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NAMI NH Youth Suicide Prevention Initiative: Most Significant Changes

Catherine E. Mayhew
Antioch University of New England

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by

Kate Mayhew

B.A., Hamilton College, 2005
M.A., Northeastern University, 2008
M.S., Antioch University New England, 2016

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The undersigned have examined the dissertation entitled:

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by

Kate Mayhew

Candidate for the degree of Doctor of Psychology
and hereby certify that it is accepted*.

Dissertation Committee Chairperson:
James Fauth, PhD

Dissertation Committee members:
George Tremblay, PhD
Gina Pasquale, PsyD

Accepted by the
Department of Clinical Psychology Chairperson
Lorraine Mangione, PhD

on **11/15/18**

* Signatures are on file with the Registrar's Office at Antioch University New England

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Abstract

In 2013, the National Alliance for Mental Illness New Hampshire (NAMI NH) was awarded the Garrett Lee Smith (GLS) grant to develop and implement grassroots suicide prevention initiatives in key regions of the State housing high proportions of at-risk youth. I investigated the effectiveness of this work by gathering stories of significant change from key grant affiliates who implemented the interventions and then verifying and enriching those stories with others who had experienced them. Below, I describe the need for suicide prevention interventions in NH youth—both at the time the grant was awarded, as well as at present. I outline the Most Significant Change (MSC) method used to examine the interventions' effectiveness through the gathering of change stories and describe the application of this method and the consequent data analysis. Finally, I present the results through revised change stories and explore the implications of these results with respect to NH youth and national suicide prevention initiatives.

Keywords: suicide prevention, youth, most significant change technique

NAMI NH Youth Suicide Prevention Initiative: Most Significant Changes

Suicide is the Second Leading Cause of Death for Youth in the United States

In 2006, in the suburbs of Missouri, 13-year-old Megan Meier hung herself after being cyber-bullied by a friend's mother, who was impersonating a boy her age. Eight years later, Roee Gutman, 17, an Israeli immigrant and resident of Newton, Massachusetts, took his own life with no warning or explanation; a successful student at Newton South High School with aspirations of becoming a doctor, his family was shocked and devastated at the sudden loss. More recently, in October 2015, at a small, private school in Portland, Maine, 16-year-old Payton Sullivan, who long suffered with depression, took her own life.

These tragic deaths exemplify an unfortunate trend: nationally, between 2000 and 2012, the youth suicide rate increased from 10.4 to 12.6 suicide deaths per 100,000 people (American Foundation for Suicide Prevention, 2018). According to the Center for Disease Control (2013), suicide was the second leading cause of death for individuals in the U.S. between the ages of 10 and 24. More young adults die from suicide than from cancer, AIDS, heart disease, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined (The Jason Foundation, 2005). Annually, one in five U.S. teenagers seriously considers suicide (CDC, 2013).

Youth Suicide Rate in New Hampshire Exceeds the National Average

From 2004 to 2013, in the period leading up to the grant, New Hampshire (NH) experienced 188 suicide deaths by youth (ages 10-17) and young adults (ages 18 to 24; NAMI NH, SPC, & YSPA, 2013); this translates to a rate of 13.8 youth suicides per 100,000, compared to the national average of 12.6. In NH, one in 17 high school-aged youth attempts suicide each year, compared to the national average of 1 in 12 (CDC, 2014). For NH youth and young adults ages 10 to 24, suicide was the second leading cause of death from 2006 to 2010; for this same

demographic, nationally, it was the third leading cause of death (NAMI NH, SPC, & YSPA, 2013). Additionally, between 2001 and 2009, the rate of hospital discharges for suicidal behavior among NH youth and young adults between the ages of 15 and 24 was the highest of all age groups, at 442.7 visits per 100,000 (NH DHHS, 2012). Because some NH residents receive hospital care in other states, the aforementioned is probably a conservative estimate.

More recent statistics reflect a worsening trend for NH youth and young adults: From 2012 to 2016, suicide remained the second leading cause of death for NH youth and young adults, and the suicide death rate for young adults ages 18 to 24 had increased to 15.02 per 100,000 (NAMI NH, SPC, & YSPA, 2018). In 2013, the total number of suicide deaths in NH youth and young adults was 21 compared to 38 in 2017—nearly doubling over the four-year period. And per the 2017 NH Suicide Prevention Annual Report, a comparison of the five-year period of 2008-2012 to the following five-year period of 2013-2017 reflects a 31% increase in suicide deaths in NH youth (NAMI NH, SPC, & YSPA, 2018).

Demographics, Substance Abuse, and History of Suicide Attempts Put Youth at Risk

Ethnic minorities, refugees, military veterans, and lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth are at increased risk for suicide nationally and in NH. While NH's population is predominantly white, the refugee population in the state is growing (U.S. Census Bureau, 2014): over 6,800 refugees have resettled in NH since 1997, with over 1,800 coming from Bhutan (Gittell & Lord, 2008). The suicide rates for refugee populations, particularly resettled Bhutanese refugees, are typically two to three times greater than that of the general population (Cochran et al., 2013; Refugee Health Technical Assistance Center, 2011).

Young military veterans are also a high-risk population (Department of Veterans Affairs, 2018). Veterans aged 18 to 24 years enrolled in the Veterans Administration's health program

took their lives at a rate of nearly 80 per 100,000 in 2011, near the grant's inception; this compared to non-veterans, who had a suicide rate of 20 per 100,000 in 2009 and 2010 (Zoroya, 2014). More recent data from the Veterans Administration's National Suicide Data Report reflects a dramatic increase in the suicide rate for young veterans between the ages of 18 and 34 despite an overall decline in veteran suicide deaths. The suicide rate for young veterans is the highest at 45 per 100,000; it increased substantially between 2005 and 2016 (Department of Veterans Affairs, 2018). Veterans are especially prominent in NH, as the U.S. Department of Veterans Affairs estimates that there are nearly 130,000 veterans in the state—more than 10 percent of the total population (U.S. Census Bureau, 2014).

Research also indicates that youth who identify as LGB are four times more likely than their straight peers to attempt suicide; questioning youth are three times more likely to attempt suicide than their straight peers (NAMI NH, 2011). "Questioning" refers to "an identity label for a person who is exploring their sexual orientation or gender identity…" (APA, 2015). Social stigmatization can lead to difficulty in self-acceptance for youth identifying as sexual minorities; bullying, psychiatric illness, and abuse or trauma only increase the risk for suicide death in these youth (Carroll, 2018). In a 2014 review of the National Transgender Discrimination Survey by researchers at the American Foundation for Suicide Prevention and the Williams Institute at UCLA, results showed that across the lifespan, 18 to 24 year-old transgender individuals had the highest reported rate of lifetime suicide attempts (Haas, Rodgers, & Herman, 2014). The difference with their cisgender counterparts is staggering; a 2018 study among 600 adolescents 11 to 19 years of age showed that in contrast to the 10% of cisgender males and 18% of cisgender females that reportedly attempted suicide, approximately half of male-to-female trans teens and 30% percent of female-to-male trans teens have made at least one attempt (Toomey,

Syvertsen, & Shramko, 2018). In the state of NH, 3% of young adult suicides were individuals who identified openly as LGBTQ (NAMI NH, 2011). This is likely an underestimate of the risk to this population, as many youth may be reticent or fearful to report their LGBTQ status.

The link between substance use and suicide is also well established. Many studies point to a correlation between substance use and other high-risk behaviors and suicide attempts in youths (Garrison, McKeown, Valois, &Vincent, 1993). Just prior to the grant period, from 2007 to 2008, NH was one of the top 10 states for rates of drug-use in several categories, including past-month illicit drug use among youth and young adults ages 12 to 25 and past-year illicit drug dependence or abuse in youth and young adults ages 12 to 25 (SAMHSA, 2014). The number of deaths in NH due to drug overdoses has doubled since 1999 to a rate of 8.6 per 100,000; the majority of these deaths have been from prescription drugs (Rudd, Seth, David, & Scholl, 2016). A 2013-2014 survey of adolescents indicates that, compared to the national average, a greater percentage of NH youth, ages 12 to 17, felt they needed substance abuse treatment for illicit drug use, but did not receive it in the 12 months prior to taking the survey, indicating that although these youths recognize a problem, they are unable or unwilling to access help (Office of Adolescent Health, 2017).

More recent studies suggest that these numbers have changed little: Widespread misuse and addiction to opioids has devastated NH. The state has the second highest rate of opioid overdose deaths in the country—three times the national average of 13.3 deaths per 100,000 in 2016 (National Institute on Drug Abuse, 2018). The 2015-2016 National Survey on Drug Use and Health continues to place NH in the top ten states for illicit drug use in the past month among young adults ages 18 to 25 (Center for Behavioral Health Statistics and Quality, 2017). At the same time, the number of youth and young adults who access help remains low: State

prevalence estimates from the 2015-2016 National Survey on Drug Use and Health reflect that the number of young adults (ages 18 to 25) needing but not receiving substance abuse treatment greatly exceeds the national average at 8.17% to the nation's 6.62% (Center for Behavioral Health Statistics and Quality, 2017).

Previous suicide attempts also place youth at higher risk for future suicide (Lewinsohn, Rohde, & Seeley, 1994). Among youth who die by suicide, approximately one-third had made a previous attempt (Shaffer et al., 1996). Several studies have demonstrated that past suicidal ideation or a previous attempt substantially increase the likelihood of a future suicide attempt (Brent et al., 1993; Shaffer et al., 1996; Shafii, Carrigan, & Whittinghill, 1985). In a 6 to 8 year naturalistic study, Pfeffer, Klerman, Hurt, Kakuma, Peskin, and Siefker (1993) found that, as opposed to non-attempters, suicide attempters were 6 times more likely to make another attempt. Further, youths who make multiple suicide attempts are more likely to die by suicide than those who make a single attempt (Kotila & Lönnqvist, 1989). In NH, both males and females aged 15 to 19 have higher rates of suicide attempts than any other age group (NAMI NH, SPC, & YPA, 2013).

