A Report of Findings to
Direct the Development of National
Guidelines for Workplace Suicide Prevention

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A Report of Findings to Direct the Development of National Guidelines for Workplace Suicide Prevention

A Collaborative Initiative Among

"The workplace is the last crucible of sustained human contact for many of the 30,000* people who kill themselves each year in the United States. A co-worker's suicide has a deep, disturbing impact on work mates. For managers, such tragedies pose challenges no one covered in management school."

Sue Shellenbarger (2001),
Impact of Colleague's Suicide Is Strongly Felt in Workplace, Wall Street Journal

*In 2017, 47,173 . people died by suicide

This report advances the U.S. Surgeon General's National Strategy for Suicide Prevention: Goals and Objectives for Action [1]

A Call to Action to Labor, Businesses, Employers & Professional Associations

- Provide information on suicide prevention to the federal workforce. (Objective 1.1)

- Implement organizational changes to promote the mental and emotional health of employees. (Objectives 1.1 and 3.1)

- Implement programs and policies to build social connectedness and promote positive mental and emotional health. (Objectives 1.1 and 3.1)

- Communicate messages of resilience, hope, and recovery to patients, clients, and their families with mental and substance use disorders. (Objective 3.3)

- Ensure that mental health services are included as a benefit in health plans and encourage employees to use these services as needed. (Objective 1.5)

- Screen for mental health needs, including suicidal thoughts and behaviors, and make referrals to treatment and community resources, as needed. (Objective 5.3)

- Train employees and supervisors to recognize coworkers in distress and respond appropriately. (Objectives 5.2 and 7.1)

- Learn the signs and symptoms of suicide and suicidal behaviors and how to reach out to those who may be at risk. (Objective 5.3)

- Ensure that counselors in an employee assistance program (EAP) are well equipped to assess and manage suicide risk. (Objective 9.1)

- Ensure that mental health services offered to employees include grief counseling for individuals bereaved by suicide. (Objective 10.1)

- Disseminate information about the National Suicide Prevention Lifeline and other local or regional crisis lines. (Objective 8.3)

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A MESSAGE FROM THE WORKPLACE COMMITTEE CO-CHAIR

Over two-thirds of the American population participates in the workforce [2]; we often spend more waking time working each week than we do with our families. When a workplace is working well, it is often a place of belonging and purpose — qualities of our well-being that can sustain us when life gets unmanageable. Many workplaces also provide access to needed mental health resources through employee assistance programs and peer support.

Because suicidal thoughts are usually invisible, employers usually assume "it doesn't happen here" — until it does. Co-workers then are often forgotten grievers after a suicide. Rarely, until now, did employers consider their role in suicide prevention. This report represents a pivotal moment as workplaces have begun to shift their perspective on suicide from "not our business" to a mindset that makes suicide prevention a health and safety priority.

If we are ever going to get in front of the tragedy of suicide, we need to widen our lens from seeing suicide only within a mental health framework to a broader public health one. In other words, when suicide and suicidal intensity are seen only as the consequence of a mental health condition, the only change agents are mental health professionals and the call to action becomes a "personal issue" that people take care of with their providers — but not all problems will be solved by getting a bunch of employees to counselors. When we understand suicide through a public health framework, many additional solutions are available. Through this broader lens workplaces now understand the importance of a culture that contributes to emotional resilience rather than to psychological toxicity, and they can take steps to create a caring community of wellbeing.

Across the United States, workplaces are taking a closer look at mental health promotion and suicide prevention 24/7. No longer is it good enough to get people from work to home safely, workplaces must also get their people from home back to work safely. As my colleague and former Co-Lead of the National Action Alliance for Suicide Prevention's Workplace Task Force, Cal Beyer reminds us, "this is the new frontier in safety."

We hope this ground-breaking effort helps provide the inspiration and the roadmap to move workplaces and the organizations that support them from inactive bystanders to bold leaders that aspire to a zero suicide mindset. Following on the heels of the "Zero Suicide in Healthcare" initiative, the success of this effort is predicated on a leadership philosophy and a set of practices. We can take a page from their playbook to implement a similar approach, because "no one should die in isolation and despair."

Sally Spencer-Thomas, Psy.D.

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EXECUTIVE SUMMARY

In 2010, the National Action Alliance for Suicide Prevention established a Workplace Task Force to assist with the implementation of the National Strategy for Suicide Prevention [1]. In 2017, this task force forged a collaborative partnership with the American Foundation for Suicide Prevention and United Suicide Survivors International to develop this nation's first set of guidelines for workplace suicide prevention. In November 2018, the CDC published a report ranking industries by rates of suicide, galvanizing the nation to urgent action. In 2019, the American Association of Suicidology adopted the Workplace Task Force, creating the Workplace Prevention and Postvention Committee (Workplace Committee), and became yet another national strategic partner in the effort.

Together the partners underwent a nine-month exploratory analysis to get a better sense of what employers wanted and would use in their efforts to implement a comprehensive and sustained strategy for suicide prevention. The framework for this "needs and strengths assessment" was based in a public health understanding that suicide is not just the consequence of a mental health problem, but that environmental factors also play a role. In other words, change comes from helping people and from changing systems and culture. In the justification section of the report many arguments are made for why workplaces and professional associations are essential partners in the nation's effort to prevent suicide. The intention of this report and the subsequent call to action to implement "best practices" in aspiring to a zero suicide mindset is to enroll leaders and other stakeholders through a process of change — from awareness to action.

The collaborative partners embarked on a significant national data collection process that involved 13 focus groups and 15 in-depth-interviews whose participants spanned diverse roles, industries, experiences and geographies. In addition, the partners distributed a national survey, conducted a comprehensive literature review and studied other countries' efforts in this space. The questions asked during this exploratory analysis included:

- How do we "bake in" suicide prevention into a workplace health and safety culture?
- What are the prioritized content areas needed and who are they for?
- What is the preferred format for the best practices? How do we make them interactive and incentivize engagement?
- How do we evaluate the effectiveness of the best practices?
- What are recommended marketing and distribution tactics?

When all of the pieces elements of the exploratory analysis came together, several themes emerged. These themes were then organized into guiding principles, motivations/barriers, integration

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recommendations, content areas, format/style suggestions, and marketing/distribution tactics. The findings resulted in recommendations for guiding principles and action steps.

The suggested guiding principles for suicide prevention in the workplace include:

- Strategic Integration

- Comprehensive and Sustained Investment

- Harm Reduction

- Culture Cultivation

- Dignity Protection

- Wellbeing Promotion

- Empowered Connection

- Action Orientation

Regarding specific content for best practices, themes emerged that addressed upstream (proactive prevention), midstream (early intervention) and downstream (crisis response) approaches. Upstream approaches focus on cultivating a culture of compassion, belonging and purpose while eliminating or reducing psychosocial hazards and bolstering suicide prevention literacy. Midstream strategies emphasize the need to build out a stratified support system of qualified mental health services and peer specialists and to guide people to these supports through universal screening and workplace-specific gatekeeper training. Additional suggestions here include getting clarity around legal concerns, disability, performance management and accommodations through the expertise of ombudsmen who are knowledgeable about policy and what works in mental health recovery. Finally, downstream content areas include how to find quality mental health service providers (e.g., EAP or crisis supports) who are competent and confident in assessing and managing suicide risk as well as empowering recovery after a suicide crisis. Additionally, workplaces facing suicide crises need direction to identify what procedures are most effective when reintegrating employees after a suicide attempt or while grieving a suicide death.

The report underscores the importance of building in an evaluation process from the beginning of the development of the guidelines. Both process and outcome evaluation approaches are suggested. The report concludes with suggestions on how to begin by outlining an interactive website portal that walks employers and other workplace stakeholders through a change process. Thus, the report suggests employers take the following steps. First, workplaces must gain awareness of why the need for workplace suicide prevention exists by making the business and humanitarian case. Second, once they are ready to move forward, they then make a pledge to make suicide prevention a health and

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safety priority. Third, they are guided through nine practices and are recognized for their efforts at each step.

The nine practices are:

Leadership
Cultivating a Caring Culture Focused on Community Well-Being

Job Strain Reduction
Assess and Address Job Strain and Toxic Work Contributors

Communication
Increase Awareness of Understanding Suicide and Reduce Fear of Suicidal People

Self-Care Orientation
Self-Screening and Stress/Crisis Inoculation Planning

Training
Build a Stratified Suicide Prevention Response Program Specialized Training by Role

Peer Support & Well-Being Ambassadors
Informal and Formal Initiatives

Mental Health & Crisis Resources
Evaluate and Promote

Mitigating Risk
Reduce Access to Lethal Means and Address Legal Issues

Crisis Response
Accommodation, Re-integration and Postvention

The report encourages building a community of practice to share resources and "lessons learned" through the facilitation of a pilot implementation effort. The recommendation for the first 18 months is to partner with a limited number of diverse employers to implement the guidelines in order to get preliminary feedback on their effectiveness and to identify industry targeted endorsements before a full-scale national launch.

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PART I: OVERVIEW AND JUSTIFICATION

Introduction

Project Origins

In 2010, the National Action Alliance for Suicide Prevention established the nation's first Workplace Task Force to take on the role determining what role workplaces and professional associations might have in assisting in the implementation of the National Strategy for Suicide Prevention [1]. This Task Force, comprised of a cross section of national leaders from different disciplines and industries, successfully developed several blueprints and resources to help workplaces prevent suicide and support workers facing suicide crises.

After the CDC's 2016 published report (retracted in 2017) that ranked suicide rates by industry, some employers started to feel more of a sense of urgency and requested tools to protect their workers from this tragedy [3]. The Workplace Task Force resolved to do something more impactful: to create a set of national guidelines for workplace suicide prevention. Over the next two years, the group enrolled dozens of partners into the effort and subsequently forged a core partnership with United Suicide Survivors International and the American Foundation for Suicide Prevention to conduct an exploratory analysis. The ultimate purpose of the exploratory analysis is to guide the development an interactive, accessible and effective on-line tool designed help employers and others achieve a "zero suicide mindset" and implement best practices to reduce the tragedy of suicide.

Two additional reports published in 2018 by the CDC underscored the timeliness of this task force's mission [4]. In June, the CDC reported that suicide rates increased more than 30% in half of states since 1999 and that the drivers of this trend went well beyond mental health concerns [4]. In fact, more than half of people who died by suicide did not have a known mental health condition and 16% were known to have job or financial problems at the time of death [4]. In November, a second CDC report updated the 2016 retracted report, finding the suicide rate among the U.S. working age population increased 34% between 2000-2016 [5]. The report concluded, "Because many adults spend a substantial amount of their time at work, the workplace is an important but underutilized location for suicide prevention. Workplaces could potentially benefit from suicide prevention activities" [5].

Prior to the CDC reports, the only nationally published data looking at suicide and industry were from the Bureau of Labor Statistics, which only tracks mortality and morbidity at a worksite (and most suicide deaths do not happen on a worksite). After many years of slow decline of suicide deaths at the worksite, an increase in worksite suicide death since 2007 has also garnered attention. Thus, together this all of this national data on suicide and the workplace has created the needed evidence to incentivize employers and professional associations to face these issues head on.

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About the Founding Partners

The [American Association of Suicidology](#) (AAS) is a not-for-profit organization that promotes research, pulic awareness programs, public education and training for professionals and volunteers. AAS is dedicated to promoting the understanding and prevention of suicide and supporting those who have been affected by it. AAS directs effort to advance Suicidology as a science; encouraging, developing and disseminating scholarly work in suicidology; encourage the development and application of strategies that reduce the incidence and prevalence of suicidal behaviors; compile, develop, evaluate and disseminate accurate information about suicidal behaviors to the public; foster the highest possible quality of suicide prevention, intervention and postvention to the public; publicize official AAS positions on issues of public policy relating to suicide, and; promote research and training in suicidology.

The [American Foundation for Suicide Prevention](#) (AFSP) is a voluntary health organization that gives those affected by suicide a nationwide community empowered by research, education and advocacy to take action against this leading cause of death. AFSP is dedicated to saving lives and bringing hope to those affected by suicide. AFSP creates a culture that's smart about mental health by engaging in the following core strategies: Funding scientific research; Educating the public about mental health and suicide prevention; Advocating for public policies in mental health and suicide prevention, and; Supporting survivors of suicide loss and those affected by suicide.

[United Suicide Survivors International](#) (United Survivors) is an independent international organization that serves as a home for people who have experienced suicide loss, people who have attempted suicide or who live with suicidal intensity (i.e., thoughts or feelings), and their friends and families -- collectively known as people with lived experience with suicide. United Survivors empowers people with lived experience to move from survivors to change agents by developing their ability to deliver safe and effective storytelling and to leverage their expertise for large scale change through advocacy and community engagement. One of the roles United Survivors team played in this project was to ensure the lived experience perspectives were of equal importance with other forms of knowledge.

Together the collaborative partners contributed resources of funding and service for this exploratory analysis. AFSP served as the funding partner contributing $25,000 to underwrite the project. The members of the Workplace Committee and United Survivors participated in facilitating focus groups and in-depth interviews. Administrative support and staff from United Survivors supported the transcription of the recordings. All partners contributed subject matter expertise and partnership engagement.

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Justification

Why Should Workplaces Care about Suicide Prevention?

Work as a Social Structure and its Relationship to Suicide. Over a century ago, Emile Durkheim considered suicide as a society-determined phenomenon in which the role of work played a significant role [6-7]. Durkheim argued that when working well, work fosters social relationships and offers people a place of purpose and solidarity [6-7]. According to Durkheim, the place of employment sets a social structure, moral values and a sense of identity for an individual — all of which helps give the individual meaning and reasons for living [6-7]. When social structures like work disintegrate, the individual suffers, and sometimes suicide can be a consequence. When workers are only seen as a source of profit or an obstacle to profit, suicidal despair may result due the disconnection people feel [8].

Over 150 years later, employers across the United States are becoming increasingly aware of the need for and benefit of addressing mental health promotion and suicide prevention in the workplace, both from a business cost perspective and from a social responsibility perspective. Awareness has been slow to turn to action because employers are not sure where to begin, how much they need to do and when they have satisfied their ability in promoting and protecting employee wellbeing.

The cost of suicides and suicidal behavior on workplaces. Recently, a team of health economists have been studying the costs of suicide and the return on investment of suicide prevention and intervention activities to workplaces and communities. For instance, they found that on average the cost of a suicide death of one male construction worker was $2.14 million, mostly due to the average 27.3 years of productive employment lost [9]. They also determined that for every dollar invested in suicide prevention $4.60 would be returned to society [9]. Another study measured a number of costs related to suicide and suicidal behaviors including production disturbance (e.g., value of lost production and staff turnover), human capital lost, medical costs, administrative costs (e.g., due to employer investigation), and more [10]. They examined the costs associated with short- and long-term absences after a suicide attempt, full incapacity and fatality and found a 1.50:1 benefit cost ratio for investing in suicide prevention [10]. They surmised that if employers were more aware of the economic consequences of the impact of suicide and suicidal behavior on their workplace, they might be more motivated to provide more mental health promotion and well-being initiatives [10].

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Not all suicide prevention is crisis oriented; in fact, proactive efforts may even have a bigger ROI. Just like promoting heart health is less expensive that responding to the crisis of a heart attack, promoting optimal and holistic well-being makes good business sense. Rather than only focus on deficit or symptom-focused models of workplace intervention many positive psychological resources can also be cultivated like self-esteem, mastery, resilience and emotional intelligence. Well-being has clear connections to greater employee engagement, proactive work behavior, and transformational leadership [11]. All together, promoting protective factors, early intervention and effective suicide crisis response save companies money and heartache.

Suicide waves in industries and the impacts on companies. In 2012 the Chief Executive of France's Telecom was forced to resign and six other executives faced legal action taken against the company following an investigation. Charges filed against the company were related to workplace bullying, harassment and toxic "management-by-terror" practices that were allegedly connected to over 80 employees' suicide attempts or deaths. Several of the suicide notes written by those who went on to die by suicide explicitly identified France Telecom as the sole cause for death due to "intolerable conditions" [8], [12].

In this case, the executives reportedly mandated a number of highly disruptive practices in order to downsize the company. For instance they repeatedly transferred highly skilled workers to low level jobs and then relocated the workers, disrupting their families. The communication around these transitions was infused with guilt and fear, and pit workers against one another. These former professional technicians were often placed in humiliating situations where they needed to ask permission to use the toilet [8], [12]. Once questioned about the suicides (which reached a peak in 2010 with 27 deaths), the leaders resorted to concealing or denying the deaths or rationalizing them as individual anomalies to keep hidden from public view [8], [12].

