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Suicide Screening, Assessment, and Intervention

Meet Our Presenters

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Primary Goals

To provide the best possible care to patients, prevent suicide, and decrease ER admissions

To standardize screening, assessment tools, and safety planning

To educate providers and reduce their stress when treating suicidal patients

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Objectives

Learn evidence-based suicide prevention protocols

Cultivate empathetic curiosity and willingness to engage with individuals experiencing suicidal ideation

Build competence in managing suicidal thinking and behaviors

Understand how to assess acute and chronic risk

Equip individuals with tools for effective Screening, Assessment, and Safety Planning Intervention

Provide recommendations for follow-up care

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The Importance of Effective Suicide Risk Assessment and Management

Research and Evidence for Best Practice

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National Statistics

Data from the National Vital Statistics System (CDC)

Suicide rates increased 37% between 2000-2018 and decreased 5% between 2018-2020. However, rates nearly returned to their peak in 2021. From 2021 to 2022 there was a 2.6% increase.

- People ages 85 and older have the highest rates of suicide at 22.4 per 100,000.
- Firearms are used in more than 50% of suicide deaths
- The suicide rate among males in 2021 was approximately four times higher than the rate among females. Males make up 50% of the population but nearly 80% of suicides.
- The racial/ethnic group with the highest rate in 2021 was non-Hispanic American Indian and Alaskan Native people at 28.1 per 100,000.
    - Also, Alaskan Native people was one of only two groups to show a decrease in 2022 of 6.1%.
- The number of deaths by suicide for 10-24 year-olds decreased from 2021 to 2022 by 8.4%.

MN State Statistics

2018-2023 Data from the National Vital Statistics System (CDC)

Data for 4,807 individuals who lost their lives to suicide in Minnesota.

- Of these individuals, 20.8% were identified as female and 79.2% male.
  - In all years except 2019, less than 10 female individuals of a race other than white died by suicide.*
  - Females represent the youngest ages and males represent the oldest ages.
- Ages primarily ranged from 12-94, with 3 children being under age 12.
  - Approx. 4.1% were minors.
  - For adults, age groups with the highest percentage of suicide deaths are 25-29 (m), 30-34 (m & f), 35-39 (f), and 55-59 (m & f).
- Considering race: 87.4% White, 4% Black/African American, 3.6% Asian, 3% American Indian/Native Alaskan, and 2% Multiracial.
- Comparing 2018 to 2023, rates of suicide have decreased for White and American Indian/Alaskan Native individuals but increased for Black, Asian, and Multiracial individuals.
- The most common methods identified are Firearm use, Poisoning, and Suffocation. Females are far less likely to use a method outside of those 3 categories.

Local Statistics

Data from the National Vital Statistics System (CDC)

From 2018 to 2023 with provisional data from 2024, the rate of suicide deaths in Anoka County was 14.6 per 100,000 people (slightly higher than the state at 14.1).

From 2020 to 2024 there were 269 individuals who lost their lives to suicide:

- The most common methods were firearm use (51.3%), suffocation (28.6%), and poisoning (14.1%).
- The highest number of suicide deaths annually was in 2021 and has been decreasing since.
- The majority of those who died from suicide identified as White (87.7%).
- People aged 15-24 (16.7%), 35-44 (17.8%), and 45-54 (19.0%) were most likely to die from suicide.
- Of the 269 individuals, 76.2% were identified as male and 23.8% were identified as female.

Local Statistics

Data from Anoka County Medical Examiner

From 2022 through 2024, 147 individuals lost their life to suicide. Firearms were the most common method of suicide, accounting for 52% of the cases, followed by hanging/asphyxiation at 33%, and drug/substance abuse (incl. OTC medications) at 10%.

- 76% were male and 24% were female
- Average age is 45.8 with a range of 11 to 95
- 8 of these individuals were minors
- 83% were identified as White, 5% Hmong, 4% Unknown or Other race, 3% Asian (incl. Asian Indian and Laotian), 2% Black/African American, 1% Native American/American Indian, and individuals who were identified as being Mexican, Kenyan, and Multiracial.

