



SPRC/AFSP Best Practice Registry

SECTION III: APPLICATION GUIDELINES



Introduction and Submission Process

This document provides instructions, definitions, and resources for applicants submitting suicide prevention programs and practices for possible inclusion in Section III of the SPRC/AFSP Best Practices Registry (BPR). It is designed to assist applicants in completing the **BPR Section III Application for Review** (a separate form downloadable from www.sprc.org.)

What Types of Materials are Listed in Section III of the BPR?

Section III (Adherence to Standards) lists awareness and outreach materials, educational and training programs, protocols, and policies whose content has been reviewed for accuracy, safety, likelihood of meeting objectives, and adherence to program design standards. Please note that the terms *program* and *practice* are used interchangeably in this document to refer to all activities and/or materials posted in this section of the BPR.

Eligibility

To be eligible for review for the BPR,

- The program must address specific objectives of the *National Strategy for Suicide Prevention*.
- Program materials must be available to the field through a website or contact person (the BPR posts only information about programs, not the materials themselves.) Programs that charge fees for materials or training are eligible for review.

Application Procedures

1. From the BPR section of SPRC's website (www.sprc.org), download the **BPR Section III Application for Review**. Complete both sections of the form (Part A: *Program Information* and Part B: *Assessment Criteria*) according to the instructions and definitions provided below.
2. Collect relevant program materials.
3. Submit the completed application and the program materials by email to prodgers@afsp.org. If materials are not available electronically, they may be submitted by regular mail to Philip Rodgers, 401 South 2nd Street #402, Philadelphia, PA 19147

The total time from submission to posting of descriptive fact sheets for approved programs will vary depending on several factors, including the number of practices waiting to be reviewed, external reviewers' schedules, and the results of the review process. Applicants can expect to hear from the BPR coordinators (Philip Rodgers from AFSP or Linda Langford from SPRC) at several points during the process. Upon receiving the application, the BPR coordinators will assess it for completeness and, if needed, contact you for more information prior to sending it out for external review. After receiving reviewer comments and resolving any discrepancies among reviewers, the BPR coordinators will provide applicants with summary of results. For practices that did not meet BPR criteria, feedback to applicants will explain why the standards were not met and provide suggestions for addressing reviewer concerns. In some cases, changes to materials may qualify a practice for BPR listing with no further review, while other practices may undergo a second round of review. After approval, applicants will be asked to approve the fact sheet describing the practice prior to posting.

Assistance

We are happy to answer questions about the application process or the criteria. Please contact either of the BPR Coordinators: Philip Rodgers (215-238-0407; prodgers@afsp.org) or Linda Langford (617-618-2719; llangford@edc.org).

Instructions: BPR Section III Application for Review

Application Overview

Part A of the application requests information about the program being submitted. In Part B, applicants complete a set of questions corresponding to the criteria that reviewers use to rate the program content. Two appendices provide information that may be useful in completing your application. Appendix 1 contains a list of resources that provide detailed information about the BPR criteria and Appendix 2 lists the *National Strategy for Suicide Prevention Goals and Objectives* (programs listed on the BPR must address at least one objective from the *National Strategy*.)

Part A: Program Information

This section of the Application for Review asks for a complete description of your program (see the BPR section of www.sprc.org to download the Application for Review.) If the program is approved for BPR listing, some of this information will be used to construct a descriptive fact sheet that will be posted on the BPR.

A1. Program Title

A2. Contact Person: please fill in the name and contact information for the person who should be contacted by the BPR coordinators during the review process. If the program is approved, there must be a way for the public to access program materials. If the contact person for accessing program materials is different than the person listed here, please provide that person's information under question #A14.

A3. Category: Please check the one category that best describes the materials. If approved for BPR listing, the program or practice would be listed under this category in Section III of the BPR.

A4. Audiences(s): Please check one or more audience(s) that the materials are designed to **reach**. Indicate the *primary* audience(s) who attend the trainings, use the policies, or view awareness materials. For example, the audience for a high school faculty gatekeeper training is teachers. Please do not include audiences who may see or use the materials but are not the intended audience.

