

**Community Health Needs Assessment**  
***Suicide Attempt Survivor***  
***Support Resources***  
***in Southeastern Pennsylvania***



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Information presented in this report may be triggering to some people. If this occurs or if you are having thoughts of suicide, please call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or text HOME to 74174 to reach the national Crisis Text Line. Both of these resources are available 24/7.

You may also call any of the following crisis services in SE PA 24/7:

*Bucks County*

Lenape Valley Foundation - 800-499-7455

*Chester County*

Valley Creek Crisis Center - 877-918-2100

*Delaware County*

Crozer Chester Medical Center Crisis - 610-447-7600

Crisis Connections - 855-889-7827

*Montgomery County*

MCES - 610-279-6102

ACCESS Mobile Crisis - 1-855-634-HOPE (4673)

*Philadelphia County*

Northeast Philadelphia - 215-831-2600

Northwest Philadelphia - 215-951-8300

North Philadelphia - 215-707-2577

Center City/South Philadelphia - 215-829-5249

West/Southwest Philadelphia - 215-748-8525

***If you or someone that you know is in imminent danger of attempting suicide call 911 immediately.***

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## **Community Health Needs Assessment**

### **Suicide Attempt Survivor Support Resources in Southeastern Pennsylvania**

#### **EXECUTIVE SUMMARY**

Individuals who have made a suicide attempt have the highest risk of dying by a subsequent suicide attempt. A suicide attempt may occur when an at-risk person develops a strong desire to die, has a plan and lethal means to bring about his death, and has overcome any protective factors and the inborn resistance to engage in potentially fatal self-harm. A suicide attempt is a traumatic event even when it results in little or no self-injury. Those who survive a suicide attempt need both professional treatment and support in recovering from the attempt and coping with the stigma, guilt, shame, and other negative sentiments that may follow an attempt. A significant number of MCES admissions involve individuals who have made or tried to make a suicide attempt.

MCES undertook an assessment of the availability of support resources in southeastern Pennsylvania. Only two support groups for persons troubled by suicidal thoughts exist in the region, one in Bucks County and another in Montgomery County. An online group for suicide attempt survivors will accept participants from other counties. MCES explored the need for suicide attempter support with stakeholders in the region and all acknowledged the need as critical and contributing to ongoing suicide risk. MCES also conducted surveys with inpatients, Carol's Place clients, and online. The majority of respondents confirmed the need for suicide prevention groups in psychiatric hospitals, a 24/7 peer-led warm line for persons dealing with suicidal thoughts, and the formation of suicide attempter support groups in each county in the region.

## STUDY BACKGROUND AND PURPOSE

In 2001, the *National Strategy for Suicide Prevention: Goals and Objectives for Action* included an objective calling for developing guidelines for aftercare treatment of individuals exhibiting suicidal behavior. In 2005, the First National Conference for Survivors of Suicide Attempts (SOSAs), Health Care Professionals, and Clergy and Laity offered these recommendations on enhancing service availability for persons who had survived suicide attempts:

- Key providers of community-based services must include primary and specialized mental health treatment providers as well as clerics and lay members of faith-based organizations.
- The support and treatment resources we provide to survivors of suicide attempts must be developed and sustained in ways that provide a stigma-free system of aftercare.
- These resources also must focus on integrating SOSAs within a strengthened network of social and community-based supports. Other resources, such as attempt survivor support groups, are needed as effective means of mitigating the risk of suicidal behaviors among those who engage in serial suicide attempts.

These objectives and recommendations have been echoed in many subsequent suicide prevention plans and calls for action. This includes *Pennsylvania Statewide Suicide Prevention Plan (2020)*: “Promote care coordination between hospitals, crisis, behavioral health providers, families, and community settings to support suicide attempt survivors and their families.”

