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The Science of Public Messages for Suicide Prevention: A Workshop Summary

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There is minimal guidance for efforts to create effective public messages that increase awareness that suicide is preventable. To address this need, several agencies in the U.S. Department of Health and Human Services and the Annenberg Foundation convened a workshop consisting of suicide prevention advocates and persons with expertise in public health evaluation, suicide contagion, decision-making, and marketing. "Logic models" were used to define intended messages and audiences, assumed mechanisms of change, and outcomes. This summary describes some of the challenges and opportunities identified by workshop participants in evaluating public awareness campaigns in suicide prevention, technical assistance needs, and a proposed research agenda.

Public health messaging campaigns can be seen everywhere. The public is inundated by images and messages on television, radio, bus stops, subway cars, roadside billboards, newspapers, and magazines, encouraging behaviors associated with more healthy lifestyles, including drug and alcohol abstention, smoking cessation, cancer screening, HIV/AIDS prevention, and domestic abuse reporting. Some of these campaigns, a number of them federally based, have been evaluated and have shown promise for desired effects (Hornik, 2002a); however, in many cases enthusiasm or beliefs by the developers of the campaigns outpace the scientific evidence for their effectiveness (U.S. GAO, 2002).

The National Strategy for Suicide Prevention has as its primary goal, to "promote awareness that suicide is a public health problem that is preventable" (U.S. DHHS, 2001). This goal, embraced by suicide prevention advocacy groups, as well as by states initiating their own suicide prevention plans, has led to various activities to develop public awareness campaigns on suicide. Little guidance is available in Medline, PsychInfo, and other research databases for efforts to create effective public messages that increase awareness that suicide is preventable. In some of these efforts it does not appear that principles identified by recent public health media rec-

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ommendations intended to reduce the risk of suicide contagion, such as avoiding normalization of suicide or idealizing persons who have died by suicide (see http://www.nimh.nih.gov/suicideresearch/mediasurvivors.cfm), or findings from studies of the impact of media on adolescent suicide (e.g., Berman, 1989), have been considered. While media coverage and public health campaigns vary in the ways they address suicide and its risk factors—across content, medium, and intended audiences—the media contagion findings raise concerns about the safety of certain approaches in public messaging pertaining to suicide. The apparent lack of systematic research on the effectiveness and safety of suicide awareness campaigns leaves federal, state, and local advocacy groups with little evidence-based guidance on how to begin to develop messages which would result in greater benefit than harm, or in any tangible beneficial effect overall.

To address this issue, the National Institute of Mental Health (NIMH), the Centers for Disease Control and Prevention (CDC), and the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration (SAMHSA) convened a workshop on "The Science of Public Messages for Suicide Prevention," on October 22–23, 2003, in Washington, DC. Suicide prevention advocates in the field; persons with evaluation experience; as well as experts in suicide contagion, public health message development, mental health literacy, decision-making, stigma, and marketing were brought together to discuss research on public messaging campaigns, and address specific issues in suicide prevention. The purpose of the workshop was to consider safe and effective ways of raising public awareness that suicide is a preventable public health problem. In breakout sessions, participants were asked to discuss three examples of current public awareness campaigns from state and regional efforts, and to use a "logic model" to consider ways of testing assumed "active ingredients," market penetration, and proposed outcomes (including untoward effects).

The workshop was supported by funds provided by the NIMH, the CDC, and contributions from the Annenberg Foundation Trust at Sunnylands through an unrestricted educational grant. Over 40 people (listed in the appendix) participated in the 2-day meeting. The morning of the first day was structured around brief presentations from scientific experts on various findings of research on public messaging campaigns, as well as on the relationship of those findings to suicide prevention. Presentations addressed topics such as: Evaluations of federal information dissemination programs that included untoward effects; public information campaign models as they might apply to suicide prevention; how findings from media contagion effects might apply to public awareness campaigns, and possible measurement approaches to untoward effects; considerations of how to reduce stigma but retain protective factors among various target audiences; approaches to and implications of choosing target audiences for public messaging campaigns; approaches to development of specific suicide prevention messaging materials; integration of public health issues into filmed media entertainment programs; and creating logic models for suicide prevention public messaging campaigns.