Suicide risk is also higher in youth who have previously been admitted to a psychiatric hospital. For individuals in a psychiatric setting, suicide risk peaks shortly after discharge and in the two weeks following release (Bickley et al., 2013; Qin & Nordentoft, 2005). In youth, this vulnerable period has been found to re-emerge 9 to 18 months post-hospitalization, with those who have made previous suicide attempts at even greater risk (Goldston et al., 1999; Prinstein et al., 2008). In 2016, over 600 youth were admitted to the NH state psychiatric hospital (SAMHSA, 2016). Since many of these youth were hospitalized for suicide risk/attempts, and

given that the post-discharge period heightens risk, youth discharged from New Hampshire Hospital (NHH) are a particularly vulnerable population.

NAMI NH Attempts to Address NH's Youth Suicide Problem

In 2013, the National Alliance on Mental Illness New Hampshire (NAMI NH), on behalf of the State of NH, received a Garret Lee Smith Memorial Youth Suicide Prevention grant to "expand, develop, and direct New Hampshire's youth suicide prevention and early intervention strategy" for youth ages 10 to 24 (NAMI NH, 2012). Over the course of the grant's three years, several interventions were implemented in service of this goal, ranging from enhanced discharge planning and post-care coordination at NH's only State Psychiatric Hospital (NHH) to the enhancement of follow-up efforts by a crisis center operating NH's National Suicide Prevention Lifeline.

Community suicide prevention initiatives in three regional public health networks (RPHNs) that feature a high percentage of high-risk youth—in particular, individuals struggling with substance abuse and members of an ethnic minority or refugee population—were also implemented as a part of NAMI NH's youth suicide prevention work. These RPHNs include the Lakes, Capital, and Greater Manchester regions—selected because rates of suicide and suicide morbidity in these three regions are higher than the state average. Further, the rates of youth substance abuse in these regions were high, and they featured the largest refugee populations in the state, rendering them fertile ground for community suicide prevention initiatives. The RPHNs were home to a sub-set of the targeted population that is at increased risk, indicating a strong need for effective programming and a ripe opportunity for change.

RPHN Interventions Were a Key Element of NAMI NH's Prevention Strategy

Within the targeted RPHNs, the goal was to establish the capacity and infrastructure to prevent, intervene, and respond to suicide risk. One major capacity-building intervention focused on the development of community protocols for detecting and responding to youth suicide risk. Implementation teams were created to enhance these regions' capacity for establishing effective networks to reach at-risk youth. These teams were comprised of individuals in each region who had both an interest in, and ability to affect change around, suicide prevention, often through their employment roles, NAMI NH worked with these implementation teams to help tailor response protocols to community needs and capacities. Research by Higgins, Miles, and Young (2012) indicates that implementation teams comprised of key internal stakeholders are a key driver of successful implementation of "organization-wide change strategies" (p. 305, as cited in Wageman, Gardner, & Mortensen, 2012).

A major focus of the implementation teams was to facilitate Connect training for key providers within these RPHNs. Connect is a one-day workshop offering training in recognizing and responding to youth at elevated risk for suicide. The training is intended to target participants whose community roles place them in a good position to observe and interact with youth; or what the suicide prevention community refers to as, "gatekeepers." Connect trainees were recruited by community-based implementation teams, then taught how to address suicide at multiple levels, ranging from the at-risk individual to the media. Trainees were taught to recognize risk and protective factors in at-risk individuals, and to consider barriers to intervening that may prevent these trainees from taking action. They were taught how to address the media when a suicide occurs and given resources to provide to affected youth and families, for example

contacts for extracurricular activities that were of interest to a particular affected youth to serve as a connection and protective factor against future suicide attempts (Connect, 2018).

While the aforementioned interventions were implemented across all RPHNs, the manner in which they were implemented was allowed to vary based on the identified needs of each region. For example, while Connect training was offered across all RPHNs, the providers who took part differed by region. In the Lakes region, for example, there was an emphasis on training mental health providers, whereas in the Capital region, first responders, like policemen and EMTs, were trained. Consequently, the way in which these initiatives unfolded varied across regions.

Suicide Prevention, Capacity Development Interventions are Hard to Evaluate With Traditional Methods

The impacts of capacity building interventions—especially those directed toward prevention of low base rate events like youth suicide—are inherently difficult to measure. Davies (1998) points out that traditional outcome evaluation methods often rely on the frequency of consensually defined outcome "indicators." Differences in subjective perspectives around significant change events may be ignored or controlled, ultimately limiting what is learned. Given that the interventions in the RPHNs have been tailored to meet the needs of each region, their outcomes may, in fact, vary across regions, presenting just this type of challenge to traditional outcome evaluation techniques. Further, given the low base rate of an indicator like youth suicide, evaluation focused on that indicator is likely to generate a weak signal. Because opportunities to assess the effectiveness of large-scale capacity-building interventions can be unpredictable and difficult to detect, Davies (1998) suggests that traditional outcome evaluation methods—typically quantitative in their content—are likely to overlook significant change

events. The diffuse nature of large-scale capacity-developing interventions like those implemented in the RPHNs makes it hard to predict how, where, and when the intended outcomes will appear (Davies, 1998). These methods also fail to accurately capture *how* and *why* these interventions work, which prevents stakeholders from learning about potential mechanisms of change, thereby blocking the identification and translation of the most successful elements of the intervention to future programs. Because these traditional outcome evaluation methods typically emphasize stakeholder accountability over learning, opportunities to better understand not only how the interventions work, but also the nature of the impact from a participant's perspective, are limited (Davies & Dart, 2005).

We Know Little About the Outcomes Associated With NAMI NH's RPHN Intervention

In an effort to better understand the impact of this intervention, stories of significant change provided by those most closely involved in both its implementation and impact were explored through qualitative interviews. Qualitative interviews allowed for deep exploration of the experiences of those involved in the intervention and its outcomes. The information obtained through interviews with individuals directly impacted by this intervention spoke to how and why the intervention was successful, clarifying or crystallizing feedback from stakeholders at the level of implementation. This important input from those most directly impacted by the intervention also illuminated regional differences that existed in the way the intervention was applied and its associated outcomes.

This Study Investigates the Successes and Mechanisms of Change of NAMI's RPHN Intervention

The purpose of this study was to better understand whether, how, and why the youth suicide prevention initiatives in the RPHNs had been successful, to provide insight around the

effectiveness of this intervention, as well as possible improvements. This research will inform NAMI NH around the efficacy of the approaches used and provide the opportunity to augment, enhance, and better them. The primary research questions are:

1. What does success look like for NAMI NH's RPHN intervention?
2. What is the mechanism(s) of change in the identified stories of significant change?

Methods

Design

This is a qualitative study, guided by the Most Significant Change (MSC) technique. Originally developed to explore the effectiveness of international development programs, MSC is a methodology for evaluating and improving large-scale programmatic interventions with diverse, diffuse, and/or hard to predict outcomes, making it ideal for assessing youth suicide prevention initiatives in the RPHNs (Dart & Davies, 2003). MSC's goal is to encourage dialogue between and use of feedback among program stakeholders and to move the program in the direction most valued by those involved (Dart & Davies, 2003). At its core, MSC hinges on a systematic search for significant change events from those most intimately involved with the intervention. These stories are first gathered by stakeholders involved in the implementation of the intervention, then verified and examined from the perspective of those most impacted by them; they will serve as the primary unit of analysis (Davies & Dart, 2005). Once augmented through the accounts of those most impacted by the change, the stories are sent back to implementing stakeholders with these new perspectives incorporated. Implementing stakeholders then review these updated stories in an effort to identify instances of significant change that best exemplify the kind of impact they intend and most value (Dart & Davies, 2003; Davies & Dart, 2005).

Through MSC, stakeholders at every level of the program have the opportunity to speak to the impact of a given intervention through story. Because the impact of the RPHN intervention is currently unknown, it is important to seek input about significant changes not only from those implementing the intervention, but also from those that have directly experienced it. MSC, therefore, is an ideal methodology for evaluating youth suicide prevention initiatives in the RPHNs, as it allows NAMI NH staff and RPHN representatives to gain valuable information about how stories of significant change are perceived by others involved in or impacted by interventions in the RPHNs; further, it provides them with examples of how key stakeholders define success in the program.

The MSC method sheds light on how or why programs are successful. According to Davies and Dart's MSC Guide (2005), MSC encourages analysis in addition to data collection, as stakeholders are asked to explain why they have selected a particular story of change over others; this paints a more complete picture of the ways in which change may have come about. Further, individuals impacted by these interventions are asked to share the specific ways in which they feel they have been changed.

Thus, MSC allows for close investigation of mechanisms of change. As Davis and Dart (2005) indicate: "[MSC] can deliver a rich picture of what is happening, rather than an oversimplified picture where organizational, social, and economic developments are reduced to a single number" (p. 12). Because this technique allows the researcher to seek feedback from individuals on both sides of the intervention, more can be learned about how and why it may have been effective. This is true not only because the story of change is examined from all angles, but also because through qualitative interviews, a richer and more complete account of

these stories can be obtained than with traditional outcome evaluation methods (Davies & Dart, 2005).

MSC is also able to detect rare or hard to predict outcomes (Davies & Dart, 2005). Its interview prompt is quite broad, allowing the researcher to focus on specific occurrences of change that might be unique or uncommon, while also offering the opportunity to glean information that might otherwise be overlooked (Davis & Dart, 2005). This is because the opportunity to share and explain a story of change is left open to the interpretation of the stakeholder. This facet of MSC is particularly useful in examining the impact of the grassroots suicide prevention initiatives implemented in the RPHNs, as there is no one specific predetermined or identified outcome to signify success (outside of specific instances of suicide prevented, which themselves, are extremely rare).

