



Great Lakes
ATTC

Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration



Welcome to today's webinar!

Suicide Prevention and Substance Abuse: A Shared Framework

Presented by:

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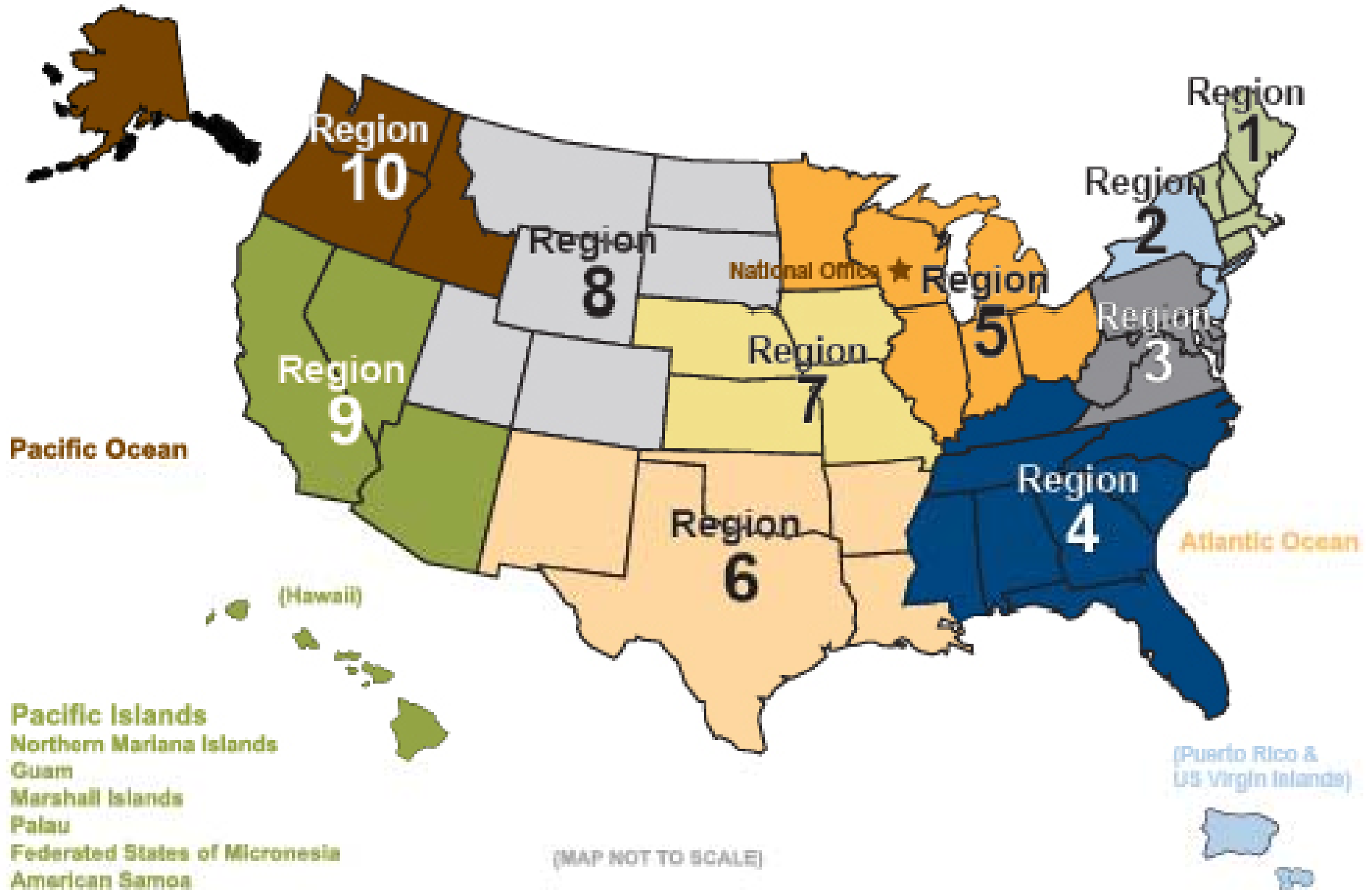
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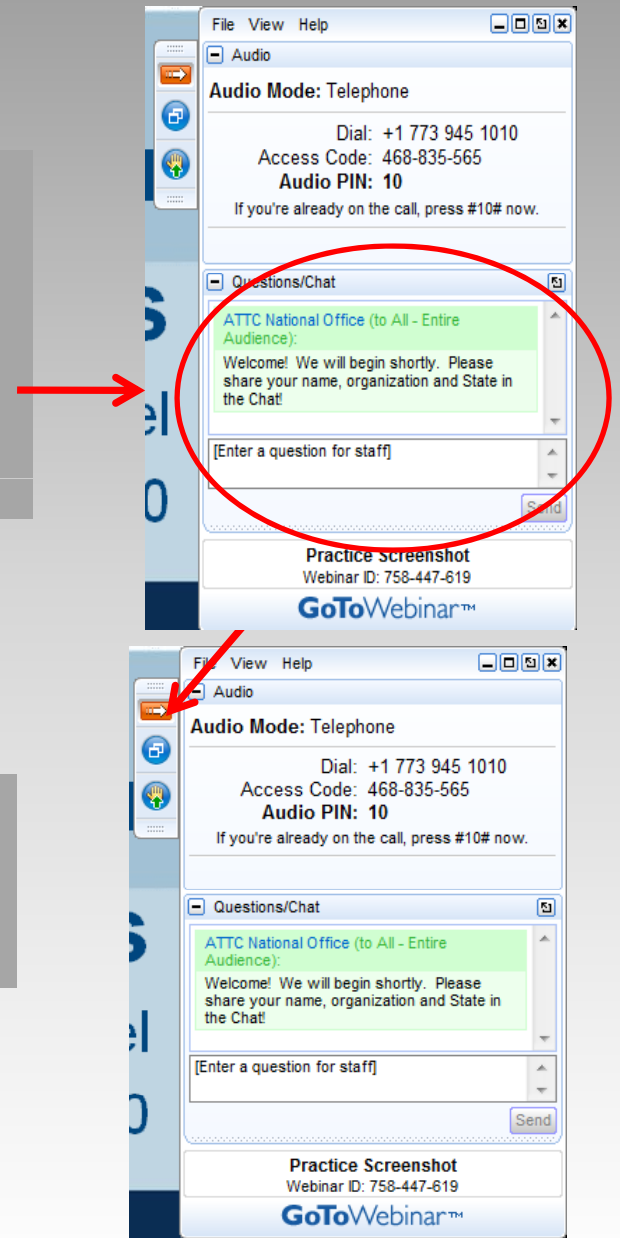
2012 – 2017 ATTC Network Map



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A photograph of a stage with heavy red curtains. A spotlight illuminates a circular area on the dark stage floor in the foreground. The text is centered over the curtains.

Ellyson Stout, MS
Jerry Reed, PhD, MSW
John Draper, PhD



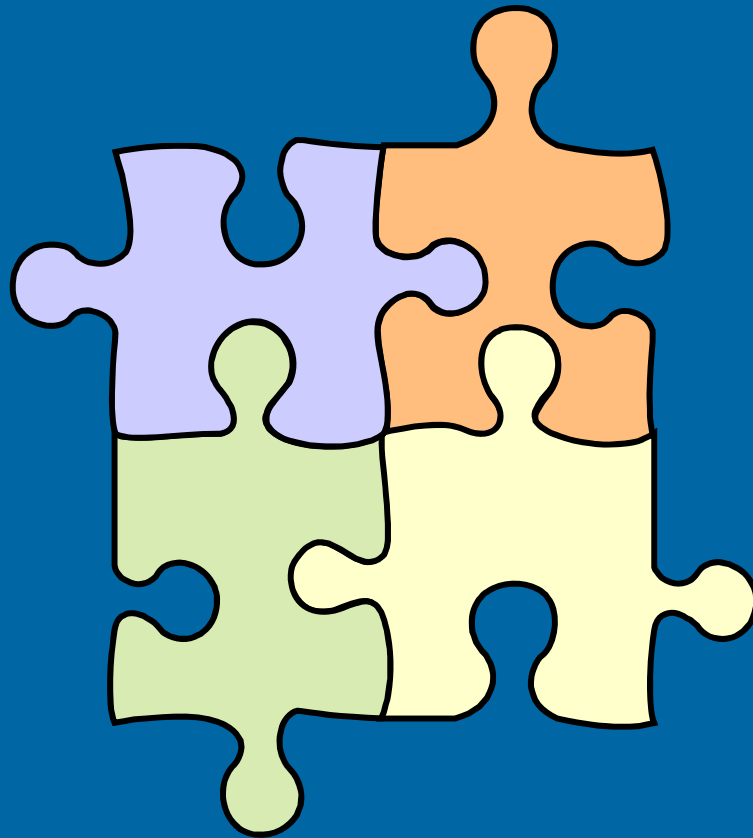
Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention

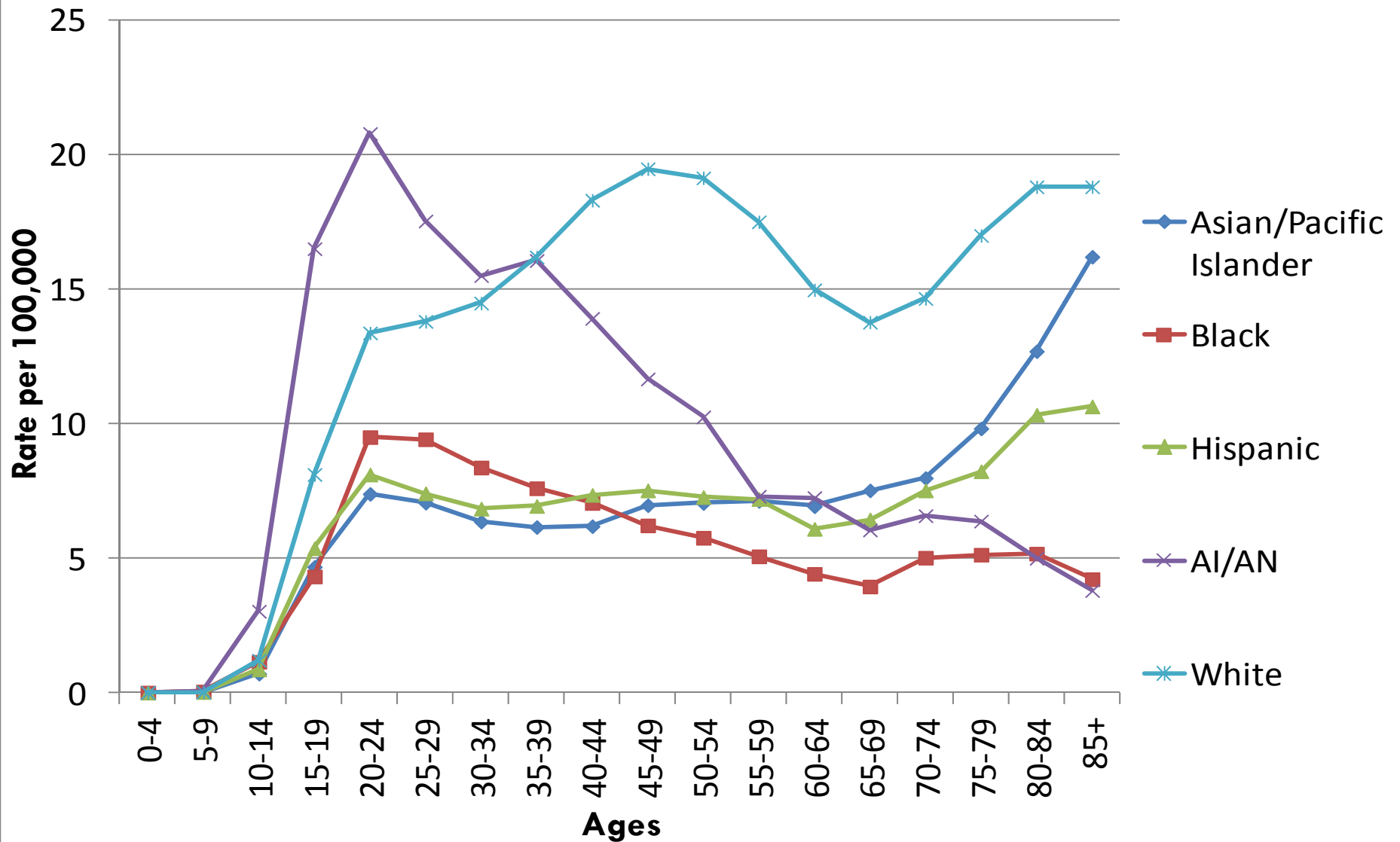


The nation's only federally supported resource center devoted to advancing the *National Strategy for Suicide Prevention*.

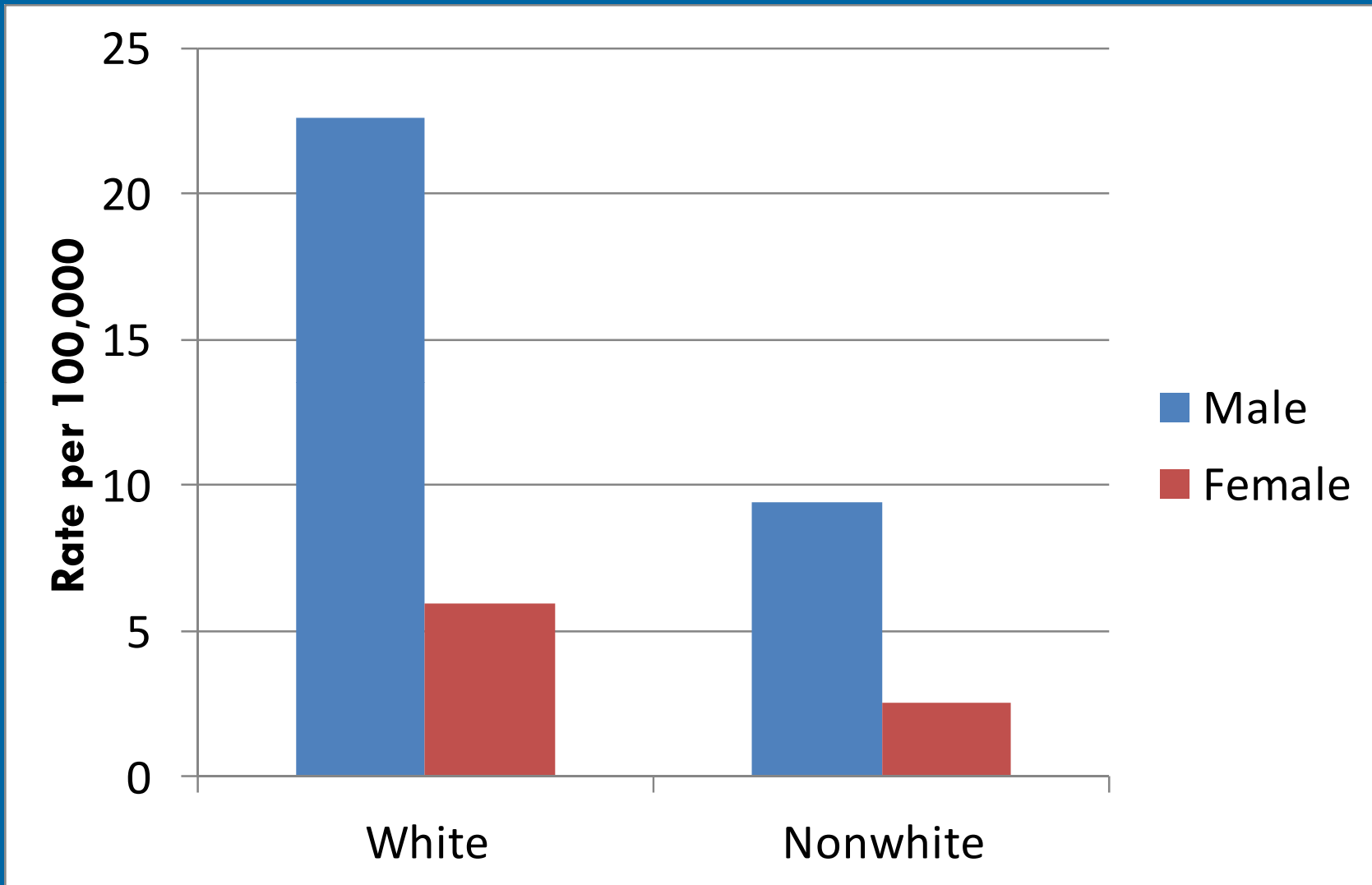
The Connection Between Suicide and Substance Use



Suicide in the United States 2000-2010

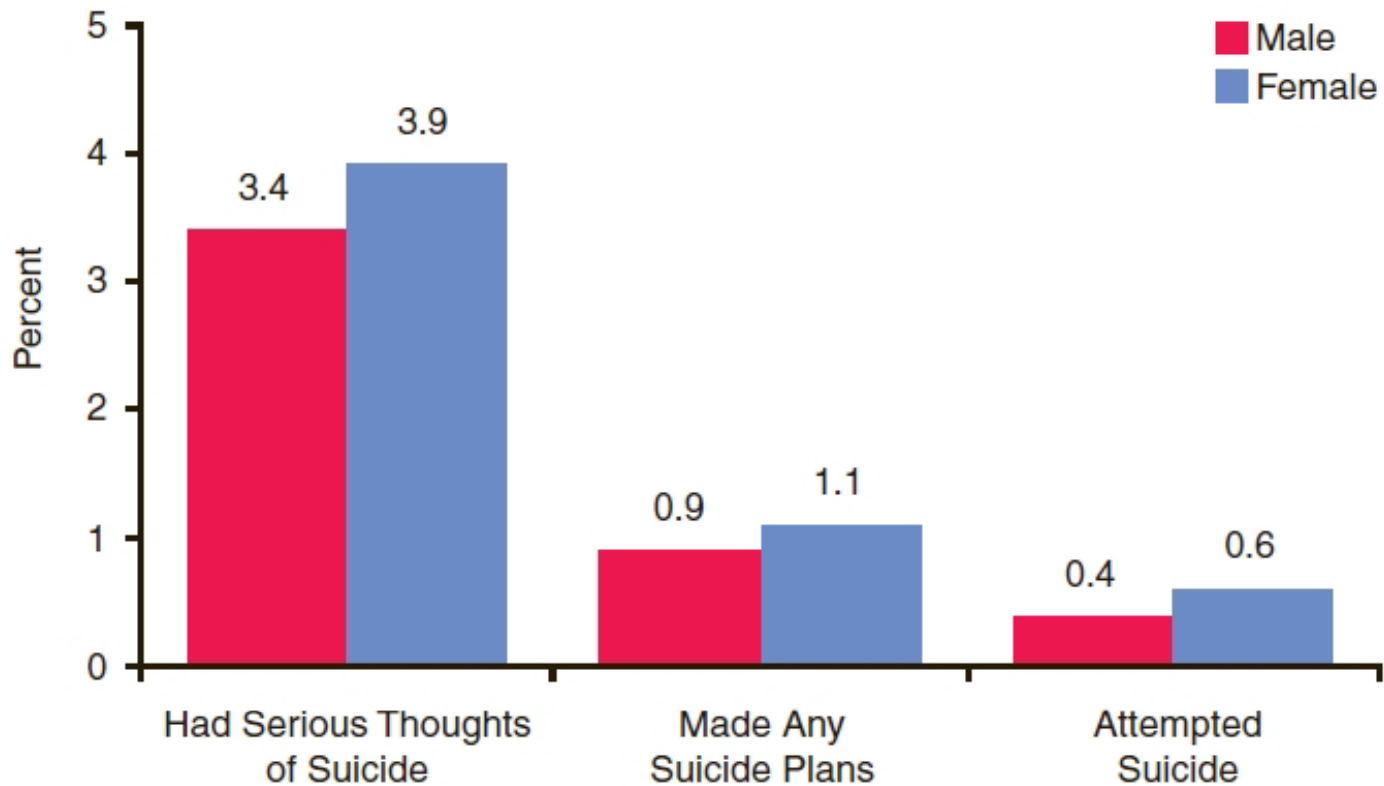


Source: CDC WISQARS Fatal Injuries Report, 2000-2010



Source: McIntosh, J.L. *USA suicide: 2010 official final data*. Washington, DC: AAS, 2012.

