

**A Call to Collaboration:
The Federal Commitment to Suicide Prevention**

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Abstract

The Federal government, largely through the U.S. Department of Health and Human Services, sponsors an array of science-based suicide prevention initiatives. This article details the prevention-related agendas and collaborative efforts of five operating divisions within the Department of Health and Human Services: the Substance Abuse and Mental Health Services Administration, National Institutes of Health, Centers for Disease Control and Prevention, Indian Health Service, and Health Resources and Services Administration. The article highlights the Department's activities and their link to the *National Strategy for Suicide Prevention*, the plan which will guide the nation's suicide prevention efforts for the next decade.

Introduction

Each year approximately 30,000 lives are lost to suicide in the United States (CDC, 1999a). Yet, this disturbing loss of American lives is preventable. The U.S. Department of Health and Human Services (HHS) is working to prevent suicide and its devastating impact on families, friends, and communities. HHS funds an array of initiatives that examine incidence, research risk and protective factors, evaluate prevention programs, and promote effective program models.

The Federal government is certainly not the only torchbearer for suicide prevention. The private sector, from local community programs to national advocacy organizations, has been responding to this public health crisis for many years. Yet, achieving significant headway can only occur through a coordinated and dedicated commitment by both the public and private sectors.

The Federal commitment to suicide prevention was notably strengthened in 2001 by the *National Strategy for Suicide Prevention: Goals and Objectives for Action (National Strategy)* (USPHS, 2001). This seminal report called for leadership and emphasized the need for extensive partnerships throughout the public and private sectors to enhance, expand, and coordinate suicide prevention activities. As a result, HHS has embarked on an ambitious plan to join forces with states, local governments, tribes, nonprofits, and the foundation community to form a public/private collaborative for the purpose of guiding and facilitating implementation of the goals and objectives outlined in the *National Strategy*.

Suicide in the United States

In 1999 the U.S. suicide rate was 10.7 completed suicides per 100,000 persons (CDC, 1999a), making it the 11th leading cause of death among all age groups (CDC, 1999b). While suicide is a public health problem for all segments of the American population, suicide disproportionately impacts people of certain ages, ethnic/racial backgrounds, and geographic locations. It is the third leading cause of death among Americans aged 15-24 and the second leading cause of death among those aged 25-34 (CDC, 1999b). Within the American Indian/Alaska Native population, those aged 15-35 experience more than 21 suicide deaths per 100,000 (CDC, 1999c). The suicide rate for older Americans is also troubling at more than 17 suicide deaths per 100,000 persons aged 75 and older (CDC, 1999d). Finally, suicide rates vary by geographic region with higher rates in Western states (including Alaska) than in other regions (CDC, 1997).

The National Response to Suicide

Suicide prevention efforts gained important momentum at the national-level during the 1990s. During the course of the decade, the grassroots survivor organization Suicide Prevention Advocacy Network (SPAN-USA) formed; the United Nations/World Health Organization issued the 1996 summary, *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies* (UN/WHO, 1996); the 105th Congress declared suicide prevention to be a national priority through passage of Senate Resolution 84 and House Resolution 212; the first National Suicide Prevention Conference assembled in Reno, Nevada in 1998; and the Surgeon General issued a *Call to Action to Prevent Suicide* (USPHS, 1999).

The Surgeon General's report underscored the importance of harnessing science to develop safe and effective approaches to suicide prevention and educating the public about those approaches. Reflecting the national conference's consensus recommendations on awareness, intervention, and methodology (AIM), the report urged that the Federal government and suicide prevention stakeholders collaborate on the development of a national plan with concrete action steps (USPHS, 1999).

The Federal government also incorporated suicide prevention into its overall public health agenda. The blueprint for improving the nation's health, *Healthy People 2010*, highlights two suicide reduction objectives: (1) decrease suicides from 11.3 suicides per 100,000 population to 5.0 suicides and (2) reduce the rate of suicide attempts by adolescents (DHHS, 2000).

