A COMMUNITY-BASED SUICIDE PREVENTION PLANNING MANUAL FOR DESIGNING A PROGRAM JUST RIGHT FOR YOUR COMMUNITY

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CHAPTER 1: AN INTRODUCTION TO COMMUNITY SUICIDE PREVENTION PLANNING
Suicide prevention is a community effort. Suicide prevention is an active effort. This manual was developed in Idaho for Idaho communities with the engagement of Idaho communities. It was developed under a grant from the Substance Abuse and Mental Health Services Administration, Center for Mental Health Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention (Grant No. SM057401).

The manual has applications for communities across the nation. The model, planning process, and resources are all based on national best-practices, evidence-based protocols, and the most current science.

About the Manual

The core of the manual is the annotated bibliography of 62 programs and resources for suicide prevention, intervention, and postvention. The list is not comprehensive, there are many programs and resources. In each section of the list we try to provide information about how to find additional programs and resources.

Because a list of programs and resources is just that, a list, the manual includes a planning process that can be used by communities. The process is designed to be led by a working group or task force but allows the planning group to find a place for everyone that respects their available time and the contributions they want to make.

But, a planning process is just a planning process without underpinnings. The underpinnings of the process in the manual are based on risks and protective factors.

Creating a Program Just Right for Your Community

To be successful, there must be a good match between the prevention, intervention, and postvention program and the community for which it is intended. There are a myriad of factors to consider. Just a few of these factors are cultural, demographic, and community resources.

Most often, a good suicide prevention program includes multiple elements from multiple programs. However, in an attempt to be broad-ranging and encompassing, it is easy to end up with multiple parts without knowing how they fit together as a whole. Sometimes using a part of a program negates or at least reduces what we know about its success as best practice or evidence-based program. Good program design is comprehensive and it is possible to understand how each part fits into the whole.

Comprehensive plans can be large or small. They may rely on cash expenditures or they may rely on volunteer time. Comprehensive programs can be very expensive or they can be essentially cost-free. The key is thoughtful planning and making sure that what you choose fits the community for which you choose it.

Values About Planning for Communities

The model we provide is community based. We hold these values about communities:

1. The quality of the fit between what a community has to share and what a community needs can define a program’s potential success for that community. It must be for the community, not about, the community.
2. Strengthening communities strengthens the youth, adults, and elders in the community.
3. Communities have people in them who have the desire and commitment to work on behalf of their communities.
Values About Comprehensive Suicide Prevention, Intervention, and Postvention Plans

1. Comprehensive plans can be better than multiple disparate plans.
2. Multiple prevention, intervention, and postvention activities can have a place in a comprehensive plan.
3. Comprehensive plans are cross-discipline and cross-organization, and they work across the community.

Values About Specific Suicide Prevention, Intervention, and Postvention Programs

1. There are many good programs.
2. It is important to consider how the program is a best practice, evidence based, and science based.
3. Not all good programs are identified as a best practice, evidence based, or science based.

Chapter 2: An Overview of Risks and Protective Factors

Suicide is not caused by a single thing. Risks and protective factors provide a way of viewing a person, a family, or a community that is strength based and seeks to build on strengths to increase protective factors and reduce risks in the lives of the individual, their family, their friends, and their community.

In this section, biopsychosocial, environmental, and sociocultural risk and protective factors are examined. Information about the factors and suicide prevention suggestions are offered. The model used is recommended by U.S. Centers for Disease Control and Prevention (CDC.gov), the American Association of Suicidology (AAS, www.suicidology.org), the American Foundation for Suicide Prevention (www.AFSP.org), and the Suicide Prevention Resource Center (www.sprc.prg).

Chapter 3: Designing a Program Just Right for Your Community

This chapter offers a method of understanding your community and building a comprehensive suicide prevention plan specific to your community. The planning process uses a modular approach. Using this method, you can discover the places where your community is strong and things can be strengthened and places where risks can be reduced. When you can see the larger picture, you can pick the things that you feel are the most needed or can be the most immediately successful in your community. You can take on as little or as much of your overall comprehensive plan as you feel is appropriate at any one time.

In community planning it is necessary to pursue the avenues where you have resources. One of the difficult realities of community is that resources shift. Volunteers may move away. Grant funds may end. Budgets may be cut. Priorities shift. By using a modular approach, you can planfully shift priorities in response to resource or community changes. You do not need to take on all programs at one time; select from the options and carry out what you can at any given time with resources available.

Types of Suicide Prevention Programs that Can be Included in the Whole

Chapter 4 explores some of the many evidence-based or best practice programs or activities that suicide prevention advocates may consider as they make plans for the future. Programs listed have various levels of research associated with them. However, the selected programs all have an evidence base pointing to their effectiveness. Programs are categorized into the following sections.
Youth Screening
These programs offer mental health and suicide risk screenings for teens. Screening provides a mental health checkup for youth and facilitates referral to mental health care, when needed.

School Programs
There are a variety of programs available for implementation in the school setting. Some focus on training school staff in signs and symptoms of mental disorders, suicide risk assessment, how to intervene and refer to care, and how to help children and youth after a suicide in the school community. Additional programs offer procedures for peer-to-peer activities that involve teens working with other teens to reduce suicide. Specific protocols for use by schools in framing postvention activities also are available.

Young Adults (college age)
Screening and educational programs for this age group are available. In addition, procedures for establishing protocols for serving distressed college students are offered. For students who proceed into jobs after high school graduation, adult workplace programs are available (see below).

Community and School
Some programs can be offered throughout a community. Many include a school component. These focus on gatekeeper training, developing a school crisis plan, peer-to-peer activities, and parent involvement. They provide information on how communities and schools can work together to prevent, intervene, and respond to a suicide crisis.

Adults
Programs for working-age adults focus on workplace efforts, educational programs, and specific interventions. Depression awareness is a focus of some programs. Toolkits for helping administrators and employees in the workplace focus on how they can prevent suicide in their ranks. The U.S. Air Force’s comprehensive community-based suicide prevention program offers 11 successful initiatives aimed at strengthening social support, developing social skills, and changing policies and norms to encourage effective help seeking.

Older Adults
Some programs are available to assist older adults. A “late life” suicide prevention toolkit helps medical and mental health clinicians, health care trainees, and other healthcare providers identify suicide warning signs, establish rapport, and assess suicide risk among older adult patients.

Family Strengthening and Problem Solving
These programs can assist parents in developing resiliency in their children. Fostering good problem-solving skills also is a focus of these programs. Tools for dealing with life changes also are available.

Community Strengthening, Problem Solving, and Conflict Resolution
Helping communities work together to solve problems in a constructive way can support suicide prevention efforts. Community-building and -organizing programs help residents develop collective skills to improve conditions in their communities, including suicide prevention. Programs that provide tools for effective conflict resolution help enhance skills for civil discourse and allow adults to model good decision-making for the children in their care. Some programs help communities identify ways to address economic recovery issues, work toward sustainable prevention activities, and enhance the ability to provide effective social and health services.
Faith-Based Communities
Many organizations provide guidelines that churches can use to prevent suicide and encourage members to seek care for mental health problems. Programs focus on helping people at high risk of suicide, working with bereavement survivors, and addressing the trauma reactions to suicides among people in the faith community. Guidelines also can help clergy or lay leaders deal with end-of-life religious issues involving people who die by suicide. Guidelines for funeral directors also are available.

Medical Settings
Many people who die by suicide have seen their healthcare provider in the months before their deaths. There are many sources of information for healthcare providers in primary care and hospital emergency departments. Materials exist for educating staff, providing information to bereavement survivors, to families of people who attempt suicide, and to attempters themselves. Resources are available for healthcare professionals who may have experienced trauma due to the nature of their work.

Bereavement Survivor Support
People who have lost a friend or family member to suicide are at very high risk of suicide themselves. Many programs acknowledge the power of self-help groups that involve survivors in helping meet the needs of the newly bereaved. Materials, educational programs, and guidelines for running support groups are available.

Individual Skill-Building: Community and Clinicians
Assessing suicide risk and intervening effectively are key skills for mental health clinicians. Several reputable programs are available to help providers increase their skills in these areas. Additionally, programs are available for lay community members that teach how to talk to someone about suicide, assess briefly for suicide risk, and refer them to care.

Evidence-based Psychotherapies
There are many evidence-based psychotherapies that can be effective in serving people at risk of suicide. Specific training is needed to offer most evidence-based programs. The choice is best made based on a clinician’s skills and training and the client or patient’s needs and diagnoses.

Additional Programs and Resources
Many other programs are available for use in a variety of settings. Treatment protocols and suicide risk assessment skill-building for substance use treatment professionals are available. Programs to reduce access to lethal means can be undertaken at the community level. Following guidelines for helping the news media report on suicide can have an impact on the suicide rate in a community.
CHAPTER 2: SUICIDE RISKS AND PROTECTIVE FACTORS
There is no single cause for suicide. Most suicide prevention, intervention, and postvention efforts consider the problem by understanding risks and protective factors. The model presented here is recommended by U.S. Centers for Disease Control and Prevention (CDC.gov), the American Association of Suicidology (AAS, www.suicidology.org), the American Foundation for Suicide Prevention (www.AFSP.org), and the Suicide Prevention Resource Center (www.sprc.org).

Protective factors increase the probability that someone will not attempt or complete suicide. When there are protective factors the person who is considering suicide may find enough structural and interpersonal social support to see alternatives to ending their lives. These can include things like positive social support, access to services, and believing that you have a place in the world. Risk factors increase the probability that a person will attempt or complete suicide. These include previous suicide attempts, friend/family that attempted or completed suicide, history of abuse, exposure to trauma, poverty, substance abuse/use, depression, and other mental health issues.

What are Risk and Protective Factors?

