

Building Bridges

Suicide Prevention Dialogue with Consumers and Survivors

"From Pain to Promise"

*A meeting held with prevention professionals,
health care providers, researchers, policymakers,
and consumers with personal experience in suicide.*

Annapolis, MD, November 28–29, 2007



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Disclaimer

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Contents

Definitions	vii
Preface	xi
Introduction	1
Suicide Dialogue Meeting	5
In Their Own Words	7
Advancing the Suicide Prevention Agenda	13
In-depth Conversations	19
Consumer Study.....	27
Recommendations.....	29
Next Steps	45
Resources	47
Participant List	53

Definitions

The focus of this report is on sharing the concerns and recommendations of people who have direct personal experience with suicide, particularly those who have attempted suicide and those who have lost a loved one to suicide. These people collectively are called consumers and survivors.

Consumer – a past or present recipient of mental health services.

Suicide attempt survivors – people who have experience with suicidal thinking and behaviors including individuals who have survived a suicide attempt.

Survivors – family members, significant others, acquaintances, or providers of health services who have lost a loved one or client due to suicide.

The term *suicide* is often used broadly to include thinking about suicide, self-harming behaviors, suicide attempts, and deaths by suicide. It is important to be clear about what aspect of suicide is being discussed.

Death by suicide – death from a self-inflicted act (e.g., injury, poisoning, or suffocation) where there is evidence that the act was intentional.

Deliberate self-harm (DSH) – intentional self-injurious behavior where there is no evidence of intent to die.

- DSH includes various methods by which individuals injure themselves, such as self-laceration, self-battering, taking overdoses, or exhibiting deliberate recklessness.

Suicidal communications – direct or indirect expressions of suicide ideation, expressed orally or through writing, artwork, or other means.

Suicide attempt – a non-fatal, self-inflicted act (e.g., injury, poisoning, or suffocation) with explicit or inferred intent to die.

- Death does not occur in an attempt for one of the following reasons: the act was not lethal; the person was rescued or thwarted; or the individual changed his or her mind. A suicide attempt may or may not result in injuries.

Suicide ideation – thoughts of harming or killing oneself.

- People who have suicide ideation may or may not form the intent to do themselves harm. They may or may not have a plan. Ideation may be transient or ruminative, active or passive, acute or ongoing.

Efforts to prevent suicide may be categorized in the following ways.

Prevention – interventions designed to stop suicide attempts or completions from occurring by focusing efforts on at-risk individuals, environmental safeguards, reducing the availability of lethal methods, and systemic reform.

Intervention, support, or treatment – the care of suicidal people by peers, loved ones, certified peer specialists, consumer-operated services, licensed mental health caregivers, health care providers, and other caregivers with individually tailored strategies designed to support, empower, respect, and change the behavior, mood, and/or environment of individuals, and help them identify and satisfy their needs without engaging in self-destructive behaviors.

Postvention/post intervention – actions taken after a suicide has occurred largely to help survivors such as family, friends, and co-workers cope with the loss of a loved one.

Warm lines – confidential non-crisis telephone support lines answered by trained consumers who offer support, hope, strength, understanding, and a willingness to listen.

- The operators of warm lines span all the stages of recovery from mental illnesses.

Preface

Building Resilience ... Facilitating Recovery...

A Life in the Community for Everyone

The Substance Abuse and Mental Health Services Administration (SAMHSA) has established a clear vision for its work: a life in the community for everyone. To realize this vision, the Agency has sharply focused its mission on building resilience and facilitating recovery for people with, or at risk for, mental health and/or substance use problems.

Suicide prevention is a priority as depicted in SAMHSA's matrix (<http://www.samhsa.gov/matrix/brochure.aspx>), which identifies 11 priority program areas. These areas have been seen as the most important for ensuring that the Agency's work is congruent with what people with substance use and mental disorders need to live a full, rewarding life in the community. A matrix workgroup that meets regularly across SAMHSA's three centers (the Center for Substance Abuse Prevention [CSAP], the Center for Substance Abuse Treatment [CSAT], and the Center for Mental Health Services [CMHS]) promotes attention to suicide as a critical issue.

Center for Mental Health Services

The Center for Mental Health Services is the Federal entity within SAMHSA that leads national efforts to improve prevention and mental health treatment services for all Americans. CMHS uses a number of vehicles for disseminating information about consumers' needs and interests so that these can be considered when policies and plans are being formulated. Some of the most important are described briefly here.

National Consensus Statement on Mental Health Recovery

Mental health recovery is a journey of healing and transformation that enables a person with a mental health

problem to live a meaningful life in a community of his or her choice, while striving to achieve his or her full potential. The National Consensus Conference produced this statement at a December 2004 meeting of more than 110 expert panelists: consumers, family members, providers, researchers, public officials, and others. The full statement can be found on SAMHSA's Web site (<http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129>).

The 10 fundamental components of recovery are as follows.

1. **Self-direction** and defining one's own life goals and unique path toward those goals
2. **Individualized and person-centered care** based on one's unique strengths and resiliencies, needs, preferences, experiences, and culture
3. **Empowerment** to choose from a range of options and to participate in all decisions
4. **Holistic** approaches that encompass one's whole life, including mind, body, spirit, and community
5. **Non-linear process of continual growth**, occasional setbacks, and learning from experience
6. **Strengths-based valuing** and building on one's capacities, resiliencies, talents, coping abilities, and the inherent worth of the individual
7. **Peer support**, including the sharing of experiential knowledge and skills and social learning
8. **Respect**, including the protection of rights and eliminating discrimination and stigma
9. **Self-responsibility** for one's own self-care and journeys of recovery
10. **Hope**, the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that they must confront

National Strategy for Suicide Prevention

Representing the combined work of advocates, clinicians, researchers, and survivors, the *National Strategy for Suicide Prevention* was published in 2001 by the U.S. Department of Health and Human Services. It outlines a coherent national plan to enhance the suicide prevention infrastructure, including the creation of a technical assistance and resource center. In 2002, the Suicide Prevention Resource Center (SPRC) was established with funding from SAMHSA/CMHS. The *National Strategy for Suicide Prevention* can be found on the SPRC Web site (<http://www.sprc.org>).*

President's New Freedom Commission on Mental Health

The President's New Freedom Commission on Mental Health report, *Achieving the Promise: Transforming Mental Health Care in America, 2003*, sets out several goals. The first states that in a transformed mental health system, Americans will seek mental health care when they need it—with the same confidence that they seek treatment for other health problems. The Commission's first recommendation for achieving the first goal is directed toward suicide prevention. The recommendation is to advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention. The second recommendation for achieving the first goal is to address mental health with the same urgency as physical health.

* On September 10, 2010, SAMHSA Administrator Pamela S. Hyde joined U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates to launch the National Action Alliance for Suicide Prevention. This group will update and advance the National Strategy for Suicide Prevention, develop approaches to constructively engage and educate the public, and examine ways to target high-risk populations.

Consumer Affairs

The Consumer Affairs program within the Office of the CMHS Director plays a lead role in developing and implementing consumer information activities, supporting consumer-directed initiatives, and coordinating CMHS social inclusion efforts. The program works in partnership with other Federal entities, as well as with public and private health and human service agencies, to develop policy and guidance for mental health services. It also ensures that consumer mental health needs receive adequate attention and promotes consumer participation in service design and delivery (e.g., peer support). The Consumer Affairs Program amplifies the voices of recipients of mental health services by promoting and facilitating meaningful consumer participation in all aspects of CMHS programs. This report is one of the *Building Bridges* series of reports of dialogues held in previous years with consumers of mental health services. This report presents the statements, discussions, and recommendations of a consumer/survivor dialogue meeting held in Annapolis, MD, on November 28 and 29, 2007, with consumer leaders and representatives of the suicide prevention community.