A5. Setting(s): Please check one or more settings where the materials are used. Indicate only the *primary* settings that the program designers had in mind when creating the materials.

A6. Demographics of the Population Benefited by the Program: Please check all of the categories (age, race/ethnicity, gender, other) that the materials are intended to **benefit**. For example, gatekeeper training for high school teachers is intended to reduce suicide risk among youth, so the age of the population benefited would be adolescents.

A7. Program Description. Please provide a narrative description of the program in 150 words or less.

A8. Program Development Process: Please provide a brief (75 words or less) description of how the submitted materials were developed. For example, who took the lead in developing materials (e.g., staff person, agency, multidisciplinary team, community coalition) and reviewed them (e.g., other stakeholders, consumers, experts)? Was program content based upon a literature review or behavioral theories? Was evaluation or testing conducted and materials revised based upon results?

A9. Program Objectives. Please provide a numbered list of program objectives. These should be measurable, short-term objectives (sometimes referred to as *outputs*).

A10. NSSP Goals and Objectives: Programs must address one or more objectives of the *National Strategy for Suicide Prevention (NSSP)* to be listed on the BPR. A complete list of NSSP goals/objectives is provided in Appendix 2 of this document. Please list the goal and objective numbers addressed by your program.

- A11. Materials Required for Implementation:** Please list all of the materials required for program implementation, including all manuals, handouts, media, etc. These are also the materials you should submit for review.
- A12. Training Required for Implementation:** Please indicate whether training is needed to implement the program or practice. If so, indicate whether it is required or optional, and describe the nature of the training and how much time it takes.
- A13. Program Costs:** Please itemize any costs for purchasing the program, materials, or related training. (Include only the costs of purchasing or learning to use the materials, not day-to-day implementation costs such as duplicating materials, paying staff members, buying media time, etc.) If none, please write "Not Applicable."
- A14. Access to Materials:** The BPR disseminates only information about programs, not program materials. Please indicate how interested parties can obtain materials if the program is approved. *Note:* materials must be accessible either through a website or contact person for programs to be approved for listing on the BPR.
- A15. Other Information:** Please provide any other background information that you think would be helpful to reviewers, for example, extent of implementation, accomplishments, recognitions, etc.

Part B: Assessment Criteria

To be listed in Section III of the BPR, program content is reviewed to assess its adherence to current program development standards and recommendations in the field. The questions in this section of the Application for Review correspond to the criteria used by reviewers to review and rate program content (see the BPR section of www.sprc.org to download the Application for Review.)

Section III Criteria

Each set of program materials is reviewed and rated on fifteen criteria organized into four categories:

- **Accuracy of Content** (1 criterion)
- **Likelihood of Meeting Objectives** (1 criterion)
- **Programmatic Guidelines:** based on the [AAS Guidelines for School-based Suicide Prevention Programs](#) (4 criteria)
- **Messaging Guidelines:** based on the [Safe and Effective Messaging Guidelines](#) (9 criteria)

Submitted materials will be reviewed by three suicide prevention experts. The fifteen criteria are rated on a scale of 1 (low) through 4 (high). Statements must receive an average score of 3 or greater on each applicable item to be listed on the BPR.

Is Compliance with All Criteria Required?

Some of the criteria are applicable to all programs; for example, every program must have accurate content and a strong likelihood of meeting objectives (criteria B1 and B2). However, because the programmatic and messaging guidelines were created for specific types of prevention efforts (school-based programs and awareness campaigns, respectively) some of the recommendations may not apply to particular programs or audiences. For example, not every media campaign will necessarily *list warning signs and risk and protective factors* (criterion B9), and this omission may make sense given the campaign's goals or audience. **Accordingly, programs will be rated based on the extent to which each applicable criterion follows the specified guidelines.** In other words, if warning signs and risk and protective factors are included in a program, the program must follow the recommended guidelines for presenting that information.

To allow reviewers to assess adherence to the Section III criteria, applicants are asked to indicate on their application whether each criterion is met, and if not, the rationale. For instance, there may be a variety of reasons for not listing risk and protective factors, e.g., the program objectives did not include increasing knowledge of these factors, or formative research showed that the intended audience already knew this information. The

Application for Review form is designed to allow applicants to explain to reviewers the applicability of each criterion and the extent to which their program complies. Specific instructions for addressing each individual item are provided below.