While the presenters had many different experiences and expertise, there was a convergence of findings and opinion in three areas: Characteristics of good campaign evaluation approaches; consideration of campaign outcomes with regard to target audiences and timing; and safety and ethical issues which incorporated ideas from evaluation practice that saw success or unintended side effects in various audiences. Each of these areas of agreement is summarized.

CHARACTERISTICS OF GOOD CAMPAIGN EVALUATION APPROACHES

A representative from the U.S. General Accounting Office (GAO) provided results from a 2002 review of various federal information dissemination programs (U.S.

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GAO, 2002). Among the main principles in the review were the following: Successful campaigns incorporate evaluation strategies for both campaign development and outcome assessment; evaluations should be designed to detect campaign outcomes, including changes in awareness, attitudes, and behavior; and the outcome measures should mirror the objectives of the campaign. It was noted that outcomes may be short-term, intermediate, and/or long-term, and that developers of campaigns should be aware that their choice of a timeframe and design needs toshould consider comprehensiveness, scope, and feasibility of the campaign (e.g., see Hornik, 2002a). For example, a short-term outcome of a campaign targeted at getting depressed people into treatment might be increased awareness of depression, an intermediate outcome might be increased referrals to depression care, and a long-term outcome might be an increase in the number of people receiving adequate depression treatment.

INTENDED AUDIENCES AND TIMING

In addition to recommendations from the GAO report, findings from a recent evaluation of the Office of National Drug Control Policy's Anti-Drug Campaign provided additional "lessons learned" with implications for other campaigns (Fishbein, Hall-Jamieson, Zimmer, von Haeften, & Nabi, 2002). Among these were: (1) The importance of focusing on the most effective campaign messages and of pre-testing new ads to ensure that they maintain the campaign's purpose. Public service campaigns can drift from their intended effect by making an undesirable behavior appear more normative. As noted by Cialdini (2003), "public service communicators should avoid the tendency to send the normatively muddled message that a targeted activity is socially disapproved but widespread" (p. 108). Pre-testing messages is essential in order to detect this effect. (2) The importance of understanding that the impact of a campaign may not easily be assessed as outcomes may change over time, may vary across multiple populations, and may not appear until long after the campaign is over. Campaign developers need to be aware of temporal effects that include shifts in popular opinion and attitudes which may result from paid advertising, current events, or other public health campaign efforts. For example, a co-occurring effort by a national sports organization to reduce illicit drug use could be initiated to move public opinion and reduce youth drug use at the same time that an anti-drug campaign is being fielded. Similarly, pharmaceutical advertising for anti-depressants could be initiated to raise awareness that depression is treatable at the same time that a campaign to treat depression to prevent suicide is being launched. (3) If people of certain age and gender (e.g., middle-aged women likely to be mothers of teens) serve as intermediate audiences (e.g., to influence the behavior of their teens), desired changes in behavior can be difficult to achieve and may take time to happen. Research on the impact of intermediaries can focus on their levels of awareness of resources and knowledge of suicide prevention, as well as their intentions to intervene where they might recognize someone at risk for suicide.

SAFETY AND ETHICAL ISSUES IN PUBLIC MESSAGING CAMPAIGNS

Several presenters took the position that some aspects of research on media coverage and suicide risk had direct application to safety issues in public messaging. Among these findings were that exposure to both fictional and true stories about suicide may not only increase awareness but also normalize suicidal behavior (Gould, Jamieson, & Romer, 2003). That is, even though persons may believe that suicide is an undesirable outcome, talking about it may make it appear more normal and thus, more acceptable (Cialdini, 2003). Public messaging campaigns on suicide prevention should also avoid using approaches that may glorify or increase the rec-

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ognition of individual cases of suicide. The secondary gain of notoriety or identification with a famous person may reinforce certain individuals' suicidal intentions and behavior (Gould et al., 2003).

