National Strategy for Suicide Prevention

Implementation Assessment Report

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National Strategy for Suicide Prevention Implementation Assessment Report

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

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Electronic Access

This publication may be downloaded at http://store.samhsa.gov/SMA17–5051.

Recommended Citation

Substance Abuse and Mental Health Services Administration: *National Strategy for Suicide Prevention Implementation Assessment Report*. HHS Publication No. SMA17–5051. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2017.

Originating Office

Suicide Prevention Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857, HHS Publication No. SMA17–5051. Printed 2017.

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PREFACE

Suicide in the United States is continuing to increase. Over 44,000 Americans died by suicide in 2015, and both the rate of suicide and the numbers of Americans who have died by suicide has increased annually over the last decade. Overall, suicide rates increased 28 percent from 2000 to 2015 (CDC, WISQARS). In addition, presentations to Emergency Departments because of suicidal ideation have been increasing at a rate of 12 percent annually (Owens et al., 2017). This has occurred despite the 2012 publication of a revised *National Strategy for Suicide Prevention*, despite a steady increase in knowledge about suicide prevention, and despite unprecedented levels of suicide prevention activity. This report concludes that despite this increasing level of activity, efforts to implement all that we know about suicide prevention as part of a comprehensive approach that seeks to prevent suicide across the lifespan (including adults as well as youth) have been rare. The report attempts to provide a snapshot of recent efforts to implement the goals and objectives of the *National Strategy for Suicide Prevention* and makes suggestions for increasing the effectiveness of these implementation efforts.

EXECUTIVE SUMMARY

The magnitude of efforts to reduce suicide in America and our growing knowledge about what is effective in reducing suicide—while still incomplete—are also greater than ever before. It was this fact that led the United States Surgeon General, in collaboration with the National Action Alliance for Suicide Prevention (Action Alliance, http://www.actionallianceforsuicideprevention.org), to revise the original *National Strategy for Suicide Prevention* (*National Strategy*) in 2012. The Action Alliance is the public-private partnership charged with advancing *National Strategy* goals that require national collaboration and leverage. It was launched by the Secretaries of the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Defense (DoD) in 2010.

In 2014, the Action Alliance created the National Strategy for Suicide Prevention Implementation Assessment Advisory Group (NSSP IAAG) to better understand how the country was implementing the 2012 *National Strategy*, challenges to implementation, and recommendations for overcoming those challenges. The goal of the *National Strategy for Suicide Prevention Implementation Assessment Report* (*National Strategy Implementation Report*) is to inform national stakeholders and policymakers as they work to enhance and refine efforts to advance the *National Strategy* and to save lives in this country.

The NSSP IAAG gathered information by:

- Surveying major national suicide prevention organizations, including members of the National Council for Suicide Prevention (http://www.thencsp.org);

- Reviewing transcripts of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Regional Directors' targeted discussions with state suicide prevention leads (http://www.sprc.org/states);

- Reviewing the work of three agencies (HHS, DoD, and the Department of Veterans Affairs) that are members of the Federal Working Group on Suicide Prevention (http://actionallianceforsuicideprevention.org/federal-working-group-suicide-prevention), which mapped their suicide prevention activities onto the *National Strategy* goals;

- Reviewing the work and accomplishments of the Action Alliance's Task Forces (http://actionallianceforsuicideprevention.org/taskforces); and

- Reviewing best practices, successes, and challenges among SAMHSA's Garrett Lee Smith Youth Suicide Prevention state and tribal grantees.

Collection and analysis of this information showed that there is more suicide prevention activity in the United States now than ever before. Informants uniformly said that the *National Strategy* is a major influence on their local, state, and organizational suicide prevention planning. The NSSP IAAG's analysis confirmed this, revealing progress in implementing each goal in the *National Strategy*. However, there is also significant variability in both the magnitude of effort and the potential for having a measurable impact on reducing suicidal behavior.

While assessing implementation of each of the *National Strategy's* 60 objectives is beyond the scope of this report, it was possible to identify themes and draw preliminary conclusions from assessing implementation of its 13 goals. In addition to the universal recommendations of encouraging stakeholders to conduct more research and to continue, enhance, and evaluate their work, the *National Strategy Implementation Report* makes four recommendations, initially presented to the Action Alliance Executive Committee:

1) **State, tribal, and community-level suicide prevention infrastructure.** States, tribes, and communities should consider building an infrastructure to support stable, comprehensive, and coordinated suicide prevention efforts, including (1) identifiable, sustained state/tribal/community-level leadership embedded within state/tribal government with the responsibility and authority to advance suicide prevention and (2) the presence of an active public-private coalition to ensure their efforts reach multiple sectors. Some entities would need to begin establishing an infrastructure; others would need to continue strengthening existing infrastructures.

2) **Blueprint for community action.** The National Action Alliance for Suicide Prevention, or some other national body, should consider developing a blueprint for community-based suicide prevention. The blueprint should specify what a stable, comprehensive, and coordinated suicide prevention effort might look like at the community level; define the unique role that each public and private partner can play; and provide strategies and tools (e.g., model resources, guidelines, policies, practices, and protocols) that communities can use as they implement their programs. This blueprint would complement the Zero Suicide model for health care systems.

3) **Comprehensive state, tribal, and community suicide prevention efforts**. Promote comprehensive state, tribal, and community suicide prevention efforts by holding quarterly or bi-annual regional meetings. The public sector, private sector, or a public/private partnership could undertake this recommendation.

4) **Regular and coordinated monitoring of *National Strategy* implementation.** Ensure regular and coordinated monitoring of *National Strategy* implementation in order to understand how the country is implementing the 2012 *National Strategy*, the impact of its implementation, challenges to implementation, and recommendations for overcoming those challenges. The public sector, private sector, or a public/private partnership could undertake this recommendation.

Since the NSSP IAAG reported its recommendations to the Action Alliance's Executive Committee in 2015, several national efforts have begun advancing those recommendations. Key among efforts that advance the first three recommendations are the Action Alliance's *Transforming Communities: Key Elements for Comprehensive Community-Based Suicide Prevention* (http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/TransformingCommunitiesPaper.pdf), which presents seven critical elements for comprehensive community-based suicide prevention that should guide program planning and implementation; the Center for Disease Control and Prevention's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (https://www.cdc.gov/violenceprevention/pdf/suicide-technicalpackage.pdf), which compiles a core set of strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to prevent suicide; and SAMHSA's 2017 State Suicide Coordinator's meeting, which strove to determine the resources, information, trainings, and other resources that would help improve their impact in reducing suicides.

METHODOLOGY

With the goal of better understanding how the country is implementing the 2012 *National Strategy*, challenges to implementation, and recommendations for overcoming those challenges, during 2014 the NSSP IAAG gathered information through the following activities:

- The NSSP IAAG private sector co-chair emailed a survey to members of the National Council for Suicide Prevention (www.thencsp.org), a coalition of the country's major national suicide prevention organizations. The survey gathered information on: 1) awareness and use of the *National Strategy*; 2) relevance of *National Strategy* goals for their work; 3) how each organization's current efforts mapped onto the goals of the *National Strategy*; 4) identifying gaps in each organization's work based on *National Strategy* goals; and 5) current organizational activities that were not included in the *National Strategy* goals or objectives. Stakeholders also responded to questions about challenges to implementation and recommendations for surmounting those challenges.

- Substance Abuse and Mental Health Services Administration (SAMHSA) Regional Administrators led semi-structured discussions with state suicide prevention coordinators (www.sprc.org/states), which paralleled the questions sent to national organizations.

- Through the Federal Working Group on Suicide Prevention (http://actionallianceforsuicideprevention.org/federal-working-group-suicide-prevention), three federal agencies mapped their current suicide prevention efforts onto the goals and objectives of the *National Strategy*. Those agencies were the DoD; HHS, including the Administration for Community Living (ACL), Centers for Disease Control and Prevention (CDC), National Institutes of Health, and SAMHSA; and the U.S. Department of Veterans Affairs (VA).[1] Together, all of these departments make significant contributions in implementing all 13 goals of the *National Strategy*.

