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 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 sbernes@edc.org. If materials are not available electronically, they may be submitted by regular mail to Sarah Bernes, 1025 Thomas Jefferson Street, NW, Suite 700W, Washington, DC 20036.

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 coordinator (Sarah Bernes) 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. If you have questions, contact Sarah Bernes (202-572-5365, sbernes@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 the BPR coordinator to discuss whether their program meets specific criteria or to ask any other questions that arise while completing the application form. Contact Sarah Bernes (202-572-5365; sbernes@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 for Suicidology. Messages should also identify protective factors that reduce the likelihood of suicide and risk factors heighten risk of suicide.

* A summary of the consensus warning signs can be found at [http://www2.sprc.org/sites/sprc.org/files/AASWarningSigns_factsheet.pdf](http://www2.sprc.org/sites/sprc.org/files/AASWarningSigns_factsheet.pdf)


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

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**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.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf.

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 (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/ViolencePrevention/NVDRS/. 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
Appendix 2:
National Strategy for Suicide Prevention: Goals and Objectives

Goals and objectives can also be found at: http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities

GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.

Objective 1.1: Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.
Objective 1.2: Establish effective, sustainable, and collaborative suicide prevention programming at the state/territorial, tribal, and local levels.
Objective 1.3: Sustain and strengthen collaborations across federal agencies to advance suicide prevention.
Objective 1.4: Develop and sustain public-private partnerships to advance suicide prevention.
Objective 1.5: Integrate suicide prevention into all relevant health care reform efforts.

GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.

Objective 2.1: Develop, implement, and evaluate communication efforts designed to reach defined segments of the population.
Objective 2.2: Reach policymakers with dedicated communication efforts.
Objective 2.3: Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.
Objective 2.4: Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.

GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.

Objective 3.1: Promote effective programs and practices that increase protection from suicide risk.
Objective 3.2: Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.
Objective 3.3: Promote the understanding that recovery from mental and substance use disorders is possible for all.

GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.

Objective 4.1: Encourage and recognize news organizations that develop and implement policies and practices addressing the safe and responsible reporting of suicide and other related behaviors.
Objective 4.2: Encourage and recognize members of the entertainment industry who follow recommendations regarding the accurate and responsible portrayals of suicide and other related behaviors.
Objective 4.3: Develop, implement, monitor, and update guidelines on the safety of online content for new and emerging communication technologies and applications.
Objective 4.4: Develop and disseminate guidance for journalism and mass communication schools regarding how to address consistent and safe messaging on suicide and related behaviors in their curricula.

Strategic Direction 2: Clinical and Community Preventive Services

GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.

Objective 5.1: Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.
Objective 5.2: Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.
Objective 5.3: Intervene to reduce suicidal thoughts and behaviors in populations with suicide risk.
Objective 5.4: Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.

**GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.**

Objective 6.1: Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.
Objective 6.2: Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.
Objective 6.3: Develop and implement new safety technologies to reduce access to lethal means.

**GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.**

Objective 7.1: Provide training on suicide prevention to community groups that have a role in the prevention of suicide and related behaviors.
Objective 7.2: Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.
Objective 7.3: Develop and promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.
Objective 7.4: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.
Objective 7.5: Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.

**Strategic Direction 3: Treatment and Support Services**

**GOAL 8. Promote suicide prevention as a core component of health care services.**

Objective 8.1: Promote the adoption of “zero suicides” as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.
Objective 8.2: Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.
Objective 8.3: Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.
Objective 8.4: Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.
Objective 8.5: Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.
Objective 8.6: Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.
Objective 8.7: Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.
Objective 8.8: Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid followup after discharge.

**GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.**

Objective 9.1: Adopt, disseminate, and implement guidelines for the assessment of suicide risk among persons receiving care in all settings.
Objective 9.2: Develop, disseminate, and implement guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk.
Objective 9.3: Promote the safe disclosure of suicidal thoughts and behaviors by all patients.
Objective 9.4: Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for persons with suicide risk.
Objective 9.5: Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among patients receiving care for mental health and/or substance use disorders.
Objective 9.6: Develop standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs.
Objective 9.7: Develop guidelines on the documentation of assessment and treatment of suicide risk and establish a training and technical assistance capacity to assist providers with implementation.

GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

Objective 10.1: Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide, and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.
Objective 10.2: Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.
Objective 10.3: Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.
Objective 10.4: Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.
Objective 10.5: Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.

Strategic Direction 4: Surveillance, Research, and Evaluation

GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

Objective 11.1: Improve the timeliness of reporting vital records data.
Objective 11.2: Improve the usefulness and quality of suicide-related data.
Objective 11.3: Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.
Objective 11.4: Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.

GOAL 12. Promote and support research on suicide prevention.

Objective 12.1: Develop a national suicide prevention research agenda with comprehensive input from multiple stakeholders.
Objective 12.2: Disseminate the national suicide prevention research agenda.
Objective 12.3: Promote the timely dissemination of suicide prevention research findings.
Objective 12.4: Develop and support a repository of research resources to help increase the amount and quality of research on suicide prevention and care in the aftermath of suicidal behaviors.

GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

Objective 13.1: Evaluate the effectiveness of suicide prevention interventions.
Objective 13.2: Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.
Objective 13.3: Examine how suicide prevention efforts are implemented in different states/territories, tribes, and communities to identify the types of delivery structures that may be most efficient and effective.
Objective 13.4: Evaluate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.