The present study looks at the availability and unavailability of resources in Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties for persons who have made or tried to make a suicide attempt. It was undertaken by Montgomery County Emergency Service (MCES) as a nonprofit psychiatric hospital to satisfy the requirement of the Affordable Care Act to conduct community health needs assessment identify and prioritize the significant health needs of the community it serves every three years.

*“The most glaring gap in the present system of treating suicide attempters seems to be a lack of follow-up and continuity of treatment.”*

*Welu (1977)*

*“Because attempted suicide is the greatest known risk factor for completed suicide, reducing suicide attempts is an important public health and clinical goal.”*

*Olfson, Blanco, Wall, Liu, Saha et al (2017)*

## SUICIDE INCIDENCE IN SOUTHEASTERN PENNSYLVANIA

Insofar as every suicide fatality involves a suicide attempt, it may be helpful to look at the incidence of fatal suicide attempts in the region.

As reported by the Pennsylvania Department of Health, there were 9769 deaths in the state in the five year period 2015 to 2019 in which the cause of death was intentional self-harm or suicide. For that period, there were an average of 1954 suicides statewide yearly.

Reported suicides in the five-county region of southeastern Pennsylvania for 2015-2019 were as follows:

County	Total	%	Age Adjusted Rate
Bucks	443	17.7	12.8/100,000
Chester	336	13.4	12/1/100,000
Delaware	379	15.2	12.3/100,000
Montgomery	547	21.9	12.4/100,000
Philadelphia	794	31.8	10.0/100,000
Total	2499	100.0	

There are an average of 500 reported suicides per year in the five-county region, which accounts for about one-fourth of all suicides in the state. More than one-half of the suicide deaths in the region over the five-year period occurred in Philadelphia and Montgomery Counties. The former accounted for just under one-third of all suicides in the region; the latter experience over one-fifth of all regional suicides for the period.

## INDIVIDUAL AND ORGANIZATIONS CONSULTED IN STUDY PLANNING

MCES sought input on this study from both internal and outside sources. Sources were contacted in person; by e-mail and telephone on issues such as study scope, data sources, and questionnaire design. The following individuals provided suggestions or advice.

Individual	Affiliation
Donna Ambrogi, MSN (Ret.)	Eagleview Hospital
Brian Barber, PhD	Montgomery County Emergency Service
Genevieve Bartuski, PsyD	Southwestern Virginia Mental Health Institute
Marina Cooney, MD	Montgomery County Emergency Service
Ruth Deming, MGPGP	New Directions Support Group
Emily Ferris	Magellan Behavioral Health of Pennsylvania
Paul De Marco	Montgomery County Commitment Office
Terri Erbacher, PhD	Philadelphia College of Osteopathic Medicine
Jess Fenchel	Access Services
Abby Grasso	NAMI-Montgomery County
Erin Hewitt	Montgomery Co. Dept. of Health and Human Services
Garra Lloyd-Lester	NY State Suicide Prevention Center
Govan Martin	Suicide Prevention Alliance, Inc.
Dave McKeighan	Chester County Medical Society
Gabriel Nathan	Suicide Prevention Activist/OCD87
Craig Oliver	Penn Foundation
Susan Shannon	Hopeworx, Inc.
Anna Trout, MSW, CPRP	Montgomery Co. Dept. of Health and Human Services
Dese'Rae L. Stage	Suicide Prevention Activist/livethroughthis.org
Moira Tumelty	Access Services
Matthew Wintersteen, PhD	Thomas Jefferson University/Prevent Suicide PA

In addition, the study was discussed at meetings of the following groups:

- Managing Agencies for Excellence (MAX) Behavioral Health Committee
- Montgomery County Suicide Prevention Task Force
- Montgomery County Community Support Program (CSP)

MCES appreciates the cooperation that these individuals provided in planning or carrying out the study. MCES is solely responsible for the content of this report.