Successful implementation of MSC results in a conversation among those most invested in the project about its most important impacts—a feature that renders it particularly well suited to goals of this research (Davies & Dart, 2005). The final product of MSC is intended to be a series of stories, prototypical of the kinds of change stakeholders wish to see through the program (Davies & Dart, 2005). In enabling the gathering of detailed feedback from participants on both sides of the intervention then, MSC allows for a closer examination of significant change stories through grassroots suicide prevention initiatives in the RPHNs to better discern what factors may be at work in facilitating success.

MSC describes participants as those individuals that are “most directly involved [in the program], such as beneficiaries, clients, and field staff” (Dart & Davies, 2003, p. 138). Because I sought input from the RPHNs in which the program was implemented, as well as individuals in the field directly impacted by the program, there were two types of participants: project and

impact participants. Project participants include the primary implementation agents: NAMI NH staff (the primary intervention agents) and RPHN representatives (who collaborate with NAMI NH staff to implement the intervention). Impact participants include individuals impacted by the RPHNs' suicide prevention initiatives. These individuals may include loss survivors, such as family members of individuals that may have attempted suicide; trainees in Connect; first responders, such as police, clergy, or fire department staff; and any other individual identified as a key participant in a significant change story.

The "full" MSC is typically comprised of 10 steps, but given that it's an emerging method, it is often modified to suit local evaluation contexts and goals (Davies & Dart, 2005). For the purposes of this research, I used 3 of the 10 steps Davies and Dart identify in their guide to using MSC: collecting stories, verification of the stories, and quantification (Davies & Dart, 2005).

In the first step—collecting stories—I gathered significant change stories from project participants. In the verification step—step 2—I shared these significant change stories with impact participants and asked for their feedback. Through these two steps, a set of coherent significant change stories were created. Finally, in step 3—quantification—I analyzed these stories of significant change, using thematic analysis to extract themes.

Typically, the MSC process begins by engaging the organization in the need to evaluate its efforts (Davies & Dart, 2005). Given NAMI NH's inherent investment in determining grant outcomes, there was no need to include this step. After this initial engagement, there is also typically a step in which participants must identify a set time period for change stories to be collected (Davies & Dart, 2005). For the purposes of this study, this collection period is the full period of the grant: October 2013 to September 2016. When stories were collected, therefore, I

asked project participants to reflect back on the most significant example of change from the past three years.

Another step in MSC that typically precedes the collection of stories—defining the domains of change—was considered, but ultimately deemed unnecessary. In this step, stakeholders are asked to establish domains that might characterize the types of outcomes produced by the intervention. These domains are intended to guide the story selection process, as stakeholders are typically asked to categorize their respective stories into a domain. Later, they review all stories in a given domain and identify those that best characterize the type of outcome they might wish to see. For example, in the case of the RPHN intervention, an example of a possible domain might include “Education”; those change stories categorized under “Education” would later be reviewed by project participants, with the best examples selected as emblematic of significant changes made in educating others about suicide prevention in the RPHNs. However, project participants never came together for the purpose of identifying distinct domains of change. Additionally, given that the full potential pool of project participants was already quite small at seven and that each participant was asked only to share one change story, it was unlikely that enough distinct stories of change would be generated to populate multiple domains. Therefore, this step was eliminated.

Additionally, within the full MSC, there are typically two steps between the collection and verification of stories: selecting the most significant of the stories and feeding back the results of the selection process (Davies & Dart, 2005). These steps are important when working with larger organizations that have several tiers of participants involved in implementing the intervention and providing feedback about stories of change. Once one tier of participants selects the most significant stories, feedback about that process is then provided to the next tier, and so

on (Davies & Dart, 2005). Given that the participants implementing the intervention in the RPHNs are so few and in total, reflect only one level of the organization, there was no need to include these steps.

Finally, two steps generally included at the end of the full MSC—secondary analysis and meta-monitoring and revision of the system—were also eliminated (Davies & Dart, 2005). These two steps are intended to help a participating organization monitor their own monitoring process (i.e., determine who participated, how that affected the contents of the stories, and how that process could then be improved; Davies & Dart, 2005). Given that the goals of this research were solely to reflect on the process of change in the RPHNs and not at a more organizational level within the framework of the grant's implementation, these steps were unnecessary.

Participants

As described above, there were two types of participants invited to provide feedback on their experiences with the grassroots suicide prevention initiatives in the RPHNs: project participants who implemented these initiatives and impact participants who were directly affected by them.

Elaine deMello, Connect Supervisor of Training and Prevention Services at NAMI NH and Project Coordinator of the GLS grant, was asked to identify project participants for their role in the implementation of youth suicide prevention initiatives in the RPHNs. These individuals regularly attended quarterly meetings run by deMello. Attendees were called upon to share updates and anecdotal examples of success from their regions, which served to identify project participants to be interviewed, as well as provided leads to be followed up on for potential impact participants. All attendees of the quarterly meetings were asked to participate as project participants.

Potential impact participants were nominated/identified by project participants, as a part of the standard project participant interviews. Impact participants were the primary characters in the significant change stories shared by project participants. Inclusion criteria for impact participants included willingness to participate and verification on their part that they were involved in the significant change stories shared by project participants. For those project and impact participants that wished to take part in the qualitative interview, informed consent was obtained. Participants were asked for permission to include their names and identifying information in the study after interviews were completed.

Project and Impact Participant Interviews

The primary data source was semi-structured interviews with project and impact participants. Interviews with project participants were intended to guide identification of impact participants. I conducted these interviews over the phone. I began by reminding project participants about the purpose of the study; informed consent had been sought via email communication prior to the interview. Project participants were then asked to reflect on their experience implementing the interventions in the RPHNs over the reporting period (October 2013 to September 2016) and to identify a particular change that exemplified success as a result of the grant. Project participant interviews were guided by one overarching question: “Based on your experience with youth prevention suicide initiatives in the RPHNs, what was the most significant change that took place?” Depending on program participants’ response to the main question, some or all of the following prompts were used: What happened? Who was there? Where did it happen and when? I also inquired about what made the change significant to them, as well as the contribution(s) of the RPHN intervention in bringing it about.

In addition, I asked project participants to identify and provide contact information for impact participants involved in the story shared; many offered to reach out to these individuals on my behalf. I contacted these potential impact participants, sought informed consent (See Appendix A), and invited them to take part in a qualitative interview similar to the one conducted with project participants. As part of the interview and to set the context, I began by sharing with impact participants the significant change story in which they were featured. Questions focused on their involvement in and perceptions of the particular project participants or interventions that they experienced or witnessed in some way. Once participants completed the qualitative interview, they were thanked for their time and provided with the contact information of this researcher should they have more to add or further questions. Additionally, permission was sought with these individuals to follow up should further questions arise and to use their identifying information in the report.

Analysis

The principles of investigative journalism were used to help guide the narrative reconstruction and analysis of the significant change stories. According to Fischer (2006), "The investigative journalist explores in depth a local social situation such as bullying in our schools, the lives of the homeless, or prison conditions. He, she, or a team interviews, observes, and after much reviewing of notes, double-checking of data, reflecting, and conferring with editors, writes a descriptive report that evokes how all parties experience and participate in the situation" (p. xxii).

Fischer (2006) further emphasizes the importance of the investigative journalist's role in laying out for readers a complete picture of a given social situation, as opposed to identifying one underlying cause. As a qualitative research technique, MSC serves a similar function,

facilitating the development of a full picture of the impact of NAMI NH's suicide prevention initiatives through interviews with participants, verification of significant change stories, and in-depth documentation and description of these shared experiences.

Consistent with guidance from Davies and Dart (2005), once a coherent narrative has been constructed for each story, thematic analysis is used to identify common patterns across stories. According to Braun and Clarke, this flexible process involves "identifying, analyzing, and reporting patterns (themes) within data" (p. 79). Braun and Clarke speak to the need for researchers to make several choices about analysis before it begins (i.e., what qualifies as a theme, whether the analysis should be inductive or theoretical, etc.). For the purposes of this research, an inductive thematic analysis was most appropriate. Given that the aim of the research was to derive an overall theory of change, this approach provided flexibility in deriving themes across significant change stories. As Braun and Clarke have said: "Inductive analysis is…a process of coding the data *without* trying to fit it into a preexisting coding frame, or the researcher's analytic preconceptions. In this sense, this form of thematic analysis is data-driven" (p. 83). The significant change stories were, therefore, the starting point for thematic analysis. These stories were collected from project participants, transcribed, and augmented by the accounts of impact participants. As full and fleshed out stories, they were reviewed for common themes, which when linked, represented emerging patterns of change. Now illuminated through a re-telling of the original stories with incorporated input from impact participants, these patterns of change led to the development of a meta-theory, reflective of key mechanisms of change in the RPHN interventions.

Procedure

First, I reached out to Connect Supervisor of Training and Prevention Services at NAMI NH and Project Coordinator for the GLS grant Elaine deMello, requesting that she identify those individuals most closely related to the implementation of grassroots suicide prevention initiatives in the RPHNs. deMello pointed to seven potential project participants: four RPHN representatives in regions across the state (Capital, Lakes, Greater Manchester); NAMI NH Community Educator and Support Specialist for Loss Survivors (Deb Baird); After-care Coordinator at NHH (Shannon Murano); and Hotline Coordinator of the suicide prevention call hotline Headrest (Caleb Kelton). deMello made clear that Murano's and Kelton's roles with respect to the implementation of the RPHN intervention were ancillary. After reaching out to the seven individuals identified by deMello, five agreed to participate: Baird, Murano, Kelton, and two of the four RPHN representatives: Kelley Gaspa of the Lakes region and Mary Forsythe-Taber of the Greater Manchester region. Despite numerous efforts to connect with the two RPHN representatives from the Capital region, they were either unresponsive or unable to schedule an interview.