Suicide prevention initiatives are underway in many parts of the Federal government. As the Department primarily responsible for promoting the public health of the Nation, HHS oversees the suicide prevention activities with the broadest reach. In addition, the Department of Defense supports various programs in each of the Military Services. The Department of Justice promotes suicide prevention efforts within its detention facilities (including juvenile justice facilities). And the Department of Education funds several efforts relevant to suicide prevention, including programs within "Safe and Drug Free Schools" and the Educational Resources Information Center (ERIC), which has produced fact sheets related to teenage suicide and school response to suicide events.

Various HHS operating divisions conduct suicide prevention activities that are consistent with their particular mandates and expertise. Coordination of these efforts is facilitated through the Federal Steering Group, operating under the oversight of the Assistant Secretary for Health through the Office of the Surgeon General. The following is a profile of these suicide prevention activities and the interagency collaboration among the Substance Abuse and Mental Health Services Administration (SAMHSA); National Institutes of Health (NIH); Centers for Disease Control and Prevention (CDC); Health Resources and Services Administration (HRSA); and Indian Health Service (IHS):

- SAMHSA provides Federal block grants to states in support of mental health and substance abuse services. SAMHSA also supports a myriad of programs to increase the use of and improve science-based prevention and treatment methods. SAMHSA's Center for Mental Health Services (CMHS) focuses on delivery of mental health services and has primary responsibility within SAMHSA for coordination of national suicide prevention activities.
- NIH consists of 27 Institutes and Centers, with the National Institute of Mental Health (NIMH) supporting the greatest proportion of suicide-related research. Other Institutes

active in suicide prevention include the National Institute of Child Health and Human Development, which funds research related to risk and protective factors for youth suicide, and the National Institute of Drug Abuse and National Institute of Alcohol Abuse and Alcoholism, both of which conduct and support research on substance use and abuse-critical suicide-related risk factors.

- CDC oversees systems of health surveillance to monitor and prevent the outbreak of diseases and supports research concerning disease and injury prevention. The National Center for Injury Prevention and Control is responsible for many of CDC's suicide prevention activities. In addition, CDC's National Center for Chronic Disease Prevention and Health Promotion's Division of Adolescent and School Health administers the Youth Risk Behavior Surveillance System and the National Center for Health Statistics collects data on the scope of suicide deaths.
- HRSA works to ensure that medically underserved populations have access to health resources. The Maternal and Child Health Bureau (MCHB) has included suicide deaths for 15 -19 year olds as one of the 18 National Performance Measures reported on every year in the Maternal and Child Health Block Grant. Other HRSA entities such as the Bureau of Primary Health Care, HIV Aids Bureau, and Office of Rural Health Policy oversee activities related to suicide prevention.
- IHS is the principal Federal health care provider and health advocate for approximately 1.5 million American Indians and Alaska Natives, representing more than 560 Federally recognized tribes. IHS strives to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people. IHS provides technical assistance related to suicide prevention through 12 Area Offices and 12 regional alcohol and substance abuse treatment centers for youth ages 12-18 years old.

Reflecting a public health approach, HHS's portfolio of activities falls into several categories:

- research and knowledge development (e.g., surveillance, epidemiology studies, services research and program evaluation);
- promotion and dissemination of best practices (e.g., pilot programs, Web sites);
- technical assistance (e.g., training, national conferences and consultation); and
- leadership activities (e.g., interagency initiatives, forums for stakeholder input, reports and publications).

National Strategy for Suicide Prevention

Development of the *National Strategy* is one example of HHS leadership in suicide prevention efforts. The *National Strategy* is a ground-breaking attempt to bolster collaboration and enhance coordination around suicide prevention. Developed by HHS under the direction of the Surgeon General and with input from a multitude of stakeholders, the document is a blueprint for action. Intended to serve as a "catalyst for social change with the power to transform attitudes, policies, and services," it calls on the Federal government to work in concert with the public and private sectors to enhance awareness, implement interventions, and develop methodologies for collecting suicide-related data (USPHS, 2001).

The *National Strategy* identifies 11 broad goals and 68 corresponding objectives. Implementing these objectives over time, the *National Strategy* aims to prevent premature deaths due to suicide, reduce rates of other suicidal behaviors, reduce harmful aftereffects associated with suicidal behaviors, and promote opportunities and settings to enhance resilience, resourcefulness, and interconnectedness (USPHS, 2001).