Around the same time another similar suicide wave emerged in a different part of the world. China's Foxconn, a telecommunications company that supports the manufacturing of Apple products, also experienced a suicide cluster in 2010 and underwent highly public scrutiny. Here, instead of highly skilled professionals, the victims were often migrant workers displaced from their rural communities to work manual labor under poor conditions [12]. At one point 300 workers allegedly took to the roof of Foxconn and threatened to jump unless they were treated more fairly.

Other "suicide waves" connecting work to suicidal despair have been noted in other cultures and industries including Australian miners, British bankers, Indian farmers and Japanese managers. In fact, the Japanese even have a word describing suicide from overwork — karo-jisatu — and consider the problem an urgent public health issue [12]. In the United States we have also seen surges of highly publicized suicide deaths related to work including numerous banker deaths in 2015 [13] and a

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current surge in first responder suicide deaths [14].

Job Strain and Suicide. Toxic work demands along with negative employee perceptions of the work environment have been historically underappreciated in the conversation about suicide prevention; however, research connects a number of job stress-related factors to risk of suicide death and attempts, even when controlling for mental health problems.

Howard, et al [15] examined the "perceived reality" workers had about certain job design characteristics and threats to personal resources and determined that several indirectly contributed to the risk of a suicide attempt including:

- Lack of job autonomy

- Lack of job variety

- Work-family conflict (i.e., work demands make family responsibilities more difficult)

- Family-work conflict (i.e., family demands make work role challenging)

- Heightened job dissatisfaction and the feeling of being "trapped"

- Work that was not meaningful or intrinsically rewarding

> "...individuals who are unsatisfied at work may perceive life as hopeless and lacking in meaning and may exhibit suicidal behavior." [15]

The increased attention to "mental health literacy" at work may in part be a deflection away from the importance of these findings. If workplaces believe that the mental health symptoms and suicide crises are only due to untreated or mistreated mental illnesses, they may be engaging in a "state of denial" about their own systemic contribution to the problem [12]. One tactic used to minimize workplaces' role is by medicalizing suicide as being the sole result of individual psychopathology rather than anything linked to work conditions [12].

Workplace Fatalities. Worker safety is a core value in many industries, and thus safety directors routinely pay attention to trends in workplace morbidity and mortality. Because most suicide deaths do not occur at a worksite, suicide has not historically been "on the radar" of safety professionals. When a workplace fatality happens, the cause is almost always determined to be "accidental" and a deeper investigation into intent to die is not undertaken. Because this deeper investigation is not done, the only remedy suggested is more safety training. While safety training will help those who did not intend self-harm, it will not benefit those whose death is intentional.

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Table 1. Fatal Occupational Injuries by Major Event, 2017 [16]

Injury Type	Number of Fatal Injuries
Transportation incidents	2,077
Falls, slips, trips	887
Violence and other injuries by persons or animals	807
Contact with objects and equipment	695
Exposure to harmful substances or environments	531
Fires and explosions	123
Total	**5,147**
Table 1. Fatal occupational injuries in the United States in 2017. More fatal work injuries resulted from transportation incidents than from any other event in 2017. Roadway incidents (N=1,299) alone accounted for about one out of every four fatal work injuries.	

When we look at the fatal occupational injuries [16], the first two most common (transportation incidents and falls) are also common ways people think about taking their lives [17-18]. Thus, it is possible that some, if not many, of these workplace fatalities are actually suicide deaths, which then means that safety training may not be effective in preventing them.

Specific Industries at Heightened Risk. Not all workplaces are created equal when it comes to suicide risk. In some situations, it is the demographics and risk factors of the types of workers coming into certain occupations (e.g. industries comprised of a majority of white men), in other situations it is the nature of the work that increases risk, and often it is a mixture of the two.

While self-reliance is often valued as a sign of strength and mental stability, it is paradoxically one of the strongest predictors of poor mental health and suicide risk [19-22]; thus, industries that value self-reliance are often at heightened risk. Attitudes and beliefs like "I can solve my own problems" and "others do not need to worry about me" are often a major barrier to seeking support from family, peers or professionals.

Thus, it is not surprising that occupations that are male-dominated and value stoicism and traditional masculine norms like construction and extraction have the highest rates (53.2/100,000 for men) of suicide. In fact, in one study looking at suicide and occupation [5], 20% of the male suicide decedents from 17 states were in the construction/extraction industry. The study went on to suggest that tailored suicide prevention approaches would be needed for these types of industries — both efforts related to promoting early identification and help-seeking as well as improving working conditions [5].

An Australian study [11] found that proximal risks to the construction workers' suicide deaths included a transition in work experiences, a workplace injury resulting in pain or disability, and financial issues.

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Top Ten Industries at Risk for Suicide for Men*

10 | Ranked by Rate per 100,000

#	Rate	Industry	Rank
1	53.2	Construction & Extraction	1st for largest number
2	39.7	Design, Entertainment, Sports, & Media	11th for largest number
3	39.1	Installation, Maintenance & Repair	4th for largest number
4	30.9	Transportation & Material Moving	2nd for largest number
5	30.5	Production	3rd for largest number
6	28.2	Protective Service	10th for largest number
7	26.8	Building & Grounds Cleaning & Maintenance	7th for largest number
8	25.6	Healthcare Practitioners & Technical	13th for largest number
9	22.8	Farming, Fishing, & Forestry	16th for largest number
10	21.5	Sales & Related	6th for largest number

Peterson C, Stone DM, Marsh SM, et al. Suicide Rates by Major Occupational Group - 17 States, 2012 and 2015. MMWR Morb Mortal Wkly Rep 2018; 67:1253-1260.
DOI: http://dx.doi.org/10.15585.mmwr.mm6745a1

The study also found that the decedent often disclosed to coworkers about suicide plans prior to death, indicating that peer support could be a life-saving intervention [11].

Some other industries also have unique risk factors, such as access to lethal means among law enforcement and exposure to trauma in protective services and some health services. For instance, the workplace suicide rate (suicide at the worksite) for protective service is 3.5 times greater than the overall U.S. worker rate; 84% of these suicide deaths involved firearms [23]. Female physicians suicide deaths are 130% percent higher compared to females in other professions; male physicians risk of suicide is 40% higher than males in other professions [24]. Like with law enforcement, this disparity may result in part from greater knowledge of lethality of drugs and easy access to means. Veterinarians also have suicide rates that are significantly higher than the general population [25], and some speculate this is in part due to their unique role in euthanizing animals, thereby increasing their exposure and reducing their fearlessness to death.

Another international study [26] found that agricultural, forestry and fishing workers had higher risk and speculated that in addition to having the trait of high self-reliance, these workers were also socially isolated. These workers experienced highly physically demanding work (possibly resulting in

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acute and chronic pain), excessive work hours, and exposure to toxic/potentially lethal substances (i.e., pesticides). Finally, they were often at the whim of weather or economic disruption that impacted their ability to sustain profitable enterprises.

In summary, suicide and the workplace is complicated and nuanced. The only way to truly address these issues with integrity and sustained purpose is to use a system-wide, broad-based and comprehensive approach. Employers and professional associations must be educated to see the benefits of addressing these issues comprehensively, with tools, resources, and training that support this continuous broad-based approach. Fortunately, the United States can learn from other nations who have already been building guidelines for workplace suicide prevention.

Other Countries' Models of Workplace Guidelines

The United States is not the first country to consider developing a set of workplace suicide prevention guidelines. Canada has had a "National Standard of Canada for Psychological Health and Safety in the Workplace" since 2013 [27] and Suicide Prevention Australia published its "Work and Suicide Position Statement" in 2014 [28].

Canada. National Standard of Canada on Psychological Health and Safety in the Workplace (the Standard) was sponsored by The Mental Health Commission of Canada (MHCC) and project managed by the Canadian Standards Association [27]. This standard is free for download and has the same depth as any other workplace safety standard, although it currently remains voluntary, and does not have specific regulations attached. There is a goal of moving the Standard to become mandatory for all employers, similar to other health and safety standards. Its broad scope addresses cultural change through evaluation and implementation related to 13 psychological risk areas using a psychological health and safety management system which addresses issues upstream, midstream and downstream [27].

The development of the National Standard spanned 18 months and included 40 diverse stakeholders representing private and public employers, labor, associations, service providers, and government. This large group of stakeholders presented a challenge as a consensus model was used for all aspects of writing and review. Following its release, resources were developed by the MHCC to assist with implementation. Many private and public organizations have developed resources and consulting programs to assist employers with implementation.

In the first four years there were over 25,000 downloads. The MHCC has a research project following organizations who are implementing the Standard with initial findings that the 75-page document is challenging to interpret and ascertain strategies for implementation.

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Development cost $475,000 with funding from Great West Life Assurance Company and Bell Canada (private) and the Government of Canada through several agencies and branches, including the Mental Health Commission of Canada (public).

(Note: Over several years prior to the Standard's development, multiple research, public education and position documents had been disseminated that led to the development of a national Standard.)

Australia. In Australia in 2014, suicide prevention was the focus of a position statement created by Suicide Prevention Australia, a non-governmental organization. The process included one author with input from an Advisory Board. The document is a public education and information piece that makes the business and social case for addressing suicide prevention in the workplace, with midstream and downstream directives presented. The document includes description of the issues, case examples, calls to action and resources [28]. It is promoted through the National Mental Health Commission, a government body.

There have been an estimated 10,000 downloads. There is no formal tracking or evaluation related to implementation, and indications are that the process needs to be simplified. The project cost $17,500 AUS, with funding provided under the Australian Government National Suicide Prevention Program.

Later the National Mental Health Commission and the Mentally Healthy Workplace Alliance reviewed the research and identified six key areas and strategies for creating mentally healthy workplaces [28].

Six Key Areas for a Mentally Healthy Workplace (Australia)

1. Smarter Work Design: more flexibility, greater individual and team input into decision-making, harm and hazard reduction

2. Build Resilience: Training on stress management for high risk jobs using evidence-based approaches, increasing physical activity, and providing opportunities for mentoring and coaching

3. Support Recovery: Helping employees reintegrate and get support during and after stressful life events and challenges with mental illness, having generous sick leave and accommodations

4. Build Better Work Culture: Senior leadership engagement, mental health education, zero tolerance for bullying or discrimination, a climate of safety, mental health education, and change management that has open and realistic communication

5. Early Intervention: Well-being checks, ability to seek help easily and early, evidence-based training for providers, opportunities for peer support

6. Increase awareness: Promoting mental health resources, trainings and programs, participating in community and national events and campaigns

National Mental Health Commission & The Mentally Healthy Workplace Alliance

PART II: MISSION, VISION & INTENDED AUDIENCE

Vision

We (the collaborative partners) envision a world where workplaces and professional associations join in the global effort to aspire to zero suicides by sustaining a comprehensive suicide prevention strategy as part of their health and safety priorities.

Mission

The mission is to change the culture of workplaces to reduce job strain and negative, fear-based, prejudicial and discriminatory thoughts, behaviors and systems regarding suicide and mental health while at the same time promoting psychologically healthy norms and environments.

The overarching goals of the best practices are twofold:

1. To engage employer/professional association leadership to address suicide prevention in a comprehensive way.

2. To provide a roadmap to workplace leaders who wish to engage in this culture-change process.

We seek to achieve our vision by developing a set of guidelines that:

- Give employers and professional associations an opportunity to pledge to engage in the effort of suicide prevention.

- Demonstrate an implementation structure for workplace best practices in a comprehensive approach.

- Provide data and resources to advance the cause of workplace suicide prevention.

- Bring together diverse stakeholders in a collaborative public-private model.

- Make recommendations for easily deployed tools, trainings and resources for short-term action inside of long-term system-wide change.

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Intended Audience Groups for This Report

Several different employer roles can benefit from learning from this report and taking the action steps listed within including:

- **Leadership:** Employer/professional association/labor leadership and internal change agents who are inspired to promote this process.

- **Implementors:** HR, management, safety, wellness, legal professionals and others tasked with implementing this process.

- **Collaborators:** Community partners who will partner on the process.

- **Investors:** Investors who will contribute resources to the development and sustainability of this process.

- **Evaluators:** Researchers who will assess the effectiveness of workplace suicide prevention.

- **Peers:** Co-workers, friends and family who want to help.

The guidelines outlined here are designed to be cross-cutting through private and public sectors, large and small employers, and all industries.

Why Suicide Prevention Focus?

Many workplace mental health and wellness programs exist. Sometimes, due to internal stigma within these programs, the topic of suicide prevention is neglected. When we do not talk about it, we cannot address some of the unique challenges within suicide prevention, intervention and crisis response that are not covered in mental health and wellness programs. For example, while suicidal despair is often linked to mental health conditions it is also connected to job strain. Just getting workers to counseling is not enough; workplaces dedicated to suicide prevention must also examine their policies and culture to see what environmental determinants might be contributing to suicidal intensity.

> "Just getting workers to counseling is not enough; workplaces dedicated to suicide prevention must also examine their policies and culture to see what environmental determinants might be contributing to suicidal intensity."
>
> ~Focus Group Participant

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While there exists some overlap among the mental health/wellness initiatives and suicide prevention, there are some differentiators within this document that justify this additional emphasis. We see our effort as complementary and collaborative with many of the other existing programs on workplace mental health and well-being.

What Do We Mean by "Aspiring to a Zero Suicide Mindset"?

We believe that no one should die in isolation and despair.

The idea of "aspiring to zero" is not foreign to many safety-conscious workplaces. Workplaces and industries that have successfully reduced work-related mortality and morbidity went beyond just being compliant with regulations for workplace safety and fully embraced a 24/7 mindset and a paradigm-shifting commitment that permeated all areas of their culture and became closely tied to the core values of the organization [29]. For instance in 2001, Lendlease, a multinational 15,000 employee construction company shifted their mindset to be incident and injury free, and after making sweeping changes to uphold this commitment, the job fatality count dropped from 72 from 2001-2013 to zero fatalities from 2013 to 2016 [30].

> "The majority of companies are fewer than 100 people. Be mindful of reaching the small players where the tragedy of suicide feels incredibly personal."
>
> ~Focus Group Participant

"Zero suicide" has become a galvanizing metric. The overall outcome of the care delivery overhaul that resulted from this paradigm shift was a dramatic and statistically significant 80% reduction in suicide in one large healthcare system. This change was maintained for over a decade, including one year when the perfection goal of zero suicides was actually achieved [31]. Internationally, a "Zero Suicide in Healthcare" movement has been emerging since 2014 offering other large healthcare systems similar leadership and practices. On regional levels, these practices are being taught in "Zero Suicide Academies" to help these healthcare companies continually improve their ability lower suicide deaths among the people they serve in a no blame, no shame learning culture. The change that Lendlease made in construction safety is a model for the healthcare community; shifting from "what do I do to manage the immediate risk to me" (as the system) to a focus on what is going to improve the culture of safety for the organization long-term [30].

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Because the Zero Suicide in Healthcare initiative has been evolving, many lessons can be learned on how to apply the successes of scale and implementation that has been achieved in healthcare to the workplace [32]. For more on Zero Suicide in Healthcare, visit: zerosuicide.sprc.org.

The concept of "Zero Suicide" is aspirational. It is not "zero tolerance," a quick fix, a marketing strategy or a short-term goal that we have "failed" if we don't reach. The intent is to create a just-culture (stress- and blame-free) that examines every suicide death with a perspective of "how can our system do better to save lives?" Thus, the workplace version is a brand extension of the highly successful initiative in healthcare and can build on the momentum and success of this effort.

Why "Best Practices"?

The evidence-base for workplace suicide prevention is in its infancy. Only a few workplace suicide prevention initiatives had been evaluated; however, the results from those that had been evaluated are promising and suggest that suicide prevention has the potential to have a positive effect when integrated into existing workplace health and safety activities [33]. Because the research is emerging, the suggestions contained within this report should be considered "promising" or "best practices" as we move toward more formal "guidelines" and "standards" in the future.

PART III: EXPLORATORY ANALYSIS

Process of the Exploratory Analysis

Why an Exploratory Analysis?

Before undergoing any large scale change, one is always advised to "seek first to understand." The listening and review process of this exploratory analysis was significant and sought to achieve the following objectives:

1. To gain buy-in by listening to the needs of various different stakeholders.

2. To better understand the resources that already exist to support workplace suicide prevention.

3. To identify champions and storytellers who can share lived experience stories of suicide grief as well as stories of living through a suicide crisis of their own, a coworker or family member.

4. To gather baseline data against which we can benchmark future change.

5. To develop a comprehensive strategy and identify best practices (upstream, midstream, downstream) for workplace suicide prevention.