## ROLE OF ATTEMPT POSTVENTION IN SUICIDE PREVENTION

The public health view of prevention consists of three levels. Primary prevention works to deter the problem. Secondary prevention works to identify the emerging problem and try to stop its progression. Tertiary prevention involves treating the problem and deterring its recurrence. This figure applies the public health model to suicide attempt prevention:

Prevention	Intervention	Postvention
Averting occurrence of a suicide attempt by: <ul style="list-style-type: none"> <li>• Managing specific risk attempt factors</li> <li>• Enhancing protective factors for attempts</li> </ul>	Averting suicide attempt by: <ul style="list-style-type: none"> <li>• Identifying and assessing suicide risk</li> <li>• Crisis counseling and referral</li> </ul>	Averting suicidality recurrence by: <ul style="list-style-type: none"> <li>• Providing post-attempt support</li> <li>• Providing post-attempt therapy</li> </ul>

There is little programming to enhance safety from behavior that may result in a suicide attempt. Most suicide attempt prevention actually involves direct efforts to dissuade or deter a person felt to be in imminent danger of making a suicide attempt from doing so. This is most often accomplished by hot lines, crisis centers, and mobile crisis teams, and police officers. The last level of suicide prevention is facilitating the recovery of a person experiencing a suicide loss or surviving a suicide attempt. The latter is known as postvention and is the focus of this study.

Making or trying to make a suicide attempt is a traumatic event. Protective factors have failed, risk factors are strong, intent to die is severe, a doable plan and lethal means are on hand, and resistance to potentially fatal self-injury has been overcome. If a suicide attempt does not proceed, or if it is survived, many of the prerequisites remain. Only intent may subside. Ongoing suicide risk is very high. Protective factors remain weak. Suicide plans may stay in mind and the means may continue to be available or accessible. Coming to the brink of ending one's life weakens resistance to do so again if the circumstances fomenting the suicide risk again occur.

An attempt survivor must contend with other issues. The negative life events or problems that precipitated the progression of the attempt survivor's suicidality may persist or return. Stressors such as loss, abuse, chronic illness or pain, disability, substance abuse, mental illness, financial or housing insecurity, interpersonal conflict, social isolation, and criminal justice involvement do not subside after a suicide attempt. Feelings of hopelessness, , guilt and shame that may accrue after a suicide attempt can make the situation worse.



Perhaps the most deleterious and compelling impediment to recovery from a suicide attempt is the stigma the individual may feel from others. While a suicide attempt is often the result of an individual being overwhelmed by events in her or his life that she or he cannot control and which have overcome their coping ability, others may see it as selfishness, attention seeking, an effort at manipulation, or a sign of weakness. In some cases, the self-stigma that may be self-inflicted. Feelings of stigma may be greater when there have been multiple attempts.

Many suicide attempts result in voluntary or involuntary treatment in a psychiatric inpatient unit or a psychiatric hospital. An involuntary hospitalization is traumatizing and may cause the individual to feel angry and betrayed, suspicious of those who might be sources of support, and less likely to follow the aftercare plan provided at discharge. The days and weeks immediately after a psychiatric hospitalization, even when not related to suicidality, is a period of high risk for suicide. This is because the stabilization and safety provided by the hospital are removed and psychosocial and environmental stressors reassert themselves.

It is the role of postvention to address the challenges that someone contending with the aftermath of an effort to try to die by suicide or surviving a deliberate suicide attempt.

Postvention can come from various sources and may include:

- Information and education about suicide risk and suicide attempts
- Self-help and self-care measures to deter the onset of suicidal thoughts
- A personal safety plan to use if a suicide crisis occurs

## SUICIDE ATTEMPTS AS A COMMUNITY HEALTH PROBLEM

The Centers for Disease Control and Prevention defines a suicide attempt as “A non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in injury. In 2019, the National Survey on Drug Use and Health (NSDUH) found that 0.6% of adults age 18 and older, 1.4 million persons, in the United States reported they attempted suicide in in the past year. Among adults across all age groups, the prevalence of suicide attempt in the past year was highest among young adults 18-25 years old (1.8%). Among adults age 18 and older, the prevalence of suicide attempts in the past year was highest among those who report having multiple (two or more) races (1.5%).