Public Policy

The history of suicide prevention legislation began in 1997, with the passage of resolutions by Congress recognizing suicide as a national problem and declaring suicide prevention a national priority. This was followed by the Surgeon General's *Call to Action to Prevent Suicide* (1999), which led to the creation of the *National Strategy for Suicide Prevention*. Since then, two major laws have been enacted: The Garrett Lee Smith Memorial Act (PL 108-355) and the Joshua Omvig Veterans Suicide Prevention Act (PL 110-110). In addition, many State governments have passed suicide prevention legislation, including resolutions recognizing suicide as a problem and authorizing the development of State suicide prevention plans.

***The Garrett Lee Smith Memorial Act, October 2004,
to Implement Suicide Prevention Programs, Enhance
Mental Health Services on College Campuses, and
Support Research and Training Centers***

More than 350 members of the House of Representatives and the entire Senate voted to pass the Garrett Lee Smith Memorial Act, bipartisan legislation to reduce youth suicide. The language that became the act was introduced by Senator Gordon Smith (R-OR) in memory of his son, who had recently died by suicide.

The Joshua Omvig Veterans Suicide Prevention Act

On November 5, 2007, President George W. Bush signed this law, which directs the Department of Veterans Affairs to develop and carry out a comprehensive program aimed at reducing suicide among veterans. Mandatory training for staff would be put in place, and veterans would be offered mental health screening and referrals, at their request, for counseling and treatment. Randy and Ellen Omvig, the parents of a young Iowa reservist who killed himself after returning from Iraq, exemplify the consumer/survivor activism that transforms grief into action to prevent future tragedies and the courage to speak out on the important public health issue of veterans' suicide.

Introduction

Suicide is a Major Public Health Problem in the United States

This is not an easy field to be in, nor an easy topic to talk about... It's a bigger problem than most people can ever know. What motivates me is that it "takes a village." Just imagine what it is like for a person who is suffering right now. If not us (to take action) who...if not now, when?
— Conference participant

Suicide—talked about, attempted, or completed—ripples like a stone dropped in a pond, spreading beyond the individual to the family, loved ones, friends, and the larger community; to caregivers and associates; and to policymakers and those who seek to help through research. The emotional tolls are impossible to calculate, and their effects endure well beyond the event, often for a lifetime.

What we can quantify are the alarming epidemiological studies and costs of suicide.

In 2005, 32,637 people died by suicide, making it the 11th leading cause of death in the United States; at this rate, someone dies by suicide every 16 minutes.* In the United States, more people die by suicide each year than die because of high blood pressure or homicide. In 2002, more than 130,000 Americans were hospitalized following suicide attempts; another 116,000 were treated in emergency departments and released.

* Source: National Vital Statistics Reports, 56(10)(available online at http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_10.pdf).

Suicide is the third leading cause of death among Americans between the ages of 15-24 and the second leading cause of death among those between the ages of 25-34. Among college students, suicide is the third leading cause of death.

According to the National Violent Death Reporting System, approximately 20 percent of all suicide deaths occur among veterans.

Suicide rates increase with age. Elderly people who die by suicide are often divorced or widowed and suffering from a physical illness. The percentage of elderly people who die by suicide is greater than the percentage of elderly people in the population.

Ninety percent of suicides that take place in the United States are associated with mental illness, including disorders involving the abuse of alcohol and other drugs. Half of those who die by suicide were afflicted with major depression. The suicide rate of people with major depression is eight times that of the general population; there also is a strong association between trauma and suicide (attempts and completions).

In addition to the tragedy of lost lives, mental illnesses come with a devastatingly high financial cost. In the United States, the annual economic, indirect cost of mental illnesses is estimated to be \$79 billion (\$63 billion in lost productivity, \$12 billion in mortality costs, and \$4 billion in productivity losses for incarcerated individuals and for the time of those who provide family care). The Suicide Prevention Resource Center (SPRC) has calculated the financial cost of each completed and attempted suicide at \$4,000 and \$9,000 per case, respectively.*

*Source: National Strategy for Suicide Prevention, Harris & Barraclough, 1997. <http://download.ncadi.samhsa.gov/ken/pdf/SMA01-3517.pdf>

Consumer/Survivor Involvement in Suicide Prevention

Suicide attempt survivors have become increasingly involved in efforts to promote suicide prevention, support, and treatment. They have joined a growing movement of survivors (family members and significant others who have lost a loved one to suicide) in providing guidance on policy, planning, and prevention services. This new way of engaging in issues parallels the growing activism in the design and delivery of mental health services.

In fact, the first-ever conference for survivors of suicide attempts, health care professionals, clergy, and laity took place on October 19-21, 2005, in Memphis, TN, and was attended by more than 100 people. It focused national attention on the continuing needs of individuals who have attempted suicide and—for the first time—how health care professionals, faith communities, and others can learn from attempt survivors to improve services and save lives. The conference, created by the Organization for Attempters and Survivors of Suicide in Interfaith Services (OASSIS) and the Suicide Prevention Action Network (SPAN USA), was titled “The First National Conference for Survivors of Suicide Attempts, Health Care Professionals, and Clergy and Laity.” A summary can be found at the SPRC Web site (<http://www.sprc.org/library/SOSAconf.pdf>).

The publication of *Lifeline Service and Outreach Strategies: Final Report of the Attempt Survivor Advisory Summit Meeting and Individual Interviews* in 2007 was another important milestone. (To view the report, go to http://www.suicidepreventionlifeline.org/media/pdf/NSPL-SOSA_Report-7-31-07_FINAL.pdf). In June 2006, the Steering Committee of the National Suicide

Prevention Lifeline Network (Lifeline) identified better outreach and service to suicide attempt survivors as a strategy for reducing suicide nationally, since a previous suicide attempt is one of the strongest known predictors of suicide. Eight attempt survivors attended a summit meeting in New York City on January 16, 2007, and four other attempt survivors contributed their suggestions during individual in-depth phone interviews conducted between January 25, and February 1, 2007. The aforementioned report summarizes the findings from the meeting and interviews. SAMHSA/CMHS has supported the consumer/survivor effort by creating the National Mental Health Consumers' Self-Help Clearinghouse and by funding Alternatives Conferences—national conferences organized by and for mental health consumers and survivors. Information about these conferences can be found on the CMHS Web site (<http://mentalhealth.samhsa.gov/csp/consumers/alternatives.asp>) by typing the phrase “alternatives conference” in the search window.

Suicide Dialogue Meeting

The purpose of the Suicide Prevention Community Dialogue with Consumers and Survivors meeting, held November 28–29, 2007, was to accomplish the following goals.

- Improve mutual understanding, respect, and partnerships between people who have experience with suicidal thoughts and behaviors and providers of health care, researchers, policymakers, and others involved in suicide prevention and behavioral health.
- Develop a set of recommendations that can lead to improved responses to suicidal thoughts, behaviors, and prevention efforts with a particular focus on overcoming attitudinal and other barriers that hinder recovery.
- Develop a report that will share consumers' voices with health care providers, researchers, and policymakers who have responsibilities for suicide prevention in this country.