6. To identify tactics that will help engage workplaces and professional associations to move along a stage-of-change model as they integrate these best practices into their health and safety culture.

Questions to Be Answered by the Exploratory Study

- How do we "bake in" suicide prevention into a workplace health and safety culture?

- What are the prioritized content areas needed and who are they for?

- What is the preferred format for the best practices? How do we make them interactive and incentivize engagement?

- How do we evaluate the effectiveness of the best practices?

- What are recommended marketing and distribution tactics?

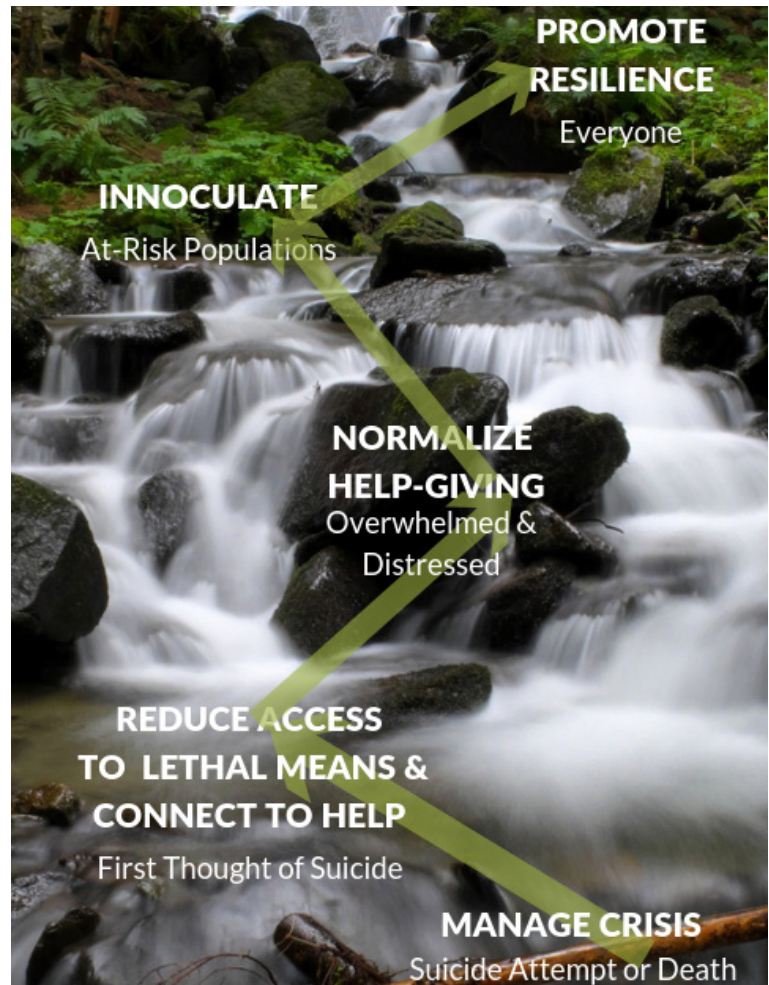**Framework for Comprehensive Approach: Stream Parable**

What the research tells us is that our best outcomes in reducing suicide rates come from comprehensive and sustained efforts where training is just one component of an overall strategy [34].

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The following common parable from the public health perspective illuminates what a comprehensive approach might entail. "Upstream, midstream and downstream" approaches are needed to prevent suicide.

Upstream strategies build protective factors that can mitigate risk, such as creating a sense of belonging, eliminating stigmatized language and discriminating actions, building resilience through life skills and mental hardiness, and enhancing mental health literacy.

Midstream approaches help identify people in emerging risk and then link them to appropriate support before the issues develop into a suicidal crisis. Midstream strategies include screening for mental health conditions and suicidal thoughts, promoting and normalizing many types of help-seeking/help-giving behavior, and training populations on how to have difficult suicide-specific conversations.

Downstream tactics are needed to guide the response when a suicide crisis has happened including when people have acute thoughts of suicide, attempt suicide or die by suicide. Current thinking about effective downstream tactics is that they are not so much about constraint (e.g., involuntary hospitalization, restraints, and isolation) but rather focus on an attempt to answer the question, "How can we approach these crises in a way that offers connection, dignity and empowerment instead of fear?"

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Stream Parable

You are walking along a river one day and you hear a plea for help from someone drowning. You are startled but energized as you dive into the water and save him. Using all your strength you pull him to shore and start administering CPR. Your adrenaline is racing as he starts to regain consciousness. Just as you are about get back on your feet, another frantic call comes from the river. You can't believe it! You dive back in the river and pull out a woman who also needs life-saving care. Now a bit frazzled but still thrilled that you have saved two lives in one day, you mop the sweat from your brow. When you turn around, however, you see more drowning people coming down the river. One after another.

You shout out to all the other people around you to help. Now there are several people in the river with you – pulling drowning people out left and right. One of the rescuers swims out to the drowning group and tries to start teaching them how to tread water. This strategy helps some, but not all because it turns out it's hard to learn how to tread water when you are drowning.

Everyone looks at each other, completely overwhelmed, wondering when this will stop. Finally, you stand up and start running upstream. Another rescuer glares at you and shouts, "Where are you going? There are so many drowning people; we need everyone here to help!" To which you reply, "I'm going upstream to find out who is pushing all of these people into the river."

Timeline

- **2017**: Workplace Taskforce of the National Action Alliance for Suicide Prevention begins monthly conversations about how to create a set of national guidelines

- **Spring 2018**: United Suicide Survivors International submits funding proposal to the American Foundation for Suicide Prevention to build the national guidelines for suicide prevention in partnership with AFSP and the Action Alliance

- **May 2018**: $25,000 in funding is awarded by AFSP to United Survivors and partners to support the exploratory analysis, on-line guideline development, marketing and evaluation of the national guidelines for suicide prevention

- **June 2018**: Facilitation guides for Focus Groups and In-depth-Interviews developed

- **July 2018**: Focus groups and In-depth-Interviews begin

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- **July-August 2018**: National Guidelines for Suicide Prevention in the Workplace survey open

- **September 2018**: Initial report for survey <u>submitted</u>

- **October 2018**: Focus groups and In-depth-Interviews conclude

- **November 2018**: The CDC releases updated <u>report</u> on suicide rates by industry

- **December 2018**: Lead researcher of CDC Report Dr. Stone briefs the Workplace Task Force on the CDC report

- **November-December 2018**: Literature review completed

- **January 2019**: Collaborative partners briefed on findings

- **April 2019**: Report of findings submitted to stakeholders for feedback

- **July 2019**: AAS adopts the Task Force, now Workplace Prevention and Postvention Committee

Data Gathering Approaches

Several data collection methods were used during this exploratory analysis including: focus groups, in-depth interviews, . The findings have been synthesized in the "results" section of the report.

Focus groups

13 focus groups were conducted, organized by role, experience and industry:

- (2) Employee Assistance Programs (EAP)

- Human Resources (HR)

- Construction

- First Responders

- Legal

- Employment Law

- Workplace Violence

- (2) Lived Experience (suicide deaths or suicide attempts — while being employed)

- Peer support

- Safety

- Wellness

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The participants were carefully selected to represent diverse perspectives (geography, type and size of company/agency, lived experience, etc.); however, an intentional effort was made to recruit perspectives from industries with the highest rates of suicide.

The focus groups lasted 90 minutes to 2 hours each and had between 3 and 14 people. A notetaker recorded key points and statements during the focus groups and identified participants only through a code (no names attached to statements). After being briefed on the ground rules for the focus group, members were asked the following questions:

Role: Please describe your role and why your industry or others in your position should care about suicide prevention in the workplace.

Integration into Health and Safety Culture: How do you think suicide is similar or different from other health conditions in prevention, intervention, and crisis planning and response? How might workplace suicide prevention be "baked in" to these other workplace priorities?:

- Recruitment, diversity and inclusion

- EEOC hiring practices and reasonable accommodations

- Employee Safety

- Employee health and wellness programs (Total Worker Health movement)

- Employee Assistance Programs

- Health Benefit packages

- Workers Compensation claims management

- Critical Incident Debriefing

- Stay at Work vs. Return to Work approaches

- Integrated Disability Management programs (PTO; FMLA, short-term & long-term disability and duty vs. non-duty related pensions in protective services)

- Employee relations and labor negotiations

- Employee engagement programs and campaigns

Stories: Do you have any stories you are able to share about how a workplace responded to suicide (death, attempt, thoughts of employee or family member of employee) or how a workplace implemented a suicide prevention tactic? What worked? What didn't? Has suicide impacted your life in any way you are able to share? How have these experiences or your "lived expertise" shaped your ideas on what might be needed in the National Guidelines for Workplace Suicide Prevention?

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What do you wish you would have known? What have you been surprised by? What do you think are unidentified factors in suicide prevention in the workplace?

Guideline Content: If you were able to have a set of guidelines that helped others in your position develop a comprehensive and effective workplace suicide prevention program, what would it include? When we think of a comprehensive approach, we consider PREVENTION (what would help us build resilience), INTERVENTION (what would help us catch emerging concerns when they are small) and CRISIS RESPONSE (what would help us respond to suicide attempts or suicide deaths).

Guideline Format: While we will be developing a written form of the guidelines, our hope is to build out an interactive, on-line tool that helps companies or professional associations track more progress on the implementation of the guidelines. What aspects of an on-line tool would be more attractive to workplaces and would help them with implementation?

Distribution: What are important distribution channels to consider when marketing these national guidelines? How do we enroll workplaces and professional associations about the importance of the guidelines?

Evaluation: What metrics should be monitored to measure the success of these guidelines?

Anything Else? Is there anything else you'd like to share with us about your experiences or how we can best develop and share the national guidelines?

In-depth-interviews

15 in-depth-interviews were conducted with the individuals from the following roles:

- International Workplace Safety Executive
- Healthcare Executive (67,000 person employer)
- Risk Management Executive
- Financial Executive (formerly employed by a Fortune 100 company)
- Industry Hygiene Leader
- Judge
- Healthcare Insurance (Strategies Director)
- Labor Health Fund Director
- Occupational Health Sciences Researcher
- Chief Medical Officer national crisis services

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- Integrated Leaves and Accommodations Manager for energy company

- Venture Capitalist (technology)

- President entertainment industry association

- (2) Lawyers in member assistance programs

Each interview lasted 30 minutes to 1 hour (one was conducted by email). Interviewees were asked similar questions as the ones posed in the focus groups, and their responses were recorded, transcribed and captured via note-taking.

National Survey

A 16-question national survey was created by members of the Workplace Committee with input from many people with lived experience with suicide and housed on Survey Monkey. Research and program evaluation consultants also weighed in on the survey's design and scope. The survey was distributed through the networks and social media reach of the projects' partners from July 18-August 16, 2018.

About the participants. When the survey closed 256 people (73% completion rate) had responded from 41 states. The majority of people who responded (58%) were from mid-sized to large companies. The majority (55%) of participants held leadership (Manager to C-Suite) roles in the company. The sample was primarily female (65%) and white (93%)/non-Hispanic (96%).

The industries most commonly represented included healthcare/social assistance (27%), construction (24%), education (12%), public administration (6%), and finance/insurance (5%) with all other industries representing less than 5% of the total group.

Health and safety connection to participant's work role. When asked "How is your role connected to the health and safety of the company?" In an open ended format, participants responded:

- 27% said that health and safety were a primary focus of their job (but on closer inspection of these responses at least 50% were because they were providing services to others as part of the mission of the company, not as a primary function for the employees of the company)

- 18% didn't feel their role was connected at all or were unsure

- 7% said that everyone's role is connected to health and safety

- The rest listed that their particular role was linked to workplace health and safety through various roles and responsibilities.

Lived Experience with suicide. The degree of lived experience among the participants was significant:

- 46% had at least one friend, co-worker or family member attempt suicide

- 43% had lost at least one friend to suicide

- 35% had been a caregiver or a support resource to someone living with suicidal thoughts after an attempt

- 34% had at least one family member die of suicide

- 34% stated that they have lived/live with suicidal thoughts

- 20% had lost a co-worker to suicide

- 15% lived through at least one suicide attempt

- 11% had no direct experience

Resource, Policy and Protocol Audit

While not exhaustive, efforts were made to pull together existing workplace mental health and suicide prevention programs, which are listed in the Appendix.

Literature Review

A fairly extensive literature review focused on research related to workplace suicide risk and prevention also help guide the direction of this report.

PART IV: RESULTS

When all of the elements of the exploratory analysis came together, several themes emerged. These themes were then organized into guiding principles, motivations/barriers, integration recommendations, content areas, format/style suggestions, and marketing/distribution tactics.

Guiding Principles, Values and Assumptions

Strategic Integration: Workplaces are a uniquely positioned and necessary part of a larger public health approach to suicide prevention, and as such they can systemically embed suicide prevention within health and safety priorities.

Comprehensive and Sustained Investment: "Upstream, midstream and downstream" approaches are all important and require adequate investment of time and financial resources.

Harm Reduction: Workplaces owe employees a safe and healthy work environment and can strive to decrease the harmful exposures and psychosocial hazards that increase the risk of suicide.

Culture Cultivation: Workplaces can offer protection from suicide by cultivating connectedness and healthy and caring community that looks out for one another. Leaders drive this culture by recognizing and rewarding these values.

Dignity Protection: Workplaces can prevent despair and promote healing by fighting against bullying, harassment, discrimination and prejudice and can uphold dignity with collaborative and respectful reintegration.

Wellbeing Promotion: In suicide prevention it's not good enough to focus on pulling people back from the brink, workplaces also contribute to enhanced hope, purpose and identity that gives people reasons for living and provide a pivotal role in recovery.

Empowered Connection: Workplaces can provide or connect to accessible and effective treatment and peer support services and can prepare employees to help compassionately link people to care.

Action Orientation: Awareness is necessary but not sufficient for change. Workplaces must engage in action through policy, training, and other tactics listed throughout the report.

Making Suicide a Health and Safety Priority at Work

Strategic Integration	Comprehensive & Sustained Investment	Harm Reduction	Culture Cultivation
Dignity Protection	Wellbeing Promotion	Empowered Connection	Action Orientation

Workplace Readiness: Motivations and Barriers

Motivations

The survey participants had many motivations for why they were interested in workplace suicide prevention. Ranked priorities included:

#1: Increase employee health and well-being (86%)

#2: Right thing to do (72%)

#3: Prevent workplace homicide-suicide (56%)

#4: Increase employee safety and productivity (55%)

#5: Improve employee engagement and retention (43%)

#6: Decrease presenteeism and absenteeism (30%)

Barriers

Many challenges and barriers were identified. The biggest challenge identified was getting leaders to buy in (47%) followed by lack of funding (39%) and time (30%). Less frequently cited barriers included "we would rather focus just on mental wellness and resilience" (19%), "branding concerns — we don't want others to think we have a problem with suicide" (18%), "I don't think my company has a problem

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with suicide" (12%), and "We don't feel it is appropriate for the company to focus on such a personal/individual matter" (10%). Other responses written in for this question centered on stigma and fear, confusion on where to start or conflicting directives regarding privacy. Several responses stated this issue was simply never one they considered before.

How do we integrate suicide prevention into a workplace health and safety culture?

Leadership Sets the Tone

Successful programs will have a top level leader that sees this as a cutting edge issue and a workplace-ethics imperative. Cultivating the mindset of civility in community and a culture of trust comes from the top. Communication from leadership on building a caring culture where people look out for each other's well-being and pull together when times are tough needs to be tied to the mission and vision of the organization and communicated to the workers. Leaders demonstrate this commitment by investing resources of time and money and by modeling self-care and compassion.

Building and sustaining workplace cultures that focus on psychological safety and that enhance well-being begins with top leadership support and is upheld at every level of management [2]. Leaders committed to these priorities will invest resources to make a work culture that rewards resilience, teamwork, and holistic health; the company will in turn be rewarded by attracting and retaining top talent [2].

Building the Business Case for Workplace Suicide Prevention

Workplaces are leaning into the conversation about suicide prevention because it is the right thing to do; however, many don't realize that it also makes good business sense. While it may seem cold to calculate the reason for investment in suicide prevention in dollars, the business case often helps businesses move from thought to action.

While workplace mental health programs have often made a strong business care for proactive mental health care for conditions like depression and anxiety (Center for Workplace Mental Health, Guarding Minds at Work and The Right Direction); additional considerations are needed to build the business case for suicide prevention. Most conclude that mental health conditions top the list of the most costly illnesses in the United States, far outpacing the cost burden of cancer, obesity, heart disease and stroke; 1/3 of this cost burden is connected to productivity loss, disability and decreased work performance [2].