A second area of concern was related to the challenges of controlling messages and campaigns geared to particular demographic audiences. Broad-based campaigns that are likely to reach multiple audiences should determine how subgroups of intended populations (or nontargeted groups of a population) might have different attitudes about suicide, and may respond differently to messages geared toward increasing help-seeking behavior (Cauce et al., 2002). There are particular demographic groups, such as African American women, who already have low rates of suicide, though researchers know little about whether specific factors protect these populations. If such protective factors are not better understood prior to a campaign, public messaging efforts could inadvertently erode them.

Even if a particular demographic is the intended audience, a poorly conceived message regarding prevalence of suicide and lack of understanding about variation within that demographic can lead to unnecessary risks. For example, certain American Indian nations have very high rates of suicide. A campaign via popular Indian radio stations that highlights the high prevalence may inadvertently normalize suicide and send the message that such behavior is expected and is inevitable. Groups with high rates may get the message that they have experienced an expected behavior, and the groups with lower rates are simply "lagging behind" on what is seen to be inevitable.

Another way intended audiences can be defined is through affiliation with service or educational settings, or positions of public health responsibility. A recent study examining whether screening for depression and suicide among youth in specific high schools (Gould, 2003) increased thoughts of depressed mood or suicidality did not find any untoward effects in such settings where responsible adults were present and able to refer for evaluation and treatment. It is not known, however, whether increasing awareness about depression and suicidality via public domains (e.g., billboards, bus stops, radio spots), absent available responsible helpers, is helpful, harmful, or effective at all.

With regard to targeting different segments of society, advocates may want to consider raising political awareness among legislators or other policymakers for the purpose of future funding, or among health providers for health consequence awareness. For example, while suicide is a relatively rare event, it may be useful to increase the awareness of politicians that suicide is more prevalent than homicide. Because suicide is the leading sentinel (adverse) event occurring in inpatient health facilities that report to the Joint Commission on Accreditation of Health Care Organizations (see http://www.jcaho.org/accredited+organizations/sentinel+event/se_stats_1204.pdf), creating greater awareness among health care providers that suicide is a frequent, preventable adverse event across many care settings may lead to improved suicide awareness and training among health providers.

Highlighting suicide's prevalence in these cases would be a very different strategy than what might be used with vulnerable populations. For persons at risk themselves, sending a message that suicide is a rare event and/or rarely used solution to a problem may be part of a campaign to promote alternative approaches to personal or mental illness crises. For example, the fact that over 95% of persons with clinical depression do not go on to kill themselves (e.g., Bostwick & Pankratz, 2000) might be a useful approach to encourage persons to better manage their illness and encourage them to chose life. Alternatively, there may be more precise, targeted approaches and messages that improve detection of suicidal ideation by urging persons with thoughts of suicide to seek help immediately.

A frequent message in many public campaigns in suicide prevention is to seek help from a hotline or from a health professional. Research is limited on the efficacy of such directed action. One study found that adolescents rarely (2% or less) used an avail-

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able youth hotline for psychiatric problems, and were more likely to use a web-based chatroom comprised most often of same-age peers (18%) (Gould, Munfakh, Lubell, Kleinman, & Parker, 2002). Another concern is that if individuals at risk do seek help from their doctor, it is questionable as to whether the provider can see the individual immediately, and whether the provider is equipped to adequately assess, treat, or refer a suicidal individual. This is particularly true for health-resource poor, rural, or other underserved areas. Some meeting participants saw raising awareness of a problem without providing adequate referral as unethical, and proposed that a more acceptable, alternative use of limited suicide prevention dollars would be to first train providers who are most likely to see persons at risk.

Two other ethical issues were discussed in the workshop. One issue was whether there was room for any risk in public health campaigns: Is a campaign that does good for a large number of persons, but possibly causes some harm among a smaller number of persons, still valuable? An aspect of this discussion included whether recipients of a campaign were fairly advised of rare but possible untoward effects, as might be the case in federally approved health products or health procedures that can also be life saving (e.g., a warning label on a medication or consent form for treatment). This might also require new strategies for the research community and Institutional Review Boards (IRBs) to consider the "acceptability" of potential adverse reactions in trials testing public messages. Given possible life or death outcomes, a second ongoing issue pertained to whether any untested or unproven public message pertaining to suicide should be fielded or supported at all.