There is no single cause for suicide, even for one individual. Rather than look for a single cause, most suicide prevention and postvention efforts consider the problem by understanding risks and protective factors (Baldessarini, Tondo & Hennen, 1999; Duberstein, Conwell, Seidlitz, Denning, Cox & Caine, 2000; Linehan, 1986; Moscicki, 1997; O’Carroll, Berman, Maris, Moscicki, Tanney & Silverman, 1996; Oquendo, Malone, Ellis, Sackeim & Mann, 1999; Plutchik & Van Praag, 1994).

Protective factors increase the probability that someone will not attempt or complete suicide. These can include things like positive social support, access to services, and believing that you have a place in the world.

Risk factors are things that increase the probability that a person will attempt or complete suicide. These can include things like previous suicide attempts, friend/family who attempted or completed suicide, history of abuse, exposure to other traumatic stressor, poverty, substance abuse/use, depression, and other mental health issues.

Mental health and substance abuse problems are among the most potent risk factors. “Multiple studies from the U.S. and Europe show that over 90 percent of people who complete suicide had a pre-existing diagnosable mental health or substance abuse disorder, especially depression” (IDHW, 2007). Another important risk factor is past suicide attempts. According to the Idaho Department of Health and Welfare, “If a male teen has attempted suicide in the past, he is more than thirty times more likely to complete suicide, while a female with a past attempt has about three times the risk” (IDHW, 2007).

This chapter is organized around risks and protective factors. The organization of identified risks and protective factors is drawn from the Suicide Prevention Resource Center (SPRC, 2010).

Protective Factors for Suicide (P)

P1. Effective clinical care for mental, physical, and substance use disorders
P2. Easy access to a variety of clinical interventions and support for help seeking
P3. Restricted access to highly lethal means of suicide
P4. Strong connections to family and community support
P5. Support through ongoing medical and mental health care relationships
P6. Skills in problem solving, conflict resolution, and nonviolent handling of disputes
P7. Cultural and religious beliefs that discourage suicide and support self preservation
However, positive resistance to suicide is not permanent, so programs that support and maintain protection against suicide should be ongoing.

Risk Factors for Suicide (R)

**Biopsychosocial Risk Factors (BR)**
- BR1. Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders
- BR2. Alcohol and other substance use disorders
- BR3. Hopelessness
- BR4. Impulsive and/or aggressive tendencies
- BR5. History of trauma or abuse
- BR6. Some major physical illnesses
- BR7. Previous suicide attempt
- BR8. Family history of suicide

**Environmental Risk Factors (ER)**
- ER1. Job or financial loss
- ER2. Relational or social loss
- ER3. Easy access to lethal means
- ER4. Local clusters of suicide that have a contagious influence

**Sociocultural Risk Factors (SR)**
- SR1. Lack of social support and sense of isolation
- SR2. Stigma associated with help-seeking behavior
- SR3. Barriers to accessing health care, especially mental health and substance abuse treatment
- SR4. Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
- SR5. Exposure to, including through the media, and influence of others who have died by suicide
- SR6. History of trauma or abuse
- SR7. Some major physical illnesses
- SR8. Previous suicide attempt
- SR9. Family history of suicide

Matrix Summary of Risks and Protective Factors

Because suicide is a multifaceted phenomenon, it is important to planfully address multiple risk factors using multiple aspects of similar protective factors. Because of the complexity and the overlapping aspects of both risks and protective factors, a matrix can be a useful organizing tool. The matrix below shows the major categories of risk factors in order to illustrate the matrix.
Table 1: Risks and Protective Factors Matrix

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<td>P2. Easy access to a variety of clinical interventions and support for help-seeking</td>
<td>P3. Restricted access to highly lethal means of suicide</td>
<td>P4. Strong connections to family and community support</td>
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<td>P3. Restricted access to highly lethal means of suicide</td>
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<td>P5. Support through ongoing medical and mental health care relationships</td>
<td>P6. Skills in problem solving, conflict resolution and nonviolent handling of disputes</td>
<td>P7. Cultural and religious</td>
</tr>
</tbody>
</table>
Biopsychosocial Risk Factors (BR)

**BR1. Mental Disorders, particularly Mood Disorders, Schizophrenia, Anxiety Disorders, and Certain Personality Disorders**

Mental disorders including depression are high risk factors for suicide. The CDC reports 9.1% of U.S. adults meet criteria for current depression (CDC, 2011a), 25% have any type of mental illness (Druss & Walker, 2011), and about half will develop a mental illness during their lifetime (CDC, 2011a).

**BR1 Prevention Strategy Example**

One prevention strategy related to mental health problems is developing a community mental health fund to pay for care. Other prevention strategies might be increasing the role of cultural and religious groups in reducing stigma and increasing awareness of available services.

**BR2. Alcohol and other Substance Use Disorders**

Alcohol and substance abuse is common. Among high school age youth in 2009, more than 40% of youth reported having had one drink of alcohol in the 30 days prior to the survey. Twenty percent of youth reported having used marijuana in the past 30 days.

*Figure 1: Student Reports of Substance Abuse on the 2009 YRBS Idaho and the U.S.*

![Graph showing drug usage by high school students in 2009, with comparisons to national data.]

**BR2 Prevention Strategy Example**

There are well established principles and programs for substance abuse. Careful selection of a substance abuse prevention program can improve its role within a suicide prevention program. An examination of programs that have been used in rural and frontier areas would be useful.

**BR3. Hopelessness**

Hopelessness arises from not being able to identify alternatives or form plans to pursue alternatives. It is often accompanied by depression but can exist on its own. Rural and frontier communities may struggle with lack of alternatives for many things ranging from recreation to job alternatives. One facet of hopelessness is lack of social support. In Idaho in 2008, 6.8% of people reported that they rarely or never received emotional support.
BR3 Prevention Strategy Example
Because hopelessness is related to not being able to envision alternatives, improving social support is one alternative to improving people’s sense of hope. A variety of alternatives might exist. Increased opportunities at church might draw a vulnerable person’s attention. Anonymous alternatives to assistance with identifying options might be an anonymous hotline.

BR4. Impulsive and/or Aggressive Tendencies
Impulsivity can lower the threshold for choosing to act or not act on an idea. Self-aggression may also factor into a decision to attempt or complete suicide.

BR4 Prevention Strategy Example
Impulsivity can be associated with two other psychosocial risk factors: substance abuse and trauma or abuse. Linking prevention efforts across areas and focusing them toward an integrated suicide prevention effort may bring improvements in this area.

BR5. History of Trauma or Abuse
Trauma or physical or sexual abuse are powerful risk factors for suicide. The chart below illustrates the additive effect of exposure to adverse experiences (Middlebrooks & Audage, 2008). The relationship between a history of adverse childhood experiences and attempted suicide may be exacerbated by alcoholism, depression, and illicit drug use (Dube, 2001). The figure below shows the pattern of risk. The greater the number of adverse childhood experiences, the higher the probability of suicide risk.

Figure 2: Number of Adverse Childhood Experiences and Lifetime History of Attempted Suicide

BR5 Prevention Suggestion
As with substance abuse and impulsive/aggressive tendencies, a preventive, coordinated approach could coalesce around the issue of suicide prevention.

BR6. Some Major Physical Disorder
Major physical disorders may lead individuals to consider suicide as a problem solving strategy. Long-term or terminal illnesses can be perceived as insurmountable. Additionally, some people worry about the disease burden—financially and emotionally—the disorder places on loved ones and close others.
**BR6 Prevention Strategy Example**
Self-help and support groups for diseases may provide the social support that people with chronic or life-threatening diseases and their families might experience.

**BR7. Previous Suicide Attempt**
A study by Owens, Horrocks & House (2002) found that the one year repetition rate for suicide attempts was 16% and the repetition was fatal in 2%. At 9 years the repetition being fatal had increased to 5%. The following chart shows the proportion that Laederach and colleagues (1999) found. They did not find a difference across males and females on previous suicide attempts to completed suicides.

*Figure 3: Number of Attempts Prior to Completed Suicide, Laederach, et al., 1999*

**BR7 Prevention Strategy Example**
The strongest prevention for reducing previous suicide attempt risk is to prevent the original attempt. An integrated, well marketed suicide prevention plan is the most effective method of prevention.

**BR8. Family History of Suicide**
A family history of suicidal behaviors is a very potent risk factor for both suicide attempts and suicide completions. There is some evidence of a genetic aspect of suicidal behavior (Statham, et al., 1998; Skegg, Nada-Raja, Dickson, Paul & Williams, 2003). In addition to a possible genetic aspect, because people learn behaviors in families, when suicidal behavior appears to be an acceptable alternative in the family culture, it can be seen as a viable problem solving option.

**BR8 Prevention Strategy Example**
Improving family function is a method to address suicide prevention for youth living at home. Because the 10-14 year old group is at growing risk for suicide, intervening with families who have younger children may be a positive strategy for longer-term outcomes. Family strengthening courses that teach things such as positive problem solving are an example of a methodology that could be part of a coordinated suicide prevention effort.
Environmental Risk Factors (ER)

**ER1. Job or Financial Loss**
Suicide is tied to business cycles with increases in suicide deaths occurring during economic downturns and decreases during business cycle upswings. A major study examined business cycles, national unemployment rates and suicide from 1928 to 2007 in the United States (Luo, et al., 2011). They found that for most age groups, suicide rates rose during recessions and fell during expansions. One well-supported study suggests that suicide is the only major health-related cause of death (heart condition, cancer, etc.) that can be associated with recessions (Rhune, 2000).