A CDC study of 1.2 million “suicidal acts” treated in emergency departments and hospitals found an increase in incidence of such acts in females and in adults ages 65-74 and an increase in the lethality of the act in adults ages 20-64 between 2006 and 2015.

The national Youth Risk Behavior Survey (YRBS) found that in 2019, 8.9% of youths interviewed in 9<sup>th</sup> to 12<sup>th</sup> grade made one or more suicide attempts in the twelve months before the survey. Medical treatment was necessary in 2.5% of the suicide attempts reported by youths in the survey. The Pennsylvania Youth Survey reported that one in ten youths in the state attempted suicide in 2017. The American Association for Suicidology (AAS) estimates that there is a suicide attempt every 26.6 seconds in the United States.

Data for suicide attempts in general is not available at the state or national levels. The Injuries in Pennsylvania Report issued by the Pennsylvania Department of Health presents the following data for 2014 (most recent data) for acute hospital discharges for intentional self-injuries, many of which were suicide attempts requiring inpatient medical treatment:

- Statewide 8524
- Bucks County 324
- Chester County 243
- Delaware County 347
- Montgomery County 437
- Philadelphia County 1014

This indicates that the five-county region accounts for almost 28% of medically serious intentional self-injuries in Pennsylvania requiring hospital treatment.

According to the American Foundation for Suicide Prevention (AFSP), it is generally accepted that there are at least 25 suicide attempts for every death by suicide. This can be used to derive a rough approximation of the total suicide attempts in the state (47,175) and in the region (13,050) in 2019.

## **SUICIDE ATTEMPTS ARE A HIGH PRIORITY COMMUNITY HEALTH PROBLEM**

A suicide attempt may be thought of as the behavior that may immediately precede and bring about a suicide fatality. It involves all of the elements of a suicide except death. These include the intent to die, a plan for how, where, and when, and the means to be used to take one's life. A suicide attempt survivor is an individual who had intent to die, a plan for bringing about her or his death at a specific time and place, and the means to do so, but for some reason, did not die as intended, planned, and acted.

Of the components of a suicide attempt that did not end in death, intent to die is both the most serious and transient. It may subside on its own or as the result of intervention or treatment. A suicide plan once conceived and means once selected are more durable. Plans remain available and may be revisited if intent returns. A suicide plan and means may also become more lethal.

A suicide attempt that did not become a suicide is the strongest risk factor for a subsequent attempt and suicide. The AFSP advises that between 25% and 50% people who kill themselves had previously attempted suicide. Those who have made suicide attempts are at higher risk for actually taking their own lives. While most who survive a suicide attempt do not re-attempt, they remain at high risk, some very high. Of suicide attempt survivors who required treatment in a hospital, about 5% to 11% go on to die by suicide.

The Interpersonal Psychological Theory (IPPT) of suicide is the prevalent theoretical model of suicide and has been supported by research across various populations. It posits that a potentially lethal suicide attempt may occur when an individual has both an intense desire to die and the ability to take her or his life. Intent may arise from a sense that one is socially disconnected from significant others or is a burden to them and that they will be better off if one were dead. The capability for a suicide attempt is achieved when one does not fear dying and has overcome the inborn resistance to self-directed death. This may come about in various ways but perhaps the most effective is by making a suicide attempt. Resistance to dying by one's own hand weakens with each attempt.

A key tenet of the IPPT and related theories is that a suicide attempt is not primarily the product of an impulsive decision. Impulsivity makes an attempt more likely but most often it is the outcome of a process of psychosocial debilitation. The factors driving this process do not necessarily abate with the attempt, even when the intent to die is lessened. One of the most dangerous myths of suicide is the belief that surviving a suicide attempt indicates a lack of intent to die. This misconception ignores the reality that intent may be rekindled by subsequent life circumstances and/or misperceptions of one's value to others, may rejoin the strengthened acquired ability to die by suicide, and restart the downward process towards an attempt.