Suicide Prevention Activities within HHS

HHS sponsors a variety of suicide prevention activities primarily through SAMHSA, NIH, CDC, IHS, and HRSA. Each operating division maintains a prevention-related agenda, including projects in direct response to the *National Strategy's* goals and objectives, as well as other activities that reflect previous, ongoing commitments to suicide prevention.

Many current HHS-supported activities directly relate to the goals and objectives outlined in the *National Strategy*. The discussion below details HHS' activities and their links to the *National Strategy's* overarching goals and, as appropriate, specific objectives.

- **Promote awareness that suicide is a public health problem that is preventable (*National Strategy* Goal 1)**

The *National Strategy* itself has been instrumental in raising awareness about suicide and suicide prevention. In partnership with key stakeholders, the five profiled HHS operating divisions actively supported the drafting and dissemination of the *National Strategy*, with 35,000 copies printed and distributed through national conferences, HHS meetings and SAMHSA's National Mental Health Information Center (formerly known as the Knowledge Exchange Network (KEN) Clearinghouse). This widespread interest in the *National Strategy* suggests that the document's concrete blueprint and timetable have been well-received.

SAMHSA maintains a Web site (<http://www.mentalhealth.org/suicideprevention>) dedicated to the *National Strategy* and suicide prevention. It offers facts about suicide, details of Federal, state and private suicide prevention activities, resources for practitioners and researchers, and funding opportunities. Recognizing the Web's importance as a tool to reach a large audience, NIMH

awarded Small Business Innovation Research (SBIR) grants to four companies for the purpose of designing innovative and useful Web sites for stakeholders interested in suicide prevention (e.g., families, professionals, government). (*Objective 1.4*)

- **Develop broad-based support for suicide prevention (*National Strategy Goal 2*)**

A critical component of the *National Strategy* is the establishment of a national coordinating body to guide and facilitate the advancement of the national strategy's goals and objectives. Under the leadership of the Assistant Secretary for Health, this coordinating body will be a public/private collaborative involving numerous stakeholders. Once formed, members of the public/private collaborative will come together to share their expertise, with the understanding that their collective knowledge and efforts will be more effective at reducing suicide rates than anyone member acting alone. (*Objective 2.2*)

The process for designing a public/private collaborative will involve identifying leadership from all sectors (e.g., national, state, local and tribal governments, foundations, non-profits, education, mental health, etc.); securing funding from multiple sources; and promoting maximum public, private and foundation participation. The public/private collaborative is expected to be operational by 2004, with a 10-year agenda to accomplish the *National Strategy's* goals.

- **Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services (*National Strategy Goal 3*)**

In June 2002, NIMH, in conjunction with the other Institutes, issued a call for applications to stimulate stigma-related research within the biomedical, social, and behavioral sciences. With \$2.5 million available in FY 2003, this research initiative will examine the etiology of stigma in relation to public health, as well as develop and test interventions to address stigma's negative effects on health outcomes. (*Objective 3.3*)

SAMHSA sponsors several activities aimed at reducing stigma, some of which are detailed on its National Mental Health Information Center Web site (see <http://www.mentalhealth.org/stigma/>). Currently, SAMHSA provides \$5.4 million for a three-year collaborative effort with states to develop and evaluate public education approaches for overcoming barriers to mental health treatment and encouraging community participation for persons with psychiatric disabilities. SAMHSA also has developed and published materials to address stigma, including *Challenging Stereotypes: An Action Guide*, a resource packet with strategies for encouraging fair, accurate, and balanced portrayals of mental illnesses in the media, as well as anti-stigma posters and pamphlets (available at <http://store.mentalhealth.org/stigma/pubs.aspx>). Finally, SAMHSA funds the Resource Center to Address Discrimination and Stigma Associated with Mental Illnesses. The Center helps states, local communities, providers, managed care organizations, advocates, family members, and mental health consumers design, implement, and operate programs to reduce discrimination and stigma.

(Objective 3.2)

- **Develop and implement community-based suicide prevention programs (*National Strategy Goal 4*)**

The *National Strategy* encourages the development of coordinated and comprehensive suicide prevention plans by each state that address local needs. Although no Federal agency currently requires the development of such plans, many states are in the process of drafting or implementing state plans. (A Western Washington University-based Web site, <http://www.ac.wvu.edu/~hayden/spsp/>, reports the status of these state efforts.)