Recent research has revealed a strong link between health and suicide with foreclosures. People who experienced greater overall risks—those who were vulnerable—suffered a disproportionately higher number of foreclosures (Pollock & Lyng, 2009). Vulnerabilities are associated with resources for recovery or coping with difficult life situations that range from health issues to social resources to uninsurance status. Previous history with suicide, either their own (BR7, SR8) or of a family member (BR6, SR9), is a risk factor for suicide. Negative economic impacts elevate the potential for developing other risk factors associated with illness, violence, or even resource deprivation.

**ER1 Prevention Strategy Example**
No strategy can remediate rapid population change and dramatic decline in economic fortunes. A strategy might be to work as a community to learn strategic problem solving and thinking about options. These skills would not be directed at “fixing” the economy or the housing market per se but would help people learn new skills that might increase coping with difficult times.

**ER2. Relational or Social Loss**
Social and relational losses can be for many reasons such as people moving away, death, or shifting of alliances among friends. One of the current underlying factors of social and relational loss is due to the economy and its effect on individuals as they lose access to financial and social resources that are caused by unemployment or reduced resources.

**ER2 Prevention Strategy Example**
A program like Foster Grandparents or a “senior” Big Brothers Big Sisters could be a way to identify older adults and help support them as role models and leaders for younger people. Mentoring youth is one commonly implemented method.

**ER3. Easy Access to Lethal Means**
Easy access to means of completing suicide may play into the impulsivity that those seeking to complete suicide can have. In the absence of means, a person may not attempt or complete suicide. Any delay in access to means opens the opportunity for an alternative to emerge.

**ER3 Prevention Strategy Example**
There are many established means restrictions programs for communities. Educational programs may be a good starting point in that they will bring about a dialog to try to understand what works best in any specific community.

**ER4. Local Clusters of Suicide that Have a Contagious Influence**
People who die in a suicide cluster may or may not have had direct contact with the other decedents. In some cases learning of the other’s suicide may even be through a distal source such as the media.
The CDC recommends moving quickly and decisively and as a community to intercede in the face of a cluster (CDC for a Community Plan, 1998). The core parts of the plan are (1) convening a coordinating committee of all sectors of the community: education, public health, mental health, local government, and suicide crisis centers; (2) delivering a public response that minimizes sensationalism and avoids glorifying the suicide victims; (3) evaluating and counseling close friends of the deceased and suicide attempters who may be at high risk.

**ER4 Prevention Strategy Example**

Engaging people in each other’s lives can serve as a protective factor and has a gatekeeper function. Cultural preservation programs could be helpful. In these programs, youth and families gather with those elders who have gathered wisdom for the elder to share a traditional story, song, or task that has a long history in the community. Projects can vary from effectively having an oral history project to a project to teach youth how to bale hay in the old way. The goals of the projects are to keep traditions alive but more than that to make a cultural linkage across the span of years so that it anchors those who participate. A potential outcome from this is that vulnerable people like youth might have developed a relationship that offers them a place for wise counsel if they are feeling hopeless, having suicidal ideation, or even feeling like they are going to attempt suicide.

**Sociocultural Risk Factors (SR)**

Many sociocultural risk factors are the same as biopsychosocial risk factors. The individual risk factor is set into the context of the sociocultural risk factor. For example, “some physical illness” appears in the biopsychosocial and the sociocultural risk factors lists. Sociocultural aspects of an illness could be those that are associated with cultural beliefs about the disease.

Factors that appear here can also influence cultural beliefs about the disease. Stigma is such a factor. A person with a terminal disease must deal with the individual aspects of the disease including pain, being unwell, fear of death, and other aspects of serious illness. The individual also may have to deal with the interpersonal aspects of having a terminal illness. At the sociocultural level beliefs about the disease may color the way the individual thinks about his or her illness. They also help define how others around the person think about the illness and can even influence access to care and insurance. Stigma can add an additional layer of difficulty, particularly when the stigma against the person’s illness is so strong that it prevents the person from accessing or receiving healthcare or being able to live in the community.

**SR1. Lack of Social Support and Sense of Isolation**

Lack of social support and sense of isolation contributes to lack of options. As noted in the biopsychosocial aspect of hopelessness, social support can be difficult to find. In Idaho in 2008, 6.8% of people reported that they rarely or never received emotional support.

**SR1 Prevention Strategy Example**

Many communities have social support than people are unable to access. People who feel a sense of isolation may not recognize or know how to tap into the social support system. Training gatekeepers to identify and reach out to individuals who have poor social support and are isolated might be a successful method to help bridge the gap between having social support available in the community and not knowing how to tap into that support.

**SR2. Stigma Associated with Help-Seeking Behavior**

Stigma is a major barrier to overcome in the context of suicide and mental health. Discrimination and negative stereotypes toward people with mental illnesses can result from stigma. Stigma about people
who struggle with suicide and mental substance abuse disorders can lead to low self-esteem and hopelessness. Stigma can prevent people from seeking care and it can lower the quality of care that a person may get. It can cause people with mental illnesses to be embarrassed or ashamed so that they hide their symptoms and may avoid seeking the very treatment, services, and supports that they need.

**SR2 Prevention Strategy Example**

Anti stigma gatekeeper programs are often successful. They may be combined with a media effort.

**SR3. Barriers to Accessing Health Care, Especially Mental Health and Substance Abuse Treatment**

There are many barriers to treatment including stigma, lack of ability to pay, and lack of access to care. Even for those who do have some insurance, coverage for mental health and substance abuse treatment may be limited.

**SR3 Prevention Strategy Example**

One prevention strategy might include stigma reduction so that people could feel comfortable accessing care.

**SR4. Certain Cultural and Religious Beliefs**

The most prevalent religious beliefs in the U.S. have a belief in an afterlife. Sometimes the afterlife may be thought of as a place of more perfection than the physical life. For some, this may have an aspect of yearning for a better life even though the Christian tradition does not validate suicide.

**SR4 Prevention Strategy Example**

Faith-based organizations can be an important vehicle for education about suicide and stigma reduction. Raising a congregation’s awareness is a type of gatekeeping that may lead to early identification of people who may be at risk. It may also reduce stigma by open discussion and by the respect and authority that a church can have with its members and others in the community. Providing gatekeeper training for religious and lay leaders may be particularly helpful. Many people seek counseling from their ministers, pastors, and bishops. Depending on the culture of the congregation, formal training in counseling regarding suicide could be a good prevention strategy. Religious and lay leaders are often at the front line with postvention. Training and support for these leaders can reduce the potential compassion fatigue they may experience.

**SR5. Exposure to, and Influence of, Others Who Have Died by Suicide**

Knowledge of another’s suicide may have an influence on a person’s suicide ideation, attempt, or completion (Gould, Wallenstein & Davidson, 1989). In some cases learning of the other’s suicide may even be through a distal source such as the media. Another person’s suicide can precipitate imitative suicidal behavior. There is evidence of a relationship between media violence and suicide. The Annenberg Public Policy Center and Robert Wood Johnson “Coding for Health and Media Project” (CHAMP, www.youthmediarisk.org) studies media and health. Jamieson and Romer (2008, 2011) conclude there is a relationship between the violence portrayed in movies and teen suicide.
**SR5 Prevention Strategy Example**

The community has to acknowledge people’s deaths as a suicide prevention effort rather than glorifying the death through movies, such as walks and other activities that strengthen community ties.

**SR6 through SR9**

Each of the remaining sociocultural risk factors has been discussed earlier in the chapter and will not be discussed individually here. In considering the risk factors from the perspective of suicide prevention and postvention, it is helpful to look at the risks both from an individual and cultural level. The sociocultural environment is the place from which the individual learns about and experiences what become individual factors.

**SR6. History of Trauma or Abuse**

See BR5.

**SR7. Some Major Physical Illnesses**

See BR6.

**SR8. Previous Suicide Attempt**

See BR7.

**SR9. Family History of Suicide**

See BR8.

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**Figure 4: Coding of Suicide Rates and Average Sexual Explicitness Rating for Health Media Project**
CHAPTER 3: DESIGNING A PROGRAM JUST RIGHT FOR YOUR COMMUNITY
Developing Your Menu of Options

A key component to any successful suicide prevention, intervention, and postvention program is the right match between the program and the community for which it is intended. This includes factors such as cultural, demographic, and community resources. In this chapter we present a method for designing a customized plan based on increasing protective and reducing risk factors.

The method uses a modularized approach. This approach allows you to take on as little or as much as you feel is appropriate at any one time. It also allows you to planfully shift priorities in response to resource or community changes. You do not need to take on all programs at one time; select from the options and carry out what you can at any given time with resources available.

**What is the Protective and Risk Factors Modular Approach?**

Modules are developed by crossing risk factors with protective factors. The intersections are places where specific activities and plans can be developed. For example, the table below shows a small grouping of risk and protective factors with some specific things a community might wish to enact.

To plan, you simply select a portion of the larger matrix (see below for an example of the whole matrix) that you would like to examine and focus on those parts.

*Table 2: Risk and Protective Factors Matrix Sample Content*

<table>
<thead>
<tr>
<th>Biopsychosocial Risk Factors</th>
<th>Protective Factors</th>
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</thead>
<tbody>
<tr>
<td><strong>Biopsychosocial Risk Factors</strong></td>
<td><strong>P1. Effective clinical care for mental, physical, and substance use disorders</strong></td>
</tr>
<tr>
<td>BR1. Mental disorders</td>
<td>1. Mental Health Professional Group</td>
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<tr>
<td></td>
<td>2. Discussions with health professionals during a gatekeeper training week</td>
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<td></td>
<td>3. Continuing education in clinical cognitive behavioral interventions</td>
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In this example, you can include any accomplishments you may have already made such as improving clinical care (#1 and #2). You can add things that you would like to accomplish that have yet to be done. For example, continuing education for mental health professionals in cognitive behavioral interventions is listed as #3. The next step is to have someone go and research continuing education options on this topic. Perhaps a speaker can be brought to town for $2,000; the Mental Health Professional Group may want to divide the cost for the training among themselves. Another method of financing the training would be for someone in the group to seek a donation for the cost of training. Alternative means of obtaining the training also can be considered. Perhaps the person who investigated options discovered that there was a self-paced online training course for $35 a person. Each member could decide if they wanted to pursue that option. A coordinating group can record the progress on the activities for evaluation purposes if that is appropriate within the program you plan.
Consider the next intersection, Mental Disorders and Access to Care, BR1 and P2. Perhaps in your community strides have already been made in this area. It may be that what you wanted to accomplish is completed. Or, you may wish to add to the list, such as helping survivor groups to find meeting space.