APPLYING SCIENCE, EVALUATION, AND PLANNING TO CAMPAIGNS ON SUICIDE PREVENTION

Given the safety risks and complexity inherent in public messaging campaigns on suicide prevention, project planning is crucial to the campaign's success. The workshop participants discussed the merits of developing a logic model to guide the development of the campaign. CDC staff illustrated steps in logic model development, including approaches to planning, implementation, and evaluation phases, each described briefly below.

The planning phase establishes the problem to be addressed (suicidality, and/or associated conditions and risk factors and the behavior changes needed), the reasons the problem exists (preferably good risk and protective factor research), and the campaign's intended outcomes. This stage also assesses the informational needs of the target audience and the barriers (physical, communicative, psychological) that must be overcome for a successful campaign.

The implementation phase of a suicide prevention campaign follows the identification of several issues: the intended audience; the knowledge (awareness), attitudes, and behavior that ought to change; the past performance of a similar intervention; the assumed theory of change; the most realistic approach; and the resources available to campaign developers.

The evaluation phase of a campaign should assess the following components: fidelity of implementation; the campaign's reach; what worked/did not work, both in the construction of the messages and in their delivery; additional barriers to implementation; opportunities for improvement; the merit and worth of the campaign; good and bad side effects; and the next steps in the campaign. This evaluation helps to identify changes in the target population and affected outcomes (e.g., increased referrals, reduced suicidality). The logic model should be able to address the following questions.

Planning Phase

- Who is the target population?
- What is the "problem" to be addressed?
- What is the theory applied to address the problem?

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- What messages need to be tested, and/or further developed? (Are there likely intended or unintended effects?)

Implementation Phase

- How do you implement the campaign (purity, specificity, duration, intensity, reach/exposure)?

Evaluation Phase

- Did the campaign accomplish its intended outcomes—short-, intermediate, and long-term?
- Are there new next steps or repetition of previous steps?

As a helpful guide to the groups, CDC staff included a pictorial representation of the phased approach for suicide prevention (Figure 1). A sample logic model that included a media campaign to support the implementation of a gatekeeper model to identify adolescents at high risk for suicide was also provided (Figure 2). In the workshop, this overview guided small group discussions that considered the development of regional and statewide suicide prevention plans. Representatives from suicide prevention efforts in multiple states worked with other workshop participants in reviewing current and future efforts in suicide prevention public messaging campaigns.

COMMON LESSONS FROM STATE AND REGIONAL APPROACHES

A common reality of state, regional, and private efforts is that suicide prevention resources are limited. In public messaging efforts, there may be pre-selected markets available, and existing messages may not be relevant to the state's populations at highest risk for suicide. For that reason, population targets may not match highest risk groups for suicide, and alternative models (reaching family or professional gatekeepers) may need to be considered. Given certain political climates, some messages may not be feasible (e.g., reducing access to firearms), and campaigns selecting a regional (rather than statewide) focus may be easier to implement. For this reason, suicide prevention campaigns may need to evolve around available re-