Local Statistics

Data From Anoka County

Hospital-Treated Suicidal and Self-Harm Injury

Among Anoka County Residents from 2016-2023, the most common causes were:

- Drug Poisoning
- Cut/Stabbing
- Other/Unspecified
- https://www.health.state.mn.us/communities/injury/midas/selfharm.html

Student Data

2022 Minnesota Student Survey (grades 8,9, & 11)

- 31% of Anoka County students reported ever **seriously considering** attempting suicide with 16% in the past year.
- This was an increase from the 2019 survey.
- 10% of Anoka County students reported ever attempting suicide, including 4% in the past year.
- Minnesota Student Survey

The Role of Behavioral Health Professionals

Joint Commission Recommendations to Reduce the Risk for Suicide

Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.

Resources for Suicide Risk Reduction | Joint Commission

https://www.jointcommission.org/sea_issue_56/

- Use screening procedures for the early detection of suicide risk.
- Conduct risk assessments that identify factors that may increase or decrease the risk of suicide.
- Address immediate safety needs and determine most appropriate setting for treatment.
- Provide suicide prevention information to the individual and their family as needed.
- Provide evidence-based treatment and follow-up care.

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Support for Standard Practices

Henry Ford Health System

A health care and medical services provider in Detroit, MI.

- In 2001 launched an initiative to redesign depression care with the goal of eliminating suicide.
- After implementing quality improvement processes with a focus on suicide care, the results showed a 75% reduction in the suicide rate among their health plan members
- https://pubmed.ncbi.nlm.nih.gov/17441556/

Centerstone

One of the largest not-for-profit community mental health centers in the nation.

- After implementing Zero Suicide practices for 3 years, there was a reduction in suicide deaths from a baseline of 35 per 100,000 people to 13 per 100,000
- Evidence | Zero Suicide
- https://zerosuicide.edc.org/sites/default/files/2023-03/Transforming%20Systems-1_0.pdf

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“The Relationship Between Suicidal Behaviors and Zero Suicide Organizational Best Practices in Outpatient Mental Health Clinics”

The Relationship Between Suicidal Behaviors and Zero Suicide Organizational Best Practices in Outpatient Mental Health Clinics | Psychiatric Services

Completed in 2021 and evaluated 110 outpatient mental health clinics implementing Zero Suicide practices and found this model was associated with lower instances of suicidal behavior among patients under care.

Organizational Best Practices

Practice 1

"Suicide-specific quality improvement activities, which the authors defined as "having suicide care embedded in the medical chart, written clinical workflows for suicide care, and data collection and review by clinical teams."

- Quality improvement infrastructure had the highest effect size in the study.
- Sustainable data-monitoring and quality improvement infrastructure are important to support suicide prevention efforts

Practice 2

Lethal means reduction or working to ensure patients are safe from the means for suicide at home. The authors noted that lethal means reduction **"requires documentation in safety plans as a standard practice"** as well as "policies addressing clinician training, family inclusion in means reduction, and confirmation of means reduction."

- The Relationship Between Suicidal Behaviors and Zero Suicide Organizational Best Practices in Outpatient Mental Health Clinics | Psychiatric Services

Five other Zero Suicide practices were also found to be important in reducing the risk of suicide:

1. Commitment of clinic leadership to suicide prevention.
2. Assessments of confidence in suicide care and of skills among staff.
3. Suicide risk assessments.
4. Engaging hard-to-reach and no-show patients.
5. Following up with patients who were discharged from acute settings.

https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.202000525

Increasing Provider Competence and Willingness

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We all play an important role in assessing and managing suicide

Most providers feel anxious or have urges to avoid the subject of suicide. Assessing and treating suicide can be difficult and scary.

You are not alone. We can do hard things together.

