

December 21, 2006

Dear Crisis Center Directors,

I would like to thank all of you for your dedication and passion to the mission of suicide prevention. We at the National Suicide Prevention Lifeline are extremely fortunate to have all of you participating in this national initiative of providing an invaluable, free service to persons at risk of suicide.

The development of the Lifeline's Suicide Risk Assessment Standards is groundbreaking as no other National organization has established such standards. I would like to thank Madelyn Gould, Ph.D., Thomas Joiner, Ph.D., John Kalafat, Ph.D. and Brian Mishara, Ph.D. for their significant research contributions in identifying the need for such standards and in helping us structure suicide risk assessment in a different way. In reading the enclosed background paper, the formulation and logic behind the core principles and subcomponents identified in the standards unfold and their relevance to suicide risk assessment is explained.

The Certification and Training Subcommittee members have spent over one year discussing, debating, developing and organizing the suicide risk assessment standards. Their expertise and experience in the field of suicide prevention, especially in directing crisis centers, and conducting research and/or in training the telephone workers, has provided added value to the Lifeline's Suicide Risk Assessment Standards. The Lifeline's standards and background paper were thoughtfully created as a means to help you (Center Directors) provide your telephone workers with an instrument and knowledge to provide quality service to Lifeline callers.

Our hope is that these standards along with various means of technical assistance (training, conference calls, etc.) will improve our ability to respond to persons at risk of suicide. The Certification and Training Division is here to help you incorporate the new Lifeline standards into what you have already been doing.

Thank you all for the great work you are doing. I look forward to our continued discussions regarding the Lifeline's Suicide Risk Assessment Standards and the process of implementing them at all of the centers!

Sincerely,



Heather Stokes, LCSW
Certification and Training Director

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Suicide Risk Assessment Policy

- A. The Lifeline Center shall have a written suicide risk assessment policy which requires that all Lifeline Callers be asked about suicidality. Appendix 1, annexed hereto and hereby made a part hereof, sets forth the recommendations of the Lifeline Administrator for a Participating Center's Suicide Risk Assessment Policy.
- B. If the Lifeline Caller responds affirmatively when asked about suicidality, the Lifeline Center's Suicide Risk Assessment Policy shall direct the Center Staff to conduct a more complete analysis of risk consistent with Lifeline's Suicide Risk Assessment Standards.
- C. The Lifeline Center shall maintain and utilize a suicide risk assessment instrument that incorporates principles and subcomponents of the Lifeline's Suicide Risk Assessment Standards. The Lifeline Center shall submit its instrument to the Lifeline Administrator.
- D. The Lifeline Centers shall implement procedures and other measures to ensure that Center Staff adhere with the Lifeline Suicide Risk Assessment Policy.
- E. Effective date of the Lifeline Suicide Risk Assessment Policy and adherence requirements:
 - 1. Implementation of the Suicide Risk Assessment Policy shall commence no later than January 1, 2007 and shall be fully implemented no later than September 2007.
 - 2. The Certification and Training Division of the Lifeline Administration shall provide technical assistance to the Lifeline Center with regard to implementation of its Suicide Risk Assessment Policy.
 - 3. If a center is unwilling to adhere to the Lifeline Suicide Risk Assessment standards or if technical assistance from the Lifeline does not help them integrate these standards then the Administrator has the option to terminate the Lifeline Center from the Lifeline network, pursuant to Section 6(c) of the Network Agreement.

**National Suicide Prevention Lifeline
Suicide Risk Assessment Standards
Core Principles and Subcomponents of Suicide Assessments**

SUICIDAL DESIRE	SUICIDAL CAPABILITY	SUICIDAL INTENT	BUFFERS/CONNECTEDNESS
Suicidal ideation – <ul style="list-style-type: none"> ▪ hurting self and/or others 	History of suicide attempts	Attempt in progress	Immediate supports
Psychological Pain <ul style="list-style-type: none"> ▪ Hopelessness ▪ Helplessness ▪ Perceived burden on others 	Exposure to someone else's death by suicide	Plan to hurt self/other <ul style="list-style-type: none"> ▪ Method known 	Social supports
Feeling Trapped	History of/current violence to others	Preparatory behaviors	Planning for the future
	Available means of hurting self/other	Expressed intent to die	Engagement with helper <ul style="list-style-type: none"> ▪ Telephone worker
	Currently intoxicated		Ambivalence for living
	Substance abuse		Core values/beliefs
	Acute symptoms of mental illness – eg. <ul style="list-style-type: none"> ▪ Recent dramatic mood change ▪ Out of touch with reality 		Sense of purpose
	Extreme agitation/Rage – eg. <ul style="list-style-type: none"> ▪ Increased anxiety ▪ Decreased sleep ▪ Recent acts and/or threats of aggression 		

SUICIDE RISK ASSESSMENT STANDARDS IMPLEMENTATION TIMELINE AND PROCESS

November 2006

- network conference call – announce distribution and implementation plan for suicide risk assessment standards (including: policy, standards, implementation process and background paper)
- continue collection of suicide risk assessment instruments submitted voluntarily by center Directors
- continue to provide feedback and technical assistance (TA) on incorporation of suicide risk assessment standards into current instrument for centers that have submitted their tool

December 2006

- disseminate suicide risk assessment standards to all network center Directors via certified mail
- alert all network centers via email that suicide risk assessment standards have been mailed
- continue collection of suicide risk assessment instruments submitted voluntarily by center Directors
- continue to provide feedback and TA on incorporation of suicide risk assessment standards into current assessment instrument for centers that have submitted their tool
- develop poster and instrument illustrating the flow of a call; including concepts such as good contact, collaborative problem solving and intervention; also demonstrating phase of call where appropriate to ask about current suicidal ideation and where to inquire about suicidal desire, suicidal capability, suicidal intent and buffers

January 2007

- network conference call 1/11/07– discuss suicide risk assessment standards; Certification and Training Subcommittee members will be present to respond to questions regarding background paper and development of standards; opportunity for network center Directors to ask questions and share feedback
- request that all network centers submit their current suicide risk assessment instrument (those that have not already done so); continue to provide TA to those who have
- post sample suicide risk assessment instruments that reflect Lifeline’s standards on the members only section of Lifeline’s website
- post (on members only section of website) database of sample questions to incorporate subcomponents into suicide risk assessment instrument

- share summary of baseline from network center assessments received to date along with successes and challenges noted by centers who are at 100% adherence – this will be featured in the *Lifelines* newsletter
- Certification and Training Subcommittee meeting – will share feedback regarding development and adaptation of training materials; will discuss how suicide risk assessment standards interface with intervention approaches

February 2007

- all centers shall have sent in current suicide risk assessment instrument
- continue to provide TA in helping centers reach 100% adherence with the suicide risk assessment standards
- Lifeline network conference call to discuss successes, questions, challenges in integrating suicide risk assessment standards

March 2007

- conduct pilot training for trainers (T4T) with 10 pilot centers (March 19th – 23rd); obtain feedback on T4T
- continue to provide TA in helping centers reach 100% adherence with the suicide risk assessment standards
- Lifeline network conference call

April 2007

- all centers shall have sent in revised copy of suicide risk assessment instrument based on feedback (technical assistance) provided in relation to adhering to Lifeline's suicide risk assessment standards
- integrate training onsite at 10 pilot Lifeline crisis centers
- disseminate poster and instrument illustrating flow of a call among all network centers to guide workers through conducting a risk assessment
- conduct suicide risk assessment workshop at AAS conference – encourage discussion of background paper and implementation of standards at centers
- continue to provide TA in helping centers reach 100% adherence with the suicide risk assessment standards

May 2007

- collect and integrate feedback from implementation of training at the 10 centers that participated in the March pilot training
- continue to provide TA in helping centers reach 100% adherence with the suicide risk assessment standards
- Lifeline network conference call

July 2007

- all network centers shall be in 100% adherence with suicide risk assessment standards
- Lifeline network conference call

ESTABLISHED STANDARDS FOR THE ASSESSMENT OF SUICIDE RISK AMONG CALLERS TO THE NATIONAL SUICIDE PREVENTION LIFELINE

A Background Paper

**Thomas Joiner, Ph.D., John Kalafat, Ph.D., John Draper, Ph.D., Heather Stokes, LCSW,
and Marshall Knudson, Ph.D.**

Introduction and Overview

As a primary component of the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Suicide Prevention Initiative, SAMHSA's Center for Mental Health Services oversees a three-year, \$6.6 million federal grant to establish and maintain a national network of certified suicide prevention hotlines. This grant, issued beginning September 30, 2004, has been awarded to Link2Health Solutions, Inc., an independent subsidiary of The Mental Health Association of New York City, along with its partners, the National Association of State Mental Health Program Directors, Columbia University's Research Foundation for Mental Hygiene, Inc., and the Rutgers Graduate School of Applied and Professional Psychology.

On January 1, 2005, SAMHSA and the grant's administrators launched The National Suicide Prevention Lifeline, 1-800-273-TALK. The Lifeline is a network of more than 120 crisis centers located in communities across the country that are committed to suicide prevention. Persons in emotional distress or in suicidal crisis can call this single toll-free number at anytime from anywhere in the nation and are routed to the networked crisis center nearest to them. Callers are then connected with a trained telephone worker who can provide emotional support, assessment, crisis intervention and/or linkages to local treatment and support resources, including emergency services.

Two major goals of the Lifeline are to promote efficient access to this service so it will reach more people nationwide at risk of suicide, and to better ensure better quality of services to its callers so as to more effectively prevent suicide. Towards the latter goal of serving callers more effectively, the Lifeline established a subcommittee of suicide prevention experts representing various regions nationwide and Canada (the Lifeline Certification and Training Subcommittee) in March 2005 to consult on developing standards and recommended practices for its network of crisis centers.

The Lifeline's Certification and Training Subcommittee's (CTS) extensive review of research and field practices yielded recommendations that are embodied in the Lifeline's Suicide Risk Assessment Standards, which will be phased in for implementation beginning January 2007 with the expectation of network-wide adherence by September 2007.

The purpose of this paper is to:

- provide the background on the need for these standards;
- describe the process that produced them;
- summarize the research and rationale supporting the standards;
- review how these standard assessment principles and their subcomponents can be weighted in relation to one another so as to more effectively guide crisis hotline workers in their everyday assessments of callers to the Lifeline; and
- discuss the implementation process and technical support that will be provided by the Lifeline Certification and Training Division.

The Need for Evidence-Based Risk Assessment Standards

Because of their unique accessibility, crisis hotlines are in a position to intervene with individuals at various points along the pathway to suicidal behavior, including the moments or hours prior to fateful decisions. This special contribution to suicide prevention is undermined if staff members are unable, unwilling, or reluctant to persistently inquire about and explore suicidal thoughts and feelings with callers.

Recently completed SAMHSA sponsored evaluations of crisis hotlines' processes and outcomes employed monitoring of hotlines and follow-up of callers to hotlines. These studies provided overall evidence in support of crisis hotlines' role of responding to crisis and suicidal callers, while raising some concerns about suicide risk assessments.