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Unfortunately, only 50-60% of adults with these mental health conditions are getting the services they need. Because many people who have suicidal thoughts do not connect their despair to a mental health issue, and the majority who die by suicide do not have a known mental health condition [4], the assumption can be made that many people living with suicidal thoughts are also not getting any treatment.

When people do get quality treatment for depression, they do get better in work and life. One report [2] mentioned that 80% of people who were treated for depression improved quickly, especially when the problems were identified early in the progression. Additionally, 86% of employees who were treated reported a decrease in absenteeism/presenteeism and an increase in work performance [2].
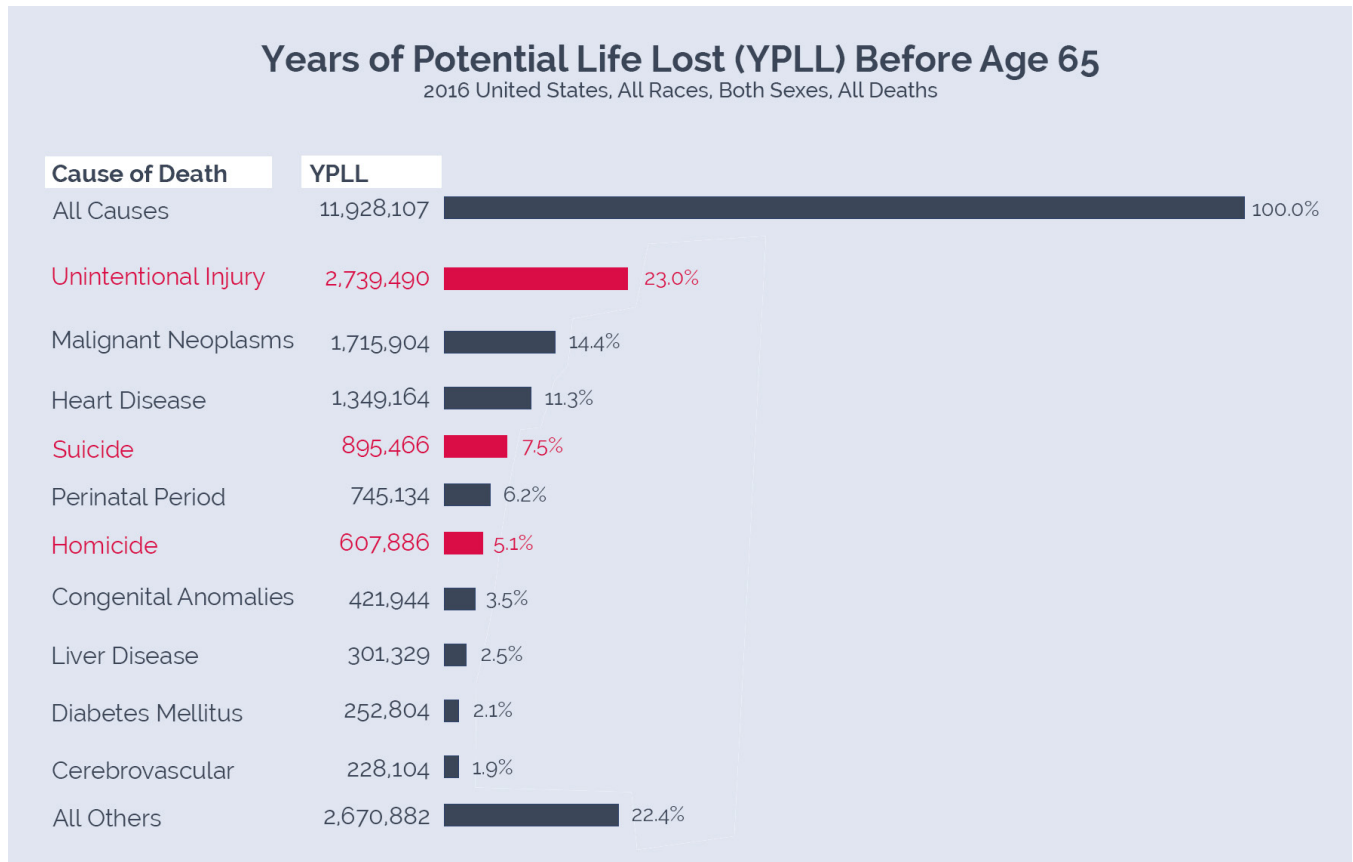
When looking at the return on investment for just one intervention (Employee Assistance Programs), one study found that 80% of costs associated with lost productivity were associated with presenteeism, with absenteeism accounting for the remainder [36]. Presenteeism occurs when people show up to work but they are not able to function due to poor energy levels and concentration, and work quantity and quality suffers. This same study [36] calculated a return on investment (ROI) and found that for every dollar spent on a "typical" EAP, there is an expected return of between $5.17 and $6.47. A more recent study on Federal Occupational Health found an ROI of $1.78 in finding cost savings by improving absenteeism, presenteeism, workplace distress, work engagement and life satisfaction [37].

In addition to the well-documented costs to workplaces for not addressing mental health proactively (medical costs, disability costs, absenteeism, presenteeism, lowered productivity, etc), several additional <u>costs are incurred when an employee dies by suicide, including</u>:

Years of productive life lost — suicide tends to take people decades before retirement; the costs of rehiring and retraining an employee lost to suicide is significant [38].

Suicide on the job site — when a suicide occurs at a job site, the work is halted indefinitely as law enforcement conducts an investigation and traumatized workers are unable to function. One of the focus group participants mentioned that after two workers died by suicide at one work site, the entire law firm closed down because people couldn't come to work. Other construction and transportation companies have mentioned that suicide deaths can completely stop operation for hours and even days, while the company remains responsible for continued payment for all employees and deliverables to clients.

Impact to employee morale — when a suicide impacts a workplace, the grief and trauma of co-workers can linger a very long time [39] [40].

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Years of Potential Life Lost (YPLL) Before Age 65
2016 United States, All Races, Both Sexes, All Deaths

Cause of Death	YPLL	
All Causes	11,928,107	100.0%
Unintentional Injury	2,739,490	23.0%
Malignant Neoplasms	1,715,904	14.4%
Heart Disease	1,349,164	11.3%
Suicide	895,466	7.5%
Perinatal Period	745,134	6.2%
Homicide	607,886	5.1%
Congenital Anomalies	421,944	3.5%
Liver Disease	301,329	2.5%
Diabetes Mellitus	252,804	2.1%
Cerebrovascular	228,104	1.9%
All Others	2,670,882	22.4%

Brand stigma impact — when a company or even an industry has been known to be prone to suicide, people become afraid that their health may become in jeopardy if they work in this area. For instance, concerns about the stigmatizing impact of suicide have emerged in veterinarian professional associations [41].

As mentioned earlier, unintentional accidents may be grey area — because "intent to die" is not always investigated when the death scene looks like an accident, many probable suicides are mis-categorized as unintentional injury. Knowing that fall and motor vehicle fatalities are common ways people think about killing themselves [17], it would not be surprising that a good number of workplace fatalities are indeed suicides and not accidents. We also have evidence that suicide prevention programs do reduce accidental death [34].

"Suicides and their social recognition jeapardize businesses whose corporate reputation and financial interests are undermined by the media exposure of suicides." [12]

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"Bake it in, Don't Bolt it On"

To borrow a phrase from the "Zero Suicide in Healthcare" champion David Covington, "When we create system change, don't bolt it on, bake it in. Change will only last as long as there is energy around something. When it is bolted on it won't stick; 'baked in' means here to stay" [41]. In other words, a comprehensive and sustained suicide prevention strategy is not a "one-and-done" training or a stand alone awareness day. Rather, activities, communications, training components, and other elements are woven into the places where other health and safety activity is already happening. This integration will not only help preserve the longevity of the efforts, it also helps people connect the dots among a variety of health and safety priorities.

For example, within the construction industry a well-established global ritual is the "Toolbox Talk." A Toolbox Talk is a short and informal safety briefing used to refresh a worker's knowledge on safety topics such as workplace hazards and safe work practices. Many construction companies are now "baking in" suicide prevention topics by developing toolbox talk briefings that share suicide warning signs, risk factors and resources (e.g., Construction Working Minds).

"Stand Down for Suicide Prevention"

According to the Occupational Safety and Health Administration (OSHA), a "Safety Stand-Down" is a voluntary event or series of events where normal work is paused and employers talk directly to employees about safety [42]. The very well-established OSHA program usually focuses on preventing falls and is highlighted in May of each year involving millions of employees [42]. After the Stand-Down, employers then provide feedback to OSHA and receive a Certificate of Participation.

Others have now taken up this concept in suicide prevention. For example, the Army has conducted a "Stand Down for Suicide Prevention" where a mandatory service-wide shut down occurred so service members could be trained in suicide prevention [43]. Union Pacific, a 10,000 person employer also conducts stand-down event every year on World Suicide Prevention Day [44]. Nearly 200 volunteers throughout the UP system make personal contact employees as they report to work or leave work and hand out wallet-size cards about suicide and give employees a key chain with the inspirational message to "Stay Connected."

What makes "stand down" initiatives successful? First, the symbolism of halting work to prioritize safety is meaningful, especially in companies where "time is money." Second, by making stand down events system-wide and often mandatory, the message gets saturated and everyone is accountable. Successful "stand down" events take careful planning and promotion and are facilitated in a spirit of honoring safety as a company value rather than as punishment for a previous incident. These lessons learned can also be applied to Stand Downs for Suicide Prevention.

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Job Strain and Total Worker Health

Many workplaces realize that the concept of "occupational health" has shifted to "total worker health." According to the National Institute for Occupational Safety and Health (NIOSH), "Total Worker Health" is a holistic approach to promote worker well-being through policy, programs and practices [45].

> "It is clear that job stressors are associated with increased risk for suicide. Thus, job stress prevention and control should be a key component of workplace…suicide prevention strategies." [11]

Researchers are clear: risk factors in the workplace can contribute to health concerns — including suicide risk — previously considered unrelated to work [45], [46], [47]. Many workplace well-being hazards and "job strain" put workers at risk for suicide and significant emotional distress. These hazards include but are not limited to:

- Low job control — lack of decision-making power and limited ability to try new things
- Lack of supervisor of collegial support — poor working relationships
- Excessive job demands and constant pressure/overtime
- Effort-reward imbalance — related to perceived insufficient financial compensation, respect/status
- Job insecurity — perceived threat of job loss and anxiety about that threat
- Bullying, harassment and hazing at work
- Prejudice and discrimination at work
- Work-related trauma
- Work-related sleep disruption
- Toxic work-design elements (exposure to environmental aspects that cause pain or illness)
- Work culture of poor self-care and maladaptive coping (e.g., alcohol and drug use)
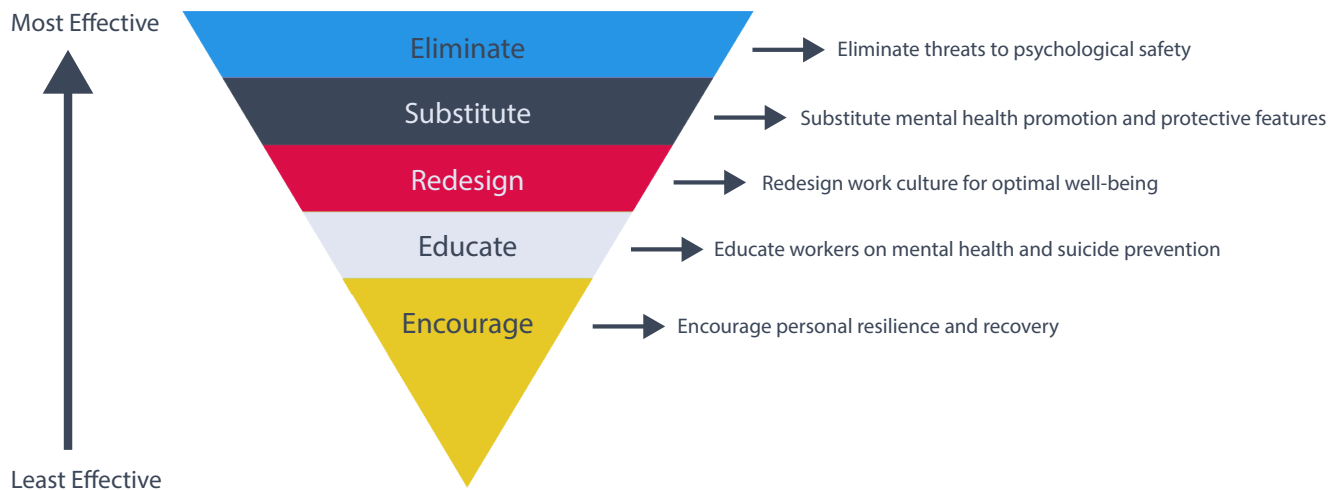
Of these, job security as been associated with higher odds of suicidal ideation and issues with job control appear to be more connected to a risk of suicide attempt and death [47]. Prospective evidence also exists that workplace bullying, especially physical intimidation, can lead to suicidal intensity [48].

One study on police suicide found that work-related adjustment issues were connected to the suicide in 43% of the cases [49]. About 1/3 of police officers who died by suicide had a work relationship

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problem and 1/3 were under investigation or some sort of work review [49]. They also found that suicidal ideation was predicted by increases in night shift hours worked. They concluded "…the largest source of job stresses and workplace mental illness among police officers stems from the organizational environment and organizational stressors…" (p. 132) rather than exposure to trauma or violence [49].

Thus, improvements in the psychosocial conditions of work may improve well-being and prevent suicide. Adapting NIOSH's Hierarchy of Controls [50], workplaces striving to prevent suicide can eliminate threats to psychological safety (e.g., bullying, toxic management practices, etc.) and substitute these unsafe practices with those that promote mental health and protective factors (e.g., cultivating a sense of belonging, volunteering, etc.).

Most Effective

Least Effective

- Eliminate → Eliminate threats to psychological safety
- Substitute → Substitute mental health promotion and protective features
- Redesign → Redesign work culture for optimal well-being
- Educate → Educate workers on mental health and suicide prevention
- Encourage → Encourage personal resilience and recovery

Adapted from NIOSH "Hierarchy of Controls"

Redesigning work culture for optimal well-being might include making access to quality mental health care (e.g., EAP services) easier or changing the process of performance review to be more collaborative and mindful of how psychological distress impacts work abilities [51]. At the bottom of the hierarchy we find the personal empowerment interventions of education and training for psychological safety and encouraging individual practices of self-care and treatment. The environmental interventions at the top of the pyramid are more likely to be effective because they impact everyone is a systemic way.

Workplace Wellness for the Employee and their Family

Humans are not able to turn off what they are experiencing outside of work when they come on to the job site; everything is coming to the job site with them. A large study conducted by the RAND Corporation reached out to 3,000 employers with 50+ employees via on-line survey, interview

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and case study methods and found the following [52]. While most of these employers had been providing wellness programs for their employees, most of the efforts have been focused on lifestyle management related to nutrition, smoking and fitness or disease management related to diabetes, asthma and heart disease [52]. The most common program components are some sort of health screening assessment combined with a behavioral change or education activity.

Table 3. Primary & Secondary Prevention Focus for Companies Offering Wellness Programs [52]

Lifestyle Management Program	% Offering Specific Interventions
Nutrition/weight	79%
Smoking	77%
Fitness	72%
Alcohol/drug abuse	52%
Stress Management	52%
Health education	36%
Other	5%
Disease Management Program	
Diabetes	85%
Asthma	60%
Heart Disease	59%
Depression	53%
Table 3. Primary and secondary prevention focus for companies offering wellness programs. 77% of companies that offer wellness programs offer the initiatives listed under "Lifestyle Management Programs" and 56% of companies that offer wellness programs offer the initiatives listed under "Disease Management Programs."	

Of note, mental health concerns have traditionally lagged behind other forms of workplace wellness — both in primary and secondary prevention. The reasons for this are not entirely clear other than the stigma surrounding mental health and the perception that conditions like mood and anxiety disorders are personal issues that are not relevant to the workplace.

That said, mental well-being programs (education and activity) at the workplace are definitely catching up [53]. Many workplaces are now more aware of the interconnectivity of physical and emotional wellbeing and are doing more to educate their workforce and support self-care through "mental health days," encouraging mindfulness practices and even providing opportunities for napping at work. Employee well-being is now considered a key business performance strategy not only boosting employee productivity, but also employee recruitment, engagement, and retention and ultimately significantly improving the company's brand [54]. One challenge, however, is that

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employers are also mindful of potential legal challenges and privacy concerns related to the ADA's voluntary participation guidelines and the collection of health data [53].