Applicants are encouraged to contact either of the BPR coordinators to discuss whether their program meets specific criteria or to ask any other questions that arise while completing the application form. Contact either Philip Rodgers (215-238-0407; prodgers@afsp.org) or Linda Langford (617-618-2719; llangford@edc.org).

Questions B1-B2: Accuracy of Content and Likelihood of Meeting Objectives

The first two criteria reflect general attributes of good prevention practice. All programs and practices listed on the BPR must meet these criteria.

Instructions for B1 and B2. For each question, indicate whether the criterion is met. You have the option of providing additional information or comments that reviewers may find helpful when rating your program on that criterion.

B1. Is program content accurate?

Required for BPR listing.

Factual claims and statistics should be based upon research findings and should be current.

B2. Are program objectives realistic and likely to be achieved?

Required for BPR listing.

If the program is implemented as intended, it should be likely that the short-term program objectives listed under Item A9 (sometimes called outputs) will be achieved. Objectives should be realistic given the content and intensity of the program.

Questions B3-B6: Programmatic Guidelines

These four questions address criteria related to program usability, safety, and implementation. The criteria listed below were adapted from a larger set of recommendations found in the *Guidelines for School-Based Suicide Prevention Programs* developed by the American Association of Suicidology and Dr. John Kalafat. The guidelines are available online at http://www.sprc.org/library/aasguide_school.pdf.

Instructions for B3-B4. These two criteria **are required** for all submitted programs and practices. For each question, please indicate whether the recommendations are met (Yes/No). If desired, provide any additional information or comments that reviewers may find helpful when rating your program on these criteria.

B3. Program objectives should be conceptually and empirically grounded.

Required for BPR listing.

Program goals and objectives should reflect relevant theory and/or research about suicide. Ideally, program developers will have created a clear program logic model* that specifies how the program activities achieve program goals or outcomes. If a logic model is available, applicants are encouraged to submit it with the application.

*For more information about program logic models, see:

http://www.sprc.org/featured_resources/trainingandevents/conferences/no/pdf/logicmodels.pdf

B4. Program materials should be clearly articulated and packaged for dissemination.

Required for BPR listing.

Program materials should be easy to understand and use. For example, education and training materials should include lesson outlines and plans, detailed instructor guidelines with talking points and common questions and answers, all handouts, and references for additional materials.

Instructions for B5-B6. These two criteria are **not required** for every program or practice; however, for some programs, meeting these criteria may be necessary to achieve program objectives.

For each question:

- Please indicate whether the recommendations are met (Yes/No) or are not applicable (N/A).
- For **all answers**, please **provide an explanation** for your response (if yes, explain how the program meets these recommendations; if *no* or *N/A*, please explain why these criteria are not addressed or not applicable to your program. Note that omission does not necessarily disqualify your program for BPR listing. See the section “Is Compliance with All Criteria Required?” on page 3 of this document.

B5. The program should address all pertinent organizational levels

Required if needed to achieve specified objectives.

In many cases, programs will achieve better results when supported by complementary efforts across multiple organizational levels or among organizations. For example, a school-based training for faculty and staff may be more successful if it includes consultation and training for administrators and/or institutional supports such as formal policies and protocols. Likewise, programs that emphasize referrals to services will be more effective when they include service providers in planning so they can be prepared to respond to inquiries from the target audience.

B6. The program should provide or recommend linkages to help resources.

Required if needed to achieve specified objectives.

Materials should provide information about how the targeted audience can readily access (or refer others) to sources of help. Examples might include providing contact information for the [National Suicide Prevention Lifeline](#) (1-800-273-TALK) or local agencies, identifying individuals in that setting who can be approached for help (professionals, trained gatekeepers, etc.), or providing contact information for a worksite Employee Assistance Program.

Questions B7-B15: Messaging Guidelines

These eight criteria address the safety of program content. They are drawn from the document [Safe and Effective Messaging for Suicide Prevention](#), an evidence-based list of “Do’s” and “Don’ts” for conveying information about suicide (available online at <http://www.sprc.org/library/SafeMessagingfinal.pdf>). The first four questions (B7-B10) address the “Do’s” and the last four questions (B11-B15) address the “Don’ts.”