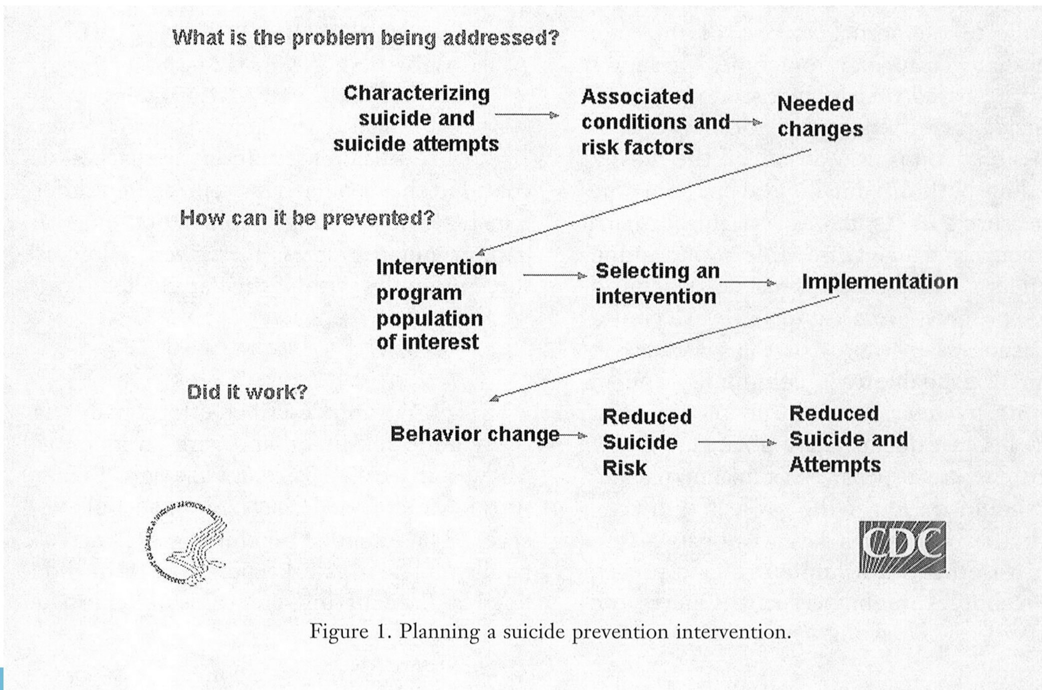

Figure 1. Planning a suicide prevention intervention.

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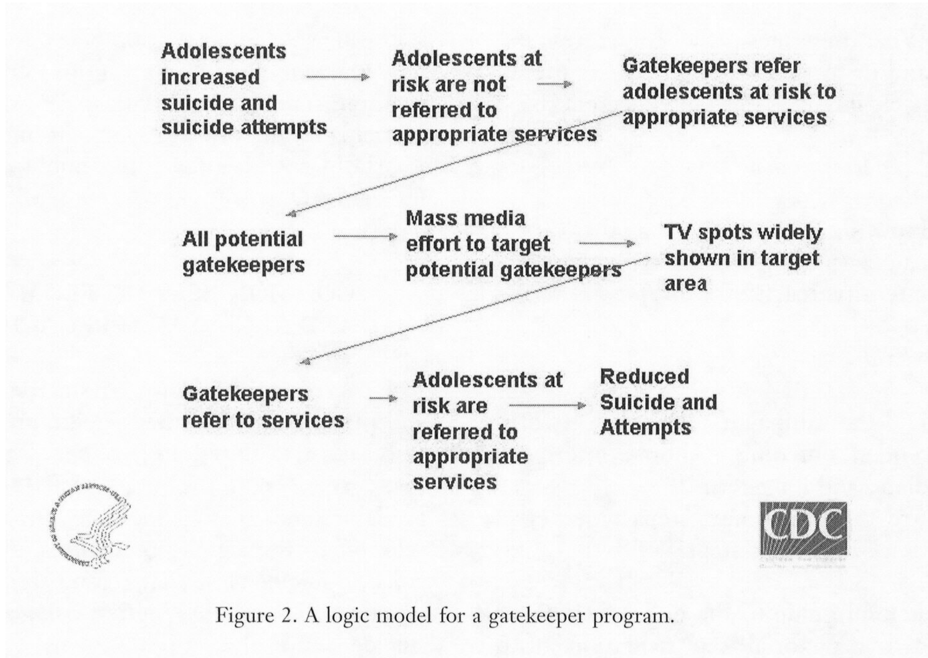

Figure 2. A logic model for a gatekeeper program.

sources such as defined markets, specified media, and possible political constraints, and consider limited scopes due to limited budgets.

