

# The Road to Recovery 2016

## June Show

### Preventing and Addressing Suicide: Everyone Plays a Role

January 25, 2016

#### Discussion Guide

The show will be filmed in a panel format, with free discussion between the show host and other panelists. This discussion guide is not to be considered a script. The information and resources provided in this discussion guide are provided to assist panelists in show preparation. The questions identified in each panel section will be asked by the show host. Panelists will respond to questions asked by the host, and they will also comment and add to information presented by other panelists in a discussion format. Panelists will bring their own keen anecdotal experiences to the show as well as references from scientific studies from the field.

---

**Show Description.** Suicide is the 10th leading cause of death in the United States, with more than 42,000 suicides in 2014. It is the second leading cause of death for young people aged 15 to 24 and third leading cause of death for young people aged 10 to 14.<sup>1</sup> In 2014, 9.4 million adults aged 18 or older thought seriously about trying to kill themselves in the past 12 months, including 2.7 million who made suicide plans and 1.1 million who made a nonfatal suicide attempt, according to data from the National Survey on Drug Use and Health (NSDUH).<sup>2</sup> Suicide has a devastating impact on family and friends—who experience complex grief reactions, including guilt, anger, abandonment, denial, and helplessness—as well as society.<sup>3</sup> This show will highlight suicide among particular groups, including members of the military; men in mid-life and older men; people who are lesbian, gay, bisexual, and transgender; members of Native American communities; and people with mental or substance use disorders. It will include information from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services' (CMHS) *A Journey Toward Health and Hope* (a support guide for attempt survivors, released September 10, 2015). The show will also cover SAMHSA's suicide prevention efforts/resources (including SAMHSA's National Suicide Prevention Lifeline [telephone hotline] and Suicide Safe [a prevention app for health care providers]). Panelists will

---

<sup>1</sup> Centers for Disease Control and Prevention. (n.d.). 10 leading causes of death by age group, United States—2013. From [http://www.cdc.gov/injury/images/lc-charts/leading\\_causes\\_of\\_death\\_by\\_age\\_group\\_2013-a.gif](http://www.cdc.gov/injury/images/lc-charts/leading_causes_of_death_by_age_group_2013-a.gif) (accessed April 19, 2016).

<sup>2</sup> Lipari, R., Piscopo, K., Kroutil, L. A., & Miller, G. K. (2015, September). Suicidal thoughts and behaviors among adults: Results from the 2014 National Survey of Drug Use and Health. *NSDUH Data Review*.

<sup>3</sup> Centers for Disease Control and Prevention. (2015, June 10). Suicide and suicide attempts take an enormous toll on society. From <http://www.cdc.gov/violenceprevention/suicide/consequences.html> (accessed April 19, 2016).

address the impact of suicide on families and the effects of prejudice and discrimination related to suicide on both individuals and loved ones. The discussion will also include the warning signs of suicide that family members and others can watch for and the actions they can take if someone seems to be contemplating suicide. For people who have attempted suicide and for those bereaved by suicide, recovery support is essential, and family plays a crucial role. This show will examine the treatment and support needed by individuals who have attempted suicide and their family members, as well as people in bereavement from suicide, as they find their own unique paths to recovery. The discussion will highlight the role that peers can play in supporting people experiencing mental or substance use disorders and the family members of those who have attempted suicide, as well as include family-to-family support for those bereaved by suicide.

---

## **Panel 1: Suicide In America: Understanding the Impact and Connection With Mental or Substance Use Disorders**

### **Key Questions**

- 1. Why is it important to address suicide? How many people die by suicide each year? What is the impact of suicide on society?**
- 2. What is the connection between mental or substance use disorders and suicide?**
- 3. What is the impact of suicide on families and loved ones?**
- 4. What are the effects of prejudice and discrimination related to suicide on both individuals and loved ones?**
- 5. How many people experience suicidal thoughts and make attempts each year?**
- 6. What is the impact of suicide attempts on individuals, families, and loved ones?**
- 7. What are some resources for people with thoughts of suicide, those who have made attempts, and their loved ones?**
- 8. What are some resources for behavioral healthcare providers and other professionals that address thoughts of suicide, attempts, and related issues?**

### Importance of Addressing Suicide

Source: Centers for Disease Control and Prevention. (2015, August 28). Definitions: Self-directed violence. From <http://www.cdc.gov/violenceprevention/suicide/definitions.html> (accessed April 19, 2016).

- Suicide—Death caused by self-directed injurious behavior with an intent to die as a result of the behavior.
- Suicide attempt—A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior; might not result in injury.
- Suicidal ideation—Thinking about, considering, or planning suicide.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). (2015, October 13). Suicide prevention. From <http://www.samhsa.gov/suicide-prevention> (accessed April 19, 2016).

- Suicide is a serious public health problem that causes immeasurable pain, suffering, and loss to individuals, families, and communities nationwide. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation.
- According to the CDC (see <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6217a1.htm>), the age-adjusted suicide death rate has been rising over the past decade, with much of the increase driven by suicides in mid-life, where the majority of all suicides in the United States now occur.

Source: Centers for Disease Control and Prevention. (n.d.). 10 leading causes of death by age group, United States—2013. From [http://www.cdc.gov/injury/images/lc-charts/leading\\_causes\\_of\\_death\\_by\\_age\\_group\\_2013-a.gif](http://www.cdc.gov/injury/images/lc-charts/leading_causes_of_death_by_age_group_2013-a.gif) (accessed April 19, 2016).

- [In 2013, suicide was the 10th leading cause of death in the United States.]
- [Among people aged 15 to 34, suicide was the second leading cause of death in the United States (behind unintentional injury).]

Source: American Foundation for Suicide Prevention. (2015). Suicide: 2015 facts & figures [infographic]. From <https://www.afsp.org/news-events/in-the-news/suicide-2015-facts-and-figures-infographic> (accessed April 25, 2015).

- An American dies by suicide every 12.95 minutes.

### Suicide Statistics

Source: Centers for Disease Control and Prevention. 2014, United States Suicide Injury Deaths and Rates per 100,000. From [http://webappa.cdc.gov/sasweb/ncipc/mortrate10\\_us.html](http://webappa.cdc.gov/sasweb/ncipc/mortrate10_us.html) (accessed April 25, 2016).

- [In 2014, there were 42,773 deaths from suicide. Of these, the number of suicides in various age categories were:]
  - Ages 10 to 14: 425
  - Ages 15 to 24: 5,079
  - Ages 25 to 34: 6,569
  - Ages 35 to 44: 6,706
  - Ages 45 to 54: 8,767
  - Ages 55 to 64: 7,527

Source: Centers for Disease Control and Prevention. (2015). Suicide facts at a glance. From <http://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf> (accessed April 19, 2016).

- Suicide is the third leading cause of death among persons aged 10–14, the second among persons aged 15–34 years.

Source: American Foundation for Suicide Prevention. (n.d.). Facts and figures. From <http://helpsavinglives.com/2015/07/02/facts-and-figures/> (accessed April 19, 2016).

- [According to information from the Centers for Disease Control and Prevention’s Fatal Injury Report (2013 data):]
  - From 1986 to 2000, suicide rates in the U.S. dropped from 12.5 to 10.4 suicide deaths per 100,000 people in the population. Over the next 12 years, however, the rate generally increased and by 2013 stood at 12.6 deaths per 100,000.
  - In 2013, the highest suicide rate (19.1) was among people 45 to 64 years old. The second highest rate (18.6) occurred in those 85 years and older. Younger groups have had consistently lower suicide rates than middle-aged and older adults. In 2013, adolescents and young adults aged 15 to 24 had a suicide rate of 10.9.
  - For many years, the suicide rate has been about 4 times higher among men than among women. In 2013, men had a suicide rate of 20.2, and women had a rate of 5.5. Of those who died by suicide in 2013, 77.9% were male and 22.1% were female.
  - In 2013, the highest U.S. suicide rate (14.2) was among Whites and the second highest rate (11.7) was among American Indians and Alaska Natives.
  - Much lower and roughly similar rates were found among Asians and Pacific Islanders (5.8), Blacks (5.4) and Hispanics (5.7).
  - In 2013, nine U.S. states, all in the West, had age-adjusted suicide rates in excess of 18: Montana (23.7), Alaska (23.1), Utah (21.4), Wyoming (21.4), New Mexico (20.3), Idaho (19.2), Nevada (18.2), Colorado (18.5), and South Dakota (18.2). Five locales had age-adjusted suicide rates lower than 9 per 100,000: District of Columbia (5.8), New Jersey (8.0), New York (8.1), Massachusetts (8.2), and Connecticut (8.7).
  - In 2013, firearms were the most common method of death by suicide, accounting for a little more than half (51.4%) of all suicide deaths. The next most common methods were suffocation (including hangings) at 24.5% and poisoning at 16.1%.

### Impact of Suicide on Society

Source: Centers for Disease Control and Prevention. (2015). Suicide facts at a glance. From <http://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf> (accessed April 19, 2016).

- Suicide results in an estimated \$51 billion in combined medical and work loss costs.
  - Original source: Centers for Disease Control and Prevention (CDC). (2013, 2011). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. National Center for Injury Prevention and Control, CDC (producer). From <http://www.cdc.gov/injury/wisqars/index.html> (accessed April 19, 2016).

Source: American Foundation for Suicide Prevention. (2015). Suicide: 2015 facts & figures [infographic]. From <https://www.afsp.org/news-events/in-the-news/suicide-2015-facts-and-figures-infographic> (accessed April 25, 2016).

- More than 1.5 million years of life are lost annually to suicide.

### Connection Between Mental or Substance Use Disorders and Suicide

Source: Lipari, R., Piscopo, K., Kroutil, L. A., & Miller, G. K. (2015, September). Suicidal thoughts and behaviors among adults: Results from the 2014 National Survey of Drug Use and Health. *NSDUH Data Review*.

- [According to information from the National Survey on Drug Use and Health (NSDUH):]
  - Adults in 2014 who had a substance use disorder (SUD) in the past year related to their use of alcohol or illicit drugs were more likely than adults who did not have an SUD to report suicidal thoughts or behavior.
  - Adults in 2014 who had a major depressive episode (MDE) in the past year were more likely than adults who did not have an MDE in the past year to have had serious thoughts of suicide, to have made suicide plans, or to have attempted suicide in the past year.
  - Among adults in 2014 who had serious thoughts of suicide in the past year, nearly half did not receive any mental health services in the past year, and about 1 in 7 perceived a need for mental health care but did not obtain care.

Source: SAMHSA. Suicide prevention. (2015, October 13). From <http://www.samhsa.gov/suicide-prevention> (accessed April 19, 2016).

- [Alcohol and drug abuse as well as depression and other mood disorders are common risk factors for suicide.]

Source: SAMHSA. (2014, August 7). Emergency department visits for drug-related suicide attempts have increased. *The DAWN Report*. From <http://www.samhsa.gov/data/sites/default/files/DAWN-Spot150-SuicideAtt-2014/DAWN-Spot150-SuicideAtt-2014.pdf> (accessed April 19, 2016).

- [According to data from the Drug Abuse Warning Network (DAWN):]
  - Drug-related emergency department (ED) visits involving suicide attempts have increased in recent years. From 2005 to 2011, there was a 51 percent increase for these types of visits among individuals aged 12 or older (from 151,477 to 228,277 visits). Specifically, such ED visits involving patients aged 18 to 29 increased 58 percent from 2005 to 2011 (from 47,512 to 75,068 visits). For patients aged 45 to 64, such ED visits increased 104 percent during this period (from 28,802 in 2005 to 58,775 in 2011). In 2011, 18 to 29 year olds and 45 to 64 year olds comprised approximately 60 percent of all drug-related ED visits involving suicide attempts. Despite the apparent increases in such visits among other age groups, these increases were not statistically significant.

Source: Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (Eds.); Committee on Pathophysiology & Prevention of Adolescent & Adult Suicide, & Board on Neuroscience and Behavioral Health. (2002). *Reducing suicide: A national imperative*. National Academies Press.

- Over 90 percent of suicides in the United States are associated with mental illness and/or alcohol and substance abuse. Yet it is important to remember that as many as 10 percent of people who complete suicide do not have any known psychiatric diagnosis [or substance use disorder].
- It is also important to remember that over 95% of those with mental disorders do not complete suicide.
- The relationship between suicide and mental illness is [complex].
- [Suicidality does not always respond to the same treatments as mental disorders. Although depressive symptoms can be reduced by medicines and psychotherapy, sometimes that is not accompanied by a reduction in suicidality. And psychotherapy can reduce suicidality without significant changes in affective symptoms.]
- [There are psychotherapies with an evidence base for reducing suicidality, specifically they are dialectical behavior therapy (DBT), suicide-specific cognitive behavioral therapy (CBT-S), and Collaborative Assessment and Management of Suicidality (CAMS).]
- Over 30 years of research confirms the relationship between hopelessness and suicide across diagnoses. Hopelessness can persist even when other symptoms of an associated disorder, such as depression, have abated. Impulsivity, especially among youth, is increasingly linked to suicidal behavior.
- Resiliency and coping skills, on the other hand, can reduce the risk of suicide. Research suggests that coping skills can be taught.

Source: Centers for Disease Control and Prevention. (2015, August 28). Suicide: Risk and protective factors. From <http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html> (accessed April 19, 2016).

- A combination of individual, relational, community, and societal factors contribute to the risk of suicide. Risk factors are those characteristics associated with suicide—they might not be direct causes. [Risk factors include:]
  - Family history of suicide
  - Family history of child maltreatment
  - Previous suicide attempt(s)
  - History of mental disorders, particularly clinical depression
  - History of alcohol and substance abuse
  - Feelings of hopelessness
  - Impulsive or aggressive tendencies
  - Cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma)
  - Local epidemics of suicide
  - Isolation, a feeling of being cut off from other people
  - Barriers to accessing mental health treatment
  - Loss (relational, social, work, or financial)
  - Physical illness

- Easy access to lethal methods
- Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts
- Protective factors buffer individuals from suicidal thoughts and behavior. To date, protective factors have not been studied as extensively or rigorously as risk factors. Identifying and understanding protective factors are, however, equally as important as researching risk factors. [Protective factors include:]
  - Effective clinical care for mental, physical, and substance abuse disorders
  - Easy access to a variety of clinical interventions and support for help seeking
  - Family and community support (connectedness)
  - Support from ongoing medical and mental health care relationships
  - Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes
  - Cultural and religious beliefs that discourage suicide and support instincts for self-preservation

Source: National Institute of Mental Health. (n.d.). Suicide In America: Frequently asked questions. From <http://www.nimh.nih.gov/health/publications/suicide-faq/index.shtml> (accessed April 19, 2016).

- [The risk factors for suicidal behavior are complex.] Research suggests that people who attempt suicide differ from others in many aspects of how they think, react to events, and make decisions. There are differences in aspects of memory, attention, planning, and emotion, for example. These differences often occur along with disorders like depression, substance use, anxiety, and psychosis.
- Sometimes suicidal behavior is triggered by events such as personal loss or violence. In order to be able to detect those at risk and prevent suicide, it is crucial that we understand the role of both long-term factors—such as experiences in childhood—and more immediate factors like mental health and recent life events. Researchers are also looking at how genes can either increase risk or make someone more resilient to loss and hardships.
- Many people have some of these risk factors but do not attempt suicide. Suicide is not a normal response to stress. It is, however, a sign of extreme distress, not a harmless bid for attention.
- Men are more likely to die by suicide than women, but women are more likely to attempt suicide. Men are more likely to use deadlier methods, such as firearms or suffocation. Women are more likely than men to attempt suicide by poisoning.

Source: Centers for Disease Control and Prevention. (2015). Suicide facts at a glance. From <http://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf> (accessed April 19, 2016).

- Based on data about suicides in 16 National Violent Death Reporting System states in 2010, 33.4% of suicide decedents tested positive for alcohol, 23.8% for antidepressants, and 20.0% for opiates, including heroin and prescription pain killers.
  - Original source: Parks S. E., Johnson, L. L., McDaniel, D. D., and Gladden, M. (2014). Surveillance for Violent Deaths – National Violent Death Reporting System, 16 states, 2010. *MMWR*, 63(ss01), 1-33. From

<http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm> (accessed April 19, 2016).

### Impact of Suicide on Families and Loved Ones

Source: Centers for Disease Control and Prevention. (2015, June 10). Suicide and suicide attempts take an enormous toll on society. From <http://www.cdc.gov/violenceprevention/suicide/consequences.html> (accessed April 19, 2016).