Another emerging trend in workplace wellness programs is family and social network engagement in employee well-being [55]. Having one's support system involved is a bigger motivator than healthcare professionals mandates resulting in better participation in the wellness activities and a strengthened sense of belonging between employees and their place of employment [55]. One group found that when they engaged friends and family in their workplace wellness, they achieved $232 of healthcare savings and productivity gains per employee [55].

> "Well-being is becoming a core responsibility of good corporate citizenship and a critical performance strategy to drive employee engagement, organizational energy, and productivity." " [54]

When it comes to wellness and suicide prevention specifically, wellness programs might consider:

- Offering suicide crisis resources as a part of the education activities to employee and their family.
- Providing a universal (i.e., everyone gets it — employees and any dependents covered by their healthcare) anonymous, interactive screening tool for suicide and other linked mental health symptoms that is then linked to qualified mental health resources
- Sharing and celebrating lived experience stories of recovery from suicidal intensity.
- Developing mental health crisis inoculation plans for employees before the crisis strikes.

What are the prioritized content areas needed and who are they for?

Priorities

When asked about content priorities, survey participants indicated that all of our suggestions were important (rating most 4 or 5 on our 5-point Likert scale); however, there were slight variations that resulted in this priority ranking:

Most important content areas (weighted average 4.09-4.35):

#1: Management training in how to support and accommodate employees experiencing a suicide crisis

#2: Crisis response — policy and protocol, especially to help families bereaved by suicide

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#3: Awareness raising regarding suicide and suicide prevention

#4: Reintegrating employees after a mental health or suicide crisis

#5: Leadership engagement in suicide prevention

Second tier priorities (weighted average 3.94-4.07):

#6 (tied): Skill building related to suicide prevention

#6 (tied): Mental health literacy

#7: Evaluating EAP and Union Assistance Program services for capacity to support mental wellness and suicidal employees

#8: Integration into wellness programs

#9: Building resilience

#10: Making the business case for suicide prevention

Third tier priorities (weighted average 3.52-3.79):

#11: Performance management when mental health issues are a concern

#12: Legal/HR issues and suicide prevention in the workplace

#13: Drug and alcohol literacy as related to workplace injuries and case management

#14: Screening for mental health conditions and suicidal thoughts

#15: Reducing access to lethal means (e.g., firearms, high places, lethal medication)

Suggested Elements

Getting Past Fear and Barriers. The participants in the exploratory analysis acknowledged a great deal of fear exists when considering suicide prevention in the workplace. Some of the concerns they are hoping the guidelines might alleviate include:

- Privacy (how is data collected, how is suicide-related information about an employee shared)
- Legal issues (ADA, HIPAA, FMLA)
- Regulatory standards and security/health status clearance in some occupations
- Resource strain (time/money) on taking on another aspect of employee well-being

System Level and Individual Level. Many of our participants had challenges in understanding that the "best practices" conversation we were having was aimed at the system level, not at the individual

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level. For instance, despite repeated clarification, some focus groups were confused on how an on-line workplace suicide prevention portal would help a suicidal employee. This confusion will most likely also exist when the best practices are rolled out; thus, the platform should acknowledge this need and direct users to other locations when they need that form of guidance (e.g., what to say to a suicidal person, or how to access crisis support) "just in time." The primary purpose of this set of guidelines, however, is to assist employers and professional associations build and implement a system-wide strategy.

Build a Community of Practice. Participants in the exploratory analysis expressed a desire to create a community of employers that shared their lessons learned and pilot programs and policies. This objective could be achieved by in-person academies and summits like the "Zero Suicide in Healthcare" initiative or via social media platforms.

Make Suicide Crisis Support Evident from the Beginning. Just like many tragedies and catastrophes, most workplaces do not believe suicide will impact them, until it does. When the crisis strikes, some of these reactive workplaces may start urgently searching for resources and will inevitably stumble upon the "best practices" in a state of postvention crisis (e.g., just after an employee death). Thus, having accessible crisis guidance for workplaces reeling from a suicide crisis will be an important feature of the website portal.

Who Will Benefit from the Guidelines?

Leadership. Because the success of workplace suicide prevention is largely driven by a cultural shift away from a reactionary denial and toward a proactive, culture of care and well-being, leadership engagement is crucial. Ideas to get leadership buy-in included:

- Build the business case
- Show models of leaders who champion momentum by selling the value of the effort
- Link suicide prevention to employer trends
- Create leadership peer groups

Several suggestions on the role of leaders were offered by the participants including guidance on authentic messaging from the organization's top person. Before any systems changes occur, leaders should publicly proclaim, "This is why I care about suicide prevention here at our organization and this is how employee well-being is tied to our mission. Your life and quality of life are important to me." Leaders who have personal lived experience with suicide can be coached to tell their story of impact safely and effectively to inspire hope. Messages from the top giving permission for self-care and reassurance for employee support can go a long way.

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Managers/Supervisors/HR. HR professionals, managers and supervisors are often in the most challenging role when it comes to suicide prevention in the workplace. Many times they are not made aware of an emerging suicide crisis until it has progressed significantly, often bringing with it a number of performance-related problems. Thus, these go-to decision-makers need clear guidance in the form of training and protocol on communication skills, legal issues, and resources.

Knowing that these professionals often feel isolated and under pressure to do the right thing for both the employees and the company, we also need to be mindful of "Who is helping the helpers?" Because these middle tier professionals are also often on the front line of any suicide or mental health crises, their risk for burnout may be higher than others.

Suggested suicide prevention, intervention and postvention topics for these professionals include:

- Familiarity with policies and the law and how policies, law and protocol are implemented in real situations.

- What to do when there is a performance issue related to suicide intensity or a mental health condition.

- Re-integration and accommodation best practices (e.g., a checklist from doctor just like with reintegration after a physical injury or illness — what can employees be expected to do and what are expected limitations?) after a mental health crisis, suicide attempt or suicide death of an employee's family member.

- How do we negotiate privacy and "need to know" concerns.

- How can these professionals send a strong message: "you are of value to us. We need you here."

Safety Manager/Trainer and Risk Management. Being a pragmatic group, many safety professionals have become the early adopters of the suicide prevention in the workplace efforts [56-59]. On one hand, unchecked suicidal intensity can lead to distraction, fatigue and unneeded risk taking, which might lead to additional safety concerns. On the other hand, the culture of workplace safety often prioritizes employees looking out for one another, which is an easily adaptable message for suicide prevention.

Security/Violence-in-the-Workplace Prevention Advocates. Knowing that most workplaces are already tuned into workplace violence prevention and that one of the biggest concerns within this area is the suicidal-homicidal avenger, security and workplace violence prevention professionals also benefit from being part of this conversation. While homicide-suicides only account for about 2% of all suicides [60], they dominate social consciousness. What experts tell us is that in most instances of

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homicide-suicide, the suicidal thinking comes first and then through a "perversion of virtue," homicidal thinking follows [60]. Thus, if we can prevent the suicide, we prevent the homicide.

Peer Supporters and Specialists/Mentors/Wellness Coordinators. Emerging evidence suggests peers are the most likely to provide desired, life-saving emotional support needed to help people overcome suicidal despair [61]. We know that many of those most at risk for suicide are sometimes least likely to reach out to professional clinical services [62], but they often will reach out to a trusted peer or colleague. A well-selected, trained, and supervised peer specialist has the potential to decrease loneliness through empathic listening and shared lived experience and may provide hope as a model of recovery. Evidence exists that peers can improve activation in helpful professional care while avoiding traumatizing, humiliating and disempowering crisis services [61]. Thus, peers' involvement in workplace suicide prevention often provides the needed link in the chain of survival for employees.

While mentors and wellness coordinators are not the same as peer supporters or peer specialists, they often share the position of a trustworthy confidant for employees, and workers may feel safe disclosing sensitive information to them. Thus, people in these roles might benefit from being included in a comprehensive workplace approach for suicide prevention.

Legal Advisors. Because the topic of suicide is so daunting and workplaces fear increased liability for making the situation worse, many look to legal advisors to help guide prudent decision-making. Unfortunately, legal advisors often succumb to the same myths and misperceptions that the general public has, because they have not received adequate training on understanding suicide and what prevents it.

Employee Assistance Professionals (EAP). Today most large and mid-sized companies have EAPs. While the research on the effectiveness of EAP is sparse, studies have found that employee's use of EAPs enhances workplace and individual outcomes. Specifically, evidence exists showing significant improvement in presenteeism, life satisfaction, functioning and often absenteeism [63-66]. In one longitudinal controlled study, EAP participants were more likely than non-EAP participants to see a reduction in anxiety and depression [67]. Another matched control study found that users of EAP services often reduce absenteeism more quickly than non-EAP users experiencing similar challenges [68]. In another longitudinal study [69], 86% of people who were suicidal when they engaged with their EAP were no longer suicidal at two years follow up. Researchers have concluded that while not all EAP are created equal, they often provide accessible services that are effective at improving employee mental health.

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Thus, EAPs have the potential to provide evidence-based suicide prevention intervention and postvention services to employers. Their contribution to the comprehensive workplace strategy is essential, and like many mental health providers, many of them "don't know what they don't know."

Workplaces that Have EAP [63]

- 100%   Federal Employees
- 86%   State Employees
- 85-97%   Large Private Sector
- 68%   100-499 Employee Workplace
- 44%   51-99 Employee Workplace
- 27%   <50 Employee Workplace

According to Dr. Paul Quinnett, past President of the American Association of Suicidology and Founder of the QPR Institute, surveys assessing clinician's (general mental health providers, not necessarily EAP) competency in suicide risk assessment and intervention often find that most mental health providers have received just basic training (usually under 10 hours during graduate school) and that many are not able to pass a basic competency assessment. For example, Dr. Quinnett administered a 25-item competency quiz to 231 practicing clinicians from Georgia's mental health system. Only 20 of the 231 passed the pre-test; however, after a day of training, 200 passed. Social workers, who provide the majority of EAP clinical services in the US, often report having no formal training in suicide formulation, response and recovery [70-71].

Labor. Unions are in a unique position to support suicide prevention in the workplace due to their commitment to uphold the dignity of work and their ability to inspire people to action. The culture of solidarity and an ethos of "I've got your back" in many unions is conducive to suicide prevention's message of people looking out for one another and supporting one another through tough times. Unions' training priorities and communication reach also make them excellent partners in suicide prevention.

What is the preferred format and style for the guidelines?

Style

When asked what features they would like to see within the National Guidelines, survey participants were most interested in links to well-organized, vetted and described resources (74%) followed by downloadable policy templates (66%). Additionally, they thought some sort of visible acknowledgement of other companies who have pledged to implement guidelines would be helpful (53%) along with company leadership endorsement (52%). Of equal priority were mini on-line video tutorials/webinars

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as well as someone to contact if there were questions. Of lower importance were case studies (33%) and recognition of achievement at each step of the process (23%).

The survey closed with an open-ended question, "Any additional comments you'd like to make about the National Guidelines for Workplace Suicide Prevention?" Here 30 people posted responses, most emphasizing their gratitude for the importance of the Guidelines as well as the urgency to "get it done." Some underscored the need to "keep it simple" and to start slowly as many workplaces are confused and fearful about the topic of suicide.

Independent Website Portal. At the heart of the Guidelines initiative participants requested an independent, free-standing, easily accessible website portal. The founding organizations and lead contributors would be acknowledged in the "About Us" tab, but the messaging and potential brand confusion would not deter from the main message of the "Aspiring to a Zero Suicide Mindset at Work" effort.

Stories. Over and over again in the focus groups and in-depth-interviews people requested stories. They wanted to see others in their similar role or industry having success in suicide prevention. These stories could come in the form of brief testimonial videos/podcasts, or blogs by thought leaders or through published case studies. What they wanted to see most was trusted peers modeling appropriate and hopeful messaging that implementing these practices can have a positive effect. When it comes to stigma reduction and building trust within a community, storytelling is an unparalleled tactic [72].

Interactive, Technologically Savvy & Visually Appealing. Several of the participants expressed a desire to engage with technology as part of the best practices implementation. At the very least, they wanted to make sure the resources were phone compatible and used multimedia with minimal text. Micro-podcasts (less than 15 minutes) or brief webinars were recommended to go along with graphic or written word downloads.

The best practices need to be portrayed in a visually appealing way that is easy to navigate and offers a simple and clear step-wise progression. So as not to overwhelm or confuse, the action steps should be given just three to five at a time and be free of jargon. The portal needs to be searchable, so employers can find what they need "just in time." One successful example given to emulate the ability to distill complicated content into simple easy-to-grasp content is the color-coded stress continuum originally created by the U.S. Marine Corps (next page) and adopted by many.

Scalable and Flexible. The best practices should be able to have alignment with different workplace cultures and regulatory/licensing requirements and also be appealing to diverse generational perspectives.

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Stress Continuum Model

READY (green)	REACTING (yellow)	INJURED (orange)	ILL (red)
DEFINITION • Optimal functioning • Adaptive growth • Wellness **FEATURES** • At one's best • Well-trained and prepared • In control • Physically, mentally, and spiritually fit • Mission-focused • Motivated • Calm and steady • Having fun • Behaving ethically	**DEFINITION** • Mild and transient distress or impairment • Always goes away • Low risk **FEATURES** • Feeling irritable, anxious or down • Loss of motivation • Loss of focus • Difficulty sleeping • Muscle tension or other • Physical changes • Not having fun **CAUSES** • Any stressor	**DEFINITION** • More severe and persistent distress or impairment • Leaves a scar • Higher risk **FEATURES** • Loss of control • Panic, rage or depression • No longer feeling like normal self • Excessive guilt, shame, or blame **CAUSES** • Life threat • Loss • Moral injury • Wear and tear	**DEFINITION** • Clinical mental disorder • Unhealed stress injury causing impairment **FEATURES** • Symptoms persist and worsen over time • Severe distress or social or occupational impairment **TYPES** • PTSD • Depression • Anxiety • Substance abuse

Engaging and Rewarding. Outward-facing "belonging" symbols like a "seal of participation" can be offered to participants and displayed as a source of pride. Social media engagement can offer opportunities to recognize and reward successful endeavors while offering effective resources and tips shared in case studies. Some even suggested offering some sort of "Workplace Recognition Award," possibly through the American Foundation for Suicide Prevention's local network.

Other incentives suggested included the opportunity to earn some sort of continuing education credit or certification that could publicly acknowledge their effort. An additional idea was to get some sort of organizational health insurance discount or benefit for participating in or completing the program.

Moving Workplace Systems along a "Stages of Change" Model

In any change process, if the intervention is mismatched with the target population, things will not progress. Usually at the beginning of the change process, people are unaware (or "in denial") that there is a problem. People and systems who are in this stage are what some have called "precontemplative." Eventually, if there truly is a problem, enough data will be presented that starts to conflict with their belief that there is "no problem" and the thinking shifts to "maybe we don't have a problem, but maybe we do." This stage is the "contemplation stage" and is one of the most critical and overlooked stages in the chain of change.

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STAGES OF CHANGE MODEL

Stages		Intervention
Precontemplation	→	Bring personalized awareness
Contemplation	→	Think more about pros/cons
Determination	→	Make plan for action
Action	→	Do something
Maintenance	→	Evaluate and support efforts

Adapted from: Prochaska J, DiClimente C, & Norcross J. (1993). In search of how people change: Applications to addictive behaviors. Journal of Addications Nursing, 5(1):2-16.

As with the "stages of change" transtheoretical model promoted by Prochaska and DiClemente (1993), we must craft our strategy of change to the readiness of the changing person or system [73]. When people or systems are precontemplative, successful change agents try to move them along the stages of change by getting them to "think about" and "notice" situations instead of recommending action steps. At some point, the consequences of not changing and the benefits of change begin to become apparent. In the effort to move a person or system from "precontemplation" to "contemplation" the person advocating change encourages the other to weigh the pros and cons of change and no change. Once the consequences of staying the same outweigh the consequences of change, a commitment to change is possible. It's not until the individual or system expresses a determination or readiness that planning and implementation of programs and policies can be productive. Once that stage of change has occurred, systems can move toward the institutionalization, expansion, and professionalization of these changes.

For example, after a 2017 "Public Health Summit" on mental health in the workplace, participants recommended the following steps in this process of change — create executive training, a "how to guide," a score card, and a recognition program [2]. As workplace systems implement these suicide prevention best practices, we should be mindful of the "stages of change" process and move them along intentionally through the following steps:

Step One: Are You Ready? In this step, we offer workplace systems an opportunity to take a quick self-assessment to help guide them through weighing the pros and cons of staying the same or making a step toward suicide prevention. At this stage we might enroll workplaces through webinars, conference presentations and academies like the "Zero Suicide in Healthcare" initiative.