Provider Willingness:

- To make informed decisions based on what is happening in the moment.
- To ask questions and discuss suicide directly.
- To engage patients with curiosity and gentleness.
- To orient all patients to therapy structure and managing suicide risk.

A Compassionate Perspective on Suicidal Behavior

From the perspective of the person helping

- Listen to their story and show compassion.
- Ask directly about suicide, calmly and without judgment.
- Show understanding and take their concerns seriously.
- Let them know their life matters to you. Convey hope and hold firm that suicide is not the answer. That one conversation could save a life.

From the perspective of a suicidal person

- Suicide is a solution to problems causing intense suffering.
- Feel they are a burden to others.
- They may want to ease the burden of others.
- Feel hopeless and alone, without options.
- This is not an act to get attention.

Prepare

- **P –** Practice asking hard questions and have solutions and strategies available.
- **R –** Role play scenarios with your supervisor or coworkers for validation and problem solving. Practice makes permanent & increases confidence!
- **E –** Evaluate patient risk within the first 5-15 minutes.
- **P –** Prepare a cope ahead plan to manage suicide in sessions.
- **A –** Assess ahead of time what you may need for self-care.
- **R –** Remember you are never without support and resources.
- **E –** Expect to experience your own emotions and reactions.

Things to remember when talking to a suicidal person

www.mentalhealthzen.com

What to do:

- Be compassionate and express love and care for the person.
- Listen patiently to what the person has to say.
- Do not be judgmental. Instead, be calm and stay positive.
- Reassure them that life can be better, and help is available.
- Take everything the person says seriously as this can help with trust and getting the necessary help.

What not to do:

- Don't try to minimize the problem or shame them into changing their mind.
- Don't appear shocked or lecture them about the situation.
- Don’t ask them to explain or defend their suicidal thoughts.
- Don’t blame the person or say something that is going to cause the person to feel invalidated or dismissed.

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Language Matters:

Suggestions on how to talk about suicide while maintaining a respectful and trusting environment

Problematic

- Commit/Committed suicide
- Successful suicide attempt
- Unsuccessful suicide or failed suicide
- Suicide victim
- <Name> is suicidal

Preferred

- Died by suicide, suicide death, took their own life, lost their life to suicide
- Fatal suicide attempt, death by suicide
- Suicide attempt or non-fatal suicide attempt, survived a suicide attempt
- Those who die by suicide
- <Name> is facing suicide, thinking of suicide, suffering through or experiencing suicidal thoughts

- IASP Language Guidelines 2022
- Words Matter | CAMH

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General guidelines for gathering information about suicide risk

- Talk about suicide openly and matter of fact.
- Be direct – ask “Are you planning to kill yourself?”
- Be flexible.
- Be active.
- Be specific, use clear and consistent terminology.
- Be honest about reasons for responses.

Have a Conversation With Your Patient About Suicide Risk

5 Action Steps for Helping Someone in Emotional Pain

ASK

"Are you thinking about killing yourself?"

KEEP THEM SAFE

Reduce access to lethal items or places.

BE THERE

Listen carefully and acknowledge their feelings.

HELP THEM CONNECT

Save the National Suicide Prevention Lifeline number 1-800-273-8255.

STAY CONNECTED

Follow up and stay in touch after a crisis.