- A survivor of suicide is a family member or friend of a person who died by suicide.
- Surviving the loss of [a] loved one to suicide is a risk factor for suicide.
  - Original source: Brent, D. (2010). What family studies teach us about suicidal behavior: implications for research, treatment, and prevention. *European Psychiatry*, 25(5), 260–263.
- Surviving family members and close friends are deeply impacted by each suicide and experience a range of complex grief reactions including, guilt, anger, abandonment, denial, helplessness, and shock.
  - Original source: Jordan, J. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide and Life-Threatening Behavior*, 31(1), 91–102.
- No exact figure exists, but it is estimated that a median of between 6 and 32 survivors exist for each suicide, depending on the definition used.
  - Original source: Berman, A. L. (2011). Estimating the population of survivors of suicide: Seeking an evidence base. *Suicide and Life-Threatening Behavior*, 41(1), 110–116.
- According to another estimate, approximately 7% of the U.S. population knew someone who died of suicide during the past 12 months.
  - Original source: Crosby A. E. and Sacks, J. J. (2002). Exposure to suicide: Incidence and association with suicidal ideation and behavior – United States, 1994. *Suicide and Life-Threatening Behavior*, 32(3), 321–328.

Source: Tal Young, I., Iglewicz, A., Glorioso, D., Lanouette, N., Seay, K., Ilapakurti, M., et al. (2012). Suicide bereavement and complicated grief. *Dialogues in Clinical Neuroscience*, 14(2), 177–186.

- [This article describes the epidemiology and circumstances of suicide and reviews the current state of research on suicide bereavement, complicated grief in suicide survivors, and grief treatment for survivors of suicide.]
- [Losing a loved one to suicide is one of life’s most painful experiences]. The feelings of loss, sadness, and loneliness experienced after any death of a loved one are often magnified in suicide survivors by feelings of guilt, confusion, rejection, shame, anger, and the effects of stigma and trauma.
- Furthermore, survivors of suicide loss are at higher risk of developing major depression, post-traumatic stress disorder, and suicidal behaviors, as well as a prolonged form of grief called complicated grief.

- Added to the burden is the substantial stigma, which can keep survivors away from much needed support and healing resources. Thus, survivors may require unique supportive measures and targeted treatment to cope with their loss.

Source: de Groot, M., & Kollen, B. J. (2013). Course of bereavement over 8–10 years in first degree relatives and spouses of people who committed suicide: Longitudinal community based cohort study. *BMJ*, 347, f5519.

- [This longitudinal cohort study involved a community-based sample located in the northern part of the Netherlands with 153 first-degree relatives and spouses of 74 people who had committed suicide. The researchers assessed complicated grief, depression, and suicide ideation at 2.5 months, 13 months, and 96–120 months (8–10 years) by means of self-report questionnaires.]
- Complicated grief, depression, and suicide ideation were mutually associated in relatives and spouses of people who had committed suicide.
- A history of attempted suicide was associated with long term suicide ideation.
- Depression was more likely to be predicted by female sex and low mastery [the general degree to which a person experiences control over what goes on in his or her life], whereas complicated grief was more likely to be predicted by the trauma of losing a child.
- The risk of both complicated grief and depression decreased over time.

#### Effects of Prejudice and Discrimination Related to Suicide on Individuals and Loved Ones

Source: Tadros, G., & Jolley, D. (2001). The stigma of suicide. *The British Journal of Psychiatry*, 179(2), 178.

- Suicide was tolerated by the Greeks and Romans, but Aristotle argued that suicide weakens the economy and upsets the gods, and in so-doing he initiated [stigmatization] of the act.
- Hinduism and Buddhism, among other Eastern religions, have not had a traditionally negative view of suicide.
- In the Judaeo-Christian tradition, stigma against suicide is not evident until the fourth century;
- Gradually, the stigma against suicide intensified in Europe and became a great sin, shame and eventually a crime.
- A number of philosophers and writers including William Shakespeare sought to encourage a more understanding and compassionate view but this movement had little impact before Durkheim's studies made clear the social rather than moral origins of suicide.
- The stigma surrounding suicide remains just high enough to discourage people—especially the elderly—from talking about their suicidal thoughts. Some people feel that they might be [labeled] as weak, lacking faith, coming from bad families or indeed 'mad' if they were to declare their suicidal thoughts. This does not help when we are trying to detect early signs of suicide or reaching out to help victims of despair.

- Any approach to prevent suicide should include the removal of blame and [stigmatization] of that individual and his or her family. One would hope that all teachers and professionals from the different faiths will take into account this insight into the condition. Scientific approaches and spiritual approaches can work together in order to eliminate this kind of stigma and to make people more comfortable in trying to seek help in their moments of despair.

#### Rates of Suicidal Thoughts and Attempts

Source: SAMHSA. (2015, October 13). Suicide prevention. From <http://www.samhsa.gov/suicide-prevention> (accessed April 19, 2016).

- Suicidal thoughts are a significant concern. Having serious thoughts of suicide increases the risk of a person making an actual suicide attempt.

Source: Lipari, R., Piscopo, K., Kroutil, L. A., & Miller, G. K. (2015, September). Suicidal thoughts and behaviors among adults: Results from the 2014 National Survey of Drug Use and Health. *NSDUH Data Review*.

- In 2014, 9.4 million adults aged 18 or older thought seriously about trying to kill themselves in the past 12 months, including 2.7 million who made suicide plans and 1.1 million who made a nonfatal suicide attempt, according to data from the National Survey on Drug Use and Health (NSDUH).
- [Overall] 3.9 percent of adults in 2014 who had serious thoughts of suicide, 1.1 percent who made suicide plans, and 0.5 percent who attempted suicide in the past year.
- These percentages for suicidal thoughts, suicide plans, and suicide attempts among adults aged 18 or older were stable between 2008 and 2014.

#### Impact of Suicide Attempts on Individuals, Families, and Loved Ones

Source: Communities Addressing Suicide Together, Canadian Mental Health Association. (2013). Suicide attempt survivors. From <http://cast-cmhans.com/suicide-attempt-survivors/> (accessed April 19, 2016).

- A suicide attempt can often be a traumatic experience, but it can also be a catalyst for positive change.
- Keep in mind that the majority of attempt survivors do get the help and support they need and end up leading meaningful, fulfilling lives.
- If you are a suicide attempt survivor, know that you are not alone. Also know that you can, and will, get through this. Find the support you need to address the underlying pain related to your suicide attempt. Know that help is available.
- Please keep in mind that there is no 'right way to feel' after a suicide attempt. Your emotions and thoughts are all valid.
- Remember that there is nothing inherently bad about you because you attempted suicide. You have been in a considerable amount of pain and were looking to find relief.
- Know however, that there are other ways to overcome the pain. Support is available.

- After a suicide attempt, survivors are often unsure of where to turn or what to say to others. As a result, they may feel isolated and alone.
- It can be challenging to tell others about a suicide attempt because suicide is a topic of taboo in our society. You might be concerned about how people will react or what they might think of you.
- It is important for you to decide the right time to tell others, as well as who you should tell, regarding your suicide attempt. That being said, survivors often feel a sense of relief when disclosing their attempt to loved ones.
- Reaching out to others and talking about your experience is an important step in healing. Another important step is seeking help to address the underlying pain.
- As mentioned above, a suicide attempt is a traumatic experience but it can also be a catalyst for change. This can be a chance to get help, recover, and find meaning in your life.
- Perhaps you have been feeling this way for so long that you cannot even imagine a different reality. Please know that the way you are feeling now can change.
- Hearing stories of people that have survived a suicide attempt and found meaning in their lives can be a helpful part of the healing process.

#### Resources for People With Thoughts of Suicide, Those Who Have Made Attempts, and Their Loved Ones

Source: SAMHSA. (n.d.). National Suicide Prevention Lifeline. From <http://www.suicidepreventionlifeline.org/> (accessed April 19, 2016).

- [Calling 1-800-273-TALK (8255) connects people to a skilled, trained counselor at a local crisis center, anytime. This counselor will listen to your problems and tell you about mental health services in your area. Calls are free and confidential.]

Source: SAMHSA. (n.d.). Behavioral Health Treatment Services Locator. From <https://findtreatment.samhsa.gov/> (accessed April 19, 2016).

- [This website provides] an on-line source of information for persons seeking treatment facilities in the United States or U.S. Territories for substance abuse/addiction and/or mental health problems.

Source: SAMHSA. (2012, August). Stories of hope and recovery: A video guide for suicide attempt survivors. From <http://store.samhsa.gov/product/Stories-Of-Hope-And-Recovery-A-Video-Guide-for-Suicide-Attempt-Survivors/SMA12-4711DVD> (accessed April 19, 2016).

- [This video] features inspiring stories from three people who survived an attempted suicide. Told through their voices and those of their families, the stories recount their journeys from the suicide attempt to a life of hope and recovery. [This resource] includes a video guide.

Source: SAMHSA. (2009, January). *A guide for taking care of your family member after treatment in the emergency department: After an attempt*. From <http://store.samhsa.gov/product/A-Guide-for-Taking-Care-of-Your-Family-Member-After-Treatment-in-the-Emergency-Department/SMA08-4357> (accessed April 19, 2016).

- [This resource] aids family members in coping with the aftermath of a relative's suicide attempt. [It] describes the emergency department treatment process, lists questions to ask about follow-up treatment, and describes how to reduce risk and ensure safety at home.

Source: SAMHSA. (2006, January). *A guide for taking care of yourself after your treatment in the emergency department: After an attempt*. From <http://store.samhsa.gov/product/A-Guide-for-Taking-Care-of-Yourself-After-Your-Treatment-in-the-Emergency-Department/SMA08-4355> (accessed April 19, 2016).

- [This resource] gives support for people recovering from a suicide attempt. [It] discusses how to move ahead after emergency department treatment for a suicide attempt and how to cope with thoughts of suicide. [It] lists information resources about suicide and mental illness.

Source: Clinic Community Health Center and the Canadian Association for Suicide Prevention. (2012, September). *After a suicide attempt: A guide for family and friends*. From <https://www.torontodistresscentre.com/sites/torontodistresscentre.com/files/CASP-After-Suicide-Attempt-12-1575.pdf> (accessed April 19, 2016).

- [This resource offers guidance for the family and friends of someone who has attempted suicide. It provides information on what will happen at the hospital, your loved one's rights, and your rights; an understanding of what is happening for someone struggling with thoughts of suicide; tips on how you can help and support someone who is struggling; ways to take care of yourself during this difficult time; and a list of resources and references.]

Source: Lezine, D. (2014, April 30). Moving forward with attempt survivors. Suicide Prevention Resource Center. From <http://www.sprc.org/directorsblog/moving-forward-attempt-survivors> (accessed April 19, 2016).

- [This online article discusses the suicide attempt survivor grassroots movement to form a community for recovery and to encourage people to talk about their attempts.]

### Resources for Professionals

Source: SAMHSA. (2015, October 13). Suicide prevention. From <http://www.samhsa.gov/suicide-prevention> (accessed April 19, 2016).

- Most people who die by suicide had seen a health care provider in the year prior to their suicide. Further, many people visited a health care provider in the month prior to their suicide. Screening and assessing for suicide risk is an important aspect of suicide prevention. Available screening tools include:
- [SAFE-T \(Suicide Assessment Five-Step Evaluation and Triage\) – 2009](#), developed for mental health professionals, identifies risk and protective factors, inquires about suicidal thoughts, determines risk levels, and makes recommendations for intervention and follow-up.
- [Patient Health Questionnaire \(PHQ-9\)—2005 \(PDF | 484 KB\)](#) is the most common screening tool to identify depression. Question 9 screens for suicide.

- [Columbia-Suicide Severity Rating Scale \(C-SSRS\) – 2008 \(DOCX | 21 KB\)](#) (link is external) assesses for suicide risk.
- [Suicide Behaviors Questionnaire \(SBQ-R\)—2001 \(PDF | 45 KB\)](#) assesses suicide-related thoughts and behaviors.
- [Suicidal Ideation Questionnaire \(SIQ\)](#) (link is external) assesses the frequency of suicidal thoughts in adolescents and may be used to evaluate or monitor troubled youths.

Source: SAMHSA. (2006, January). *A guide for medical providers in the emergency department taking care of suicide attempt survivors: After an attempt*. From <http://store.samhsa.gov/product/A-Guide-for-Medical-Providers-in-the-Emergency-Department-Taking-Care-of-Suicide-Attempt-Survivors/SMA08-4359> (accessed April 19, 2016).

- [This document] gives professional care providers tips to enhance emergency department treatment for people who have attempted suicide. [It] discusses the assessment, communicating with family and with other treatment providers, and HIPAA [Health Insurance Portability and Accountability Act. [It] lists additional resources.

Source: SAMHSA. (2015, September). *TIP 50: Addressing suicidal thoughts and behaviors in substance abuse treatment*. From <http://store.samhsa.gov/product/TIP-50-Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/SMA15-4381> (accessed April 19, 2016).

- [This document] provides guidelines to help substance abuse treatment counselors work with suicidal adult clients. [It] covers risk factors and warning signs for suicide, core counselor competencies, clinical vignettes, and information for administrators and clinical supervisors.
- [The video companion is available at <http://store.samhsa.gov/product/TIP-50-Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/VA10-TIP50>.]

Source: SAMHSA. (2013, November). *Addressing suicidal thoughts and behaviors in substance abuse treatment: Quick guide for clinicians based on TIP 50*. From <http://store.samhsa.gov/product/Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment-Quick-Guide-for-Clinicians-Based-on-TIP-50/SMA13-4793> (accessed April 19, 2016).

- [This document] equips clinicians and other service providers a quick reference guide to addressing suicide and suicide prevention in clients with substance use disorders. [It] covers risk factors and warning signs for suicide, core competencies, and information for administrators and clinical supervisors.

Source: SAMHSA. (2013, November). *Addressing suicidal thoughts and behaviors in substance abuse treatment: Quick guide for administrators based on TIP 50*. From <http://store.samhsa.gov/product/Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment-Quick-Guide-for-Administrators-Based-on-TIP-50/SMA13-4786> (accessed April 19, 2016).

- [This document] equips administrators of substance abuse treatment facilities with a quick guide to implementing programs that address suicide among clients with

substance use disorders. [It addresses] legal and ethical issues, referrals, as well as privacy and confidentiality.

Source: SAMHSA. (2009, January). *TIP 48: Managing depressive symptoms in substance abuse clients during early recovery*. From <http://store.samhsa.gov/product/TIP-48-Managing-Depressive-Symptoms-in-Substance-Abuse-Clients-During-Early-Recovery/SMA13-4353> (accessed April 19, 2016).

- [This document] gives substance abuse counselors guidelines for treating clients with symptoms of depression and alcohol abuse or drug abuse problems. [It] covers screening, assessment, treatment, counseling, cultural competence, and continuing care. [It] tells program administrators how to integrate depression treatment into early drug treatment.

Source: SAMHSA. (2009, July). *A guide for funeral directors: Supporting survivors of a suicide loss*. From <http://store.samhsa.gov/product/A-Guide-for-Funeral-Directors-Supporting-Survivors-of-Suicide-Loss/SMA09-4375> (accessed April 19, 2016).

- [This document] guides funeral directors in supporting survivors of suicide loss. [It] explains what is different about suicide death, what survivors may feel, the stigma and discrimination of suicide, how to show sensitivity, and steps to manage stress and burnout.

## **Panel 2: Promoting Recovery for People Who Have Attempted and Those Bereaved by Suicide**

### **Key Questions**

1. **What are the treatment and support needs for individuals who have attempted suicide? What are the support needs for their family members and loved ones?**
2. **What are some research-based practices to support people who have attempted suicide?**
3. **What are some resources to promote recovery—particularly wellness and a sense of purpose—among people who have attempted suicide? What is *A Journey Toward Health and Hope*, and how does it provide guidance to people who have survived a suicide attempt?**
4. **How does family play a crucial role in supporting recovery?**
5. **Why is it important to support the recovery of people bereaved by suicide?**
6. **What are some efforts and resources to support people bereaved by suicide?**
7. **How can family-to-family peer support help people who are bereaved by suicide?**

Treatment and Support Needs for Individuals Who Have Attempted Suicide

Source: American Foundation for Suicide Prevention. (n.d.). Treatment. From <https://www.afsp.org/preventing-suicide/treatment> (accessed April 19, 2016).

- Ninety percent of people who die by suicide have a mental disorder at the time of their deaths. One of the best ways to prevent suicide is by understanding and treating these disorders. There are biological and psychological treatments that can help address the underlying health issues that put people at risk for suicide.