Step Two: Pledge to Action. In this step organizations make a public pledge to make suicide prevention a health and safety priority. As part of this pledge, they agree to announce to their internal team and external partners that this is their intention and also agree to put their company logo on the

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"Aspiring to a Zero Suicide Mindset at Work" website. At this stage they register with the portal and open an account to start the process of implementing the best practices.

Step Three: Engage in the Step-Wise Pathway of Implementation. Here the workplace system is engaged in a step-by-step process through all of the identified practices. At each step they are encouraged to demonstrate some threshold for accountability in order to achieve a final certification of psychological safety. Along the way a "thermometer of progress" shows their accomplishments and lessons learned in the hopes that positive peer pressure will get others to say, "Others are doing it, we need to rise to that level." The website account can be set up to send quarterly reminders and tips for taking another step.

Tools and Resources

Very consistently the participants requested well-organized and easily adapted resources. Some ideas for these "plug and play" resources included:

Small Group (Team-Based) Interactions. These small group interactions could be in the form of table-top exercises ("what would you do?") or psychological safety briefings (e.g., "Toolbox Talks").

Fact sheets. Checklists and Flowcharts. These quick reference tools can help guide decision-making and provide content for communication.

Vetted Programs and Communications. Here they can assess social media collateral and ideas on how they can participate in things like National Suicide Prevention Week, World Suicide Prevention Day or International Survivors of Suicide Loss Day.

Sample Policy and Protocol. Examples here include the "Manager's Guide to Suicide Postvention," accommodation protocol for reintegration, and sample "Second Chance Agreements" for employees who are having chronic challenges overcoming destructive patterns of behavioral health.

What are recommended marketing and distribution tactics?

Pilot First

A number of participants recommended that once the best practices and the engagement process are up on the website portal, a handful of employers and professional associations try out the program to get preliminary feedback on its ease of use and effectiveness. The organizations selected for this pilot should represent diverse industries and sizes of companies. Should their experiences be positive, their endorsements would carry significant weight in the future promotional efforts.

Dissemination Tools

- Trade journal publications

- Conference presentations

- Guest podcasts/blogs/webinars

- One-pager — call to action "Take this to your employer"

- Public service announcements: Once the program was ready for launch, a brief PSA could help communicate an urgency for workplace engagement. For example, one participant suggested a 30-second video of a worker going to the gate or door of a worksite holding the hand of a small child with the voiceover: "she needs you — your psychological safety is as important as your physical safety. Find out how to get your employer to be a leader in workplace suicide prevention today."

Channels of Distribution

Labor

- American Federation of Labor (AFL)

- Congress of Industrial Organizations (CIO)

- International Labor Association

- North America's Building Trades Unions (NABTU)

- Other Local Trade Unions/Guilds

Professional Associations

- American Society of Safety Professionals

- American Safety Council

- Associated General Contractors

- Associated Builders and Contractors

- American Industrial Hygiene Association

- Association of Union Contractors

- Bar Associations

- Employee Assistance Professionals Association (EAPA)

- International Risk Management Institute (IRMI)

- National Association of Emergency Medical Technicians

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- National Safety Council

- Society of Military Engineers

- Society for Human Resource Management

- United States Army Corps of Engineers

- Chambers of Commerce

- Rotary Clubs

- Construction Users Roundtable (CURT)

- The Association of Union Constructors

Insurers (Health and Workers Compensation)

- ACE Risk Management

- Aetna

- AmTrust Group

- Anthem

- American Contractors Insurance Group (ACIG)

- Berkshire Hathaway

- Chubb Ltd. Group

- Cigna

- Hartford Group

- Humana

- Kaiser Permanente

- Liberty Mutual Group

- Magellan Health

- New York State Fund

- Pinnacle

- State Compensation Fund of California

- Texas Mutual

- Travelers Group

- UnitedHealthCare (UHC)

- Zurich Ins. Group

Universities

- Business management programs

Public Health, Standards and Regulatory Agencies

- American National Standards Institute

- Bureau of Labor Statistics

- Centers for Disease Control and Prevention (CDC)

- National Institute for Occupational Safety and Health (NIOSH)

- Occupational Safety and Health Administration (OSHA)

Suicide Prevention and Mental Health Promotion Organizations

- American Association for Suicidology

- American Foundation for Suicide Prevention (AFSP)

- Center for Workplace Mental Health

- Construction Industry Alliance for Suicide Prevention

- Crisis Text Line

- Mental Health America

- National Alliance on Mental Illness (NAMI)

- National Action Alliance for Suicide Prevention

- National Council for Behavioral Health

- National Suicide Prevention Lifeline

- Professionals In Human Resources Association (PIHRA)

- Responder Strong

- United Suicide Survivors International

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PART V: PROPOSED SOLUTIONS

Upstream

As a reminder, upstream strategies are those prevention efforts we put in place to bolster protective factors and to help prevent the problems from happening in the first place. Here are some recurrent themes related to potentially viable upstream suicide prevention strategies for a workplace or industry group.

Recruitment, On-Boarding & Work Transitions

Before new employees have even started, messages about well-being and support should be prominent. For instance, one participant suggested that recruitment strategies say something like, "To us, the 'best and brightest' also means the most well-rounded." Outward facing recruitment practices should connect the dots between emotional health and employer priorities with statements like, "You are an asset. We want our workplace to be psychologically safe, so you can thrive here."

Additionally, key tactics to build a culture of trust and community resilience should be enforced early and often and raise the question, "What does it mean to be a 'best place to work'?" from a psychological perspective?

During the on-boarding process, employees would benefit from some sort of stress inoculation training as well as an in-depth orientation to the mental health and crisis resources available to them. This orientation should go beyond a pamphlet in a folder, allow employees to ask questions, and meet mental health providers face-to-face.

Knowing employees in transition can be vulnerable, additional booster sessions might be offered when employees are experiencing a:

- New job
- New role
- Disability
- Lay-off/Furlough
- Retirement

Sense of Purpose and Belonging

When communities pull together and strive toward a common and compelling mission the experience of solidarity helps people get through the day-to-day drudgery and hardship that often comes with

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work. Work identities can also bolster our sense of self-worth and sense of connection. According to Dr. Thomas Joiner's 2006 interpersonal psychological theory of suicide risk, when this sense of belonging is thwarted or we lose our sense of purpose, our risk for suicide increases [74]. Thus, workplaces that strategically foster positive and purposeful group bonding are also adding to the resilience of the workers. With the movement toward telework, organizations will need to get creative on how to help people feel connected (e.g., work group video calls instead of just telephone) to help ward off loneliness that so many Americans feel [75]. Reminding workers of how their contributions serve a bigger vision can help people feel connected to one another and a sense of mission. Other tactics include creating many opportunities for affinity or social groups to thrive or engaging workers' families in the workplace community.

Suicide Prevention Literacy

Because so much misinformation and myth surround suicide, basic education can help people move from stigmatized and prejudicial views to compassion. Basic theory like Joiner's theory can chip away at beliefs like "suicide is a selfish act" or "suicide is cowardly" [74]. Some appreciation of brain science and recovery processes can also shatter myths about moral failing and inevitability. Suicide prevention literacy is also about promoting suicide-specific resources like the National Suicide Prevention Lifeline, Crisis Text Line, HelpPro Suicide Prevention Therapist Finder, Alliance of Hope (for people bereaved by suicide), and suicide-specific support groups (post loss and attempt). Suicide prevention literacy can be integrated into the work that many companies are doing to support mental health literacy, but workplaces should be aware that not all people living with suicidal intensity have a mental health condition and that most people living with a mental health condition do not experience suicidal intensity. Finally, awareness is necessary but insufficient for social change — workplaces must go beyond raising awareness if they are genuine in their desire to reduce suicide.

Recognize and Reward Resilience, Recovery and Compassion

Companies seeking to shift culture to a "Zero Suicide Mindset" will seek to recognize and reward practices and experiences of empathy and recovery. When we think about "mental health" and "suicide prevention" we are usually only thinking about the symptoms of mental illness. What if instead we actually put energy toward encouraging emotional well-being by encouraging gratitude, kindness and making meaning?

One way would be to promote core tenets of positive psychology by offering incentivized wellness programs like KyndHub. KyndHub is an online workplace community that rewards and incentivizes daily practices of volunteerism, intentional acts of kindness, and gratitude in a fun and social way.

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Recognition of skilled and committed employees is easy and free – and one of the best tactics to reduce the experience of distress and increase morale and productivity at work. This expression of gratitude works best when it is specific and authentic. A simple handwritten note of heartfelt gratitude can go a lot farther than forced workplace appreciation assemblies or meaningless "thank you for your hard work" statements.

> "[When it comes to supporting someone in a suicide crisis] Where do we find counselors who know what to do?"
>
> - Business leader, In-Depth Interview

Kindness and compassion are also positive psychology practices that employers can model and promote to increase a mindset of caring for one another. Building skills in empathy among supervisors, for example can be a part of leadership training.

Finally, positive psychology practices of learning how to "make meaning" can be developed by understanding how employees want to give back. For some, this may take the form of mentoring newer employees. For others, it may mean being engaged in community volunteering on behalf of the company. Contributing the common good helps people feel good about themselves and their workplace.

Wellness Fairs and Safety Milestone Celebrations

Positioning suicide prevention in a positive light can shift the experience from dark and taboo to one of strength and celebration. One creative employer offered family-friendly wellness fairs for their employees. Among the bouncy castles for kids and pancakes were booths where family members could get information on mental health and crisis resources and meet providers. This event underscored the message that health, including emotional health, is a family priority that the workplace supports. Another effort publicly and enthusiastically displayed cardboard stars where each star represented a member of the community that had reached out for mental health services.

Connect the Dots among Health Concerns Like Sleep, Pain and Addiction

While there are many mind-body connections tied to suicide, two consistently emerged in the exploratory analysis: sleep and the opioid crisis. Because the ethos of work pride can often be misconstrued by who works the longest hours or through the most pain, these two health concerns can sometimes be exacerbated by the workplace climate. Even when controlling for depression, one

study found that poor sleep status resulted in a three-fold increase in suicidal behaviors in college students [76]. Specific sleep problems connected to suicidal intensity include shorter sleep duration, nightmares, and greater sleep medication use.

Chronic pain and suicide are connected [77]. This connection may be exacerbated by the increased access to opioids from prescriptions that up the dosage levels and larger quantities (i.e., a supply issue), and the opioid-suicide connection may also be connected to the "deaths of despair" trend (i.e., a demand issue). The "deaths of despair" is a concerning trend identified by health economists who noticed the mortality rates of men in the middle years were going up, and almost all of the deaths were attributable to suicide, overdose and the consequences of addiction [78-79]. The researchers who coined this phase dug into why this was happening and concluded that the trend is "consistent with the labor market collapsing for people with less than a college degree." In turn, people experiencing such a fall in social and economic status are challenged to hold stable family structure (e.g., marriage), which starts to unravel all other areas of life. In other words, the people in the "deaths of despair" trend had expectations — hopes and dreams of living the American dream — and when these dreams are crushed, mortality and morbidity ensue.

One challenge is how to determine cause of death in situations involving overdoses and the consequences of addiction. Without a suicide note (and only about 1/3 of people leave notes), intent is unclear. Furthermore, intent can be very dynamic and dimensional rather than categorical [77]. When coroners do not conduct a psychological autopsy, many "deaths of despair" may be misclassified as overdose when in fact they were suicide deaths.
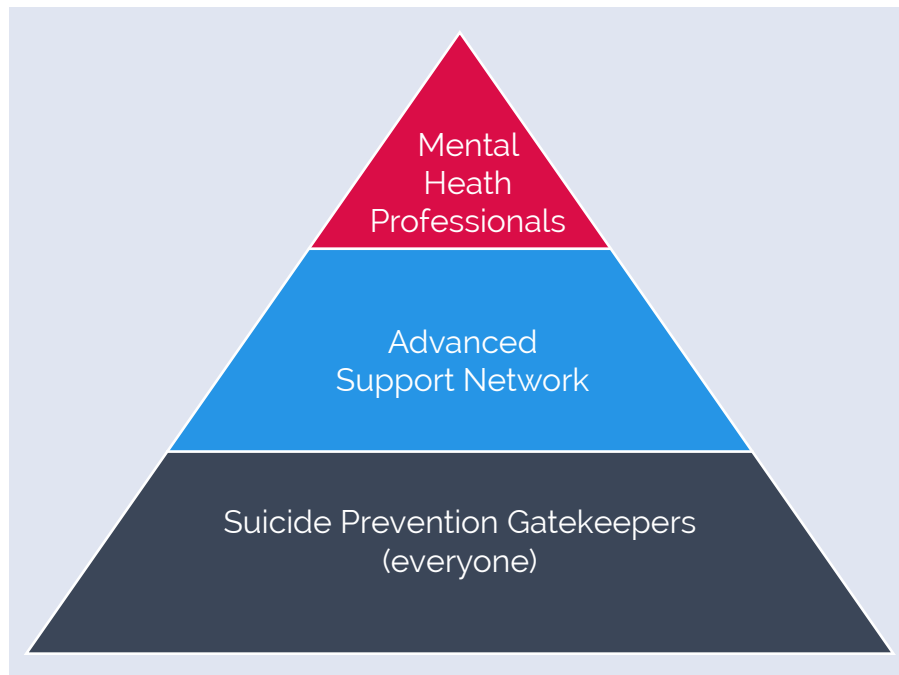
Midstream

Midstream approaches are those used to catch emerging problems when they are small and more manageable. In the case of suicide prevention, we want to be able to identify and intervene when people are having the "first thought" of suicide or when their ability to cope with the distress is on the cusp of failing. Just like screening for cancer, finding a small lump is much easier to correct than discovering cancer at Stage 4. The following "midstream" recommendations are considered best practices and may be viable for a workplace community.

Building Out Safety Net (or Pyramid)

No longer is it only the mental health professionals' responsibility to prevent suicide — everyone can play a role. In fact, as the founder of the well-known suicide prevention gatekeeper training program QPR (Question, Persuade, Refer) Dr. Paul Quinnett states, "the person most likely to save your life from suicide is someone you already know" - a friend, family member, classmate, etc.

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A best practice for a comprehensive suicide prevention program within any large system is to build out a stratification of roles and skills. At the bottom level everyone gets some basic awareness and skills, just like CPR. The more people know these skills, the more "eyes we have on the playing field" and the more likely someone will notice and take action when needed. Indeed research supports the conclusion that greater awareness of symptoms of suicidality is associated with greater help-seeking [11].

At the middle tier are managers, peer supporters, wellness coordinators, safety managers and the like with advanced gatekeeper awareness/skills and psychological first aid (e.g., mindfulness, emotional regulation, wellness action plans and safety agreements). MATES in Construction, an evidence-based workplace program call this tier "The Connectors." This tier is like the EMT level of the comprehensive suicide prevention community. They are the ones people turn to when they are wondering "should we be worried?" Well-trained people at this advanced support level can help triage the concerns by either resolving the emotional challenges of others with basic active listening, empathy, empowerment and caring follow up, or being a caring liaison if a more rigorous intervention is needed. Anecdotally, a repeated finding among systems (e.g., firefighters, law enforcement, aviation, mental health peer specialists, etc.) that have activated this middle tier is that about 80% of the distress can be resolved at this level. [See more in the sections that follow]

At the top level are highly trained and supported EAP mental health professionals and trusted community mental health partners. These professionals assist with the most complicated and acute cases and also help supervise and train the middle tier.

Annual Multi-Component Suicide-Specific Training Program

Most workplaces lack the confidence and competence to start conversations about suicide. Thus, a tiered model of on-going training is needed such as how to have safe and effective conversations about suicide at work. For example, a preferred approach might be to say, "You are not yourself lately. I am concerned and would like to help you because I know you would do the same thing for me. I want to get you back on track." vs. "I think you have this mental illness." Training can help coworkers set a tone of support out of the gate and to troubleshoot what to do when people refuse help.

In Australia, the well-established program called MATES in Construction demonstrated that a one-hour general awareness training that highlighted an understanding of suicide and mental health, offered support and encouraged help-seeking/help-giving resulted in significant positive shifts in attitudes [80].

With this stratified model, it now becomes everyone's responsibility to be alert to possibility of suicide. Just like with CPR, the workplace will need to be regularly refreshed on these skills or the effect of the training will wane over time [81]. In order to be fully effective, workplace communities should be saturated with gatekeeper trainings, meaning all members need to have taken it at least once. Several suggestions for gatekeeper trainings (basic and advanced) are listed in the Appendix.