Participants at this meeting reviewed this report prior to publication and provided many useful comments and suggestions to ensure that the report accurately reflects their thoughts and intentions.

Participants recommended the names of places and people for national distribution: SAMHSA's suicide prevention grantees and list of stakeholder groups; researchers funded by the National Institute of Mental Health (NIMH); policymakers and those responsible for creating and implementing State suicide prevention plans; national suicide prevention organizations and trade associations for every relevant discipline; providers and their professional organizations across the healthcare spectrum as well as those working in corrections; and graduate education programs in appropriate discipline areas.

Meeting Expectations and Norms

Recognizing the emotionally potent and delicate content of the meeting, participants and facilitators established expectations and norms at the outset. Included in these expectations and norms are the following.

- Take the morning to get to know each other and establish trust.
- All information is confidential.
- Keep in mind people's experiences; everyone in the room has a level of expertise; remember to be respectful and sensitive.
- It's important for everyone to say everything she or he needs to say; really listen to each other; no side conversations.
- If you need to leave, do that, but try to stay focused and be there for each other. If you need peer or clinical support, please ask.

In Their Own Words

Participants at the dialogue meeting introduced themselves and shared experiences that highlighted their pain and expressed their hope, what they are doing to make a difference in suicide prevention, and what they would like providers of health care services to know. Space prohibits sharing every comment, but the ones below represent a spectrum of experiences and concerns.

The Pain

The pain that led to an attempt or that followed an attempt (completed or not) of a loved one was expressed in many ways. Here are some quotes.

My sister—7 years older than me—had depression, as did my father. A few weeks before I was set to graduate from college, my sister took her life. I was totally unprepared, shocked. I was her support system, but I was not prepared for a suicide. In taking care of her papers afterward, I found out that she had called me 7 times that day. I know what it is like to deal with the impact of suicide on the individual and the family.

I lost my youngest son 1½ years ago...in all, five close family members, including my husband [have died by suicide]. The pain lasts the rest of your life. My 14-year-old granddaughter attempted suicide last July. Native Americans have to deal with a number of issues that the general population doesn't know about. We get commodity care if we get care at all, and then only when you are in danger with life or limb. Health care is very inadequate; mental health care is even worse. I spent many years keeping my husband and son alive.

It isn't safe to be gay with a mental health problem and it isn't safe to be healthy and gay. I live with bipolar disease and have been 7 years in recovery from addictions. I have problems from head to toe—I've been HIV positive for 19 years; I'm dyslexic, have a hearing loss, to name a few...and I am a suicide attempt survivor. My sister, who was an addict, was admitted to a 3-day program, rather than 30 days with a medication; that is not good for addictions. She died by suicide 2 weeks later; I honor her and know that she is here at the table with me.

I struggle with depression and have a family history of suicide. I grew up in rural America; my aunt threatened to kill herself by jumping into a cistern.

I remember very clearly as a young psychology intern working with a man who was at very high risk of suicide. During his hospitalization I had to leave for a few days to defend my dissertation. While I was gone, this man had been discharged to day treatment, a change in his level of care. He took an overdose and died. I remember vividly how disorienting it was when I returned. I was looking for him in his usual spots; but he wasn't there.

I was working in the emergency department and talking with the family of a mother who had taken an overdose. A staff member came in to tell us that the mother had died. I can still hear the cry of anguish from the family.

The Promise—Never Give Up Hope

Believing in hope, believing in a future, no matter how intense the pain or bleak the prospect, kept many from acting on their thoughts. Indeed, the need for hope was expressed in many different ways throughout the meeting. And for some, the realization of the pain

they might cause others was a powerful force. Some participants' comments are below.

In my darkest moments I sat in my car in the garage, turning the engine on and off ...wanting to end the pain, not really my life.

My daughter was actively suicidal and came close on a number of occasions; but I'm a firm believer of recovery and hope and how that inspires others. I was a depressed teenager myself. It's not just about willpower...it's about willpower and certainly hope. My daughter decided that she would live; she wrote in her college essay, "I have manic/depressive illness, but it doesn't define my life."

My younger son has had depression and expressed suicidal thoughts. Last spring, when he was home from school, we received a call from my older son who told us that a mutual friend of theirs since childhood had died by suicide at college. We went to the wake...and my younger son saw the grieving parents of the young man who died and saw how destroyed they were by their son's death. He said, "I didn't realize how awful it would be for you."

I'm moved by hearing other people's courage and strength; it helps me to be more open about my life. I have had suicide attempts; my parents had mental illnesses. I'm passionate about care in the emergency department. The care I received had a coldness and harshness. I was 14 years old. I believe I lost my adolescence due to fragmented systems of care. I'm passionate about wellness and developing internal resilience to deal with life's ups and downs.

I have a diagnosis of schizophrenia and anxiety disorder. It's humbling to hear what I have heard here today. I attempted suicide in my younger years as a result of mourning my father's death. The schizophrenia started after my wife's death

from cancer. My last attempt resulted in a lock-up in an institution. I am very attuned to the brutalization that occurs in a system controlled by providers. When locked up, I survived by centering prayer, and mindfulness meditation... I still have daily practices. Spirituality is key.

I have had mental illness, [been] dysfunctional, housebound, completely isolated due to severe anxiety, panic attacks, phobias, and ADHD, and made a near-death suicide attempt. [But] I suddenly realized I hadn't tried everything and I had no right to kill myself unless I had tried everything possible to save my life. I'm now married with children and have just about completely recovered... I recognized the trauma that I had experienced and that my illness [had] developed to help me recover.

Making a Difference

It is not unusual for those whose lives have been touched by suicide to want to help others. Many have been inspired to become active in suicide prevention in the hope that they can ease the pain of others, as they describe below.

My journey began after my son's suicide while he was in college. I teach "Suicide and the Human Experience" on college campuses, direct a federally funded grant program for college students, and teach suicide assessment in medical schools. I started a national organization with a mission to create an open dialogue in communities of color about mental illness and suicide prevention and to support those who have lost loved ones to suicide.

Seventeen years ago my sister shot herself. We didn't know at the time, but I know now, she was a victim of rape and kept it a secret. I started a nonprofit organization to address suicide in young people. I'm an advocate for reducing access to lethal means of suicide to people at risk. Suicide and secrets are a deadly combination.

I realized it was the depression that was talking when I heard the voices saying that "things would be better if you were dead." I'm passionate about relapses, those who have been treated, but relapse and go on to die by suicide. I founded a nonprofit organization dedicated to supporting people affected by depression or the loss of a loved one to suicide.

My first suicide attempt was when I was 12. I'm 22 now, a student, and on the board of directors of several organizations dealing with health.

In 1998 I was diagnosed with bipolar after a mental breakdown. I had paranoia, delusions, and so many medications to take. I was up and down due to my lack of compliance, and dived into depression on weekends. I also dived off the Golden Gate Bridge in San Francisco. After fully recovering from my physical injuries, I was still in denial and just wanted it all to go away. In my last episode, I saw that parents and friends were getting very tired...and had an epiphany that I wanted to get better. I happened to read an article about the need to have strict structure. Now I am on the speaking circuit, talking about this with Tipper Gore's campaign; and I wrote a memoir. It's important for those of us who have survived a suicide attempt to speak about our experience and what we learned.