## SELECTED RESEARCH FINDINGS ON SUICIDE ATTEMPT SURVIVORS

Key findings from recent studies of suicide attempt survivors' postvention needs and preferences, impediments to access to mental health services and recommended changes:

- A first suicide attempt creates high risk for suicide; the great majority of completed suicides occur within a year of the first attempt, hospitalization following the attempt, as well as a scheduled follow-up visit with a psychiatrist significantly, reduced that risk.
- Persons who made suicide attempts had disproportionately elevated risk because of high levels of economic insecurity associated with unemployment and low income and educational attainment.
- Persons who have made a suicide attempt are may not disclose it to avoid stigma. Responding to anticipated suicide stigma was found to be significantly associated with increased suicidality in attempt survivors.
- Persons who have made a suicide attempt want practical information countering stigma, addressing negative community attitudes towards suicide, and promoting hope. Personal stories of recovery by attempt survivors were identified as very useful.
- Person who have made a suicide attempt and treated in a hospital emergency department provide family information but collateral contacts may not be made and when they are family members are not always given written information on resources.
- Persons who made suicide attempts and participated in a Survivors of Suicide Attempts peer-led support group for 8-weeks offering peer discussion and information sharing had a decrease in suicidality and hopelessness and a significant increase in resilience.
- Persons who made suicide attempts and who were treated in an emergency psychiatric unit received follow-up telephone calls from a psychiatric nurse at 8, 30, and 60 days within one year after discharge made fewer subsequent attempts.
- Low social support was strongly associated with suicide attempts among low-income African American men and women treated at a large, urban hospital. Greater availability of social supports can be a protective factor for suicide attempts in this population.
- Persons who made suicide attempts and who were associated with a suicide education advocacy project reported a high degree of engagement with mental health services but experienced stigma, loss of autonomy, issues with assessment and medication.

- Persons who made suicide attempts and utilized available mental health services reported dissatisfaction with outpatient and inpatient treatment. Most recommended that being able to connect with persons with lived experience would be helpful.
- Persons who made suicide attempts who are members of gender and sexual minorities reported severe stigma and hopelessness after their attempts. They identified a need for peer support to enhance their recovery and reduce the risk of future attempts.
- Two-thirds of persons who made a recent suicide attempts surveyed as part of the National Epidemiological Survey on Alcohol and Related Conditions had a diagnosis of borderline personality disorder and experienced negative provider attitudes.
- Persons who made suicide attempts in a South African study voiced a desire for mental health services addressing suicide risk and deterring suicidal behavior, teaching self-help strategies and promoting social connectiveness and support.
- A study of psychiatric inpatients who had made suicide attempts found that those who had made only one attempt reported less social support than those who had made multiple attempts suggesting that support may be a buffer against further attempts.
- Persons who made planned suicide attempts manifest distinct suicide-related clinical characteristics that are severe and warrant early, targeted intervention and long-term follow-up by treatment providers.

## STUDY DESIGN AND METHODOLOGY

The study was generally qualitative in nature and loosely involved a mixed methods approach including the following activities:

- Consultation with groups and organizations involved with suicide prevention, crisis intervention, and mental health advocacy to determine interest in the topic. A one-page outline of the proposed study was distributed by e-mail to prospective stakeholders in the 5-county region.
- Review of research articles reporting the need for support by suicide attempt survivors or findings relevant to this topic.
- Review of the literature describing support resources (e.g., peer support, peer-led groups) for suicide attempt survivors
- Identifying existing suicide attempt support resources in SE PA by surveying health and behavioral health providers serving individuals who have made suicide attempts.
- Consultation with a focus group of individuals with lived experience of a suicide attempt or an interest in developing supports for suicide attempt survivors
- Surveying individuals in SE PA who identified as suicide attempt survivors or who had felt at risk of making a suicide attempt to determine the type of support resources they feel best supports the needs of persons recovering from a suicide attempt. A copy of the questionnaire is in the Appendices.