Project participant interviews were then conducted via telephone. Within these interviews, contact information for impact participants was elicited from project participants; in several instances, project participants offered to reach out to impact participants on my behalf. Three impact participants were identified through interviews with the aforementioned project participants: Lieutenant Rich Simmons of the Laconia Police Department; loss survivor Sandy Lang, whose son died by suicide six years prior; and Executive Vice President and Chief Operating Officer of the Mental Health Center of Greater Manchester, Patricia Carty. Caleb Kelton identified a Headrest employee to serve as an impact participant but she could not be

reached. Through follow-up communication with Headrest's Business Manager, Eric Harbeck, I identified another current employee of Headrest, who agreed to be interviewed. I shared the significant change stories with impact participants and elicited feedback about their experience. Once the impact participant interviews were complete, I transcribed the interviews of all participants.

Once transcriptions were complete, I augmented project participant accounts with that of impact participants, aiming to create full and complete accounts of change stories. If necessary, I reached back out to project and impact participants for follow-up interviews to gather more information. In reviewing the data at this point, I paid particular attention to the change stories surrounding NHH's After-care Coordinator Shannon Murano and Headrest's Caleb Kelton, as their roles in the GLS grant had been identified as ancillary to the RPHN intervention. In reviewing Murano's and Kelton's change stories, it became evident that Kelton's role in the grant did not overlap with the intervention in the RPHNs, rendering his change story irrelevant to the overall picture of what happened; it was eliminated.

Using inductive analysis, I reviewed the full and complete change stories for emergent themes, eliciting these through a "realist/essentialist" lens per Braun and Clarke (2006). Through this perspective I was free to "theorize motivations, experience, and meaning in a straightforward way", relying on the language used by project and impact participants to glean clear themes from their accounts (p. 85). By observing these themes across change stories, I derived patterns of change reflective of underlying change mechanisms at work in the RPHN intervention. Taken together, these patterns of change comprise a meta-theory of change, depicted in Figure 1 and explored further in the Results below.

Results

Change stories are the primary "unit of analysis" in MSC. Below, four change stories that incorporate the perspective of both project and impact participants are provided. Key informants and lessons learned are identified for each story, which ultimately contribute to a "meta-theory of change."

Change Story #1: Training and Resource Cards Aid Laconia Police Officers in Responding to Deaths by Suicide

The Suicide Prevention and Postvention Response Team–a work group developed as an off-shoot of a regional team in Laconia called Partners in Wellness–worked in conjunction with Genesis Behavioral Health and the Partnership for Public Health in the Lakes region to develop a protocol, tailored training, and resource card intended to guide what police officers should and should not say to loss survivors when informing them of the death by suicide of a family member. According to RPHN Representative for the Lakes region Kelley Gaspa, this was "…probably the most significant achievement in [her] time in this role." These Police Officer Resource Cards fit easily into uniform shirt pockets and provide simple, straight-forward, and clear guidelines for informing family members of a sudden death. Officers are provided guidance around how to speak to loss survivors–to listen patiently and respond to their pain with genuine emotion, to use the name of loss survivors' loved ones, and to designate a point person with whom loss survivors can engage in ongoing communication. Additionally, officers are provided information on aspects of unattended death notifications that are typically overlooked: how to assist loss survivors with clean-up, for example, as family members are often tasked with this if their loved one died in the home.

Not only do these resources improve the experience of loss survivors during a critical moment, but they also provide support to police officers, who, themselves, are impacted by the loss. Said Lt. Simmons of the Laconia Police Department: “[Unattended death notifications] are by far the worst thing that we do, and we don't really ever have any training in it. And it's, you know what happens during that initial time has such a profound effect in the future.” In better preparing officers to scaffold the emotional experience of loss survivors in these moments, the possibility of further trauma is reduced for all involved.

The Police Officer Resource Cards were an unanticipated consequence of work done by the Suicide Prevention and Postvention Response Team, whose original goal was simply to raise awareness around suicide prevention resources in the community. Lt. Simmons had been randomly assigned a POP (Problem-Oriented Policing) Project on suicide prevention through his department in Laconia. According to Lt. Simmons, “When you do POP, first off, is solving the issue, but then, the other thing is kind of proving that you did something.” Lt. Simmons indicates, too, that POP projects are meant to engage other stakeholders in a police-oriented community project. In beginning to educate himself around suicide prevention, Lt. Simmons attended a Connect training offered through NAMI NH and led by Loss Survivor Support Specialist Deb Baird and Supervisor of Training and Prevention Services Elaine deMello. On a break, Lt. Simmons reportedly spoke individually to Baird and deMello, enlisting their help in tackling the POP project; they quickly agreed, prompting formation of what ultimately became the Suicide Prevention and Postvention Response Team.

After convening for over a year and completing their goal of raising community awareness of local resources for suicide prevention, Lt. Simmons was called to an unattended death notification. He said: “We had [a death by suicide] that happened. And I just met up with

the group during one of our regular meetings and said, ‘Hey, we don't really have a set procedure for notifications and dealing with this,’ and I know talking to the victims that I've met a lot of times this gets screwed up. And we can do better.” Lt. Simmons recognized the resources he had at his disposal and asked for help. In so doing, he sparked a collaboration between NAMI NH’s deMello and Baird, as well as representatives from several other organized work groups, including Genesis Behavioral Health and RPHN Representative Kelley Gaspa from the Partnership for Public Health in the Lakes region. These professionals guided development of the Police Officer Resource Cards, as well as a protocol and training that is now held in NAMI NH’s repertoire to be tailored and delivered to first responders across the state and the country.

Both Gaspa and Lt. Simmons credit the team of individuals involved for the development of the Police Officer Resource Card. Said Gaspa: “Just by having those meetings and being able to advocate for the officers and what their needs were. It just shows the power of collaboration.” Lt. Simmons noted that the input gleaned from professionals with mental health expertise and even personal experience was vital: “I could have sat down and just come up with something myself, but it wouldn't have been as good and it wouldn't have meant as much…there was literally you know, emergency service workers from Genesis…people that deal with suicidal people and those emergencies and deal with people that just got those kind of news.” Given, too, that the team had already met their goal of expanding community awareness of suicide prevention resources in the area, their ongoing meetings presented an opportunity for these individuals to consider other ways in which they might address suicide and those impacted by it.

The success of the Police Officer Resource Card in the Laconia region has had ramifications throughout NH and beyond. Lt. Simmons reflected on his own experience, saying, “When I hear that there's a call—somebody is going to go do a death notification, a lot of times,

I'll call the officer on their way and say, 'Hey, do you have your card?' And I've never had a time where they've come back and said, 'No, I don't.' They carry it. They know." Additionally, because NAMI NH created an original protocol and training for the Laconia Police Department, both can be and have been adapted to meet the needs of other departments around the state. Baird said: "We just trained–Ann Douglas [of NAMI NH] just trained all of the NH state troopers on suicide prevention and mental health. All of them." Further, these cards are now issued to Police Academy recruits in NH, who receive the training prior to graduating. As a result, NH first responders state-wide are better prepared to respond to suicide fatalities.

Lessons learned.

- Implementation teams facilitate first responder access to resources for mental health and suicide prevention.
- NAMI NH is a NH suicide prevention and postvention hub.
- Enhanced postvention training for first responders leads to a better experience for loss survivors.

Change Story #2: Facilitating Opportunities for Loss Survivors to Write and Present Their Loss Stories Empowers and Heals

Through her role as Community Educator and Loss Survivor Support Specialist for NAMI NH, Deb Baird has worked extensively with loss survivors, both in NH and outside. Over the course of the grant period, Baird—a loss survivor, herself—has held numerous Survivor Voices Speaker Trainings, helping to facilitate the telling of stories by those whose loved ones died by suicide–a practice that facilitates healing. These trainings–held either with adults (25 years of age or older) or young adults (18 to 25 years of age) are two days long. Baird engages participants in grief work, before having other loss survivors model the re-telling of their stories.

Overnight, participants are asked to engage in self-care and to begin writing their stories, which are revised and rehearsed before their peers the following day. While this training is impactful to loss survivors on a personal level, Baird says the process has broader implications: “Survivors of suicide loss—they're actually really, if you think about it, they're really key partners in suicide prevention. And helping their communities to heal.”

Sandy Lang, whose son, Corey, died by suicide six years ago, participated in one of Baird’s Survivor Voices Speaker Trainings with the intention of learning to tell her own story with less anger. Lang was angry at the mental health system and law enforcement, both of which she felt had allowed her son–diagnosed with paranoid schizophrenia—to fall through the cracks. Lang notes that it took several years for her to make sense of these events, attempting to reconcile with the systems she believed had let she and her son down.

During this period, Lang reportedly attended numerous suicide prevention conferences; eventually, she was approached by Baird. Lang said: “They were letting people ask questions. I kind of stood up and told a little bit about my story and you know, ‘how could my son have fallen through the cracks? Look at what you're saying's being done, but look what happened to me.’ And then, I think it was after that [Baird] came up to me and introduced herself.” Baird encouraged Lang to access NAMI support groups–advice that Lang took. A year later, they reunited at the NAMIWalks NH event, where Deb noticed a significant shift in Lang: less anger. At that point, Baird was reaching out to loss survivors she felt might be interested in taking the Survivor Voices Speaker Training; she included Lang in that invitation. Lang signed up and through the two-day training, learned to re-tell her story with less anger. In this process, loss survivors are asked to focus on the facts of their story, which allows them to move through a painful narrative with intention and limits the possibility of eliciting defensiveness in audiences.

Lang said: “I had to sit here—and this took a long time—I wrote Corey's story and [Baird] would remind me that it couldn't sound blameful.”