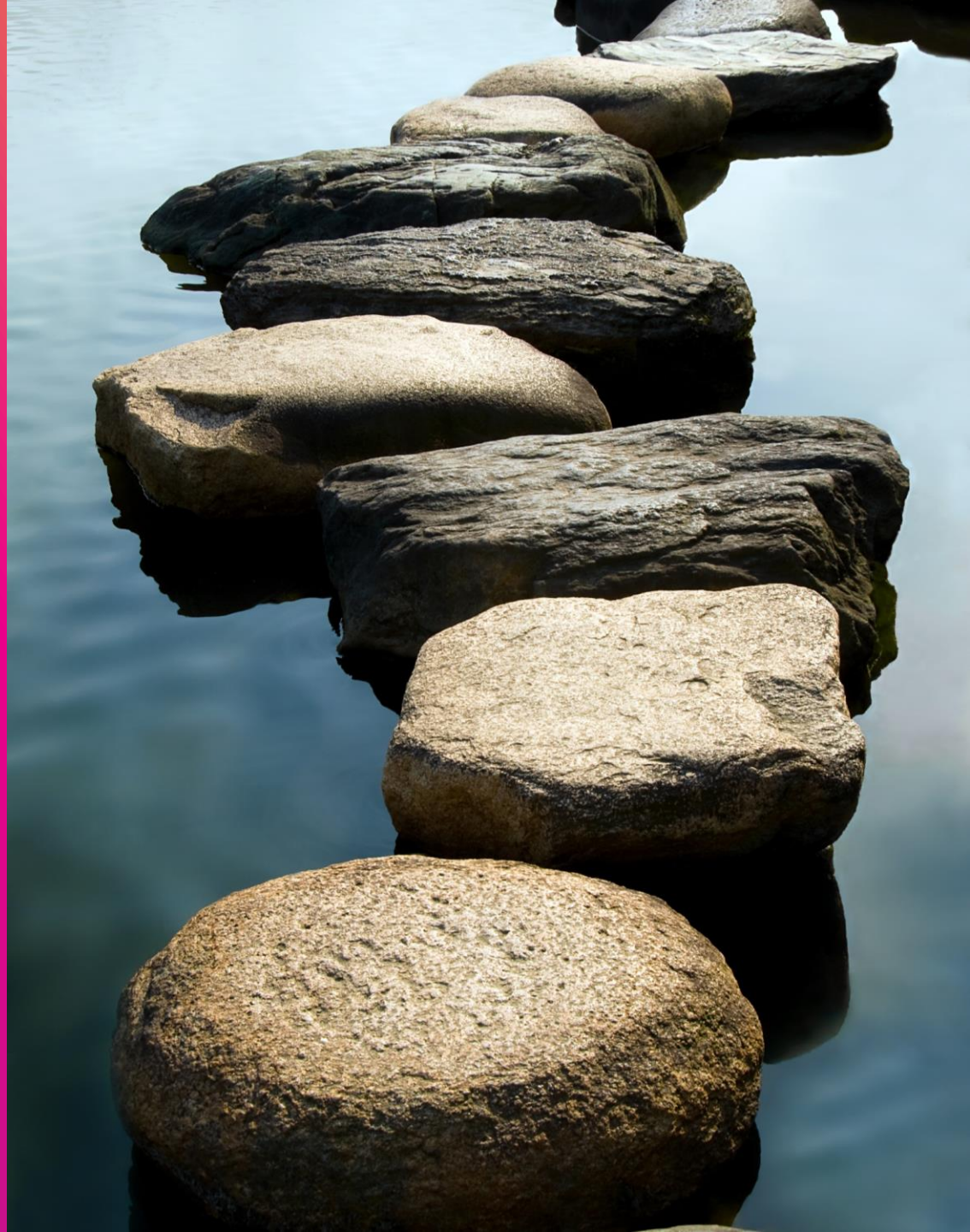
National Institute of Mental Health

www.nimh.nih.gov/suicideprevention

Asking about suicidal thoughts or feelings won't push someone into doing something self-destructive.

Rather, it’s important to know that

Offering an opportunity to talk about feelings may reduce the risk of acting on suicidal feelings.



Screening and Assessment Tools

C-SSRS and SAFE-T

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Columbia Suicide Severity Rating Scale (C-SSRS)

https://cssrs.columbia.edu

"Just ask. You can save a life."

