal behavior.

- It is noted in a review[1] that at least some public-level media interventions that have been successful at reducing suicide deaths have included aspects of stigma reduction, particularly with regard to increasing help seeking. In addition, those broad-based efforts have achieved success for suicide reduction where simultaneous stigma-reduction and suicide prevention messaging has occurred, and that such effects are significantly improved compared to the presence of only one or the other 'campaign'. However the stigma reduction element has received less attention than other parts of interventions such as the USAF Program (Knox, 2003) or the national suicide prevention program in England (Paton, 2001) and the causal link or interaction between suicide prevention and stigma-change remains unclear.

Etiology

- Studies that inquire about the decision-making involved in suicide, specifically choice of method, might be useful. What role do personality, disorder, access to means, and psychological needs play in suicidal planning?

- There is a lack of studies that have examined the relationship between onset of suicidal behavior in adolescence (as opposed to in adulthood) and future reattempts or death by suicide. This type of longitudinal or prospective research would be in line with Joiner's concept of capability for suicidal behavior.

- There is also little research about resilience factors, beyond protective factors, that help people to recover after a suicide attempt or after experiencing serious suicidal ideation.

Interventions

- There has been little, if any, study of peer supports as an intervention for suicidal individuals (e.g., support groups, peer specialists, etc.). Although consumer-run services including peer support programs have been established as evidence-based by SAMHSA, we do not have an evidence base around the feasibility, safety, acceptability, and efficacy of peer provided services for suicidal individuals. It may be useful to examine which components of existing interventions (that have been efficacious in reducing suicidal ideation and behavior) could be replicated or enhanced by employing peer providers. One example design for experimentation would be treatment as usual or waitlist vs. clinician led groups vs. peer led groups.

- The experiences that people who attempt suicide have in the services milieu can be a significant factor in how or whether they follow up with treatment recommendations, seek or avoid services in the future and, prospectively, the likelihood of future attempts or death. In one study both attempt survivors and relatives reported very negative experiences in relevant emergency room services (Cerel, 2005). Additionally many studies of service recipients have reported negative experiences in psychiatric emergency and inpatient psychiatric settings, including demeaning treatment, abuse and severe trauma (Cusack, et al, 2003; Robins, et al, 2005). However no studies have been conducted into the relationship between personal treatment experiences generally and outcomes for suicide death or reattempt.

- Some studies suggest that help-seeking is hindered by perceived need for treatment, with individuals often minimizing symptoms or preferring approaches they classify as "self-help" Gould, 2012; Bruffaerts, 2011). What do suicidal individuals consider “self-help”? What do they see as the most acceptable or desirable forms/channels for help? Interestingly, there is evidence that people unwilling to seek ‘traditional’ help sometimes call the National Suicide Prevention Lifeline (Gould, 2012). What is the feasibility, acceptability, and effectiveness of engaging suicide attempt survivors through 24-7 telephonic, computer or other mobile communications devices?

- Would changing the diagnostic codes or billing/reimbursement codes increase service provision for suicidal individuals or the accuracy of their clinical care?

- There was a suggestion of developing more interventions based on Shneidman’s psychache theory and Joiner’s Interpersonal Theory of suicidal behavior.

- What are the effects of family (and significant persons) education and involvement in clinical care? Are there effects on social connectedness or social loss, and eventually does this have an impact on reattempts?

Outcomes / Measures of effectiveness

- Some contributors asked for additional research on the impact of suicidal behavior on family and significant person survivors. While there is no a great amount of study on the effects of suicide on siblings, friends, colleagues, or patients, there are far fewer studies that examine the experience of the family and significant persons of suicide attempt survivors.

- Some studies have examined the mental health impact of suicide on loss survivors (e.g., complicated grief and bereavement, depression, and increased risk of suicidal behavior), and some cross-sectional research has indicated that adolescents who are exposed to a suicide or that attempt suicide are more likely to be involved in substance abuse, violence, and low family connectedness (e.g., Cerel, 2005). We know little about the potential positive effects of suicide prevention programs for the family and significant persons for suicide attempt survivors (or individuals at risk for suicide). Are there secondary benefits that accrue from suicide prevention interventions? Do participants share information with others? Do family/friend attitudes change when they see successful interventions? Does their emotional distress decrease?