After helping Lang re-shape her story, Baird invited her to attend a conference, which featured the type of speaking she anticipated Lang doing. Lang voiced readiness to tell her story immediately thereafter. Baird arranged to have Lang speak for the first time at a refresher postvention training for law enforcement: “We had [Lang] speak and I can't—I'm getting chills just remembering it. She just delivered it in such a great way that we both—Ann [Douglas of NAMI NH] and I both—agreed that she could be doing this for law enforcement.” Lang has since become a fixture in postvention training for NH law enforcement.

For Lang, the opportunity to give a voice to her son, to others struggling with mental health concerns, and to loss survivors and family members has been profoundly impactful: “I feel like I'm giving Corey a voice because he never had one. And now I'm making it so that he's not forgotten. And that maybe his story can help other people.”

According to Baird, the Survivor Voices Speaker Training program—one specific to NAMI NH—has only grown over the course of the grant period; she now trains and coordinates speakers both in and out of state. Baird says that Lang exemplifies the impact of training loss survivors to re-tell their stories for the purpose of creating change: The community comes together to understand suicide prevention and postvention as an effort that touches all. Said Baird: “[Telling loss stories] can help with reducing the stigma, understanding what loss survivors are going through. But also to help our communities to help themselves because [loss survivors are] a part of this family, because they're in the community…in essence, we all need to learn to heal.”

Lesson learned.

- Training loss survivors to re-tell their stories facilitates personal healing and fosters community support for suicide prevention and postvention efforts.

Change Story #3: Mental Health Center of Greater Manchester Embraces Zero Suicide

The Mental Health Center of Greater Manchester (MHCGM)—a community mental health center that frequently scaffolds the outpatient after-care of attempt survivors discharged from New Hampshire Hospital (NHH)—was inspired to re-consider and re-conceive of their suicide prevention and postvention practices through access to Zero Suicide resources provided by grant affiliates. Zero Suicide was a key component of the 2012 National Strategy for Suicide Prevention, based on the tenet that suicide deaths for those in health and behavioral health care systems are preventable. It reflects the understanding that individuals that die by suicide frequently fall through the cracks of fragmented health care systems and represents a commitment by individuals within these health care systems to patient safety ("What is Zero Suicide?", n.d.). Invited to participate in meetings with NHH's After-care Coordinator, Shannon Murano, NAMI NH's Coordinator of Suicide Prevention Services Elaine deMello, and RPHN Representative for the Manchester region Mary Forsythe-Taber, liaisons between NHH and MHCGM worked to coordinate more comprehensive and seamless transitional procedures between the two organizations. As a result of MHCGM's place at the table, they were exposed to protocols for Zero Suicide, which had the indirect effect of shifting entirely the institution's approach to death by suicide and suicide prevention. Forsythe-Taber observed: "[MHCGM] brought that suicide prevention awareness into their own office, making sure that people understand warning signs and how that's different from other mental illnesses, kind of what to do about that."

For Forsythe-Taber, the enhanced relationship with MHCGM was integral to their adopting the Zero Suicide framework: “It helped strengthen that relationship with the Mental Health [Center] of Greater Manchester…Now because of that work that we did through the Connect project, we deepened our relationship.” In facilitating this deeper relationship, Executive Vice President and Chief Operating Officer Patricia Carty noted the ease in access to Murano and deMello, in particular, for Zero Suicide resources: “I think it really came from Shannon and Elaine reaching out. And reaching out to our, initially to our CEO. I think that prior to that, there'd been a communication to the executive directors from the Bureau of Mental Health Services, saying that that this was going to really need some coordination.” Carty reported that the resulting discussions helped both sides understand more clearly their roles in referrals, safety planning, and coordination of liaisons between NHH and MHCGM, particularly for at-risk youth: “I think clinically there was an uptick in how we were viewing some of these folks. And the implementation of what we were going to do for follow-up.”

Carty notes the “ripple effect” that took place, as MHCGM has since developed a core competency training for all existing and new staff. Several staff members have been sent to Zero Suicide Academy, enabling them to better construct the educational components of MHCGM’s own Zero Suicide model. Said Carty: “For me, it's kind of amazing because you do this and then, you think, you know, all these things are going on and you see the benefit. And then you say, ‘Well, how do we take that and roll it into some new initiatives? And how does that have an impact?’”

These new initiatives have extended to MHCGM’s development of original materials to support family members of attempt survivors during critical moments of transition. Carty said: “We just finished that [brochure], and it's gone now to our printers so that our emergency

service—our folks who are in those places where kids and adults are getting assessed, and family members are part of that and often a part of the discharge planning—have a brochure that really speaks to them about, you know, their role, sort of all the emotions that come up with this."

Carty reports that these initiatives are on-going within MHCGM as well, and have been adopted holistically across the organization, reflecting the overall shift in approach sparked through regular access to resources for best practices in suicide prevention. Carty reports that MHCGM continues to adapt as they continue to learn: "Now we're full-on trying to roll [Zero Suicide] out completely within the context of our whole agency—including non-clinical staff. So, how you weave people, how you weave all of these things into the fabric of what you're doing is kind of what we're doing right now."

Lessons learned.

- Coordination across health care providers facilitates better transitional care for attempt survivors.
- NAMI NH provides organizational resources and support for best practices in suicide prevention.

Change Story #4 More Coordinated Responses to Death by Suicide

Shannon Murano's After-care Coordinator role at NHH—created to fulfill a deliverable of the GLS grant—presented a unique opportunity to better scaffold attempt survivors' discharge and transitional care. RPHN representatives designated in areas of NH with particularly high populations of at-risk youth served as resources for Murano, helping her to identify local behavioral health—and even non-behavioral health—supports for attempt survivors. Frequently, Murano would call upon RPHN representatives from regions to which attempt survivors were returning for the purposes of coordinating these supports, reducing the high risk of re-attempt in

the wake of discharge. Additionally, through quarterly meetings, Murano connected regularly with RPHN representatives, who provided information regarding updates or changes in their regions.

The relationship between RPHN representatives and Murano was credited frequently for the success with which attempt survivors' transitions were facilitated back to their respective communities. Murano noted the importance of the regional knowledge harbored by each representative: "They just really were a great wealth of information about the resources that were available in their particular region. And so they would pass along those resources to me, and I would then pass those resources along to the families I was working with." From the perspective of the RPHN representatives, this relationship with Murano brought them in closer contact with at-risk individuals of whom they would have otherwise been unaware. Said RPHN Representative for the Manchester region Mary Forsythe-Taber: "What that did is it connected us in a more consistent way with that whole process for someone coming out of Hampshire Hospital, that's coming back into our region. Specifically, that young adult population, which is very hard to connect with in general."

The impact of these relationships had implications for broader community support to be provided to at-risk individuals returning to their respective regions. Further, these relationships facilitated a more coordinated postvention response to death by suicide. This response extended into schools, community mental health centers, as well as the homes of those directly affected by the loss or near-loss of a loved one to death by suicide. RPHN Representative for the Lakes region Kelley Gaspa describes this enhanced postvention response and how it allowed for more support, particularly within the school system: "If you've got the suicide of a 21 year-old individual, the first question we're asking is, 'Did they have younger siblings in schools? Do the

schools know about the suicide? And how do we get them the information that they need and make sure that families are well-supported?'"

As RPHN representatives have become more connected to their communities and to local suicide prevention and postvention resources, therefore, they have broadened their network, reaching more individuals and entities that may require support in the wake of a death by suicide or suicide attempt. Murano said: "New Hampshire's a small state, as you know, and it's about who you know sometimes...I truly think that connectivity throughout this project was in my eyes, one of the most beneficial pieces."

Lessons learned.

- RPHN representatives act as gatekeepers to community resources for support in the wake of a death by suicide or suicide attempt.
- A more coordinated prevention and postvention response resulted from the network created by RPHN representatives across their regions.

What Happened?

Patterns. The changes stories above and their resulting lessons reflect several significant patterns, described below.

NAMI NH as a resource and a relationship. Across change stories, NAMI NH and RPHN representatives were identified as ongoing resources for suicide prevention and postvention support. Impact participants consistently pointed to specific individuals at NAMI NH or in their regions—typically by name—as resources, often claiming that in knowing them more personally, it was easier to reach out. Of his own experience asking for assistance in better preparing to make unattended death notifications, Lt. Simmons said: "It's one thing to say, 'Well, I know we can reach out to NAMI NH'—is good. But knowing I can reach out to Deb and Elaine

is way better, you know. So having that connection…and just knowing who you're talking to on the other end of the phone—I just think this has made a world of difference." Loss survivor Sandy Lang had a similar experience, noting that the consistency and trust developed through her on-going relationship with NAMI NH's Baird scaffolded her developing capacity to learn more about how to tell her loss story: "We kept running into each other. Like anything, the suicide prevention. And then because I go to Samaritans, [Baird] was offering up a chance to come up for a two-day training on how to tell your story effectively…and then I think it cemented our relationship even more."

What is clear in these two change stories are the persistent efforts of NAMI NH staff to provide on-going support, not only when it is specifically requested—as in the case of Lt. Simmons–but also when it is simply recognized as necessary—as in the case of Lang. Baird understood that Lang would benefit from participation in a local support group and encouraged her to start there, continuing to maintain contact and reaching out to invite Lang to a Survivor Voices Speaker Training when she felt ready to engage more purposely with her loss story. That these relationships had not only been built, but also nurtured over time, created space for individuals at NAMI NH to be accessed if and when there was a need for their support and expertise.