**Benefits of Using a Modular “Menu” Protective and Risk Factors Planning Approach**

*Improves the ability to utilize existing programs and interventions*

The array of resources for suicide prevention, interventions, and postvention is significant. Identifying programs that address the needs of your community can be a daunting and sometimes a seemingly impossible task. Using a modularized protective and risk factor model gives you a specific thing to look for in programs. If you have your priority goals from the matrix, you can examine programs with multiple criteria for your community in mind. You can tell if a program as a whole meets your needs or if you need multiple programs.

*Useful*

The modular approach outlined above is useful in planning for the big picture or smaller specific activity. It helps the planning team zero in on a specific risk or protective factor, or stand back and see the whole.

*Focused*

This approach keeps a group focused because it is specific. Ideas can be fitted into their appropriate places. Because an idea can fit into more than one place, it can be maximized without becoming lost because the links to various parts of the plan are clear.

*Easy to identify an area that you would like to address*

Planning can be difficult, particularly when you have specific resources or events in your community you want to utilize or address. By considering the intersections of the risks and protective factors, the planning team can identify specific places where you feel you can make the most difference with your local resources and needs. You are not left with trying to figure out “a plan” but you can see the parts that can make up your plan and work on them as best suits your community.

*Manageable bites*

One of the common causes of frustration with planning and problem-solving is having too large a bite of the problem to work with. While this modular method does not guarantee that the bites you take won’t be too large, it does make it easier to see the size of a bite and to scale it to the resources and time that the group has.

*Multiple bites can build a program*

In many cases you will only be able to take on one or two specific things at a time. However, if you keep the big picture in mind, and take multiple bites, the program builds out in a way that is scalable and manageable. Most importantly it can withstand the ups and downs of volunteer activities since you can scale the activities to the amount of personnel and other resources you have.

*Supports customization for that community*

Selecting and filling the intersections is specific to a particular community. The Task Force or Planning Group determines what goes into the intersection. The information that the group needs comes from information about the community.
Allows planners to focus on aspects where there are resources available in or to the community
All public and nonprofit programs are subject to being shaped by the money or resources that are available. Using this model, when you identify money, you can look to see where or if it would fit for your community. Additionally, if you have identified a good fit, it makes it easier for you to obtain the resources because you can show what you could accomplish with them.

Easy to evaluate
Because the activities are discrete and identifiable, it is easier to evaluate them. At the simplest level of evaluation you can check the chart and see if you have accomplished a particular task. It is akin to “checking it off your list.” This is particularly useful for management purposes. More in-depth evaluations can be conducted on portions or all of the plan. The project organization makes it easier to plan for evaluation and to know what data you need to keep for respective parts of an evaluation.

Easy to bring in other groups and have them fit into the whole
Perhaps a group wants to contribute and asks what they can do. Using this method, you can help them pick something from the menu that the Task Force has selected. The planning group can help scale the problem to ensure success by the group that wants to do the work.

Each bite is discrete and can be explained to others, including the press
Descriptions of the bits that make up the whole can be developed by the planning group and used across various situations so that there is a consistent message. Consistency is a benefit for management and for marketing your program.

Adjustments can be made easily since the program is developed modularly
Due to changes in resources or needs, it may be appropriate to enhance, reduce, replace, or implement different activities than were originally identified. Using the modular approach you can shift things around until you have a balance that fits you at the time. You can do this and still keep the big picture in mind.

Easier for fundraising
Having a clearly defined goal and message improves people’s ability to understand what you want. When a funder or donor can understand what you need they are far more likely to give it to you. Additionally, if you can clearly show them what you are doing they are likely to have more confidence in giving you the money. You also can show how their grant or donation fits into the context of your program.

Useful for facilitated and community planning
Using the modules, identifiable groups can be facilitated to consider portions of the whole or they can provide feedback about what portions should make up the whole. With the matrix you can pick an area (or pick and then work with) and have a town meeting or facilitated planning that is focused and people can understand.

Multiple channels for the same method
The content of the activities to meet the module can be determined by the situation in which it will be addressed. For example, it may be appropriate to take on the biopsychosocial risk factor of hopelessness. A faith community may approach this by encouraging a deeper faith and connection to others who have similar beliefs. A school may take this on with a mentoring program focused on individual at-risk student skills building. The Chamber of Commerce may choose to take this on by
bringing motivational speakers to town. Individual psychotherapists may address the issue with cognitive behavioral treatment. Each element addresses the whole. Addressing the whole from multiple avenues lets the portions build on and enhance each other. While not all people would encounter all messages, many people will encounter more than one. Consider students who participate in the school activities and also in an after-school program at their church that is based on learned optimism. Perhaps the youth’s parents attend one of the motivational speeches and then the family happens to talk about it at home. Repeated exposure to the same core message enhances the comprehension of the message and the potential for change.

Having the big picture created from modules allows you to gather ideas and information from other communities’ success and plug them in where they fit for you. Because they are being fitted into your plan they will be fitted in ways that are customized for you.

Identifying Programs and Plans to Meet the Activities on Your Menu

Chapter 4 contains a large annotated bibliography of suicide prevention, intervention, and postvention resources. This, along with your knowledge of the community, is the knowledge you need to make decisions about what you would like to do in your community.

Some of your selected activities will not need a specific program in order to accomplish them. For example, a phone call or two may identify space where a support group could meet.

Some activities will need programs and plans. For example, training a cadre of crisis responders who are able to talk with a person who may be suicidal may be done best by selecting from several programs, the one that is best for your community. These could include QPR, ASIST, or another protocol. Chapter 4 is full of programs and protocols that are well established. Many of them have considerable research showing them as evidence-based interventions. The options are classified by audience type.

Protective and Risk Factors for Suicide

“Protective factors” increase the probability that someone will not attempt or complete suicide. These can include thing like positive social support, access to services, or believing that you have a place in the world.

“Risk factors” are things that increase the probability that a person will attempt or complete suicide. These can include things like previous suicide attempts, friend/family who attempted or completed suicide, history of abuse, exposure to other traumatic stressor, poverty, substance abuse/use, depression, and other mental health issues.

Protective Factors for Suicide (P)

P1. Effective clinical care for mental, physical, and substance use disorders
P2. Easy access to a variety of clinical interventions and support for help-seeking
P3. Restricted access to highly lethal means of suicide
P4. Strong connections to family and community support
P5. Support through ongoing medical and mental health care relationships
P6. Skills in problem solving, conflict resolution, and nonviolent handling of disputes
P7. Cultural and religious beliefs that discourage suicide and support self preservation
P8. However, positive resistance to suicide is not permanent, so programs that support and maintain protection against suicide should be ongoing.
Risk Factors for Suicide (R)

**Biopsychosocial Risk Factors (BR)**
- BR1. Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders
- BR2. Alcohol and other substance use disorders
- BR3. Hopelessness
- BR4. Impulsive and/or aggressive tendencies
- BR5. History of trauma or abuse
- BR6. Some major physical illnesses
- BR7. Previous suicide attempt
- BR8. Family history of suicide

**Environmental Risk Factors (ER)**
- ER1. Job or financial loss
- ER2. Relational or social loss
- ER3. Easy access to lethal means
- ER4. Local clusters of suicide that have a contagious influence

**Sociocultural Risk Factors (SR)**
- SR1. Lack of social support and sense of isolation
- SR2. Stigma associated with help-seeking behavior
- SR3. Barriers to accessing health care, especially mental health and substance abuse treatment
- SR4. Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
- SR5. Exposure to, including through the media, and influence of others who have died by suicide
- SR6. History of trauma or abuse
- SR7. Some major physical illnesses
- SR8. Previous suicide attempt
- SR9. Family history of suicide

**Planning Handouts**

This section includes a repeat of the summary of protective and risk factors presented in Chapter 2. It also contains worksheets for planning. The worksheets can be copied for use.

Here are two color coded portions for each risk factor. The first is an activity worksheet and the second is a color coded definition list with room for working notes on each risk and protective factor.

It is important to keep the definitions handy while working through a matrix. This helps each person in the planning group work from a common definition.

At times the group will need to spend time understanding and refining a definition for its community. Other times the definition can be used as it stands.