### Support Needs for Family Members and Loved Ones

Source: Rappaport, N. (2012, May 9). A suicide in the family. *Psychology Today*. From <https://www.psychologytoday.com/blog/we-are-only-human/201205/suicide-in-the-family> (accessed April 19, 2016).

- The early recognition and treatment of depression and other psychiatric illness is one of the best ways to prevent suicide. If someone can get the appropriate treatment—including psychotherapy, medication, or a combination of both—and stay with it, the prognosis is actually quite good; over 80 percent of people feel better with combined treatment. It's true that some antidepressants can slightly raise the risk of suicidal thoughts and behaviors in adolescents and young adults, but suicide is far more common in people whose depression goes untreated.
- Families often struggle with how to carry on following a suicide loss and are tortured by feelings of guilt and shame. Silent grief can be overwhelming, and blaming can occur as a way to avoid sadness. It is pivotal to communicate constructively and find comforting rituals to share, such as participating in religious observations, lighting candles, or creating and keeping a memory box. When there's been a suicide in the family, parents often think it's best to hide that knowledge from their children. But studies have shown that being direct is the better approach. Avoid euphemisms, which can be confusing to children. Often families need to revisit the conversation many times as the child grows up and his level of understanding and ability to ask questions grows.

### Research-based Practices To Support People Who Have Attempted Suicide

Source: American Foundation for Suicide Prevention. (n.d.). Treatment. From <https://www.afsp.org/preventing-suicide/treatment> (accessed April 19, 2016).

- There are two proven psychotherapies for treating those who attempt suicide: cognitive behavior therapy for suicide attempters (CBT for suicide attempters) and dialectical behavioral therapy (DBT) for patients with borderline personality disorder and recurrent suicidal ideation and behaviors. Clearly [these] short term interactive therapies make a difference. The goal now is to transport evidence based treatments into community based settings.
- Research shows that teaching health care professionals to recognize and treat depression is an effective way to reduce suicide rates. [It is also important to address other behavioral health problems, including bipolar disorder and substance use disorder.]

Source: SAMHSA. (2015, June 14). SAMHSA's National Registry of Evidence-based Programs and Practices. Suicide attempt. From <http://nrepp.samhsa.gov/AdvancedSearch.aspx> (accessed April 19, 2016).

[The following are relevant interventions that have been reviewed by NREPP. SAMHSA does not recommend them specifically.]

- Assisted outpatient treatment (AOT) is the practice of delivering outpatient treatment under court order to adults with severe mental illness who are found by a judge, in consideration of prior history, to be unlikely to adhere to prescribed treatment on a voluntary basis.
- CAST (Coping And Support Training) is a high school–based suicide prevention program targeting youth 14 to 19 years old. CAST delivers life-skills training and social support in a small-group format (6–8 students per group).
- Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes.
- Dynamic Deconstructive Psychotherapy (DDP) is a 12- to 18-month, manual-driven treatment for adults with borderline personality disorder and other complex behavior problems, such as alcohol or drug dependence, self-harm, eating disorders, and recurrent suicide attempts.
- Emergency Department Means Restriction Education is an intervention for the adult caregivers of youth (aged 6 to 19 years) who are seen in an emergency department (ED) and determined through a mental health assessment to be at risk for committing suicide.
- Emergency Room Intervention for Adolescent Females is a program for teenage girls 12 to 18 years old who are admitted to the emergency room after attempting suicide. The intervention, which involves the girl and one or more family members who accompany her to the emergency room, aims to increase attendance in outpatient treatment following discharge from the emergency room and to reduce future suicide attempts.
- The Family Intervention for Suicide Prevention (FISP) is a cognitive behavioral family intervention for youth ages 10–18 who are presenting to an emergency department (ED) with suicidal ideation or after a suicide attempt.
- Lifelines is a comprehensive, [school-wide] suicide prevention program for middle and high school students. The goal of Lifelines is to promote a caring, competent school community in which help seeking is encouraged and modeled and suicidal behavior is recognized as an issue that cannot be kept secret.
- The Model Adolescent Suicide Prevention Program (MASPP) is a public health–oriented suicidal-behavior prevention and intervention program originally developed for a small American Indian tribe in rural New Mexico to target high rates of suicide among its adolescents and young adults.
- Multisystemic Therapy With Psychiatric Supports (MST-Psychiatric) is designed to treat youth who are at risk for out-of-home placement (in some cases, psychiatric hospitalization) due to serious behavioral problems and co-occurring mental health symptoms such as thought disorder, bipolar affective disorder, depression, anxiety, and impulsivity.

- Reconnecting Youth: A Peer Group Approach to Building Life Skills (RY) is a school-based prevention program for students ages 14–19 years that teaches skills to build resiliency against risk factors and control early signs of substance abuse and emotional distress.
- SOS Signs of Suicide is a secondary school–based suicide prevention program that includes screening and education. Students are screened for depression and suicide risk and referred for professional help as indicated.

Source: Suicide Prevention Resource Center. (n.d.). Section I: Evidence-based programs. From <http://www.sprc.org/bpr/section-i-evidence-based-programs> (accessed April 19, 2016).

- [This website provides links to evidence-based suicide prevention programs.]

### Resources To Promote Recovery Among People Who Have Attempted Suicide

Source: SAMHSA. (2015, October 5). Recovery and recovery support. From <http://www.samhsa.gov/recovery> (accessed April 19, 2016).

- SAMHSA has established a working definition of recovery that defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations.
- SAMHSA has delineated four major dimensions that support a life in recovery:
  - Health—overcoming or managing one’s disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being
  - Home—having a stable and safe place to live
  - Purpose—conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
  - Community—having relationships and social networks that provide support, friendship, love, and hope
- Hope, the belief that these challenges and conditions can be overcome, is the foundation of recovery. A person’s recovery is built on his or her strengths, talents, coping abilities, resources, and inherent values. It is holistic, addresses the whole person and their community, and is supported by peers, friends, and family members.
- The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. Recovery is characterized by continual growth and improvement in one’s health and wellness that may involve setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery.
- Resilience refers to an individual’s ability to cope with adversity and adapt to challenges or change. Resilience develops over time and gives an individual the capacity not only to cope with life’s challenges but also to be better prepared for the next stressful situation. Optimism and the ability to remain hopeful are essential to resilience and the process of recovery.

- Because recovery is a highly individualized process, recovery services and supports must be flexible to ensure cultural relevancy. What may work for adults in recovery may be very different for youth or older adults in recovery. For example, the promotion of resiliency in young people, and the nature of social supports, peer mentors, and recovery coaching for adolescents and transitional age youth are different than recovery support services for adults and older adults.
- The process of recovery is supported through relationships and social networks. This often involves family members who become the champions of their loved one's recovery. They provide essential support to their family member's journey of recovery and similarly experience the moments of positive healing as well as the difficult challenges. Families of people in recovery may experience adversities in their social, occupational, and financial lives, as well as in their overall quality of family life. These experiences can lead to increased family stress, guilt, shame, anger, fear, anxiety, loss, grief, and isolation. The concept of resilience in recovery is also vital for family members who need access to intentional supports that promote their health and well-being. The support of peers and friends is also crucial in engaging and supporting individuals in recovery.

Source: SAMHSA. (2015, July 2). Wellness. From <http://www.samhsa.gov/wellness> (accessed April 19, 2016).

- Wellness concerns maintaining an overall quality of life and the pursuit of optimal emotional, mental, and physical health.
- Focusing on health and wellness is particularly important for people with, or at risk for, behavioral health conditions. Behavioral health is a critical aspect of maintaining physical health and wellness.
- SAMHSA defines wellness not as the absence of disease, illness, or stress but the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness.

Source: SAMHSA. (2015, July 2). Wellness Strategies. From <http://www.samhsa.gov/wellness/strategies> (accessed April 19, 2016).

- SAMHSA practice has proven that integrating mental health, substance use, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple health care needs. Wellness strategies are best achieved by a combination of the following:
  - Follow a Healthy Lifestyle
    - Don't smoke or use addictive substances.
    - Limit alcohol intake.
    - Eat healthy foods and exercise regularly.
    - Monitor your weight, blood pressure, sleep patterns, and other important health indicators including oral (teeth and gum) health.
  - Work with a Primary Care Doctor
    - Communication between people with mental health problems, mental health professionals, and primary care providers is essential.
    - See a primary care physician regularly (at least twice a year).

- Ask Questions!
  - Know about medications or alternative treatments.
  - Review and act on results of check-ups and health screenings.
  - Monitor existing and/or new symptoms.
  - Speak up about any concerns or doubts.

Source: SAMHSA. (2012, August). Stories of hope and recovery: A video guide for suicide attempt survivors. From <http://store.samhsa.gov/product/Stories-Of-Hope-And-Recovery-A-Video-Guide-for-Suicide-Attempt-Survivors/SMA12-4711DVD> (accessed April 19, 2016).

- [This video] features inspiring stories from three people who survived an attempted suicide. Told through their voices and those of their families, the stories recount their journeys from the suicide attempt to a life of hope and recovery. [This resource] includes a video guide.

Source: SAMHSA. (2006, January). *A guide for taking care of yourself after your treatment in the emergency department: After an attempt*. From <http://store.samhsa.gov/product/A-Guide-for-Taking-Care-of-Yourself-After-Your-Treatment-in-the-Emergency-Department/SMA08-4355> (accessed April 19, 2016).

- [This resource] gives support for people recovering from a suicide attempt. [It] discusses how to move ahead after emergency department treatment for a suicide attempt and how to cope with thoughts of suicide. [It] lists information resources for suicide and mental illness.

#### *A Journey Toward Health and Hope and Its Guidance*

Source: SAMHSA. (2015, September). *A journey toward health and hope: Your handbook for recovery after a suicide attempt*. From <http://store.samhsa.gov/product/A-Journey-Toward-Health-and-Hope-Your-Handbook-for-Recovery-After-a-Suicide-Attempt/SMA15-4419> (accessed April 19, 2016).

- [This booklet] guides people through the first steps toward recovery and a hopeful future after a suicide attempt. [It] includes personal stories from survivors who share their experiences as well as strategies, such as re-establishing connections and finding a counselor to work with.
- [This booklet helps people consider what led to their attempt and shares the stories of others, which let them know that they are not alone and that it may take time for negative feelings to subside. Guidance includes:]
  - Knowing how others made it through can help you learn new ways to recover from your own suicide attempt.
  - You are not alone. You matter. Life can get better. It may be difficult, but the effort you invest in your recovery will be worth it.
- [This resource helps prepare people to talk about their attempt with others, re-establish connections with others, make a plan to stay safe, find a counselor and get what they need from therapy, and take steps toward recovery without counseling.]

- [This resource offers guidance on maintaining hope, staying in control by being organized, getting in touch with spirituality, maintaining a healthy lifestyle, taking medication, and advocating for others to support your recovery.]
- [This booklet also offers resources, including a couple of sample safety plans and places to get additional information.]

### Crucial Role of Family in Supporting Recovery

Source: Klinik Community Health Center and the Canadian Association for Suicide Prevention. (2012, September). *After a suicide attempt: A guide for family and friends*. From <https://www.torontodistresscentre.com/sites/torontodistresscentre.com/files/CASP-After-Suicide-Attempt-12-1575.pdf> (accessed April 19, 2016).

- [Family and friends can help support recovery by knowing the signs and asking whether someone is thinking about suicide. It is also helpful for loved ones to know the signs of acute risk and what to do when someone is at risk of suicide.]
- When people get to a point of thinking about suicide, it is often because they are finding it difficult to soothe themselves and manage difficult and intense emotions. Sometimes simply being with someone who is fully present and calm will help them. You do not need to fix the problem; just quietly be with them.
- Once your loved one is out of immediate danger, and if they are open to the idea, you may want to try and talk with them about what has happened.
- In order to help keep the home safe for you and your loved one:
  - Remove access to any means of suicide.
  - Keep only small quantities of alcohol, drugs or medications in the home, or none at all.
  - Give your loved one plenty of opportunities to talk about the attempt.
  - Let them know it's okay to tell someone if they feel suicidal in the future.
  - Ask them if meeting with a professional would be helpful, and encourage them to follow through with this.
  - Offer to help them connect to supports, resources, culture and/or spiritual beliefs.
  - Get support for yourself—you don't need to do this alone.
  - Have the safety plan in writing and in a place where it is accessible to you and your loved one.

### Importance of Supporting the Recovery of People Bereaved by Suicide

Source: SAMHSA. (2015, October 13). Suicide prevention. From <http://www.samhsa.gov/suicide-prevention> (accessed April 19, 2016).

- The emotional toll of a person's suicide can put surviving family, friends, and other loved ones at greater risk of dying by suicide.

Source: Klinik Community Health Center and the Canadian Association for Suicide Prevention. (n.d.). What you can do to help survivors. From

<https://www.torontodistresscentre.com/resources/what-you-can-do-help-survivors> (accessed April 19, 2016).

- [This website offers guidance on how to help suicide survivors.]
- Don't be surprised by the intensity of their feelings. Sometimes, when they least expect it, survivors may be overwhelmed by feelings of grief. Accept that survivors might struggle with explosive emotions, guilt, fear and shame—all well beyond...what is experienced with other types of death. Be patient, compassionate and understanding. Helping begins with your ability to be an active listener. Your physical presence and desire to listen without judgment are critical helping tools. Familiarize yourself with the wide spectrum of emotions that many survivors experience. Allow your family member/friend to experience all the hurt, sorrow and pain that he/she is feeling at the time.
- Respect the need to grieve. Because of the nature of the death, it is sometimes kept a secret. If the death cannot be talked about openly, the wounds of grief will go unhealed. The grief experience is unique, so be patient. The process of grief takes a long time, so allow your family member/friend to proceed at his/her own pace. Use the name of the person who has died when talking to survivors. Hearing the name can be comforting, and it confirms that you have not forgotten this important person who was so much a part of their lives.
- Other helpful hints:
  - Avoid simplistic explanations and clichés. Clichés can be extremely painful for a survivor.
  - Be aware of special occasions. Survivors may have a difficult time during occasions like holidays, anniversaries and birthdays.
  - Support groups are one of the best ways to help survivors of suicide. In a group, survivors can connect with other people who share the commonality of the experience. They are allowed and encouraged to tell their stories as much, and as often, as they like. You may be able to help survivors locate such a group. This particular effort on your part will be appreciated.

### Resources for Survivors

Source: American Association of Suicidology. From <http://www.suicidology.org/> (accessed April 19, 2016).

- [This organization addresses many aspects of suicide prevention, intervention, and survivor support. Its website has a section called "Suicide Loss Survivors," which includes newsletter articles, personal stories, and a directory of support groups for survivors of suicide loss. There is also a section for clinicians who have lost a patient and/or family member to suicide.]

Source: American Foundation for Suicide Prevention. From <http://www.afsp.org/> (accessed April 19, 2016).

- [This organization provides a wide variety of services related to suicide prevention and coping with suicide. Its website offers information for survivors of suicide loss, as well

as personal stories and a directory of support groups for the survivors. This organization provides a training program for support group facilitators and a survivor outreach program as well as sponsors the International Survivors of Suicide Day, an event where the survivor community comes together for support and healing.]

Source: Suicide Prevention Resource Center. From <http://www.sprc.org/> (accessed April 19, 2016).

- [This website provides information, training, and technical assistance related to suicide and suicide prevention. It also offers a large number of materials for survivors of suicide loss.]

Source: Suicide Prevention Resource Center. (2004). *After a suicide: Recommendations for religious services and other public memorial observances*. From <http://www.sprc.org/sites/sprc.org/files/library/aftersuicide.pdf> (accessed April 19, 2016).

- [This booklet helps community and faith leaders plan memorial observances and provide support to survivors.]

Source: American Association of Suicidology. (2003). *SOS: A handbook for survivors of suicide*. From [http://www.detrick.army.mil/asap/SOS\\_handbook.pdf](http://www.detrick.army.mil/asap/SOS_handbook.pdf) (accessed April 19, 2016).

- [This brief handbook, which is available in English and Spanish, is designed to help people who have experienced a loss by suicide cope with their emotions and questions.]

#### Family-to-Family Peer Support To Help People Who Have Attempted or Are Bereaved by Suicide

Source: Reed, J. (2013, March 8). Advancing peer support in suicide prevention. From <http://www.sprc.org/directorsblog/advancing-peer-support-suicide-prevention> (accessed April 19, 2016).

- Peer support has long been recognized as important in prevention. Those bereaved by suicide loss—that is, the family and friends of people who have died by suicide—form an essential and active part of the suicide prevention community. It is difficult to think of a major suicide prevention organization or initiative that does not include persons bereaved by suicide. Those who have lost a loved one to suicide are reaching out and supporting one another in support groups as well as providing support and advocacy for suicide prevention.