More broadly, the relationship built between MHCGM and NAMI NH—as well as NHH—reflected how organizations benefitted, too, from these closely developed ties. Through regular meetings with NAMI NH staff and with Murano at NHH, COO of MHCGM Carty recognized the need to adopt Zero Suicide in her organization on behalf of her patients. She credits contact with deMello and Murano for sparking this shift: "And the reason I would say [the shift to Zero Suicide has been sustained] is that I think obviously Shannon's framework was

really from a Zero Suicide framework. And I think, during that time and since that time and even more so, at the end...we started really talking about it. And…it's had a ripple effect for us here at the Center, in that we are now full on currently in a Zero Suicide Implementation." Given NAMI NH's expertise and knowledge in suicide pre- and postvention best practices, the relationships built by their staff provide continual opportunities to educate. As relationships deepen, NAMI NH remains present for further opportunities to support suicide prevention practices by those under their tutelage, as in the case of MHCGM. Further, as part of those best practices, clinicians, counselors, first responders, and loss survivors receiving this training are better prepared to respond to suicide and better able to care for themselves when impacted directly by a loss.

Even from *within* the system, NAMI NH staff, RPHN representatives, and grant affiliates like Murano, are supported by *one another* in providing these resources to those in need. As described in change story #4, Murano is well supported in her role as After-care Coordinator at NHH by the RPHN representatives and their knowledge of respective regions to which her patients might be returning. RPHN representatives have even established these resource lists online, to facilitate a sustainable guide for others who might need to access these supports quickly and easily. Said Manchester region's RPHN Representative Mary Forsythe-Taber: "So we're still, you know, we're still a resource for Shannon. What we have in Manchester is we have a resource guide, which is online…But if she had any kind of situation or questions, she would give me a call." This colloquial kind of connection—as demonstrated between Forsythe-Taber and Murano—is emblematic of the type of relationship forged by NAMI NH staff. The ability to just pick up the phone and talk reflects the depth of connection and ease of communication

forged between these suicide prevention agents. These relationships were integral to the significant change identified by project participants and elaborated by impact participants.

***Training as intervention*.** Training as a key educational component and consequent intervention emerged as a consistent pattern. Across change stories, training through NAMI NH enhanced understanding of suicide prevention and postvention strategies among members of key groups, including first responders and loss survivors. For first responders like Lt. Simmons, this training became an important part of ongoing work meant to support two populations: first responders as they attend to sudden death notifications and loss survivors impacted by the news that their loved one is gone. While NAMI NH already has a wide repertoire of trainings in their arsenal that they often tailor to specific audiences, that protocol, training, and Police Officer Resource Card was developed originally for the Laconia Police Department. NAMI NH is now armed, however, to provide this same protocol, training, and resource card nationally as a best practice and has done so. Said Lt. Simmons: “It's branched out because we've been down to, you know, our police academy and stuff. And then Elaine from NAMI NH—she goes all over the country, she brings it with her.”

Increased training also inspired enhanced efficacy in first responders, which in turn, improved the experience of loss survivors. As Lt. Simmons noted, Police Officer Resource Cards are utilized by first responders because they understand the weight of this conversation with loss survivors, yet have long operated with little training in how to approach it. Said Lt. Simmons: “It's not exclusive to this or police work. When you're in a stressful situation like that, you know, when you don't know what to do, it's the most horrible thing ever.” In better preparing officers to deliver this news in a caring and supportive manner, loss survivors can carry forward the message that they–and their loved one–are cared about.

Further, loss survivors—as evidenced in Lang's story—are receiving their own training from NAMI NH and benefitting as well. The growing NAMI NH Survivor Voices Speaker Training program has provided not just education, but also catharsis, as loss survivors learn to tell their stories in a manner that significantly impacts audiences and elicits support for suicide prevention and postvention best practices. Lang indicated that it took a great deal of work and consultation with Baird at NAMI NH to shape her story. She was encouraged by Baird to focus on the facts, which Lang understood prevented her from sounding blaming. In so doing, Lang was able to share her story in a way that elicited understanding, and ultimately, support from first responders, rather than defensiveness or dismissal. Says Lang: "I just tell the story of the way it was handled. And I guess it's their take basically whether they want to handle something like that, when they see what it was like for a survivor."

An example of this might include Lang's disclosure in her speaking engagements that she was given specific information from first responders about Corey's location on the French King Bridge on the day he died—information that has haunted her since. In providing insight into the impact of hearing this news—as well as Lang's wish to not have—first responders are exposed to the experience of a loss survivor in a manner that shifts their perspective. Further, Lang is able to authentically share her pain—and that of her son—without compromise; this is an act of healing that requires tremendous education and support, both of which NAMI NH provided.

Even less formal training—as was provided to MHCGM's Patricia Carty through NAMI NH and the connection to NHH's Murano—led to independent research into best practices for their organization. Murano and deMello's provision of educational resources facilitated a type of informal training in how to best approach at-risk populations, as well as the clinicians who care

for them. This inspired the creation of organization-specific training, now delivered in-house, which furthers enhances suicide prevention best practices.

It is also noteworthy that training often served as an introduction to NAMI NH and a jumping-off point for conversation and collaboration. As Lt. Simmons pointed out, it was a Connect training that ultimately facilitated his relationship to NAMI NH: “I didn't know anything about this stuff. So the first thing we did when I was tasked with the POP project was to go to a training and it was Connect training. And I think Elaine put it on—Elaine and Deb—and that's where I met those two.” In this way, the one-time delivery of training did not–and does not–present the only opportunity to learn. As discussed above, while training could be considered a stand-alone intervention, those at NAMI NH and in the RPHNs used it instead as an opportunity to establish on-going relationships with individuals and organizations.

***Enhanced coordination in suicide prevention and postvention*.** The main aim of the GLS grant—to create a coordinated system of suicide prevention and postvention care across RPHNs—was achieved in ways both anticipated and unanticipated. Based on feedback from NHH’s Murano and the RPHN representatives, this system grew out of intentional efforts by all to develop greater depth of knowledge about at-risk patients and the regions from which they hail. In this way, Murano and the RPHN representatives were serving to expand upon the work that NAMI NH was already doing. RPHN Representative for the Manchester region Forsythe-Taber said: “Each region–the three regions that were part of this–were required to have a kind of, to be on the team, and make the connection…make sure the connections stayed in place because NAMI can't be everywhere. But we were there, so we are able to do that.”

By acting as an extension of NAMI NH, RPHN representatives developed more region-specific knowledge and were, consequently, able to enact more region-specific interventions.

Examples of this were easy to come by, as Murano frequently tapped RPHN representatives for help in identifying local resources that might fit the interests of a particular patient. Murano said: "So what I would do is I would get to know a kiddo that I was working with and for instance, if they were interested in therapeutic horseback riding and they were from the North Country I may reach out to that RPHN."

This more coordinated response extends to postvention in and across regions, as RPHN Representative for the Lakes region Gaspa pointed out: "I think because of the collaboration and the professionals that were brought together as a result of this grant—the training that they received—it was sort of working more hand-in-hand to ensure that people were getting the services and the support that they needed in the event of a suicide." Because NAMI NH is limited in their reach, the RPHN representatives were able to serve as community conduits to resources, training, and support that might not have otherwise been accessed; conversely, NAMI NH became better connected to individuals that may have otherwise fallen through the cracks.

Even Murano was able to expand the impact of her role at NHH by facilitating coordination between local outpatient resources, like MHCGM, for patients being discharged from the hospital. In improving transitions for at-risk individuals, a sustainable overall shift occurred, allowing current and future patients to benefit from a more coordinated system of care. Further, as in the case of MHCGM, sheer involvement in these talks of transition was significant, as it prompted an overall shift in organizational approach to suicide prevention best practices.

Meta Theory of Change

Figure 1 depicts a broad model of change derived from the patterns described above and reflective of the oft-described "ripple effect" occurring through the GLS grant. At the center sits NAMI NH and the RPHN representatives, who acted as hub for suicide prevention and

postvention and instigators of change. Their trainings, resources, support, education, and advocacy were key interventions through the grant, facilitating change both in NH and outside. Impact participants fall in the second circle, reflecting the direct impact of NAMI NH's work. This circle is inclusive of the individual-level impact that occurred and was confirmed by Lt. Simmons, Sandy Lang, and Patricia Carty.

Yet each of these impact participant's individual experiences with NAMI NH facilitated a second layer of intervention that enacted change at a more macro level. This secondary intervention reflects, for example, Lang's speaking engagements with law enforcement and other loss survivors; Lt. Simmons's development of the Police Officer Resource Cards; as well MHCGM's shift to adopt a Zero Suicide approach with its patients and staff. Those populations affected by these impact participant-driven interventions reflect a third circle of change and could include the audiences Lang addresses, the Police Academy graduates now receiving training in the use of the Police Officer Resource Cards, and the patients receiving care under a Zero Suicide strategy at MHCGM.

In this way, the meta-change model is reflective of the change facilitated through direct interaction between project and impact participants—and the undeniable fact that these interactions led to further change through the impact participants. While the effects to those impacted by impact participants have not been targeted through this research, project participants estimated shifts at the state level, as well as connections to related state issues and advocacy projects, which have been reflected in the model as a possible indirect and broader consequence of the micro-level interventions enacted by NAMI NH and the RPHN representatives. These broader consequences and implications for the model, more generally, will be explored further in Discussion.

Discussion

In exploring the impact of grassroots suicide prevention initiatives enacted in NH RPHNs through the GLS grant, patterns emerged that reflect the significant role of NAMI NH as both a resource and a relationship, the efficacy of training as intervention, and the more robust and coordinated pre- and postvention response to suicide that developed state-wide. RPHN representatives in key regions acted as extensions of NAMI NH, connecting those at-risk to local resources and to on-going support through NAMI NH's training, education, advocacy, and support. Below, I consider these results in the context of the prevention literature presented in Chapter 1, explore their future clinical implications, identify key limitations to the study, and present a personal reflection.