These handouts are intended to be used with relevant community data as well as with Chapter 4 which includes an extensive annotated bibliography of suicide prevention, intervention, and postvention resources.
### BIOPSYCHOSOCIAL PROTECTIVE AND RISK FACTORS WORK SHEET Page 1 of 2

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#### Risk Factors (R)

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- **BR2.** Alcohol and other substance use disorders
- **BR3.** Hopelessness
- **BR4.** Impulsive and/or aggressive tendencies
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**ENVIRONMENTAL PROTECTIVE AND RISK FACTORS WORKSHEET Page 1 of 1**

**ER1. Job or financial loss**

**ER2. Relational or social loss**

**ER3. Easy access to lethal means**

**ER4. Local clusters of suicide that have a contagious influence**
## SOCIOCULTURAL PROTECTIVE AND RISK FACTORS WORK SHEET Page 1 of 2

### Protective Factors (P)

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<tr>
<td>SR2.</td>
<td>Stigma associated with help-seeking behavior</td>
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<td>SR3.</td>
<td>Barriers to accessing health care, mental health, substance abuse treatment</td>
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<td>SR4.</td>
<td>Certain cultural &amp; religious beliefs</td>
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<td>SR5.</td>
<td>Exposure to and influence of others who died by suicide</td>
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### SocioCultural Protective and Risk Factors Worksheet Page 2 of 2

<table>
<thead>
<tr>
<th>Risk Factors (R)</th>
<th>Protective Factors (P)</th>
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<tbody>
<tr>
<td>P1. Effective clinical care for mental, physical, and substance use disorders</td>
<td>P2. Easy access to a variety of clinical interventions and support for help-seeking</td>
</tr>
<tr>
<td>P3. Restricted access to highly lethal means of suicide</td>
<td>P4. Strong connections to family and community support</td>
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<tr>
<td>P7. Cultural and religious</td>
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**Risk Factors (R):**
- SR6. History of trauma or abuse
- SR7. Some major physical illnesses
- SR8. Previous suicide attempt
- SR9. Family history of suicide
<table>
<thead>
<tr>
<th>Protective Factors for Suicide (P)</th>
<th>Discussion Notes</th>
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<tr>
<td>P1. Effective clinical care for mental, physical, and substance use disorders</td>
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<td>P4. Strong connections to family and community support</td>
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<td>P5. Support through ongoing medical and mental health care relationships</td>
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<tr>
<td>P6. Skills in problem solving, conflict resolution, and nonviolent handling of disputes</td>
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<tr>
<td>P7. Cultural and religious beliefs that discourage suicide and support self preservation</td>
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<td>P8. Programs that support and maintain protection against suicide should be ongoing</td>
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<tr>
<td>Biopsychosocial Risk Factors (BR)</td>
<td>Discussion Notes Page 2 of 2</td>
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<td>BR1. Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders</td>
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<td>BR2. Alcohol and other substance use disorders</td>
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<td>BR3. Hopelessness</td>
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<td>BR4. Impulsive and/or aggressive tendencies</td>
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<td>BR5. History of trauma or abuse</td>
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<td>BR6. Some major physical illnesses</td>
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<td>BR7. Previous suicide attempt</td>
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<td>Environmental Risk Factors (ER)</td>
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<td>ER1. Job or financial loss</td>
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<td>ER2. Relational or social loss</td>
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<td>ER3. Easy access to lethal means</td>
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<tr>
<td>ER4. Local clusters of suicide that have a contagious influence</td>
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### Protective Factors for Suicide (P)

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<tr>
<td>Sociocultural Risk Factors (SR)</td>
<td>Discussion Notes Page 2 of 2</td>
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<td>-------------------------------</td>
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</tr>
<tr>
<td>SR1. Lack of social support and sense of isolation</td>
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<td>SR2. Stigma associated with help-seeking behavior</td>
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<tr>
<td>SR3. Barriers to accessing health care, especially mental health and substance abuse treatment</td>
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<td>SR4. Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)</td>
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<tr>
<td>SR5. Exposure to, including through the media, and influence of others who have died by suicide</td>
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<tr>
<td>SR6. History of trauma or abuse</td>
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<tr>
<td>SR7. Some major physical illnesses</td>
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CHAPTER 4: ANNOTATED BIBLIOGRAPHY OF PROGRAMS AND OTHER RESOURCES
This section of the report explores various evidence-based or best practice programs or activities that suicide prevention advocates may consider as they make plans for the future. Those included from the National Registry of Evidence-based Programs and Practices (NREPP) have been tested to determine their efficacy. NREPP is a register compiled by the Substance Abuse and Mental Health Services Administration (SAMHSA) to help individuals and organizations select resources which have a proven track record for being effective in suicide prevention. When an NREPP certified program is listed, “NREPP” will appear as a parenthetical phrase following the name of the intervention. This resource can be accessed online at http://nrepp.samhsa.gov/ for a searchable online registry of more than 190 interventions supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment.

The following list also includes items from the “best practices registry” provided by the Suicide Prevention Resource Center (SPRC) at http://sprc.org/. SPRC’s list includes NREPP certified programs but also includes additional programs which have been studied for effectiveness but not as rigorously as NREPP designation.

Some resources appear more than once in the document. When a resource was particularly important to more than one group, a portion of it was included in each category.

**Youth Screening**

**SOS Signs of Suicide (NREPP)**

SOS Signs of Suicide is a 2-day secondary school-based intervention that includes screening and education. Students are screened for depression and suicide risk and referred for professional help as indicated. Students also view a video that teaches them to recognize signs of depression and suicide in others. They are taught that the appropriate response to these signs is to acknowledge them, let the person know you care, and tell a responsible adult. SOS kits cost $300. Implementing this program will increase awareness among students, faculty, and staff of the warning signs to look for and help them know what steps to take. You can learn more about SOS at http://www.mentalhealthscreening.org/highschool/

**Columbia University TeenScreen (NREPP)**

(For schools, primary care, other aggregate settings for youth.) The Columbia University TeenScreen Program identifies teens in need of mental health services due to risk for suicide and undetected mental illness. The program’s main objective is to assist in the early identification of problems that might not otherwise come to the attention of professionals. TeenScreen can be implemented in schools, clinics, doctors’ offices, juvenile justice settings, shelters, or any other youth-serving setting. To access further information about TeenScreen go to http://www.teenscreen.org/programs/schools-communities/

**Guidelines for School Based Suicide Prevention Programs**

National Guidelines for Seniors’ Mental Health: The Assessment of Suicide Risk and Prevention of Suicide. This Canadian report discusses 38 recommendations regarding the assessment of suicide risk and prevention of suicide in seniors. Each of the recommendations is graded on an A, B, C, D scale, according to its corresponding level of scientific evidence. To access the report directly go to http://www.cccsmh.ca/pdf/final supplement.pdf
School Based Awareness Training

**More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel**
American Foundation for Suicide Prevention. This is an awareness program for school staff built around two 25 minute DVDs. One is geared toward educating teens and the other is aimed at school staff, but can also be used with parents or other groups of interested adults. This awareness program should be supported by having a comprehensive school crisis management plan, policies regarding bullying and harassment, and procedures for referring students for mental health evaluation. Cost for the 2 DVDs and guides is $99.99. To see brief video clips and learn more about the program you may go to http://www.morethansad.org/

**School Suicide Prevention Accreditation**
American Association of Suicidology. School Suicide Prevention Accreditation Program is a self-study course for school professionals who want to increase their knowledge of school-based suicide prevention issues. Participants receive a school suicide prevention resource guide, recommended reading list, and sample exam. Participants study at their own pace. When ready, participants take an online accreditation exam. Upon successful completion of the exam, participants receive a certificate of accreditation by the American Association of Suicidology (AAS). Cost for this program is $350 for school-based professionals and $250 for graduate students. A school can choose to designate a staff person as a suicide prevention specialist. www.suicidology.org

**Youth Suicide Prevention, Intervention, and Postvention Guidelines: A Resource for School Personnel**
The Maine Youth Suicide Prevention, Intervention, and Postvention Guidelines were developed for school personnel in Maine but are suitable for schools anywhere. It provides rationale for developing protocols and includes discussion on planning for school-based suicide prevention, intervention, and postvention. The manual contains a self-assessment, “Is Your School Prepared to Manage Suicidal Behavior?” and numerous appendices, including sample forms for documentation, announcements, issues to consider when a student returns following a mental health related absence, media guidelines, and other resources. To access the guidelines manual directly go to http://www.maine.gov/suicide/docs/Guidelines 10-2009--w discl.pdf

**Idaho School Postvention Guidelines**
A task force from the Suicide Prevention Action Network of Idaho (SPAN-Idaho), the Idaho Department of Education, and Idaho State University has prepared postvention guidelines for schools, kindergarten through 12th grade. They can be found at http://www.sde.idaho.gov/site/docs/Annual Superintendent 2010/When the Unthinkable Happens/Guidelines for School-Based Suicide Intervention.pdf

Young Adults (college age)

**Interactive Screening Program**
ISP is a computer based program for identifying college students at risk for depression. Students take screening surveys online and those who score as being at high risk receive emails from the school counseling department which engage them in online supportive conversations encouraging them to seek professional help. To access the program brochure go to http://www.afsp.org/files/Chapter_Documents/AFSP_NYC/ISP_Brochure.pdf
Student Mental Health and the Law
This report is intended as a resource for colleges and universities. The goal of this document is to provide campus professionals with a summary of applicable laws and professional guidelines, as well as related good practice recommendations (highlighted in text boxes), to support well-informed decision-making around students at risk. This guide can be downloaded directly from the Jed Foundation website: http://www.jedfoundation.org/assets/Programs/Program_downloads/StudentMentalHealth_Law_2008.pdf

Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student
This resource provides colleges and universities, regardless of size, culture, and resources, with a list of issues to consider when drafting or revising protocols relating to the management of the student in acute distress or at risk for suicide. Document may be downloaded at http://www.jedfoundation.org/assets/Programs/Program_downloads/Framework_color.pdf

Community and School

Yellow Ribbon Community Be A Link! Suicide Prevention Gatekeeper Training
Be A Link! is a two-hour adult gatekeeper training program. The program can be implemented in a variety of settings, including schools, workplaces, and community groups. The training provides participants with knowledge to help them identify youth at risk for suicide and refer them to appropriate help resources. Training includes information on:

- Risk and warning signs of suicide.
- Community referral points for those who may need help.
- Crisis protocols for those who may be at risk.

Training materials include a PowerPoint presentation (provided on a CD) and a Be A Link! trainer’s manual, which includes talking points for each of the PowerPoint slides, a program overview and outline, an FAQ, preparation worksheet, recommendations for safe and effective messaging, and links to additional resources.