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[1] The objective-by-objective review of National Strategy implementation by DoD, HHS, and VA is available as an addendum to this document at http://actionallianceforsuicideprevention.org/national-strategy-suicide-prevention-0.

- The NSSP IAAG reviewed the work and accomplishments of the Action Alliance's task forces.

- SAMHSA summarized best practices, successes, and challenges among its current Garrett Lee Smith (GLS) Youth Suicide Prevention state and tribal grantees.

The NSSP IAAG is aware that this was not a comprehensive process. For instance, a majority of, but not all, states participated in the Regional Administrators' discussions. Additionally, SAMHSA had 36 tribal GLS grantees at the time it collected "active grantee" information, which is neither a majority nor representative of the country's 562 federally recognized tribes. Still, the NSSP IAAG was able to map activities to the *National Strategy* goals; identify themes and promising approaches and programs; and describe significant policy and practice gaps in the overall *National Strategy* implementation. They reported their recommendations to the Action Alliance's Executive Committee in 2015.

NATIONAL STRATEGY FOR SUICIDE PREVENTION GOAL-BY-GOAL IMPLEMENTATION SUMMARY

This chapter briefly summarizes the results of NSSP IAAG's work and analysis in mapping state, organizational, and federal activities to the *National Strategy* goals. It focuses on the identification of themes in policy and practice, highlights promising approaches and programs, notes significant gaps and challenges to implementation, and makes recommendations for overcoming those challenges.

Two findings quickly emerged as the NSSP IAAG organized its information. First, it was clear there was more suicide prevention activity in the United States than ever before. This fact was established by comparing the benchmark activities detailed in the 2010 publication *Charting the Future of Suicide Prevention: A Progress Review of the National Strategy and Recommendations for the Decade Ahead* (SPRC & SPAN USA, http://www.sprc.org/sites/default/files/migrate/library/ChartingTheFuture_Fullbook.pdf) with the initiatives compiled by the NSSP IAAG. Second, although there was activity and progress in implementing each goal in the *National Strategy*, the NSSP IAAG found significant variability in both the magnitude of effort and the potential for having a measurable impact on reducing suicidal behavior.

Goal 1—Integrate and coordinate suicide prevention activities across multiple sectors and settings

Mapping national activities to Goal 1 of the *National Strategy* showed that the Action Alliance, federal government, states, tribes, and private stakeholders were individually and collectively initiating a large number of suicide prevention programs within a range of sectors and settings (e.g., public and private health care systems, education, justice, faith communities). Stakeholder descriptions of the programs clearly indicated that the *National Strategy* influenced the planning and implementation of the work.

While the level of activity (including resource/tool development) is encouraging, the NSSP IAAG generally categorized these activities as emerging best practices that are not yet standard policy, practice, or protocol. For example, in 2013 the Action Alliance's "Youth in Contact with the Juvenile Justice System Task Force" (YICJJSTF) developed state-of-the-art suicide prevention recommendations and tools (Action Alliance YICJJSTF, 2013, http://actionallianceforsuicideprevention.org/youth-contact-juvenile-justice-system-task-force). However, these recommendations and resources have not been widely implemented in juvenile justice programs across the country, nor is any entity actively promoting adaptation at the national level.

There is a mechanism for states and tribes to disseminate their promising and best practices to counterparts across the country. State and tribal stakeholders reported that receiving technical assistance from the Suicide Prevention Resource Center (SPRC; the SAMHSA-funded resource center devoted to advancing the *National Strategy*) was critical to their ability to learn from their colleagues and implement *National Strategy* goals and objectives.

A number of stakeholders made it clear that the infrastructure necessary for stable, successful, comprehensive suicide prevention programming is frequently not present at the state and community levels. For instance, the role and authority of state leadership in suicide prevention vary across states. State suicide prevention coordinators range from identifiable leaders positioned in state behavioral health or public health departments to individuals working for the state who count suicide prevention among multiple, demanding roles to individuals with a passion for preventing suicide who work in community mental health programs.

Further, stakeholders reported that funding for suicide prevention programs tends to come almost exclusively from federal or community/charitable sources. Many state informants validated one another's experiences of relying on SAMHSA-funded GLS grants to provide the focal point for their suicide prevention efforts. When the funding ends, these states are at risk of losing the leadership, staffing, momentum, and multi-sector interagency coordination needed to maximize the likelihood of success and sustain their work. Additionally, complete reliance on GLS funds for suicide prevention limits a state to working with young people ages 10–24, while the majority of suicides in this country (and in each state) are among adults in the middle years. The bottom line is that without sustained leadership and infrastructure, well-intentioned suicide prevention activities can become fragmented and non-strategic, unable to achieve sufficient range, depth, or focus to have a measurable impact on reducing suicides or suicide attempts.

Some states have made independent investments in suicide prevention, allowing them to tailor programs to the needs of their citizens, maintain interagency collaboration, and provide stability over time. For instance, Tennessee has a strong six-person Office of Suicide Prevention and Crisis Intervention coupled with a robust public/private partnership that reaches into counties and local communities. The Tennessee Suicide Prevention Network (TSPN) provides suicide prevention training, postvention services, and technical assistance to counties and local communities. Established in 2001, TSPN is a public-private partnership charged with implementing the Tennessee Strategy for Suicide Prevention, based on the *National Strategy* and revised seven times since TSPN's founding. TSPN receives 95 percent of its funding from the State of Tennessee, with

administrative oversight provided by Mental Health America of Middle Tennessee and its 32-member Advisory Council appointed by the Office of the Governor.

Other examples of states that have invested in their suicide prevention infrastructure include Massachusetts and Texas. Massachusetts collaborates with regional, statewide, and local suicide prevention coalitions to support and promote youth suicide prevention programming. The State of Texas has strong relationships with its Local Mental Health Authorities and is implementing the Zero Suicide (http://zerosuicide.sprc.org) model in one pilot location, with plans to expand statewide. Texas also hosts summits and symposia—some of which top 1,000 participants—to disseminate best practices to a wide range of organizations across the state.

Tribes and territories could also benefit from this kind of infrastructure; their unique needs and challenges highlight the importance of a fully engaged community response. For instance, the Model Adolescent Suicide Prevention Program (May et al., 2005), evaluated through the University of New Mexico, demonstrated reductions in suicidal behavior using such a community approach. Another example of a successful community response is the White Mountain Apache Tribe (a GLS grantee) where tribal leadership has required a tribal surveillance system to which each community member is obligated to report communications about suicidal ideation, threats, or attempts. An evaluation of the impact of this comprehensive, multi-tiered youth suicide prevention program between 2007 and 2012 showed a significant reduction in suicide attempts (from 75 to 35 individuals), a 23 percent decrease in the suicide rate among youth, and an overall tribal suicide rate decrease of more than 38 percent (Cwik et al., 2016). It is important to note that during this same period of time, national rates remained stable or increased slightly.

The NSSP IAAG did not identify any states or communities implementing the full range of comprehensive, coordinated, and effective suicide prevention efforts across all relevant settings and populations. However, among the states that have invested in infrastructure, they identified common elements necessary to support a stable, comprehensive, and coordinated suicide prevention effort, leading to the following recommendation:

> **State, tribal, community-level suicide prevention infrastructure.**
> States, tribes, and communities should consider building an infrastructure to support stable, comprehensive, and coordinated suicide prevention efforts, including (1) identifiable, sustained state/tribal/ community-level leadership embedded within state/tribal government with the responsibility and authority to advance suicide prevention and (2) the presence of an active public-private coalition to ensure their efforts reach multiple

sectors. Some entities would need to begin establishing an infrastructure; others would need to continue strengthening existing infrastructures.

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

A large number of stakeholders in the public and private sectors have made significant efforts to advance this goal, which includes objectives dealing with effective communication designed to reach at-risk populations; use of emerging and evolving technology (e.g., social media, online, and mobile applications); safe messaging (see also Goal 4); and connecting individuals in crisis with assistance and care.