To assist states with planning initiatives, CDC is conducting a multi-state study of state suicide prevention plans. The study will examine several states' efforts to draft suicide prevention plans, including plan development and implementation, partnerships, successes, obstacles, and lessons learned. By 2004, the study will finalize and disseminate its findings and compile a "template for action" as a technical assistance tool for other states. (*Objective 4.1*)

HRSA's Maternal and Child Health Block Grant encourages state planning as it requires that states and territories report on youth suicide rates and establish five-year target rates. Since MCHB Grant funds are awarded to state health departments, public health is often the lead agency or a major partner in the planning process. To develop comprehensive plans and obtain accurate data, the public health system works with a variety of stakeholders (e.g., mental health, law enforcement, medical examiner, family, survivors, education, substance abuse, juvenile justice, and faith-based organizations). (*Objective 4.1*)

SAMHSA provides funding support to *Signs of Suicide* (SOS), a peer program that teaches students to recognize depression in peers and to ACT - that is, ACKNOWLEDGE that a friend has a serious problem, let the friend know you CARE and TELL a responsible adult. SAMHSA funds SOS evaluation activities to determine the impact of the program on students' knowledge of and attitudes toward suicide, help seeking behavior, and suicide attempts. (*Objective 4.2*)

By providing \$3.0 million in funding annually over three years, SAMHSA sponsors the Hotline Evaluation and Linkage Project (HELP). The Kristin Brooks Hope Center operates a national toll-free number that links callers to the closest network suicide crisis center. These centers are certified by the American Association of Suicidology and are linked to form a national network. Researchers from Rutgers University and Columbia University are evaluating HELP by working with several network centers to establish protocols and tools, examine collected data, and measure the impact of the assistance provided by the centers.

SAMHSA is overseeing the launch of the National Suicide Prevention Technical Resource Center in late 2002. Funded at \$7.5 million over its first three years, the Center will be dedicated exclusively to suicide prevention and serve as a central resource for states and communities seeking to build capacity to implement and evaluate suicide prevention programs. The Center will provide technical assistance to

stakeholders, serve as a clearinghouse for best practices, promote evaluation of suicide prevention programs, gather and assemble suicide information used by states, and support training. (*Objective 4.8*)

Several HHS operating divisions fund technical assistance efforts aimed at suicide prevention. HRSA provides technical assistance through the Children's Safety Network, a network of four technical assistance centers which assist public health officials with their injury prevention initiatives, including youth suicide prevention, and through MCHB Field offices, which have sponsored regional conferences focused on youth suicide prevention. IHS assists tribes with their suicide prevention efforts and provides technical assistance in a manner that is respectful of tribal sovereignty and consistent with the tribe's cultural beliefs and philosophy. Finally, NIMH offers technical assistance to investigators by sponsoring workshops, at which NIMH and other Institute grantees present data, examine specific issues related to suicide risk, and discuss issues with other key stakeholders.

- **Promote efforts to reduce access to lethal means and methods of self harm (*National Strategy Goal 5*)**

Another example of collaboration within HHS was the joint sponsorship of the recently issued Institute of Medicine report, *Reducing Suicide: A National Imperative*. The report (see <http://books.nap.edu/books/0309083214/html/index.html>) gave a scientific overview of the current knowledge base about suicide; evaluation of current primary and secondary prevention interventions; identification of gaps in the knowledge base; and suggested opportunities for further scientific study.

Relevant to this goal, several prevention interventions were examined, including efforts to reduce availability (e.g., secure gun storage); policy changes (e.g., restrictive gun laws); use of barriers and restraints (e.g., barriers on bridges, blister packs for medications); and availability of crisis hotlines. The science-based discussion on prevention interventions is a useful reference as stakeholders and the eventual public/private collaborative address the *National Strategy* goal of reducing access to methods of self harm. (*Objectives 5.3 -5.5*)

- **Implement training for recognition of at-risk behavior and delivery of effective treatment (*National Strategy Goal 6*)**

HHS will continue to support the development of effective training and rely upon schools and universities to implement many of the training activities envisioned under this goal. An example of a public-private training effort is IHS partnering with the American Psychological Association to fund a scholarship program known as Indians into Psychology Doctoral Education (INPSYDE). The goal of this joint effort is to produce a cadre of Native American clinical psychologists who can provide their communities with culturally appropriate mental health interventions, including assessment of suicide risk.