I have been suicidal and been involved in the consumer/survivor effort for 20 years. What contributes to the problem is the feeling of worthlessness that occurs in people with these diagnoses [e.g., bipolar, personality disorder, obsessive-compulsive]; how do we integrate the messages we receive that go along with these diagnoses?

For 7 years I worked with a mobile crisis unit in New York City and came to believe that the best way to care for people is in their homes, with their family. Getting into their world and in their lives has taught me more than sitting with patients in offices.

From these personal histories, participants moved to a discussion of how to advance the agenda of suicide prevention.

Advancing the Suicide Prevention Agenda

Participants discussed what helps and what does not help from a consumer/survivor perspective in suicide prevention, intervention, and postvention. The initial discussion focused on individual and clinical issues, followed by a discussion of systems-related issues.

Individual and Clinical Issues

What Helps?

Throughout, many meeting participants spoke about the need for sensitivity in the way that language, especially diagnostic language, is used; they emphasized the need to see a person as more than his or her diagnosis and not to pathologize a person or that person's behavior. Many also spoke with urgency about the need for education that would lead to a greater awareness of and sensitivity to mental health issues; they saw this need as urgent in educational environments where teachers could learn to recognize warning signs. Others emphasized "everyday" factors that can be addressed that might minimize crises, including encouraging proper diet, rest, exercise, and companionship for those who seem to be depressed or showing other signs that might be of concern. Participants also mentioned that community counseling centers, which offer free and/or sliding scale services, are a helpful resource when attempting to reach the underserved community.

Perhaps above all, participants repeated the idea that it is important for both those in treatment and for the public at large to understand that there are far more success stories than stories with unhappy endings.

Each person finds something unique or individual that helps. Here are statements from the participants.

Get out of learned helplessness. Learn how to live with your voices...do not let yourself be treated as victims or helpless. Normalization is important, rather than being in a fishbowl of only family and therapists.

When my suicidal thoughts were demystified, I realized that they are just thoughts and that I can work with them; work proactively with suicidal/negative voices.

I find support groups to be very helpful.

Hopelessness and aloneness can be dealt with; sharing stories of recovery builds hope; it helps to know others feel like I do and are getting better.

Look for suicide ideation in substance abuse and substance abuse relapse; talk about what might happen when you relapse.

Encourage people to have a purpose in life; to reclaim their dreams...go beyond treatment goals and recovery.

Have an individualized recovery plan and safety plan when in a crisis situation.

What Does Not Help?

A frequently heard theme was that silence about suicide is ill advised; conversely, openness—as mentioned above—is often a great relief not only for the person, but for family and friends as well. Support may be withdrawn after an attempt, or even just a discussion; many found this extremely discouraging and emphasized that thoughts of suicide may never disappear completely, so it is vitally important that continuing care and concern be available. Below are statements from participants.

Hearing only about bad outcomes in the press doesn't let people know you can do something to prevent suicide; this bad press results in shame and not talking openly about suicide.

Being treated poorly at the scene of a suicide attempt or death is detrimental.

Force doesn't work.

People want you to get better quickly because it is so painful to them; people don't understand the need for acute [and chronic] care...they think people are better when they leave the hospital.

Issues related to Native Americans are unique. For example, Native Americans face discrimination. Men often don't talk about their problems and if you do, it's a sign of weakness. In reality, they can't talk about it because it is too painful.

Lack of communication between the psychiatrist who prescribes the medication and the psychotherapist is a common problem.

Alcohol abuse makes suicidal thinking and behavior worse.

Being given a treatment plan and not being a partner in the treatment planning doesn't work; plus...we need a recovery plan, not a treatment plan.

Systems Issues

Attempt survivors and family members engaged in suicide prevention and treatment have a unique lens through which to see how we might change our systems of care to better help those receiving services. The need for peer support came up many times, as did parity in insurance coverage for mental health treatment and having good access to prevention services and treatment. Participants urged policymakers and funders to pay more attention and provide funding to rural and tribal areas; these groups are behind and just starting to think about suicide prevention.

Many also noted the need for well-funded, long-term research studies that might point the way to improved services and supports. Here is a list of suggestions for what helps and what doesn't help related to systems issues.

What Helps?

- Linkages between emergency department and outpatient services.
- Same-day scheduling needed for crisis that does not require emergency department services.
- Emphasis on prevention and public health...too divided on the different kinds of prevention. Think about prevention broadly.
- Expertise and competency—primary care providers should think about their skills and limitations... how much mental health care can be provided by primary care providers?
- Connection between provider groups and consumer/survivor groups.
- Education in judicial and legal systems. One participant noted, “Our Tribe didn’t know what to do with my son; they turned him over to the State system. He needed mental health care, not prison or punishment. My son was put in a holding cell (not the other person involved); [my son] hung himself. I was told you ‘can’t prevent everything’ but it [the cell] wasn’t a safe place to put my son.”
- Booklets that help you choose a provider or questions to ask your provider. Anything that is readable reinforces hope; makes it concrete when you see it on paper.

What Does Not Help?

- Lack of attention to men, especially given [their suicide death] rates; we don't target that population. What systems would men access? Our systems are more accessible to women. What is structurally different that would appeal to or support men?
- Rushing to blame in the aftermath of a suicide in a facility. It is important how people respond; providers are traumatized as well. They have to explain and deal with the media.
- Criminalization of mental health problems. There was a case in Florida where the initial crime was sleeping on a park bench, then mental health problems in prison were seen as problematic behaviors or offenses that could result in punishment or an extended sentence.
- Lack of research in alternative approaches. Leadership at leading research institutions should support recovery-oriented or alternative approaches to prevention and healing.
- Force or coercion into hospital care. When people hear the word suicide, it connotes that something needs to be fixed by getting people help. Then it is the job of people with little training to make that happen, first responders, for example, to get them into care. They have the most contact with people in crisis, which often leads them to be coercive as the only solution to avert a crisis. Provide more training regarding alternatives to force and coercion, and expand the options of where people can go, not just hospitals.

In-depth Conversations

At several times throughout the day, participants had in-depth conversations about a topic that held particular interest. Here are the comments made about these topics.

“Committing” suicide

The term “committing suicide” is a problem. Is it empowering to use that term? Committing suicide sounds like it is a commitment, a decision that someone makes...what you are committed to. Is it a choice, something you are committed to do?

It is better to say, “He died by suicide” or “He killed himself.” Much more direct, without language that has underlying negative connotations.

There was a voice telling me to jump, it was a voice, not my conscious self. I didn’t decide...the voices compelled me to jump.

It’s not a choice that people make.

“It is difficult and tiring to be around someone who is suicidal.”

Families need concrete assistance with what to do. I understand that it must be exhausting to be vigilant.

Fatigue is not an education issue...it is more about family support. Peer helpers become fatigued as well. Family fatigue is a systems issue...need for caregiver support.

As providers, we generally are good the first time we see someone, after the second attempt, we may not be as compassionate. The more we see someone, the more judgmental we become. Why is that so...why become more judgmental? The provider experiences self-doubt, doesn’t know what to do, so it is easy to blame the patient. Who is defining the expectations of what the recovery is?

Are you supposed to be better after 10 sessions...or does it take years? Or do patients decide?

Fatigue, of emergency department personnel, is common; they are often in situations with individuals with suicidal thoughts or behaviors and don't know what to do.