All the discussion groups reported that it was difficult to find ways to easily gauge campaign success over time. While proximal outcomes such as increased referrals and greater awareness of services might be used to indicate the initial success of the campaign, later campaign outcomes preferably would be based on a demonstrated decrease in suicidality within a population. While the discussion groups acknowledged the need of including both proximal and distal outcomes to measure success, it was recognized that it is difficult to gauge reasonable and meaningful effect sizes. Other approaches to considering "progress" of a campaign were considered, such as measures of the awareness of resources available to a community and intentions to refer relevant people to treatment. Because adequately evaluated, full-scale campaigns are expensive, campaign planners also should decide if the projected effect is worth the effort of a large campaign compared to other ways limited suicide prevention resources might be spent. One recommendation was to pilot efforts in order to gauge possible effect sizes and possible unwanted effects before a full-scale launch of the campaign. Early testing may lead to fine-tuning the messages or even to the conclusion that available resources can be used in other ways.

EXAMPLES OF SPECIFIC PUBLIC AWARENESS CAMPAIGNS IN SUICIDE PREVENTION

The suicide prevention approaches discussed in the small groups represented different stages of planning, implementation, evaluation, and resources. Described below are three examples with particular challenges.

Group A

This group described efforts with relatively good resources, and with an identified Midwest market available (middle-aged women) through radio, TV, magazine, and billboard space. The intended outcome was to increase family and peer gate-keeping, which they defined as "looking for symptoms of depression

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in people in one's network of relationships; intervening with those showing symptoms and getting them to medical treatment." Their main media message was "Prevent Suicide. Treat Depression." While the message was intended to create a life-saving link between suicide and depression, and to get persons in need of help, it also ran the risk of being too negative and over-generalizing the association between depression and suicide (as opposed to "Make a Life, Treat Depression," for example).

No data were available on how intended audiences would interpret the message, or the degree to which unintended audiences would be exposed or interpret the message. For these reasons, it was recommended that the campaign developers pilot test the campaign with intended groups (women with husbands with depression), as well as with groups where the effect of the message was uncertain (e.g., men with depression who have not considered suicide, or men who have attempted suicide about whether they believe the message would have helped); as well as persons at low risk (men who have never experienced depression). Additional questions to address prior to mounting the campaign included whether women might be made to feel overly responsible as the result of being targeted to help men, and whether health specialists would be ready to treat increasing numbers of referrals. Participants also questioned whether this model assumed that directing individuals toward help actually increased help-seeking behavior where there is little evidence to support this assumption, particularly among men (e.g., Addis & Mahalik, 2003).

Group B

The second group addressed a state suicide prevention plan that included a radio public awareness campaign for youth, and gatekeeper training in middle and secondary high schools across the state. Public service announcements were based on an already-produced youth suicide prevention campaign. The radio spots were aired during National Suicide Prevention Week in May 2003, and the initial intent of the campaign organizers was to continue airing them. Given the difficulty of evaluating a multiple component campaign (radio advertisements and school gatekeeper training), the group recommended that the state launch its efforts sequentially to better gauge the effectiveness of each effort.

Overall, the group found implementing and tracking their efforts to be difficult as it was hard to secure funding to evaluate unproven prevention programs. For the radio spot, the planning group noted the challenge of keeping the control area free from exposure to the radio spot. Next steps for this group included consideration of other alternatives for youth suicide prevention: specifically whether school-based gatekeeper programs were as effective as other case-finding strategies (e.g., screening). In addition, the discussion group wanted to know the degree to which screening and gatekeeper program "awareness" components for staff and students are in and of themselves potent interventions for preventing suicide. A study comparing the effectiveness of different components of awareness, gatekeeper, and screening might help schools consider the most cost effective approaches to identify youth at risk in the schools.

Group C

A third breakout group discussed two different state-led efforts where one state had "borrowed" awareness campaign materials from the other. The first effort evolved from 6 years of working with the state legislature and was structured around increasing the use of hotlines for suicide prevention. Radio advertisements, bus stop posters, and a website guided people to 1-800-SUICIDE (a national help-line that links to local crisis centers). The intended audiences of the messages were youth and elderly males, with messages informing individuals of the frequency of suicide, that suicide is preventable, and that help could be received through hotlines.