## Panel 3: Groups Particularly Affected by Suicide: Who, Why, and What Are We Doing?

### Key Questions

1. What are some groups that have higher risk of suicide than the general population?<sup>4</sup>
2. What are some special considerations regarding suicide and members of the military and veterans compared with suicide risk and the general population? What are some suicide prevention efforts and resources specifically designed for members of the military and veterans? What is the Clay Hunt Suicide Prevention for American Veterans Act?
3. What are some special considerations regarding suicide and men in mid-life and older men compared with suicide risk and the general population? What are some suicide prevention efforts and resources specifically designed for men in mid-life and older men?
4. What are some special considerations regarding suicide and people who are lesbian, gay, bisexual, and transgender (LGBT) compared with suicide risk and the general population? What are some suicide prevention efforts and resources specifically designed for people who are LGBT?
5. What are some special considerations regarding suicide and members of the Native American community compared with suicide risk and the general population? What are some suicide prevention efforts and resources specifically designed for members of the Native American community?
6. What are some special considerations regarding suicide and adolescents and young people compared with suicide risk and the general population? What are some suicide prevention efforts and resources specifically designed for adolescents and young people?

### Groups With Higher Risk of Suicide Compared With the General Population

Source: SAMHSA. (2015, October 29). Suicide prevention. From <http://www.samhsa.gov/suicide-prevention> (accessed April 19, 2016).

- Suicide touches all ages and backgrounds, all racial and ethnic groups, in all parts of the country. However, some populations are at higher risk for suicidal behavior.

Source: SAMHSA. (2014, October 9). Populations at risk for suicide. From <http://www.samhsa.gov/suicide-prevention/at-risk-populations> (accessed April 19, 2016).

---

<sup>4</sup> A discussion of the risk for suicidal thoughts and behavior among older adults, aged 65 and older, was discussed in Discussion Guide 1, *Generational Issues Affecting Recovery: From Childhood to Grandparenthood*.

- Suicide is a complex human behavior, with no single determining cause. The following groups have demonstrated a higher risk for suicide or suicide attempts than the general population:
  - American Indians and Alaska Natives
  - People bereaved by suicide
  - People in justice and child welfare settings
  - People who intentionally hurt themselves (non-suicidal self-injury)
  - People who have previously attempted suicide
  - People with medical conditions
  - People with mental and/or substance use disorders
  - People who are lesbian, gay, bisexual, or transgender
  - Members of the military and veterans
  - Men in midlife and older men

### Special Considerations—Members of the Military and Veterans

Source: Schoenbaum, M., Kessler, R. C., Gilman, S. E., Colpe, L. J., Heeringa, S. G., Stein, M. B., et al. (2014). Predictors of suicide and accident death in the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS): Results from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). *JAMA Psychiatry*, 71(5), 493–503.

- Although historically, the suicide death rates in the U.S. Army have been below the civilian rate, the suicide rate in the U.S. Army began climbing in the early 2000s, and by 2008, it exceeded the demographically-matched civilian rate (20.2 suicide deaths per 100,000 vs. 19.2).
- [The Army STARRS is the largest study of mental health risk and resilience ever conducted among U.S. military personnel.]
- [The authors examined the suicide and accident death rates in relation to basic sociodemographic and Army experience factors among the 975,057 regular Army soldiers who served between January 1, 2004, and December 31, 2009.]
- [Results indicated that suicide rates increased during this time period, even among those who had never deployed, and also found that being deployed increased suicide risk for women more than it did for men.]
- [Suicide risk still remained lower for deployed women than for deployed men.]
- [The study identified a correlation between demotion and suicide risk: Soldiers who had been demoted in the past 2 years experienced increased suicide risk, compared to those without such demotions.]
- [The findings suggested that being male, white, or of a junior enlisted rank put individuals at the highest risk of suicide.]

Source: Ursano, R. J., Kessler, R. C., Heeringa, S. G., Cox, K. L., Naifeh, J. A., Fullerton, C. S., et al. (2015). Nonfatal suicidal behaviors in U.S. Army administrative records, 2004–2009: Results from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). *Psychiatry*, 78(1), 1–21. doi: 10.1080/00332747.2015.1006512

- [The authors used the Army STARRS Historical Administrative Data Study (HADS), which integrates administrative records for all soldiers on active duty during the years 2004

- through 2009 (n = 1.66 million), to examine trends and sociodemographic correlates of suicide attempts, suspicious injuries, and suicide ideation among regular Army soldiers.]
- [The study] identified 21,740 unique regular Army soldiers with a nonfatal suicidal event documented at some point during the HADS study period. There were substantial increases in the annual incidence rates of suicide attempts (179–400/100,000 person-years) and suicide ideation (557–830/100,000 person-years), but not suspicious injuries.
  - [The researchers] found increased risk of all outcomes among those who were female, non-Hispanic White, never married, lower-ranking enlisted, less educated, and of younger age when entering Army service. These sociodemographic associations significantly differed across outcomes, despite some patterns that appear similar.

Source: Nock, M. K., Stein, M. B., Heeringa, S. G., Ursano, R. J., Colpe, L. J., Fullerton, C. S., et al. (2014). Prevalence and correlates of suicidal behavior among soldiers: Results from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). *JAMA Psychiatry*, 71(5), 514–522.

- [The researchers estimated] the lifetime prevalence and sociodemographic, Army career, and psychiatric predictors of suicidal behaviors among nondeployed US Army soldiers.
- [They used] a representative cross-sectional survey of 5428 nondeployed soldiers participating in a group self-administered survey [to examine lifetime suicidal ideation, suicide plans, and suicide attempts.]
- [Results indicated that] the lifetime prevalence estimates of suicidal ideation, suicide plans, and suicide attempts are 13.9%, 5.3%, and 2.4%.
- Most reported cases (47.0%–58.2%) had pre-enlistment onsets.
- [Post-enlistment attempts were positively related to being a woman, of lower rank, and previously deployed.]
- [Post-enlistment attempts were negatively related to being unmarried and assigned to Special Operations Command.]
- [The study found] that approximately one-third of post-enlistment suicide attempts are associated with pre-enlistment mental disorders, [which] suggests that pre-enlistment mental disorders might be targets for early screening and intervention.
- The possibility of higher fatality rates among Army suicide attempts than among civilian suicide attempts highlights the potential importance of means control (i.e., restricting access to lethal means [such as firearms]) as a suicide prevention strategy.

Source: Kessler, R. C., Heeringa, S. G., Stein, M. B., Colpe, L. J., Fullerton, C. S., Hwang, I., et al. (2014). Thirty-day prevalence of DSM-IV mental disorders among nondeployed soldiers in the US Army: Results from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). *JAMA Psychiatry*, 71(5), 504–513.

- [This study estimated] the proportions of 30-day DSM-IV mental disorders among nondeployed US Army personnel with first onsets prior to enlistment and the extent which role impairments associated with 30-day disorders differ depending on whether the disorders had pre- vs post-enlistment onsets.

- [The researchers used data from completed self-administered questionnaires and administrative records from a representative sample of 5,428 soldiers participating in the Army STARRS.]
- A total of 25.1% of respondents met criteria for any 30-day disorder (15.0% internalizing; 18.4% externalizing) and 11.1% for multiple disorders.
- A total of 76.6% of cases reported pre-enlistment age at onset of at least one 30-day disorder (49.6% internalizing; 81.7% externalizing).
- Also, 12.8% of respondents reported severe role impairment.
- Interventions to limit accession or increase resilience of new soldiers with pre-enlistment mental disorders might reduce prevalence and impairments of mental disorders in the US Army.

Source: U.S. Department of Veterans Affairs. (n.d.). Women veterans health care. From <http://www.womenshealth.va.gov/outreachmaterials/mentalhealth/suicideprevention.asp> (accessed April 19, 2016).

- People experience emotional and mental health crises in response to a wide range of situations—from difficulties in their personal relationships to the loss of a job. Women Veterans may experience challenges as a result of their military service, including readjustment issues, post-traumatic stress disorder (PTSD), Military Sexual Trauma (MST), trouble sleeping or even physical injury. It is important for Veterans, clinicians and loved ones of women Veterans to understand the risk of suicide and recognize the warning signs.

Source: U.S. Department of Veterans Affairs. (2015, August 13). Traumatic brain injury and PTSD. National Center for PTSD. From [http://www.ptsd.va.gov/public/problems/traumatic\\_brain\\_injury\\_and\\_ptsd.asp](http://www.ptsd.va.gov/public/problems/traumatic_brain_injury_and_ptsd.asp) (accessed April 19, 2016).

- Traumatic brain injury (TBI) occurs from a sudden blow or jolt to the head. Brain injury often occurs during some type of trauma, such as an accident, blast, or a fall.
- Often when people refer to TBI, they are mistakenly talking about the symptoms that occur following a TBI. Actually, a TBI is the injury, not the symptoms. Symptoms that result from TBI are known as post-concussion syndrome (PCS).
- [Symptoms include: headache, trouble sleeping, memory problems, trouble focusing, poor judgment and acting without thinking, depression, and outbursts of anger.]
- Because TBI is caused by trauma and there is symptom overlap, it can be hard to tell what the underlying problem is. In addition, many people who get a TBI also develop PTSD.
- The conflicts in Afghanistan and Iraq (OEF/OIF [Operation Enduring Freedom /Operation Iraqi Freedom]) have resulted in increased numbers of Veterans who have TBI.
- Veterans seem to have symptoms for longer than civilians. Some studies show most will still have symptoms 18–24 months after the TBI. Also, many Veterans have more than one medical problem, including: PTSD, chronic pain, or substance abuse. From 60–80% of service members who are hurt in other ways by a blast may have a TBI. These other problems make it harder to get better from any single problem.

## Suicide Prevention Efforts and Resources—Members of the Military and Veterans

Source: U.S. Department of Veterans Affairs. (n.d.). Veterans Crisis Line. From <http://www.veteranscrisisline.net/> (accessed April 19, 2016).

- The Veterans Crisis Line connects Veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs responders through a confidential toll-free hotline, online chat, or text. Veterans and their loved ones can call **1-800-273-8255** and **Press 1**, chat online, or send a text message to **838255** to receive confidential support 24 hours a day, 7 days a week, 365 days a year. Support for deaf and hard of hearing individuals is available.

Source: U.S. Department of Veterans Affairs. (n.d.). Veterans Crisis Line: Resources. From <http://www.veteranscrisisline.net/Resources/Default.aspx> (accessed April 19, 2016).

- [This website offers materials for print or the web to show support for our Veterans, information on support available for homeless Veterans, and resources for Veterans and their loved ones from the Department of Veterans Affairs, military, and civilian communities.]
- [MakeTheConnection.net](http://www.maketheconnection.net)—connects Veterans and their friends and family members with information, resources, and solutions to issues affecting their health, well-being, and everyday lives. Hear inspiring stories of strength. Learn what has worked for other Veterans. Discover positive steps you can take—all in the words of Veterans just like you.

Source: U.S. Department of Veterans Affairs. (2015, October 22). Mental health: Suicide prevention. From [http://www.mentalhealth.va.gov/suicide\\_prevention/](http://www.mentalhealth.va.gov/suicide_prevention/) (accessed April 19, 2016).

- The responders at the Veterans Crisis Line are specially trained and experienced in helping Veterans of all ages and circumstances—from those coping with mental health issues that were never addressed to recent Veterans dealing with relationships or the transition back to civilian life.
- Since its launch in 2007, the Veterans Crisis Line has answered more than 1.86 million calls and made more than 50,000 lifesaving rescues. In 2009, the Veterans Crisis Line added an anonymous online chat service and has engaged in more than 240,000 chats. In November 2011, the Veterans Crisis Line introduced a text-messaging service to provide another way for Veterans to connect with confidential, round-the-clock support, and since then has responded to more than 39,000 texts.

Source: SAMHSA's National Registry of Evidence-based Programs and Practices. (2015, June 14). From <http://www.samhsa.gov/nrepp> (accessed April 25, 2016).

[The following are relevant interventions that have been reviewed by NREPP. SAMHSA does not recommend them specifically.]

- Kognito Family of Heroes is a 1-hour, online role-playing training simulation for military families of servicemembers recently returned from deployment (within the past 4 years). The training is designed to: (1) increase awareness of signs of postdeployment stress, including posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), depression, and suicidal ideation, and (2) motivate family members to access mental health services when they show signs of postdeployment stress.
- The United States Air Force Suicide Prevention Program (AFSPP) is a population-oriented approach to reducing the risk of suicide. The Air Force has implemented 11 initiatives aimed at strengthening social support, promoting development of social skills, and changing policies and norms to encourage effective help-seeking behaviors.
- Eye Movement Desensitization and Reprocessing (EMDR) is a one-on-one form of psychotherapy that is designed to reduce trauma-related stress, anxiety, and depression symptoms associated with posttraumatic stress disorder (PTSD) and to improve overall mental health functioning. [There is no evidence that this treatment reduces suicidal behavior.] Treatment is provided by an EMDR therapist, who first reviews the client's history and assesses the client's readiness for EMDR.

Source: SAMHSA. (2015, June 4 ). Service Members, Veterans, and Their Families Technical Assistance (SMVF TA) Center. From <http://www.samhsa.gov/smvf-ta-center> (accessed April 19, 2016).

- The SMVF TA Center works with states and territories to strengthen their behavioral health systems for service members, veterans, and their families.

Source: SAMHSA. (2014, September 30). SAMHSA's efforts to support veterans and military families. From <http://www.samhsa.gov/veterans-military-families/samhsas-efforts> (accessed April 19, 2016).

- SAMHSA provides technical assistance, consultation, and training to address the behavioral health needs of America's military members and their families.

Source: SAMHSA. (2015, July 2). Publications and resources on veterans and military families. From <http://www.samhsa.gov/veterans-military-families/publications-resources> (accessed April 19, 2016).

- [Behavioral Health Issues Among Afghanistan and Iraq U.S. War Veterans—2012](#)
- [Coming Home: Supporting Military Service Members, Veterans, and Their Families \[webcast\]—2012](#)
- [Military Families: Access to Care for Active Duty, National Guard, Reserve, Veterans, Their Families and Those Close to Them \[webcast\]—2011](#)
- [SAMHSA News: Paving the Road Home: Returning Veterans and Behavioral Health—2008](#)
- [SAMHSA News: What Military Patients Want Civilian Providers to Know—2011](#)

Source: Real Warriors Campaign. (n.d.). From <http://www.realwarriors.net/> (accessed April 19, 2016).

- [This organization] is focused on combating discrimination associated with seeking care and treatment for psychological health concerns.

Source: U.S. Department of Veterans Affairs. (2015, October 22). Suicide prevention: Educational materials. From [http://www.mentalhealth.va.gov/suicide\\_prevention/index.asp](http://www.mentalhealth.va.gov/suicide_prevention/index.asp) (accessed April 19, 2016).

- [This website provides links to a range of resources for members of the military and their families regarding suicide.]

### The Clay Hunt Suicide Prevention for American Veterans Act

Source: The White House Blog. (2015, February 12). The Clay Hunt Act: What the President just signed. From <http://www.whitehouse.gov/blog/2015/02/12/clay-hunt-act-what-president-just-signed> (accessed April 19, 2016).

- The new suicide prevention law (signed February 12, 2015)—the Clay Hunt Act—will:
  - Require annual third-party evaluations of VA’s mental health care and suicide prevention programs;
  - Create a centralized website with resources and information for veterans about the range of mental health services available from the VA; and
  - Require collaboration on suicide prevention efforts between VA and nonprofit mental health organizations.

### Special Considerations—Men in Mid-life/Older Men

Source: Centers for Disease Control and Prevention (CDC). (2013, May 3). Suicide among adults aged 35–64 years—United States, 1999–2010. *Morbidity and Mortality Weekly Report*, 62(17), 321–325. From <http://www.cdc.gov/mmwr/pdf/wk/mm6217.pdf> (accessed April 19, 2016).