- **Develop and promote effective clinical and professional practices (*National Strategy Goal 7*)**

NIMH supports research related to improving treatments for those persons at high risk for suicidal behavior. By funding a range of studies, NIMH is increasing the number of empirically-based approaches available to reduce suicidal behavior for persons in a variety of settings. For example, a 3-site study called PROSPECT (Prevention of Suicide in Primary care Elderly Collaborative Trial) is investigating the effectiveness of an intervention aimed at improving the recognition of suicidal ideation and depression in older primary care patients. (*Objective 7.2*)

- **Improve access to and community linkages with mental health and substance abuse services (*National Strategy Goal 8*)**

SAMHSA provides funds for the development of school suicide prevention guidelines which will help school professionals and staff to identify and intervene with students who exhibit suicidal behaviors and risk factors. Once formulated, they are intended to increase expertise of school counselors when assessing suicide risk; identify and refer at-risk students to connect with local services; and develop a crisis management plan for a serious suicide attempt or death of a community member. (*Objective 8.3*)

Communities are able to review and select effective substance abuse and mental health programs through a SAMHSA-funded registry (see <http://www.modelprograms.samhsa.gov>). Sponsored by the Center for Substance Abuse Prevention, the National Registry of Effective Prevention Programs screens and identifies scientifically supported model programs that can meet communities' needs. The Web site features close to 100 effective programs that enhance outcomes for substance abuse, violence and high-risk behaviors in community, family, school, clinical, faith-based, and workplace settings.

SAMHSA, HRSA and the Veteran Affairs Administration provide a further focus on accessing substance abuse and mental health services by funding PRISMe (Primary Care Research in Substance Abuse and Mental Health for the Elderly). PRISMe is an 11-site study comparing two models of care for older persons with depression, anxiety and at-risk for increased alcohol consumption. To determine the effectiveness of various levels of integrated mental health services or referral models of care, the study will examine several outcome variables, including suicide ideation, attempts and death rates.

Recognizing the disparities in suicidal behavior across ethnic groups, SAMHSA issued *Mental Health: Culture, Race, Ethnicity*, a 2001 supplement to the *Mental Health Report of the Surgeon General* (see <http://www.surgeongeneral.gov/library/mentalhealth/home.html>). The report discussed the unequal access, quality, and availability of mental health services experienced by racial and ethnic minorities and suggested broad changes to address the disparities. Similarly, NIMH continues to support research to further

understand barriers to access within the mental health and primary care systems, as evidenced by its *Five-Year Strategic Plan for Reducing Health Disparities*, which includes a specific objective on suicide, depression and other severe mental illnesses in minority populations.

- **Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media (*National Strategy Goal 9*)**

SAMHSA, NIMH, CDC and the Office of the Surgeon General partnered with several national suicide prevention organizations to develop recommendations for media reporting on suicide (see <http://www.nimh.nih.gov/research/suicidemediacfm>). In addition, the *National Strategy* Web site features links to news stories and other resources of interest to the media (see <http://www.mentalhealth.org/suicideprevention/newsroom.asp>). The goal is to educate the media on more effective ways to report about suicide-related events and trends. (*Objective 9.3*)

HRSA is sponsoring an initiative which meets the aims of the *National Strategy's* media goal and addresses a risk for suicide: bullying. MCHB's National Bullying Prevention Campaign is part of a Congressionally-mandated Youth Media Campaign designed to promote healthy lifestyles and displace unhealthy, risky behaviors among youth aged 10-13.

- **Promote and support research on suicide and suicide prevention (*National Strategy Goal 10*)**

NIMH has the lead to promote and support mental health related research on suicide and suicide prevention within the Federal government. The Suicide Research Consortium is the informational focal point for all of the NIMH suicide research activity. The Consortium's Web page (<http://www.nimh.nih.gov/research/suicide.cfm>) provides a range of information on suicide and suicide research, including abstracts of currently funded suicide research studies and reviews of measures of suicidality used in research studies.