In the SAMHSA study conducted by Kalafat, Gould, & Munfakh (2005), 1085 suicidal and 1617 non-suicidal crisis callers to eight crisis hotlines that agreed to use standardized, evidence-based suicide risk assessments and measures of crisis states were assessed near the start and at the end of their calls; and, for those who consented, at a follow up call approx 3 weeks after the original call to the center. Significant reductions in crisis and suicide status occurred during the calls and continued to the follow up. Notably, in response to an open-ended question as to what was helpful about the call, 11.6% (n = 44) of suicidal callers said that the call prevented them from killing or harming themselves.

Follow-up assessments were conducted with 801 of the 1617 callers who had been categorized by centers as non-suicidal crisis callers. At follow-up 52 (6.5%) reported having suicidal thoughts when they had originally called the centers, and 27 of these said they had told the crisis worker of these thoughts. These callers were more distressed than callers who did not report suicidal thoughts. Crisis centers had not conducted risk assessments for these callers. This study highlighted the need to inquire about suicide on crisis calls, particularly with more distressed callers.

In a second SAMHSA study conducted by Mishara and colleagues (2005), 1431 calls to 14 centers were monitored. Overall, when changes occurred from the beginning to the end of the calls, they were positive. This report concluded that the centers had helped a significant number of callers and may have saved some lives. For example, at the end of the calls, 52.3% of callers were less confused and more decided about next steps, 48.7% were less helpless and more resourceful, and 40% were more hopeful.

Of the 1431 callers, 723 were not asked about suicidal thoughts. Of the 474 who were asked or spontaneously reported suicidal thoughts, no questions about the means were asked on 46% of the calls. In 159 instances when the helper was aware that the caller was considering suicide and had determined what means to use, in only 30 calls did the helper ask if an attempt was in progress. Questions about prior attempts were asked of only 104 callers. The report qualified these risk assessments as not following the accreditation guidelines of the American Association of Suicidology or procedures mandated by center directors.

It should be noted that failure to conduct appropriate suicide risk assessments or to pursue clients' suicidal communications is not unique to crisis hotline staff, as this has also been found among professional mental health providers (Bongar, Maris, Berman, & Litman, 1998; Coombs, et al, 1992); and, among primary care physicians (Adamek, & Kaplan, 2000; Williams et al, 1999). Nevertheless, this finding for organizations, many of which include suicide intervention as a primary part of their mission, prompted the CTS of the Lifeline Network to make the development of standards for evidence-based risk assessment their first priority.

Again, primarily due to their accessibility, crisis hotlines are one of the agencies that must engage in the assessment of imminent risk. As telephone services, crisis hotlines face unique challenges in conducting suicide risk assessments and intervening with suicidal persons. Crisis workers must establish and maintain rapport with callers with whom there is less control than in face-to-face situations, who may be using a phone service primarily because they wish to retain this control, and/or may be reluctant to commit to a face-to-face contact or ongoing treatment. They may also be using a phone service because they are currently in an acute state.

The challenge, then, is to conduct a systematic and thorough risk assessment within the connection and flow of a telephone contact. To accomplish this, crisis staff must be thoroughly familiar with the current risk and protective factors for suicide, and be comfortable enough with the topic to weave the risk assessment into the ongoing flow of the call. Most importantly, crisis staff must be assured the persistent pursuit of suicidal thoughts, feelings, and plans, as well as alternatives and inhibitors, is the most effective way to reduce callers' isolation, anxiety, and despair, and to begin the exploration of alternative ways of addressing their problems.

National Suicide Prevention Lifeline Response to the Need: The Process of Developing Suicide Risk Assessment Standards for Network Centers

Establishing Expert Consensus on Standards

In order to meet the goals of reaching more people nationwide at risk of suicide and serving them more effectively, the Lifeline has engaged national and international experts and stakeholders in suicide prevention who provide ongoing consultation and advisement to the project's Executive Leadership Team (ELT). The ELT consists of Lifeline's Administration at Link2Health Solutions, Lifeline's SAMHSA Project Officer, and the project's partners, the National Association of State Mental Health Program Directors and the project's evaluation team, Rutgers Graduate School of Applied and Professional Psychology and the Columbia University Research Foundation for Mental Hygiene, Inc. In addition, the Lifeline has formed a Steering Committee, a Certification and Training Subcommittee (CTS), and a Consumer-Recipient Subcommittee. These committees, also comprised of experts and stakeholders in suicide prevention from around the country, meet at least three times a year to discuss and provide recommendations for priorities and focal activities of the Lifeline Administration. For a complete listing and brief biographies of the Lifeline's Committee members, see Appendix 2 of this document.

In order to better ensure effective service for Lifeline callers, the Lifeline created the CTS to help promote quality improvement practices among the network's crisis centers. This was to be accomplished through satisfying the following objectives: 1) identifying appropriate credentialing organizations for certifying reliable administration of a center in accordance with network needs; 2) establishing research-based standards for crisis center work with callers; and 3) analyzing, recommending and consulting in the development of best practice trainings and program evaluation tools to support the maintenance of the network's practice standards. The CTS reports to and seeks advisement from the Project's Steering Committee, which, together guide the ELT's final reviews and approval of their recommendations.

The CTS was established by the Lifeline's ELT in March of 2005 following a review of qualified nominees submitted by stakeholders in suicide prevention across the country. The CTS is comprised of experts in the field of suicide prevention research, training, crisis center evaluation and administration. In order to better ensure the application of crisis center research findings into field practices, the ELT also appointed to the CTS the primary investigators of two recently completed, groundbreaking studies examining process and outcomes related to crisis center work, Brian Mishara, Ph.D., John Kalafat, Ph.D., and Madelyn Gould, Ph.D., M.P.H.

At the first CTS meeting in May 2005, committee members concluded that the establishment of suicide risk assessment standards must be their first priority in enhancing quality service to all Lifeline callers. They based this decision upon several factors, including the research findings from the Mishara, et al (2005) and Kalafat, Gould & Munfakh (2005) studies indicating a need for more consistent, thorough assessment of caller risk by telephone crisis workers. In addition, the absence of evidenced-based suicide risk assessment standards for crisis centers further underscored the need to address this issue immediately. From this discussion, the CTS identified two goals relating to the Lifeline's suicide risk assessment standards initiative: 1) identify the most salient evidence-based risk and protective factors that can inform our efforts to assess suicide risk during a telephone contact; and 2) work collaboratively with centers to develop and deliver a pilot training on conducting risk assessments that can be adapted to and incorporated into crisis centers' current training programs.

The process of arriving at the suicide risk assessment standards took place over one year. Initially, the group determined that the nature of crisis call center work required a distinction for assessing immediate (as opposed to long-term) risk factors. The group then examined the results of a factor analysis conducted by Gould on the suicide risk assessment instrument used in the Kalafat & Gould outcome study on crisis centers, and compared that with a similar analysis by the Lifeline's Draper and Kessler of a research-based suicide risk assessment used by LifeNet, a Lifeline crisis center in New York City. Other sample suicide assessments currently being used by networked crisis centers were reviewed by the CTS to survey common field practices. The findings from these analyses were then cross-checked with several studies isolating significant, imminent factors in suicide risk assessment not specific to crisis center work. The results of both the factor analysis and reviews supported the designated four core principles for the Lifeline's standards for suicide assessment: Suicidal Desire; Suicidal Intent; Suicidal Capability; and Buffers/Social Connectedness.

Crisis Center Input

Representation from network crisis center leadership was present at every level of the standards development and review. Network crisis center directors were represented on the CTS where the standards were developed (2 current center directors, 4 past directors) and the Steering Committee (4 current directors) where the standards were reviewed and approved.

After extensive revisions based on CTS member discussions, Steering Committee and Executive Leadership Team feedback, the CTS introduced the suicide risk assessment standards to over 40 crisis center directors across the country at the American Association of Suicidology (AAS) Conference in May 2006. At the interactive workshop at AAS conducted by John Kalafat, Ph.D and Shawn Shea, M.D., the crisis center directors and supervisors present, expressed appreciation for the opportunity to engage in dialogue about the impending standards prior to their implementation. As a result of the workshop, Eduardo Vega, the Chair of Lifeline's Consumer Recipient Subcommittee, also provided essential feedback that enhanced emphasis on worker assessment of "protective factors" ("reasons for living"), the fourth core principle of the standards.

The Lifeline then hosted a conference call in June 2006 with the Lifeline network crisis center directors where the standards were presented and discussed. Many of the directors reinforced the standards by stating that their current suicide risk assessment closely reflects the core principles and subcomponents. The one principle that seemed to be omitted in many suicide assessments currently used by crisis centers was suicidal intent. However, consensus was reached regarding the importance and necessity of having suicidal intent assessed among crisis and suicidal callers. In addition, since the presentation of the standards at the AAS Conference, several of the training directors reported that they had since incorporated suicidal intent into their suicide risk assessment and training.

Empirical Basis for the Standards

Empirical research and clinical experience suggest that suicidality is a multi-faceted phenomenon. Research to date indicates that three facets – suicidal desire, suicidal capability, and suicidal intent – cover the domain of the phenomenon (and importantly, are not redundant with one another). We believe a fourth facet – *buffers against suicidality* – also needs to be included to provide a full framework for suicide assessment in the context of crisis center hotline work. In what follows, the four facets are described, some research on each is summarized, and the inter-relations of the facets are discussed.

Suicidal Desire

In studies by Beck, Joiner, Rudd, and colleagues (e.g., Beck et al., 1997; Joiner et al., 1997, 2003), suicidal desire has been shown to be made up of the following components: No reasons for living; wish to die; wish not to carry on; passive attempt (e.g., not caring if death occurred); and desire for suicide attempt. Influenced by several other strands of research (e.g., Rudd et al., 2006; Joiner [2005] on burdensomeness; Williams [2006] on feeling trapped), the CTS has emphasized psychological conditions that, while not the same as suicidal desire, are strong contributors to it – namely, feeling trapped, like there is no alternative course of action or escape, and psychological pain (i.e., hopelessness, helplessness, and perceiving oneself as a burden on others). Of these factors, two in particular (perceived burdensomeness and feeling trapped) may be unfamiliar in risk assessment contexts.

Joiner's (2005) theory of suicidal behavior asserts that *perceived burdensomeness* is a key component of the life-and-death psychological processes of people seriously contemplating suicide. Suicidal people perceive themselves to be ineffective or incompetent, but moreover, they also perceive that their ineffectiveness affects not just them, but spills over to negatively affect others. There is one more aspect still: They perceive that this ineffectiveness that negatively affects everyone is stable and permanent, forcing a choice between continued perceptions of burdening others and escalating feelings of shame, on the one hand, or death on the other hand.