- Traditionally, suicide prevention efforts have been focused mostly on youths and older adults, but recent evidence suggests that there have been substantial increases in suicide rates among middle-aged adults in the United States.
- To investigate trends in suicide rates among adults aged 35–64 years over the last decade, CDC analyzed National Vital Statistics System (NVSS) mortality data from 1999–2010. Trends in suicide rates were examined by sex, age group, race/ethnicity, state and region of residence, and mechanism of suicide.
- The results of this analysis indicated that the annual, age-adjusted suicide rate among persons aged 35–64 years increased 28.4%, from 13.7 per 100,000 population in 1999 to 17.6 in 2010.
- Among racial/ethnic populations, the greatest increases were observed among American Indian/Alaska Natives (AI/ANs) (65.2%, from 11.2 to 18.5) and whites (40.4%, from 15.9 to 22.3).
- By mechanism, the greatest increase was observed for use of suffocation (81.3%, from 2.3 to 4.1), followed by poisoning (24.4%, from 3.0 to 3.8) and firearms (14.4%, from 7.2 to 8.3).

- The findings underscore the need for suicide preventive measures directed toward middle-aged populations.

Source: Centers for Disease Control and Prevention. (2015). Suicide facts at a glance. From <http://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf> (accessed April 19, 2016).

- In 2011, middle-aged adults accounted for the largest proportion of suicides (56%), and from 1999–2010, the suicide rate among this group increased by nearly 30%.

Source: SAMHSA. (2014, August 7). *The DAWN report: Emergency department visits for drug-related suicide attempts among middle-aged adults aged 45 to 64*. From <http://archive.samhsa.gov/data/2k14/DAWN154/sr154-suicide-attempts-2014.pdf> (accessed April 19, 2016).

[According to data from the Drug Abuse Warning Network (DAWN):]

- From 2005 to 2011, emergency department (ED) visits involving drug-related suicide attempts among patients aged 45 to 64 doubled (from 28,802 visits in 2005 to 58,775 visits in 2011).
- Drug-related ED visits involving suicide attempts among patients aged 45 to 64 doubled for both males (from 12,756 visits in 2005 to 25,587 visits in 2011) and females (from 15,942 visits in 2005 to 33,188 visits in 2011).
- In 2011, the majority of drug-related ED visits involving suicide attempts among patients aged 45 to 64 involved prescription drugs and over-the-counter medications, such as anti-anxiety and insomnia medications (48 percent), pain relievers (29 percent), and antidepressants (22 percent).
- In 2011, 22 percent (12,887 visits) of drug-related ED visits involving suicide attempts among patients aged 45 to 64 did not result in follow-up care.

Source: American Foundation for Suicide Prevention. (n.d.). Facts and figures. From <http://helpsavinglives.com/2015/07/02/facts-and-figures/> (accessed April 19, 2016).<sup>5</sup>

- [According to information from the Centers for Disease Control and Prevention:] In 2013, the highest suicide rate (19.1) was among people 45 to 64 years old. The second highest rate (18.6) occurred in those 85 years and older. For many years, the suicide rate has been about 4 times higher among men than among women. In 2013, men had a suicide rate of 20.2, and women had a rate of 5.5. Of those who died by suicide in 2013, 77.9% were male and 22.1% were female.

---

<sup>5</sup> A discussion of the risk for suicidal thoughts and behavior among older adults, aged 65 and older, was discussed in Discussion Guide 1, *Generational Issues Affecting Recovery: From Childhood to Grandparenthood*.

Source: American Foundation for Suicide Prevention. (n.d.). Understanding recent changes in suicide rates among the middle-aged. From <http://afsp.org/about-suicide/suicide-statistics/> (accessed April 25, 2015).

- While suicide is relatively uncommon, the suicide rate for middle aged white men has gone up since 1979, and the same is true for middle aged white women since 2000. Is it something about “baby boomers,” middle age or both? It turns out that this group of “baby boomers” has had higher rates of suicide across their lives. Being unmarried and not having a college degree added risk.
- [According to the research of Dr. Julie Phillips,] “baby boomers” have had higher rates of suicide across their lifespan when compared to groups as far back as 1935.
- She found that rates were higher for unmarried men and women as well as for married women between the ages of 40–49. This showed that there were separate effects for age and for marital status. For all current middle agers, education was also related to suicide rates with rates highest for those who had a high school diploma or less.
- Middle age is a time of increased rates of suicide for everyone but especially for those in the current group. This cohort has experienced increased rates of depression and anxiety, increasing economic strain and more chronic illness, all of which can contribute to suicide risk. Knowing this affords us the opportunity to develop interventions such as raising awareness of effective treatment options and educating physicians on mental health risks associated with chronic illness.

Source: Cornwell, Y. (2011). Suicide in older adults: Management and prevention. PsychCentral. (Reprinted from *Psychiatric Times*, 2007.) From <http://pro.psychcentral.com/suicide-in-older-adults-management-and-prevention/00230.html#> (accessed April 19, 2016).

- The United States is somewhat atypical in that suicide rates for women peak at midlife and remain stable thereafter, while the suicide rates for men rise dramatically through old age. The risk is particularly great for white men. Rates of suicide among African Americans peak in young adulthood, drop somewhat through midlife, remain stable to about age 70, and then rise again; at each point, however, the rate remains lower than that of whites. Just as for younger persons, older adults who are married are at lower risk for suicide than those who are single, separated, divorced, or widowed.
- Older adults who take their own lives typically do so in the midst of active psychiatric illness.
- High neuroticism and low openness to experience (preference for the routine and familiar, a constricted range of intellectual interests, and blunted affective and hedonic responses) have been associated with completed suicides in older adults. An introverted style that prevents the development of support networks to mobilize in times of need may also be a factor.
- Physical illness may increase the risk of suicide in older people, even when the effects of depression are accounted for.
- Life events tend to cluster in the days and weeks before suicide in older adults just as for younger persons. The events tend to be those associated with aging, such as bereavement, other interpersonal losses, and social isolation.
- Studies show significantly greater impairment in the conduct of instrumental and basic activities of daily living for suicide decedents than for controls.

- Having a rich social support network, and, in particular, friends or relatives in whom one can confide is associated with lower suicide risk. Similarly, religious practice and higher ratings on spiritual values are associated with lower suicide rates.

Source: Case, A., & Deaton, A. (2015). Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century. *Proceedings of the National Academy of Sciences of the United States of America*. Advance online publication. doi: 10.1073/pnas.1518393112

- This paper documents a marked increase in the all-cause mortality of middle-aged white non-Hispanic men and women in the United States between 1999 and 2013.
- This change reversed decades of progress in mortality and was unique to the United States; no other rich country saw a similar turnaround.
- The midlife mortality reversal was confined to white non-Hispanics; black non-Hispanics and Hispanics at midlife, and those aged 65 and above in every racial and ethnic group, continued to see mortality rates fall.
- This increase for whites was largely accounted for by increasing death rates from drug and alcohol poisonings, suicide, and chronic liver diseases and cirrhosis.
- Although all education groups saw increases in mortality from suicide and poisonings, and an overall increase in external cause mortality, those with less education saw the most marked increases.
- Rising midlife mortality rates of white non-Hispanics were paralleled by increases in midlife morbidity. Self-reported declines in health, mental health, and ability to conduct activities of daily living, and increases in chronic pain and inability to work, as well as clinically measured deteriorations in liver function, all point to growing distress in this population.
- Although the epidemic of pain, suicide, and drug overdoses preceded the financial crisis, ties to economic insecurity are possible. After the productivity slowdown in the early 1970s, and with widening income inequality, many of the baby-boom generation are the first to find, in midlife, that they will not be better off than were their parents.

#### Suicide Prevention Efforts and Resources—Men in Mid-life/Older Men

Source: Canadian Mental Health Association. (2007, April). Men and suicide. Part 1: Risk factors. Centre for Suicide Prevention. From <https://suicideinfo.ca/LinkClick.aspx?fileticket=2XdwKwf1lwA%3d&tabid=538> (accessed April 19, 2016).

- A fact sheet on the incidence of suicide among men, risk factors, and the reluctance of men to seek help.

Source: Canadian Mental Health Association. (2007, December). Men and suicide. Part II: Encouraging help-seeking and the promise of social support. Centre for Suicide Prevention. From <https://suicideinfo.ca/LinkClick.aspx?fileticket=xRlem-wXleQ%3d&tabid=538> (accessed April 19, 2016).

- This newsletter issue describes the recent research studies on men seeking help and on the role of family and friends.

Source: Caine, E. D. (2003). Preventing suicide, attempted suicide, and their antecedents among men in the middle years of life (ages 25–54 years). Center for the Study and Prevention of Suicide. From [http://www.sprc.org/sites/sprc.org/files/library/middle\\_years.pdf](http://www.sprc.org/sites/sprc.org/files/library/middle_years.pdf) (accessed April 19, 2016).

- Executive Summary of a Scientific Consensus Conference developed by the UR [University of Rochester] Center for the Study and Prevention of Suicide, 11–12 June 2003, Washington, D.C. Sponsored by a R13 Meeting Grant from NIMH [National Institute of Mental Health], NIAAA [National Institute on Alcohol Abuse and Alcoholism], NIDA [National Institute on Drug Abuse], NINR [National Institute of Nursing Research], CDC [Centers for Disease Control and Prevention], with contributions from Forest Laboratories and the Pfizer Co.

Source: Cloutier, C. (2015, May 29). New suicide prevention website targets middle-aged men. *Boston Globe*. From <https://www.bostonglobe.com/metro/2015/05/29/new-suicide-prevention-website-targets-middle-aged-men/cRLzUSMUPgRBtpndxXbkZO/story.html> (accessed April 19, 2016).

- The website, called MassMen.org, has three buttons: a mental health screening, a directory of local suicide prevention organizations, and ManTherapy, a tongue-in-cheek take on virtual counseling. Launched in March, the site is part of a statewide initiative to curb the increasing number of suicides by middle-aged men in Massachusetts in recent years. Services on the website are free and allow for users to remain anonymous.

### Special Considerations—LGBT Adults and LGBT and Questioning Youth

Source: Centers for Disease Control and Prevention. (2014, November 12). Lesbian, gay, bisexual, and transgender health. From <http://www.cdc.gov/lgbthealth/youth.htm> (accessed April 19, 2016).

- Most lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth are happy and thrive during their adolescent years. Going to a school that creates a safe and supportive learning environment for all students and having caring and accepting parents are especially important. This helps all youth achieve good grades and maintain good mental and physical health. However, some LGBTQ youth are more likely than their heterosexual peers to experience difficulties in their lives and school environments, such as violence.
- Negative attitudes toward lesbian, gay, and bisexual (LGB) people put these youth at increased risk for experiences with violence, compared with other students. Violence can include behaviors such as bullying, teasing, harassment, physical assault, and suicide-related behaviors.
- LGBTQ youth are also at increased risk for suicidal thoughts and behaviors, suicide attempts, and suicide. A nationally representative study of adolescents in grades 7–12 found that lesbian, gay, and bisexual youth were more than twice as likely to have

- attempted suicide as their heterosexual peers. More studies are needed to better understand the risks for suicide among transgender youth. However, one study with 55 transgender youth found that about 25% reported suicide attempts.
- Another survey of more than 7,000 seventh- and eighth-grade students from a large Midwestern county examined the effects of school [social] climate and homophobic bullying on lesbian, gay, bisexual, and questioning (LGBQ) youth and found that
    - LGBQ youth were more likely than heterosexual youth to report high levels of bullying and substance use;
    - Students who were questioning their sexual orientation reported more bullying, homophobic victimization, unexcused absences from school, drug use, feelings of depression, and suicidal behaviors than either heterosexual or LGB students;
    - LGB students who did not experience homophobic teasing reported the lowest levels of depression and suicidal feelings of all student groups (heterosexual, LGB, and questioning students); and
    - All students, regardless of sexual orientation, reported the lowest levels of depression, suicidal feelings, alcohol and marijuana use, and unexcused absences from school when they were
      - In a positive school climate and
      - Not experiencing homophobic teasing.

Source: Mereish, E. H., O’Cleirigh, C., & Bradford, J. B. (2014). Interrelationships between LGBT-based victimization, suicide, and substance use problems in a diverse sample of sexual and gender minorities. *Psychology, Health & Medicine*, 19(1), 1–13.

- Research has documented significant relationships between sexual and gender minority stress and higher rates of suicidality (i.e. suicidal ideation and attempts) and substance use problems. [The researchers] examined the potential mediating role of substance use problems on the relationship between sexual and gender minority stress (i.e. victimization based on lesbian, gay, bisexual, or transgender identity [LGBT]) and suicidality.
- [The research involved] LGBT patients from a community health center (N = 1457) [aged 19–70 years]. Participants reported history of lifetime suicidal ideation and attempts, substance use problems, as well as experiences of LGBT-based verbal and physical attacks.
- Substance use problems were a significant partial mediator between LGBT-based victimization and suicidal ideation and between LGBT-based victimization and suicide attempts for sexual and gender minorities.
- Nuanced gender differences revealed that substance use problems did not significantly mediate the relationship between victimization and suicide attempts for sexual minority men.
- [Substance misuse] might be a temporary and deleterious coping resource in response to LGBT-based victimization, which have serious effects on suicidal ideation and behaviors.

Source: Moody, C., & Smith, N. G. (2013). Suicide protective factors among trans adults. *Archives of Sexual Behavior*, 42(5), 739–752.

- [The researchers recruited participants from a sample of self-identified trans Canadian adults (N = 133) from LGBT and trans Listservs and collected data online using a secure survey platform.]
- Social support from friends, social support from family, and optimism significantly and negatively predicted 33 % of variance in participants' suicidal behavior after controlling for age.
- Reasons for living and suicide resilience accounted for an additional 19 % of the variance in participants' suicidal behavior after controlling for age, social support from friends, social support from family, and optimism.
- Of the factors mentioned above, perceived social support from family, one of three suicide resilience factors (emotional stability), and one of six reasons for living (child-related concerns) significantly and negatively predicted participants' suicidal behavior.

### Suicide Prevention Efforts and Resources—LGBT Adults and LGBT and Questioning Youth

Source: Suicide Prevention Resource Center. (2008). Suicide risk and prevention for lesbian, gay, bisexual, and transgender youth. Newton, MA: Education Development Center, Inc. From [http://www.sprc.org/library/SPRC\\_LGBT\\_Youth.pdf](http://www.sprc.org/library/SPRC_LGBT_Youth.pdf)? (accessed April 19, 2016).

- [This paper discusses suicide prevention for LGBT youth.]

Source: Suicide Prevention Resource Center. (n.d.). Suicide prevention among LGBT youth: A workshop for professionals who serve youth. From <http://www.sprc.org/training-institute/lgbt-youth-workshop> (accessed April 19, 2016).

- Suicide Prevention among LGBT Youth: A Workshop for Professionals Who Serve Youth is a free workshop kit to help staff in schools, youth-serving organizations, and suicide prevention programs take action to reduce suicidal behavior among lesbian, gay, bisexual, and transgender (LGBT) youth.
- Topics covered include suicidal behavior among LGBT youth, risk and protective factors for suicidal behavior, strategies to reduce the risk, and ways to increase school or agency cultural competence.
- The kit contains everything you need to host a workshop: a Leader's Guide, sample agenda, PowerPoint presentations, sample script, and handouts. The workshop includes lecture, small group exercises, and group discussion. All these can be adapted to meet the needs of your audiences.

Source: Centers for Disease Control and Prevention. (n.d.). Lesbian, gay, bisexual, and transgender health: LGBT youth resources. From <http://www.cdc.gov/lgbthealth/youth-resources.htm> (accessed April 19, 2016).

- [This website offers information for LGBT youth and those who want to support them, including parents, family members, educators, and school administrators.]

### Special Considerations—Native American Community

Source: Centers for Disease Control and Prevention. (2015). Suicide facts at a glance. From <http://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf> (accessed April 19, 2016).

- Suicide is the eighth leading cause of death among American Indians/Alaska Natives across all ages.
- Among American Indians/Alaska Natives aged 10 to 34 years, suicide is the second leading cause of death.
- The suicide rate among American Indian/Alaska Native adolescents and young adults ages 15 to 34 (19.5 per 100,000) is 1.5 times higher than the national average for that age group (12.9 per 100,000).

Source: Herne, M. A., Bartholomew, M. L., & Weahkee, R. L. (2014). Suicide mortality among American Indians and Alaska Natives, 1999–2009. *American Journal of Public Health, 104*(Suppl 3), S336–S342.

- [The researchers] assessed national and regional suicide mortality for American Indian and Alaska Native (AI/AN) persons [using] 1999 to 2009 death certificate data linked with Indian Health Service (IHS) patient registration data.
- [The study found that] death rates from suicide were approximately 50% higher among AI/AN persons (21.2) than Whites (14.2).
- By region, rates for AI/AN people were highest in Alaska (rates = 65.4 and 19.3, for males and females, respectively) and in the Northern Plains (rates = 41.6 and 11.9 for males and females, respectively).