If implemented in a school setting, a school-based crisis management plan should be adopted prior to implementing Be A Link! The program toolkit is available for $299.95. The toolkit includes trainer manuals for the Be A Link! and Ask for Help! programs, associated PowerPoint presentations, and Ask 4 Help wallet cards. www.yellowribbon.org

Connect Community Connect/Frameworks Suicide Postvention Program, NAMI New Hampshire
This program trains key service providers and community members to provide an integrated community response to reduce risk and promote healing in the aftermath of a suicide. The focus of the training is to create an integrated, coordinated community response that (1) enhances collaboration and coordination to provide the most effective intervention; (2) assures outreach and prevention through rapid and comprehensive communication, including best practices, safe messaging, appropriate memorial services, and media guidelines; and (3) engages resources to help survivors and the community with grieving and healing. Specialized training for up to 20 participants is available for $1,600 (excluding travel) per trainer per day. Off-site consultation is available for $160 per hour. Connect will customize its response to specific community needs. If training is not needed, interventions are available for across the wider community. http://www.theconnectproject.org/
Adults

**Depression Wellness Guide for Adults with Depression and their Family and Friends**
Families for Depression Awareness. The Depression Wellness Guide is an educational booklet that helps adults already diagnosed with depression (and their family members) monitor treatment with daily and weekly tools. It is intended for those already in treatment to increase effectiveness of that treatment. The printed guide can be purchased on Amazon.com for $6.95 at http://www.amazon.com/Depression-Wellness-Guide-Families-Awareness/dp/0979154405/sr=8-1/qid=1166641019/ref=sr_1_1/105-8320287-8567637?ie=UTF8&s=books. For further information go to: http://www.familyaware.org/

**Working Minds: Suicide Prevention in the Workplace**
Carson J Spencer Foundation. This toolkit includes a facilitator’s guide and 30-minute training DVD designed to help workplace administrators and employees better understand and prevent suicide. The program builds a business case for suicide prevention while promoting help-seeking and help-giving. Several interactive exercises and case studies help employers and their staff apply and customize the content to their specific work culture. The program provides three options depending on resources and training needs: a 1-hour “lunchtime” presentation, a 1.5-hour in-service workshop, and a 3.5-hour intensive training. The toolkit with DVD is available for $99. Full-day training for trainers is available for $1,000 ($500 for non profits). http://workingminds.org/

**United States Air Force Suicide Prevention Program (NREPP)**
The United States Air Force (USAF) has implemented 11 successful initiatives aimed at strengthening social support, promoting development of social skills, and changing policies and norms to encourage effective help-seeking behaviors. The Air Force Suicide Prevention webpage can be accessed at http://afsp.org/

Older Adults

**Suicide Prevention Training for Gatekeepers of Older Adults, Samaritans of Merrimack Valley, MA**
This program is available only in Massachusetts. However, the Massachusetts Coalition for Suicide Prevention has a website at http://www.masspreventssuicide.org/ which contains several pages of useful information.

**Late Life Suicide Prevention Toolkit**
Canadian Coalition for Seniors’ Mental Health. This educational program was developed for use by front-line providers, medical and mental health care clinicians, and health care trainees. It focuses on how to identify suicide warning signs, establish rapport and assess suicide risk and resiliency factors, and manage immediate and ongoing risk for suicide among older adults. The Toolkit contains:

1. Suicide Assessment & Prevention for Older Adults: Life Saving Tools for Health Care Providers DVD
2. PowerPoint presentation (57 slides)
3. Facilitator’s Guide (19 pages)
4. Suicide Assessment & Prevention for Older Adults clinician pocket card
5. CCSMH National Guidelines for Seniors’ Mental Health: The Assessment of Suicide Risk and Prevention of Suicide

The information can be downloaded and DVD viewed for free at http://www.ccsmh.ca/en/projects/suicide.cfm or a hard copy may be purchased for $20.
Family Strengthening and Problem Solving

**Strengthening Families Program**
The Strengthening Families Program (SFP) is a nationally and internationally recognized parenting and family strengthening program for high-risk and other families. SFP is an evidence-based family skills training program found to significantly reduce problem behaviors, delinquency, and alcohol and drug abuse in children and to improve social competencies and school performance. Child maltreatment also decreases as parents strengthen bonds with their children and learn more effective parenting skills.

SFP was developed and found effective on a National Institute on Drug Abuse (NIDA) research grant in the early 1980s. More than 15 subsequent independent replications have found similar positive results with families in many different ethnic groups. Both culturally adapted versions and the core version of SFP have been found effective with African-American, Hispanic, Asian, Pacific Islander, and First Nations families. http://www.strengtheningfamiliesprogram.org/

**All About Life Challenges**
Do you find yourself in a life challenge or trial—not sure which way to turn? Has an event or illness suddenly changed the whole pattern of your life and your plan for the future? Life Challenges can shake you at your very core. It is our desire that through the articles on this website, you will find comfort for your past, practical help for today, and lasting hope for your future. www.allaboutlifechallenges.org

Community Strengthening, Problem Solving, and Conflict Resolution

**NeighborWorks**
Community building and organizing activities are central to effective community development and foundational to the NeighborWorks network. Community Building & Organizing (CB&O) Programs support NeighborWorks organizations and other community-based development organizations to build healthy communities by developing resident leadership, strengthening resident-led associations, and sponsoring community-building activities that enhance relationships among neighbors and spur organizing efforts leading to positive community change.

At NeighborWorks, Community Building and Organizing is defined as continuous, self-renewing efforts led by community residents who are engaged in collective action. This is aimed at relationship building, problem solving, and building a stronger community.

Conflict is an unavoidable part of our lives that can tear the fabric of our families and communities. The resolution center believes conflict presents both a challenge and an opportunity to heal and restore relationships. It promotes peaceful conflict resolution that empowers the parties, generates open and honest communication, results in mutually agreeable solutions, and encourages respect for others. The resolution center is founded on principles of restorative justice and collaboration. Contact NeighborWorks at http://www.nw.org/network/neighborworksprogs/leadership/default.asp

**The Resolution Center**
This program focuses on Victim-Youth Offender Mediation. It brings both a victim and a youth offender together, face to face. The goal is to personalize the crime for the juvenile by providing the victim a safe and relaxed forum in which to tell the offender about the impact of the crime. Victims have the opportunity to ask questions that might not otherwise be answered. They have an opportunity to ask for and receive an apology. In this program, youth offenders are held accountable, have the opportunity to understand the harm they have caused and make restitution.
Another component of the program is Parent-Adolescent Mediation (PAM). The Resolution Center provides a confidential, safe process to help families resolve problems. Sometimes all a family needs is someone who can help them talk and, more importantly, to listen to each other. In PAM, teens are heard, parents are heard, and both work together to resolve problems. Community referrals are accepted. For more information, contact http://www.alaska.net/~cdrc/

**The Headington Institute**

This program focuses on psychological and spiritual support for humanitarian relief and development workers. Our vision is that one day all humanitarian workers will have the personal skills, social support, organizational resources, and public interest needed to maintain their wellbeing and thrive in their work.

The Institute provides skills building courses and consultation in conflict resolution. Some of the most significant challenges that humanitarian workers face in high-stress or crises environments relate to interpersonal conflict and other communication difficulties. This workshop explores our natural communication tendencies when we encounter potential conflict and strategies for communicating more effectively with others. http://headington-institute.org/

**Strengthening Communities Fund**

This program is from the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Community Services. The Strengthening Communities Fund provides money to governments and nonprofit intermediaries to build the capacity of nonprofit organizations, whether secular or faith based, to address the broad economic recovery issues present in their communities. Capacity building activities are designed to increase project partners’ sustainability and effectiveness, enhance their ability to provide social services, and create collaborations to better serve those in need. For more information, contact www.acf.hhs.gov/programs/ocs/scf/index.html

**Strengthening Nonprofits: A Capacity Builder’s Resource Library**

This library includes content that is useful for communities as a whole, not just nonprofit organizations. The resources include Conducting a Community Assessment, Delivering Training and Technical Assistance, Designing and Managing grant programs, using electronic resources, identifying and promoting effective practices, managing crises, evaluation, and establishing and maintaining partnerships. http://www.strengtheningnonprofits.org/

**Community Conflict Resolution and Mediation**

Alternative dispute resolution is a tool for resolving conflicts within a community, and mediation is used in the workplace and in institutions to help individuals find common ground and peaceful solutions to problems. This section includes resources that community organizations can employ. http://www.sustainable.org/creating-community/conflict-resolution-a-mediation

**Conflict Transformation and Peace-building: A Selected Bibliography**

http://www.peacemakers.ca/bibliography/bib28community.html

**Faith-Based Communities**

**Center for Substance Abuse Prevention, SAMHSA Faith-Based Suicide Prevention Initiatives**

One of the organizations that is part of the National Council on Suicide Prevention is OASSIS: the Organization for Attempters and Survivors of Suicide in Interfaith Services. This organization has worked with a number of different faith traditions to offer support and help to those who are at risk for suicide, as well as to family members, people bereaved by a friend or family member’s suicide, and others.
OASSIS provides a forum for people to gather around this difficult topic. It acts as an umbrella organization for religious communities that care about suicide prevention.