- More generally, research might be improved by including positive outcomes from interventions such as improved mental health and wellness, increased hope or optimism, and increased skills.

Roadblocks

- There appear to be some barriers related to the IRB process, in particular, beliefs about what increases suicide risk (e.g., Does asking questions about suicide increase risk?). Given that IRBs are often regulated by NIH, perhaps there could be an education campaign for the IRBs that offers clear guidance on what is known about iatrogenic effects (or lack thereof) of asking about suicide. Are researchers avoiding the topic of suicide to preempt IRB (or grant reviewer) concerns or delays? Similarly, the field might benefit by having some clear guidelines around including suicidal people or people with a history of suicidal behavior in research studies.

- In general, there is little study of the actual thought process that is involved in suicidal decision-making or suicidal ideation, as opposed to a study of general risk or contributing factors. Due to multiple factors that influence and relate to the development of suicidal ideation and behavior, this has posed difficulties for research. It may be useful to examine methods that have been used in cognitive science and neuroscience that could be applied to the process of suicidal thinking.

- A major roadblock to studying the community level affects of interventions is the delay in having access to suicide and suicide attempt data (though this may be a suggestion more relevant to the Data and Surveillance Task Force).

- Methods are needed for measuring intermediate community or group outcomes from large interventions (universal or selective). For example, what type of interventions actually increase

connectedness, improve the dialogue around suicide and comfort with discussing suicide and related topics (as a counter to stigma), or improve the social climate and culture around mental health in general? Additionally, methods or indicators are needed for examining the effect that leaders and institutions have on mental health and suicidal outcomes when they prioritize and promote (or hinder and hide) mental health issues.

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Appendix E: Expert Interviewees, Reviewers, Funding Organizations

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Prevention Communities

Substance Abuse and Mental Health Services Administration

Suicide Prevention Resource Center

Glossary

Accessibility (of care) – the location, hours, and placement of care which facilitates or inhibits individuals from getting care.

Assertive Community Treatment (ACT) – a team approach to intensive, comprehensive, community-based treatment and support for individuals with chronic or persistent mental health challenges.

Attempt survivor – see suicide attempt survivor

Behavioral health—a state of mental/emotional being and/or choices and actions that affect wellness.

Behavioral health challenges – issues, problems or challenges including mental and substance use disorders, severe psychological distress, and suicidal thinking or behavior.

Behavioral health care – clinical services that promote mental or emotional health, seek to prevent or treat behavioral health challenges, and/or support recovery

Bibliotherapy – the use of self-help materials or recommended reading as a way of helping a person cope with mental health challenges

Care plan – a collaborative and comprehensive plan for treatment and/or support

Cognitive behavior therapy for suicide prevention (CBT-SP) – an evidence-based form of therapy or treatment that specifically focuses on the thoughts and behavior that challenge suicidal individuals

Connectedness – relationships between individuals, groups, and/or organizations that are experienced as positive, satisfying, helpful, or supportive

Continuity of care – an approach to treatment or support that ensures that a person and his or her clinical records can go from one provider to another with few (if any) delays

Core Value – a concept describing a perspective and/or belief that attempt survivors identified as factors that make care both helpful and preferable for a person experiencing, or recovering from, a suicidal crisis

Crisis respite – a facility that provides an individual with a supportive environment that promotes recovery from acute distress or crisis, when a person is not in immediate danger

Crisis support – care or services specifically aimed at helping individuals in mental or emotional distress

Dialectical behavior therapy (DBT) – an evidence-based form of therapy or treatment that specifically focuses on controlling chronic or long-term suicidal thoughts, feelings, and behaviors

Dignity – value and respect, concern for a person's needs and feelings, and avoiding the use of labels and stereotypes

Ecological model (Social Ecological Model) – a framework for examining the factors that influence an issue that encompasses attitudes and behaviors at the individual, relationship or group, community, and social or cultural levels

Evaluation – systematic investigation of program or practice value, process, and/or impact

Evidence-based – practices or programs that have scientific research or evaluation results demonstrating that the desired outcome can be achieved

Federally qualified health centers – health care organizations that serve an underserved area, provide comprehensive services, and receive special Medicare and Medicaid funding

HIPAA – the Health Insurance Portability and Accountability Act issued standards and safeguards about the use and disclosure of individual health information, privacy rights, and control of information