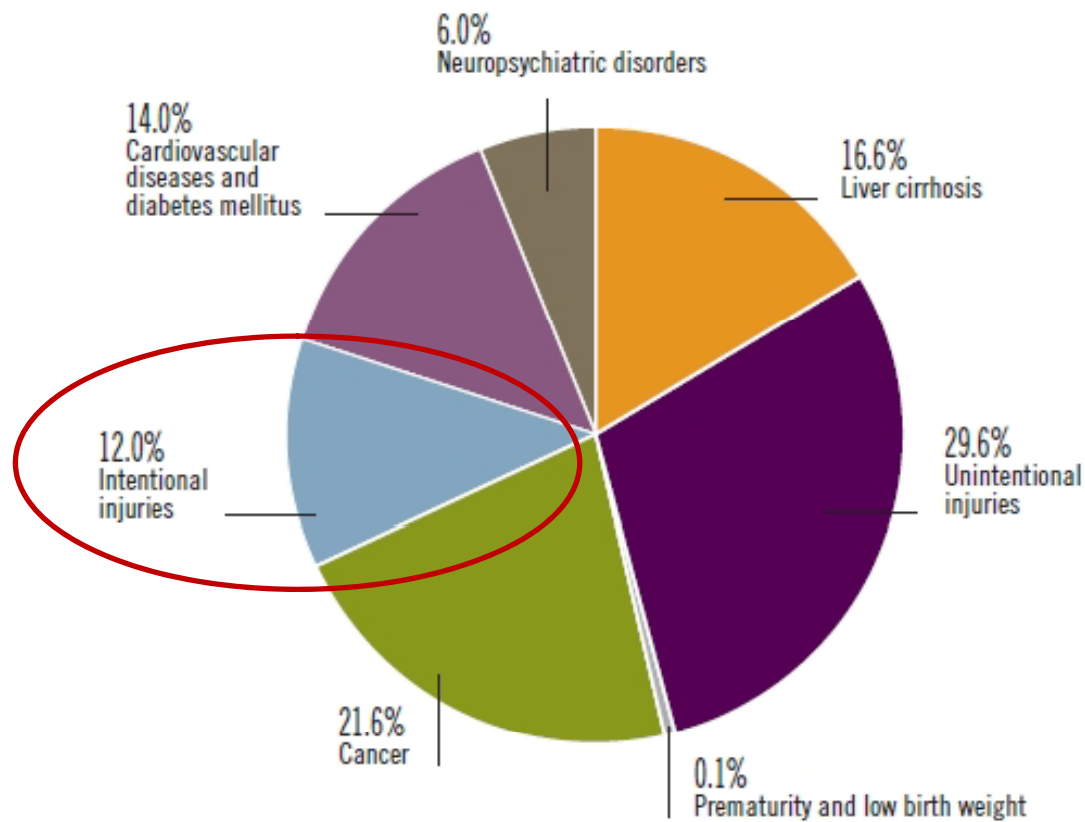
Figure 2. Suicidal Thoughts and Behaviors in the Past Year among Adults, by Gender: 2008



Source: 2008 SAMHSA National Survey on Drug Use and Health (NSDUH).

Source: SAMHSA Office of Applied Studies. (Sep 17, 2009). *The NSDUH Report: Suicidal Thoughts and Behaviors among Adults*. Rockville, MD.

Figure 13. Global distribution of all alcohol-attributable deaths by disease or injury, 2004^a



^a Percentages may not add up to 100% due to rounding.

Source: WHO. *Global Status Report on Alcohol and Health*. Geneva, Switzerland: WHO, 2011.

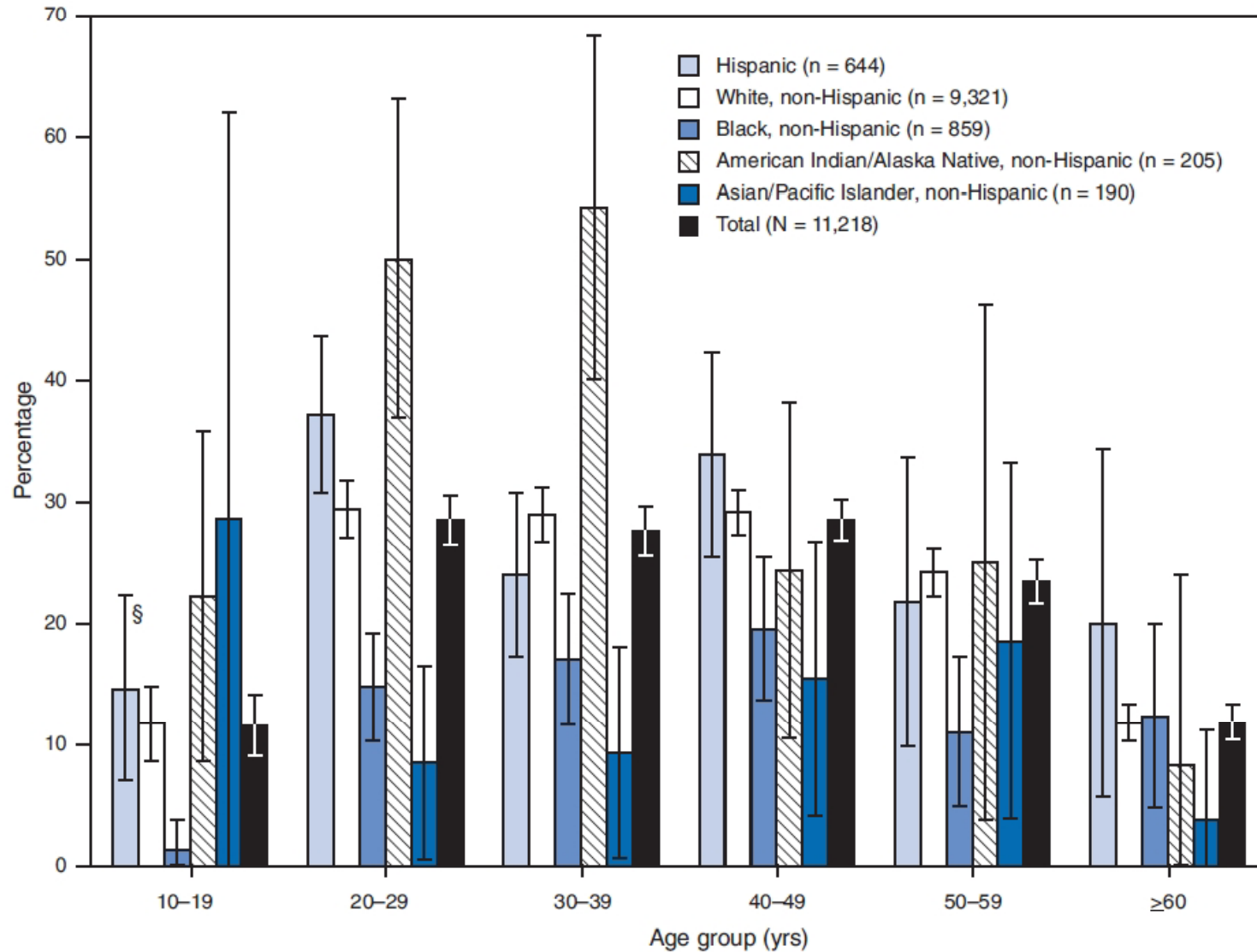
Suicide and Substance Use

Circumstance	Death Counts	Percentage
All Persons with Known Circumstances	8,703	100.00
Alcohol Dependence	1,615	18.56
Other Substance Problem	1,273	14.63



Source: 2009, 16 NVDRS States: AK, CO, GA, KY, MD, MA, NJ, NM, NC, OK, OR, RI, SC, UT, VA, WI Death Counts by Circumstances of Death, Abstracter Assigned Mode, Suicide Circumstances, All Mechanisms, All Races, Both Sexes, All Ages

FIGURE 1. Percentage of suicide decedents with blood alcohol concentrations (BACs) ≥ 0.08 g/dL,* by race/ethnicity and age group† — National Violent Death Reporting System, 17 states, 2005–2006



Source: CDC NVDRS WISQARS 2003-2008

Suicide Attempts and Substance Use

Table 17
Suicide attempts, by patient and visit characteristics: 2005

Patient characteristics	Estimated visits ^{1,2}
Total drug-related ED visits, suicide attempts	151,568
Gender	
Male	58,775
Female	92,682
Unknown	...
Age	
0-5 years	...
6-11 years	...
12-17 years	17,869
18-20 years	13,763
21-24 years	14,989
25-29 years	18,761
30-34 years	14,074
35-44 years	39,140
45-54 years	22,057
55-64 years	6,745
65 years and older	4,079
Unknown	...
Race/ethnicity	
White	89,172
Black	26,229
Hispanic	13,353
Race/ethnicity not tabulated above (NTA)	2,132
Unknown	20,682

¹ These are estimates of ED visits based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.

² Three dots (...) indicate that an estimate with an RSE greater than 50% or an estimate less than 30 has been suppressed.

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 2005 (03/2008 update).