**Pathways**
The National Alliance on Mental Illness (NAMI) also addresses the connection between faith and mental illness. The resources listed by NAMI are provided in the spirit of offering support and compassion to persons with mental illnesses. There are a number of pastoral and religiously-based organizations that can offer mental health counseling, participation in community, education, linkages, and resources to those who seek to approach co-occurring disorders from a spiritual point of view. http://pathwayscourses.samhsa.gov/suicide/suicide_6_pg25.htm

**Risking Connection® in Faith Communities: A Training for Faith Leaders Supporting Trauma Survivors**
Studies show that as many as one in four of the people encountered by faith leaders may have been deeply wounded by life experiences. Risking Connection in Faith Communities will help clergy and lay leaders understand the nature of psychological trauma, how it affects people, and how faith leaders can help. Because the training is addressed to spiritual leaders, particular attention is paid to the spiritual impact of trauma.

The two-day training explains the effects of trauma; focuses on the need for growth-promoting relationships; explores the connection between trauma and spiritual distress; recognizes the value of spirituality in recovery; addresses the impact of trauma on the helper; and looks at how faith communities can promote healing.

Because the curriculum is intended to be useful to clergy and lay leaders of many faiths and denomination, the training takes a neutral stance on belief systems. However examples incorporating such perspectives are offered. http://www.riskingconnection.com/

**The Headington Institute**
This program focuses on psychological and spiritual support for humanitarian relief and development workers. The vision is that one day all humanitarian workers will have the personal skills, social support, organizational resources, and public interest needed to maintain their wellbeing and thrive in their work. http://headington-institute.org/. Values of the program include:

- **Compassion:** We care for others by providing support to humanitarian workers
- **Excellence:** We offer the best services and resources available anywhere
- **Transcendence:** We believe that spirituality is a vital personal resource
- **Responsibility:** Our highest priority is local national staff with few resources
- **Generosity:** Our services are available to all humanitarian aid organizations
- **Cooperation:** We collaborate with others to multiply our impact
- **Advocacy:** We inform the public of the needs of humanitarian workers.
- **Conflict resolution and communication skills in stressful environments**

**Supporting Survivors of Suicide Loss: A Guide for Funeral Directors**
The Guide’s purpose is to provide funeral directors with a greater understanding of the issue of suicide as it relates to their profession. Topics covered in the Guide include:

1. Why suicide is different than other types of deaths.
2. How to avoid stigmatizing those who’ve died by suicide.
3. How to be sensitive to the needs of survivors of suicide loss.
4. How to deal with compassion fatigue.
5. Frequently asked questions about suicide loss.
6. Resources for funeral directors and their clients.
7. Recommended readings.

It can be ordered free (shipping charges may apply) from SAMHSA or it can be downloaded in PDF format from http://store.samhsa.gov/shin/content//SMA09-4375/SMA09-4375.pdf

Medical Settings

“Is Your Patient Suicidal?” Emergency Department Poster and Clinical Guide
This program from the Suicide Prevention Resource Center (SPRC) was developed for emergency departments to increase knowledge of warning signs for suicide and the questions medical professionals can ask to determine if their patients who present with other types of concerns may also be suicidal. Poster size is 11” X 17.” Poster content includes: (1) signs of acute suicide risk, (2) key risk factors for suicide, and (3) questions that can be asked of those who might be at risk for suicide. The clinical guide is contained on a standard 11” X 8.5” sheet with information on the front and back. Clinical guide content includes information about (1) assessing suicide risk, (2) recommended interventions, (3) discharge protocols, (4) suggested documentation, and (5) procedures to use when a patient elopes.

The poster and accompanying guide can be ordered from the Emergency Nurses Association (ENA) through the ENA website at http://admin.ena.org/store/. The cost of the poster and guide is $7 for ENA members and $10 for non-ENA members. Free PDF copies of the poster and guide are available at http://library.sprc.org

After an Attempt: A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors
This 14-page brochure from U.S. Substance Abuse and Mental Health Services Administration provides information regarding Emergency Department care of suicide attempters. It is intended to increase awareness among medical professionals for serving patients who have had a suicide attempt. The brochure can be downloaded at http://store.samhsa.gov/shin/content//SMA08-4359/SMA08-4359.pdf and addresses the following topics:

1. Patient Care in the Emergency Department: Helpful Tips
2. Communicating With a Patient’s Family or Other Caregiver
3. Communicating With Other Medical Professionals About a Patient
4. Patient Discharge From the Emergency Department: What the ED Can Do To Ease the Transition
5. Resources for Professionals in the Emergency Department

After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department
This brochure from the U.S. Substance Abuse and Mental Health Services Administration is for emergency department staff to distribute to the family members of individuals who have survived a suicide attempt. Topics addressed include:

1. What Happens in the Emergency Department
2. What the Emergency Department Needs to Know: How You Can Help
3. Next Steps after the Emergency Department
4. What you Need to Know
5. Moving Forward
6. Links to Additional Resources
This resource can be downloaded at http://store.samhsa.gov/shin/content//SMA08-4357/SMA08-4357.pdf

After an Attempt: A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department
This brochure from the Substance Abuse and Mental Health Services Administration is for emergency department staff to distribute to patients who have survived a suicide attempt when they are being discharged. Topics addressed include:
1. Your Emotional Response to a Suicide Attempt
2. What to do After the Emergency Department Visit
3. What if You Don’t Want to Go to the Hospital?
4. Next Steps: Moving Ahead and Coping with Future Thoughts of Suicide
5. Creating a Safety Plan
6. Building a Support System
7. Learning to Live Again
8. Everyone’s Recovery is Different
9. Links to Additional Resources

This resource can be downloaded at http://store.samhsa.gov/shin/content//SMA08-4355/SMA08-4355.pdf

Recognizing and Responding to Suicide Risk in Primary Care (RRSR—PC)
This program from the American Association of Suicidology focuses on recognizing and responding to suicide risk in primary care (RRSR—PC). It is a one-hour facilitated training for primary care physicians, physician assistants, and others who work in primary care settings. The training will help them better identify, manage, and treat adult patients who are at risk for suicide. Training is deliverable face-to-face or by webinar. Costs vary depending on type of training, setting and number of attendees. Features of RRSR—PC training include:
1. One-hour PowerPoint presentation
2. Video vignettes demonstrating suicide risk assessment and management skills
3. Suicide Risk Assessment & Triage Pocket Card
4. Seven resource sheet handouts

Further information about this program is available at http://www.suicidology.org/education-and-training/recognizing-responding-suicide-risk-primary-care

Emergency Department Means Restriction Education (NREPP)
ED Means Restriction Education is designed to help parents and adult caregivers of at-risk youth recognize the importance of taking immediate, new action to restrict access to firearms, alcohol, and prescription and over-the-counter drugs in the home. The intervention also gives parents and caregivers specific, practical advice on how to dispose of or lock up firearms and substances that may be used in a suicide attempt. Further information about this program can be found at:

Emergency Room Intervention for Adolescent Females (NREPP)
Emergency Room Intervention for Adolescent Females is a program for teenage girls 12 to 18 years old who are admitted to the emergency room after attempting suicide. The intervention, which involves the girl and one or more family members who accompany her to the emergency room, aims to increase

**Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)**

The Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) pocket card for mental health clinicians and health care professionals from Screening for Mental Health Inc. provides protocols for conducting a comprehensive suicide assessment, estimating suicide risk, identifying protective factors, and developing treatment plans and interventions responsive to the risk level of patients. The pocket card includes triage and documentation guidelines for clinicians. This pocket card can be downloaded from http://www.sprc.org/library/safe_t_pcktcrd_edc.pdf or laminated colored cards can be ordered from SAMHSA at http://store.samhsa.gov.

**A Resource Guide for Implementing the Joint Commissions 2007 Patient Goals on Suicide**

This guide from SPRC summarizes steps for conducting comprehensive suicide assessment, estimating suicide risk, and developing treatment plans and interventions. It features the five step SAFE-T method of evaluation and triage. This guide can be downloaded at:


**Effects on Helpers and Responders Working with Suicide: Compassion Satisfaction and Compassion Fatigue**

**Risking Connection**

Risking Connection® teaches a relational framework and skills for working with survivors of traumatic experiences. The focus is on relationship as healing, and on self-care for service providers. Our mission is to help people recover from traumatic experiences through RICH® relationships—those hallmarked by Respect, Information Sharing, Connection, and Hope, and in so doing to reduce the time, trauma, and costs of healing for all involved. http://www.riskingconnection.com/

**Compassion Fatigue Awareness Project**

Caring too much can hurt. When caregivers focus on others without practicing self-care, destructive behaviors can surface. Apathy, isolation, bottled up emotions, and substance abuse head a long list of symptoms associated with the secondary traumatic stress disorder now known as “Compassion Fatigue.” While the effects of Compassion Fatigue can cause pain and suffering, learning to recognize and manage its symptoms is the first step toward healing. The Compassion Fatigue Awareness Project® is dedicated to educating caregivers about authentic, sustainable self-care and aiding organizations in their goal of providing healthy, compassionate care to those whom they serve. The Compassion Fatigue Awareness Project© also offers original training materials, workbooks, and texts through our parent organization, Healthy Caregiving LLC. www.compassionfatigue.org

**The Figley Institute**

Figley Institute offers cutting-edge training and continuing education programs developed by Dr. Charles R. Figley, Dr. Kathleen Regan Figley, and Adjunct Faculty to those who provide relief to emotionally traumatized individuals and communities. Compassion Stress Management Course Goal: To provide each participant with the knowledge and skills necessary to reduce the secondary impact of working with traumatized populations. The target audience is professionals and laypersons working with traumatized populations, including disaster survivors. http://www.figleyinstitute.com/
**ProQOL.org, Professional Quality of Life: Compassion Satisfaction and Compassion Fatigue**

Professional quality of life is the quality one feels in relation to their work as a helper. Both the positive and negative aspects of doing one’s job influence one’s professional quality of life. People who work in helping professions may respond to individual, community, national, and even international crises. Helpers can be found in health care professionals, social service workers, teachers, attorneys, police officers, firefighters, clergy, airline and other transportation staff, disaster site clean-up crews, and others who offer assistance at the time of the event or later. Understanding the positive and negative aspects of helping those who experience trauma and suffering can improve your ability to help them and your ability to keep your own balance.