- Brief non-proprietary evaluation used to determine whether higher level of care should be considered.
- Most evidenced supported tool of its kind.
- Available in multiple languages and has been used in studies internationally.
- Questions 1-5 are to scale for suicidal ideation severity.
- Responses: Yes or No
- Question 6 establishes if behaviors have occurred over the lifetime and then specifically asks about the last 3 months.
- Determines response level using Columbia Response Protocol.

Using the Columbia Suicide Severity Rating Scale with Patients

Introduce the Columbia

Encourage patients to be open and explain that you will work with them to manage suicidal thoughts.

- Be matter of fact, even with children and adolescents. Apprise – "I'm going to ask you very direct questions about suicide."
- Explain why – "We know that suicidal thoughts are not unusual when people are feeling the way you are."
- Orient to expected response "Yes or No" – Explain more details are not needed at this time.
- When appropriate, such as instances in which the child is young (0-5) or not in attendance, questions can be phrased to a parent or caregiver to answer on behalf of the child.

Columbia Suicide Severity Rating Scale (C-SSRS)

Response determined by level of risk.

Young child version:

- Utilize the C-SSRS for Very Young Children and Cognitively Impaired (age 4-5).
- A full lifetime/recent scale with adjusted language.
- https://cssrs.columbia.edu/documents/c-ssrs-full-lifetime-recent-scale-young-children-4-5/

Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	High Risk	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	High Risk	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself; or collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, etc. **If yes, was this within the past 3 months?**		High Risk

Suicide Assessment Five-step Evaluation and Triage

SAFE-T

SAFE-T Suicide Assessment Five Step Evaluation and Triage | SAMHSA Library

Suicide Assessment Five-Step Evaluation and Triage

SAFE-T

- Suicide risk assessment tool.
- Developed by Dr. Douglas Jacobs and sponsored by PRMS (professional risk management services).
- Collaboration between Screening for Mental Health, Inc. and the Suicide Prevention Resource Center.
- Distributed by SAMHSA (substance abuse and mental health services administration).
- Designed to help healthcare professionals assess suicide risk effectively.
- Drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors. (APA 2003)
  - http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx

Effectiveness of SAFE-T

Numerous studies and clinical evaluations have demonstrated the effectiveness of SAFE-T in assessing suicide risk.

- A study by Boudreaux et al. (2015) found that SAFE-T improved the identification of at-risk individuals and increased the likelihood of appropriate interventions.
- In a review by Jobes (2016), SAFE-T was praised for its structured and standardized approach to risk assessment, reducing subjectivity in clinical decision-making.
- Teaching the SAFE-T to ED nurses has been shown to enhance suicide inquiry and increase knowledge regarding identifying risk and protective factors and determining risk level and appropriate intervention (Rico, 2016).

SAFE-T Components

Step 1: Identify Risk Factors	• Examines factors contributing to suicide risk • **Note those that can be modified to reduce risk**
Step 2: Identify Protective Factors	• Assesses internal and external protective factors that may mitigate risk • **Note those that can be enhanced**
Step 3: Conduct Suicide Inquiry	• Helps determine the presence, frequency, intensity, and duration of suicidal thoughts. • Specific questioning about plans, behaviors, and intent.
Step 4: Determine Risk Level/Intervention	• Combines information from steps 1-3 to classify risk level as low, moderate, or high. • Identify possible interventions to address and reduce risk
Step 5: Document	• Assessment of risk level and rationale, current intervention, current plan to address/reduce risk, and follow-up plan. • Develop a tailored safety plan

Defining Suicide Risk

Acute and Chronic Risk

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Acute (imminent) Risk Factors

- Intense anxiety w/ recent exacerbation
- Sense of hopelessness & desperation
- Intense sense of guilt & self-hatred
- Intense feelings of shame
- Recent loss of relationships or death of loved one
- Death of loved one by suicide
- Recent change in medical condition w/ increase disability
- Current preoccupation w/ suicidal thoughts
- Current serious intent + plan to attempt suicide with means to attempt (access to lethal means)
- Reported suicide attempt
- Feeling Trapped – not able to problem solve (no way out)
- Psyche Pain – acute distress in response to loss, defeat, rejection