151,568 ED
visits for suicide
attempts

Single Drug: 39%
Multiple Drugs: 61%

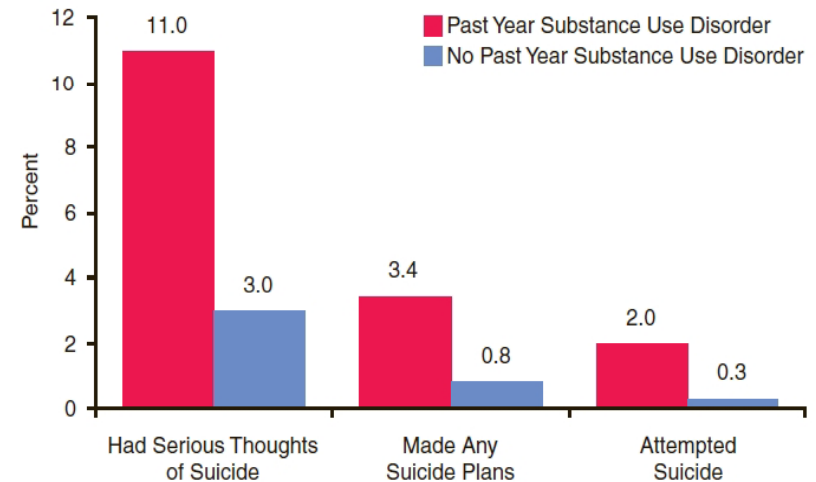
Alcohol: 32%
Illicit Drugs: 23%
Psych Drugs: 55%
Analgesics: 37%

Source: Office of Applied Studies (2007c). *Drug Abuse Warning Network, 2005: National Estimates of Drug-Related Emergency Department Visits*. DAWN Series D-29, DHHS Publication No. (SMA) 07-4256. Rockville, MD: SAMHSA.

Suicide and Substance Use

- Substance use is the second biggest risk factor for suicide
- AOD disorders → 6-10 times greater risk of suicide attempts
- 14 times greater risk for injecting drug users

Figure 3. Suicidal Thoughts and Behaviors in the Past Year among Adults, by Past Year Substance Use Disorder: 2008



Source: 2008 SAMHSA National Survey on Drug Use and Health (NSDUH).

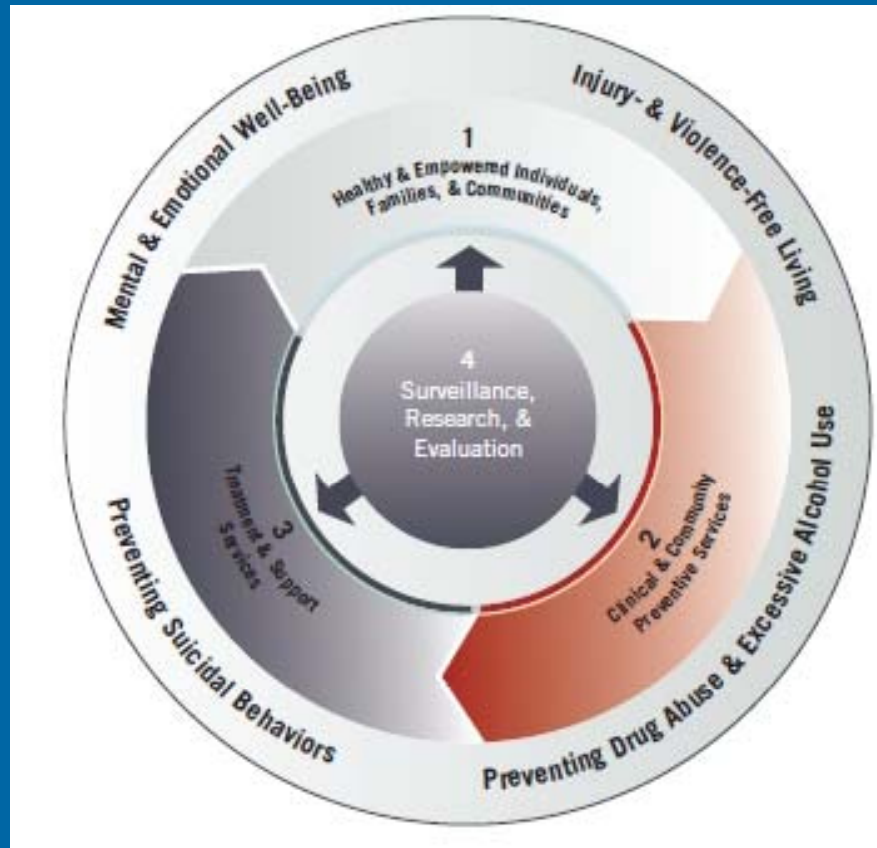


Public Health Approach to Prevention

- ✓ Use data for planning
- ✓ Understand risk and protective factors
- ✓ Develop and implement effective interventions
- ✓ Evaluate and revise



Comprehensive Suicide Prevention



Key high-risk groups

- ✓ Individuals with key risk factors:
 - mental health issues
 - substance use disorders
 - individuals who have attempted suicide
- ✓ Individuals who:
 - engage in non-suicidal self-injury
 - have been bereaved by suicide
 - have a medical condition(s)

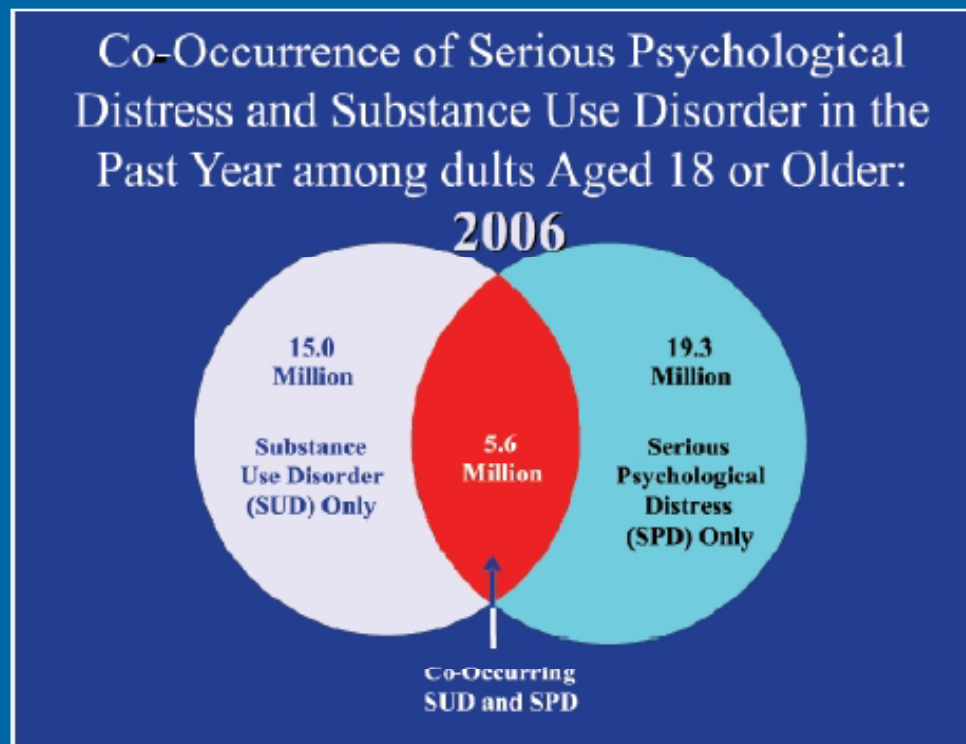
Key high-risk groups (cont.)

- ✓ Individuals in justice and child welfare settings
- ✓ Specific populations:
 - American Indian/Alaska Native
 - Lesbian, gay, bisexual, and transgender
 - Members of the armed forces and veterans
 - Men in mid-life
 - Older men

Shared Risk Factors

- ✓ Depression
- ✓ Impulsivity
- ✓ Delinquency

→ Underlying Primary
Mental Health Issues



Shared Protective Factors

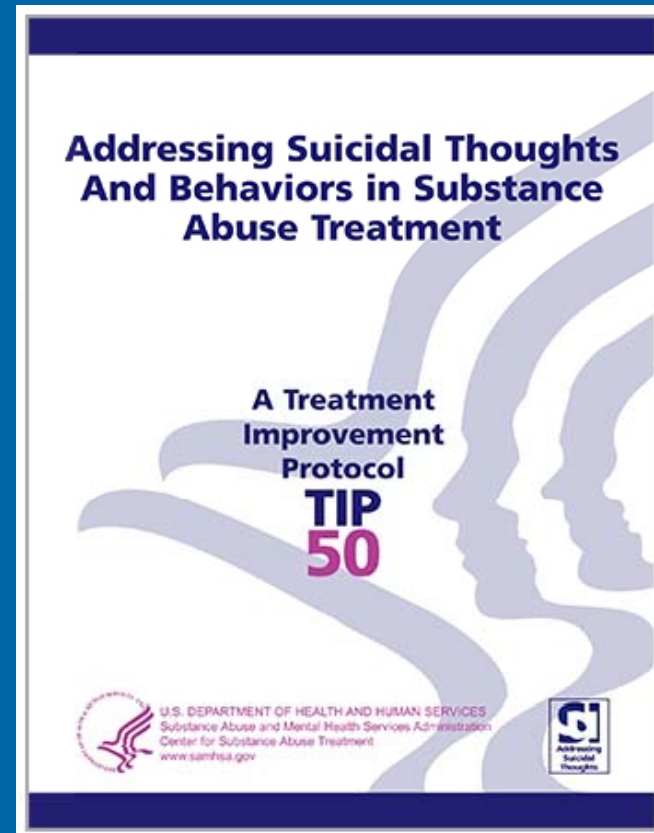


- ✓ Parental involvement
- ✓ Social Support
- ✓ Life/coping skills
- ✓ Connectedness to institutions and community

The Role of Substance Abuse Counselors

GATE

- ✓ Gather information
- ✓ Access supervision
- ✓ Take responsible actions
- ✓ Extend the actions



Resources

- ✓ Suicide Prevention Resource Center: www.sprc.org
- ✓ National Suicide Prevention Lifeline: www.suicidepreventionlifeline.org
- ✓ Tip 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment: <http://store.samhsa.gov/home> (search for TIP 50)
- ✓ National Strategy for Suicide Prevention 2012: <http://store.samhsa.gov/home> (search for Suicide Prevention)

References

- CDC, National Center for Injury Prevention and Control. Fatal Injury Data: Web-based Injury Statistics Query and Reporting System (WISQARS) [online] (2010). Available from: www.cdc.gov/ncipc/wisqars
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- SAMHSA Office of Applied Studies. *The NSDUH Report: Suicidal Thoughts and Behaviors among Adults*. Rockville, MD, 2009.
- WHO. *Global Status Report on Alcohol and Health*. Geneva, Switzerland: WHO, 2011.