One of the Action Alliance's three priorities (http://actionallianceforsuicideprevention.org/priorities) is "Changing the Conversation," defined as "Leveraging the media, national leaders, and all those who communicate about suicide prevention to change the national narratives around suicide and suicide prevention to ones that promote hope, connectedness, social support, resilience, treatment, and recovery. This priority focuses on fundamentally transforming attitudes and behaviors related to suicide and suicide prevention. It includes elements of both Goals 2 and 4 of the *National Strategy*.

Safe messaging—based on research showing that certain kinds of messaging and media coverage about suicides can increase the likelihood of suicide in vulnerable individuals, while other kinds of messages can promote help-seeking behavior—is an area of continuing emphasis for suicide prevention programs, as are efforts to encourage help-seeking by those at risk for suicide.

Although for many years, the standard "action step" in suicide prevention public messaging has been directing audiences to the toll-free telephone numbers for SAMHSA's National Suicide Prevention Lifeline (Lifeline) and the VA's Veterans Crisis Line (VCL), recent years have seen an increase in the provision of crisis chat and text services. The Trevor Project, the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people, was an early adopter of both chat and text services. The Crisis Text Line, a text-messaging support line for those in crisis, began its work in 2013. The field is making major efforts to promote and provide suicide prevention and crisis intervention services online, including VA's crisis chat and text services and Lifeline's expansion to a 24/7 crisis chat service. All providers report that call, chat, and text volume rise each year.

SAMHSA conducts ongoing evaluations of its own crisis services, and SAMHSA, DoD, and VA are planning additional evaluations in the future.

Using the power of social media to prevent suicide continues to be an emphasis within the suicide prevention community. Suicide Awareness Voices of Education (SAVE, http://www.save.org), a national organization dedicated to preventing suicide through education and awareness, and Lifeline are leading successful efforts to partner with social networking sites such as Facebook and Twitter. In an effort to help those who may be expressing suicidal thoughts on Facebook, and in consultation with SAVE, Lifeline, and others in the field, Facebook developed tools that provide resources, advice, and support to those users, as well as friends and family members who might be worried about them when reading those posts. Lifeline was one of the first suicide prevention programs to establish a strong presence on social networking sites (e.g., Facebook, Twitter, Tumblr, Pinterest). Most suicide prevention organizations now maintain active accounts.

The public and private sectors are making progress in refining and promoting awareness of suicide warning signs, coupled with action steps for people who are concerned about themselves or someone else. For instance, SAMHSA, the American Association of Suicidology, and the National Center for the Prevention of Youth Suicide convened an expert panel in 2013 that developed consensus, evidence-based warning signs for youth. SAVE led focus groups to refine the warning signs and then launched a Youth Suicide Warning Signs website (http://www.youthsuicidewarningsigns.org) to keep them in the public eye and educate gatekeepers about how to respond. Additionally, since publication of the 2012 *National Strategy*, SAMHSA has distributed more than 3.8 million warning signs wallet cards that promote the Lifeline number, including 376,000 in Spanish.

Both DoD and VA have ongoing communication campaigns designed to promote help-seeking among their constituencies. DoD's Real Warriors Campaign (http://dcoe.mil/Families/Real_Warriors_Campaign.aspx) is a multimedia public education effort designed to encourage help-seeking behavior among service members, veterans, and military families coping with invisible wounds. The campaign is an integral part of the Defense Department's overall effort to connect warriors and their families with appropriate care and support for psychological health concerns. VA's Make the Connection campaign (http://maketheconnection.net) helps veterans and their families "make the connection" with other people, resources, symptoms of mental health issues, treatment, and support to get their lives on a better track. The website includes brief videos with stories of strength and resilience from fellow veterans and family members.

The NSSP IAAG identified numerous research-informed communications efforts, as well as national leadership to advance this goal within the Action Alliance and the public and private sectors. No particular challenges or gaps were identified, and no

recommendations are offered toward advancing this goal, aside from the universal recommendations regarding the need for more research and encouragement to stakeholders to continue, enhance, and evaluate their work.

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

The NSSP IAAG found a range of federal, state, tribal, and community programs that work to prevent suicide by increasing protective factors and enhancing resilience. SAMHSA, DoD, VA, and other federal agencies direct numerous activities that promote wellness and recovery. For instance, CDC funds two cooperative agreements to evaluate connectedness as a suicide prevention tool; one focuses on high-risk adolescents, the other on socially disconnected seniors. The agency also supports other research on beneficial social connections (www.grants.gov/web/grants/view-opportunity.html?oppId=51411).

In 2014, SAMHSA awarded 20 tribes 5-year grants through its new Native Connections program (http://www.samhsa.gov/native-connections), which uses a strength-based approach to reduce suicidal behavior and substance use and promote mental health among Native youth. This approach builds protective factors by enhancing connections between youth and the inherent strengths of tribal communities and culture.

The private sector conducts an array of programs that draw on protective factors to reduce suicidal behavior; some have an evidence base while others are promising. Examples of evidence-based programs[2] include Sources of Strength https://sourcesofstrength.org/), *American Indian Life Skills Development/Zuni Life Skills Development* (http://www.sprc.org/resources-programs/american-indian-life-skills-developmentzuni-life-skills-development), and PEARLS: Program to Encourage Active, Rewarding Lives for Seniors (http://www.pearlsprogram.org).

Sources of Strength is a comprehensive, strength-based, wellness program that can be implemented in schools, colleges, and faith, cultural, and community-based settings and focuses on adolescents. It utilizes peer and caring adult relationships to improve social norms, enhance coping and social support, and increase help-seeing behaviors to reduce suicidal risk and other risk-taking behaviors.

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[2] See SAMHSA's National Registry of Evidence-based Program's and Practices (http://nrepp.samhsa.gov)

For Native youth ages 14 to 19, *American Indian Life Skills Development/Zuni Life Skills Development* is a school-based suicide prevention curriculum to reduce suicide risk and improve protective factors. The curriculum covers topics such as building self-esteem, identifying emotions and stress, and increasing communication and problem-solving skills.

PEARLS is designed to reduce depressive symptoms and improve the quality of life in older adults through six to eight in-home sessions that empower individuals to achieve a greater sense of well-being and figure out how to solve problems, make more social connections, and become involved in activities and in their communities.

Other programs developed to increase protective factors and enhance resilience are promising but do not yet have an evidence base. One example is the Umatter for Schools Suicide Prevention program, (www.sprc.org/resources-programs/umatter-schools-youth-suicide-prevention) a 2-day training that provides teams of school staff with the knowledge and skills to develop a comprehensive, asset-based approach to suicide prevention in their school. The Circles 4 Hope (http://hope4utah.com/phase-i-circles-4-hope-2/) program from Utah includes training for teachers and HOPE squads (trained peer groups) with connections to community resources, including mental health services.

The Action Alliance's Faith.Hope.Life. (www.actionallianceforsuicideprevention.org/faithhopelife-0) initiative helps faith communities, regardless of creed, focus one Sabbath each year on the characteristics common to most faiths that also help prevent suicides. These characteristics promote hope, build healthy social connections, provide answers to life's challenging questions, and recognize and celebrate the myriad reasons for living.

The NSSP IAAG was not able to detect particular challenges, themes, momentum, or national leadership in advancing Goal 3. Because this was true of many of the goals the group mapped, it makes the following recommendation:

> **Ensure regular and coordinated monitoring of** *National Strategy* **implementation** to understand how the country is implementing the 2012 *National Strategy*, the impact of its implementation, and challenges to implementation, and to provide recommendations for overcoming those challenges. The public sector, private sector, or a public/private partnership could undertake this recommendation.

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

Traditional news media, online/mobile media, and the entertainment industry all play important roles in educating the public and shaping its perception about suicide, suicide prevention, and help-seeking. Therefore, as referenced in Goal 2, promoting safe and responsible messaging is a continuing area of emphasis in suicide prevention.