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The second state effort arose from a governor's advisory group which developed a state suicide prevention plan. A state office coordinated and oversaw focus groups to assess what materials would best aid prevention. The intended audiences were individuals with high levels of suicidality, as well as possible interveners (e.g., family members and friends of persons who attempted suicide). The message was that suicide prevention is everyone's business, there's hope and help for those who need it, and that possible interveners should be encouraged to offer help. Posters, television, and radio public awareness campaigns were created, which resulted in a substantial increase in calls to an available hotline. Poster distribution is being tracked, and the state office now has a video of text and voiceovers of six public service announcements for television that they can share with other constituents. The staff has systematically worked to inform and change awareness and attitudes of policymakers regarding suicide prevention across the state through personal contacts and by encouraging follow-up contacts by constituents.

Currently, both states are trying to focus on how to mobilize constituent awareness with limited resources, using suicide survivors' commitment and contributions. Common questions for both states included: How to evaluate programs led by survivors to increase program evidence-base; how survivors can lend their unique expertise to programs while keeping fidelity around program implementation; how programs can leverage resources to obtain more funding for evaluation; and how programs can create social capital (relationships to help spread their messages) and maintain interest to fully evaluate programs.

Technical Assistance Needs Identified by Groups. A number of specific suggestions for technical assistance arose as each group shared their discussion themes. These included recommending that the following be available in one national (web-based) location so that they could be readily accessible: identification of tested, effective campaign materials; methodological development and evaluation tools such as approaches to using focus groups, and common outcome measures (possibly developed and made available through Small Business Initiative Research funding); identification of evaluation experts willing to consult; identification of university partners (schools of business, marketing, communications, and psychology); and university courses and programs (e.g., marketing, MBA projects) that could facilitate development and testing of campaigns.

A RESEARCH AGENDA

The workshop presentations and small group discussions highlighted a number of research needs that, if addressed, could advance the scientific evidence base for public messaging for suicide prevention.

1. To what degree does the evidence from the associations among fictional and nonfictional media coverage and suicide contagion apply to public messaging in suicide prevention? The operationalization of concepts such as "media contagion," "reactivity," "stigmatization," and "normalization" would benefit from scientific consensus to facilitate their application to research on public messaging as well as media coverage.

2. Little attention has been paid to a "positive framing" or health promoting approach in suicide prevention awareness efforts. Can these approaches be effective, and if so, for whom, and would they be more likely to have fewer untoward effects?

3. To what degree can models and methodologies be transferred, adapted, and tested from other public health efforts? Several summaries of a range of efforts are available (e.g., Hornik, 2002b; http://www.gao.gov/new.items/d02923.pdf; http://www.gse.harvard.edu/hfrp/pubs/onlinepubs/lessons/index.html;). Particular aspects of campaign logic models, such as theories supporting the assumed attitude or behavior changes, in-

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tended audience or multiple audience identification, intermediary targets (gatekeepers or community leaders), evaluation designs, effect sizes, durability of outcomes, and methodological challenges in identifying possible unintended effects from these prior efforts could be considered for adaptation and testing.

4. What ongoing efforts in other health and safety areas might have positive implications for suicide prevention through their reduction of associated risk factors (e.g., efforts to reduce child abuse, substance use, under-age drinking, or the promotion of physical exercise or pharmaceutical industry-sponsored depression awareness)? How would these effects be operationalized and evaluated with regard to suicide prevention?

5. What is the "state of the science" with regard to the adequacy of referral efforts in suicide prevention, and what is its utility for monitoring outcomes? Assuming that referrals and hotlines are effective for individuals to obtain adequate assessment and treatment for suicidality, are there ways of gathering surveillance data on such referrals (e.g., frequency of 1–800-SUICIDE calls as an outcome)?