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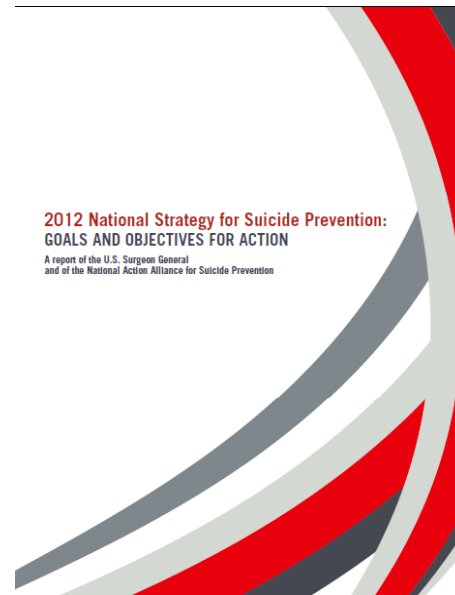
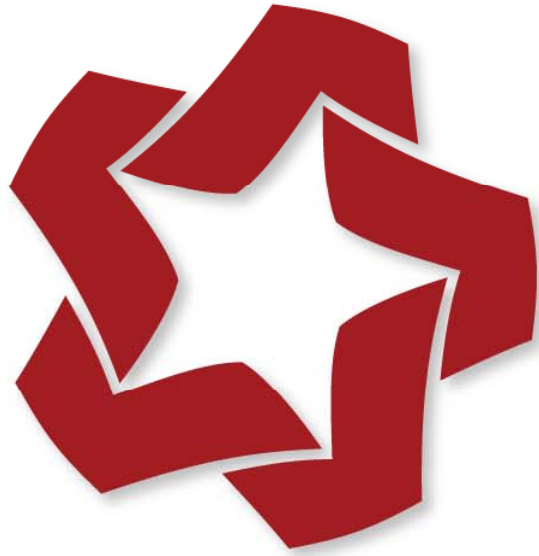
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National Strategy for Suicide Prevention



Presentation Overview

- Historical context for a new NSSP
- Document overview
- Key points and themes
- Strategic directions
- Appendices
- NSSP action steps
- Crosswalk



Why revise now? What has changed since 2001?

- **Data**
 - Increase in suicide rates and numbers
 - Documented reports of suicidal thoughts/behavior/attempts

- **Science**
 - Advances in science and evidence
 - SPRC/AFSP Best Practices Registry for Suicide Prevention
 - Growing awareness that suicide is preventable, treatments are effective, and recovery is possible
 - Effective suicide prevention is about engaging support, systems, sectors, and science to save lives



Why revise now? What has changed since 2001?

- **Environmental**

- Nation involved in two wars
- Period of economic uncertainty
- Several natural disasters
- Greater public awareness and media interest regarding suicide

- **Policy**

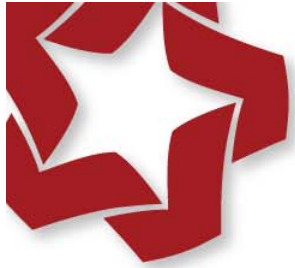
- Legislative and executive branch advances
- Action Alliance for Suicide Prevention



National Strategy for Suicide Prevention Task Force

Mission

- Propose a revision to and the review, refinement, and approval of the revised NSSP.
- Stimulate and coordinate dialogue to ensure that the NSSP reflects input from as many stakeholders and perspectives as possible.
- Work toward an NSSP that is strategic in direction and meant to stimulate planning and actions by both public- and private-sector stakeholders.



Overview of the Revised NSSP

- Builds on advances made since 2001
- Written to appeal to a broad base – everyone has a role
- Aligns with framework of the *National Prevention Strategy*, released June 2011
- Includes four strategic directions, 13 goals, and 60 objectives
- Addresses public and mental health
- Ready for application/implementation at all times



Key Points

- Suicide is preventable
- Advance public health and mental health approach
- Strengthen continuity of care
- Promote synergistic approach
- Advance multi-sectoral engagement
- Promote connectedness as protective factor
- Postvention and aftercare are vital components
- Clinical training and assessment in multiple settings is needed
- Consider alternatives to approach and setting



Themes of the NSSP

Suicide prevention efforts should:

- Foster positive public dialogue; counter shame, prejudice, and silence; and build public support for suicide prevention.
- Address the needs of vulnerable groups, be tailored to the cultural and situational contexts in which they are offered, and seek to eliminate disparities.
- Be coordinated and integrated with existing efforts addressing health and behavioral health, and ensure continuity of care.



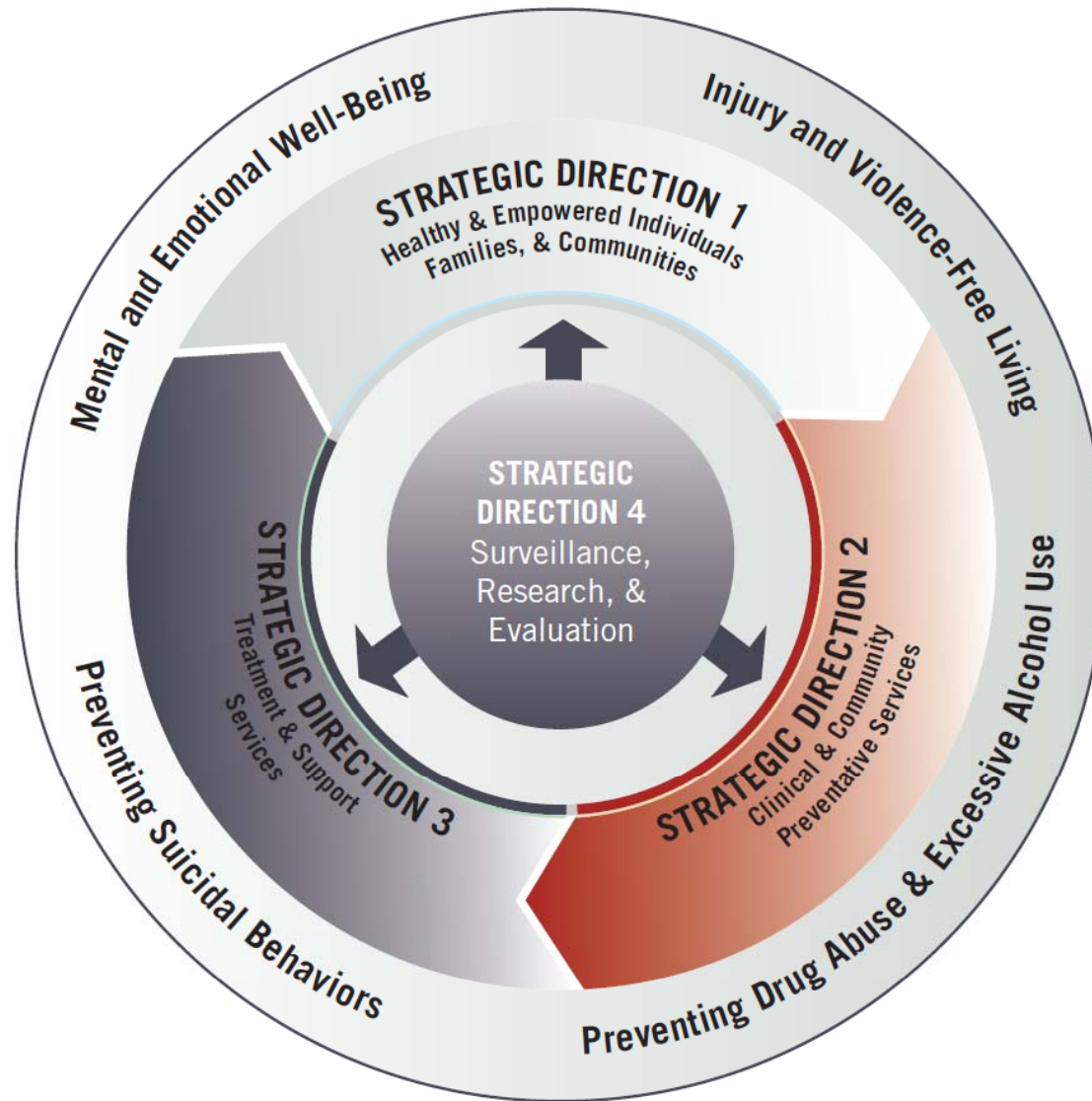
Themes of the NSSP

Suicide prevention efforts should:

- Promote changes in systems, policies, and environments that will support and facilitate the prevention of suicide and related problems.
- Bring together public health and behavioral health.
- Promote efforts to reduce access to lethal means among individuals with identified suicide risks.
- Apply the most up-to-date knowledge base for suicide prevention.