In FY 2001, NIMH invested \$20.8 million in ongoing support of suicide-related studies conducted by researchers outside of the Institute. Funded studies include examinations of suicide incidence, intervention research, risk factor studies, and multiple trials focused on reducing suicidality. This research includes studies on suicidality in specific populations (e.g., NIMH-funded researchers collaborate with IHS on studies involving surveillance and service provision for Native Americans). (*Objective 10.4*)

NIMH recently awarded a training grant in suicide research. Provided to universities to train junior researchers, the training grant will increase the field's capacity to study suicide and suicide prevention. NIMH also awarded a five-year conference grant to the University of Rochester to review suicide prevention approaches. This grant funded recent conferences focusing on youth suicide prevention (summer 2001) and adult suicide prevention (summer 2002).

CDC also maintains its own research program, which examines suicide from outside of the mental health context. In June 2002, CDC released *Injury Research Agenda*, a broad research plan for the National Center for Injury Prevention and Control (NCIPC), which identified suicide as priority area for research. It will direct funding decisions, guide researchers both within and outside of CDC, and steer NCIPC's collaboration with other funding organizations.

- **Improve and expand surveillance systems (*National Strategy Goal 11*)**

CDC operates several of the reporting and surveillance systems used to capture important data about suicide deaths. CDC's National Center for Injury Prevention and Control maintains the Web-based Injury Statistics Query & Reporting System known as WISQARS. (<http://www.cdc.gov/ncipc/wisqars/default.htm>). The online database enables users to easily view data on injury mortality and leading cause of death statistics sorted by intent, method, year, state and demographics. The data is derived from death certificate information that the CDC's Center for Health Statistics enters into its national mortality database.

Another method for capturing statistics about suicides and violent deaths - the National Violent Death Reporting System - is under development by CDC. By Fall 2002, a few states will pilot the new reporting system, which will provide more detailed data than is currently available and will assist with policy decisions and the design of prevention programs by providing uniform and comparable state data. (*Objective 11.4*)

MCHB has a built-in mechanism for collecting data. In the Maternal and Child Health Block Grant applications, states report on the number of suicide deaths among 15-19 year olds, their 5-year targets, and their activities to address youth suicide. Generated from the vital statistics database, these state data are available through the Internet (<http://www.MCHdata.net>).

Because suicide is a relatively rare event in any given locality, communities implementing suicide prevention programs need measures other than "number of completed suicides" to gauge the success of their efforts. These measures might include suicide attempts; suicide-related calls to a crisis hotline; crime data; hospital, emergency room, and ambulance data; and other indicators related to suicide risk factors. CDC is overseeing a Community Indicator Project to develop such measures. The Project aims to identify and compile indicators that are available from existing data systems in the community and conduct a pilot test of these community indicators. (*Objective 11.7*)

A project to develop indicators of progress for the *National Strategy* is also underway. Funded by SAMHSA, the indicators will be used as a benchmark for determining change resulting from implementation of the *National Strategy*. In the collaborative spirit of the *National Strategy*, a Web site (<http://www.nsspi.org>) invites stakeholders to contribute to this important project and recommend possible national indicators.

Conclusion

SAMHSA, NIH, CDC, IHS, and HRSA have joined forces to spearhead HHS's commitment to prevent suicide. In addition to supporting their own suicide prevention activities, these operating divisions participate in a Federal Steering Group and work collaboratively to develop and implement a unified agenda for the Department. As appropriate, the Federal Steering Group will join with other Federal departments, such as the Departments of Justice, Education, and Defense, to address suicide prevention among incarcerated individuals, students, and members of the military. Under the direction of the Assistant Secretary of Health, HHS's operating divisions are continually expanding their suicide prevention efforts, based on the *National Strategy's* comprehensive framework. To fully accomplish the *National Strategy's* far-reaching goals, however, the journey requires the continued development of partnerships between government agencies, the private sector, and the philanthropic community, as well as the creation of a public/private collaborative to facilitate joint activities. This increasing synergy will result in expanded science-based efforts to reduce the number of American lives lost to suicide each year.

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