Trauma-informed care

Participants returned to the topic of trauma several times throughout the meeting, underscoring the importance of understanding and dealing with the connection between trauma and how it impacts depression, suicide, and other mental illnesses. Interventions should not re-traumatize individuals who have experienced trauma earlier in their lives.

Ask, "What happened with you?" rather than saying or implying, "What's wrong with you?"

I had abandonment issues starting at a very early age. I was born to addicted people. I had many physical symptoms of illness...all emotional.

I was adopted at an early age.

I was sexually abused and assaulted three times.

I was traumatized by the mental health system.

I want people to really look at what works... and what leads to suicide. I will not ever go to the ER [emergency room] and will only seek care from people I trust. When I was in the hospital for a physical health issue, I was guarded by two people, even though I wasn't in for mental health reasons. I was guarded because I revealed the medication I take.

Force and coercion

Participants spoke about some negative experiences with the health care system related to the use of force and coercion. Many concluded that the liberal use of force and coercion has no inherent healing properties and often prevents the person at risk for suicide from seeking services.

We must have alternatives to emergency rooms... more options; also, same day scheduling for mental health services and in-home crisis care.

Hospitals and other mental health care settings must be non-judgmental and psychologically safe places in which to receive services.

Peer support services¹

Many participants spoke passionately about the need for peer support in prevention, intervention, and post intervention services. An example pointed to a study that showed that individuals reported a range of negative experiences in emergency departments following visits for suicide attempts.

Why is there a much higher bar when it comes to research on whether or when mutual or peer support helps? When is the resistance to alternative, peer support approaches going to stop?

During this conversation, participants pointed to research and services that address peer support from various perspectives.

- State Medicaid programs can reimburse for peer support services.

¹Consumer and family experiences in the emergency department following a suicide attempt. Cerel J, Currier GW, Conwell Y. *Psychiatr Pract.* 2006 Nov; 12(6):341-7.

In August 2007, the Director of the Federal Centers for Medicare & Medicaid Services (CMS) informed Directors of every State Medicaid program that CMS “recognized that the experiences of peer support providers, as consumers of mental health and substance abuse services, can be an important component to a State’s delivery of effective treatment.” Director Dennis G. Smith spelled out the conditions that would apply to Medicaid payment for peer support services, while noting “...the mental health field has seen a big shift in the paradigm of care over the last few years. Now, more than ever, there is a great emphasis on recovery....” The full text of the letter, which also contains information about a contact person at CMS, can be found online ([http://www.ncmhcsso.org/downloads/smd07011%20\(2\).pdf](http://www.ncmhcsso.org/downloads/smd07011%20(2).pdf)).

The Georgia Certified Peer Specialist Project has developed a model training and certification process that allows services provided by certified peer specialists (CPS) to be reimbursed by Medicare under Georgia’s new Rehab Option. (See the Web site at <http://www.gacps.org/Home.html>.)

For information on States currently using peer support counselors, please contact the National Association of Peer Specialists (NAPS) at 755 Alta Dale SE., Ada, MI 49301, or by e-mail at steveh@napos.org.

- In Memphis, the crisis intervention teams (CIT) program is a community effort joining the police and the mental health community together for common goals of safety, understanding, and service to the mentally ill and their families. Police officers receive training to increase their awareness of how to handle people who are

in crisis. This approach can reduce incidents of “suicide by cop,” when a person in a suicidal crisis is shot by a police officer. For more information, see the Web site (<http://www.cityofmemphis.org/framework.aspx?page=302>).

- Hotlines and warm lines, such as SAMHSA’s **National Suicide Prevention Lifeline**, are 24-hour, toll-free suicide prevention services available to anyone in suicidal crisis. If you need help, please dial **1-800-273-TALK (8255)**.
- Safe haven houses are places where individuals and families may go to share and ease their pain. A crisis hostel is a place where people who are experiencing an emotional or mental crisis have an alternative to psychiatric hospitalization.

“What we would like providers of care to know.”

This conversation took place throughout the 2-day meeting. The discussion was focused especially on what participants thought would help providers offer more effective and sensitive support, services, and treatment, and how health care systems could better address their needs.

Help us to set goals that go beyond relieving suicidal thoughts.

Work with us to create individual safety plans... what should I do when I have these thoughts?

Be understanding and take our individual concerns seriously and go the extra mile. For example, one of my providers actually tasted a medicine to see how awful it tastes. Be genuinely interested and supportive of changed behavior. For example, one of my therapists made a deal with me: “Sleep at least 6 hours and I’ll stand on my head; you can take a picture of me.”

Take a holistic approach, including recognizing the physical issues that affect emotional health (e.g., nutrition and sleep) and spirituality.

Erase and eradicate your judgment that “he or she will never get better.” Empathize 100 percent with that person, every day.

Build resilience with your clients; teach them early how to manage emotions.

Be willing to refer clients to someone else if you lack the expertise in certain areas...and provide qualified references.

Eliminate the fixer/fixee- and helper/helpee duality thinking. We are all in this together. Each person takes responsibility; the provider is not solely responsible.

Be aware of your perspectives and beliefs while interacting with consumers, and be aware of your cultural beliefs about mental illness; different cultures view suicide differently.

Deal with your impatience and your thoughts about the helplessness and hopelessness when you don't know what to do...providers need to patiently accept what they do not know and be comfortable with ending up in a place of not knowing. Then they can bear witness to that and share it with the patient. Then, spontaneously, solutions may appear.

Avoid automatic alarm or jumping to hospitalize when listening would work.

Don't be afraid to talk with us about suicide... don't be afraid that talking will make it happen.

In response, a health care provider shared an observation.

Professionals learn through both education and experience, and many experiences stay with them over years, shaping their perceptions and molding their approaches in new ways while deepening their respect for the resilience of those they seek to help. In a forum such as this, professionals have a unique opportunity to tell their own stories, listen to consumers, and share thoughts with each other.

Consumer Study

Ed Knight, a participant, presented a brief overview of a study conducted with 205 consumers in 14 consumer-run dialogue meetings in New York State.² The purpose of the study was to identify how individuals with severe mental illnesses and a history of suicidal behavior cope with suicidal thoughts. Study participants were asked to identify up to five strategies they use to deal with suicidal thoughts. They named the following groups of first-line coping strategies, starting with those mentioned most often:

- Spirituality/religious practices: 18 percent of study participants;
- Talking to someone/companionship: 14 percent;
- Positive thinking: 13 percent;
- Using the mental health system: 12 percent;
- Considering consequences to people close to me: 9 percent;
- Using peer supports: 8 percent;
- Doing something pleasurable: 8 percent;
- Protecting myself from means: 5 percent;
- Doing grounding activities: 4 percent;
- Considering consequences to myself/fear: 2 percent;
- Doing tasks to keep busy: 2 percent;
- Maintaining sobriety: 1 percent;
- Helping others: 0.5 percent; and
- Seeking emotional outlets: 0.5 percent.

²Ed Knight et al. Coping with Thoughts of Suicide: Consumers' Strategies. Paper presented at the annual meeting of the American Public Health Association, November 7, 2007.

Recommendations

After identifying and addressing what promotes and what hinders recovery and effective suicide prevention, the participants made recommendations about what should be done in several areas of suicide prevention, intervention, and post intervention.

In addition, participants thought about what they could do individually and as a group to keep the dialogue going and be more proactive in their areas of work and influence.

Participants were asked to suggest recommendations that would further suicide prevention from personal, clinical, and systems perspectives, keeping in mind that the recommendations should be specific to suicide prevention rather than to mental health recovery in general.