Strategic Directions within the National Strategy for Suicide Prevention





Additional Features of the Revised NSSP

Topics receiving more attention in the Revised NSSP:

- Groups at higher risk for suicidal behavior than the general population
- Crisis Lines as a best practice
- Aftercare/postvention: supporting persons impacted by suicide attempts and deaths



Appendices

- Appendix A: NSSP Goals and Objectives for Action Summary List
- Appendix B: Crosswalk of Goals and Objectives from 2001 to 2012
- Appendix C: Brief History of Suicide Prevention in the United States
- Appendix D: Groups with Increased Suicide Risk
 - American Indians/Alaska Natives
 - Individuals Bereaved by Suicide
 - Individuals in Justice and Child Welfare Settings
 - Individuals Who Engage in Non-Suicidal Self-Injury
 - Individuals Who Have Attempted Suicide
 - Individuals with Medical Conditions
 - Individuals with Mental and/or Substance Use Disorders
 - Lesbian, Gay, Bisexual and Transgender (LGBT) Populations
 - Members of the Armed Forces and Veterans
 - Men in Midlife
 - Older Men
- Appendix E: General Suicide Prevention Resources
- Appendix F: Glossary
- Appendix G: Federal Working Group Agency Descriptions
- Acknowledgments
- References



Action Steps for Using the NSSP

- The **Federal Government** can...
- **State, Tribal, Local, and Territorial Governments** can...
- **Businesses and Employers** can...
- **Health Care Systems, Insurers, and Clinicians** can...
- **Schools, Colleges, and Universities** can...
- **Non-Profit, Community, and Faith-Based Organizations** can...
- **Individuals and Families** can...



Crosswalk

Element of Recovery-Oriented Systems	Corresponding NSSP Goal or Objective
•Person-centered	Objective 3.3: Promote the understanding that recovery from mental and substance use disorders is possible for all.
•Family and other ally involvement	Objective 9.4: Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for persons with suicide risk.
•Individualized and comprehensive services across the lifespan	Objective 5.1: Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.
•Systems anchored in the community	Objective 5.2: Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.



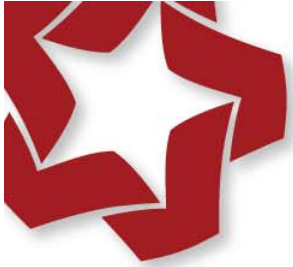
Crosswalk

Element of Recovery-Oriented Systems	Corresponding NSSP Goal or Objective
•Continuity of care	<p>Objective 8.4: Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.</p> <p>Objective 9.2: Develop, disseminate, and implement guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk.</p>
•Partnership-consultant relationships	Objective 9.3: Promote the safe disclosure of suicidal thoughts and behaviors by all patients.
•Strength-based	Objective 3.2: Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.



Crosswalk

Element of Recovery-Oriented Systems	Corresponding NSSP Goal or Objective
•Culturally responsive	Objective 10.4: Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.
•Responsiveness to personal belief systems	Objective 8.2: Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.
•Commitment to peer recovery support services	



Crosswalk

Element of Recovery-Oriented Systems	Corresponding NSSP Goal or Objective
<ul style="list-style-type: none">•Inclusion of the voices and experiences of recovering individuals and their families	<p>Objective 10.3: Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.</p>
<ul style="list-style-type: none">•Integrated services	<p>Objective 8.6: Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.</p> <p>Objective 8.7: Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.</p>



Crosswalk

Element of Recovery-Oriented Systems	Corresponding NSSP Goal or Objective
•System-wide education and training	GOAL 7: Provide training to community and clinical service providers on the prevention of suicide and related behaviors. (5 Objectives)
•Ongoing monitoring and outreach	Objective 9.5: Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among patients receiving care for mental health and/or substance use disorders.
•Outcomes driven	GOAL 13: Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings. (4 Objectives)



Crosswalk

Element of Recovery-Oriented Systems	Corresponding NSSP Goal or Objective
•Research based	GOAL 12: Promote and support research on suicide prevention. (4 Objectives)
•Adequately and flexibly financed	GOAL 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings. (5 Objectives)



Website Resources

- **National Strategy for Suicide Prevention (NSSP)**

Download a copy at http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

Order a copy at <http://store.samhsa.gov/product/PEP12-NSSPGOALS>

- **National Action Alliance for Suicide Prevention (NAASP)**

<http://www.actionallianceforsuicideprevention.org>

- **Suicide Prevention Resource Center (SPRC)**

<http://www.sprc.org>



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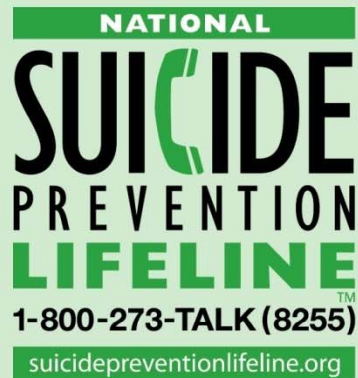
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Recovery-Oriented Systems of Care in Suicide Prevention Programs: *The National Suicide Prevention Lifeline and Task Forces of the Action Alliance for Suicide Prevention*

John Draper, Ph.D.
Lifeline Project Director
December 13, 2012

NATIONAL SUICIDE PREVENTION LIFELINE

“Suicide represents a worst case failure in mental health care. We must work to make it a ‘never event’ in our programs and systems of care.” –

Dr. Mike Hogan

*Commissioner, New York State Office of Mental Health; and
Co-Chair, Clinical Care & Intervention Task Force, National
Action Alliance for Suicide Prevention*

ROSC & Effective Suicide Prevention Programs

How ROSC elements “live” in:

- What attempt survivors want

(Suicide Attempt Survivors Task Force)

- Clinical best practices in suicide prevention

(Clinical Care Task Force Report)

- Crisis Hotlines **(Lifeline network)**

Action Alliance: Suicide Attempt Survivors Task Force

Core Values: “What we need to stay alive and recover”

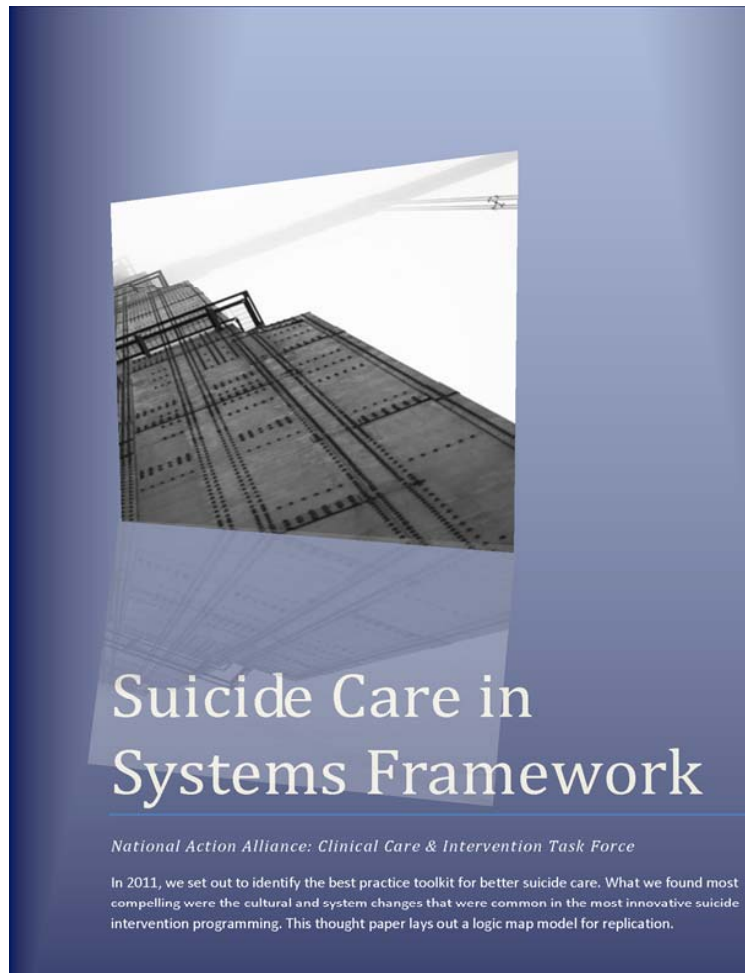
- Continuous connectedness
- Engagement of family/caring others
- Respect and support for spiritual beliefs

Action Alliance: Suicide Attempt Survivors Task Force

Core Values (cont):

- Provide access to care when & how a person wants it
- Preserve dignity, promote choice and collaboration in care
- Connect persons to supportive others with similar experiences

NAASP: Clinical Care & Intervention Task Force Report



- Recommendations for
 - National leadership
 - Adoption by every health and behavioral health plan and provider

Action Alliance: Clinical Care & Intervention Task Force

Core Values:

- Leadership leading to core transformation
- Continuity of care and shared responsibility
- Immediate access to care for all persons in suicidal crisis (person-centered—when/how they want it)

Action Alliance: Clinical Care & Intervention Task Force

Core Values (cont):

- Productive interactions between persons at risk and persons providing care (collaboration, least restrictive; clinicians trained in suicide prevention)
- Evaluate performance and use for QI

International Support for Systems Approaches

Mental Health Services that Reduced Suicides, England and Wales (1997-2006)– D. While, et al, 2012

- Examined impact of implementing seven to nine key mental health service recommendations to reduce suicide across National Health Service regions
- “Services that had implemented at least 7 of the recommendations had significantly lower suicide rate than those implementing fewer.”
- Suicide death rate 17% lower under comprehensive approaches (in U.S. = 6,000 lives)

What care can reduce suicide?

England and Wales, D. While, et al, 2012 (cont)

Some significant recommendations reducing suicide included:

- 24 hour crisis team (“single point of access for people in crisis available 24/7”)
- Assertive community outreach teams for noncompliance with meds/outpt appt.
- Follow-up post-discharge within 7 days
- Multi-disciplinary review post-suicide
- Dual Diagnosis Policy—written policy on how to care and treat MI/Substance Disorders

What care can reduce suicide?

Findings regarding follow-up/continuous contact:

- **WHO Study, 2008:** 800 attempters FU from 8 EDs around the world, 9 contacts (1 education session in ED, telephone and face to face contacts) over 18 mos. = **9x fewer suicides** than control group
- **DeLeo, 2002:** Telecheck FU in Italy **reduced suicide rate 6x among elderly women**
- **(Motto, 1976):** Letters (24 over 5 yrs) sent to 389 attempters post-discharge **sig. reduced suicides**
- **(Carter 2005):** Postcard follow-ups over 1 yr. to 378 attempters **reduced attempts 50%**

ROSC Elements in Effective Suicide Prevention Care (Research)

- Continuity of Care (Follow-Up)
- Ongoing Monitoring and Outreach (ACT, Mobile Teams, follow-up)
- Person-Centered (24/7 access)

The Ideal of Person-Centered HealthCare

Overarching aim for an ideal practice that its patients would say of it :

“They give me exactly the help I need and want exactly ***when and how*** I need and want it.”