As noted above, the messaging guidelines were created to guide the development of public awareness campaigns and therefore they may not apply to every type of program or audience. For example, while messages for general audiences should not normalize suicide by presenting it as a common event (criterion #B12), it may be appropriate to discuss the commonality of suicide ideation among patients admitted to emergency departments in materials created for physicians.

Instructions for B7-B10. These four criteria address the messaging “Do’s”—suggestions about what information to include or emphasize in public awareness campaigns. **Not every practice listed in the BPR is required to include all of this information; however, if the information is omitted, applicants are required to provide a rationale.** Note that omission does not necessarily disqualify your program for BPR listing. See the section “Is Compliance with All Criteria Required?” on page 3 of this document.

For each question:

- Please indicate whether the specified information is included by checking “Yes”, “No”, or “N/A” (Not Applicable).
- If the material is included (“Yes”), please indicate where in the materials reviewers can find the content (required) and provide any additional explanation you think the reviewers would find helpful (optional.)
- If it is not included (“No”) or not applicable (N/A), please provide a rationale for its omission.

B7. Do emphasize prevention.

Programs are not required to include this information; however, applicants should explain the rationale for its omission.

Recommendation: Reinforce the fact that there are preventative actions individuals can take if they are having thoughts of suicide or know others who are or might be. Emphasize that suicides are preventable and should be prevented to the extent possible.

B8. Do emphasize help-seeking and provide information on finding help.

Programs are not required to include this information; however, applicants should explain the rationale for its omission.

Recommendation: When recommending mental health treatment, provide concrete steps for finding help. Inform people that help is available through the National Suicide Prevention Lifeline (1-800-273-TALK [8255]) and through established local service providers and crisis centers.

B9. Do list the warning signs*, as well as risk and protective factors for suicide.**

Programs are not required to include this information; however, applicants should explain the rationale for its omission.

Recommendation: Teach people how to tell if they or someone they know may be thinking of harming themselves. Include lists of warning signs, such as those developed through a consensus process led by the American Association of Suicidology. Messages should also identify protective factors that reduce the likelihood of suicide and risk factors heighten risk of suicide.

* The consensus warning signs can be found at <http://www.suicidology.org/displaycommon.cfm?an=2>

** A list of risk and protective factors for suicide can be found at <http://www.sprc.org/library/srisk.pdf>

B10. Do highlight effective treatments for underlying mental health problems.

Programs are not required to include this information; however, applicants should explain the rationale for its omission.

Recommendation: 60-90 percent of those who die by suicide suffer from a significant psychiatric illness, substance abuse disorder or both at the time of their death. The impact of mental illness and substance abuse as risk factors for suicide can be reduced by access to effective treatments and strengthened social support in an understanding community.

Instructions for B11-B15. These four criteria address the messaging “Don’ts”—Practices that may be problematic in public awareness campaigns. **In most cases, practices listed in the BPR is should not include the types of content listed in this section; however, if the information is included, applicants are required provide a rationale.** Note that inclusion does not necessarily disqualify your program for BPR listing. See the section “Is Compliance with All Criteria Required?” on page 3 of this document.

For each question

- Please indicate whether the specified content is avoided by marking Yes (content is avoided) or No (content is not avoided.) A “Yes” answer means your program complies with the recommendation.
- If the material is avoided (Yes), no additional information is needed. However, please feel free to add any comments that you think the reviewers would find helpful.
- If the material *is* included (No), please provide a rationale for its inclusion.

B11. Don’t glorify or romanticize suicide or people who have died by suicide.

Programs generally should not include this information; however, if present, applicants should explain the rationale for its inclusion.

Recommendation: Vulnerable people, especially young people, may identify with the attention and sympathy garnered by individuals who have died by suicide. The decedents should not be held up as role models.

B12. Don't normalize suicide by presenting it as a common event.

Programs generally should not include this information; however, if present, applicants should explain the rationale for its inclusion.