6. How do culturally salient or culture specific norms (by age, gender, rural/urban and/or ethnic characteristics) affect message development, dissemination, and interpretation of suicide prevention messages? What methods are needed to better identify culturally salient or specific norms related to suicide prevention?

7. What methodologies can be used to test the most effective approaches for communicating with different audiences (e.g., political leaders, health policymakers, care providers, family members)? Are focus groups adequate or are other methods needed to develop and test different messages?

8. What lessons can be learned about suicide prevention programs in "contained" communities such as the U.S. Air Force which showed a significant reduction in suicide through a broad campaign (Knox, Litts, Talcott, Feig, & Caine, 2003)? These campaigns await application and testing in other contained communities such as particular work forces (e.g., police departments) or communities (e.g., churches or colleges).

SUMMARY

Future public awareness campaigns for suicide prevention have the opportunity to apply and test the knowledge accumulated from prior research, particularly in areas of suicide prevention, public health media campaigns, and marketing. Findings from research documenting media influences on suicide contagion indicate approaches to avoid, as well as highlight the need to assess possible untoward effects. Efforts to evaluate suicide prevention campaigns are challenging, but lessons learned from other public health areas can provide guidance. Without effective planning, implementation, and evaluation, it cannot be known if campaign efforts at the federal, state, and local levels will have any effect at all—a waste of time and resources—and worse yet, if they contribute to harm. The good news is that the challenges in developing safe and effective public awareness campaigns for suicide prevention can be addressed through research, and carefully panned and evaluated campaigns have the potential to save lives. The passion, devotion, and immediacy demanded by suicide prevention advocates to "do something" to make the public aware of suicide should also demand that such life and death prevention efforts benefit from our best scientific efforts.

APPENDIX: MEETING PARTICIPANTS

Nonfederal participants included: Stuart Berlow, Association of State and Territorial Health Officials; Lidia Bernik, SPAN USA; Kim Brater, Ant Hill Marketing; Shannon Breitzman, Office of Suicide Prevention,

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Colorado Department of Public Health and Environment; Mark J. Brekke, Brekke Associates, Inc.; Lucy Davidson, The Task Force for Child Survival and Development; Marie Gallo Dyak, Entertainment Industries Council, Inc; Linda L. Flatt, SPAN USA; Kaia Gallagher, Center for Research Strategies, LLC; Kristine Girard, Massachusetts Institutes of Technology; Madelyn S. Gould, Columbia University/New York State Psychiatric Institute; Patty Johnson, SAVE; Jodi Karlowicz, Virginia Commonwealth University; Suzanne Kennedy Leahy, OMNI Research and Training, Inc.; Kerry Knox, University of Rochester; Julie Linker, Virginia Commonwealth University; David A. Litts, Suicide Prevention Resource Center, Education Development Center, Inc.; Sherry Davis Molock, George Washington University; Calvin Nunnaly, Virginia Department of Health; Ellen M. Peters, University of Oregon; Thomas M. Richardson, University of Rochester; Jerry Reed, SPAN USA; Dan Romer, Annenberg Public Policy Center, University of Pennsylvania; Deb Stone, National Center for Suicide Prevention Training; Patricia Stout, University of Texas at Austin.

Federal Participants from the National Institute of Mental Health included: Joan G. Abell; Bernard S. Arons; Jean Griffin Baum; Susan Brandon; David Chambers; Regina Dolan-Sewell; Eve Moscicki; Kevin O'Brien; Emeline Otey; Jane L. Pearson; Jennifer Roemer; Belinda E. Sims; Clarissa Wittenberg. Federal Participants from the Centers for Disease Control and Prevention were: Tara Balsley; Thomas A. Bartenfeld; Keri M. Lubell. Federal participants from the Substance Abuse and Mental Health Services Administration: Denise Middlebrook; Ann Jacobs Smith; Janet Zinn. Other federal participations: Stephanie Shipman, U.S. General Accounting Office; Gayle M. Boyd, National Institute on Alcohol Abuse and Alcoholism; Lynda Erinoff, Susan Martin, National Institute on Drug Abuse.

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