This website provides free and easy access to a multitude of resources on Compassion Satisfaction, Compassion Fatigue, and Professional Quality of Life. We know that accessing tools requires resources. The resources you need for the ProQOL are your energy, vision, and commitment. The resources at ProQOL.org are free. A commitment was made over 20 years ago that these resources would be given away and we continue to believe that was the right thing. There are hundreds of resources through the various parts of this website. Information on how to use them is on the site. Most can be downloaded and customized for your organization or your use. www.proqol.org

**Bereavement Survivor Support**

**Towards Good Practice: Standards and Guidelines for Suicide Bereavement Support Groups**

This program established standards and guidelines for suicide bereavement support groups. To access the guide directly go to:

**Suicide: Coping with the Loss of a Friend or Loved One**

Suicide Awareness Voices of Education (SAVE) provides this 21-page booklet containing useful information for those who have suffered the loss of a friend or loved one to suicide (survivors of suicide loss). The cost is $4. The booklet includes:

1. Advice for survivors, from survivors.
2. Recommendations for how to deal with grief, anger and other emotions related to loss.
3. Questions and answers about suicide.
4. Suggestions for how to talk to children and others about suicide loss.
5. Resources for additional information.

Additionally, SAVE has a variety of other suicide prevention material. All SAVE brochures, posters, and other information can be ordered at http://www.save.org/

**Supporting Survivors of Suicide Loss: A Guide for Funeral Directors**

The Guide’s purpose is to provide funeral directors with a greater understanding of the issue of suicide as it relates to their profession. Topics covered in the Guide include:

1. Why suicide is different than other types of deaths.
2. How to avoid stigmatizing those who’ve died by suicide.
3. How to be sensitive to the needs of survivors of suicide loss.
4. How to deal with compassion fatigue.
5. Frequently asked questions about suicide loss.
6. Resources for funeral directors and their clients.
7. Recommended readings.
It can be ordered free (shipping charges may apply) from SAMHSA or it can be downloaded in PDF format from http://store.samhsa.gov/shin/content//SMA09-4375/SMA09-4375.pdf

Individual Skill-Building: Community and Clinicians

**QPR Suicide Risk Assessment and Management Training**

QPR Institute provides these suicide risk assessment protocols as guided clinical interviews that produce a standardized suicide risk assessment. The training program can be delivered either in person or online. A “train-the-trainer” course also is available. Cost varies according to which format is used. www.qprinstitute.com

**Question, Persuade, Refer (QPR) Gatekeeper Training for Suicide Prevention**

QPR Institute. This gatekeeper training teaches people to recognize and respond positively to those at risk for suicide. The training is delivered in a 1-2 hour multi-media format. Idaho State University Institute of Rural Health has sponsored the training of a number of QPR trainers throughout the state who are available to provide this course to community groups. Further information about QPR can be found at http://www.qprinstitute.com/. For information about a QPR trainer in your area, contact preventsuicide@isu.edu.

**ASIST**

From Livingworks, ASIST stands for Applies Suicide Intervention Skills Training. It is a two day training that teaches individuals to recognize warning signs for suicide, how to talk to people at risk of suicide, and how to intervene effectively. Role plays are used to give participants practice in asking questions to assess suicide risk and helping to create a safety plan. For further information see http://www.livingworks.net/page/Applied Suicide Intervention Skills Training (ASIST)

**Clinicians Assessing and Managing Suicide Risk: Core Competencies (AMSR)**

This nationally recognized program from the Suicide Prevention Resource Center provides skills for Assessing and Managing Suicide Risk (AMSR). It is a one-day workshop for mental health professionals that will help them better assess suicide risk, plan treatment, and manage the ongoing care of at-risk clients. AMSR requires instruction by a qualified trainer. Training is available from the SPRC Training Institute for a fee. Up to 25 people can be trained at once. CEUs are offered for psychologists, physicians, social workers, counselors, or other licensed mental health professionals. Idaho State University Institute for Rural Health sponsored an AMSR clinical training in June 2011 and has contact information for professionals who have received this training. For information, contact the SPRC’s training resources page at www.sprc.org, or for contact information email preventsuicide@isu.edu.

**Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians**

From the American Association of Suicidology, this program is an advanced two-day training for mental health clinicians. It is based on 24 core clinical competencies for working with clients at risk for suicide. The base RRSR training fee is $4,600, plus trainer travel and lodging. Up to 40 participants can be trained at once. www.suicidology.org

**Evidence-based Psychotherapies**

There are many evidence-based psychotherapies from which to choose. The choice is best made based on a clinician’s skills and training and the client or patient’s needs and diagnoses. Below are some options.
**Cognitive-Behavioral Therapy (NREPP and Others)**

There are a variety of cognitive-behavioral therapies (CBT). One such version is CBT for Adolescent Depression (NREPP) which is a developmental adaptation of the classic cognitive therapy model developed by Aaron Beck and colleagues. CBT emphasizes collaborative empiricism, the importance of socializing patients to the cognitive therapy model, and the monitoring and modification of automatic thoughts, assumptions, and beliefs. To adapt CBT for adolescents, more emphasis is placed on (1) the use of concrete examples to illustrate points, (2) education about the nature of psychotherapy and socialization to the treatment model, (3) active exploration autonomy and trust issues, (4) focus on cognitive distortions and affective shifts that occur during sessions, and (5) acquisition of problem-solving, affect-regulation, and social skills. As teens frequently do not complete detailed thought logs, internal experiences such as monitoring cognitions associated with in-session affective shifts are used to illustrate the cognitive model. To match the more concrete cognitive style of younger adolescents, therapists summarize session content frequently. Abstraction is kept to a minimum, and concrete examples linked to personal experience are used when possible. The treatment program is delivered in 12 to 16 weekly sessions. http://nrepp.samhsa.gov/ViewIntervention.aspx?id=106.

**Dialectical Behavior Therapy (NREPP)**

DBT is a comprehensive cognitive therapy that is conceptualized in progressive stages. The initial stage focuses on stabilizing the patient and achieving behavioral control. Subsequent treatment is designed to increase distress tolerance, emotional regulation, and personal effectiveness. For further information about DBT see http://depts.washington.edu/brtc/about/dbt

**Multisystemic Therapy with Psychiatric Supports (MST-Psychiatric) (NREPP)**

Multisystemic Therapy With Psychiatric Supports (MST-Psychiatric) is designed to treat youth who are at risk for out-of-home placement (in some cases, psychiatric hospitalization) due to serious behavioral problems and co-occurring mental health symptoms, such as thought disorder, bipolar affective disorder, depression, anxiety, and impulsivity. Youth receiving MST-Psychiatric typically are between the ages of 9 and 17. The goal of MST-Psychiatric is to improve mental health symptoms, suicidal behaviors, and family relations while allowing youth to spend more time in school and in home-based placements. For more information about this approach see http://www.mstservices.com/

**PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial) (NREPP)**

The goal of PROSPECT is to prevent suicide among older adults in primary care settings by reducing suicidal ideation and depression. Health specialists collaborate with physicians to monitor patients and encourage adherence to recommended treatments. Patients are treated and monitored for 24 months. For further information about PROSPECT see http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=128

**Additional Programs and Resources**

The following tools are the result of scientific consensus among practitioners, researchers, survivors, and others involved in suicide prevention. They may be helpful to various segments of the community as additional programs are contemplated.

**Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment: A Treatment Improvement Protocol TIP 50**

This resource is designed to help substance abuse counselors assist adult clients in treatment. The text of this resource can be downloaded at
http://www.kap.samhsa.gov/products/manuals/tips/pdf/TIP50.pdf. There is also an accompanying DVD which can be ordered from SAMHSA.

**Consensus Statement on Youth Suicide by Firearms**
This document provides recommendations for public practice and policy regarding access to lethal means for suicide. It was written in 1998 so the statistics listed are out of date, however the main points described are still relevant. The original publication may be accessed at http://www.suicidology.org/c/document_library/get_file?folderId=235&name=DLFE-44.pdf

**Reporting on Suicide: Recommendations for the Media**
The objective of this guide is to ensure that information about suicide deaths is conveyed in a responsible manner to avoid over sensationalizing or romanticizing suicide. These recommendations will help media avoid myths and misunderstandings about suicide and prevent contributing to stigma or suicide contagion. This information should be shared with all media outlets. To access directly go to reportingonsuicide.org

**Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority**
This report summarizes the epidemiology of suicidal behaviors among those with serious mental illness (SMI). A discussion of the risk and protective factors that are common among the various categories of mental illness is followed by information about factors specific to each. Next, perspectives of individuals with SMI who have survived their own attempts and those who have survived the suicide of a loved one are discussed. The remainder of the report describes generally accepted approaches for preventing suicide and how they should inform the work and involvement of the State Mental Health Authority. To access the report directly go to http://www.oregon.gov/OHA/mentalhealth/docs/nasmhpd.pdf?ga=t

**Video Evaluation Guidelines (for Youth Suicide Prevention)**
The American Association of Suicidology outlines criteria for determining the merit of videos pertaining to suicide prevention. A list of specific videos are described with recommendations at http://www.suicidology.org/stats-and-tools/videos-suicide-prevention

**Warning Signs for Suicide Prevention**
From the American Association of Suicidology, this is an article from the June 2006 journal “Suicide and Life Threatening Behavior” published by the American Association of Suicidology. The article addresses the issue of warning signs for suicide, clarifying the difference between risk factors and warning signs. The article may be accessed directly at http://onlinelibrary.wiley.com/doi/10.1111/sltb.2006.36.issue-3/issuetoc
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