Recommendation: Although significant numbers of people attempt suicide, it is important not to present the data in a way that makes suicide seem common, normal or acceptable. Most people do not seriously consider suicide an option; therefore, suicidal ideation is not normal. Most individuals, and most youth, who seriously consider suicide do not overtly act on those thoughts, but find more constructive ways to resolve them. Presenting suicide as a common event may unintentionally remove a protective bias against suicide in a community.

B13. Don't present suicide as an inexplicable act or explain it as a result of stress only.

Programs generally should not include this information; however, if present, applicants should explain the rationale for its inclusion.

Recommendation: Presenting suicide as the inexplicable act of an otherwise healthy or high-achieving person may encourage identification with the victim. Additionally, it misses the opportunity to inform audiences of both the complexity and preventability of suicide. The same applies to any explanation of suicide as the understandable response to an individual's stressful situation or to an individual's membership in a group encountering discrimination. Oversimplification of suicide in any of these ways can mislead people to believe that it is a normal response to fairly common life circumstances.

B14. Don't focus on personal details of people who have died by suicide.

Programs generally should not include this information; however, if present, applicants should explain the rationale for its inclusion.

Recommendation: Vulnerable individuals may identify with the personal details of someone who died by suicide, leading them to consider ending their lives in the same way.

B15. Don't present overly detailed descriptions of a suicide victim or methods of suicide.

Programs generally should not include this information; however, if present, applicants should explain the rationale for its inclusion.

Recommendation: Research shows that pictures or detailed descriptions of how or where a person died by suicide can be a factor in vulnerable individuals imitating the act. Clinicians believe the danger is even greater if there is a detailed description of the method.

Appendix 1: Resources

Logic Models

Logic models provide a coherent and logical outline of program implementation and anticipated effects. An introduction to logic models is available online at

http://www.sprc.org/featured_resources/trainingandevents/conferences/no/pdf/logicmodels.pdf

National Strategy for Suicide Prevention

The *National Strategy for Suicide Prevention* (NSSP) provides a comprehensive overview of suicide prevention. In addition, submissions for Sections II and III of the BPR must meet one or more specific NSSP goals and objectives. The full document is available online at <http://www.sprc.org/library/nssp.pdf>. A listing of the goals and objectives can be found at: <http://mentalhealth.samhsa.gov/publications/allpubs/SMA01-3517/appendixa.asp>.

Prevention Program Guidelines

The American Association of Suicidology and Dr. John Kalafat jointly produced *Guidelines for School-Based Suicide Prevention Programs*. Some of the guidelines were adapted to become BPR Section III programmatic guidelines. The guidelines are available online at

<http://www.suicidology.org/associations/1045/files/School%20guidelines.pdf>

Risk and Protective Factors for Suicide

One of the messaging guidelines recommends that public awareness campaigns include information about protective factors that reduce the likelihood of suicide and risk factors that heighten risk of suicide. A list of risk and protective factors can be found on the SPRC website at <http://www.sprc.org/library/srisk.pdf>.

Safe and Effective Messaging for Suicide Prevention

SPRC, with the help of Dr. Madelyn Gould, produced a list of messaging “Do’s and Don’ts”. This list provides a basis for the BPR Section III Messaging Guidelines. A summary of the “Do’s and Don’ts” is available online at

<http://www.sprc.org/library/SafeMessagingfinal.pdf>.

Suicide Statistics

Use of current statistics is an important aspect of program accuracy. The Centers for Disease Control and Prevention provides an interactive online database of injury and death statistics called the [Web-based Injury Statistics Query and Reporting System](http://www.cdc.gov/ncipc/profiles/nvdrs/default.htm) (WISQARS) where the latest national and state statistics on suicide can be found. States that are part of the National Violent Death Reporting System (NVDRS) may have available detailed information on suicide deaths. To find out whether your state is part of NVDRS, click here:

<http://www.cdc.gov/ncipc/profiles/nvdrs/default.htm>. For other sources of data and statistics, including the document “Finding Data on Suicidal Behavior”, see *Suicide Prevention Basics: Data* at http://www.sprc.org/suicide_prev_basics/data.asp.