Source: DeCou, C. R., Skewes, M. C., & López, E. D. (2013). Traditional living and cultural ways as protective factors against suicide: Perceptions of Alaska Native university students. *International Journal of Circumpolar Health, 72*. doi: 10.3402/ijch.v72i0.20968. eCollection 2013.

- Native peoples living in Alaska have one of the highest rates of suicide in the world.
- This research was part of a larger study that explored qualitatively the perceptions of Alaska Native university students from rural communities regarding suicide.
- [This study] explored the resilience that arose from participants' experiences of traditional ways, including subsistence activities.
- Semi-structured interviews were conducted with 25 university students who had migrated to Fairbanks, Alaska, from rural Alaskan communities. An interview protocol was developed in collaboration with cultural and community advisors.
- Participants were asked specific questions concerning the strengthening of traditional practices towards the prevention of suicide.
- Participants identified several resilience factors against suicide, including traditional practices and subsistence activities, meaningful community involvement and an active lifestyle.
- Traditional practices and subsistence activities were perceived to create the context for important relationships, promote healthy living to prevent suicide, contrast with current challenges and transmit important cultural values.
- Participants considered the strengthening of these traditional ways as important in suicide prevention efforts. However, subsistence and traditional practices were viewed as a diminishing aspect of daily living in rural Alaska.

Source: Wexler, L. M., & Gone, J. P. (2012). Culturally responsive suicide prevention in indigenous communities: Unexamined assumptions and new possibilities. *American Journal of Public Health, 102*(5), 800–806.

- Often, suicide in tribal communities is associated with culture loss, colonialism, and social disruption. Professional suicide interventions often ignore these conceptions, placing suicidal acts in the realm of psychopathology—internal to each person—to be addressed through individual mental health treatment.
- This transmutation (what sociologists refer to as the medicalization of the social) deprives matters rich in cultural meaning, historical situatedness, and social significance of their local intelligibility.
- Indigenous suicide prevention must be formulated in response to local cultural meanings and practices.
- It is important to consider an individual’s historical context, social network, and community resources outside of clinical systems of support. If suicide is an expression of collective as well as personal suffering, then interventions must address the community and family as well as the suicidal individual.
- This approach requires social interventions facilitated by intimates, as augmented (perhaps) by professional protocols that can aid in these efforts.

#### Suicide Prevention Efforts and Resources—Native American Community

Source: SAMHSA Tribal Training and Technical Assistance Center. (n.d.). Suicide prevention. From <http://www.samhsa.gov/tribal-ttac/resources/suicide-prevention> (accessed April 19, 2016).

- [This website offers] a list of organizations, links, articles, and other resources for suicide prevention [in tribal communities].

Source: SAMHSA’s National Registry of Evidence-based Programs and Practices. (n.d.). American Indian life skills development/Zuni life skills development. From <http://www.sprc.org/bpr/section-i/american-indian-life-skills-developmentzuni-life-skills-development> (accessed April 25, 2016).

[The following is a relevant interventions that have been reviewed by NREPP. SAMHSA does not recommend any treatment specifically.]

- American Indian Life Skills Development (the currently available version of the former Zuni Life Skills Development program) is a school-based suicide prevention curriculum designed to address this problem by reducing suicide risk and improving protective factors among American Indian adolescents 14 to 19 years old.

Source: SAMHSA. (2006, January). National Suicide Prevention Lifeline: American Indian/Alaska Native teen suicide prevention [poster]. From

<http://store.samhsa.gov/product/National-Suicide-Prevention-Lifeline-American-Indian-Alaska-Native-Teen-Suicide-Prevention/SVP06-0164> (accessed April 19, 2016).

- [This 11- by 17-inch poster] provides the National Suicide Prevention Lifeline toll-free number. [It] depicts a photo of an American Indian male who appears to have lost hope. [The poster] emphasizes that there is help, and with help comes hope. [It] urges those who are thinking about suicide to call.

Source: SAMHSA. (2010, April). *To live to see the great day that dawns: Preventing suicide by American Indian and Alaska Native youth and young adults*. From <http://store.samhsa.gov/product/To-Live-To-See-the-Great-Day-That-Dawns-Preventing-Suicide-by-American-Indian-and-Alaska-Native-Youth-and-Young-Adults/SMA10-4480> (accessed April 19, 2016).

- [This document] lays the groundwork for community-based suicide prevention and mental health promotion plans for American Indian and Alaska Native youth and young adults. [It] addresses risks, protective factors, and awareness, and describes prevention models for action.

Source: SAMHSA. (2010, April). American Indian and Alaska Native culture card: A guide to build cultural awareness. From <http://store.samhsa.gov/product/American-Indian-and-Alaska-Native-Culture-Card/SMA08-4354> (accessed April 19, 2016).

- [This document is] intended to enhance cultural competence when serving American Indian and Alaska Native communities. [It] covers regional differences; cultural customs; spirituality; communications styles; the role of veterans and the elderly, and health disparities, such as suicide.

Source: National Action Alliance for Suicide Prevention. (n.d.). *Hope for Life Day*. From <http://actionallianceforsuicideprevention.org/task-force/aian2/hope-for-life> (accessed April 19, 2016).

- [The National Action Alliance for Suicide Prevention comprises various task forces.] The American Indian/Alaska Native (AI/AN) Task Force is a public–private partnership formed to help reduce suicide in AI/AN communities. To further advance the Action Alliance’s priority to change the public conversation around suicide and suicide prevention, the AI/AN Task Force developed the **National AI/AN Hope for Life Day** toolkit.
- The toolkit is geared towards professionals and grass-roots organizers working in AI/AN communities to implement a community-wide **Hope for Life Day** on September 10 of each year. The National **American Indian/Alaska Native Hope for Life Day** coincides with World Suicide Prevention Day on September 10 of each year.
- This Action Alliance toolkit will help community organizers take specific steps to change the conversation around suicide, initiate action for awareness, and foster hope in the effort to reduce or eliminate suicide in their community. Organizers are encouraged to host culturally tailored events in their community to promote hope, life, cultural

resiliency, and community transformation. Examples of cultural activities can be found under the tab “Cultural Activities.”

Source: Suicide Prevention Resource Center. (2013). Suicide among racial/ethnic populations in the U.S.: American Indians/Alaska Natives. From [http://www.sprc.org/sites/sprc.org/files/library/AI AN%20Sheet%20Aug%2028%202013%20Final.pdf](http://www.sprc.org/sites/sprc.org/files/library/AI_AN%20Sheet%20Aug%2028%202013%20Final.pdf) (accessed April 19, 2016).

- [This factsheet outlines data on suicides and suicide-related behaviors as well as risk and protective factors.]

Source: Suicide Prevention Resource Center. (n.d.). Locate Garrett Lee Smith grantees. From [http://www.sprc.org/grantees/listing?title=&field\\_grant\\_type\\_value\\_many\\_to\\_one=Tribal&field\\_program\\_status\\_value\\_many\\_to\\_one=All&province](http://www.sprc.org/grantees/listing?title=&field_grant_type_value_many_to_one=Tribal&field_program_status_value_many_to_one=All&province) (accessed April 19, 2016).

- The Garrett Lee Smith State/Tribal Prevention Program is a part of a nationwide State-Tribal Youth Suicide Prevention and Early Intervention Program funded by SAMHSA.
- Grantees focus efforts on middle and high schools.

Source: SAMHSA. (2014). Cooperative agreements for tribal behavioral health/Native connections. From <http://www.samhsa.gov/grants/grant-announcements/sm-14-013> (accessed April 19, 2016).

- [Funded through the Center for Mental Health Services], the purpose of this program is to prevent and reduce suicidal behavior and substance abuse and promote mental health among American Indian/Alaska Native young people up to and including age 24.
- This program will help grantees reduce the impact of substance abuse, mental illness, and trauma on AI/AN communities through a public health approach. In addition, this grant will allow AI/AN communities to support youth and young adults as they transition into adulthood by facilitating collaboration among agencies.
- In 2014, SAMHSA awarded grants to 20 tribes to prevent and reduce suicidal behavior and substance abuse, and promote mental health among American Indian and Alaska Native young people up to and including age 24.

Source: SAMHSA. (2014). Cooperative agreements for state-sponsored youth suicide prevention and early intervention. From <http://www.samhsa.gov/grants/grant-announcements/sm-14-008> (accessed April 19, 2016).

- The purpose of this program is to support states and tribes (including Alaska Villages and urban Indian organizations) in developing and implementing statewide or tribal youth suicide prevention and early intervention strategies, grounded in public/private collaboration. Such efforts must involve public/private collaboration among youth-serving institutions and agencies and should include schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child and youth supporting organizations.

Source: SAMHSA. (2014, October 9). Cultural awareness and competency around suicide prevention. From <http://www.samhsa.gov/suicide-prevention/cultural-awareness-competency> (accessed April 19, 2016).

- SAMHSA encourages practitioners to develop suicide prevention strategies that account for the cultural beliefs and practices of different population groups. [This website describes some of SAMHSA's efforts to support culturally competent suicide prevention programs.]

Source: SAMHSA. (2014). Promoting suicide prevention efforts in American Indian/Alaska Native communities (AI/AN): A cross-agency approach. From [http://www.samhsa.gov/sites/default/files/combined\\_suicide\\_resources\\_overview.pdf](http://www.samhsa.gov/sites/default/files/combined_suicide_resources_overview.pdf) (accessed April 19, 2016).

- [This document lists federal agencies' workforce and training, telehealth resources and activities, and general resources and tools related to suicide prevention in AI/AN communities.]

#### Special Considerations—Adolescents and Young People

Source: Centers for Disease Control and Prevention. (2015). Suicide facts at a glance. From <http://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf> (accessed April 19, 2016).

- Suicide is the third leading cause of death among persons aged 10–14, the second among persons aged 15–34 years.

Source: Centers for Disease Control and Prevention. (2013, August 1). Suicide among youth. From <http://www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/suicideyouth.html> (accessed April 19, 2016).

- Suicide is a serious public health problem that affects many young people. Suicide is the third leading cause of death for youth between the ages of 10 and 24, and results in approximately 4,600 lives lost each year.
- Deaths from youth suicide are only part of the problem. More young people survive suicide attempts than actually die. A nationwide survey of high school students in the United States found that 16% of students reported seriously considering suicide, 13% reported creating a plan, and 8% reporting trying to take their own life in the 12 months preceding the survey. Each year, approximately 157,000 youth between the ages of 10 and 24 are treated Emergency Departments across the U.S. for self-inflicted injuries.
- Suicide among teens and young adults has nearly tripled since the 1940's. Several factors can put a young person at risk for suicide; however, having risk factors does not always mean that a young person will attempt suicide. Risk factors include: family history of suicide; history of depression, other mental health problems, or incarceration; easy access to lethal means; alcohol and drug use; exposure to previous suicidal

behavior by others; and residential mobility that might lessen opportunities for developing healthy social connections and supports.

Source: American Academy of Child & Adolescent Psychiatry. (2013, October). Teen suicide. From [https://www.aacap.org/AACAP/Families\\_and\\_Youth/Facts\\_for\\_Families/FFF-Guide/Teen-Suicide-010.aspx](https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Teen-Suicide-010.aspx) (accessed April 19, 2016).

- Teenagers experience strong feelings of stress, confusion, self-doubt, pressure to succeed, financial uncertainty, and other fears while growing up. For some teenagers, divorce, the formation of a new family with step-parents and step-siblings, or moving to a new community can be very unsettling and can intensify self-doubts. For some teens, suicide may appear to be a solution to their problems and stress.
- Depression and suicidal feelings are treatable mental disorders. The child or adolescent needs to have his or her illness recognized and diagnosed, and appropriate treatment plans developed. When parents are in doubt whether their child has a serious problem, a psychiatric examination can be very helpful.
- Many of the signs and symptoms of suicidal feelings are similar to those of depression.
- Parents should be aware of the following signs of adolescents who may try to kill themselves:
  - change in eating and sleeping habits
  - withdrawal from friends, family, and regular activities
  - violent actions, rebellious behavior, or running away
  - drug and alcohol use
  - unusual neglect of personal appearance
  - marked personality change
  - persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
  - frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
  - loss of interest in pleasurable activities
  - not tolerating praise or rewards
- A teenager who is planning to commit suicide may also:
  - complain of being a bad person or feeling rotten inside
  - give verbal hints with statements such as: I won't be a problem for you much longer, Nothing matters, It's no use, and I won't see you again
  - put his or her affairs in order, for example, give away favorite possessions, clean his or her room, throw away important belongings, etc.
  - become suddenly cheerful after a period of depression
  - have signs of psychosis (hallucinations or bizarre thoughts)
- If a child or adolescent says, I want to kill myself, or I'm going to commit suicide, always take the statement seriously and immediately seek assistance from a qualified mental health professional. People often feel uncomfortable talking about death. However, asking the child or adolescent whether he or she is depressed or thinking about suicide can be helpful. Rather than putting thoughts in the child's head, such a question will provide assurance that somebody cares and will give the young person the chance to talk about problems.

- If one or more of these signs occurs, parents need to talk to their child about their concerns and seek professional help from a physician or a qualified mental health professional. With support from family and appropriate treatment, children and teenagers who are suicidal can heal and return to a more healthy path of development.

Source: SAMHSA. (2014, October 9). Bullying and suicide. From <http://www.samhsa.gov/suicide-prevention/bullying> (accessed April 19, 2016).

- The connection between bullying and suicide is often oversimplified, when, in fact, it is very complex. Many issues contribute to suicide risk, including depression, substance use, problems at home, and trauma history. According to Centers for Disease Control and Prevention (CDC) research, it is potentially harmful to suggest that bullying frequently leads to suicide. CDC research indicates that linking suicide with bullying as a direct cause and effect minimizes other possible issues that may lead to suicide. Instead, a more integrated approach should be considered to preventing suicide and youth violence, which focuses on shared risk and protective factors such as:
  - Individual coping skills
  - Family and school social support
  - Supportive school environments

Source: Suicide Resource Prevention Center. (2014). Suicide among college and university students in the United States. From <http://www.sprc.org/sites/sprc.org/files/library/SuicideAmongCollegeStudentsInUS.pdf> (accessed April 19, 2016).

- Suicide is a leading cause of death among college and university students in the United States. In addition, many other college and university students have suicidal thoughts and attempt suicide. Suicide and suicidal behaviors are a major concern for colleges and universities, and efforts are underway to introduce suicide prevention programming on many college and university campuses.

#### Suicide Prevention Efforts and Resources—Adolescents and Young People

Source: You Matter. (2015). From <http://www.youmatter.suicidepreventionlifeline.org/> (accessed April 19, 2016).

- You Matter is a movement to spread the word that your problems, your worries, your fears, and above all you—unique and real you—matter. And because just about everyone—at some point—hits the wall, we’re here to help.
- You Matter was created by the National Suicide Prevention Lifeline to let people know that suicide is preventable. If you need support, call 1-800-273-8255 or chat with the Lifeline.

Source: SAMHSA’s National Registry of Evidence-based Programs and Practices. (2015, June 14). From <http://www.samhsa.gov/nrepp> (accessed April 25, 2016).

[The following are relevant interventions that have been reviewed by NREPP. SAMHSA does not recommend them specifically.]

### *Youth and Adolescents*

- CAST (Coping And Support Training) is a high school-based suicide prevention program targeting youth 14 to 19 years old. CAST delivers life-skills training and social support in a small-group format (6–8 students per group).
- Emergency Department Means Restriction Education is an intervention for the adult caregivers of youth (aged 6 to 19 years) who are seen in an emergency department (ED) and determined through a mental health assessment to be at risk for committing suicide.
- The Family Intervention for Suicide Prevention (FISP) is a cognitive behavioral family intervention for youth ages 10–18 who are presenting to an emergency department (ED) with suicidal ideation or after a suicide attempt.
- Kognito At-Risk for High School Educators is a 1-hour, online, interactive gatekeeper training program that prepares high school teachers and other school personnel to identify, approach, and refer students who are exhibiting signs of psychological distress such as depression, anxiety, substance abuse, and suicidal ideation.
- LEADS: For Youth (Linking Education and Awareness of Depression and Suicide) is a curriculum for high school students in grades 9–12 that is designed to increase knowledge of depression and suicide, modify perceptions of depression and suicide, increase knowledge of suicide prevention resources, and improve intentions to engage in help-seeking behaviors.
- Lifelines is a comprehensive, [school-wide] suicide prevention program for middle and high school students. The goal of Lifelines is to promote a caring, competent school community in which help seeking is encouraged and modeled and suicidal behavior is recognized as an issue that cannot be kept secret.
- The Model Adolescent Suicide Prevention Program (MASPP) is a public health-oriented suicidal-behavior prevention and intervention program originally developed for a small American Indian tribe in rural New Mexico to target high rates of suicide among its adolescents and young adults.
- Reconnecting Youth: A Peer Group Approach to Building Life Skills (RY) is a school-based prevention program for students ages 14–19 years that teaches skills to build resiliency against risk factors and control early signs of substance abuse and emotional distress.
- SOS Signs of Suicide is a secondary school-based suicide prevention program that includes screening and education. Students are screened for depression and suicide risk and referred for professional help as indicated.
- Sources of Strength, a universal suicide prevention program, is designed to build socioecological protective influences among youth to reduce the likelihood that vulnerable high school students will become suicidal.