## SUICIDE ATTEMPT SUPPORT NEEDS SURVEY

### Summary:

- Majority of respondents do not feel that mental health services do enough to help suicidal persons
- Majority of respondents feel there is a need for a suicide attempters support group
- Majority of respondents would seek help from a peer specialists with lived experience of a suicide attempt
- Majority of respondents felt that should be a warm line for persons having thoughts of suicide
- Majority of respondents would seek help from a family member, other trusted person, a peer specialist, or a peer-led resource if having thoughts of making a suicide attempt
- All respondents feel that psychiatric hospitals should have inpatient suicide prevention groups
- Great majority of respondents acted in some way to make a suicide attempt
- Almost three-fourths of respondents made two or more suicide attempts
- Most respondents who made a suicide attempt sought medical help
- Almost one-half of respondents who made attempt had thoughts of suicide in the past and over one-third had frequent thoughts of suicide

### 1. Do mental health services offer enough help for suicidal persons?

Strongly Agree	2	5.35
Agree Somewhat	4	10.5%
Strongly Disagree	20	52.6%
Agree Somewhat	12	31.6%

### 2. Do you feel there is a need for a support group to help persons who have made suicide attempts?

Yes	36	94.7%
No	0	-
DK	2	5.3%

### 3. Would you seek help from a peer specialist who had experienced a suicide attempt if one were available?

Definitely Would	19	50.0%
Probably Would	10	26.3%
Probably Would Not	7	18.4%
Definitely Would Not	0	-

4. Do you think that there should be a 24/7 peer warm line for persons with thoughts of suicide?

Yes	34	89.5%
No	1	2.6%
DK	3	7.9%

5. What would you do to get help if you had thoughts of making a suicide attempt?

Family Member, Friend, Other Trusted Person	10	26.3%
Peer Specialist or Other Peer-led Resource	9	23.7%
Use W.R.A.P. or Safety Plan	3	7.9%
Hot Line, Crisis Center, Mobile Crisis Team	8	21.0%
Hospital Emergency Department	6	15.8%

6. Should psychiatric hospitals have suicide prevention groups for current patients?

Strongly Agree	25	65.8%
Agree	13	34.2%
Strongly Disagree	0	-
Disagree	0	-

7. Have you ever made a suicide attempt, i.e., wanted to die and did something to try to end your life?

Yes	33	86.8%
No	5	13.2%

8. If yes, how many suicide attempts have you made?

One	9	27.3%
Two to four	19	57.6%
Five or more	4	12.1%

9. If yes, did you ever require medical treatment for hurting yourself in a suicide attempt?

Received care at a hospital/healthcare provider	24	72.7%
Did not seek medical treatment	5	15.1%
Did not need medical treatment	4	12.1%

10. If yes, have you ever had thoughts of making a suicide attempt or making another attempt?

Have had thoughts in the past	16	48.5%
Have frequent thoughts	12	36.4%
Have not had any thoughts	5	15.1%



## **SUPPORT RESOURCES IN SOUTHEASTERN PENNSYLVANIA**

An internet search and inquiries to stakeholders did not identify any community-based support groups or other resources in the region with the explicit mission or purpose of aiding or supporting suicide attempt survivors. The following resources offering help to persons troubled by suicidal thoughts and behaviors are presently available in the five-county area. At the time of this writing, all groups are meeting online because of COVID-19.

### **Bucks County**

Alternatives to Suicide Peer-to-Peer Support Group: Sponsored by NAMI Bucks County. Meets 2<sup>nd</sup> and 4<sup>th</sup> Tuesdays and every Saturday. “The opportunity to talk openly about suicide and feelings of deep emotional distress with others who have or are experiencing similar struggles.”