Warning Signs for Suicide

One of the messaging guidelines recommends inclusion of suicide warning signs in public awareness campaigns. A list of [suicide warning signs](http://www.suicidology.org/displaycommon.cfm?an=2) was developed through a consensus process led by the American Association of Suicidology at <http://www.suicidology.org/displaycommon.cfm?an=2>. For a literature review and detailed description of the AAS-led consensus process, see: Rudd, M. D., Berman, A. L., Joiner, T. E., Jr., Nock, M. K., Silverman, M. M., Mandrusiak, M., et al. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior*, 36(3), 255-262.

Appendix 2: National Strategy for Suicide Prevention: Goals and Objectives

Goals and objectives can also be found at: <http://mentalhealth.samhsa.gov/publications/allpubs/SMA01-3517/appendixa.asp>

Section 1: Awareness

Goal 1. Promote Awareness that Suicide is a Public Health Problem that is Preventable

- Obj. 1.1: By 2005, increase the number of States in which public information campaigns designed to increase public knowledge of suicide prevention reach at least 50 percent of the State's population.
- Obj. 1.2: By 2005, establish regular national congresses on suicide prevention designed to foster collaboration with stakeholders on prevention strategies across disciplines and with the public.
- Obj. 1.3: By 2005, convene national forums to focus on issues likely to strongly influence the effectiveness of suicide prevention messages.
- Obj. 1.4: By 2005, increase the number of both public and private institutions active in suicide prevention that are involved in collaborative, complementary dissemination of information on the World Wide Web.

Goal 2. Develop Broad-Based Support for Suicide Prevention

- Obj. 2.1: By 2001, expand the Federal Steering Group to appropriate Federal agencies to improve Federal coordination on suicide prevention, to help implement the National Strategy for Suicide Prevention, and to coordinate future revisions of the National Strategy
- Obj. 2.2: By 2002, establish a public/private partnership(s) (e.g., a national coordinating body) with the purpose of advancing and coordinating the implementation of the National Strategy.
- Obj. 2.3: By 2005, increase the number of national professional, voluntary, and other groups that integrate suicide prevention activities into their ongoing programs and activities.
- Obj. 2.4: By 2005, increase the number of nationally organized faith communities adopting institutional policies promoting suicide prevention.

Goal 3. Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse and Suicide Prevention Services

- Obj. 3.1: By 2005, increase the proportion of the public that views mental and physical health as equal and inseparable components of overall health.
- Obj. 3.2: By 2005, increase the proportion of the public that views mental disorders as real illnesses that respond to specific treatments.
- Obj. 3.3: By 2005, increase the proportion of the public that views consumers of mental health, substance abuse, and suicide prevention services as pursuing fundamental care and treatment for overall health.
- Obj. 3.4: By 2005, increase the proportion of those suicidal persons with underlying mental disorders who receive appropriate mental health treatment.

Section 2: Intervention

Goal 4. Develop and Implement Community-Based Suicide Prevention Programs

- Obj. 4.1: By 2005, increase the proportion of States with comprehensive suicide prevention plans that a) coordinate across government agencies, b) involve the private sector, and c) support plan development, implementation, and evaluation in its communities.
- Obj. 4.2: By 2005, increase the proportion of school districts and private school associations with evidence-based programs designed to address serious childhood and adolescent distress and prevent suicide.
- Obj. 4.3: By 2005, increase the proportion of colleges and universities with evidence-based programs designed to address serious young adult distress and prevent suicide.
- Obj. 4.4: By 2005, increase the proportion of employers that ensure the availability of evidence-based prevention strategies for suicide.
- Obj. 4.5: By 2005, increase the proportion of correctional institutions, jails and detention centers housing either adult or juvenile offenders, with evidence-based suicide prevention programs.
- Obj. 4.6: By 2005, increase the proportion of State Aging Networks that have evidence-based suicide prevention programs designed to identify and refer for treatment of elderly people at risk for suicidal behavior.
- Obj. 4.7: By 2005, increase the proportion of family, youth and community service providers and organizations with evidence-based suicide prevention programs.
- Obj. 4.8: By 2005, develop one or more training and technical resource centers to build capacity for States and communities to implement and evaluate suicide prevention programs.