A caller who voices some desire for death and exhibits psychological pain or feeling trapped can be said to be experiencing suicidal desire according to the current framework. Regarding feeling trapped, several prominent models of the development of suicidal behavior emphasize that suicidal people wish to escape psychological pain, and that their state of extreme distress diminishes their ability to think of adaptive ways to do so. The combination of desperately wishing to escape and being unable to think of ways to do so leads some people to consider suicide as an escape. A roughly synonymous concept to feeling trapped is “cognitive constriction” – emotional crises tend to constrict people's ability to solve problems, leading in turn to a sense of desperation, feeling trapped, and suicidal behavior as an escape.

A key point about suicidal desire is that, although it is of clinical import, it is not, by itself, very telling about suicide risk status. This is because suicidal desire is a very common symptom of mood disorders (Joiner et al., 1997), and indeed a relatively common experience in the general population at large (Kessler et al., 2005). Regarding suicide risk status, suicidal desire is roughly as indicative as are the other prominent symptoms of depression like anhedonia (inability to experience pleasure in previously enjoyed activities) and insomnia for instance. These symptoms are of concern (and should prompt referrals for treatment), but their endorsement alone is not enough to raise serious worry about imminent suicide risk. Rather, it is when suicidal desire occurs in combination with other facets of suicidality – described next – that concern escalates. The presence of suicidal desire alerts one to explore and elicit suicidal capability and suicidal intent.

Suicidal Capability

The same series of studies that elucidated the nature of suicidal desire has characterized the components of suicidal capability. They are: a sense of fearlessness to make an attempt; a sense of competence to make an attempt; availability of means to and opportunity for attempt; specificity of plan for attempt; and preparations for attempt.

It is important to note that the “suicidal capability” factor, as defined above, relates to imminent plans and fearlessness about suicidality. Fearlessness about suicidality is a key but under-recognized concept. Serious suicidal behavior is by definition fearsome and is often painful; many studies and clinical case studies show that it is this fearsomeness that prevents many people from acting on suicidal ideas. Those that do act have come to terms with the prospects of fear, and often pain. This point does not relate (at least not as directly) to fearlessness in general, as there are many people who are fearless but who, as a function of their fearlessness, are not necessarily at risk for death by suicide (e.g., fighter pilots; NASCAR drivers).

The CTS, again influenced by past work (e.g., Rudd et al, 2006; Joiner [2005]), has identified the following factors as at least contributory to and in some cases definitive of suicidal capability:

- *History of suicide attempt, particularly multiple attempts* (Rudd et al., 1996). This factor is a clear risk for future suicidality due, in part, to the fact that past behavior is a strong predictor of future behavior. Relatedly, research indicates that, for those who resort to suicidality in the face of distress (especially repeatedly), suicidality may have become a primary way of coping, to the exclusion of more adaptive coping methods.
- *History of/current violence to others* (Conner et al., 2003). This factor’s relevance resides in the fact that those who are capable of violence or injury in general are capable of self-injury in particular.
- *Exposure to someone else’s death by suicide*. Some research has suggested that the impact of suicide on those left behind is associated with future suicidal behavior and increased frequency of mental health issues (Agerbo, 2003).
- *Availability of means*. Seeking access to means of suicide is a clear warning sign; past research has shown that it is part of a cluster of symptoms reflecting dangerous parameters like capability and intent (Joiner et al., 1997, 2003).
- *Current intoxication* (Bartels et al., 2002). Current intoxication diminishes problem-solving abilities and reduces inhibitions; lowered problem-solving and lowered inhibitions, in turn, contribute to elevated risk for suicidal behavior.
- *Tendency toward frequent intoxication* (Bartels et al., 2002). The tendency toward frequent intoxication makes intoxication in the near future more likely, with attendant risks of decreased problem-solving and lowered inhibitions noted above.
- *Acute symptoms of mental illness* (Cavanagh et al., 2002). The experience of severe and acute symptoms of the vast majority of mental disorders contributes to many risk factors noted herein; for example, psychological pain, agitation, insomnia, being out of touch with reality, etc.
- *Recent dramatic mood change* (Cavanagh et al., 2002). A dramatic mood change can be indicative of the onset or worsening of a mood disorder or other disorders – disorders which in turn heighten the risk for suicidal behavior.
- *Out of touch with reality* (Cavanagh et al., 2002). Problem-solving ability and inhibitions are both lowered by psychosis; command hallucinations (e.g., hearing a voice telling one to injure or kill oneself) are a related concern.
- *Extreme rage* (Conner et al., 2003). Rage indicates loss of control and potential for violence, both of which are common precursors to serious suicidal behavior.

- *Increased agitation* (Busch et al., 2003). Increased agitation (extreme physical restlessness combined with emotional turmoil) suggests intense psychological pain, which as noted above, constitutes an important risk factor for serious suicidality.
- *Decreased sleep* (Sabo et al., 1990). Insomnia can lead to mood changes and lack of clarity in thinking, and is a key symptom of mood disorders. Research has documented insomnia as a key risk factor for suicidality.

Past research has made it clear that the suicidal desire and suicidal capability factors are not similarly related to key suicide-related indices. For instance, Joiner et al. (1997, 2001) showed that, although the presence of either factor is of clinical concern, the “suicidal capability” factor is, relatively speaking, of more concern than the “suicidal desire” factor – the “suicidal capability” factor was more related than the “suicidal desire” to pernicious suicide indicators such as having recently attempted suicide as well as eventual death by suicide.

Suicidal Intent

Some past research has viewed suicidal intent as part of suicidal desire or suicidal capability, but the CTS has separated it out, for two key reasons. First, even more than desire and capability, its relation to suicidality is plain – those who intend a behavior often enact it. In the previously noted SAMHSA hotline evaluation by Kalafat, Gould & Munfakh, in the weeks following the suicidal callers’ original calls to crisis lines, callers’ hopelessness and psychological pain continued to lessen but the intensity of their intent to die did not continue to diminish. Moreover, a substantial proportion (43.2%) of the callers continued to express suicidal ideation a few weeks after the initial call and nearly three percent had made a suicide attempt after their call. The callers’ intent to die score at the end of the crisis intervention was the only significant independent predictor of suicidality following the call; although having made any specific plan to hurt or kill self prior to the call and persistent suicidal thoughts at baseline were also significant, albeit not independent, predictors of any suicidality (ideation, plan or attempt).

Second, neither desire nor capability necessarily imply intent, as evidenced by those who have desire and capability but do not intend and thus do not attempt or die by suicide because they are buffered by the factors addressed in the next section (e.g., ties to family and friends).

According to the current framework, suicidal intent is made up of the following:

- *Plan or attempt in progress*. This factor is of course the clearest indicator of intent to attempt, in that the attempt is already in progress.
- *Imminent plan to hurt self/other (e.g., method known)*. Virtually all risk assessment frameworks emphasize plans for suicide as a key danger sign (e.g., Joiner et al., 1999), a practice affirmed by research demonstrating that plans for suicide represent among the most dangerous aspects of suicidality (Joiner et al., 1997, 2001). Plans to hurt others are relevant too, in light of the research on violence and aggression noted above.
- *Preparatory behaviors*. These behaviors (e.g., arranging suicide method; leaving possessions to others) are noteworthy for the same reasons that imminent plans are. They can be viewed as behavioral expressions of imminent plans.
- *Expressed intent to die*. It is common for suicidal behaviors to be accompanied by relatively low intent to die or ambivalence about death. When intent to die is high, the protective aspects of ambivalence about death are removed. Intent to die is a strong predictor of lethality of attempt (Brown et al., 2002).

Suicidal intent deserves considerable weight in a suicide risk assessment, but it should be recognized that some studies have documented a low association between intent and lethality of method (e.g., Eaton & Reynolds, 1985). We believe our framework partly explains this – the relationship of intent to lethality is qualified by factors like buffers (covered next) and capability.

Buffers against Suicidality

In even the most suicidal person, there is likely some will to live. This is demonstrated by numerous instances of extremely suicidal individuals who have survived high lethality attempts and have reported back on their states of mind. For instance, a *New Yorker* article in 2003 quoted a man who had jumped off the Golden Gate Bridge and survived: "I instantly realized that everything in my life that I'd thought was unfixable was totally fixable – except for having just jumped." A man who jumped into the water leading up to Niagara Falls in 2003 said that he changed his mind the instant he hit the water. "At that point," he said, "I wished I had not done it. But I guess I knew it was way too late for that." He survived the plunge over the falls, and now feels a new lease on life. Harry Stack Sullivan (1953, pp. 48-49) described people who had ingested bichloride of mercury: "One is horribly ill. If one survives the first days of hellish agony, there comes a period of relative convalescence – during which all of the patients I have seen were most repentant and strongly desirous of living." Unfortunately for these patients, another phase of several days of agony then resumes, usually ending in death. The will to live is powerful enough that it returns even in people who have suppressed it enough to imbibe bichloride of mercury, to jump off the Golden Gate Bridge, or to go over Niagara Falls.

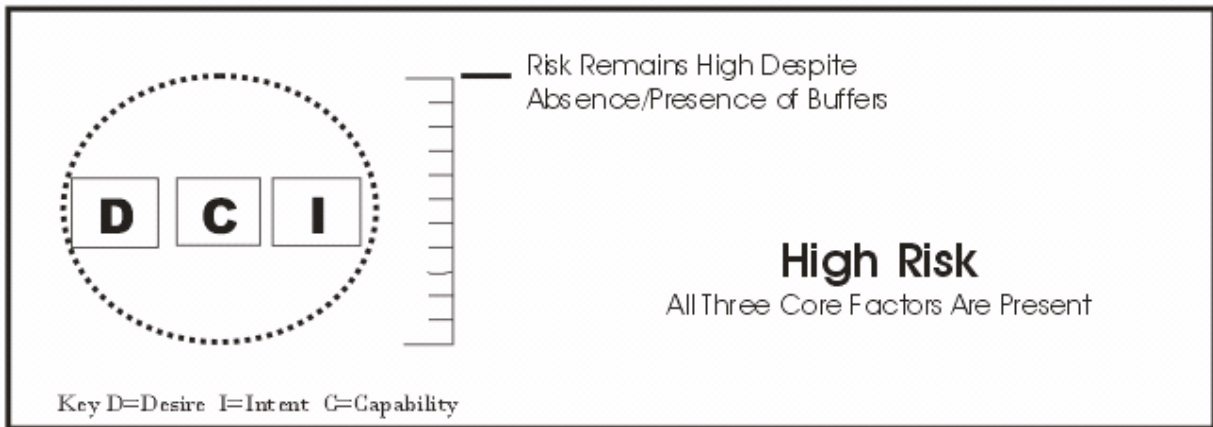
The CTS has identified the following buffers as key:

- *Perceived immediate supports* (e.g., person present with the caller). This factor is of clear pragmatic importance – callers who are with a supportive other will experience the buffering effects of social support as well as the practical effects of removal of means, access to emergency care, etc.
- *Other social supports*. Lack of access to social support is a strong predictor of suicidal behavior (e.g., Joiner, 2005); its presence, by converse, is protective.
- *Planning for the future*. Expressed reasons for living, both in the long-term (e.g., life goals) and the short-term (e.g., plans to complete a project), have been documented as protective against suicidal behavior (Strosahl et al., 1992).
- *Engagement with helper (telephone worker)*. This factor is a specific instance of those more general factors on social support, noted above.
- *Ambivalence for living* (see below).
- *Core values/beliefs* (see below).
- *Sense of purpose*. This factor, as well as some reasons for living (i.e., an ambivalence about death that includes attraction to life) and core values/beliefs (e.g., duty to family; religious beliefs), all represent the same process as "planning for the future," noted above. Specifically, each of these factors reflects a connection to living.
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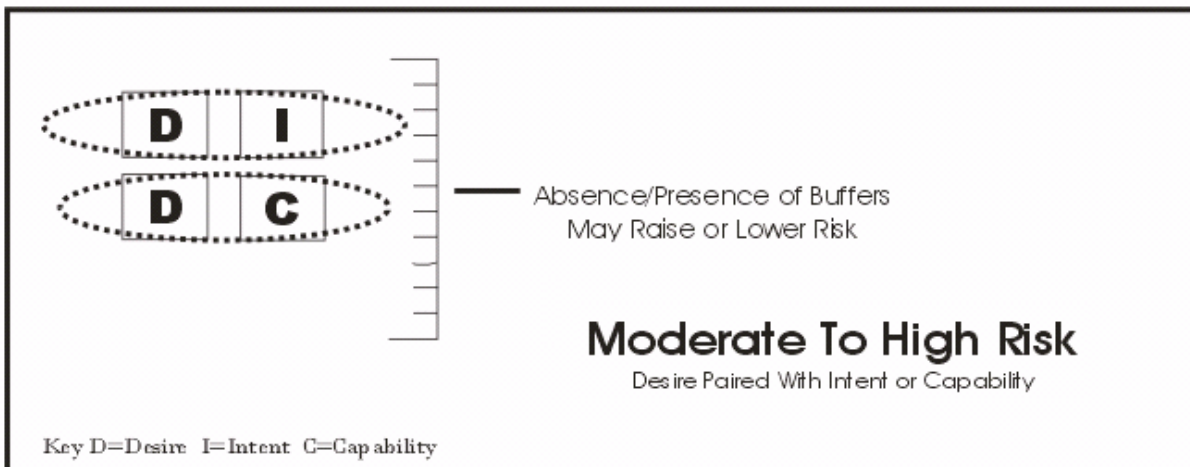
Presence of these buffers do not automatically offset risk based on the other three facets of suicidal desire, suicidal capability, and suicidal intent, but as will be seen in the next section, they may affect risk calculations in significant ways.

The Inter-Relations of the Four Facets, and Attendant Implications for Crisis Calls

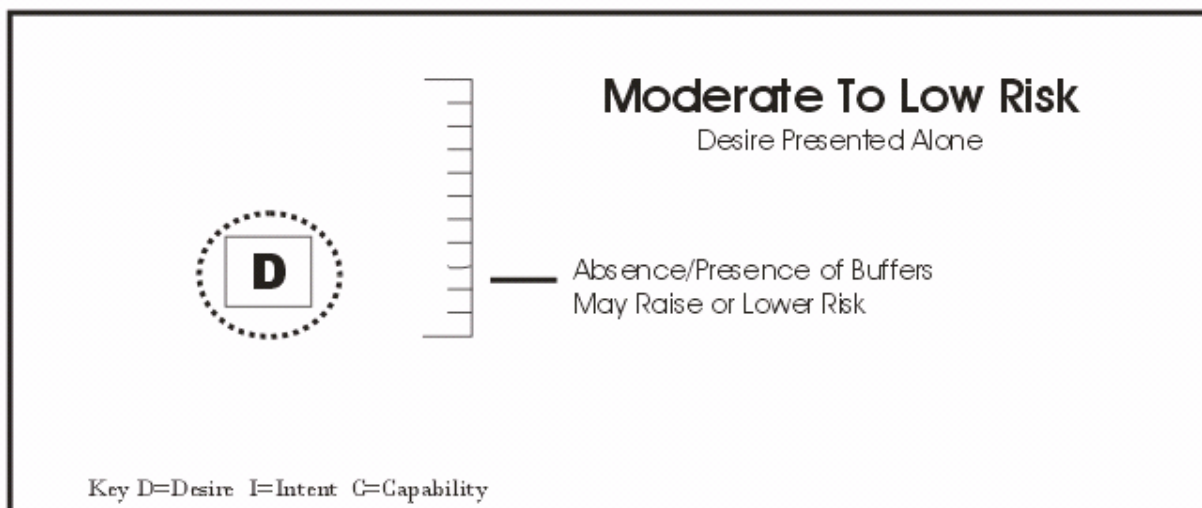
As previously noted, suicidal desire occurring independent of suicidal capability and/or suicidal intent typically presents a low-risk-of-suicide scenario. However, when desire combines with capability and/or intent, then suicidal risk may dramatically increase and the intervening impact of buffers may also need to enter into the equation. Below are representations of possible combinations of factors.



Starting with the clearest – and highest risk – scenario, when suicidal desire, suicidal capability, and suicidal intent are all present, risk is high, *and this is essentially true regardless of the presence of buffers.*



When desire is paired with either intent or capability (but not with both), risk is lower but still considerable, and the determination of whether risk is particularly high rests with the safety afforded by buffers – if safety is high, risk is more moderate (though still elevated and in need of regular monitoring); if safety is low, risk is approximately as high as when desire, capability, and intent are all present.



Desire by itself is best viewed as a symptom of a mood disorder, and does not entail significant risk by itself. Capability and intent are more pernicious, and here again, the safety afforded by buffers is partly determinative. If safety is high, capability and/or intent do not convey the higher risk categories, but may convey moderate risk and require regular monitoring. If safety is low, capability and/or intent is a more serious concern, and requires active intervention, though probably not to the level of rigor or immediacy occasioned by the combinations of desire, capability, and intent, as noted in the prior graphics.

NSPL Implementation Process of Standards for Suicide Risk Assessment

In January 2007, the suicide risk assessment standards will become policy for all Lifeline network crisis centers. The implementation process will involve a formal announcement to all the Lifeline network centers. All centers will receive by direct certified mail: 1) The Policy; 2) The Standards; 3) The Network Implementation Timeline and Process; and 4) this Background Paper.

Extensive technical assistance will be provided by the CTS and the Lifeline Certification and Training Division through various means. Some of these methods include: network wide conference calls; newsletter articles; email communications; sample suicide risk assessment questions and instruments; and individualized assistance when requested/needed. All network centers will be required to submit their suicide risk assessment instrument to the Lifeline Certification and Training Division for review to ensure that their tool meets network standards. Centers will also be encouraged to submit examples of suicide risk assessment trainings that demonstrate how they have incorporated the standards into their routine educational and skill-building activities for crisis line workers. Once reviewed by the CTS to ensure adherence to the standards, these examples will be posted and available to all network crisis centers, with the permission of the crisis centers. It is expected that all Lifeline network centers will be in adherence with the new standards by September 29, 2007.

The Lifeline is actively promoted nationally as a resource for suicidal persons. Lifeline's policy regarding the suicide risk assessment standards will require some degree of suicide risk assessment on every Lifeline call. As a suicide prevention hotline, it is essential that every Lifeline caller be assessed for potential suicidality.

A common misconception is that asking about suicidality might aggravate or upset callers, or, in the extreme, "plant the idea in the person's mind". Research does not support this assumption.

A study examining the impact of suicide risk questions to at risk youth (e.g., impaired from substance abuse, depressed or past history of suicide attempt) as well as a general youth population found that neither group was distressed nor more suicidal following the introduction of the questions (Gould, Marrocco, Thomas, Mostkoff, Cote & Davies, 2005). However, as noted earlier, research has shown that failure to routinely ask hotline callers about suicidality can allow for a significant number of suicidal persons to be missed (Mishara, et al; Kalafat, Gould & Munfakh).

Lifeline's administrators recognize that a full suicide risk assessment covering all four core principles will not be appropriate for some callers. Therefore, for every Lifeline call, Lifeline's policy will require that telephone workers ask the callers about suicidality. The CTS will be recommending that crisis center staff ask a minimum of three "prompt questions" that, if answered affirmatively, could prompt a full scale assessment (e.g., "Are you—or the person you are calling about—thinking about suicide?"; please see appendix 1). These questions will address current suicidal desire, recent (previous two months) suicidal desire and past suicide attempts. Clearly, it is important to elicit current suicidal desire given the caller is calling the Lifeline *now*. What is happening in the caller's life today that motivated him/her to reach out by calling the Lifeline *now*? If the caller denies current suicidal ideation, inquiring about recent suicidal ideation (eg., past two months) may indicate the caller's emotional instability. In addition, a caller may feel more ready to acknowledge previous thoughts/behaviors rather than to discuss the more immediate situation. Depending on how the crisis center worker responds, discussing previous suicidal desire and/or attempts can increase rapport and trust leading to disclosure of current suicidal desire if present. Inquiring about previous suicidal attempts also allows for the telephone worker to engage the caller in a discussion about what happened during and after the attempt, which has the potential to increase awareness of the caller's coping skills, reasons for living and awareness of available resources.

Centers can incorporate these standards and recommendations into their current risk assessments by simply adding those subcomponents of the standards that are not addressed in their assessments; or, by adopting an alternative risk assessment instrument that addresses all of the subcomponents. The CTS also recognizes that telephone workers conducting risk assessments need not address each subcomponent in a rote, survey-like manner. Often, risk status can be established based on clear statements by callers; by their answers or elaborations in response to a few questions; or by obvious behaviors, such as an attempt in progress (for example, the caller reporting the ingestion of a lethal dose of pills).

Lifeline's Certification and Training Division will offer free (to Lifeline networked centers), evidence-informed trainings on how to incorporate the suicide risk assessment questions into the dialogue with a caller. These trainings will also include how to establish rapport with callers to enhance assessment and intervention practices, as well as how the assessment can be utilized in the context of collaborating with callers to better ensure their safety.

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Appendix 1

Recommended Questions for Assessing Suicidal Ideation With Lifeline Callers

1. Are you thinking of suicide?
2. Have you thought about suicide in the last two months?
3. Have you ever attempted to kill yourself?

The above questions are referred to as “prompt questions,” in that an affirmative answer to any or all of the above will require that the telephone worker conduct a full suicide risk assessment with the caller consistent with the core principles and subcomponents of the Lifeline’s Suicide Risk Assessment Standards (Appendix 2).

The Certification and Training Subcommittee recommends that crisis center workers ask a minimum of three “prompt questions” (listed above) that, if answered affirmatively, could prompt a full scale assessment. The above questions address current suicidal desire, recent (past two months) suicidal desire and past suicide attempts.

It is important to elicit current suicidal desire given the caller is calling the Lifeline now. What is happening in the caller’s life today that motivated him/her to reach out by calling the Lifeline now?