Participants made the following recommendations:

- 1. Include the consumers' voice and active consumer participation, specifically that of the suicide attempt survivor, in policymaking, educating the public, training health care providers, and planning and improving prevention and support services.**

Everyone agreed that “there should be more than one seat at the table” because no one person can adequately represent the diversity of perspectives that must be brought to bear. This thought expanded to suggestions of how and where consumer/survivor voices need to be heard: the Suicide Action Alliance was mentioned as a critical venue, as well as the myriad opportunities that might be taken to have consumers/survivors visible not only to the public but also to health care providers. SAMHSA was seen as a vital resource, not only for creating opportunities but also for providing scholarships and financial support to ensure that consumers/survivors could

be present at the many venues where their voices could make a difference. It is important to support consumers and survivors when they are sharing their experiences. Participants noted that there is a great deal of fear on the part of consumers/survivors about talking openly of their experiences.

2. Many, many groups must be educated from a consumer perspective.

One goal of such education, said a participant, would be to “change prejudices and stereotypes” both by addressing specific groups (e.g., first responders) and by seeking publication opportunities (e.g., the publications of the American Association of Suicidology). Faith-based communities were also mentioned as a group to work with, and one participant made the following observation:

A prominent reverend of a national church spoke about someone who died by suicide and said that suicide is not a sin; this was an important message to come from him that was so healing.

Work with those who organize conferences to ensure that there are opportunities to hear from suicide attempt survivors and family member survivors.

3. Educate the physical and mental health workforce from a consumer/survivor perspective.

One participant noted that it is important for providers to be free of fear that something they might do would increase the risk of suicide; in this and many other areas, education is critical. All physicians should be exposed to a suicidology course that incorporates the thoughts and experiences of consumers/survivors. Across the board, educational materials should teach providers “how to call upon consumers/survivors and other resources that are available in their community.” Participants also agreed that physicians and other health care

providers should receive training and support that includes strategies to cope with their own feelings of fatigue and distress when working with mental health consumers. Mental health consumers sometimes feel that they are treated with detachment and disrespect by health care providers. Training may help alleviate those issues.

4. Support workforce development and training of health care providers.

All health care providers should be trained to be alert to the risk of suicide; participants suggested the advisability of training providers to “conduct suicide assessment early in the treatment of at-risk populations and those who have experienced trauma.”

In addition, participants thought that mental health professionals needed encouragement to work in rural areas, and that it would be desirable to incorporate peers in all hospital workforces. The need for trained Native American providers and educators was also mentioned, with the suggestion that more scholarships be available.

The discussion included the need to train providers on alternatives to seclusion, restraint, coercion, and involuntary treatment. One participant noted that this type of training is already a requirement, and made the following observations.

What would we recommend to raise the bar? Reporting requirements should be tied to funding; or loss of accreditation. The system should promote consumer monitoring and encourage consumers to report violations, using external advocates to help with monitoring.

5. Promote cultural respect.

Specific suggestions included incorporating linguistic competency whenever there is talk of “cultural” competency; generating more data, research, education, and inclusion regarding the gay, lesbian, bisexual, and transgendered (GLBT) and Native American communities; and ensuring diversity by including a wide variety of consumers/survivors.

6. Improve mental health service delivery and service options.

Suggestions for such improvements covered a wide range of issues, but major themes involved alternative types of services/providers, better understanding of communication among providers, and the importance of trauma-informed care.

- **Provide alternatives to emergency departments.**

Participants stressed how helpful it would be to have “...same day scheduling for mental health services and in-home crisis care, crisis intervention teams.” They also pointed to the growing trend (but unmet need) to integrate physical and mental health services, pointing out that “...medical doctors are providing early intervention and assessment and being reimbursed for these services.”

- **Increase peer support services.**

Echoed in a variety of contexts throughout the meeting, there was a strong, favorable sentiment to making increasing use of peer specialists: “It is a high priority to have peer specialists in the hospital/ER like the rape crisis model SANE³ to help people through the process.”

³Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims (available online at http://www.ojp.usdoj.gov/ovc/publications/bulletins/sane_4_2001/welcome.html).

- **Create postvention services similar to those being created for other issues.**

At the other end of the intervention spectrum, the utility of a post-attempt follow-up “...visit from a social worker to a person who attempted suicide” was mentioned. In a similar vein, it was suggested that community-based guidelines be developed “that have to be implemented after a suicide, similar to the protocol for a trauma, disaster, violent behavior event; it would be a postvention protocol.”

- **Ensure that providers communicate with each other when caring for the same individual.**

With regard to communication among providers, one participant noted “The most common factor in all sentient events is [lack of] communication,” while another pointed to the urgency of ensuring that “people treating the same person are in communication with each other. Ensure that providers understand that the Health Insurance Portability and Accountability Act (HIPAA) allows shared information.” Also, ensure that providers request and respect informed consent in the use of personal health care information.

- **Ensure trauma-informed care.**

A strong theme emerged around the needs related to preventing trauma (e.g., by “increasing awareness of bullying and increasing school policies to deal with it”) and addressing the consequences (e.g., ensuring that care after a “violent or traumatic experience” is adequate and sensitive, and understanding the long-term, enduring aspects of trauma on mental health).

Moreover, participants urged that “Suicide prevention organizations collaborate with the SAMHSA/CMHS National Center for Trauma-informed Care (NCTIC) to create trauma-informed care settings. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or

triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.”

7. Dedicate resources to explore the issue of involuntary hospitalizations from a consumer perspective in the context of providing real alternatives. Create a SAMHSA-supported task force to explore this issue from a consumer perspective.

“Eliminate the use of force and coercion.” This theme was heard throughout the meeting as an issue that requires thoughtful attention across a range of ethical and legal considerations: “Involuntary hospitalization is to prevent self-harm or harm to others; how do you accomplish this without traumatizing the individual or criminalizing the behaviors?” Participants voiced concerns about both a general lack of information about how an involuntary commitment affects the consumer, and about what alternatives might be available to avoid commitment.

Participants were very enthusiastic about the recommendation that SAMHSA sponsor a task force on alternatives to involuntary commitments. Subjects to be explored include “promoting crisis intervention teams,” “having advance directives” for consumers to ensure their autonomy, and “valuing peer support services as a means of avoiding involuntary commitments.”

8. Promote the SAMHSA wellness initiative within the suicide prevention movement.

Participants were familiar with the SAMHSA/CMHS Wellness Initiative and the 10 by 10 campaign to reduce premature mortality by 10 years over the next 10 years. The life expectancy for individuals with serious mental illnesses is decades less than

the general population. As reported on the SAMHSA Web site, data show that male consumers are likely to die at a younger age than female consumers. The National Association of State Mental Health Program Directors (NASMHPD) Medical Director's Council recently reported that more people with serious mental illnesses die of treatable medical conditions that are caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care (go to <http://mentalhealth.samhsa.gov/newsroom/speeches/091707.asp>).

In addition, participants recommended the following: "Understand and promote protective factors (such as having peer support); do not focus exclusively on reducing risk factors; conduct focus groups and understand college students' perspectives on wellness." Participants urged SAMHSA to collaborate and share information with other Federal entities as it develops an action plan related to a recent conference on wellness.