Dr. Don Berwick

12/2011

Why don't many suicidal persons access care?

WHO study (Bruffaerts et al, 2011)

- Of 45%-51% attempt survivors that did not receive care:
 - 58% said “low perceived need” for care
 - 40% wish to handle the problem alone
 - 15% structural barriers (financial, distance)
 - 7% stigma

SAMHSA Lifeline evaluation (Gould et al, 2012)

- Interviewed 376 suicide callers from 16 centers
 - 57% past attempts, 37% had plan, 7% attempting at call
 - Over half not linked to care stated main reason was “the problem was not severe enough and/or could be handled without treatment”

Telephone Follow Up Post-ED Discharge: Preferences of Participants

Vaiva et al., 2006:

- 605 attempt survivors, discharged from 13 EDs in France
- Telephone follow-up at one month vs. three months vs. TAU; Follow-up method: empathy, reassurance, explanation, suggestion, crisis intervention as needed
- Significant reductions in re-attempts at 1 month (12% of FU group reattempt vs. 22% of control group)—recommended FU in 1-2 weeks
- High recruitment rates for study (75% consent) attributed by authors to participants preferring **phone contact to clinic appointments**

Crisis Hotlines: Shared ROSC Values

- Person-centered (values and access)
- Anchored in the community
- Collaborative
- System-wide education and training
- Continuity of care

Community Hubs for BH Care and Suicide Prevention

- **Community Involvement:** Use of volunteers
- **Community-wide Access:** Free access to all, no stigma, no care barriers if have phone
- **Community of providers:** Refer to other services
- **Community outreach:** public education, training, mental health “anti-stigma” promotions

Crisis Hotlines: Overview

- **First suicide/crisis hotline in U.S.: 1958**
- **Now over 1200 crisis centers in 61 countries; approx. 600 in USA**
- **Size, funding, staffing and operations vary**
- **All: nonjudgmental listening; confidential; assessment; referral**
- **Many venturing into chat/texting/e-mail help**
- **Many have different lines of business (211, teen line, peer warm line, etc.)**
- **Most deal equally with substance abuse and mental health issues equally, but some have special lines**

Suicide Issues: Addictions vs. Behavioral Health vs. Suicide Helplines

LifeNet Contact Center, MHA-NYC

Suicidal thoughts reported on lines annually

- Addictions hotline: 6% of 20,000 callers
- Behavioral health crisis, information and referral line: 9% of 75,000 callers
- Lifeline: 40% of 15,000 callers

With help comes hope

NATIONAL

SUICIDE
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www.suicidepreventionlifeline.org

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NATIONAL SUICIDE PREVENTION LIFELINE

Lifeline Mission

To effectively reach and serve all persons who could be at risk of suicide in the United States through a national network of crisis call centers.

SAMHSA-funded Lifeline Administrator and Partners

Link2Health Solutions, Inc.— wholly owned subsidiary of MHA of NYC; grant since Sept 2004

Partners

- National Association of State Mental Health Program Directors (since 2004)
- MHA of NYC (since 2005 when grant transferred to subsidiary)
- Columbia University/Research Foundation for Mental Health (since 2004)
- Living Works (2006-present)

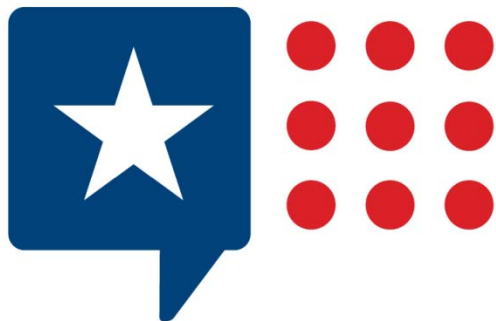
About The Network

- 160 centers in network, at least one in every state
- Independently operating
- Most are mix of volunteers & professional staff
- Voluntary network membership
- All are certified
- Centers adopt Lifeline best practice standards

How the Lifeline Works

- Caller dials **800-273-TALK** or **800-SUICIDE**
- Calls are free and confidential
- Links to the nearest of 159 centers
 - Listen, Assess
 - Support, Refer or Link to services
- Back-up centers to assure all calls answered