If the caller denies current suicidal ideation, inquiring about recent suicidal ideation (eg., past two months) may indicate the caller’s emotional instability. In addition, a caller may feel more ready to acknowledge previous thoughts/behaviors rather than to discuss the more immediate situation. Depending on how the crisis center worker responds, discussing previous suicidal desire and/or attempts can increase rapport and trust leading to disclosure of current suicidal desire if present.

Inquiring about previous suicidal attempts also allows for the telephone worker to engage the caller in a discussion about what happened during and after the attempt, which has the potential to increase awareness of the caller’s coping skills, reasons for living and awareness of available resources.

Appendix 2

NATIONAL SUICIDE PREVENTION LIFELINE CERTIFICATION AND TRAINING SUBCOMMITTEE

Thomas Joiner, Ph.D. (joiner@psy.fsu.edu)

Chairperson, Certification and Training Subcommittee

Dr. Joiner is the Bright-Burton Professor and Director of the University Psychology Clinic for the Department of Psychology at Florida State University. Dr. Joiner's work is on the psychology, neurobiology, and treatment of suicidal behavior, depression, anxiety, and eating disorders. Author of more than 320 peer-reviewed publications, Dr. Joiner was recently awarded the Guggenheim Fellowship. He was elected Fellow of the American Psychological Association and received the Young Investigator Award from the National Alliance for Research on Schizophrenia and Depression, the Shakow Award for Early Career Achievement from the Division of Clinical Psychology of the American Psychological Association, the Shneidman Award for excellence in suicide research from the American Association of Suicidology, and the Award for Distinguished Scientific Early Career Contributions from the American Psychological Association. He also has received research grants from the National Institute of Mental Health and various foundations. His 11th book, entitled *Why People Die By Suicide*, was published in 2005 by Harvard University Press.

Virginia Bainbridge, M.P.H. (vbainbridge@sbcglobal.net)

Ms. Bainbridge is currently Executive Director of CONTACT USA. From 1979-1995, Ms. Bainbridge worked for the State of Connecticut, Department of Mental Health, first as Assistant Regional Director (1979-1985), then as District Director (1985-1995). In 1995, she left State service to be Executive Director of a CONTACT Helpline (1995-2001), where she had been a volunteer since 1981. While serving as Executive Director, she was nominated by her peers to represent them on the CONTACT USA Board of Directors. While serving on the board, she was elected to represent CONTACT USA on the *LifeLine International* Board of Directors, a position she still holds. In 2001, Ms. Bainbridge served as Interim Executive Director for CONTACT USA and was appointed to this post again in 2004.

Besides developing training for crisis workers at the CONTACT Center, Ms. Bainbridge wrote the Standards for the Mental Health section of the CONTACT USA Core Competency Standards. She has been lead evaluator on the accreditation of four centers, provided management consultation to another center, and has been trained as a site visitor for the American Association of Suicidology's certification process. During her career, Ms. Bainbridge has been honored by the Connecticut Alliance for the Mentally Ill and the National Association of Crisis Center Directors, among others.

Suicide has touched her family several times. An uncle, two cousins and two children of cousins all committed suicide. One of her children has struggled with depression since high school.

Madelyn Gould, Ph.D., M.P.H. (GouldM@childpsych.columbia.edu)

Ms. Gould is a Professor in Child Psychiatry and Public Health (Epidemiology) at Columbia University, College of Physicians and Surgeons, and a Research Scientist at the New York State Psychiatric Institute. Her long-standing research interests include the epidemiology of youth suicide, as well as the evaluation of youth suicide prevention interventions. Dr. Gould has received numerous federally funded grants from the National Institutes of Health (NIMH) and the Centers for Disease Control (CDC) for studies examining risk factors for teenage suicide, various aspects of cluster suicides, the impact of the media on suicide, the effect of a peer's suicide on fellow students, suicide prevention programs in schools, the effect of youth suicide screening programs, the utility of telephone crisis services for teenagers, and has received grants funded from the Substance Abuse Mental Health Services Administration (SAMHSA) to evaluate crisis hotline outcomes for adults.

She also received a W.T. Grant Faculty Scholar's Award to examine psychosocial risk factors for teenage suicide and a Distinguished Investigator Award from the American Foundation for Suicide Prevention to investigate the role of the media in the initiation of suicide clusters. Her participation in numerous state and national government commissions include the 1978 President's Commission on Mental Health and the Secretary of Health and Human Services' Task Force on Youth Suicide in 1989. In addition, she authored the chapter on youth suicide prevention for the Surgeon General's 1999 National Suicide Prevention Strategy, and served as a leadership consultant for the Surgeon General's Leadership Working Group for the National Suicide Prevention Strategy. Dr. Gould was also a founding member of the New York State Suicide Prevention Council and has been actively engaged in the development of the suicide prevention plan for New York State. She contributed to the Center for Disease Control's community response plan for suicide clusters (1988) and recommendations to optimize media reporting of suicide (1994), and was a member of an international workgroup, sponsored by the American Foundation for Suicide Prevention and the Annenberg Public Policy Center, which updated these media recommendations in 2001. The recipient of the Shneidman Award for Research from the American Association of Suicidology (AAS) in 1991, the New York State Office of Mental Health Research Award in 2002, and the 2006 American Foundation for Suicide Prevention (AFSP) Research Award, Dr. Gould has a strong commitment to applying her research to program and policy development.

John Kalafat, Ph.D. (kalafat@rci.rutgers.edu)

Dr. Kalafat is currently a faculty member of the Rutgers Graduate School of Applied and Professional Psychology. He is a past President of the American Association of Suicidology, a member of the Scientific Advisory Council of the American Foundation for Suicide Prevention and the SAMHSA Garrett Lee Smith Evaluation Steering Committee. He was the Principal Investigator on the SAMHSA Hotline Evaluation & Linkage project. He is also a consultant for the Maine Youth Suicide Prevention Program funded by SAMHSA and the Centers for Disease Control. He has authored a variety of publications on program evaluation and suicide prevention, including *Lifelines School-Based Adolescent Suicide Prevention Program*, which has been implemented in several States and has been designated a Promising Program by the National Registry of Evidence-Based Prevention Programs. He was the co-

founder and Director of a Regional Telephone Counseling and Referral Service and has been providing consultation and training to crisis hotlines for 35 years.

Marshall Knudson, Ph.D. (mknudson@alachua.co.fl.us)

Dr. Knudson has been the Director of the Alachua County Crisis Center (Gainesville, FL) for the last 20 years and has worked in the field of crisis and suicide intervention for more than 25 years. He holds the positions of adjunct faculty in the University of Florida's departments of psychology and counselor education and affiliate staff in the University's Counseling Center. Dr. Knudson is a licensed psychologist and has been active on the local, State, and national level as a speaker, consultant, trainer, and interventionist in the areas of suicide, crisis, and community trauma response. He is also recognized for his work in the field of crisis center issues, including such topics as the use of volunteers and paraprofessionals, related training models, and the expanded role of crisis centers in their communities. Dr. Knudson is a senior certification examiner and a member of the certification committee with the American Association of Suicidology. He is also a member of the Florida Governor's Suicide Prevention Taskforce.

Lesley Levin, M.S.W. (llevin@bhrworldwide.org)

Ms. Levin is president of Behavioral Health Response (BHR), a not-for-profit, private corporation that provides 24/7 mental health crisis call center services to the residents of St. Louis and seven surrounding Missouri counties. The call center handles more than 12,000 calls a month. Ms. Levin has more than 35 years of experience in the medical, mental health, and substance abuse fields. Prior to joining BHR, Ms. Levin worked for Personal Performance Consultants (PPC), an international employee assistance program. Her responsibilities at PPC included the management of the 24/7 call center that handled all of the EAP and managed care calls. When Medco Behavioral Care (one of the Nation's largest managed behavioral care firms) purchased PPC, Ms. Levin became a Vice President for Medco's National Account Administration. Today, Medco is Magellan Behavioral Care.

Ms. Levin has been a Commission for Accreditation of Rehabilitation Facilities (CARF) surveyor since 1999 and an AAS surveyor since 2000. She has had both inpatient and outpatient psychiatric and substance abuse treatment experience, including serving as a hospital social work director and the director of an inpatient substance abuse program. She has also been a guest on the *Phil Donahue Show* and the *Today Show*.

Gary McConahay, Ph.D. (mcconahay1@netscape.org)

Dr. McConahay has 25 of years continuous experience in suicide prevention. Starting as a crisis line volunteer, Dr. McConahay eventually became the Executive Director of a suicide prevention agency. He has worked as a mobile crisis clinician and has supervised crisis teams and outpatient treatment teams. Dr. McConahay has personally intervened with more than 5,000 people at elevated risk of suicide, including at least 1,000 people in hospital emergency rooms, jails, and other public facilities. Dr. McConahay has been active in training others in suicide intervention skills and has been part of the suicide prevention efforts of Oregon,

California, Washington, Tennessee, Virginia, the U.S. Army, the U.S. Air Force, and the nation of Scotland. He actively assisted in the development of the State of Oregon youth and elder suicide prevention plans and currently serves on the Technical Advisory Workgroup for the DHS Health Services “Connecting Youth” project.

Currently, Dr. McConahay is the Clinical Director of Oregon Regional Behavioral Services, a statewide nonprofit organization providing housing and services for persons with mental illnesses. He also contracts and consults with government and nonprofit agencies on suicide prevention and promotes community mental health, and is a senior coaching trainer of the Applied Suicide Intervention Skills Training (ASIST) workshop. Dr. McConahay supports suicide survivors on a *pro bono* basis and operates a private practice in Grants Pass, OR.

Brian Mishara (mishara.brian@uqam.ca)

Professor Mishara is Professor of Psychology and Director of the Centre for Research and Intervention on Suicide and Euthanasia (CRISE) at the University of Quebec at Montreal. His publications, including six books in English and five in French in the areas of suicidology and gerontology, include research on the effectiveness of suicide prevention programs, studies of how children develop an understanding of suicide, theories of the development of suicidality, ethical issues in research, euthanasia and “assisted suicide,” and evaluations of helpline effectiveness. Besides his university activities, Professor Mishara was a founder of Suicide Action Montreal, the Montreal regional suicide prevention centre and the Quebec Association of Suicidology. He is vice president of the International Association for Suicide Prevention and a past president of the Canadian Association for Suicide Prevention. He was the recipient of the 1994-1995 Bora Laskin Canadian National Fellowship on Human Rights Research for his work on human rights issues regarding the involvement of physicians and family members in assisted suicide and euthanasia.

Shawn Christopher Shea, M.D. (sheainte@worldpath.net)

Dr. Shea is recognized nationally as a prominent leader in suicide prevention and clinical interviewing. He founded and is the Director of the Training Institute for Suicide Assessment and Clinical Interviewing, a training and consultation service providing workshops, consultations, and quality assurance design in mental health assessments for both mental health professionals and primary care clinicians. He is also an Adjunct Assistant Professor of Psychiatry at the Dartmouth School of Medicine and in private practice.