### **Chester County**

None located

### **Delaware County**

None located

### **Montgomery County**

Alternatives to Suicide Peer-to-Peer Support Group: Program of Resources for Human Development initiated in March 2019, hosting weekly meetings in Abington, PA, where individuals can discuss and explore suicidal thoughts and feelings.

### **Philadelphia County**

None located

### **Regional**

AFSP of Greater Philadelphia includes the page “I’ve survived a suicide attempt” on its website at <https://afsp.org/after-an-attempt> offering information for suicide attempt survivors.

## THE NATIONAL SUICIDE PREVENTION LIFELINE AS A RESOURCE

MCES has been part of the National Suicide Prevention Lifeline since 2014. We frequently receive on the Lifeline are from individuals who feel at risk of making a suicide attempt. There are now three other Lifeline call centers in SE PA. How can this availability and accessibility be used to optimally serve suicide attempt survivors and others at risk of suicidal behavior? A 2007 publication, **Lifeline Service and Outreach Strategies Suggested by Suicide Attempt Survivors**, offers several recommendations that are still timely:

- Crisis line workers should recognize that attempt survivors who are struggling with thoughts of suicide often feel immobilized. Just calling the hotline is a big step. Therefore, working with a caller to develop a plan—including encouraging him/her to call back and report on progress—will have helped the person substantially.
- Follow-up calls for attempt survivors would be both welcome and beneficial. Primarily, helping survivors set “achievable goals” and empowering them to facilitate their own linkages to services would be most helpful. The crisis line worker could then follow-up with the caller to see how the call went.
- The Lifeline should offer resources dealing with the issue of isolation and opportunities for callers to become involved in groups or organizations in their communities.
- Some “suicide prevention lines” only serve persons who are suicidal. Suicide prevention lines, such as the Lifeline, should serve not only imminently suicidal persons but also persons in emotional distress, to help them before they are in danger.
- The Lifeline should engage peers (i.e., attempt survivors) to be “mentors” for persons who have recently attempted suicide, providing understanding, support, and hope.
- When people call, they need is warmth and compassion, not someone who is going to take information quickly and then move to an intervention as quickly as possible. If a survivor believes the person answering the call is taking a clinical position, they will likely hang up, stop talking, or not tell the truth about what is going on.
- Crisis line workers should be direct, talk about suicide, and not hide it under other things such as depression.

Full or part-time crisis workers primarily trained and experienced in mental health crisis intervention staff three of the four Lifeline centers in SE PA, including MCES. Some of these recommendations suggest that suicide attempt postvention should be added to their skill set.

## RECOMMENDATIONS

1. The county suicide prevention task forces in region or other appropriate stakeholder should facilitate the formation of a suicide attempters support group in their respective counties.
2. The county suicide prevention task forces in Chester, Delaware, and Philadelphia Counties or other appropriate stakeholder should facilitate the formation of an Alternatives to Suicide Peer-to-Peer Support Group in their respective county.
3. Freestanding psychiatric hospitals and psychiatric units at community hospitals in the region should initiate voluntary inpatient suicide prevention groups for their inpatients.
4. Freestanding psychiatric hospitals should include information for patients and family members on dealing with thoughts of suicide and resources for suicide attempt survivors in the discharge packets required by The Joint Commission.
5. Certified Peer Specialists in the region should receive training to enable them to provide peer counseling to persons seeking their help with thoughts of suicide or other suicidal behavior.
6. The county suicide prevention task forces in region or other appropriate stakeholder should facilitate the expansion of peer-led warm lines to offer support 24/7 to persons having thoughts of suicide.
7. Create a State Suicide Attempt Survivor web site in Pennsylvania.