Veterans Crisis Line

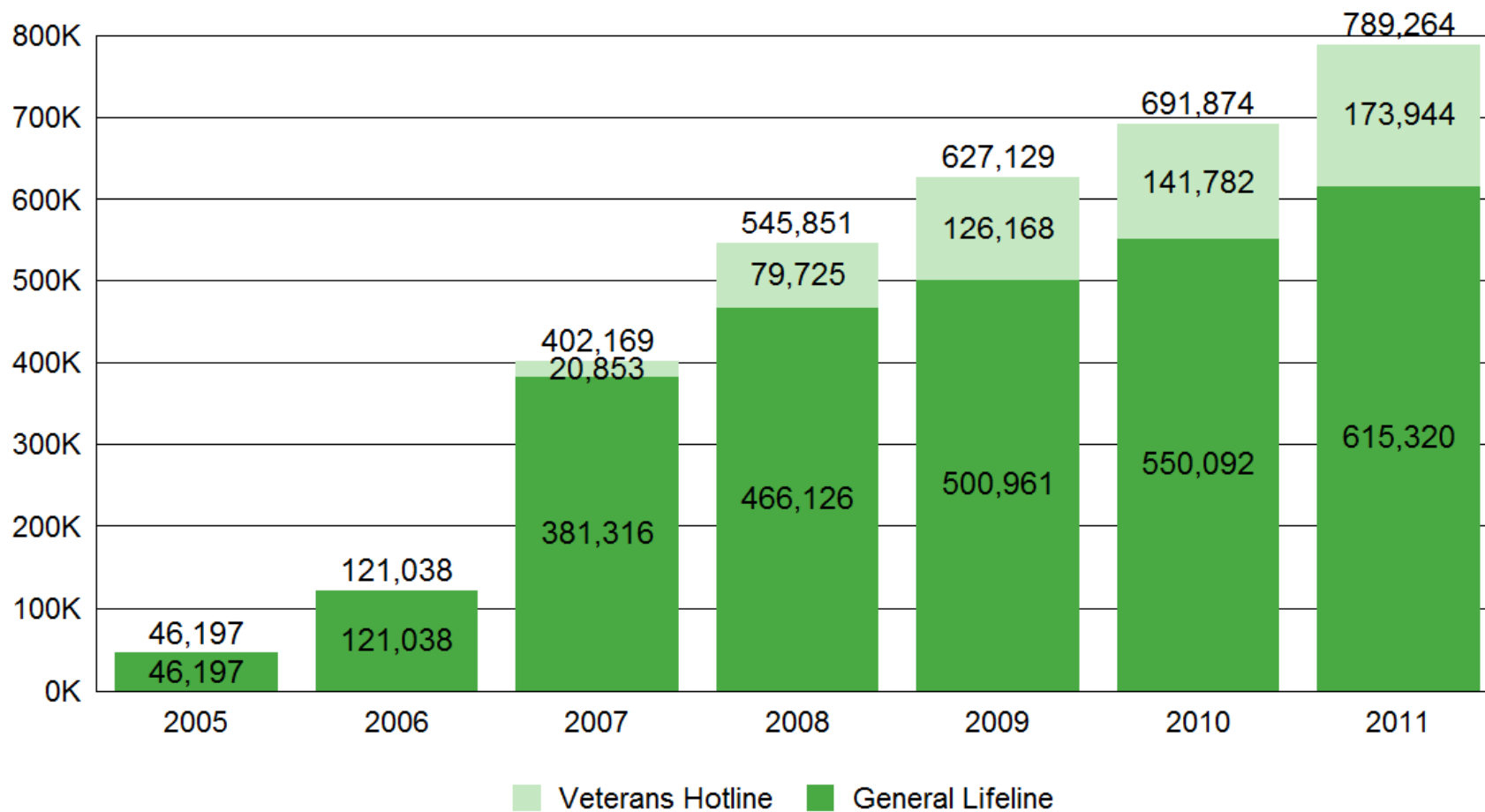


1-800-273-8255
PRESS 1

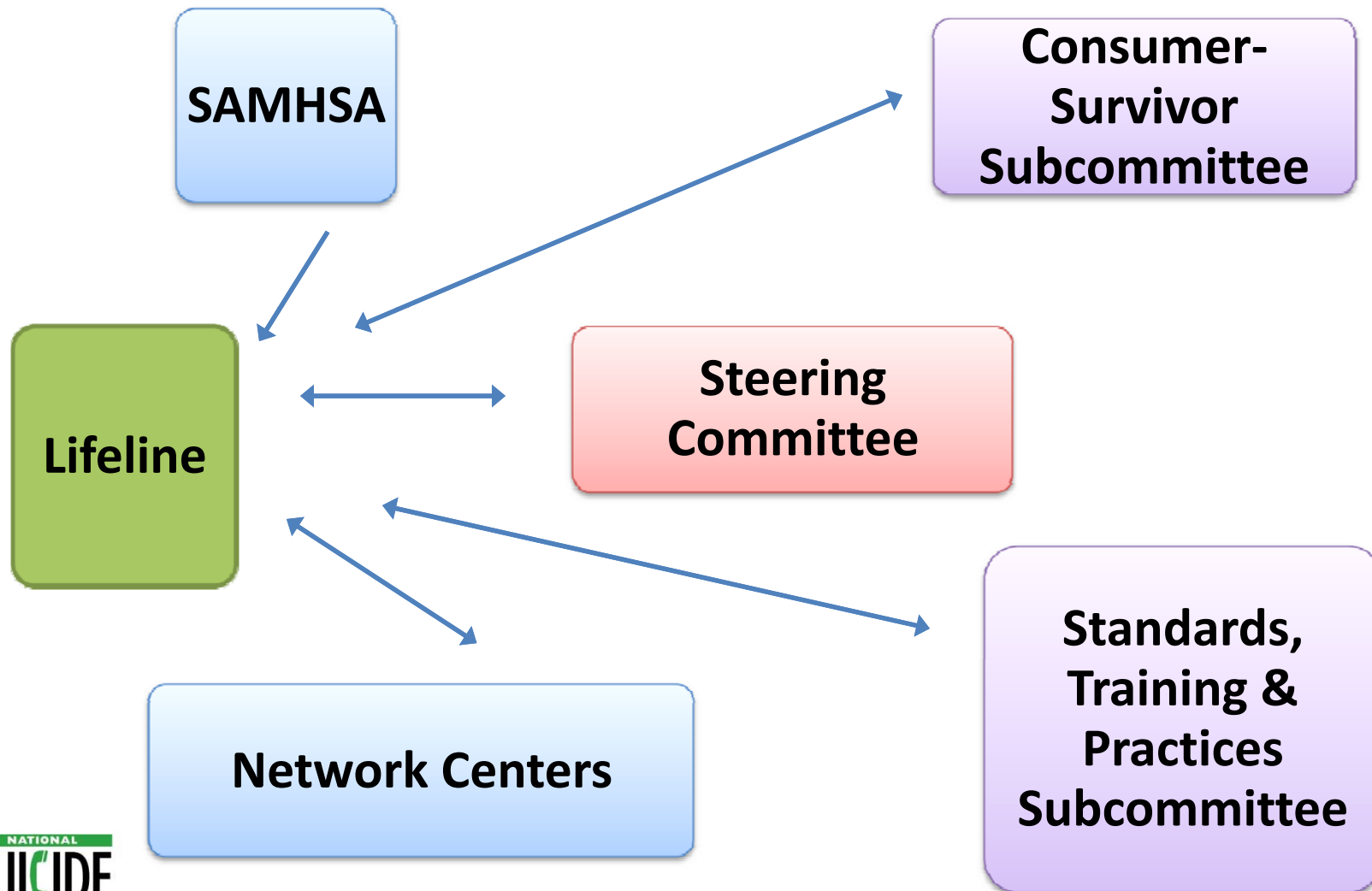
- **JULY 2007:** VA & SAMHSA launch first national suicide hotline for Vets
- Calls routed through 800-273-TALK (press 1 for vets & active military service)
- 24-7 access to trained counselors at VA
- Lifeline Centers back-up service to ensure all calls are answered

Lifeline & Veterans Crisis Line (2005-2011)

Call Volume Per Year



Lifeline's Network of Collaborators



Lifeline Evaluation and QI Process



Lifeline Evaluation Findings

Access point for acutely suicidal:

- About 25% of Lifeline callers present with suicidal thoughts, plans, attempts (Gould, 2009)
- More than 50% of 1080 suicidal callers had plan, over 8% with an attempt in progress; nearly 60% had past suicide attempts (Gould et al 2007)

Effective in reducing distress & suicidality

- significant reductions in confusion, anger, anxiety, helplessness, hopelessness and suicidality at end of call & 3 wks later
- **12% of suicidal callers report call prevented them from killing self**

WHAT WORKS?

Crisis Center Evaluation

Behaviors Related to Positive Outcomes (Mishara et al, 2007)

- ***Empathy & respect***
- ***Supportive approach and good contact*** (moral support, engaged, offers call back, reframing, self-disclosure)
- ***Collaborative problem solving*** (reformulation, reflection of feelings, empowers to plan & act on resources, etc.)
- ***Not “active listening” alone***

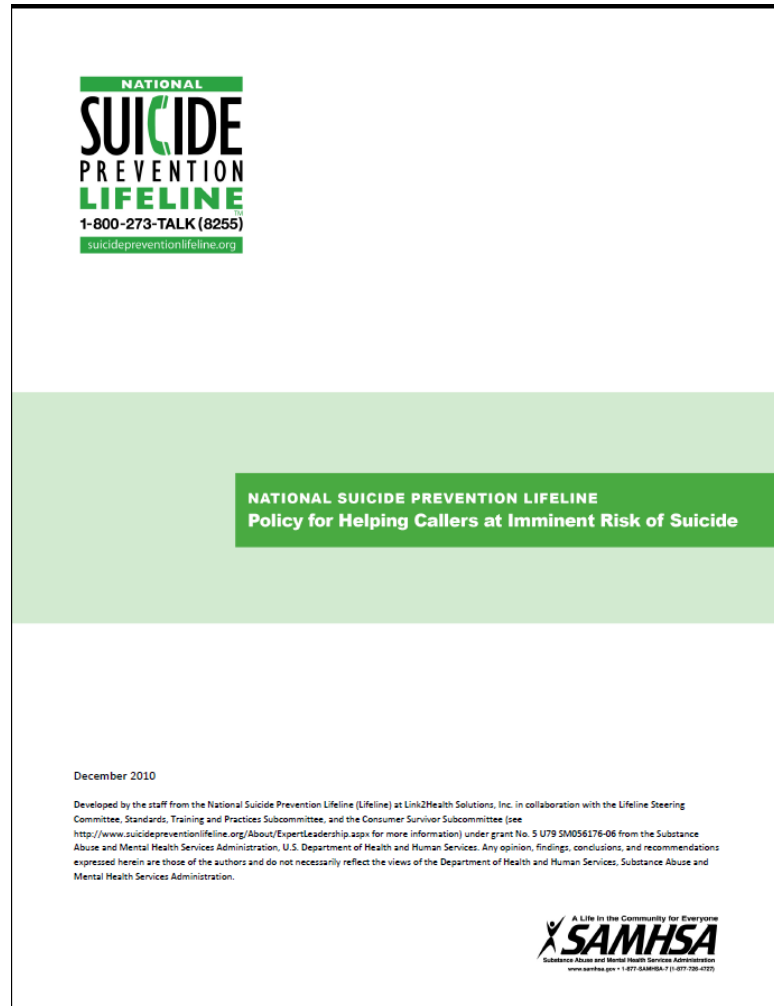
2007: Lifeline Provides



ASIST

- Training: good contact, collaborative problem solving, risk assessment & intervention
- Independent workgroup evaluated existing suicide prevention trainings
- ASIST (Living Works) scored highest
- ASIST adapted for crisis centers (2006)
 - 88 (58%) centers have participated in the T4T
 - 195 individuals have completed ASIST T4T
 - 410 workshops completed since 2007
 - At least 5,100 individuals have been trained

IMMINENT RISK POLICY (2011)



Lifeline Values: Helping Callers at Imminent Risk of Suicide

The Lifeline promotes:

- Taking all action necessary to secure the health, safety and well being of the individuals it serves
- Taking most collaborative, least invasive course(s) of action to secure the health, safety and well-being of the individuals it serves.
- Collaboration with community crisis and emergency services

Examples of Active Engagement

- Supporting caller's needs, wishes, values
- Seeking dynamic, interactive dialogue towards agreement of necessary actions to reduce imminent risk
- Reflecting, affirming, clarifying, summarizing
- Promoting exchanges that explore reasons for dying and living
- Allowing for caller to contribute to action plan

Active Engagement and Partnership

From the very beginning I felt like she was an ally interested in getting to know me better. It felt safe to really, really open up to her because [the helper] accepted me as I was, where I was. There was just no lack of acceptance.... I think this is one of things that made [the helper] such a special operator, and made our talk so helpful to me. She listened to me and she heard me. . . . I felt like she was a partner, working with me - and it felt safe...

Lifeline Crisis Centers and Follow-Up

Many Crisis Centers conduct follow-up:

Network Survey 2011 (preliminary results, 57 records). The Lifeline centers report:

- 18% have experience Follow-Up with ED Discharges
- 56% routine Follow-Up with High Risk Callers

Crisis Center follow-up appears effective

- 80% of 625 suicidal callers consenting to follow-up reported calls had suicide prevention effects, with 53.4% reporting that the calls stopped them from killing themselves (Gould & Lake, 2011)

Follow-up Suicide Prevention Tool: Safety Planning

6 Steps for collaborating with caller, identifying:

- Personal warning signs
- Internal coping strategies
- Social contacts who may distract from crisis
- Family members who can be helpful
- Professionals and agencies to contact
- How to make the environment safe

Barbara Stanley & Gregory K. Brown, 2008

Follow-Up: Examples of Caller Feedback

What was it about the follow-up calls that stopped you / that kept you safe?

“What stopped me was that someone who doesn't know me had interest in me, cared about me. I've lost so many people in my life, in such a hard way, and I stopped caring about my life. I haven't had anyone support me that way, and them calling me gave me a boost.”

“The follow-up calls really gave me the message that they really did care, and that it wasn't just a one-time resource if I needed to turn to them again. That was really what kept me from continuing with my [suicidal] thoughts.”

Using Chat and Text

- Nearly 1/3 of Lifeline centers practicing web-based, chat or SMS crisis services (Lifeline survey, 2011)
- Why Chat/Text for Crisis Intervention and Suicide Prevention?
 - Increase in requests for online crisis intervention services
 - Need to access populations that are typically hard to engage over the phone – including the hearing impaired, youth, people with social anxieties and phobias, gender questioning
 - Create a safe space, online, where people can access help
 - Provide people with anonymous means to access mental health support services
 - Online dis-inhibition effect – same for text and chat

ROSC Elements in Lifeline Network

- Person-centered (access to any/all 24/7/365)
- Anchored in community
- Promote partnership-consultant relations
(collaboration with caller, systems)
- Continuity of care (follow-up)
- Strength-based (active engagement, safe plan)
- Inclusion of consumer voices (CSS)
- System-wide education and training
- Research/evaluation based

Call to Action:

- Connect with your local Lifeline crisis center(s):
 - Use crisis center locator on Lifeline web site www.suicidepreventionlifeline.org
- Review trainings/resource needs in substance use & addictions
- Joint community outreach & education
- Promote 24/7 access to care and follow-up

Thank you!

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<http://suicidepreventionlifeline.org>