Dr. Shea is the author of *Psychiatric Interviewing: The Art of Understanding, 2nd Edition*. In their first years of publication, both the first and second editions were honored by being chosen by the Medical Library Association for the Brandon/Hill List as one of the 16 most important books in the field of psychiatry. His next book *The Practical Art of Suicide Assessment* by John Wiley & Sons, Inc., first published in 1999 and more recently released as an expanded paperback in 2002, is considered a modern classic in the field of suicidology. In November of 2004, he published his first book for the general public, the best selling *Happiness Is*, subtitled *Unexpected Answers to Practical Questions in Curious Times*.

Dr. Shea created and is featured on the innovative learning module, "Suicide Assessment for Primary Care Physicians" on the CD-ROM produced by GlaxoSmithKline entitled, *The Hidden Diagnosis: Uncovering Anxiety & Depressive Disorders*. He also created the full-length DVD *Transforming Angry Resistance: From Theory to Practice* in which one of his most popular workshops was captured live by the cameras and production team of the Eli Lilly pharmaceutical corporation.

Kathryn VanBoskirk, C.S.W. (kathrynvboskirk@earthlink.net)

Ms. VanBoskirk has over 30 years of experience in clinical mental health services as a therapist, advocate, and educator. She has taught at the University of Pennsylvania School of Social Work. She is a licensed clinical social worker and served as a training consultant in suicide intervention for the California State Department of Mental Health for 5 years. Since that time, she has trained trainers in suicide intervention through Living Works Education, Inc., throughout the United States, Europe, Scandinavia, Australia, and Asia. Currently, she is a consultant in Sedona, AZ.

NATIONAL SUICIDE PREVENTION LIFELINE STEERING COMMITTEE

Sharon Carpinello, R.N., Ph.D. (coevsec@omh.state.ny.us)

Chairperson, Steering Committee

As Commissioner of the New York State Office of Mental Health, Dr. Carpinello is leading a transformation of New York State's public mental health system, changing the landscape in numerous areas including strategic planning, the science-to-practice agenda, and mental health promotion. She believes that an important step in preventing suicide is to "speak up" and cast it as a public health issue. Insofar as silence and suicide go hand-in-hand, she has publicly shared her own story of having lost a loved one to suicide. With the goal of saving lives, she initiated the development and implementation of SPEAK (Suicide Prevention Education Awareness Kit), a statewide education and awareness campaign that uses a public mental health model to help people become familiar with the risks for and warning signs of suicide. Launched in May 2004, SPEAK has received wide attention in both the public and private sectors and has been featured in regional and national publications, including *Governing Magazine*, *Mental Health Weekly*, and *Behavioral Healthcare Tomorrow*.

Dr. Carpinello is committed to a recovery model that emphasizes the uniqueness of each person, a perspective drawn from her nursing career which integrates the concept of holism into practice. In addition, her "science to practice" approach is further informed by her experience conducting mental health services research in the area of self-help and recovery, as well as her years as a policy maker and leader of the largest public mental health system in the country. In 2005, she was invited to receive the Institute for Community Living's Public Service Award, the New York Association for Psychiatric Rehabilitation Services' President's Award, the Samaritans' Lifekeeper Memory Award, the Federation of

Organizations' Woman of the Year Award, and the Mental Health Association of New York City's first "Hope Award."

David Covington, M.S., M.B.A. (dcovington@ihrcorp.com)

Vice-Chairperson, Steering Committee

As Chief Operating Officer of Behavioral Health Link, Mr. Covington manages the Georgia Crisis & Access Line which provides a Single Point of Contact for mental health, addiction and behavioral healthcare crisis services throughout the state. It is estimated that this service will receive 500,000 calls next year. In addition, BHL serves as the Regional Overflow Crisis Center for the Southeastern United States with 1-800-273-TALK. He has been instrumental in the development of the Georgia Crisis Intervention Team model for training law enforcement on de-escalating mental health crises and serves as a member of the Georgia CIT Advisory Board.

Prior to his work at the AAS and URAC-accredited Behavioral Health Link, Mr. Covington was director of Quality Improvement for APS Healthcare, Inc., the external review organization that oversees the delivery of all rehabilitation option mental health services in Georgia. Mr. Covington is a licensed professional counselor, is a national certified counselor and has an M.B.A. from Kennesaw State University and a master of science from the University of Memphis.

Charlotte Anderson (211director@tuw.org)

Ms. Anderson has worked with Hotline, a 24-hour crisis and information service in Charleston, SC, since 1981 and served as the Executive Director since 1986. She recently spearheaded her community's initiative to implement "211" and designed a merge of Hotline with the local United Way. Ms. Anderson served two terms as the crisis center division director on the Board of the American Association of Suicidology. She has led a suicide survivors support group for over 15 years and is part of the local crisis response team. In addition, she has worked as a Teaching Parent with emotionally disturbed youth, provided drug and alcohol education for the Navy, and designed and taught a course at Trident Technical College. Ms. Anderson passionately believes in the power of the "collective brain" and has seen incredible community changes occur when groups work together.

John Bateson (johnb@crisis-center.org)

Mr. Bateson has been Executive Director of the Contra Costa Crisis Center, in Contra Costa County, California (San Francisco Bay Area), since 1996. His agency answers 18 hotlines, including separate, toll-free, 24-hour lines for child abuse, elder abuse, grief, homelessness, and youth violence prevention, as well as for crisis and suicide. The crisis center also handles 211 calls, and operates a limited-hours Chinese-language helpline. In addition, the agency has one of the oldest, largest, and most diverse grief counseling programs in California, and answers after-hours and Spanish-language calls to the California SIDS Hotline. Mr. Bateson is on the Board of Directors of CAIRS (California Alliance of Information and Referral

Services), represents crisis centers on the California 211 Steering Committee, and is a member of BASCIA (Bay Area Suicide and Crisis Intervention Alliance). Formerly he was Associate Director for 15 years of a multi-county social service agency. In 1992 he managed a temporary distribution center on the East Coast for victims of Hurricane Andrew. In 1996 he was named a "community hero" by United Way of America and chosen to carry the Olympic torch. His wife is Executive Director of a metro area food bank. He is especially interested in issues of cultural competency, and is committed to the concept of providing multilingual, multicultural crisis counseling.

Alan Berman, Ph.D., A.B.P.P. (berman@suicidology.org)

Dr. Berman is currently the Executive Director of the American Association of Suicidology and former Director of the National Center for the Study and Prevention of Suicide at the Washington School of Psychiatry. He taught for 22 years at American University in Washington, DC, attaining the rank of tenured full professor. At American, he initiated development of the second University-based, student-operated crisis service in 1970. Thirty-one years later, he served as Principal Investigator of SAMHSA's predecessor 3-year grant (2001-2004) to network and certify crisis centers. Dr. Berman is author/editor of 7 books in suicidology and more than 90 peer-reviewed articles and book chapters. In 2005, he completes his sixth year on the Board of the International Association for Suicide Prevention (until September, he is treasurer). He is a Fellow of the International Academy of Suicide Research and is on the editorial boards of three journals in suicidology.

Shannon Breitzman, M.A. (shannon.breitzman@state.co.us)

Ms. Breitzman is the director of injury and suicide prevention programs at the Colorado Department of Public Health and Environment, including prevention programs for sexual assault, violence, suicide, childhood injury, and unintentional injuries. She serves as the Principal Investigator for three Federal grants, including youth violence and sexual assault prevention. She is the Director for the Colorado Child Fatality Review Committee and facilitates a number of multidisciplinary coalitions and advisory boards, including the Colorado Injury Prevention Advisory Committee and the Colorado Sexual Assault Prevention Advisory Counsel. Ms. Breitzman was the first director of the Colorado Office of Suicide Prevention and was a leader in implementing Colorado's suicide prevention plan. She has studied the impact of public service announcements on crisis line use. She has also worked with crisis line directors on funding, technology, and service delivery issues. Ms. Breitzman has worked in the fields of mental health and human services for 12 years. Her professional experience has included working with children, adolescents, and their families, including assessment and treatment planning for adolescents at risk for suicide. She is a certified trainer in applied suicide intervention skills training and is a public speaker on suicide and violence. Ms. Breitzman has a master's degree in marriage, family, and child therapy and a master's degree in art therapy.

Esther A. Castillo, L.C.S.W. (comadre@pacbell.net)

Ms. Castillo has worked in the Mental Health field for 30 years, with an emphasis in substance abuse and crisis stabilization. She has been a Program Administrator for the past 24 years in both the public and private sector. She has worked with behavior health programs and administered crisis response teams for Catholic Health Care West and for Merit Behavior Care (a program developed by Merck Corporation and currently with Magellan Behavioral Health.)

Ms. Castillo was Director of Yolo County Department of Alcohol, Drug and Mental Health for seven years. During her tenure as a Behavioral Health Director Ms. Castillo oversaw programs offered by Suicide Prevention of Yolo County. Although she took an early retirement to care for her husband who was diagnosed with terminal cancer, Ms. Castillo continued to chair several Committees for the California Mental Health Directors Association (CMHDA). These committees include Adults System of Care and Women's Mental Health Policy Counsel. She also represents the CMHDA on the Cultural Competency Advisory Committee of California State Department of Mental Health. Ms. Castillo has maintained a private practice in Sacramento for nine years.

John Draper, Ph.D. (jdraper@mhaofnyc.org)

Dr. Draper is the Project Director of the National Suicide Prevention Lifeline. He has extensive experience in suicide prevention, crisis center management, and systems coordination. As a counseling psychologist, he worked with hundreds of persons at risk for suicide in their homes as a Brooklyn mobile crisis professional for 7 years. He eventually served as Clinical Director and consultant to the city's Department of Mental Health. Dr. Draper continues to work as a consultant to the city, training mobile crisis professionals in risk assessment. As the founding Director of the Mental Health Association of New York City's 24-7 LifeNet multicultural hotline network and public education division in 1996, Dr. Draper was responsible for overseeing all aspects of the hotline network's development, including staff hiring and training, customized software program design and implementation, data management and reporting, and all network-related multicultural outreach and education activities. Under his stewardship, the Mental Health Association of New York City's public education and hotline capacity grew exponentially, expanding its funding more than fourfold to a \$2 million operation, from initially serving 10,000 persons in its first year to serving more than 120,000 persons through its hotline, depression screening, and other outreach initiatives in its seventh year. Dr. Draper's training as a family systems therapist has also aided him in his work to facilitate collaborations among major human service, law enforcement, and emergency systems in the area. He has engineered major behavioral health, public education, and outreach initiatives through the city's police, fire, education, aging, health, and mental health departments, and he has chaired three city behavioral health committees to ensure ongoing systems collaborations.

Beginning September 11, 2001, Dr. Draper's 1-800-LIFENET crisis call center became the primary vehicle for mobilizing the largest disaster mental health response ever undertaken in the United States. Following the attacks on 9/11, LifeNet became the central network entry point for federally funded crisis counseling services and hotlines throughout New York and

to some parts of New Jersey and Connecticut. Currently, LifeNet continues to function as the American Red Cross's main entry point for persons seeking 9/11-related behavioral health assistance throughout the nation. Dr. Draper has authored chapters on the role of hotlines in disaster mental health in two books.