As mentioned in the introduction to this report, SAMHSA/CMHS convened the National Consensus Conference on Mental Health Recovery in 2004. The full statement and the 10 fundamental components of recovery can be found on SAMSHA's Web site (<http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/>).

The concept of wellness embraces the growing recognition of the fundamental integration of mental health and physical health. Working toward wellness underscores the major goal of recovery for mental health consumers, and acknowledges that recovery must encompass the whole person.

9. Establish funding for the following priorities.

Participants listed many areas where they felt more funding was needed. Their priorities are as follows.

- Create a nonfatal surveillance data system and funding to collect the data. We only have rough estimates of the prevalence of suicide attempts. Be sure to “de-identify” by using numbers, not names.
- SAMHSA/CMHS, the National Institute of Mental Health (NIMH), the Health Research and Services Administration (HRSA), and other relevant Federal entities should fund consumer/survivor-run services and treatment and conduct research on cost-effectiveness.
- Disseminate effective programs, including effective consumer-operated programs.
- Provide technical assistance related to the evaluation of programs and development of long-term solutions.

10. Promote research priorities and involve consumers in research initiatives.

Participants identified the following research priorities.

- Environmental issues that are outside a biomedical research focus
- Cost-effectiveness of consumer-run services
- Determine the explanation(s) for the 25-year disparity in life expectancy
- Research that includes the experiences of suicide attempt survivors, rather than excludes attempt survivors from participating in research studies

Participants recommended supporting the research interests of coroners; for example, some State coroners are very interested in conducting psychological autopsies. A psychological autopsy helps promote the epidemiological study of suicide. It is important that it not be used to assign blame. This is a research method that offers the most direct technique currently available for examining the relationship between particular antecedents and suicide. The autopsy helps answer the question, “Why did the individual kill himself?” The results of a systematic review that examined studies of suicide that used a psychological autopsy method indicated that mental disorder was the most strongly associated variable of those that have been studied.⁴ Further studies should focus on specific disorders and psychological factors; suicide prevention strategies may be most effective if focused on the treatment of mental disorders. Also, coroners could play an important role in looking into accidents and poisonings, and the relationship of these topics to suicide.

In addition to these funding priorities, participants recommended “increased training of survivors/ suicide attempt survivors so that they may design, implement, and participate in research” and “involving consumers in review and setting the research agenda (not token representation).”

11. Engage media on a regular basis.

Throughout the meeting, participants pointed to the power of the media as both a positive and negative force. As a positive force, media can help to dispel stereotypes and educate the public; as a negative force, media can perpetuate misconceptions and stigma. Engaging the media is critical, and participants had several recommendations for how to approach this.

⁴*Psychol Med.* 2003 Apr; 33(3):395-405.

- **SAMHSA and the participants should promote the suicide dialogue report and the meeting in the media.**

Others mentioned the need for editorials and opinion pieces, and suggested the Suicide Prevention Action Network's (SPAN) Web site as a source of useful templates for preparing materials for newspapers.

- **Create a suicide prevention award.**

Some noted that various types of awards are often a useful way to garner positive media attention, and mentioned the example of the Didi Hirsch Annual Erasing the Stigma Leadership Award, made in California, for people who have made a significant contribution to alleviating the stigma attached to mental illness, and especially to suicide. The recipients often have national prominence in sports, the arts, or other fields.

- **Use electronic media—Internet and television—to reach young people and college-age audiences.**

More specifically, "Include suicide issues on TV shows that are popular with high school and college students; have a Web site after the shows, to have an online discussion." Another participant noted that Lifeline is using the Internet successfully to reach young people through YouTube, MySpace, and so forth, and mentioned Lifeline's new online project, *Lifeline Gallery: Stories of Hope and Recovery*, which allows survivors, suicide attempt survivors, helpers, and advocates to share their experiences with suicide online (see the Web site at <http://www.lifelinegallery.org>).

- **Promote a consistent and hopeful message... recovery is possible.**

All media were thought to be good avenues for what many consider the most difficult and critical message

of all: that recovery is possible. SAMHSA might consider working with advertising agencies and other mainstream organizations as well as well-known public figures to send positive messages about recovery. At the same time, such messages demand sensitivity and careful thinking. As one participant mentioned, “A person with mental illness doesn’t look any different... so how would you show someone who may be at risk for suicide...maybe you are adding to the problem, by saying ‘you never [can] know.’”

12. Support families.

Family support can be manifested in a variety of ways. For example, it would be helpful to have “guidelines for college campuses to use for determining when they can notify parents of a student’s issues [while still] respecting the need for confidentiality.” In addition, participants urged that consumers should have the ability to make clear directives about who should be informed of their situations, “similar to advanced directives. In this way, consumers would be empowered to take personal responsibility for their care.”

13. Adapt and adopt programs and services to address rural/frontier issues.

Participants pointed out that face-to-face service in rural/frontier areas is often not practical. Regulations must be relaxed for these areas with regard to the types of services offered and their reimbursement. These include “evidence-based practices that don’t apply to rural/frontier settings such as some Assertive Community Treatment (ACT) recommendations,” which need to be adapted for use outside urban areas. At the same time, it is important to identify and reimburse practices that do work, such as tele-psychiatry or tele-mental health, and to offer such alternatives as warm lines.

Participants also suggested looking into the possibility of student loan forgiveness as an incentive for (mental) health professionals to work in rural or economically distressed areas.

14. Native Americans must get direct and appropriate national funding, not funds funneled through the State.

Throughout the dialogue, the message was clear that Native Americans face a host of cultural and structural issues that may be more profound than for other groups. Many supported the recommendation, for example, that requests for proposals specifically allow flexibility to adapt national policy to native culture (noting, too, that Native Americans have their own Institutional Review Board requirements). At the same time, Tribes and native organizations need technical assistance to help write grants, and there should be “genuine outreach to help communities apply for grants.”

15. Promote gun safety and restriction of access to lethal means to at-risk individuals.

Participants recognize that even the most insistent suicidal voices or impulses can be quelled if the *means* to act on them are not available. With this in mind, the issues of gun safety and the safety of other lethal means sparked several recommendations, most having to do with educating the public and special interest groups on mental health issues. For example, the LOK-IT-UP campaign is a public awareness program encouraging the safe storage of firearms and is underway in several counties in Washington State (for further information, go to <http://depts.washington.edu/lokitup/overview.html>).

Recommendations for proactive gun safety efforts included the following.

- Post hotline numbers near places where people can legally obtain guns.
- Host a plenary session at firearm association conventions to educate and create awareness about implications of access to guns.
- Work with the firearm associations on gun safety programs.
- Promote collaboration with the Brady Campaign and share information about mental illnesses and suicide prevention.
- Promote safe storage and separation of ammunition from firearms.
- Share successful program stories. For example, the State police in Pennsylvania are passing out gun locks free of charge. In Maryland, gun locks are mandatory.
- Create protocols for the restriction of lethal means and methods of self-harm for people at risk for suicide.

16. Promote and widely disseminate information about suicide prevention organizations and effective programs.

- The American Foundation for Suicide Prevention (AFSP) is composed of a number of programs, including support and community education-focused programs. In 2001, AFSP began developing an innovative, Web-based screening method to identify college students at risk for suicide and encourage them to get treatment. In collaboration with Emory University, in Atlanta, GA, and the University of North Carolina, in Chapel Hill, NC,

the method was pilot-tested over a 3-year period (2002-2005). (go to the Web site at <http://www.afsp.org>).