Research shows that certain types of messaging about suicide deaths can increase risk among vulnerable individuals, normalizing suicide as a natural outcome for certain kinds of life crises. For instance, individuals who identify with a decedent in a story—such as bullied lesbian, gay, bisexual, and transgender (LGBT) teens or combat veterans with post-traumatic stress disorder (PTSD)—may grow to believe that suicide is the natural and inevitable end to their story.

Conversely, positive and safe messaging can help individuals in crisis find the help they need and educate the public about how they can be involved in preventing suicide. Studies have shown that media coverage carrying positive narratives that include stories of hope and recovery can help reduce the suicide rate in the areas in which they were widely distributed, with some evidence of nationwide impact (Etzersdorfer & Sonneck, 1998; Michel et al., 1995; Niederkrotenthaler & Sonneck, 2007; Pirkis et al., 2009). Prior to the release of the 2012 *National Strategy*, the suicide prevention community translated the research into recommendations for reporting on suicide (www.ReportingOnSuicide.org) to assist journalists in safely covering suicide.

As part of its "Changing the Conversation" priority, the Action Alliance took the next steps, working with the journalism community, disseminating the recommendations, and promoting their implementation. With funding from the public and private sectors, in 2014 the Action Alliance partnered with the Poynter Institute—a journalism school that is an international leader in journalism standards and ethics—to host three institutes titled Covering Suicide and Mental Health Reporting and to develop an online training for reporting on suicide (https://www.newsu.org/reporting-mental-health-suicide). The workshops featured experts discussing how reporters can best cover suicide and suicide prevention in balanced, safe, and meaningful ways. In all, 53 journalists from 23 states, representing broadcast, print, and digital media outlets, attended the 2.5-day events.

Approximately 10 of the journalists have hosted their own brown bag workshops to educate colleagues in their own newsrooms on lessons learned from the Covering Suicide and Mental Health Reporting institutes. A number of participating journalists wrote stories after the institutes that reflected their newfound knowledge and insights. The majority of news coverage focused on veteran suicide prevention and included information (as recommended) on local/national mental health resources for those in need of help. The *Bangor Daily News*, *The Virginia Pilot*, *U.S. News & World Report*, and the *Chicago Tribune* were among the publications and digital platforms in which articles appeared. Broadcast news outlets in Alabama and Utah also featured stories that included balanced and safe reporting on suicide.

As was true for Goal 2 implementation, a large number of stakeholders in the public and private sectors have made significant efforts to advance this goal. Through the SPRC, the Action Alliance developed the Framework for Successful Messaging (http://suicidepreventionmessaging.actionallianceforsuicideprevention.org), an online reference tool that helps people working in suicide prevention use best practices in their messaging, including strategy, safety, positive narrative, and guidelines.

Similar to its conclusions for Goal 2, the NSSP IAAG identified national leadership to advance this goal within the public and private sectors, as well as numerous Goal 4-related activities in the field. The group is not offering recommendations toward advancing this goal beyond the universal recommendations regarding the need for more research and encouragement to all stakeholders to continue, enhance, and evaluate their work.

Goal 5—Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors

Goal 5 builds on the call for integrated and coordinated suicide prevention efforts within diverse clinical and community settings by emphasizing the importance of using evidence-based practices. While there is accumulating evidence regarding effective interventions in both community and clinical systems, the absence of state, tribal, and community infrastructure described in Goal 1 has hampered the field's ability to monitor the effectiveness of existing programs and adapt them according to need and local context.

Additionally, when asked what barriers prevented them from implementing the *National Strategy,* a number of states reported that the *National Strategy* is a valuable, rich plan but has a heavy academic slant. They did not find it to be a "community friendly" tool

that explains *how* to achieve the various objectives. They also expressed the need for guidance that translates *National Strategy* goals and objectives into policies and practices—tools for implementing suicide prevention at the state and community levels.

States argued that it is difficult to respond for calls to implement the *National Strategy* when, as one said, "There are no guidelines… [T]hat's [the] kind of leadership that [you] on the national level can provide." As one state representative said, "[w]henever the term protocol…or guidelines are used…it would be really helpful if there was a toolbox that includes model guidelines…. If you leave people to their own devices to develop their own protocols and their own guidelines, they will spend an enormous amount of time and resources developing them. And what each group develops…could be vastly different."

States requested the development of a community-level toolkit with model guidelines and protocols to help implement the *National Strategy* that would parallel the blueprint used for health care systems in Zero Suicide. The Zero Suicide initiative is a solid example of how experts have operationalized Goals 8 and 9 for health care systems and translated them into practice. Stakeholders regularly applaud this model for its helpfulness and practicality, noting the fact that it is concrete, focused, and has clear, measurable outcomes.

At the federal level, DoD created its own tool by organizing its suicide prevention efforts around the framework of the *National Strategy*, beginning with formal adoption of the *National Strategy* in June 2014. DoD's Defense Suicide Prevention Office then crafted a Defense Strategy for Suicide Prevention, whose goals and objectives align with the *National Strategy* but better reflects the needs of service members, reservists, and National Guard members.

In a study of state suicide prevention planning conducted by CDC prior to the revision of the *National Strategy*, several key findings remain highly relevant today (Lubell, n.d.). These findings include the need for a leadership group within the state composed of public and private partners and the pressing need to move from planning to implementation. The report identified that "[a] major roadblock to implementation is a lack of explicit criteria for success or definite evaluation strategies to track progress or outcomes" (p. 11). While there are examples of states that are attempting to develop, implement, and monitor effective programs in the way envisioned by the *National Strategy* (see descriptions of Tennessee, Texas, and Massachusetts in Goal 1), such work is not yet common or typical. Most states are doing at least some promotion of evidenced-based strategies but lack the ability to determine whether/the extent to which their implementation has been successful.

The NSSP IAAG makes the following recommendation:

Blueprint for community action. The National Action Alliance for Suicide Prevention, or some other national body, should consider developing a blueprint for community-based suicide prevention. The blueprint should specify what a stable, comprehensive, and coordinated suicide prevention effort might look like at the community level; define the unique role that each public and private partner can play; and provide strategies and tools (e.g., model resources, guidelines, policies, practices, and protocols) that communities can use as they implement their programs. This blueprint would complement the Zero Suicide model for health care systems.

As noted under Goal 1, the NSSP IAAG was unable to identify a state or community implementing the full range of comprehensive, coordinated, and effective suicide prevention efforts across all relevant settings and populations. Many communities are implementing best practices, but there is considerable variability across states and communities. In order to achieve this comprehensive approach, states will need to learn from one another, serving as laboratories for effective suicide prevention. Some SAMHSA Regional Administrators currently hold regular calls with state suicide prevention coordinators in their regions. The NSSP IAAG recommends:

Comprehensive state, tribal, and community suicide prevention efforts. Promote comprehensive state, tribal, and community suicide prevention efforts by holding quarterly or bi-annual regional meetings. The public sector, private sector, or a public/private partnership could undertake this recommendation.

Goal 6—Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk

Reducing access to lethal means is one of the most successful suicide prevention interventions internationally. Successful interventions for means reduction include reducing access to medications (over-the-counter and prescription), firearms, hanging implements, pesticides, razors, bridge barriers, and more (Mann et al., 2005; van der Feltz-Cornelis et al., 2011). As outlined in the *National Strategy*, reducing access to lethal means during a suicidal crisis can increase the likelihood that the person will delay or survive a suicide attempt (p. 43).

The Action Alliance's Zero Suicide initiative (http://zerosuicide.sprc.org) incorporates as a key dimension reducing access to lethal means among people experiencing a suicidal crisis. SPRC developed a popular, free online course, Counseling on Access to Lethal Means (CALM) (http://www.sprc.org/resources-programs/calm-counseling-access-lethal-

means), to assist clinicians working with people who are at risk for suicide. Reducing access to lethal means is also a standard component of safety planning with and for people who are suicidal.