In-person gatekeeper trainings. In-person gatekeeper training models are usually offered for groups of 10-30 people and go beyond awareness to teach and practice conversational and referral skills to lay people. Examples workplace-friendly gatekeeper trainings are QPR (Question, Persuade, Refer), safeTALK and Working Minds (see Appendix for more information). These trainings can be given in 90 minutes to 3 1/3 hours and, like CPR are designed to raise the confidence and competence of the lay person to notice when someone is in distress and take steps to sustain their life until professional helpers can assist.

When building out a stratified suicide prevention program another training tier is often needed for managers/HR and peer specialists. Within this "Advanced Support Network" the advanced peers would get additional training on how best to triage workers who disclose suicidal thoughts or feelings and how to help them build a collaborative safety and wellness agreement. At this "EMT" level, many systems choose the two-day ASIST training.

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In the guidebook titled, "How to Move from Awareness to Action in Suicide Prevention and Mental Health Promotion," twenty-three suggestions are offered to help assure trainings are as safe and effective as possible. Some suggestions include:

- Balance training fidelity with cultural responsiveness

- Include varying multi-sensorial learning methods

- Model and practice new skill sets

- Highlight lived experience through real stories of hope and recovery or how people cope with suicide grief

- Connect content to science (e.g., neuroscience, suicide prevention success research)

- Offer small group interactive exercises based on problem-solving

- Engage local resources and help participants learn how to evaluate and access them

- Optimally, trainings should be led by highly trained peers who have "walked in the shoes" and supported by mental health professionals. Thus, train-the-trainer models for the basic skills training are needed

On-line gatekeeper trainings. Significant advances in artificial intelligence, simulation and gaming technology have led to the development of emotionally responsive virtual humans that are able to process aspects of conversation like personality and non-verbal gestures so they react like actual humans engaged in real-life health conversations [83]. Several factors make this form of web-based suicide prevention training and self-screening particularly advantageous, including the fact that emerging evidence suggests that participants in on-line gatekeeper trainings such as those provided by Kognito (see Appendix for more information) may actually be more authentic than in face-to-face trainings [83]. Thus, on-line training can be used to supplement in-person trainings as a refresher or to train workers who are unable to attend the in-person version due to remote working status or other barriers.

Gatekeeper refers to "individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine." They may be trained to "identify persons at risk of suicide and refer them to treatment or supporting services as appropriate."   [82]

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Saturation and Recertification. Just like with CPR, workplaces who are dedicated to psychological safety should ensure that all workers — regardless of status — receive the basic level of gatekeeper training. And just like with CPR, workers will often need to be retrained on a regular basis to keep the skills fresh.

Gatekeeper trainings for workplace managers have been shown to improve knowledge, attitudes and self-reported behavior in supporting employees [84], but it's not yet clear if these changes result in changes in psychological distress among employees. We can infer from other large scale studies in military personnel that report promising results with a significant reduction in suicidal ideation, suicide attempts, and deaths by suicide after gatekeeper training; however, the longevity of these findings is uncertain, indicating that a "one-and-done" training may not have lasting effects [85]. Recommendations to help sustain the impact of gatekeeper trainings include [81]:

- Building a social network of trainers

- Strengthen the skills learned with more opportunities to practice, observe and get feedback on mastery, potentially through gamified on-line training such as Kognito

- Send follow-up materials to trainees in a way that simply reminds them of key aspects of the training

All trainings must offer ample opportunity to practice skills and get feedback with the goal of proficiency and ultimately mastery.

Build a Support Network: Power of Peers

Peers within and outside of work who are aware of distress among their coworkers often feel helpless, frustrated, ill-equipped and overwhelmed when trying to support them. Those with the highest risk for suicide often don't seek help on their own due to perceived lack of time or need and a skepticism that treatment would be helpful.

An Advanced Support Network of trained peer supporters or peer specialists offers an excellent model of a gap-filling intervention for workplaces. Who are these peer specialists? Key staff can be recruited from formal leadership positions, while others are nominated as natural helpers by the workplace community. Still others can self-nominate and volunteer because of their desire to serve. Candidates for these leadership roles often complete a competitive application process that assesses their motivation, commitment and skills to become trusted confidants.

After an orientation and advanced training program that helps them build advanced skills of empathy and referral, the selected peers are then identified to the rest of workplace community as trustworthy listeners and liaisons. The peers then receive on-going training on the boundaries of their service and

are assisted by licensed professional mental health providers who can help them troubleshoot more difficult situations.

Formal peer support programs in workplaces have existed for decades in some larger municipal emergency responder communities and professional "member assistance programs" for doctors and lawyers, but they remain a relatively new and innovative concept for most other industries. Some unions within transportation and construction have also adopted the ideas of building formal peer support programs, and within these male dominated workforces, the peer help is often preferable to professional help.

Communication — Baked In to Health and Safety Culture

To supplement an organization-wide training program, communication about upstream, midstream and downstream suicide prevention approaches can be integrated into all places where health and safety show up at work. The communication might include what to notice, how to cope, how to reach out, how to pull together as a community, and how to make meaning out of difficult times. Resources for all levels (self-care, peer care, professional care and crisis care) should be continually promoted, with personal endorsements and reassurance from members of the workplace community. When possible, specific communication such as the use of humor, a unique connection to workplace culture, or a connection to the workplace's values will help increase the acceptance of the messages.

Communication can take many forms: newsletter articles, social media, safety briefings, and so on. One company even built proactive suicide prevention communication into their benefits renewal process by having their wellness coordinator state to each worker individually, "You know, this year suicide prevention is our wellness priority. So, if you or anyone in your family should find yourself in suicidal despair, we have your back. Here is the National Suicide Prevention Lifeline and our EAP resource. If you get stuck, please reach out to me so we can figure out next steps together."

Others are looking for ways to incentivize engagement in emotional health through their formal wellness program by acknowledging and rewarding (e.g., earning points toward prizes) when employees complete anonymous self-screening tools, attend lunch-and-learns on related topics, or complete trainings.

Screening

Screening helps people self-assess "how bad is it?" and answer the internal question "can I fix this myself, or should I see a doctor?" Screening can often be the intervention that moves people from "I don't have a problem" to "maybe I have a problem," which, as mentioned, is one of the most important steps in the process of change.

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Anonymous and confidential screening can help engage those most reluctant to seek help on their own. For a while we have known that frequent and regular screenings for breast and testicular cancer can help identify problems before they develop into life-or-death situations. Similarly, the prognoses for mental health conditions or emerging suicidal crises are most favorable when they are detected early and treated appropriately. Unfortunately, suicidal thoughts sometimes fester because people are too ashamed to reach out or because they are not able to connect symptoms like insomnia or agitation to an underlying risk for suicide.

> "Unknown risk is unmanageable risk. You can't change what you don't measure."
>
> - Dr. Paul Quinnett (Personal Communication, 2019)

The longer mental health problems and suicidal thoughts go unaddressed, however, the more catastrophic they can become. Treating a highly suicidal individual is much more invasive and complicated that treating someone in the early stages of depression or anxiety. Like other medical checkups, screenings for mental health conditions and suicidal thoughts are most effective when they are repeated over time and considered a standard part of one's overall healthcare routine.

Self-screenings can be a universal tool, meaning anyone can use them to help detect signs and symptoms of larger issues. They should not be used to diagnose, but they can provide a quick-and-dirty snapshot to help identify low- and high-risk populations and empower people to be proactive in this form of their health. Like all the other public health interventions, the best screening tools are scientifically sound. While it might be tempting to just create your own, you are better off using one of the many that have already been validated (suggestions are offered in the Appendix).

These tools should also provide is a call to action. Screenings are not living up to their potential if all they do is sort people into different levels of risk. They must also provide the participants with a prescription for next steps. For example, after someone's self-screen results indicate potentially elevated levels of substance use, they can be given information and encouragement to visit the Employee Assistance Program, to employ these self-care strategies, or to call this hotline, etc.

Online self-screening tools offer an additional benefit: They are accessible just about everywhere. Many people often start their health inquiries on the Internet, which provides the privacy and lack of perceived judgment they need to get their questions answered.

There are risks associated with screening tools, however, including too many false positives or too many false negatives. False positives mean the tool identified people at risk for a mental health

condition or suicide who really aren't. This problem, while inconvenient for the individual who needs to go through an extra layer of evaluation, is the side that most screening tools would like to err on. Usually people in this category are more relieved than anything else to know they were mis-categorized, and the undue burden on the mental healthcare system is often short-lived.

False negatives are another matter. They occur when someone who is suicidal or has a mental health condition is not recognized by the screening tool and slips through the system's cracks.

Sometimes people fall through the cracks because people are not being totally honest when taking the screening. This outcome is understandable when we consider the incentive many might have to "fake good" and avoid consequences, such as involuntary leave or discrimination.

Screening tools are also not great at telling us when a person might experience a mental health or suicide crisis, they are good tools for letting us know we need to dig deeper. When possible, a follow-up effort to engage people who have screened positive is recommended. This extra step is often the difference maker when it comes to encouraging individuals to move forward along the help-seeking pathway. Knowing that there are many good reasons why people do not disclose this type of sensitive information and that no screening tool is perfect, self-screening practices should be acknowledged for their strengths and limitations, and be just one part of a comprehensive plan — just like screening practices for cancer and other health concerns.

Screening that is given throughout a workplace repeatedly over time sends a strong cultural message – we value what we measure. A universal screen sends the message that screening is for everyone, and screening for mental health is just as important as taking our blood pressure or measuring our weight. When we bake mental health screening into other health promotion activities, the idea of integrated mental and physical health makes sense. There are a number of workplace-based screening programs that have successfully been integrated into workplaces' wellness initiatives.

First, the pioneered concept of large-scale mental health screening and education programs started in 1991, with a flagship program, National Depression Screening Day (NDSD). Subsequently, a Workplace Response program now provides resources for both in-person and online opportunities to screen employees for depression, bipolar disorder, generalized anxiety disorder, posttraumatic stress disorder, eating disorders, alcohol use disorders, and suicide and then connect those who need additional evaluation to the local EAP. As mentioned earlier, screening for sleep problems can be an accessible window into potential suicidal intensity [76].

Second, the American Foundation for Suicide Prevention (AFSP) developed a workplace interactive web-based method that not only identifies people with psychiatric problems, but also supports those at high risk through a series of communications designed to help eliminate barriers to treatment.

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A study that published the findings from the AFSP's Interactive Screening Program approach is very encouraging. Although almost 85% of the participants indicated that they experienced some level of distress, less than 10% of those who screened at high or moderate risk were seeing a counselor at the beginning of the program. Through the anonymous dialogue with the counselor, the high risk individuals were the ones most likely to engage and initiated more of the conversations. Ultimately about 20% of the highest risk people did come in for an in-person evaluation, and 15% entered treatment. The researchers speculated that the dialogue feature made the difference in moving these hard-to-reach and high-risk people down the help-seeking pathway because it helped remove barriers and initiated a therapeutic alliance.

Navigate the Perceived Legal Barriers, Workers Compensation, Disability Rights and Performance Standards

A big barrier that prevents workplaces from being proactive in the area of suicide prevention is fear of legal consequences. Some fear they will be sued for negligence if they provide staff with suicide prevention training and then employees do not respond according to how they have been trained. Interestingly, we do not have these same fears for CPR. We know many people trained in CPR do not use their skills when needed and even when giving the skills, many are apt to do it imperfectly. Nevertheless, workplaces value the fact that by training all, the chances of someone stepping in to do the right thing goes up. We should have the same mindset for suicide crisis responses and understand how Good Samaritan laws are applicable here.

Others employers get concerned about ADA, HIPAA, and FMLA, and fear if they step into the arena of talking about suicide and mental health, this conversation will leave them vulnerable for a claim. Employers need guidance about what behaviors do and do not violate these laws and how to talk to employees about emotional well-being without tripping into protected health information.

Along these lines, some employers worry about how to balance the need to uphold standards of performance while also allowing for compassion and accommodation. Judge (Ret.) Mary McClatchey says that sometimes employers can get into a dynamic of a "silent suicide spiral" with employees when trying to address performance issues that are driven by unaddressed mental health concerns [51]. Instead of micromanaging an employee whose performance has declined, McClatchey suggests a different approach — saying something like "sometimes when people's performance starts to decline, there is something else going on. I don't need to know if that is true for you or not, but if it is, I have resources that might help you get through whatever you might be facing. Are there any tweaks we can make to your current work status that will help you get back on your feet?"

These supportive conversations are much more likely to build trust between HR or a supervisor and

the distressed employee, and much less likely to result in legal action. Because illness like addiction and mood disorders can be pernicious, sometimes relapses occur — just like they do with cancer — and employers supporting employees experiencing relapses need to anticipate going through this process more than once and to prepare to offer "second chance agreements."

When it comes to workers compensation and disability related to psychological injury, workplaces — especially in trauma-related fields like emergency response — are looking for the guideposts [86]. For instance, questions often arise as to how much of the disability is actually work related versus the result of non-work related contributions.

Finally, should a company experience a suicide some fear a lawsuit by the family and believe they should "stay away" and shut down all communication. This practice often frustrates a family and can increase hostility, when what is usually needed is an acknowledgement of the pain of the loss. Thus, part of the workplace guidelines should deliver clear recommendations of best practice for how to respond in the aftermath of an employee (or their family member) suicide death, either on the worksite or off (see Downstream section).

Some of the participants in the focus groups suggested that companies consider identifying an ombudsman — someone who is familiar with the complexities of mental health and suicide issues, the resources, and the legal issues — to help employees and employers feel confident and competent about the decisions being made in the best interest of both the person and the company.

Downstream

Downstream approaches are about how best to respond to the crises of suicide thoughts and behavior and suicide death with dignity, compassion and empowerment.

Evaluate and Promote Mental Health Benefits and Local Services

Many of the participants in our focus groups mentioned that the elements of their workplace benefit program that supported emotional health were either not well known to the workers or insufficient to meet the needs of the workers. Specifically, many believed that employers simply "checked a box" when getting the benefit of an Employee Assistance Program (EAP) and never really knew what the benefit covered or how their employees were using it. Employees sometimes had no idea that they have the benefit of an EAP, and so they did not even think to access it when going through a tough time. Often employees in some of the male dominated industries like emergency responders felt that their EAP did not understand the nature of their work and thus, frequently employees felt mismatched with their mental health providers.

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Additionally, mental health providers are usually not adequately prepared to help clients experiencing suicidal intensity, and when referred a client who is suicidal, the provider's common reaction is fear. Clinician fear is a significant problem for both the clinician's ability to respond empathically and the client's ability to find the provider trustworthy.

> "Interventions should be designed—and clinicians should be sufficiently skilled—to work with the person in outpatient treatment, with an array of supports, and avoid hospitalization if at all possible."
>
> - From Providing the Least Restrictive Care;
> Zero Suicide in Health and Behavioral Health Care

When it comes to suicide prevention, this gap in the chain of survival is concerning. If one of the main messages in suicide prevention is "seek help," we need to make sure the providers are confident and competent with state-of-the-art approaches to alleviate suicidal despair and to get people back on track to a life worth living. Thus, dedicated employers will evaluate and even challenge their EAP providers to demonstrate continuing education in the areas of suicide prevention, intervention and postvention skills. In fact, some states are mandating that all mental health professionals, including EAP have some sort of on-going training in suicide risk formulation and recovery.

In addition to making sure the providers have the needed skills, companies need to make sure that their employees know when and how to access the care. Employers who are mindful of their workers well-being will continually promote well-vetted and employee-backed resources throughout the career of the workers. Leadership testimonials of the efficacy of the resources after the leaders have used them for their own mental health would bring credibility to the resources and model appropriate self-care to the employees. Bringing the resources on-site to the workers (and not waiting until the workers stumble upon the resources) is another way to break through the barriers to care.

Much diversity in EAP structure and quality exists [65]. Some companies use internal EAPs, where providers are also employees of the company. This arrangement often provides the benefit of having an immediate resource that has clear knowledge of the company and industry culture. Evaluation of internal EAPs have found increased utilization, customization and supervisor referrals [65]; however, there are some drawbacks. Internal EAPs, because they are so closely connected to the company run the risk of being perceived as having blurred lines of confidentiality and objectivity. By contrast, external EAPs are often more diverse and can respond 24/7 across a vast geography. Because of these benefits and consequences, many companies have moved to a hybrid model to get the best of both models.

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EAPs are most effective when they understand the industry and organizational culture, have business acumen and can adapt to changes in organizational structure [65].

EAP staff would benefit from on-going training in state-of-the-art suicide response (e.g., Collaborative Assessment and Management of Suicidality). Treatment that is suicide-specific is more effective in preventing suicide than treatment of the "underlying mental health conditions" [87].