The Results and the Existing Literature

RPHN interventions enhance support during a sensitive time—and beyond it. As discussed in Chapter 1, previous suicide attempts are known to place youth at higher risk for future suicide (Lewinsohn, Rohde, & Seeley, 1994), with the period following psychiatric discharge being a particularly high-risk time. For youth, this vulnerable period re-emerges 9 to 18 months post-hospitalization (Bickley, Hunt, Windfuhr, Shaw, Appleby & Kapur, 2013; Qin & Nordentoft, 2005; Goldston, Daniel, Reboussin, Reboussin, Frazier, & Kelley, 1999; Prinstein, Nock, Simon, Atkins, Cheah, & Spirito, 2008). Given this, the coordinated pre- and postvention response developed in RPHNs where higher concentrations of at-risk youth reside is significant. When at-risk youth are discharged from NHH, After-care Coordinator Shannon Murano coordinates their behavioral health care post-discharge. As a result of Murano and NAMI NH's Elaine deMello, coordination and transition of behavioral health care for at-risk youth at NHH is far smoother. Enhanced communication between NHH and local outpatient institutions like

MHCGM ensure that at-risk patients do not fall through the cracks. These youth are followed and supported to ensure that they connect with an outpatient care provider at MHCGM whose services can then be guided by communication with former care providers at NHH. Further, MHCGM's adoption of a Zero Suicide approach means that all incoming patients are now treated with best practices in lowering risk for suicide.

Murano also identifies the region in which these youth live and taps into the RPHN representatives' knowledge of local resources in order to provide non-behavioral health supports post-discharge. Whether it is ROTC, art, or horseback riding, Murano identifies a given youth's interest and relies on the information compiled by RPHNs through the grant to help connect these youth with local activities. Used to augment behavioral health supports like MHCGM, these activities build on the interests of youth. Non-behavioral health supports are preventative because they build self-esteem, purpose, and ultimately, the desire to live. Connection to local resources supports at risk youth well past their discharge, into the vulnerable periods both immediately after and those that re-emerge months later. This on-going support for at-risk youth is a direct result of NAMI NH and the RPHN representatives' increased knowledge of and access to state resources. RPHN representatives' presence in regions with a high percentage of at-risk youth established and strengthened the connection to NAMI NH, facilitating access to necessary support at crucial times.

The intended–and unintended–impact of implementation teams. In Chapter 1, I discussed the utility of implementation teams in enacting large-scale organizational change (Wageman, Gardner, & Mortensen, 2012). Implementation teams were important to the capacity-building interventions developed in the RPHNs, as they were comprised of select community gatekeepers best positioned to reach at-risk youth. Based on observable shifts in the

RPHNs, implementation teams were integral to the development of both anticipated and unanticipated outcomes. It is clear that the goals of NAMI NH, the RPHN representatives, and more broadly, the grant itself were met, reflecting the utility of implementation teams in instituting grassroots suicide prevention initiatives. These goals include the provision of Connect trainings to community gatekeepers and the opportunity to adapt these trainings and who they were presented to in order to meet community needs.

Yet the use of implementation teams also resulted in unanticipated outcomes, the most significant example being the development of the Police Officer Resource Cards. Lt. Simmons' role on the Suicide Prevention and Postvention Response Team led to the development of a resource card and protocol that NAMI NH now provides to first responders nation-wide. His proximity to mental health professionals facilitated access to resources around suicide prevention and postvention. What this development reflects is the far-reaching impact of relationships developed through *participation on* implementation teams. When Lt. Simmons presented his unique perspective as a police officer attempting to deliver the painful news of a family member's sudden death, others on the implementation team—which included mental health providers, NAMI NH staff, and RPHN Representative Kelley Gaspa—became aware of a particularly problematic gap in knowledge for first responders. Their access to Lt. Simmons and his shared perspective was the impetus for addressing this knowledge gap and for developing a community protocol for first responders. According to Lt. Simmons, the primary goal of the implementation team was to raise awareness around suicide prevention through the provision of Connect trainings. However, once the team recognized this need in first responders, they immediately set to work to address it. Said Lt. Simmons: "So we'd actually completed our task. And then said, 'Hey, we still got all these people. We still meet up. We can do something else.'

And [the sudden death notification protocol] came up, and we said ‘Let's just tag this on to the end of it. Let's complete this before we wrap this up.’” The team considered Lt. Simmons’ concerns with an understanding that they’d already technically met the goals of the grant. Yet team members all agreed that the development of a first responder protocol for sudden death notifications was also very much in in keeping with the goals of the grant, to build infrastructure supporting suicide prevention state-wide. Consequently, the implementation team moved to create a community protocol that is now adapted nationally for first responder use.

Regularly bringing community gatekeepers together, therefore, appears to create synergistic opportunities to make things happen, as they access each other as key supports and resources. The differing sets of expertise of RPHN representatives, first responders, mental health providers, and other team members fostered awareness of alternative perspectives on suicide prevention, which led to new opportunities for unplanned interventions and unanticipated outcomes. Eager to use their expertise or to access that of others, implementation team members sought out opportunities to build upon the work they were already expected to do in the RPHNs, embracing the chance to develop new connections, new resources, and new training. Thus, member investment and willingness to embrace the goals and values of the project were key for the implementation team to foster lasting change. Uniting these community gatekeepers through a specific agenda and goal allowed their shared values and distinct perspectives to breed new approaches to suicide prevention.

Future Clinical Implications

While this study focuses on the direct impact of project participants on impact participants, a third level of observable changes was reported by impact participants that have clinical implications for suicide prevention in NH and nation-wide. Grassroots, capacity-building

interventions like those used in the RPHNs led to better transitional care for at-risk youth discharged from NHH and a more coordinated state-wide pre- and postvention response to suicide. Thus, the designation of key regional representatives that are well-connected to both local resources and to a key state resource in NAMI NH supports suicide prevention efforts. State-wide suicide prevention initiatives should, therefore, incorporate regional representatives into implementation, particularly in regions with high concentrations of at-risk individuals. Close coordination with state resources at NAMI extends its reach to at-risk individuals that might not otherwise be affected. NAMI's knowledge of local resources also grows through their connection to regional representatives. These connections build a state-wide safety net, providing support to those at-risk for suicide and for those affected by suicide. The repeated use of this coordinated system for preventing and responding to suicide only strengthens it, as all involved become more knowledgeable about what to do and who to contact. This leads to faster and better postvention responses and ultimately, fewer deaths by suicide.

Grassroots suicide prevention interventions are best enacted through the use of implementation teams. These teams are effective in meeting expected project goals and in fostering unexpected outcomes, both of which enhance suicide prevention and postvention through the development and distribution of training and resources. Implementation team members and their commitment to the goal of suicide prevention were key to its success, rendering the process of populating these teams an important one. Implementation teams should be comprised of individuals dedicated to the values underlying the goals of community-based interventions: the building of a connective infrastructure; the provision of training, support, and education; and the flexibility to address community needs as they arise. When guided by a broad

goal like suicide prevention, the implementation team is then free to approach it with ingenuity, leading to unexpected outcomes in service of this goal.

Limitations and Future Research

One key limitation to this study is the low number of participants. Because there were only a few stories of change gathered—which served as the units of analysis for this research—this limited the data from which to derive themes. While the full pool of project participants to be contacted was already small at seven, only four agreed to participate in this study; the two who did not participate were RPHN representatives, leaving unknown the possible significant change that may have taken place in other key parts of the state. Securing participation of all project participants would ensure that the themes derived reflect the full picture of what happened in the RPHNs.

Another limitation is the lack of clear criteria for selection of change stories. Having project participants convene to develop broad criteria for change story selection might have created clear and agreed-upon guidelines as they considered what to share. This would reduce subjective differences due to project participant bias with respect to how “significant change” was interpreted and ultimately, what stories were shared. Because the theme of relationships emerged so strongly, it is possible that bias may have played a role in project participants selecting stories populated by individuals with whom they are close. For example, Loss Survivor Support Specialist Deb Baird’s close and ongoing relationship to loss survivor Sandy Lang may have influenced Baird’s identifying her story as exemplary of significant change. Given Baird’s established role with loss survivors, it is not surprising that she might select significant change emblematic of the work she’s done and observed, particularly as it applies to individuals with whom she is close. However, this story’s selection might belie a bias that produced results,

which suggest a greater emphasis on relationship than may have actually existed in the RPHN intervention. The development of clear guidelines for identifying change stories might reduce the incidence of bias in story selection and allow project participants to more objectively consider significant change that occurred outside of particular areas of expertise or close relationships.

Another limitation was that of retrospective recall. The GLS grant period spanned three years, beginning in 2013 and officially closing in September 2016. For this study, change stories were collected, beginning one year after the grant period ended in September 2017. Both project and impact participants were asked not only to participate at a time when their investment in the grant may have waned, but also to reflect back on a three-year period that terminated a year or more prior. Given what is known about decay theory, the sheer passing of time would have undermined project participants' memories of grant-related events, unless they were being accessed with regularity (Berman, 2009). Project participants that continued to maintain roles and relationships with NAMI NH once the grant lapsed would likely have more investment in participating in the study, as well as greater ease in remembering stories of significant change.

Future studies might consider engaging project participants in study participation in the waning months of a given grant period to ensure that all are still invested and already meeting within the parameters of the grant. More project participants would likely be willing to participate, resolving concerns around the low number in this study. Further, with grant meetings already scheduled, there would be existing opportunity for project participants to identify domains to categorize change, as well as broad selection criteria for change stories, which would reduce the potential for bias in story selection. This discussion might also prime project participants to consider from different perspectives what constitutes significant change through the grant, which would likely mitigate some of the effects of memory and bias.

Future research might also focus on the "third-level impact" that went unexplored in this study—that of impact participants on others. It would be helpful to clarify the nature of this impact—how far it goes, who feels it, and whether those impacted feel compelled to perpetuate change, as the impact participants have done in this study.