Goal 5. Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm

- Obj. 5.1: By 2005, increase the proportion of primary care clinicians, other health care providers, and health and safety officials who routinely assess the presence of lethal means (including firearms, drugs, and poisons) in the home and educate about actions to reduce associated risks.
- Obj. 5.2: By 2005, expose a proportion of households to public information campaign(s) designed to reduce the accessibility of lethal means, including firearms, in the home.
- Obj. 5.3: By 2005, develop and implement improved firearm safety design using technology where appropriate.
- Obj. 5.4: By 2005, develop guidelines for safer dispensing of medications for individuals at heightened risk of suicide.
- Obj. 5.5: By 2005, improve automobile design to impede carbon monoxide-mediated suicide. Obj. 5.6: By 2005, institute incentives for the discovery of new technologies to prevent suicide.

Goal 6. Implement Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment

- Obj. 6.1: By 2005, define minimum course objectives for providers of nursing care in assessment and management of suicide risk, and identification and promotion of protective factors. Incorporate this material into curricula for nursing care providers at all professional levels.
- Obj. 6.2: By 2005, increase the proportion of physician assistant educational programs and medical residency programs that include training in the assessment and management of suicide risk and identification and promotion of protective factors.
- Obj. 6.3: By 2005, increase the proportion of clinical social work, counseling, and psychology graduate programs that include training in the assessment and management of suicide risk, and the identification and promotion of protective factors.
- Obj. 6.4: By 2005, increase the proportion of clergy who have received training in identification of and response to suicide risk and behaviors and the differentiation of mental disorders and faith crises.
- Obj. 6.5: By 2005, increase the proportion of educational faculty and staff who have received training on identifying and responding to children and adolescents at risk for suicide.
- Obj. 6.6: By 2005, increase the proportion of correctional workers who have received training on identifying and responding to persons at risk for suicide.
- Obj. 6.7: By 2005, increase the proportion of divorce and family law and criminal defense attorneys who have received training in identifying and responding to persons at risk for suicide.
- Obj. 6.8: By 2005, increase the proportion of counties (or comparable jurisdictions such as cities or tribes) in which education programs are available to family members and others in close relationships with those at risk for suicide.
- Obj. 6.9: By 2005, increase the number of recertification or licensing programs in relevant professions that require or promote competencies in depression assessment and management and suicide prevention.

Goal 7. Develop and Promote Effective Clinical and Professional Practices

- Obj. 7.1: By 2005, increase the proportion of patients treated for self-destructive behavior in hospital emergency departments that pursue the proposed mental health follow-up plan.
- Obj. 7.2: By 2005, develop guidelines for assessment of suicidal risk among persons receiving care in primary health care settings, emergency departments, and specialty mental health and substance abuse treatment centers. Implement these guidelines in a proportion of these settings.
- Obj. 7.3: By 2005, increase the proportion of specialty mental health and substance abuse treatment centers that have policies, procedures, and evaluation programs designed to assess suicide risk and intervene to reduce suicidal behaviors among their patients.
- Obj. 7.4: By 2005, develop guidelines for aftercare treatment programs for individuals exhibiting suicidal behavior (including those discharged from inpatient facilities). Implement these guidelines in a proportion of these settings.
- Obj. 7.5: By 2005, increase the proportion of those who provide key services to suicide survivors (e.g., emergency medical technicians, firefighters, law enforcement officers, funeral directors, clergy) who have received training that addresses their own exposure to suicide and the unique needs of suicide survivors.
- Obj. 7.6: By 2005, increase the proportion of patients with mood disorders who complete a course of treatment or continue maintenance treatment as recommended.
- Obj. 7.7: By 2005, increase the proportion of hospital emergency departments that routinely provide immediate post-trauma psychological support and mental health education for all victims of sexual assault and/or physical abuse.
- Obj. 7.8: By 2005, develop guidelines for providing education to family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide. Implement the guidelines in facilities (including general and mental hospitals, mental health clinics, and substance abuse treatment centers).
- Obj. 7.9: By 2005, incorporate screening for depression, substance abuse and suicide risk as a minimum standard of care for assessment in primary care settings, hospice, and skilled nursing facilities for all Federally-supported healthcare programs (e.g., Medicaid, CHAMPUS/TRICARE, CHIP, and Medicare).
- Obj. 7.10: By 2005, include screening for depression, substance abuse and suicide risk as measurable performance items in the Health Plan Employer Data and Information Set (HEDIS).