Robert W. Glover, Ph.D. (bob.glover@nasmhpd.org)

Dr. Glover has been the Executive Director of the National Association of State Mental Health Program Directors (NASMHPD) since September of 1993. Due to NASMHPD's partnership with the Mental Health Association of New York City in the federally funded National Suicide Prevention Lifeline project, Dr. Glover is a key member of the Lifeline's Executive Leadership Team (ELT). Founded in 1959, NASMHPD was organized to reflect and advocate for the collective interests of State Mental Health Agency directors and staff at the national level, playing a vital role in the delivery, financing, and evaluation of public mental health services within a rapidly evolving health care environment. Prior to this position, Dr. Glover served as Commissioner of the Department of Mental Health and Mental Retardation in Maine for 3 years. He has worked in several states' mental health departments, including Colorado (Director), Idaho (Administrator), Pennsylvania (Deputy Health Commissioner), and Ohio (Assistant Commissioner). Dr. Glover was President of the NASMHPD Board of Directors from 1985-86 and President of the NASMHPD Research Institute, Inc. Board of Directors from 1987-88, and he is currently a faculty member for Harvard University. He served as a member of the Joint Commission on Accreditation of Healthcare Organizations Advisory Panel on Seclusion and Restraint, and he served on the experts' panel for the U.S. Surgeon General's National Strategy for Suicide Prevention. Dr. Glover continues to highlight suicide prevention as a NASMHPD priority, including partnering with the Association of State and Territorial Health Officials (ASTHO) to coordinate regional Youth Suicide Prevention Roundtable meetings. He is a licensed psychologist in Ohio and received his Ph.D. in clinical psychology from Ohio State University in 1974.

Cathleen Dwyer Kelly, C.R.S., C.I.R.S (ckelly@mhaofnyc.org)

Ms. Kelly is the Director of Network Development at the National Suicide Prevention Lifeline. She has extensive experience in information and referral hotline work. She currently sits on the National AIRS Board, and co-chairs the AIRS National Affiliates Council. Cathleen is the immediate past President of the New York State Alliance of Information and Referral Systems (NYS AIRS). She has over ten years experience in national networking efforts with hotlines and in-depth knowledge of 211 issues. Prior to joining NSPL, she was Information Services Coordinator at Rochester, NY's 211 Lifeline Program (a member of the NSPL Network). As Information Services Coordinator, she directed the resource department, and was responsible for a database that served a call center which answered over 100,000 calls per year from eleven counties.

Bob Kessler (BKessler@mhaofnyc.org)

Mr. Kessler is Director of Information Technology for the National Suicide Prevention Lifeline. He has been involved with technology development for over thirty years and holds several certifications. Prior to his current position he was Director of IT for the Mental Health Association of New York City and maintained the technology infrastructure to help support its 200 staff members. As a software developer and original equipment manufacturer, Mr. Kessler has developed systems that have been employed by organizations throughout North America including a major NY Hospital, a state electric utility, the County of San Diego and many manufacturing companies.

Richard McKeon, Ph.D., M.P.H. (Richard.McKeon@samhsa.hhs.gov)

Dr. McKeon received his Ph.D. in clinical psychology from the University of Arizona and a master's of public health in health administration from Columbia University. He has spent most of his career working in community mental health, including 11 years as director of a psychiatric emergency service and 4 years as associate administrator/clinical director of a hospital-based community mental health center in Newton, NJ. He established the first evidenced-based treatment program for chronically suicidal borderline patients in New Jersey, using Marsha Linehan's dialectical behavior therapy. In 2001, he was awarded an American Psychological Association Congressional Fellowship and worked for U.S. Senator Paul Wellstone, covering health and mental health policy issues. He spent 5 years on the Board of the American Association of Suicidology as clinical division director, and he also has served on the Board of the Division of Clinical Psychology of the American Psychological Association. He is currently a special advisor on suicide prevention for the Substance Abuse and Mental Health Services Administration.

Scott Ridgway, M.A. (sridgway@tspn.org)

Mr. Ridgway is Executive Director of the Tennessee Suicide Prevention Network (TSPN), an independent, voluntary group of individuals, organizations, and agencies (public and private) that promote community awareness of the warning signs of suicide and strategies for suicide prevention. TSPN is a member of the Association of Tennessee CONTACT/Crisis Centers and works closely with all 11 centers in the State to ensure their participation in the mission of suicide prevention. TSPN itself is housed in Nashville's Crisis Intervention Center, an AAS-certified agency that has operated a suicide hotline for more than 37 years and takes more than 30,000 calls a year. In the past 15 years, Mr. Ridgway has served CIC in many diverse and important capacities, including that of telephone counselor, crisis specialist, postvention coordinator, board member, and past president of the board of directors.

Working closely with the TSPN Advisory Council and the Governor's Office, Mr. Ridgway coordinates the implementation of the Tennessee Strategy for Suicide Prevention activities on all local and statewide levels. *The Tennessean* has included him in the "Top 40 under 40," an annual listing of young leaders in middle Tennessee, and recently he received the I.C. Hope Award from the Mental Health Association of Tennessee, in recognition of his outstanding work to provide hope for the mentally ill.

Heather Stokes, L.C.S.W (hstokes@mhaofnyc.org)

Ms. Stokes is the Certification and Training Director at the National Suicide Prevention Lifeline. She also has a part-time clinical private practice treating adolescents and adults; specialties include suicide prevention, loss/bereavement, domestic violence and trauma. Ms. Stokes serves on the Board of the National Association of Crisis Center Directors (NASCOD) and recently served on the Board of the New York State Alliance of Information and Referral Services (NYS AIRS). She also serves on the Steering Committee of the National Association of Social Work Managers – NYC Chapter.

Prior to joining NSPL, she was the Director of HELPLINE and the Family Violence Hotline at the Jewish Board of Family and Children’s Services (JBFCS) in NYC. Ms. Stokes founded the Protected Pets Program in 2003, a collaboration between JBFCS and Animal General Veterinary Hospital, providing foster care and medical treatment for pets whose families were entering Domestic Violence Shelters in NYC. She was awarded Woman of the Future in 2002 by the New York Women’s Agenda. She received her MSSW from Columbia University in 1995 and completed post-graduate training at the Institute for Child, Adolescent and Family Studies in 2001.

Stephanie Weber, M.S., L.C.P.C. (stephanie@spsfv.org)

Ms. Weber is Executive Director of Suicide Prevention Services, Inc., Batavia, IL. Her Survivors of Suicide of Fox Valley program, founded in 1982, has served over 1,000 families who have lost a family member to suicide, providing support groups (which she still facilitates), a monthly newsletter, and survivor outreach. In 1984, she created the Crisis Line of Fox Valley in Aurora, IL, a 24/7 hotline staffed by volunteers with 88 hours of training. In 1998, Ms. Weber became the founding Director of Suicide Prevention Services, Inc., an agency that provides prevention in the form of education and outreach, intervention in the form of 24/7 hotlines, and postvention that includes survivor groups for adults as well as for children and teens. Suicide Prevention Services, Inc. also does crisis intervention, counseling, and depression screenings.

Ms. Weber has traveled extensively to conduct suicide prevention training and to help agencies set up hotlines. She is a member of the American Association of Suicidology, having been their survivor division director as well as their Survivor of the Year for 2000. She has received numerous local, State, and national awards since 1987. Ms. Weber is also a member of the American Counseling Association.

**NATIONAL SUICIDE PREVENTION LIFELINE
CONSUMER/RECIPIENTS SUBCOMMITTEE**

Eduardo Vega, M.A. (evega@mhala.org)
Chairperson, Consumer/Recipients Subcommittee

Currently Director of Education/Assistant Director at Project Return: The Next Step in Los Angeles, one of the nation's largest and oldest consumer-run peer support programs, Mr. Vega provides training on recovery practice, peer support, community integration, self-advocacy, advanced directives and personal care planning among others. A recovering mental health consumer with extensive experience as a provider, he has also authored articles, fact sheets, curricula and research review for the SAMHSA Resource Center to Address Discrimination and Stigma Associated with Mental Illness (the ADS Center), the UPenn Collaborative on Community Integration, Behavioral Healthcare Tomorrow, Mental Health Weekly, and the IAPSRs journal, among others.

Previously, as Project Manager for the SAMHSA-funded National Mental Health Consumers' Self-Help Clearinghouse, he served as General Editor for major Clearinghouse products and developed the Consumer-Driven Services Directory, the first national internet service of its kind. In addition he served as Spanish-language translator and liaison to mental health advocacy and consumer organizations representing Hispanics and other cultural minority groups. Mr. Vega has presented at major conferences including USpra, NASMHPD, ACMHA, Alternatives, and NMHA. A contributor to national projects including the Mental Health Disparities Initiative, Olmstead Implementation and the National Strategy on Adult Care Homes, Mr. Vega has over fifteen years experience in five states as a mental health advocate, social services worker and counselor. He holds an M.A. in Psychology from New School for Social Research and serves as President of the national Advocates for Latino Mental Health Advancement (ALMHA).

James T. Clemons, Ph.D. (JamesTClemons@aol.com)

Beginning his career as a Methodist Minister in Arkansas, Dr. Clemons has become a national leader in suicide prevention efforts within faith-based communities. He earned his Doctor of Philosophy degree in Biblical Studies from Duke University and an honorary Doctor of Divinity degree from Hendrix College in 1968, and resided as a faculty member of Wesley Theological Seminary in Washington, DC, for 32 years before his retirement in 1995. He has received several honors for his outstanding scholarship in biblical studies and humanitarian services. From his teaching and research he became interested in suicide from biblical and religious perspectives. This led to his conducting workshops for religious leaders, preaching in several states and writing articles. He wrote What does the Bible say about Suicide?, now in its third edition, and edited and contributed to Perspectives on Suicide and Sermons on Suicide. His latest book is Children of Jonah: Personal Stories of Survivors of Suicide Attempts, with a foreword by Judy Collins.

After his retirement he founded and serves as President of the Organization for Attempters and Survivors of Suicide in Interfaith Services, a 501(c)3 organization. OASSIS is a charter

member of the National Council of Suicide Prevention and a member of the International Association of Suicide Prevention.

In 2000 it sponsored the first National Interfaith Conference on Religion and Suicide in Atlanta and, with the National Organization for People of Color Against Suicide and the Healing Center of Memphis, sponsored the first ever Conference on Suicide and the Black Church. In October 2005, OASSIS will sponsor the first National Conference for Survivors of Suicide Attempts, Healthcare Professionals, Clergy and Laity in Memphis.

The work of OASSIS has been highly commended by former U. S. Surgeons General M. Jocelyn Elders, a member of its Board of Advisors, and David M. Satcher.