Because firearms are the most lethal and common method of suicide in the United States, ensuring safety around firearms is the goal of a wide variety of initiatives. One of the most novel and fastest growing programs in the country, the New Hampshire (NH) Gun Shop Project (http://theconnectprogram.org/firearms-safety-coalitions-role-nh-suicide-prevention) began in 2009 when the NH medical examiner informed NAMI New Hampshire that three people (with no connection to one another) each bought a firearm from a single store and died by suicide within hours of the purchase. A small group of firearm retailers and mental health/public health practitioners met to explore whether there was a role for gun stores in preventing suicide. With invaluable input from gun shop owners and the help of the Harvard School of Public Health's Means Matter program (https://www.hsph.harvard.edu/means-matter/), the group developed suicide prevention materials for use in gun shops. The NH Firearms Safety Coalition—a diverse group of firearms dealers, gun rights advocates, firing range instructors, and mental health/public health professionals with a shared interest in preventing suicide—later adopted the project. The coalition works together with the state medical examiner's office using real-time data analysis of suicide deaths to target interventions. Some of the gun shop owners developed a video based on the safety brochure from the project; others have written editorials and articles for newspapers and gun enthusiast websites. At the time of this writing, about half of NH businesses that sell firearms display and distribute these materials, which include Lifeline wallet cards and information about gun safety.

Although New Hampshire has not yet seen a reduction in firearm deaths, a number of states, including Colorado and South Dakota, have adapted the New Hampshire Gun Shop Project model for their own use. New Hampshire continues to respond to inquiries from states (from both traditional suicide prevention advocates and from gun shop owners) that express an interest in learning more about their Gun Shop Project.

DoD and VA manage a national gunlock distribution initiative as part of broader safety initiatives. New Mexico works with youth and veterans groups to hand out gunlocks at trainings and other events. Beyond an exclusive focus on firearms, Colorado is conducting a pilot program in Denver that adapts SPRC's CALM course in a pediatric emergency department as part of a quality improvement project for the hospital. Although evaluation results are preliminary, the state reports that they are very promising.

Aside from DoD, VA, and a few states, the NSSP IAAG did not find widespread implementation of Goal 6 activities. There was, however, a strong interest in the New

Hampshire Gun Shop Project, as well as an appreciation of the growing international literature base showing the effectiveness of lethal means reduction at the population level.

To monitor effectiveness, successes, and challenges for Goal 6 initiatives, the NSSP IAAG re-states the need for regular and coordinated monitoring of *National Strategy* implementation.

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

There are widespread initiatives in the country to conduct community "gatekeeper" training: teaching community groups to recognize warning signs and know what to do when they are concerned that someone may be at risk for suicide. For example, at the state level, the Jason Flatt Act (http://jasonfoundation.com/about-us/jason-flatt-act), which mandates formal suicide prevention training for educators, has passed in 12 states.

DoD, VA, and SAMHSA have all provided significant amounts of suicide prevention gatekeeper training for the military and community groups. DoD provides community-focused gatekeeper suicide prevention training across military installations nationwide. VA provides suicide prevention training for all staff, clinical and non-clinical, working in its medical facilities.

Since 2005, SAMHSA's GLS State and Tribal Youth Suicide Prevention grantees have trained more than 500,000 community members in suicide prevention, with evidence of lives saved and attempts averted in the year after trainings. A cross-site evaluation investigated the relationship between suicide prevention trainings provided by GLS grantees and youth suicide mortality (Walrath et al., 2015). Findings demonstrated that counties implementing GLS trainings plus other activities had significantly lower youth suicide rates in the year following training compared to similar counties that did not conduct GLS trainings. Results suggest that between 2007 and 2010, approximately 427 deaths were avoided in the year after GLS program implementation. Similarly, researchers found that counties implementing GLS program activities had significantly lower suicide attempt rates among youth in the year following GLS program implementation than did similar counties that did not implement GLS program activities (Godoy Garraza et al., 2015). More than 79,000 suicide attempts may have been averted during the period studied (2008-2011).

In recognition that clinicians from a wide range of professions routinely encounter individuals at risk for suicide, the country is seeing a growing number of initiatives focused on training the clinical workforce to improve competency in assessing and

treating suicidal individuals. A major advancement in this area is the VA's requirement that its entire mental health workforce be trained in suicide risk assessment and management.

Two significant sets of guidelines have been published since the release of the 2012 *National Strategy*. In 2013, VA and DoD released the VA/DoD Clinical Practice Guideline on Assessment and Management of Patients at Risk for Suicide (U.S. Department of Veterans Affairs & U.S. Department of Defense, 2013, http://www.healthquality.va.gov/guidelines/MH/srb/VADODCP_SuicideRisk_Full.pdf), which is likely to have a broad impact over time on suicide care nationally.

A year later, the Action Alliance published its *Suicide Prevention and the Clinical Workforce: Guidelines for Training* (National Action Alliance: Clinical Workforce Preparedness Task Force, 2014, http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Guidelines.pdf). Developed by the Action Alliance's Clinical Workforce Preparedness Task Force (co-chaired by leadership from CARF International and HRSA), the guidelines are intended to be used as a framework in the development, adoption, and adaptation of training efforts for all health professionals who must be licensed to practice by state regulatory or licensing bodies and/or are governed by professional association requirements. However, despite the task force's initial outreach to stakeholders, the widespread dissemination of the guidelines to health professions and subsequent adoption into graduate training, continuing education, and by credentialing, accreditation, and licensing bodies has not yet been accomplished.

There are encouraging signs that some mental health and substance use professional associations and accreditation bodies are promoting suicide risk assessment and management training. The American Psychiatric Nurses Association (APNA) released a set of nine competencies for psychiatric/mental health registered nurses that provide a systematic process for assessing and managing individuals at risk for suicide in inpatient settings (American Psychiatric Nurses Association, n.d.). Among accreditors, the Council on Accreditation has updated its standards for Counseling, Support, and Education Services; Crisis Response and Information Services; Mental Health and/or Substance Use Disorders; and Training and Supervision to incorporate best practices in suicide prevention (Council on Accreditation, n.d.). Additionally, The Joint Commission issued a National Patient Safety Goal (2015) focused on suicide prevention and, as mentioned, CARF International co-led the Action Alliance effort to develop clinical workforce guidelines.

The Lifeline, which had previously created and evaluated risk assessment standards for crisis centers, has also evaluated its guidelines for callers at imminent risk. They found

that crisis centers, when able to actively engage callers at imminent risk in collaborative efforts to keep them safe, were able to reduce the need for emergency rescue procedures such as calling police (Gould et al., 2015).

Several states are also advancing Goal 7 by mandating suicide prevention training for portions of their clinical workforce. Two examples are Washington State's Matt Adler Suicide Assessment, Treatment, and Management Training Act (2012), and Kentucky's SB 72 (2013), both of which serve as models for a number of interested states.

Programmatic and policy activities advancing this goal are growing quickly. To gauge progress and identify successes and challenges to implementation, the NSSP IAAG reiterates its recommendation for ensuring regular and coordinated monitoring of *National Strategy* implementation.

Goal 8—Promote suicide prevention as a core component of health care services

The suicide prevention field is making significant efforts to incorporate suicide prevention as a core component of health care services. The VA, Action Alliance, and SPRC are implementing two of the most promising and far-reaching initiatives.

There is encouraging evidence that suicide among veterans in VA care is reduced when those identified as high risk receive an "enhanced care package" (Katz et al., 2012; Veterans Health Administration, 2011). This package of services includes elements such as development of a safety plan, follow-up after missed appointments, involvement of family and/or friends, an individualized care plan that directly addresses a person's suicidality, and incorporation of a flagging system within electronic health records.

Since 2012, SPRC and the Action Alliance have promoted Zero Suicide as an organizing principle and a model for health and behavioral health care systems by supporting efforts to systematically embed suicide prevention best practices into clinical systems. This work builds on the momentum of the Action Alliance Clinical Care and Intervention Task Force's report *Suicide Care in Systems Framework* (2011, http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf), which identified critical factors common to several highly successful suicide prevention programs.