- The National Suicide Prevention Lifeline is a network of more than 130 crisis centers across the nation that are available 24/7 via one toll-free phone number: 1-800-273-TALK(8255).
- Active Minds on Campus is a campus-based, college peer advocacy program focused on decreasing stigma about mental health issues and treatment (go to <http://www.activemindsoncampus.org/>).
- The Lok-It-Up Campaign (go to <http://depts.washington.edu/lokitup/overview.html>).
- Applied Suicide Intervention Skills Training (ASIST) was developed by Living Works. The 2-day, highly interactive, practical, practice-oriented ASIST workshop is for caregivers, and others who are in positions that help others, who want to feel more comfortable, confident, and competent in helping to prevent the immediate risk of suicide (go to <http://www.livingworks.net/>).
- On Our Own of Maryland, Inc., is a statewide mental health consumer education and advocacy group that promotes equality in all aspects of society for people who receive mental health services; it also develops alternative, recovery-based mental health initiatives. Programs include an anti-stigma campaign, The Recovery Training Project Main Street Housing, Inc., and the Olmstead Peer Support Program. (go to their Web site at <http://www.onourownmd.org>).
- Yellow Ribbon is a community-based program using a public health approach with an emphasis on preventing teen suicide. See their Web site (<http://www.yellowribbon.org>) and/or e-mail for further information (ask4help@yellowribbon.org).

- Jason Foundation: Provides educational and training curricula for students, educators/youth workers, and parents, on the subject of youth suicide (<http://www.jasonfoundation.com>).
- NAMI, New Hampshire, has many resources, including a post intervention program for survivors (http://www.nami.org/frameworks_community_protocols_postvention_main_page.php); there is also a national support line, Friends of Survivors, at 1-800-646-7322.
- San Francisco Suicide Prevention (SFSP) is the oldest volunteer crisis line in the United States. Founded in 1963, with the initial focus of providing telephone intervention to people experiencing suicidal crisis, the focus of the agency has gradually shifted from strictly suicide prevention to more general counseling services. Services are provided 24 hours a day by more than 150 trained volunteers with the supervision of a small multidisciplinary staff (go to <http://www.sfsuicide.org/index2html> for further information).
- Memphis, Tennessee's, Crisis Intervention Team is operated through the city's police department to work with mental health consumers and family members (go to <http://www.cityofmemphis.org/framework.aspx?page=302> for more information).
- Erasing the Stigma Leadership Awards (information is available at http://www.didihirsch.org/news/ets_awards).
- Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims (more information is available at http://www.ojp.usdoj.gov/ovc/publications/bulletins/sane_4_2001/welcome.html).

- Managing Sudden Traumatic Loss in the Schools, by Maureen M. Underwood and Karen Dunne-Maxim, is a program for school staff to help them understand grief in school populations (an excerpt is available at http://www.psybc.com/pdfs/Loss_article).
- People, Inc., in New York State, provides a unique model for partnerships between members of the public and professionals to meet special needs. Although it does not target services to people with mental health issues, the ideas and their implementation may be of interest to groups with similar goals of "...providing support so that individuals can participate and succeed in an accepting society." (go to the Web site at http://www.people-inc.org/what_we_do.asp).
- SPRC/AFSP Best Practices Registry (BPR) for Suicide Prevention (go to http://www.sprc.org/featured_resources/bpr/index.asp).
- Means Matter (<http://www.hsph.harvard.edu/means-matter/>).

Next Steps

Participants reflected on what they could do when they return home from this meeting. Here are some of their thoughts.

We have providers, family members, attempt survivors in one room, here today; we could promote collaborative organizations.

Foster collaboration between consumer organizations and suicide prevention organizations. We can work to have the consumer organizations that we belong to include suicide prevention in their activities.

SAMHSA, perhaps through its Suicide Prevention Resource Center (SPRC) could do a schematic of all the groups and how they inter-relate...and then network with each other... a clearinghouse of sorts.⁵

Promote our own accountability on these issues and recommendations and reconvene to discuss progress.

The National Council of Suicide Prevention is a group of 10 nonprofit organizations with a mission of suicide prevention. Participants agreed to support the inclusion of consumer-run organizations.

⁵ The Suicide Prevention Resource Center (SPRC), funded by SAMHSA/CMHS, provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies, and to advance the National Strategy for Suicide Prevention.

Final Thoughts

Participants shared their thoughts as the meeting came to a close.

We wear many hats, as researcher, policy[maker], family member...it's great to wear all these hats in one place.

This has been a phenomenal process...moving, inspirational, and informative...so many different voices sitting around the table.

This was a useful experience, pragmatic purpose...it wasn't a waste of time. It is useful to hear from people whom I don't normally talk [with]. It is good to know that the consumer voice is being taken seriously.

We welcome the voice of the attempt survivor.

We've learned that people can have their emotions and feel their pain and they can move on.

Resources

Data generated by the Center for Disease Control and Prevention's WISQARS system.

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Web sites for consumers and survivors

1. What A Difference A Friend Makes:
<http://www.whatadifference.samhsa.gov>
2. National Mental Health Information Center:
<http://www.mentalhealth.samhsa.gov>
3. National Center for Trauma Informed Care:
<http://mentalhealth.samhsa.gov/ntic>
4. Suicide Prevention Action Network:
<http://www.spanusa.org>
5. American Society of Suicidology:
<http://www.suicidology.org>
6. Suicide Prevention Resource Center:
<http://www.sprc.org>
7. Suicide Prevention Resource Center:
<http://www.afsp.org>
8. National Association of Peer Specialists:
<http://www.naops.org>
9. National Mental Health Awareness Campaign:
<http://www.nostigma.org>
10. The Jason Foundation:
<http://www.jasonfoundation.com>
11. Suicide Anonymous:
<http://www.suicideanonymous.org>

Resource materials

SAMHSA services and programs

- 1-800-273-TALK(8255), the National Suicide Prevention Lifeline:
<http://www.suicidepreventionlifeline.org>
- Suicide Prevention Resource Center:
Center for Technical Assistance and Resources
Telephone: 877-GET-SPRC (877-438-7772)
TTY: 617-964-5448
Web: <http://www.sprc.org>
Email: info@sprc.org
- Grant programs
 - Garrett Lee Smith Memorial Act Grant Program:
Youth Suicide Prevention
Contact SAMHSA's Division of Grants Management
at 240-276-1400.
 - Garrett Lee Smith Memorial Act Grant Program:
Campus Suicide Prevention Grants
 - SAMHSA: State/Tribal Youth Suicide Prevention Grants
 - SAMHSA: SM06-010: Hurricane Katrina-related
Suicide Prevention Grants

Coordinating groups

- The Action Alliance for Suicide Prevention. Objective 2.2 of the National Strategy for Suicide Prevention called for the establishment of public/private partnership(s) (e.g., a national coordinating body) with the purpose of advancing and coordinating the implementation of the National Strategy. For more information contact SPAN USA.

Suicide Prevention Action Network USA (SPAN USA)
1010 Vermont Avenue, NW, Suite 408
Washington, DC 20005
Phone: (202) 449-3600
Fax: (202) 449-3601
E-mail: info@spanusa.org

- As a follow-up to the President's New Freedom Commission Report, a Federal working group for suicide prevention was created to gather information and collaborate with representatives of Federal Agencies involved in suicide prevention. For more information contact the co-chair of the group, Richard McKeon, at SAMHSA/CMHS.

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