Franklin Cook, M.A. (franklin@unifiedcommunities.com)

Mr. Cook is the owner of Unified Community Solutions, <http://www.unifiedcommunities.com>, which helps grassroots groups address suicide prevention and other public health challenges. He currently co-facilitates implementation of the South Dakota Strategy for Suicide Prevention. After 20 years as an editor and writer in book, magazine, and newspaper publishing, Mr. Cook entered his "second career" in public health via volunteer work in suicide prevention and survivor grief support.

He is a survivor of his father's suicide in 1978 and has been active on the Survivor Council of the American Foundation for Suicide Prevention (AFSP) and as a member of the Survivor Division of the American Association of Suicidology (AAS). Mr. Cook has continued his volunteer work with two suicide grief groups in Rapid City: Black Hills Area Survivors of Suicide, a peer-led support group, and the LOSS Team (Local Outreach to Survivors of Suicide), which assists survivors immediately after a death. He is also a member of the Board of Directors of the Suicide Prevention Action Network (SPAN USA). Mr. Cook is the author of "All Together Now," a newspaper column on mental health in the *Rapid City Journal*, as well as of articles in AFSP's "Lifesavers" and AAS's "Surviving Suicide" newsletters. In addition, he was a leader in the development of the South Dakota Strategy for Suicide Prevention, which was completed in January 2005, and has worked in Native American communities delivering suicide prevention gatekeeper training and assisting with public health advocacy.

Mr. Cook also has experience in youth substance abuse and addiction prevention and aftercare services. His latest endeavor in that field is as project director for Community Linkages for Youth, an interagency collaboration initiative of Lifeways, a nonprofit organization he helped found in 2002 that places certified chemical dependency counselors full-time in Rapid City schools.

Mark Davis, M.A. (mark.davis@phila.gov)

As a behavioral health system special needs analyst for the Philadelphia Mental Health Care Corporation in consultation with the Philadelphia Office of Behavioral Health, Mr. Davis has received several awards for his outstanding work in consumer advocacy. As a person who is

gay, living with mental illness, in recovery from addiction, dealing with hearing loss, and living with an HIV-positive diagnosis, he has consistently used his experiences and skills to combat stigma, inspire others in similar circumstances, and effect change in both health and behavioral health systems. He is the founding President of the Pennsylvania Mental Health Consumers' Association (PMHCA), an organization dedicated to restoring the respect, human rights, and dignity of consumers/survivors of behavioral health services. He has developed more than 75 consumer-run groups and services in Pennsylvania, and his consumer advocacy efforts have helped increase Pennsylvania's State funding for mental health programs; enhance coordination of care for persons using multiple service systems; and affect the development of culturally competent approaches to care for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) citizens, persons receiving behavioral health services, and people living with HIV/AIDS.

Beyond Pennsylvania, he has been a speaker, consultant, and trainer in 43 States for a variety of consumer, family, community, and professional associations, and his work has been featured in a wide array of print and broadcast media. He has also consulted with CMHS and SAMHSA on a number of issues, ranging from co-occurring disorders to statewide consumer/survivor organizing. As a person who has attempted suicide in the past and who lost his sister, Jennifer, to suicide 10 years ago, Mr. Davis has a special interest in this national program dedicated to addressing this public health concern.

Dar Emme(demme@yellowribbon.org)

Ms. Emme is founder and Deputy Director of Yellow Ribbon International Suicide Prevention Program®. She is the survivor of her son Mike's death by suicide in 1994. She led the development of the Yellow Ribbon Training programs that are being used by chapters and program sites in all states and internationally. Working and traveling full time with the program, she is the Co-founder of the Yellow Ribbon International Youth Council and has addressed and taught more than 200,000 youth that it is OK to Ask for Help!®. She was appointed to the Colorado Governor's Suicide Prevention Advisory Commission in 1998, helping to develop the Colorado State Suicide Prevention Plan and create the Colorado Office of Suicide Prevention and the Suicide Prevention Coalition of Colorado. She also is a founding Member of the National Council of Suicide Prevention. Ms. Emme works to forge collaborations with organizations and has partnered with the American Osteopathic Association and BBYO (B'nai B'rith Youth Organization). She serves as a national judge for the Alliance of the American Psychiatric Association's *When Not to Keep a Secret* national essay contest. She is co-author of "I'll Always Be With You" in Chicken Soup for the Teenage Soul and "Legacy of the Yellow Mustang".

Ms. Emme has worked to establish an international Yellow Ribbon Suicide Awareness and Prevention Week, which is recognized by the U.S. Senate and State Governors and has been observed nationally the third full week of September for 10 years. She has also been recognized for her work by the U.S. House of Representatives.

DeQuincy A. Lezine, Ph.D. (Dequincy_Lezine@URMC.Rochester.edu)

Dr. Lezine attempted suicide in 1995, his first year at college, and was diagnosed with bipolar disorder. In the following year (1996) he formed the first student-led college mental health and suicide prevention group (Brown University chapter of the Suicide Prevention Action Network; B-SPAN). Working with the SPAN USA, Dr. Lezine was an early advocate for individuals who were living with mental disorders or who had attempted suicide in the development of suicide prevention programs and policy.

Through SPAN USA and later through the National Alliance for the Mentally Ill (NAMI), Dr. Lezine spoke about his experiences in conference presentations (SPAN USA, NAMI, American Association of Suicidology, Organization of Attempters and Survivors of Suicide in Interfaith Services – OASSIS, National Medical Association), in public service announcements (NAMI), television interviews (CNN, Extra!), radio interviews (NPR, BBC), and informational videos (NAMI, American Foundation for Suicide Prevention). He was a featured speaker at the OASSIS/SPAN First National Conference for Survivors of Suicide Attempts, and has recently joined the Consumer and Recipient Subcommittee for the National Suicide Prevention Lifeline.

Dr. Lezine completed his doctoral training in clinical psychology at UCLA. He has 10 years of experience working with community coalitions in the development of suicide prevention strategies. Currently, he is a postdoctoral fellow at the University of Rochester Center for the Study and Prevention of Suicide with training specific to suicide prevention research. Dr. Lezine's research focuses on the question: "Can community mental health initiatives actively engage youth and consumers in various roles, and does engagement have a positive impact on the success of the initiative?"

Alison Malmon (amalmon@activeminds.org)

Alison Malmon is founder and Executive Director of Active Minds, Inc., a student-run mental health organization on the college and high school campus. She started the program in 2001, while a junior at the University of Pennsylvania, following the suicide of her older brother, Brian, one year earlier. Wanting to combat the stigma that had caused her brother to suffer in silence and ultimately take his own life, she created a group on her campus that promoted an open, enlightened dialogue around the issues. Just two years later, Ms. Malmon formed the 501(c)(3) organization in order to develop and support chapters of the student group on campuses around the country. She currently serves as President and Executive Director of the organization, setting up chapters of the student group and creating a unified national voice for young adults in the mental health awareness movement.

Ms. Malmon was the 2003 recipient of the Tipper Gore Remember the Children Award from the National Mental Health Association, and the 2004 Young Leadership Award from the National Alliance for Research on Schizophrenia and Depression. Having graduated from University of Pennsylvania in 2003, she now lives and works in Washington, DC, where she sits on numerous Boards and planning committees.

Karen M. Marshall (KarenMMarshall12@aol.com)

Ms. Marshall is the Program Development Director for the American Association of Suicidology, headquartered in Washington, DC. She is a career journalist with extensive experience in print, broadcast, and Web-based reporting. After losing her father and an uncle to suicide, she became involved in prevention efforts, first as a volunteer and later in full-time professional capacities. She has helped to advance the work of nonprofit suicide prevention organizations since 1990. She began her work at The Link Counseling Center in Atlanta as Assistant to its Executive Director, Iris Bolton, and has received training from noted experts in the field of suicide prevention, intervention, and healing. She has taught basic suicide prevention skills to community groups, schools, first responders, medical professionals, and civic and professional associations. She is a member of the National Advisory Board for the University of Michigan's Depression Center.

Ms. Marshall has assisted several communities and States with forming suicide prevention coalitions and task forces, and she was involved in developing Virginia's Youth Suicide Prevention Plan (expanded in 2005 to a comprehensive, across-the-lifespan suicide prevention plan) as well as Michigan's Suicide Prevention Plan. She served as the first President of the Kristin Brooks Hope Center (KBHC), which operates the National Hopeline Network, 1-800-SUICIDE. KBHC managed and expanded the network from October 2001 through September 2004 as part of SAMHSA's Hotline Evaluation and Linkage Project grant. After leaving KBHC in May 2002, she returned to her home state of Michigan to found the Stop Suicide Alliance (formerly the Lifehouse Foundation), an organization unique in its mission to stop suicide by partnering with employers to bring effective depression awareness and suicide prevention programs to employees. Programs developed by the Alliance, now closed, are part of her ongoing work with AAS.

Susan Soule

Ms. Soule moved to Alaska in 1979, spending her first 8 years in the village of Aniak as Director of the Kuskokwim Native Association Community Counseling Program and as consultant to the Yukon Kuskokwim Health Corporation in suicide prevention. In 1987, she began her 18-year career in State Government, working for the Divisions of Mental Health, Alcoholism and Drug Abuse, and Behavioral Health. Focusing on community-based programs for rural Alaska, she developed and administered the Community-Based Suicide Prevention Program (CBSPP) and, in cooperation with the University of Alaska and a number of Native Health Corporations and nonprofits, the Rural Human Services System Project (RHS). The CBSBP awards small grants to Alaskan villages and provided training and support for their work to develop and implement community-directed projects to prevent suicide and self-destructive behavior. The RHS program, through grants to Native Health Corporations and social service agencies, trains, employs, and supervises a statewide network of village-based counselors.

Ms. Soule was a member of the Alaska Statewide Suicide Prevention Council and the expert panel at the National Suicide Prevention Conference in Reno in 1998. She has consulted and presented on suicide prevention in the United States, Russia, and Canada. Ms. Soule retired

from State Government in January 2005 and currently trains and consults on community-based suicide prevention and health promotion.

Ellen Swedberg, B.S.R.N. (swedfh@frontiernet.net)

Ms. Swedberg is co-owner of Swedberg Funeral Home, Inc., Shawano and Gresham, WI. She was also a supervisor of Nursing in Menominee County and worked in public health at Eau Claire City's County Health Department. Through her personal and professional life as both a former public health worker and funeral home owner, Ms. Swedberg has often been affected by the suicides of friends and coworkers. Due to her frequent encounters with suicide in her community, she sought to actively provide suicide prevention education and assistance for families in this area. She was instrumental in forming a local group (ROADS—Reaching Out About Depression and Suicide) in her area in 2002, which mostly serves Shawano and Menominee Counties, Menominee County being a predominant enclave for Native American populations. ROADS achieved 501C3 status in 2004 and provides—in conjunction with local schools—the Yellow Ribbon Suicide Prevention Program as an education/prevention tool to nearby communities.

Ms. Swedberg is also a certified QPR (Question, Persuade, and Refer) Trainer, teaching persons to recognize signs and symptoms of individuals potentially in suicidal crisis, how to talk with them, and how to refer them for help.