With funding from both SAMHSA and the private sector, SPRC manages the Zero Suicide initiative, which includes the Zero Suicide website and toolkit (http://www.zerosuicide.sprc.org), technical assistance, and the provision of expert faculty members. The National Council for Behavioral Health (http://www.thenationalcouncil.org) worked with SPRC to lead a "breakthrough series"

inspired by the Institute for Healthcare Improvement, through which six states developed plans, recommendations, and best practices to embed Zero Suicide in their state mental health systems. SPRC has conducted several intensive 2-day Zero Suicide Academies that included teams from states and health care organizations. Additionally, Zero Suicide faculty deliver presentations at a growing number of state, national, and international venues.

Resources and tools for this initiative continue to evolve and are heavily influenced by "lessons learned" and successes of the early group of implementers. Centerstone in Tennessee—an early adopter of the Zero Suicide model—reported in May 2015 that suicides dropped from 3.1 per 10,000 to 1.3 per 10,000 in the preceding 21 months. This is the equivalent of a reduction from 31 suicide deaths per 100,000 to 13 per 100,000.

Health systems are implementing the approach in a variety of settings, including outpatient behavioral health, inpatient psychiatric hospitals, integrated delivery systems, and state mental health systems. As of December 31, 2016, 249 health and behavioral health care organizations in 35 states had begun adopting a Zero Suicide approach. Twenty-one states have also supported Zero Suicide by either attending a national Academy, sponsoring their own state Academy, sponsoring own state workshop or site visit, holding own learning collaborative, or participating in a national Community of Practice.

While this is very encouraging progress with significant momentum, the nation will not feel the impact of lives saved until a majority of health care organizations begin adopting the model.

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

Goal 9 includes activities promoted through the Zero Suicide initiative that are integral to making suicide prevention a core priority in health care systems. SAMHSA now makes implementation of Goals 8 and 9 a core requirement of its GLS State and Tribal Youth Suicide Prevention grant program, as well as its National Strategy for Suicide Prevention (NSSP) grant program. Awarded for the first time in 2014, NSSP grants went to mental health authorities in four states: New Mexico, New York, Oklahoma, and Tennessee. NSSP grants require states to focus their efforts on preventing suicide and suicide attempts among working-age adults (ages 25-64).

Texas is an example of a state that has already made significant progress in implementing Goals 8 and 9 through its Suicide Safe Care initiative. The initiative focuses on improving suicide prevention efforts within the state's public behavioral health care system by integrating best practices in prevention, assessment, and intervention. The state is developing Suicide Safe Care Centers within the public mental health system, and then expanding and coordinating the model across youth-serving organizations to create Suicide Safe Care Communities. Texas has also adopted the innovative model pioneered by VA, which embeds suicide prevention coordinators in each of its medical centers and large community-based outpatient centers. VA has found this to be a vitally important intervention to assure a sustained focus on suicide prevention within health care settings. Texas is piloting the model—embedding suicide prevention coordinators in its community mental health centers and state hospitals—in Denton County (surrounding Austin, TX) and will expand it across the state over the next few years.

Also to advance Goal 9, SPRC led an expert group of emergency medicine and psychiatric service stakeholders in the development of the consensus recommendations and protocols, Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments (Suicide Prevention Resource Center, 2015, http://www.sprc.org/ed-guide). The guide is designed to assist emergency department health care professionals with decisions about the care and discharge of patients with suicide risk, with the goal of improving patient outcomes after discharge. SPRC and the emergency medicine experts are working to disseminate the guide.

Stakeholders often implement Goals 8 and 9 simultaneously. Both of these rapidly growing areas would benefit from regular and coordinated monitoring.

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

Goal 10 encompasses the need to support people affected by suicide, such as individuals bereaved by the suicide of a loved one, survivors of their own suicidal crisis or attempt, providers whose patient dies by suicide, and communities that need to heal and prevent further suicidal behavior and contagion among their members.

A major development in the suicide prevention field since the revision of the *National Strategy* has been the growing understanding that the voices of people with lived experience—those who have survived suicide crises or attempts—must play a critical role in the field. The Action Alliance's Suicide Attempt Survivor Task Force released *The Way Forward* in 2014 (http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org

/files/The-Way-Forward-Final-2014-07-01.pdf), a seminal report advancing the objective that calls for the engagement of suicide attempt survivors in suicide prevention planning and the development of guidelines and protocols for suicide attempt survivor support groups. *The Way Forward* emphasizes the critical nature of peer support and provides recommendations, including the need to establish training protocols and core competencies for peer supports and guidance to facilitate that process.

Also of great significance, the Action Alliance's Survivors of Suicide Loss Task Force developed *Responding to Grief, Trauma, and Distress after a Suicide: U.S. National Guidelines* in 2015 (http://www.sprc.org/resources-programs/responding-grief-trauma-and-distress-after-suicide-us-national-guidelines). These guidelines advance the *National Strategy* objective calling for the development of effective comprehensive support programs for individuals bereaved by suicide and promotion of the full implementation of these guidelines at the state/territorial, tribal, and community levels. This report is the first-ever comprehensive, strategic document outlining how communities can effectively respond to the devastating impact of suicide loss.

These reports pave the way for decisive advances in engaging individuals affected by suicide deaths and attempts and for shaping prevention, treatment, and postvention services. Future evaluations of *National Strategy* implementation could examine the extent to which attempt and loss survivors are part of state-level implementation efforts as part of regular and coordinated monitoring of the *National Strategy*.

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

The suicide prevention field is making progress toward advancing Goal 11 of the *National Strategy*.

The Action Alliance's Data and Surveillance Task Force reviewed the characteristics of 28 existing national data systems to identify their current usefulness in monitoring suicide and suicidal behavior and to identify gaps and areas for improvement. Its report (Crosby et al., 2014) summarizes the findings from the review, discusses strengths and weaknesses related to data on suicide in the major types of available data sources, and provides recommendations for improving data timeliness, quality, and accessibility.

CDC released the nation's 2013, 2014, and 2015 mortality data within the 12-month period recommended in the *National Strategy*, which represents a significant improvement in the timeliness of suicide data. When the *National Strategy* was written, there was a 2-year time gap (HHS, 2012, p. 67). CDC's 2014 expansion of the National

Violent Death Reporting System (NVDRS) from 18 to 32 states will also significantly improve the data collection infrastructure for suicide prevention in many states. NVDRS is a state-based surveillance (reporting) system that pools data on violent deaths from multiple sources into a usable, anonymous database. These sources include state and local medical examiner, coroner, law enforcement, toxicology, and vital statistics records.

Work is still needed to meet the objective calling for expansion of state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions. SAMHSA requires its GLS state and tribal grantees to implement this objective, stating, "[t]hese local surveillance systems should include but are not limited to juvenile justice care, foster care, and behavioral health, including both mental health and substance abuse services." Several states (Kentucky, Ohio, New York, and Vermont) track suicide deaths among individuals receiving public sector behavioral health services. These states serve as models for this important work. Montana has taken the significant step of reviewing every death by suicide within the state in an effort to strengthen and guide prevention efforts.

Such data are key to effective prevention efforts, as there is significant need to monitor how suicidal behaviors differentially impact particular groups, including those who utilize mental health and substance use services. Published data from the NVDRS shows that 28.5 percent of those who died by suicide had received mental health treatment within two months before death (Niederkrotenthaler et al., 2014).

SAMHSA's National Survey on Drug Use and Health (NSDUH) collects data on mental disorders, co-occurring substance use and mental disorders, suicidal thoughts and behaviors, and treatment for behavioral health disorders for the U.S. civilian, noninstitutionalized population ages 12 and older. SAMHSA produces analytical studies based on this national and state-level data, including an analysis of mental health service utilization by adults who have attempted suicide. SAMHSA encourages its NSSP grantees to use this data and to expand surveillance within their public health systems with the goal of routinely collecting, analyzing, reporting, and using suicide-related data to inform planning and policy decisions.