A collaborative and least restrictive approach is recommended [88-89]. There is not great evidence for the effectiveness of psychiatric hospitalization's impact on suicide prevention. In fact, a 2017 systematic review and meta-analysis published in JAMA Psychiatry found that all clients who are discharged from psychiatric facilities are at heightened risk for suicide (not just the ones admitted for suicidal thoughts) [90]. The risk for clients admitted for suicidal intensity was nearly 200 times the global rate in the first three months after discharge and remained high even many years after they were discharged.

A list of evidence-based clinical trainings and clinical suicide intervention tools for mental health professionals are listed in the Appendix. Clinical staff should engage in refreshing their suicide prevention clinical skills at least every other year.

Protocol Needed for Suicide Crises

In the aftermath of a suicide crisis — a suicide attempt, near miss or suicide death — employers need clear direction on how to respond. In 2013, the Carson J Spencer Foundation, American Association of Suicidology, the National Action Alliance for Suicide Prevention and the Crisis Care Network published "A Manager's Guide to Suicide Postvention in the Workplace: 10 Action Steps for Dealing with the Aftermath of Suicide" — a crisis management protocol with checklists and flowcharts on what to do in the immediate aftermath, short-term response and long-term recovery periods. When responding to the crisis of a suicide attempt or concerns about elevated risk, employers should have familiarity with the National Suicide Prevention Lifeline and Crisis Text Line as options to help them support employees and create a plan for response.

New expanded guidelines should also explore how suicide is linked to workplace violence like homicide and sabotage, as this is a common concern for employers that can create significant fear and unproductive reactions. While we know only 2% of all suicides involve a homicide [60], and that most of these are domestic violence cases (e.g., husband kills wife then kill self), a predominant narrative in the United States is the mass shootings, often in workplaces, where the perpetrator dies by suicide. Thus, the guidelines will need to address these high level security concerns by offering suggestions that do not perpetuate a myth that all people who are suicidal are potentially dangerous.

From a prevention standpoint, Joiner (2014) argues that for many homicide-suicide cases, the suicidal thoughts came first [60]. Once the person decided they were going to die, they engaged in a "perversion of virtue" to justify taking another's life in the process. For example, in the case of workplace violence, there is sometimes a perversion of justice — "I am going to kill myself, but before I do, I need to right a wrong that has been done to me." If we can decrease the suicidal intensity, the inclination to kill others can fall away.

Additionally, the new guidelines should also address best practices in reintegrating employees during their recovery from a suicidal experience or suicide loss. Too often, employers are not only not clear on how best to help someone who has experienced a suicide crisis get back into their work life, they are also often frightened. This combination of fear and uncertainty can lead to decisions that end up terminating an employee, which then adds to the loss and hardship of that employee and a domino effect of suffering continues. Instead, employers can be guided on best practices on how to negotiate and collaborate with the employee on issues like workload and need for accommodations, privacy concerns (both within work teams and between the workplace and the mental health providers), and workplace supports, and bring the employee back in a way that is best for both them and the company's mission.

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PART VI: EVALUATION

Building an evaluation plan BEFORE flushing out the a comprehensive program is prudent. Together the program development team and a hired external evaluator should identify the intended outcomes, core components, and estimated time frame for impact [91]. The main question to answer is — how will we know if our program has done what we have hoped it would do?

Creating a logic model like the one in the Appendix is a good place to start. To increase the confidence of the evaluation outcomes, the national guidelines leadership partners should consider increasing the scientific rigor by comparing the program participants (e.g., companies who are implementing the guidelines) to a control or comparison group. Both qualitative and quantitative evaluation information will be helpful in understanding what is working and what is not. For example, if it is possible to identify a benchmarking tool, perhaps through the Gallup poll, we may be able to measure changes in the spread of the idea of suicide prevention in the workplace. We can also get users' testimonials about their experience working with the guidelines.

RESOURCE

Worksheet Best Practices on Suicide Prevention Program Evaluation

Developed by the Office of the Secretary of Defense [91]

Initial evaluation measures may include some basic analytics and demographics — who is engaging with the Guidelines and why? Have they had conversations about the project with others? Did they pledge to make suicide prevention a health and safety priority?

When companies complete the gap analysis part of the guidelines, evaluators can notice patterns in those data across companies and industries. Do some of the strategies have bigger gaps than others? Do these patterns differ by industry? Noticing these trends will help the Guideline developers continue to improve the process.

As they are progressing through the best practice modules, an evaluation might look at implementation metrics including number of activities initiated and satisfaction with those initiatives — where did they start and why? What were the barriers in implementation? Are there changes in culture within the workplace that indicate shifts in attitudes, knowledge and behavior since the best practices have started being implemented? Can they share new materials they have developed that include suicide prevention topics/resources/protocol?

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For those that take on the activity of building a stratified training program, many things can be measured. How many people have been trained in each tier? What percentage of the organization has been trained (saturation metric)? As the participants are learning and practicing new skills, meaningful feedback could be matched to a rubric of expected proficiency and constructive instruction given in a nonthreatening way by the trainers.

Immediately and 6-months to 1-year post-implementation is needed to measure whether or not the project had any impact on changing knowledge, attitudes and skills. Some measurements might include:

- Skill testing for proficiency and mastery against set skill expectations

- Pre- and Post-test on knowledge

- Self-report on how material used: self-help, help-giving, help-seeking

- Changes in attitude — stigma, social norms

- Changes in confidence and competence

- Resources evaluation — "How likely would you use these in a crisis or when going through a tough time — why or why not?"

- Changes in proximal metrics (safety dashboard) like absenteeism, presenteeism, disability, accidents/incidents/near misses, productivity, quality, employee engagement, turnover, change in claims (workers compensation), FMLA use, grievances, measure of trust in organization

- Utilization of EAP

- Post-Crisis Debrief — what worked, what didn't

- Suicide Death — most workplaces are not tracking, even repressing

It is unlikely that a suicide prevention training program alone will have the long-term outcome of reducing suicide deaths, attempts and near misses. Rather the trainings should be part of a much larger suicide prevention strategy (upstream, midstream and downstream). Because suicidal behaviors have a fairly low base rate, accurate data collection over multiple years using multiple measures is needed to get a better idea of whether or not the entire suicide prevention program has had the intended impact.

PART VII: PRIORITIZING DEVELOPMENT AND IMPLEMENTATION PHASES

Having just a white paper or brief summary of the best practices is helpful in raising awareness, but insufficient for creating the systems change needed. Thus, a process for creating support for implementation is recommended. The following three phase model would move the Guidelines from awareness to implementation over the next three years.

Phase 1: Build Out Initial Website Portal

April - August 2019

The hub of the National Guidelines for Workplace Suicide Prevention will be an interactive website portal that will walk organizations through a series of steps. The goal is to launch this website portal on World Suicide Prevention Day 2019.

Website Portal Outline

- Justification

- Why should workplaces care?

- Why is it good for business?

- Part of an urgent national movement — national and industry statistics; why workplaces essential

- Relationship to safety/health, employee engagement/recruitment and retention

- CPR model for emotional crises

- Stories — video testimonials of many roles and industries invested, lived experience stories of recovery, rescue and grief

- Address barriers/FAQ

- Pledge Process — enrolling companies pledging to make suicide prevention a health and safety priority

- Gap Analysis Assessment — providing a tool for employers to self-assess how well they are performing on upstream, midstream and downstream strategies

- Nine Best Practices Highlighted:

    1. Leadership: Cultivating a Caring Culture Focused on Community Well-Being

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2. Assess and Address Job Strain and Toxic Work Contributors

3. Communication: Increase Awareness of Understanding Suicide and Reduce Fear

4. Self-Care Orientation: Self-Screening and Stress/Crisis Inoculation Planning

5. Training: Build a Stratified Suicide Prevention Response Program

    • Specialized Training by Role

6. Peer Support and Well-Being Ambassadors: Informal and Formal Initiatives

7. Mental Health and Crisis Resources: Evaluate and Promote

8. Mitigating Risk: Reducing Access to Lethal Means and Addressing Legal Issues

9. Crisis Response: Accommodation, Re-integration and Postvention

Phase 2: Pilot with Key Stakeholders, Major Companies/Professional Associations

August 2019 - July 2020

Pilot Process

Select 50 employers of different sizes and industries to walk through the steps and provide feedback over one-year time.

    • Evaluate their experiences (quantitive/qualitative) and adjust

Phase 3: Build Out New Features and Scale through Regional Academy Trainings and Support

July 2020 and Beyond

Based on the evaluation of the pilot effort, new features of the Guidelines would continually improve the recommendations and implementation strategies. One potential practice and longer-term would be to develop an "academy" training process along the lines of what the "Zero Suicide in Healthcare" initiative has accomplished. Here, local training and orientation sessions would on-board employers into the process with in-person, in-depth meetings that give them the tools as well as build a local community of practice.

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PART VIII: SUMMARY OF RECOMMENDATIONS

In conclusion, this exploratory analysis is a starting point to develop guidelines and best practices to help employers and professional associations "aspire to a zero suicide mindset" and implement tactics to alleviate suffering and enhance "a passion for living" in the workplace. The process identified high level motivations for (predominantly around worker safety and well-being) and barriers (lack of leadership buy-in and resources) that prevent the establishment of national guidelines for workplace suicide prevention. The research also uncovered a number of suggestions for nine areas of practice and a process of on-boarding workplaces and moving them through a series of stages of change.

9 Practices to Make Suicide Prevention a Health and Safety Priority

Leadership
Cultivating a Caring Culture Focused on Community Well-Being

Job Strain Reduction
Assess and Address Job Strain and Toxic Work Contributors

Communication
Increase Awareness of Understanding Suicide and Reduce Fear of Suicidal People

Self-Care Orientation
Self-Screening and Stress/Crisis Inoculation Planning

Training
Build a Stratified Suicide Prevention Response Program Specialized Training by Role

Peer Support & Well-Being Ambassadors
Informal and Formal Initiatives

Mental Health & Crisis Resources
Evaluate and Promote

Mitigating Risk
Reduce Access to Lethal Means and Address Legal Issues

Crisis Response
Accommodation, Re-integration and Postvention

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The stages of change include first increasing awareness; then getting companies to pledge to commit to making suicide prevention a health and safety priority; then guiding them through a gap analysis to self-assess where the biggest need might be; then to sharing with them specific tactics of change; and finally recognizing and rewarding those employers who demonstrate implementation and success.

In the process of developing the Guidelines, a pilot effort is recommended. Here we can get buy-in from early adopters and build the evidence base and testimonials needed for a larger scale role out.

The sentiment from the exploratory analysis participants was that workplace suicide prevention guidelines are needed and overdue, and many expressed a sense of hopefulness that the impact would make a difference to employees and their families.

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APPENDIX A: WORKPLACE SUICIDE PREVENTION RESOURCES

Postvention Response

- [A Manager's Guide to Suicide Postvention in the Workplace: 10 Action Steps for Dealing with the Aftermath of Suicide](#)
- [Workplace Suicide Response](#); from Workplace Strategies for Mental Health of Canada
- [Supporting Someone in the Workplace at Risk of Suicide](#); from Beyond Blue and the Mentally Healthy Workplace Alliance in Australia

Strategy

- [Comprehensive Blueprint for Workplace Suicide Prevention](#); Workplace Task Force, National Action Alliance for Suicide Prevention
- [Mentally Healthy Workplace Alliance](#); Australia

Communication

- [Framework for Successful Messaging](#)

Stratified Training Curricula

- [Matrix of all Gatekeeper Trainings](#)
- [How to Move from Awareness to Action in Suicide Prevention and Mental Health Promotion](#); Guidebook on Training Programs: 23 Characteristics that Make Trainings Great

Basic Mental Health Literacy

- [Mental Health First Aid](#) (for Workplace)

Basic Gatekeeper Skill Development

- [Working Minds](#); Suicide prevention in the workplace
- [safeTALK](#)
- [QPR](#)
- [Kognito](#)

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Advanced Support Network Gatekeeper Training

Gatekeeper Training for Peers and Other Non-Clinicians

- ASIST

Training for Professional Mental Health Services (training for EAPs)

- Collaborative Assessment & Management of Suicidal Behavior (CAMS)
- Assessing and Managing Suicide Risk (AMSR)
- Suicide to Hope (LivingWorks Training)
- Dialectical Behavior Therapy (DBT)
- Counseling on Access to Lethal Means (FREE)
- Crisis Response Planning
- Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP)

Screening Programs

- Interactive Screening Program (by the American Foundation for Suicide Prevention)
- Mindwise Workplace Screening Program

Safety Agreement and Other On-Line Clinical Tools

- My 3 App
- Virtual Hope Box (App)
- Now Matters Now (online DBT skills)

Upstream and Midstream Workplace Resources

- WorkSmart Partners
- KyndHub
- ProjectHelping
- NIOSH Fundamentals of Total Worker Health Approaches: Essential Elements for Advancing Worker Safety, Health, and Well-Being
- Workplace Peer Support Considerations
- Peer Support Guidelines from the International Association of Chiefs of Police (ICAP)

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Mental Health and Crisis Resources

- [National Suicide Prevention Lifeline](#); 1-800-273-8255

- [Crisis Text Line](#); text TALK to 741 741

- [Veterans Crisis Line](#); 1-800-273-8255, press 1

- [Find Community Mental Health Centers](#)

- **Employee Assistance Programs**

  - [International Employee Assistance Professionals Association (EAPA)](#)

  - [How to evaluate EAPs](#)

Model Programs

- [MATES in Construction: Suicide Prevention in the Construction Industry](#); Australia

- [Guarding Minds at Work](#); Canada

- [JMJ Safety Practices](#)

- [RUOK](#)

- [Psychological Health Workplace Award](#) (American Psychological Association)

- [NAMI Workplace Stigma](#)

- [R3 Continuum](#)

- [Construction Working Minds](#)

- [Construction Industry Alliance for Suicide Prevention](#)

- [The Lighthouse Project of Columbia University](#)

- [WorkSmart Partners](#)

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APPENDIX B: LOGIC MODEL

Inputs	Potential Outputs	Potential Process Data	Short-Term Change (6 months - 1 year)	Long-Term Change (1 year+ with refreshers in training and communication)

• Investment of time
• Investment of money
• Comprehensive strategy
	• Needs and Strengths Assessment
	• Strategy linked to mission/vision
	• Policy reviewed
	• On-going Communication plan
	• Support resources list vetted and promoted
	• Support Network
	• Stratified training program
	• Screening program
	• Suicide Crisis Management Plan (safety agreements)
		• Numbers of people trained/reached
		• Number using counseling and health services (for MH)
		• Number involved in Support Network
		• Demographics of participants
		• Immediate Outcomes
		• Program satisfaction
		• Awareness of and confidence in resources
		• Self-Efficacy/ Competence
		  • Ability to identify people with emerging concerns
		  • How to approach someone who might be suicidal
		  • How to negotiate reducing access to lethal means
		• Identification in gaps in supports
			• Program content spread (how many people told)
			• Change in Attitudes
			  • Confidence
			  • Stigma (self and public) about suicide, mental health of help-seeking
			  • Hope
			  • Cultural perception of suffering vs. care and resilience
			• Change in Knowledge
			  • Resources
			  • How to access support
			  • Warning signs and risk factors
			  • Making home safer from suicide
			• Change in Behaviors
			  • Peer care gatekeeper skills improved
			  • Increased help-giving and help-seeking
			  • Other
			  • Resources improved and more accessible
				• Elimination of barriers to support
				• Increase in help-giving
				• Increase in help-seeking
				• Decrease in despair
				• Decreased isolation
				• Increased coping
				• Increased successful reintegration after suicide crisis
				• Decreased plans for suicide
				• Decreased
				• suicide attempts & near misses
				• Decreased
				• suicide death

NOTE FROM THE AUTHOR

About the Author: Sally Spencer-Thomas is a clinical psychologist, inspirational international speaker and an impact entrepreneur. Dr. Spencer-Thomas was moved to work in suicide prevention after her younger brother, a Denver entrepreneur, died of suicide after a difficult battle with bipolar condition. Known nationally and internationally as an innovator in social change, Spencer-Thomas has helped start up multiple large-scale, gap filling efforts in mental health including the award-winning campaign Man Therapy and the nation's first initiative for suicide prevention in the workplace. In 2016 she was an invited speaker at the White House where she presented on men's mental health. In her recent TEDx Talk she shares her goal to elevate the conversation and make suicide prevention a health and safety priority in our schools, workplaces and communities. Connect with Sally at www.SallySpencerThomas.com and on Facebook (@DrSallySpeaks), Twitter (@sspencerthomas) and LinkedIn.

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