### *College Students*

- Kognito At-Risk for College Students is a 30-minute, online, interactive training simulation that prepares college students and student leaders, including resident assistants, to provide support to peers who are exhibiting signs of psychological distress such as depression, anxiety, substance abuse, and suicidal ideation.

Source: SAMHSA. (2011, March/April). Preventing suicide on college campuses. *SAMHSA News*. From <http://store.samhsa.gov/product/SAMHSA-News-Preventing-Suicide-on-College-Campuses/SAM11-192> (accessed April 19, 2016).

- [This article] explores suicide among college students and reports on suicide prevention programs targeted to college campuses. [It] highlights grants on campuses in Tennessee, Boston, and Guam. [It] also covers alcohol awareness, women and substance abuse, and an initiative that encourages the sharing of ideas between U.S. and Iraqi behavioral health providers.

Source: U.S. Department of Health and Human Services. (n.d.). Stop bullying. From <http://www.stopbullying.gov/> (accessed April 19, 2016).

- [This website offers information on bullying, cyberbullying, how to prevent bullying, ways to respond, and how to get help. There is a version of the website for kids at <http://www.stopbullying.gov/kids/>]
- [SAMHSA offers a free app for bullying prevention at <http://www.stopbullying.gov/>]

Source: SAMHSA. (2015, November 5). SAMHSA's suicide prevention efforts. *Now Is The Time*—Prevention and early intervention. From <http://www.samhsa.gov/suicide-prevention/samhsas-efforts> (accessed April 19, 2016).

- On January 16, 2013, President Barack Obama released the *Now Is The Time* plan, which outlines how the nation can better support the behavioral health needs of young people. SAMHSA has played a key role in supporting activities outlined in the plan, including developing and funding new grant programs.
- The *Now Is The Time* Project AWARE (Advancing Wellness and Resilience Education) builds and expands the capacity of state and local educational agencies to increase awareness of mental health and substance abuse issues among school-age youth.
- In addition, SAMHSA's Healthy Transitions program improves access to treatment and services for youth and young adults aged 16 to 25 that either have, or are at risk of developing, a serious mental health condition. Individuals in this age group are also at high risk for substance use and suicide. Unfortunately, they are also among the least likely to seek and receive help.
- Grants awarded under the Healthy Transitions program are designed to:
  - Increase awareness about early indications of serious mental health concerns
  - Identify action strategies to use when a serious mental health concern is detected
  - Provide training to provider and community groups to improve services and supports specific to this age group
  - Enhance peer and family supports
  - Develop effective services and interventions for youth, young adults, and their families as these young people transition to adult roles and responsibilities

Source: SAMHSA. (2012, June). Preventing Suicide: A Toolkit for High Schools. From <http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669> (accessed April 19, 2016).

- [This resource] assists high schools and school districts in designing and implementing strategies to prevent suicide and promote behavioral health. [It] includes tools to implement a multi-faceted suicide prevention program that responds to the needs and cultures of students.

Source: SAMHSA. (2015, March 30). 2015 Campus Suicide Prevention Grant. From <http://www.samhsa.gov/grants/grant-announcements/sm-15-008> (accessed April 19, 2016).

- The Campus Suicide Prevention grant supports a wide range of program activities and prevention strategies to build and sustain a foundation for mental health promotion, suicide prevention, substance abuse prevention and other prevention activities such as interpersonal violence and by-stander interventions. As an Infrastructure Development grant, funds cannot be used to pay for direct traditional mental health and substance abuse treatment services such as therapy, counseling, and medication management.
- The Campus Suicide Prevention Grant program seeks to address behavioral health disparities among racial, ethnic, sexual and gender minorities by encouraging the implementation of strategies to decrease the differences in access, service use and outcomes among the racial and ethnic minority populations served.

Source: American Psychological Association. (n.d.). Teen suicide is preventable. From <http://www.apa.org/research/action/suicide.aspx> (accessed April 19, 2016).

- **The Teen Screen®** Program is a community-based mental health screening program for young people that accurately identifies youth who are suffering from mental illness or are at risk of suicide. The program's primary objective is to help young people and their parents through the early identification of mental health problems, such as depression. Parents of youth found to be at possible risk are notified and helped with identifying and connecting to local mental health services where they can obtain further evaluation. Most importantly, mental health screening detect youth with depression and other emotional disorders before they fall behind in school and end up in serious trouble, or worst of all end their lives.
- **Stop a Suicide Today!** is a school-based suicide prevention program that has experienced success with a documented reduction in self-reported suicide attempts. Developed by Harvard psychiatrist Douglas Jacobs, MD, Stop a Suicide, Today! teaches people how to recognize the signs of suicide in family members, friends and co-workers, and empowers people to make a difference in the lives of their loved ones. It emphasizes the relationship between suicide and mental illness and the notion that a key step in reducing suicide is to get those in need into mental health treatment.

Source: Suicide Prevention Resource Center. (n.d.). From [http://www.sprc.org/search/apachesolr\\_search/teen?filters](http://www.sprc.org/search/apachesolr_search/teen?filters) (accessed April 19, 2016).

- [This website shows search results for information and resources on teen suicide.]

Source: American Foundation for Suicide Prevention. (n.d.). Programs for teens and young adults. From <http://afsp.org/our-work/education/> (accessed April 25, 2016).

- AFSP’s programs for teens and young adults cover a variety of different topics that range from educating teens to recognize the signs and symptoms of depression in themselves and others, how suicide-related problems are commonly [experienced] by college students, to providing information and guidance to schools that have been touched by the tragedy of a suicide.
  - More Than Sad has taught over a million students and educators how to be smart about mental health. [More information is available at <http://afsp.org/our-work/education/more-than-sad/> (accessed April 25, 2016)].
- *After a Suicide: A Toolkit for Schools* provides information, tools, and guidance to schools that have been touched by the tragedy of a suicide. The Toolkit covers Crisis Response, Helping Students Cope, Working with the Community, Memorialization, Social Media, Suicide Contagion, and Bringing in Outside Help. [More information is available at <http://www.afsp.org/preventing-suicide/our-education-and-prevention-programs/programs-for-teens-and-young-adults/after-a-suicide-a-toolkit-for-schools>] (accessed April 25, 2016).
- *The Truth about Suicide: Real Stories of Depression in College* is an educational tool designed to achieve several specific goals related to suicide prevention: educate college students and other young adults to recognize the signs and symptoms of depression in themselves and others; convey the destigmatizing notion that depression and other mental illnesses are real illnesses that respond to specific treatments; promote the importance and acceptability of seeking help for a friend or for oneself; and provide information about sources of professional help and ways to self-refer for treatment or assist a peer in getting help. [More information is available at <http://afsp.org/our-work/education/truth-suicide-real-stories-depression-college/> (accessed April 25, 2016)].
- Four leading organizations have come together to release a Model School District Policy on Suicide Prevention. This modular, adaptable document will help educators and school administrators implement comprehensive suicide prevention policies in communities nationwide. When suicide is the third leading cause of death among youth as young as 10 through age-19, it is crucial that our school districts have proactive suicide prevention policies in place. [More information is available at <http://www.afsp.org/preventing-suicide/our-education-and-prevention-programs/programs-for-teens-and-young-adults/a-model-school-policy-on-suicide-prevention>] (accessed April 25, 2016).

## Panel 4: Efforts To Prevent Suicide: Offering Health and Hope

### Key Questions

1. How can suicide be prevented? What are SAMHSA's efforts and resources to help prevent suicide?
2. What are some research-based practices in suicide prevention?
3. What are some additional federal efforts and resources to help prevent suicide? How are federal government agencies working together to prevent suicide?
4. What are the warning signs of suicide that family members and others can watch for and the actions they can take if someone seems to be contemplating suicide?
5. What are some resources on suicide prevention?
6. How can peers help people who are considering or have attempted suicide?

### Suicide Prevention

Source: SAMHSA. (2015, October 29). Suicide prevention. From <http://www.samhsa.gov/suicide-prevention> (accessed April 21, 2016).

- Fortunately, there is strong evidence that a comprehensive public health approach is effective in reducing suicide rates.
- Suicide prevention efforts seek to:
  - Reduce factors that increase the risk for suicidal thoughts and behaviors
  - Increase the factors that help strengthen, support, and protect individuals from suicide
- Ideally, these efforts address individual, relationship, community, and societal factors while promoting hope, easing access into effective treatment, encouraging connectedness, and supporting recovery.

Source: National Institute of Mental Health. (2015). Suicide in America: Frequently asked questions. From <http://www.nimh.nih.gov/health/publications/suicide-faq/index.shtml> (accessed April 21, 2016).

- Effective suicide prevention is based on sound research. Programs that work take into account people's risk factors and promote interventions that are appropriate to specific groups of people. For example, research has shown that mental and substance abuse disorders are risk factors for suicide. Therefore, many programs focus on treating these disorders in addition to addressing suicide risk specifically.
- Psychotherapy, or "talk therapy," can effectively reduce suicide risk. One type is called cognitive behavioral therapy (CBT). CBT can help people learn new ways of dealing with stressful experiences by training them to consider alternative actions when thoughts of suicide arise.
- Another type of psychotherapy called dialectical behavior therapy (DBT) has been shown to reduce the rate of suicide among people with borderline personality disorder,

a serious mental illness characterized by unstable moods, relationships, self- image, and behavior. A therapist trained in DBT helps a person recognize when his or her feelings or actions are disruptive or unhealthy, and teaches the skills needed to deal better with upsetting situations.

- Medications may also help; promising medications and psychosocial treatments for suicidal people are being tested.
- Still other research has found that many older adults and women who die by suicide saw their primary care providers in the year before death. Training doctors to recognize signs that a person may be considering suicide may help prevent even more suicides.

### SAMHSA's Efforts and Resources for Suicide Prevention

Source: SAMHSA. (2015, October 29). Suicide prevention. From <http://www.samhsa.gov/suicide-prevention> (accessed April 21, 2016).

- SAMHSA is a proud partner of the National Action Alliance for Suicide Prevention, a public-private partnership with more than 200 participating organizations advancing the national strategy for suicide prevention.
- SAMHSA is committed to continuing to working with its federal partners and private organizations to provide states, territories, tribal entities, communities, and the public with the assistance and prevention resources they need.

### *SAMHSA's National Suicide Prevention Lifeline*

Source: SAMHSA. (n.d.). National Suicide Prevention Lifeline. From <http://www.suicidepreventionlifeline.org/> (accessed April 21, 2016).

- [Calling 1-800-273-TALK (8255) connects people to a skilled, trained counselor at a local crisis center, anytime. This counselor will listen to your problems and tell you about mental health services in your area. Calls are free and confidential.]
- [The Lifeline is available for people who speak Spanish at <http://www.suicidepreventionlifeline.org/gethelp/spanish.aspx>]
- [The Lifeline also makes options available for people who are deaf or hard of hearing at <http://www.suicidepreventionlifeline.org/GetHelp/Accessibility>]

Source: SAMHSA. (2014, Spring). Preventing suicide: Following up after the crisis. *SAMHSA News*, 22(2). From [http://www.samhsa.gov/samhsaNewsLetter/Volume\\_22\\_Number\\_2/preventing\\_suicide/](http://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_2/preventing_suicide/) (accessed April 21, 2016).

- More than 1.5 million people receive help by calling the National Suicide Prevention Lifeline each year. Evaluations show that most callers who were in crisis report decreased feelings of distress and hopelessness and fewer thoughts about suicide as a result of their calls.
- However, evaluations also show that 43 percent of callers contemplating suicide had recurring thoughts about killing themselves in the weeks after a call, yet fewer than a

quarter of them had seen a behavioral health care provider even four to six weeks following their crisis call.

- SAMHSA's Cooperative Agreements for the National Suicide Prevention Lifeline Crisis Center Follow-Up are changing that. Launched in 2008, the program supports crisis centers within Lifeline's network in systematically following up with Lifeline callers to see how they're doing, offer emotional support and tips on coping strategies, and check to ensure that they follow up with treatment referrals. In 2013, the program expanded to include follow-up with people at risk for suicide who have been discharged from emergency rooms and inpatient hospital units. Eighteen crisis centers are currently participating.
- An ongoing evaluation suggests that following up is an effective suicide prevention technique. In a study of the first cohort of grantees, for example, 80 percent of participants said that the follow-up calls helped at least a little in stopping them from killing themselves. Callers with prior suicide attempts were more likely to describe the program as an effective prevention strategy, as were callers who received a greater number of follow-up calls. Callers whose counselors discussed suicide warning signs and how to rely on social contacts as sources of distraction and help were also more likely to describe follow-up as an effective strategy.

### *Suicide Safe*

Source: SAMHSA. (2015, February). SAMHSA Suicide Safe mobile app. From <http://store.samhsa.gov/product/SAMHSA-Suicide-Safe-Mobile-App/PEP15-SAFEAPP1> (accessed April 21, 2016).

- [This app] equips providers with education and support resources to assess patients' risk of suicide, communicate effectively with patients and families, determine appropriate next steps, and make referrals to treatment and community resources.

### *SAMHSA's Suicide Prevention Resource Center*

- [SAMHSA funds the Suicide Prevention Resource Center at <http://www.sprc.org/>, which promotes a public health approach to suicide prevention and has a library of resources at [http://www.sprc.org/library\\_resources/listing](http://www.sprc.org/library_resources/listing)]
- SPRC serves individuals, groups, and organizations that play important roles in suicide prevention—including professionals providing social services, health and behavioral health care providers, SAMHSA Youth Suicide Prevention Grantees, states and communities, American Indian/Alaska Native communities and providers, and colleges and universities.

### *SAMHSA Resources*

Source: SAMHSA. (2005, January). National Suicide Prevention Lifeline wallet card. From <http://store.samhsa.gov/product/National-Suicide-Prevention-Lifeline-Wallet-Card-Assessing-Suicide-Risk-Initial-Tips-for-Counselors/SVP13-0153>(accessed April 21, 2016).

- [This resource] lists warning signs for suicide risk and urges those who exhibit any of the signs to contact a mental health professional or call the suicide prevention hotline. [It also] lists the National Suicide Prevention Lifeline toll-free number on the wallet card.

Source: SAMHSA. (2009, September). Suicide assessment five-step evaluation and triage (SAFE-T): Pocket card for clinicians. From <http://store.samhsa.gov/product/Suicide-Assessment-Five-Step-Evaluation-and-Triage-SAFE-T-Pocket-Card-for-Clinicians/SMA09-4432> (accessed April 21, 2016).

- [This resource] assists clinicians in conducting a suicide assessment using a 5-step evaluation and triage plan to identify risk factors and protective factors, conduct a suicide inquiry, determine risk level and potential interventions, and document a treatment plan.

Source: SAMHSA. (2015, September). *TIP 50: Addressing suicidal thoughts and behaviors in substance abuse treatment*. From <http://store.samhsa.gov/product/TIP-50-Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/SMA15-4381> (accessed April 21, 2016).

- [This document] provides guidelines to help substance abuse treatment counselors work with suicidal adult clients. [It] covers risk factors and warning signs for suicide, core counselor competencies, clinical vignettes, and information for administrators and clinical supervisors.

Source: SAMHSA. (2014). Cooperative agreements to implement the National Strategy for Suicide Prevention. From <http://www.samhsa.gov/grants/grant-announcements/sm-14-016> (accessed April 21, 2016).

- The purpose of this program is to support states in implementing the 2012 National Strategy for Suicide Prevention (NSSP) goals and objectives focused on preventing suicide and suicide attempts among working-age adults 25–64 years old in order to reduce the overall suicide rate and number of suicides in the U.S. nationally.
- Eligibility is limited to the Mental Health Authority in states, territories, and the District of Columbia.
- The Mental Health Authority within states and territories are uniquely positioned and have the necessary statewide infrastructure in place to promote suicide prevention as a core component of health care services and to coordinate the required activities, including convening all other relevant state agencies to advise and/or participate in the initiative.