Here are examples from other states:

Suicide Prevention: attempt survivors | Mass.gov <https://www.mass.gov/info-details/suicide-prevention-attempt-survivors>

FL Department of Children and Families <https://www.myflfamilies.com/service-programs/samh/prevention/suicide-prevention/suicide-attempt-survivors.shtml>

Attempt Survivors : Lifeline (suicidepreventionlifeline.org)  
<https://suicidepreventionlifeline.org/help-yourself/attempt-survivors/>

Survivors of Suicide Attempt — South Dakota Suicide Prevention (sdsuicideprevention.org) <https://sdsuicideprevention.org/survivors/survivors-of-suicide-attempt/>

## SELECTED RESOURCES FOR ATTEMPT SURVIVORS

This listing is not exhaustive and is for information only. Inclusion does not imply endorsement.

### Support Groups Development

*Manual for Support Groups for Suicide Attempt Survivors.* Didi Hirsch Mental Health Services, [https://didihirsch.org/wp-content/uploads/Manual\\_for\\_Support\\_Groups\\_for\\_Suicide\\_Attempt\\_Survivors.pdf](https://didihirsch.org/wp-content/uploads/Manual_for_Support_Groups_for_Suicide_Attempt_Survivors.pdf)

*Support Group Facilitation Guide.* Mental Health America. <https://www.mhanational.org/sites/default/files/MHA%20Support%20Group%20Facilitation%20Guide%202016.pdf>

### Self-help Guides

“A Guide for Taking Care of Yourself after your Treatment in the Emergency Department.” SAMHSA. <https://store.samhsa.gov/product/A-Guide-for-Taking-Care-of-Yourself-After-Your-Treatment-in-the-Emergency-Department/SMA18-4355ENG>

*A Journey Toward Health and Hope: Your Handbook for Recovery After a Suicide Attempt.* SAMHSA. <https://suicidology.org/wp-content/uploads/2019/06/HandbookForRecoveryAfterAttemptSAMHSA.pdf>

"Now Matters Now" Ursula Whiteside. Teaches specific emotion regulation skills. [https://www.youtube.com/watch?v=JV81fmuvqoI&list=UU\\_NQ14VoXhmabaSZ4RWgKWw](https://www.youtube.com/watch?v=JV81fmuvqoI&list=UU_NQ14VoXhmabaSZ4RWgKWw)

*Toolkit for People who have been Impacted by a Suicide Attempt.* Mental Health Commission of Canada, Ottawa, ON. [https://www.mentalhealthcommission.ca/sites/default/files/2018-05/suicide\\_attempt\\_toolkit\\_eng.pdf](https://www.mentalhealthcommission.ca/sites/default/files/2018-05/suicide_attempt_toolkit_eng.pdf)

### Web Sites

“After an Attempt” AFSP. <https://afsp.org/after-an-attempt>

“After a Suicide Attempt” Beyond Blue. <https://www.beyondblue.org.au/the-facts/suicide-prevention/after-a-suicide-attempt>

“Live Through This” Resource supporting and advocating for persons who have made a suicide attempt and educating others about suicide. <https://livethroughthis.org>

“With Help Comes Hope: Support for Persons Living with Suicidal Thoughts and Suicide Attempts.” <https://lifelineforattemptsurvivors.org/for-friends-family/7-things-attempt-survivors-wish-their-families-and-friends-knew/>

Connections. <https://livedexp.academy/> Directory those who have survived attempts can use to connect with others who have “been there” for support.

“Lived Experience Academy” <https://livedexp.academy> Educational website to help suicide attempt survivors after they have gotten through a suicidal crisis,

“A Voice at the Table” <http://avoicetatthetable.org/index.html> “The national ‘home base’ for the Family & Friends emotionally impacted by the suicidal crisis of a loved one.”

“Suicide is Different” <https://www.suicideisdifferent.org/> A site for “suicide caregivers” who are “struggling with someone with thoughts of suicide.”

## SOURCES

The following publications were reviewed in the course of this study. Findings pertinent to the focus of this study are summarized above.

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