VA and DoD jointly created the Suicide Data Repository (SDR) in 2013; it became operational in 2014. The SDR is a unique, collaborative effort to merge existing data from multiple federal agencies. It improves DoD and VA's ability to understand suicide behaviors, inform researchers, and evaluate suicide prevention programs through a comprehensive mortality database.

Goal 12—Promote and support research on suicide prevention

Goal 12 of the *National Strategy* speaks to the need for developing and disseminating a national research agenda, timely dissemination of research findings, and the development of a repository of research resources to help increase the amount and quality of research on suicide prevention and care in the aftermath of suicidal behaviors.

The Action Alliance's Research Prioritization Task Force, initiated in 2010 by the National Council for Suicide Prevention (http://www.thencsp.org), released *A Prioritized Research Agenda for Suicide Prevention: An Action Plan to Save Lives* in 2014. The task force began its work by surveying more than 700 stakeholders about suicide research, then used these data to generate aspirational research goals intended to reduce the burden of suicide in the United States. Based on the aspirational goals, more than 70 international suicide research experts participated in a process to review and recommend priorities across the breadth of suicide research (etiology, risk detection, interventions, services, public health interventions, and research infrastructure). Their findings formed the foundation of the 2014 *Research Agenda*. A special supplement of the *American Journal of Preventive Medicin*e (Silverman et al., 2014), includes papers describing the task force's work and products (e.g., identifying burden, approaches to modeling benefits of interventions, quality of existing research), as well as summaries of many of the expert presentations addressing aspirational research goals.

Dissemination and use of the *Research Agenda* are ongoing. NIMH utilizes it to prioritize suicide research funding. The task force continues to publicize the *Research Agenda* nationally and internationally with the goal of encouraging stakeholders and researchers in diverse fields (e.g., injury prevention, emergency care, neuroscience) to align their work with *Research Agenda* priorities to reduce suicide risk.

In March 2015, the task force released a portfolio review and report of funded U.S. research on suicide prevention, which includes analyses of how current research is addressing priorities and identifies research gaps (National Action Alliance: Research Prioritization Task Force, 2015). The task force plans annual updates, which will advance the objective to promote timely dissemination of research findings while enabling researchers and funding sources to identify and target research gaps.

NIMH is building a repository of research resources to increase the amount and quality of research on suicide prevention. This repository will encourage researchers to use common data elements and to bank their suicide research data (with appropriate safeguards).

Together, these efforts have synthesized the current research on suicide and opened a path for future research to be more efficient, strategic, and potent in the effort to reduce the burden of suicide in the United States.

Goal 13—Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings

Although there are more suicide prevention activities in the United States than ever before, this goal describes the critical need to evaluate effectiveness, assess and disseminate the evidence in support of interventions, examine the types of delivery structures that may be most efficient and effective, and evaluate the overall impact and effectiveness of the *National Strategy* in reducing suicide morbidity and mortality.

Federal agencies have made some progress in support of evaluating implementation effectiveness and assessing and disseminating evidence in support of interventions. Evaluations of the impact of SAMHSA's GLS Youth Suicide Prevention grant program activities on suicide attempts and deaths were cited previously in Goal 7. DoD commissioned the Rand Corporation to produce multiple reports including *The War Within: Preventing Suicide in the U.S. Military* (Ramchand et al., 2011) and *Gatekeeper Training for Suicide Prevention* (Burnette et al., 2015). VA has evaluated many components of its suicide prevention initiatives and the Clay Hunt Veterans Suicide Prevention Act (2015) mandates annual evaluations of VA's efforts.

Since suicide shares risk factors with a wide range of other issues (e.g., substance abuse and intimate partner violence), it is critical that broader prevention activities include suicide-related outcome variables such as suicidal ideation, suicide attempts, and deaths by suicide. The Good Behavior Game—an elementary school classroom behavior management program—is the most widely known example of a universal, non-suicide specific prevention program that examined, analyzed, and documented suicidal behavior among its outcomes (Kellam et al., 2011). There is a need to increase the number of non-suicide-specific interventions that evaluate their impact on suicide behaviors.

We still have much to learn about the most effective delivery structures for suicide prevention within states, tribes, territories, and communities. Once implemented, the NSSP IAAG recommendations to establish or strengthen state, tribal, and community-level suicide prevention infrastructure (NSSP IAAG Goal 1), and to develop a blueprint for community-based suicide prevention (NSSP IAAG Goal 5) will both require an evaluation of their effectiveness.

The need for ongoing evaluation of the impact of the *National Strategy* on reducing the nation's suicide morbidity and mortality cannot be underestimated. The Scottish government's evaluation of its National Suicide Prevention Strategy from 2002 to 2013 showed it had reduced suicides by 18 percent and identified five components they felt were key to its success (Scottish Government, 2013). They highlighted the importance of "[h]aving a 10-year national strategy and action plan that has been regularly evaluated and refreshed, giving us a sustained focus on suicide prevention actions and outcomes." The *National Strategy Implementation Report* is a step toward achieving that objective for the United States, but it is limited in both rigor and scope. Ensuring regular and coordinated monitoring of the *National Strategy* would be an important next step toward understanding its impact and identifying ways to advance and refine its implementation.

SUMMARY OF RECOMMENDATIONS

Based on analysis of information gathered during this process, the NSSP IAAG makes the following four overarching recommendations. These recommendations speak to the need for: 1) state, tribal, and community infrastructure for suicide prevention; 2) a blueprint for effective community action that complements the guidance provided for health care by the Zero Suicide initiative; 3) comprehensive state and community suicide prevention efforts; and 4) regular and coordinated monitoring of *National Strategy* implementation.

State, tribal, and community-level suicide prevention infrastructure

State, tribal, community-level suicide prevention infrastructure. States, tribes, and communities should consider building an infrastructure to support stable, comprehensive, and coordinated suicide prevention efforts, including (1) identifiable, sustained state/tribal/community-level leadership embedded within state/tribal government with the responsibility and authority to advance suicide prevention and (2) the presence of an active public-private coalition to ensure their efforts reach multiple sectors. Some entities would need to begin establishing an infrastructure; others would need to continue strengthening existing infrastructures.

The NSSP IAAG found that the infrastructure necessary for stable, successful, comprehensive suicide prevention programming is frequently not present at the state and community levels. States need strong suicide prevention infrastructures to support coordinated, comprehensive implementation of the *National Strategy*. As Surgeon General Benjamin stated in the preface to the *2012 National Strategy*, "[r]educing the number of suicides requires the engagement and commitment of people in many sectors in and outside of government, including public health, mental health, and health care, the Armed Forces, business, entertainment, media and education." In order for these sectors to be engaged in a coordinated and comprehensive effort of the magnitude necessary to reduce deaths by suicide, there should be identifiable state-level leadership with the responsibility and authority to:

- convene public and private partners;

- assure coordination of efforts across a variety of sectors;

- promote prioritization of suicide prevention efforts in a wide range of settings, including specialty behavioral health care, primary care, justice/corrections, and education;

- monitor trends in suicidal behavior utilizing ever-improving state and system-level surveillance data;

- robustly evaluate suicide prevention efforts to inform planning and implementation; and

- work continuously to improve suicide prevention activities and their impact.

The presence of a strong state infrastructure does not guarantee reduced suicides within the state, but the absence of such an infrastructure almost certainly compromises suicide reduction efforts to a significant degree. This infrastructure should include a state suicide prevention coordinator who is embedded within state government with sufficient resources and authority to effectively guide and promote state suicide prevention efforts as well as significant private sector involvement. State suicide prevention coordinators are typically located in state departments of either health or behavioral health. Either model can work, but both health and behavioral health departments must be engaged actively and must strategically engage a variety of other public and private partners. The presence of an active public/private coalition is a vital part of such a system so that state level efforts may reach into communities across the state.