Inclusion – meaningful engagement of persons from a specified group in the initiation, development, dissemination, promotion, implementation, and/or evaluation of activities

Informed care decision – choices about treatment and support to promote health and well-being that are based on a clear understanding of the risks and benefits of available options

Lethal means – instruments, objects, or materials used for suicidal behavior that have a high rate of death

Lived experience – first-person knowledge about suicidal thinking and/or behavior from having lived through one or more suicidal experiences

Lived expertise – the combination of lived experience and relevant training or practice that enables a person to apply personal knowledge to professional activities

Mental health (see also behavioral health) – a person's capacity to fully use his or her mental abilities, experience social and cognitive development, interact with others, and experience well-being

Mental health challenges (see also behavioral health challenges) – the temporary or long-term symptoms, problems, concerns that cause a person distress and/or disrupt his or her life, which includes traditionally defined 'mental illness.'

NSSP – the National Strategy for Suicide Prevention finalized in 2012

Peer – a person who has lived experience from mental or behavioral health challenges, particularly experience from a suicidal crisis

Peer respite – crisis respite that is operated by peers, or includes significant numbers of staff who are peers

Person-centered approach – an approach to treatment that is guided by an individual's needs, wishes, strengths, values, resources, and goals

Policy – a written or formal statement intended to guide the actions of governments, organizations, or individuals

Practice – a process, method, technique, approach, procedure or other behavior that occurs on a regular basis

Primary care – clinical services that are aimed primarily at general or physical health and well-being

Program – a specific intervention, therapy, treatment, campaign, course, workshop, or other activity or resource designed to support or help someone

Protective factors – characteristics, situations, or other elements in a person's life that make it less likely that he or she will develop a disorder or experience a suicidal crisis

Recovery – a concept of living a hopeful, meaningful, and fulfilling life in spite of behavioral health challenges

Recovery practices (Recovery-oriented services) – support or clinical practices and services that aim to support recovery

Research – systematic investigation of a concept, theory, program, practice, or policy to increase general knowledge and understanding of its components, mechanisms, outcomes, or other qualities

Resilience/Resiliency – a person's capacity for positive outcomes and/or protection from negative outcomes in spite of challenges

Risk factors – characteristics, situations, or other elements in a person's life that make it more likely that he or she will develop a disorder or experience a suicidal crisis

Self-advocacy – the process of asserting one's rights and/or informing service or support providers about one's needs, wishes, strengths, values, resources, and goals

Self-care or self-help – information a person acquires and/or actions a person takes to maintain or improve his or her health and well-being

Self-management – self-care that is specifically aimed at modifying, coping, or tolerating behavioral health challenges

Self-stigma – negative perceptions of oneself based on beliefs about a condition, disorder, or circumstance

Stigma – the combination of bias, negative stereotypes, fear, avoidance, shame, discrimination, and/or abuse that is associated with a labelled condition or circumstance

Suicide – death caused by self-inflicted injury, poisoning, or suffocation; a fatal suicide attempt

Suicide attempt – a self-inflicted injury, poisoning, or suffocation with some intent to die

Suicidal behavior – a suicide attempt and/or actions preparing for a suicide attempt

Suicidal crisis – a situation when a person is experiencing suicidal thoughts, feelings, and/or impulses, which may involve suicidal behavior

Suicide attempt survivor – a person who survived a prior suicide attempt

Suicide prevention supports – actions and activities that have the potential to prevent, intervene, or assist recovery from a suicidal crisis

Support network – the persons identified by an individual as potential or active providers of tangible, social, emotional, or psychological support

Trauma informed care – support or services that is aware of a person's potential history of sexual, physical, or emotional abuse, traumatic service experiences, and how such life experiences can impact behavioral health challenges and care

Warm line – a pre-crisis telephone-based service that provides supportive listening, social support, and/or advice about coping that is often staffed by peers or paraprofessionals

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The National Action Alliance for Suicide Prevention is the public-private partnership advancing the *National Strategy for Suicide Prevention* (NSSP) (http://actionallianceforsuicideprevention.org/NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the NSSP, and cultivating the resources needed to sustain progress. The Action Alliance envisions a nation free from the tragic experience of suicide. For electronic copies of this paper or for additional information about the Action Alliance and its task forces, please visit http://www.actionallianceforsuicideprevention.org.