Goal 8. Increase Access to and Community Linkages with Mental Health and Substance Abuse Services

- Obj. 8.1: By 2005, increase the number of States that require health insurance plans to cover mental health and substance abuse services on par with coverage for physical health.
- Obj. 8.2: By 2005, increase the proportion of counties (or comparable jurisdictions) with health and/or social services outreach programs for at-risk populations that incorporate mental health services and suicide prevention.
- Obj. 8.3: By 2005, define guidelines for mental health (including substance abuse) screening and referral of students in schools and colleges. Implement those guidelines in a proportion of school districts and colleges.
- Obj. 8.4: By 2005, develop guidelines for schools on appropriate linkages with mental health and substance abuse treatment services and implement those guidelines in a proportion of school districts.
- Obj. 8.5: By 2005, increase the proportion of school districts in which school-based clinics incorporate mental health and substance abuse assessment and management into their scope of activities.
- Obj. 8.6: By 2005, for adult and juvenile incarcerated populations, define national guidelines for mental health screening, assessment and treatment of suicidal individuals. Implement the guidelines in correctional institutions, jails and detention centers.
- Obj. 8.7: By 2005, define national guidelines for effective comprehensive support programs for suicide survivors. Increase the proportion of counties (or comparable jurisdictions) in which the guidelines are implemented.
- Obj. 8.8: By 2005, develop quality care/utilization management guidelines for effective response to suicidal risk or behavior and implement these guidelines in managed care and health insurance plans.

Goal 9. Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media

- Obj. 9.1: By 2005, establish an association of public and private organizations for the purpose of promoting the accurate and responsible representation of suicidal behaviors, mental illness and related issues on television and in movies.
- Obj. 9.2: By 2005, increase the proportion of television programs and movies that observe promoting accurate and responsible depiction of suicidal behavior, mental illness and related issues.
- Obj. 9.3: By 2005, increase the proportion of news reports on suicide that observe consensus reporting recommendations.
- Obj. 9.4: By 2005, increase the number of journalism schools that include in their curricula guidance on the portrayal and reporting of mental illness, suicide and suicidal behaviors.

Section 3: Methodology

Goal 10. Promote and Support Research on Suicide and Suicide Prevention

- Obj. 10.1: By 2002, develop a national suicide research agenda with input from survivors, practitioners, researchers, and advocates.
- Obj. 10.2: By 2005, increase funding (public and private) for suicide prevention research, for research on translating scientific knowledge into practice, and for training of researchers in suicidology.
- Obj. 10.3: By 2005, establish and maintain a registry of prevention activities with demonstrated effectiveness for suicide or suicidal behaviors.
- Obj. 10.4: By 2005, perform scientific evaluation studies of new or existing suicide prevention interventions.

Goal 11. Improve and Expand Surveillance Systems

- Obj. 11.1: By 2005, develop and refine standardized protocols for death scene investigations and implement these protocols in counties (or comparable jurisdictions).
- Obj. 11.2: By 2005, increase the proportion of jurisdictions that regularly collect and provide information for follow-back studies on suicides.
- Obj. 11.3: By 2005, increase the proportion of hospitals (including emergency departments) that collect uniform and reliable data on suicidal behavior by coding external cause of injuries, utilizing the categories included in the International Classification of Diseases.
- Obj. 11.4: By 2005, implement a national violent death reporting system that includes suicides and collects information not currently available from death certificates.
- Obj. 11.5: By 2005, increase the number of States that produce annual reports on suicide and suicide attempts, integrating data from multiple State data management systems.
- Obj. 11.6: By 2005, increase the number of nationally representative surveys that include questions on suicidal behavior.
- Obj. 11.7: By 2005, implement pilot projects in several States that link and analyze information related to self-destructive behavior derived from separate data systems, including for example law enforcement, emergency medical services, and hospitals.