Stability in funding is another critical element in states' and tribes' ability to be strategic; target their resources to areas of greatest need; and achieve sufficient range, depth, and focus to have a measurable impact on reducing suicides and suicide attempts. A prime example is the fact that many states report relying on SAMHSA's GLS Youth Suicide Prevention grant funding to propel their work, and if that funding is lost, leadership, staffing, momentum, and the multi-sector interagency coordination needed to sustain that work may also be lost. Furthermore, although GLS dollars can fund suicide prevention activities for the 10–24 age group, the majority of suicides in this country (and in each state) are among adults ages 35–64.

Blueprint for community action

Blueprint for community action. The National Action Alliance for Suicide Prevention, or some other national body, should consider developing a blueprint for community-based suicide prevention. The blueprint should specify what a stable, comprehensive, and coordinated suicide prevention effort might look like at the community level; define the unique role that each public and private partner can play; and provide

strategies and tools (e.g., model resources, guidelines, policies, practices, and protocols) that communities can use as they implement their programs. This blueprint would complement the Zero Suicide model for health care systems.

States clearly articulated that the complexity of the *National Strategy* makes it a challenge to implement, expressing the need for a "community friendly" tool that explains *how* to achieve the various objectives using model policies and practices. They asked for assistance in translating *National Strategy* goals and objectives into policies and practices at the state level for suicide prevention and mental health promotion. Specifically, they recommended the development of a community-level toolkit with model guidelines and protocols to help implement the *National Strategy*, which would parallel the blueprint used for health care systems in Zero Suicide.

The NSSP IAAG strongly agrees that integration of suicide prevention activities into broader community and state systems has been hampered by a failure of the suicide prevention field to specify what a comprehensive, integrated suicide prevention effort should look like and, in particular, what role should be played by each of the public and private partners called upon to participate. These pages would include concrete, focused, and practical ways to operationalize the objectives. Perhaps housed on websites of the Action Alliance or SPRC, this tool would show how all relevant partners within states and local communities could and should engage with each objective on a practical level. This specification of activities would include all relevant partners in communities including community members, governmental organizations, private organizations, etc.

While the federal and state governments can and should do much to support suicide prevention, communities ultimately perform the vast majority of suicide prevention work at the local level. It is at the community level where schools, workplaces, faith communities, hospitals, community mental health centers, local non-profits, and local governments must come together to actually implement lifesaving, comprehensive suicide prevention efforts. These communities need and deserve more explicit guidance on how to best organize themselves to do this work. Their efforts also can be supported through community coalitions that are part of a larger statewide public-private partnership.

One example of a goal that could be advanced at the local level with national leadership is Goal 12 ("Promote and support research on suicide prevention"). Not typically a priority for states or tribes, the Action Alliance could pave the way by working with the National Institute of Mental Health's Outreach Partnership Program and private sector

foundations to develop and disseminate practical ways for non-research communities to use research in their suicide prevention efforts.

Comprehensive state and community suicide prevention efforts

> **Comprehensive state, tribal, and community suicide prevention efforts**. Promote comprehensive state, tribal, and community suicide prevention efforts by holding quarterly or bi-annual regional meetings. The public sector, private sector, or a public/private partnership could undertake this recommendation.

This report found that there is more suicide prevention activity in the United States now than ever before and that we know more than ever about how to prevent suicide. Many communities are implementing best practices, with considerable variability across states and communities. The NSSP IAAG was, however, unable to find any state or community implementing the full range of comprehensive, coordinated, and effective suicide prevention efforts across all relevant settings and populations. This critical aim, outlined in Goals 1 and 5 of the *National Strategy*, has yet to be realized. In order to achieve a comprehensive approach, states will need to learn from one another, serving as laboratories for effective suicide prevention. The value of states learning from one another within a region is likely to be a vital component for successful state- and nation-wide suicide prevention efforts.

Several SAMHSA Regional Administrators already hold regular calls with their region's state suicide prevention coordinators, but with support, those calls could spread to all HHS regions and become more robust and strategic. Organized with specific learning goals and using the *National Strategy* as a framework for a comprehensive approach, the meetings could include discussions about lessons learned with opportunities for sharing and collaboration, bolstered by participation from national experts. While many of these meetings could be done virtually, it is likely that some face-to-face meetings would be necessary to maximize their impact.

One possible mechanism to use for regional meetings is the model piloted by HHS' Region V in 2013. This model "Suicide Prevention: What's Your Role?" won the People's Choice award for the 2014 *HHS Innovates* competition (which recognizes employees and their achievements in using new concepts to solve important challenges in the workplace). With the goal of engaging communities across the country in developing their own suicide prevention plans, the program was developed by a multi-agency team in HHS' Region V, including the Administration for Children and Families, ACL, Centers for Medicare & Medicaid Services, Health Resources and Services Administration, Office of Women's Health, and SAMHSA. The team organized an interactive webcast of

national experts to provide the core content for the communities. Gathered in local settings with trained facilitators, the communities participated first in the webcast and then in facilitated discussions, which led them through the process of developing local suicide prevention action plans. This model offers an innovative way to couple face-to-face meetings and cost-savings with minimal compromise on results.

Regular and coordinated monitoring of *National Strategy* implementation

> **Regular and coordinated monitoring of *National Strategy* implementation.** Ensure regular and coordinated monitoring of *National Strategy* implementation in order to understand how the country is implementing the 2012 *National Strategy*, the impact of its implementation, challenges to implementation, and recommendations for overcoming those challenges. The public sector, private sector, or a public/private partnership could undertake this recommendation.

While the NSSP IAAG Report can serve as baseline data, the fact that its data collection was limited in rigor and scope means that it provides only a partial look at *National Strategy* implementation in this country. For instance, although SAMHSA's Regional Administrators led discussions with suicide prevention coordinators about *National Strategy*-related activities in their states, the coordinators could only report on activities that they were familiar with and could easily recall. They described very few community partner activities. The NSSP IAAG believes this was a result of unfamiliarity with community activities as opposed to a lack of community activity. Data collection from the private sector also lacked rigor. Responses to the survey were often incomplete, and only a limited number of organizations returned their survey. Finally, the only tribal data collected were from SAMHSA's American Indian/Alaska Native GLS grantees in 2014. These 26 tribes were neither a majority nor representative of the country's 562 federally recognized tribes.

The NSSP IAAG believes it would be beneficial to develop an online tool to conduct annual reviews of *National Strategy* implementation, allowing states, tribes, the private sector, and other stakeholders to regularly update their *National Strategy* information. As a complement to the regional meetings, this ongoing exchange would both provide information about the actual implementation and serve as a motivator for the field to continue and refine implementation. With resources from a public or private organization or a public/private partnership, an analysis of the data would help the field monitor implementation of the 2012 *National Strategy* and understand challenges to implementation and recommendations for overcoming those challenges.

CONCLUSION

Conventional wisdom advises that a strategy will never have an impact if it sits around collecting dust on a shelf.

With the help of SAMHSA Regional Administrators, HHS Regional Health Administrators, and the National Council on Suicide Prevention, the NSSP IAAG reached out to public and private stakeholders across the country to take a snapshot of how the country is implementing the 2012 *National Strategy*, identify challenges to implementation, and make recommendations for overcoming those challenges.

The results were enlightening and gratifying. They heard from stakeholders that the *National Strategy* is a major influence on local, state, and organizational suicide prevention planning. Although no claim is made as to cause and effect, the group learned that more suicide prevention activity is taking place in the United States today than ever before. They also found that some activity is occurring around every goal in the *National Strategy*, with growing scientific evidence about practices that are effective in saving lives.

The *National Strategy* envisions comprehensive, coordinated suicide prevention efforts that have integrated community and clinical components. Although many states and tribes are working toward this goal, the *National Strategy Implementation Report* did not identify any entity that is implementing everything currently known to be effective. The recommendations in this report address the challenges faced by dedicated communities, organizations, and individuals across this country that are working every day to save lives.

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