#### *SAMHSA Publications*

- [SAMHSA provides publications on the subject of suicide at <http://store.samhsa.gov/facet/Treatment-Prevention-Recovery/term/Suicide-Prevention>]

#### *SAMHSA and Partner Webinars*

Source: Suicide Prevention Resource Center. (n.d.). SAMHSA webinars. From <http://www.sprc.org/training-institute/samhsa-webinars> (accessed April 21, 2016).

- This [website] hosts [archived] webinars from SAMHSA and its partners dedicated to a variety of suicide-related topics.

### Research-based Practices in Suicide Prevention

Source: Suicide Prevention Resource Center. (n.d.). Best Practices Registry. From <http://www.sprc.org/bpr> (accessed April 21, 2016).

- The purpose of the Best Practices Registry (BPR) is to identify, review, and disseminate information about best practices that address specific objectives of the National Strategy for Suicide Prevention.

Source: SAMHSA’s National Registry of Evidence-based Programs and Practices. (2015, June 14). From <http://www.samhsa.gov/nrepp> (accessed April 25, 2016).

[The following are relevant interventions that have been reviewed by NREPP. SAMHSA does not recommend them specifically.]

- The National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers.
- [NREPP lists 16 programs for suicide prevention. Selected programs (others for specific populations are listed in Panel 3) include:]
  - The QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention is a brief educational program designed to teach “gatekeepers”—those who are strategically positioned to recognize and refer someone at risk of suicide (e.g., parents, friends, neighbors, teachers, coaches, caseworkers, police officers)—the warning signs of a suicide crisis and how to respond by following three steps: (1) Question the individual’s desire or intent regarding suicide, (2) persuade the person to seek and accept help, and (3) refer the person to appropriate resources. The 1- to 2-hour training is delivered by certified instructors in person or online, and it covers (1) the epidemiology of suicide and current statistics, as well as myths and misconceptions about suicide and suicide prevention; (2) general warning signs of suicide; and (3) the three target gatekeeper skills (i.e., question, persuade, refer). Any adult (18 years or older) can become a certified instructor after receiving a minimum of 8 hours of formal instruction. After completing this instruction, the instructor is certified for 3 years, although annual booster sessions are recommended. Certified instructors are provided with technical and Web-based support, newsletters, and free program upgrades. [More information is available at <http://www.samhsa.gov/nrepp>
  - Wellness Recovery Action Plan (WRAP) is a manualized group intervention for adults with mental illness. WRAP guides participants through the process of identifying and understanding their personal wellness resources (“wellness tools”) and then helps them develop an individualized plan to use these

resources on a daily basis to manage their mental illness. [More information is available at <http://www.samhsa.gov/nrepp> WRAP has the following goals:

- Teach participants how to implement the key concepts of recovery (hope, personal responsibility, education, self-advocacy, and support) in their day-to-day lives
- Help participants organize a list of their wellness tools—activities they can use to help themselves feel better when they are experiencing mental health difficulties and to prevent these difficulties from arising
- Assist each participant in creating an advance directive that guides the involvement of family members or supporters when he or she can no longer take appropriate actions on his or her own behalf
- Help each participant develop an individualized post-crisis plan for use as the mental health difficulty subsides, to promote a return to wellness

### Federal Efforts and Resources in Suicide Prevention

Source: National Action Alliance for Suicide Prevention. (n.d.). National Strategy for Suicide Prevention. From <http://actionallianceforsuicideprevention.org/NSSP> (accessed April 21, 2016).

- On September 10, 2012 the U.S. Surgeon General and the National Action Alliance for Suicide Prevention released the revised *National Strategy for Suicide Prevention* (NSSP). The revised strategy emphasizes the role every American can play in protecting their friends, family members, and colleagues from suicide. It also provides guidance for schools, businesses, health systems, clinicians and many other sectors that takes into account nearly a decade of research and other advancements in the field since the last strategy was published.
- The NSSP features 13 goals and 60 objectives with the themes that suicide prevention should:
  - Foster positive public dialogue; counter shame, prejudice, and silence; and build public support for suicide prevention;
  - Address the needs of vulnerable groups, be tailored to the cultural and situational contexts in which they are offered, and seek to eliminate disparities;
  - Be coordinated and integrated with existing efforts addressing health and behavioral health and ensure continuity of care;
  - Promote changes in systems, policies, and environments that will support and facilitate the prevention of suicide and related problems;
  - Bring together public health and behavioral health;
  - Promote efforts to reduce access to lethal means among individuals with identified suicide risks;
  - Apply the most up-to-date knowledge base for suicide prevention.

Source: U.S. Surgeon General. (2012). Overview: 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. From <http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/overview.pdf> (accessed April 21, 2016).

- The National Strategy’s goals and objectives fall within four strategic directions, which, when working together, may most effectively prevent suicides:
  1. Create supportive environments that promote healthy and empowered individuals, families, and communities (4 goals, 16 objectives);
  2. Enhance clinical and community preventive services (3 goals, 12 objectives);
  3. Promote the availability of timely treatment and support services (3 goals, 20 objectives); and
  4. Improve suicide prevention surveillance collection, research, and evaluation (3 goals, 12 objectives).
- Although some groups have higher rates of suicidal behaviors than others, the goals and objectives do not focus on specific populations or settings. Rather, they are meant to be adapted to meet the distinctive needs of each group, including new groups that may be identified in the future as being at an increased risk for suicidal behaviors.

Source: Lubell, K. M., Singer, H. H., & Gonzalez, B. (n.d.). State suicide prevention planning: A CDC research brief. Centers for Disease Control and Prevention (CDC). From <http://www.cdc.gov/violenceprevention/pdf/state-suicide-prevention-planning-brief.pdf> (accessed April 21, 2016).

- This document summarizes the results of a CDC research study conducted to describe the key ingredients of successful state-based suicide prevention planning.

#### Federal Agencies Working Together for Suicide Prevention

Source: DeMartino, R. E., Crosby, A. E., EchoHawk, M., Litts, D. A., Pearson, J., Reed, G. A., et al. (2003). A call to collaboration: The federal commitment to suicide prevention. *Suicide and Life-Threatening Behavior*, 33(2), 101–110.

- The federal government, largely through the U.S. Department of Health and Human Services (HHS), 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 (SAMHSA), National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Indian Health Service (IHS), and Health Resources and Services Administration (HRSA). The article highlights HHS’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.
- 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.

Source: Suicide Prevention Resource Center. (n.d.). State and national partners in suicide prevention. From <http://www.sprc.org/basics/partners> (accessed April 21, 2016).

- Many organizations and agencies at the state and national levels welcome the opportunity to partner with communities, campuses, and others to prevent suicide. Some of these organizations and agencies offer funding, resources, technical assistance, and training.
- [This website provides links to organizations' suicide prevention efforts, including those of various Federal agencies.]

### Warning Signs of Suicide

Source: SAMHSA. (2015, October 29). Suicide prevention. From <http://www.samhsa.gov/suicide-prevention> (accessed April 21, 2016).

- These signs may mean that someone is at risk for suicide. Risk is greater if the behavior is new, or has increased, and if it seems related to a painful event, loss, or change:
  - Talking about wanting to die or kill oneself
  - Looking for a way to kill oneself
  - Talking about feeling hopeless or having no reason to live
  - Talking about feeling trapped or being in unbearable pain
  - Talking about being a burden to others
  - Increasing the use of alcohol or drugs
  - Acting anxious or agitated; behaving recklessly
  - Sleeping too little or too much
  - Withdrawing or feeling isolated
  - Showing rage or talking about seeking revenge
  - Displaying extreme mood swings

### Actions To Take If You Notice Signs of Suicide

Source: SAMHSA. (2015, October 29). Suicide prevention. From <http://www.samhsa.gov/suicide-prevention> (accessed April 21, 2016).

- If you believe someone may be thinking about suicide:
  - Ask them if they are thinking about killing themselves. (This will not put the idea into their head or make it more likely that they will attempt suicide.)
  - Listen without judging and show you care.
  - Stay with the person (or make sure the person is in a private, secure place with another caring person) until you can get further help.
  - Remove any objects that could be used in a suicide attempt.
  - Call SAMHSA's National Suicide Prevention Lifeline at 1-800-273-TALK (8255) and follow their guidance.

- If danger for self-harm seems imminent, call 911.
- Everyone has a role to play in preventing suicide. For instance, faith communities can work to prevent suicide simply by fostering cultures and norms that are life-preserving, providing perspective and social support to community members, and helping people navigate the struggles of life to find a sustainable sense of hope, meaning, and purpose.

### Suicide Prevention Resources (General)

Source: Action Alliance for Suicide Prevention. (n.d.). Resources. From <http://actionallianceforsuicideprevention.org/resources> (accessed April 21, 2016).

- This list includes selected resources that may be particularly helpful to Action Alliance members and partners in their work related to suicide prevention.

Source: Zero Suicide. (n.d.). Resources. From <http://zerosuicide.sprc.org/resources> (accessed April 21, 2016).

- [Zero Suicide is a national effort to prevent suicides among individuals under care in the health and behavioral health systems.]

Source: Suicide Prevention Resource Center. (n.d.). Roles in suicide prevention. From <http://www.sprc.org/basics/roles-suicide-prevention> (accessed April 21, 2016).

- Suicide prevention can—and should—take place in many settings. Almost anyone can take action to help prevent suicide. SPRC offers resources to help you play a role in suicide prevention.
  - Resource for high school teachers at <http://www.sprc.org/sites/sprc.org/files/Teachers.pdf>
  - Resource for high school mental health providers at <http://www.sprc.org/sites/sprc.org/files/SchoolMentalHealth.pdf>
  - Resource for managers at <http://www.sprc.org/sites/sprc.org/files/managers.pdf>
  - Resource for co-workers at <http://www.sprc.org/sites/sprc.org/files/CoWorkers.pdf>
  - Resource for faith community leaders at <http://www.sprc.org/sites/sprc.org/files/FaithCommunityLeaders.pdf>
  - Resource for emergency medical services providers at <http://www.sprc.org/sites/sprc.org/files/ems.pdf>
  - Resource for law enforcement officers at <http://www.sprc.org/sites/sprc.org/files/LawEnforcement.pdf>
  - Resource for adult correctional officers at <http://www.sprc.org/sites/sprc.org/files/CorrectionOfficers.pdf>
  - Resource for senior living community professionals at [http://www.sprc.org/sites/sprc.org/files/slc\\_providers.pdf](http://www.sprc.org/sites/sprc.org/files/slc_providers.pdf)
  - Resource for parents/guardians/families at <http://www.sprc.org/sites/sprc.org/files/Families.pdf>
  - Resource for teens at <http://www.sprc.org/sites/sprc.org/files/Teens.pdf>

## Peers and Suicide Prevention

Source: Reed, J. (2013, March 8). Advancing peer support in suicide prevention. From <http://www.sprc.org/directorsblog/advancing-peer-support-suicide-prevention> (accessed April 21, 2016).

- The revised National Strategy for Suicide Prevention (NSSP) states that “peer support plays an important role in the treatment of mental and substance use disorders and holds a potential for helping those at risk for suicide.” The NSSP also points out that mental health consumers have come to be an important peer-support resource in recovery services. Peer support is not a substitute for mental health treatment, and we should not promote peer support to those who may not be ready to provide support to others. However, there is evidence that peer support can assist the recovery of those who have experienced suicidal crises, including attempts.
- Many suicide attempt survivors have bravely shared their stories in support of suicide prevention and others who may be at risk. Yet the participation of suicide attempt survivors is not yet as overt or as organized as that of persons who have survived the loss of loved ones. However, this is starting to change. Two examples of efforts to provide forums for survivors of suicide attempts are [Live Through This](#) and [What Happens Now?](#) People who have survived suicide attempts have experienced reentering a workplace, classroom, or family after an attempt or hospitalization. They can address this experience with authenticity.
- We should look to what is happening in the mental health community as a model for involving attempt survivors in suicide prevention. But attempt survivors can do more than support their peers. They can also help us understand what resources and supports are needed to assist attempt survivors in their journeys to recovery. The [Suicide Attempt Survivors Task Force](#) of the National Action Alliance is creating a framework to help engage and empower suicide attempt survivors as suicide prevention champions at the local, state, and national levels. I look forward to the results of their labor.
- We need to expand efforts to encourage and support attempt survivors in bringing their expertise to the struggle against suicide, and their firsthand experience with facing and triumphing over suicide to others at risk through peer support networks. And we need to continue and expand opportunities for members of a wide range of cultural and ethnic communities, as well as youth, veterans, and the LGBT community, to organize and provide support to their peers, as well as to share their ideas and experience to the field of suicide prevention. We all have a role to play in this effort.

Source: Action Alliance for Suicide Prevention. (n.d.). Peers. From <http://actionallianceforsuicideprevention.org/task-force/suicide-attempt-survivors/peers> (accessed April 21, 2016).

- Suicide attempt survivors need more trained peer supports at every step: warm lines, crisis lines, mobile crisis response, emergency department advocates, community mental health centers, and beyond. Certified peer specialists should be essential staff members.

- Suicide attempt survivors need more peer-run or peer-facilitated support groups for people who are or have been suicidal.
- Suicide attempt survivors need to see more peers in messaging. Seeing real people who have made it through this experience is powerful evidence that we can, too.
- Suicide attempt survivors need to have peers involved at every level of suicide prevention efforts, including in leadership positions.

Source: National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force. (2014). *The way forward: Pathways to hope, recovery, and wellness with insights from lived experience*. From <http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/The-Way-Forward-Final-2014-07-01.pdf> (accessed April 21, 2016).

- For far too long, the suicide prevention field and behavioral healthcare system have not engaged the perspectives of those with lived experience of suicide and a culture of silence has prevailed due to fear, social stigma, and personal shame. There is a strong movement underway to change this, and suicide attempt survivors are emerging with a collective voice and cohesive framework for shaping the future of suicide prevention.
- This is a pivotal time in the history of suicide prevention in this country. We are embracing those with lived experience to broaden and shape the future of suicide prevention. The National Action Alliance for Suicide Prevention’s *The Way Forward* sets the stage for a constructive collaboration in developing new, more effective means for reducing suicide attempts and deaths. It does so by providing recommendations based on evidence-based practices which incorporate personal lived experience of recovery and resilience.
- Examples of the short-term goals include:
  - Establishing training protocols and core competencies for peer supports around suicidal experiences, and methods for assessing them.
  - Training human resources staff at agencies and organizations in best practices for supporting those employees with histories of mental health challenges or suicidal experiences
  - Including and endorsing attempt survivors in suicide prevention efforts within all levels of agencies and organizations (federal, state, community, etc.).
- The overarching long-term goal of this document 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.

Source: Wyman, P. A., Brown, C. H., LoMurray, M., Schmeelk-Cone, K., Petrova, M., Yu, Q., et al. (2010). An outcome evaluation of the Sources of Strength suicide prevention program delivered by adolescent peer leaders in high schools. *American Journal of Public Health, 100*(9), 1653–1661.

- [The researchers randomly assigned 18 high schools—6 metropolitan and 12 rural—to immediate intervention or the wait-list control.] Surveys were administered at baseline and 4 months after program implementation to 453 peer leaders in all schools and to 2675 students selected as representative of the 12 rural schools.

- [Sources of Strength] training improved the peer leaders' adaptive norms regarding suicide, their connectedness to adults, and their school engagement, with the largest gains for those entering with the least adaptive norms.
- Trained peer leaders in larger schools were 4 times as likely as were untrained peer leaders to refer a suicidal friend to an adult. Among students, the intervention increased perceptions of adult support for suicidal youths and the acceptability of seeking help. Perception of adult support increased most in students with a history of suicidal ideation.

Source: American Association of Suicidology. (n.d.). U OK? Friends ask. Peers engaging peers to prevent suicide. From <http://www.suicidology.org/ncpys/u-ok-program> (accessed April 21, 2016).

- The National Center for the Prevention of Youth Suicide (NCPYS), a program of the American Association of Suicidology (AAS), is working to change how schools and communities address the issue of suicide among young people, by inviting you to take the lead. We recognize the need for student involvement and ideas in shaping the campaign against suicide. By engaging young adults and providing the facts, the NCPYS seeks not only to help those most at risk, but also to equip school communities with the skills they need to recognize warning signs, help friends in need, and know where to go for help.

*A link check was run on all the external websites listed in the discussion guide to identify and fix any broken links as of 11/16/15. However, we acknowledge that URLs change frequently and may require ongoing link checks for accuracy. Last Updated: 4/25/2016.*