Personal Reflection

Engaging with project and impact participants through this research drew me into the very network I was investigating. Given my own need to reach out to participants several times with additional questions, I had the opportunity to experience for myself the openness and ease with which NAMI NH's Training and Education Services Manager Elaine deMello and Loss Survivor Support Specialist Deb Baird received them. Warm, welcoming, and always prompt in their responses, deMello and Baird were all that I'd heard they would be. In this way, I was personally privy to the experiences of impact participants when reaching out to NAMI NH for help. It was clear just how easy deMello and Baird make it to do so.

This paralleled my experience with impact participants, seeming to reflect the cues they'd taken from deMello and Baird. I reached out to both Lt. Simmons and loss survivor Sandy Lang several times with follow-up questions. For Lang, in particular, whose story is painful to recount, the decision to invite me in took time, primarily because she was concerned she would not be sufficiently helpful. After we spoke the first time, around Christmas 2017, I reached out to her again in late summer 2018. Lang sent me a photo of her son, Corey, a few days later—"because [she] talked so much about him and [she] wanted me to see how handsome he was." This was meaningful to me as a satellite in the NAMI NH universe. I knew that it was not easy for Lang to relive these extremely difficult experiences. That she allowed me in seemed to reflect her ongoing desire to share Corey's story if it might be of help to others. Even if it hurt to tell it,

even if she was hesitant about its utility, Lang let me in. In this same way, I found that each of the project and impact participants that took part in this study opened a window to their view of the intervention enacted in the RPHNs. This willingness to engage for the purposes of destigmatizing and, ultimately, preventing suicide lies at the core of NAMI NH's work, and by extension, the work of those impacted. To be around it is to become a part of it.

Figure 1. Meta-Change Theory

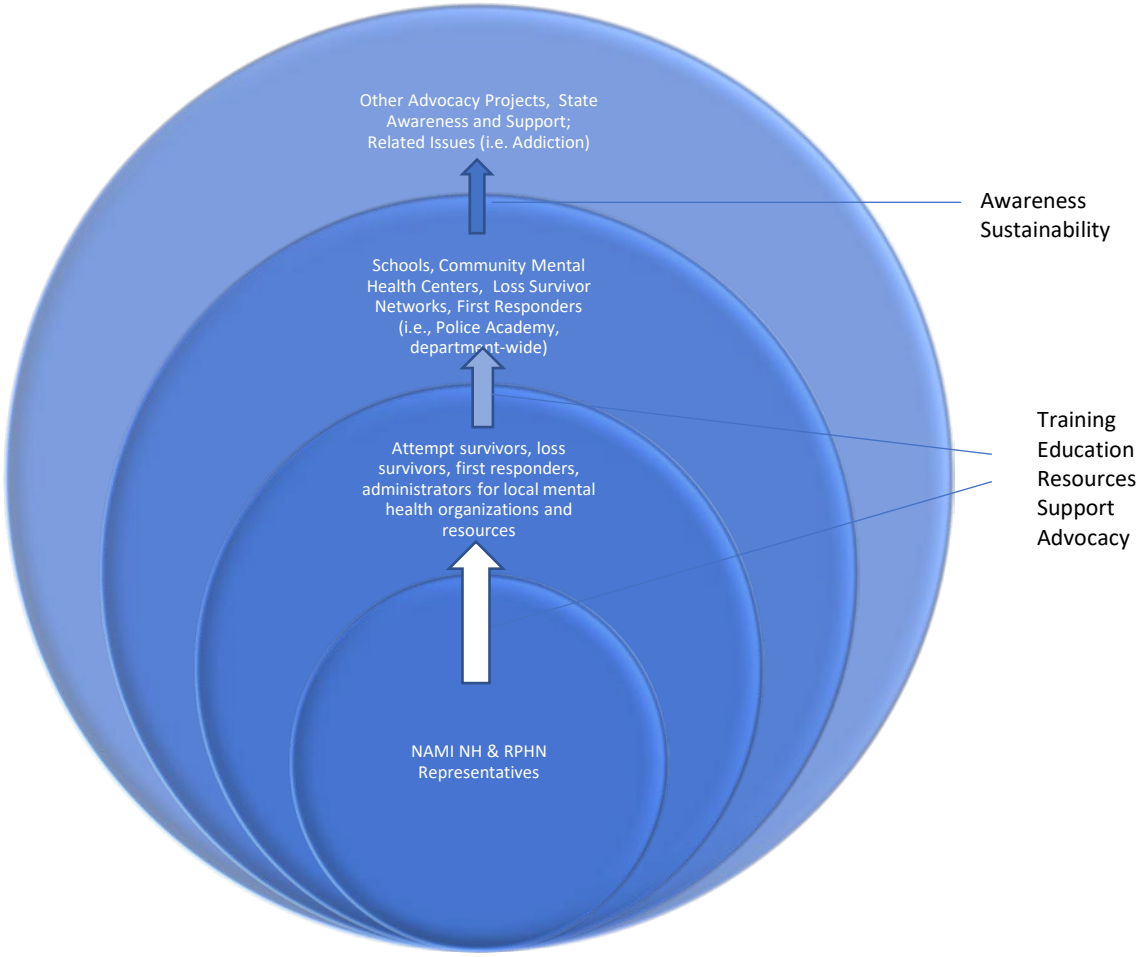

Figure 1. Graphic representation of the patterns of change identified through analysis of significant change stories.

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Appendix A

NAMI NH Study on Suicide Prevention Efforts

Consent Form – Project Participant

I am part of a research team at Antioch University-New England. I am helping the National Alliance for the Mentally Ill – New Hampshire (NAMI NH) learn about the experiences of people impacted through their efforts to prevent suicide.

What I hope to learn:
Below are some of the things I would like to ask you about:

- What you believe is the most important change to come from NAMI NH's efforts to prevent suicide
- Who are the key people that have taken part in this story of change
- How and why you believe those efforts may have worked

Why I want to learn about your experience:
Learning about your experiences through NAMI NH's efforts to prevent suicide may help you improve the program and the experiences of others.

If you decide to participate:
I will call or email you to arrange a 30-40 minute phone interview at your convenience.

I don't want you to feel you have to take part in this interview. Even if you decide to take part, you don't have to answer any question that you don't want to. If you don't want to answer a question, just tell me you would rather not answer, and I will move on. If you would rather not be interviewed, let me know. You should only take part in the interview if you want to.

Benefits to you:
You may enjoy the chance to reflect back on these efforts. You could also positively impact the experiences of others.

A note about privacy:
It is likely that you will be named in the final report. This might be by name or through information specific to your region. Given this, please decide whether you would still like to take part in the study.

If you have any questions about the study, you may contact me, Kate Mayhew, via telephone at [redacted] or via email at [redacted]. If you have any questions about your rights as a research participant, you may contact the Chair of Antioch's research ethics review committee, [redacted], via telephone at [redacted] or via email at

[redacted] or, or the provost and CEO of Antioch University-New England, [redacted], via telephone at [redacted] or via email at [redacted]

Best,

Kate Mayhew, M.S.
Doctoral Candidate
Clinical Psychology
Antioch University-New England

_____

I have read and understood the information on this form. I have had my questions answered and understand that I am taking part in this study because I want to. I also know that I may stop participating at any point. I agree to take part in this study.

Print Name: _____

Signature: _____ Date: _____

Please indicate the best way to contact you in order to schedule a time to interview.

____ Telephone: _____ (Home/Cell/Work)

____ Email: _____

NAMI NH Study on Suicide Prevention Efforts

Consent Form – Impact Participant

I am part of a research team at Antioch University-New England. I am helping the National Alliance for the Mentally Ill – New Hampshire (NAMI NH) learn about the experiences of people impacted through their efforts to prevent suicide.

What I hope to learn:
Below are some of the things I would like to ask you about:

- How you became involved with NAMI NH's suicide prevention efforts
- How you have experienced these suicide prevention efforts
- How those efforts have impacted you as an individual

Why I want to learn about your experience:
Learning about your experiences through NAMI NH's suicide prevention efforts may help them improve the program and the experiences of others.

If you decide to take part:
I will call or email you to arrange a 30-40 minute phone interview at your convenience.

I don't want you to feel you have to take part in this interview. Even if you decide to take part, you don't have to answer any question that you don't want to. If you don't want to answer a question, just tell me you would rather not answer, and I will move on. If you would rather not be interviewed, let me know. You should only take part in the interview if you want to.

Risks of taking part:
Some of the experiences I am asking about are related to suicide prevention, which can be a difficult topic. It is possible that the material could remind you of a past experience you found difficult. You might feel stress talking about these experiences.

Benefits to you:
You may find the interview rewarding. You may enjoy having the chance to think back on positive experiences. Your input could also positively impact the experiences of others.

I respect and will protect your privacy:
I will keep all information about who you are separate from all the other information you give me. For example, I will record my conversation with you, but I will identify those recordings (and any notes taken about them) by a number. Only I will hear the recordings. Once I have had a chance to listen to the recordings, I will erase them. In any report I write about this project, I will describe what I have learned from *all* of the participants together. If I want to use any of your exact words, I will ask for your approval.

If you have any questions about the study, you may contact me, Kate Mayhew, via telephone at [redacted] or via email at [redacted]. If you have any questions about your rights as a research participant, you may contact the Chair of Antioch's research ethics review committee, [redacted], via telephone at [redacted] or via email at [redacted] or, or the provost and CEO of Antioch University-New England, [redacted], via telephone at [redacted] or via email at [redacted].

Best,

Kate Mayhew, M.S.
Doctoral Candidate
Clinical Psychology
Antioch University-New England

_____

I have read and understood the information on this form. I have had my questions answered and understand that I am taking part in this study because I want to. I also know that I may stop participating at any point. I agree to take part in this study.

Print Name: _____

Signature: _____ Date: _____

Please tell us the best way to contact you to schedule a time to interview.

____ Telephone: _____ (Home/Cell/Work)

____ Email: _____