Chronic Risk Factors

- Active substance abuse or dependence
- Other mental disorders
- Previous suicide attempt
- Family history of suicide attempt or completion
- Poor or dysfunctional social support (including bullying)
- Chronic adverse life event (unemployment, financial stress, etc.)
- Living alone
- Medical illness and low total cholesterol (less than 160)
- Adverse family history of violence or substance abuse

	Essential Features	Suicidal Ideation	Intent	Plan	Prep. Behaviors	Protective Factors	Action
Low Acute Risk	• Has a care provider • Is able to be safe • Modifiable risk factors • Strong protective factors	Yes – Some	No	No	No	Several	• Outpatient • Ongoing assessment for a possible safety plan.
Intermediate Acute Risk	• Multiple risk factors • Few protective factors • Ability to maintain independent safety • Some moderate distress • Good self-control	Yes	No	Some Specificity	Mostly Absent	Few	• Consider hospitalization • More frequent contact w/ outpatient care • Well-articulated safety plan
High Acute Risk	• Psychiatric Dx with severe features • Acute precipitative event • Impaired self-control • Inability to stay safe • Acute stressors	Yes – Frequent & Intense	Yes	Yes – Specific Plan	Yes – Ongoing	None – Very Few	• Hospitalization • Remove access to lethal means • Psyche symptoms addressed

	Essential Features	Protective Factors	Action
Low Chronic Risk	• None to little mental health or SUD problems • No history of self-violence • No history of chronic suicide ideation • No tendency toward risky behavior • No high impulsivity	• Good coping skills • Reasons for living • Psychosocial stability • Economic security • Support from spiritual beliefs • Positive parent/child relationships	• Therapy on an as needed basis
Intermediate Chronic Risk	• May have chronic major mental illness • May have chronic pain • History of substance abuse/dependence • Some family history of violence • Less family/social support	• Limited protective factors	• Routine, ongoing mental health therapy • Develop stronger coping skills & protective factors • Well-articulated safety plan
High Chronic Risk	• Recent change in mood • Chronic, major mental illness • History of prior suicide attempts • Family history of suicide • Limited coping skills • Chronic pain and medical condition • Low total Cholesterol (less than 160)	• Very few protective factors	• Calculated risk assessment • Well-articulated safety plan • Routine suicide risk screening • Evidence-based treatment • Build coping skills • Routine building of protective factors

Suicide Narratives/Behaviors

- Hopelessness
- Harsh attitudes toward self
- Self-blame, self-contempt
- Stockpiling medications
- Giving away possessions
- Increased isolation
- Missing appointments

- "I am a burden"
- "The future is unimaginable"
- "I cannot see a solution to my problem"
- "My family would be better off without me."

Protective Factors

- Hope for the future
- Self-efficacy in problem area
- Meaningful family relationships (including pets)
- Significant other/child or other person responsibilities
- Religious/Spiritual Beliefs
- Strong desire to live/Attachment to life
- Connections to cultural groups or support systems like friends/community supports
- Connected to and engaged in health care or mental health care

Protective Factors

Continued:

- The ability to cope with stress
- Frustration tolerance
- Absence of psychosis
- Economic security
- Reasons for living
- Therapeutic relationship

Be careful not to get a false sense of security due to the presence of protective factors

Protective factors are necessary but not sufficient in an acute crisis

Safety Planning Intervention

Stanley-Brown

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What is Safety Planning?

A brief risk management intervention intended to provide people at risk for suicide with a specific set of concrete strategies to use to decrease the risk of suicide.

- Can be used as a stand-alone intervention in acute settings.
  - Preferable to standard “assess and refer” approach
- Can be used during ongoing mental health treatment for patients with:
  - A history of suicidal behavior
  - Current suicidal ideation
  - Other factors indicating potential suicide risk

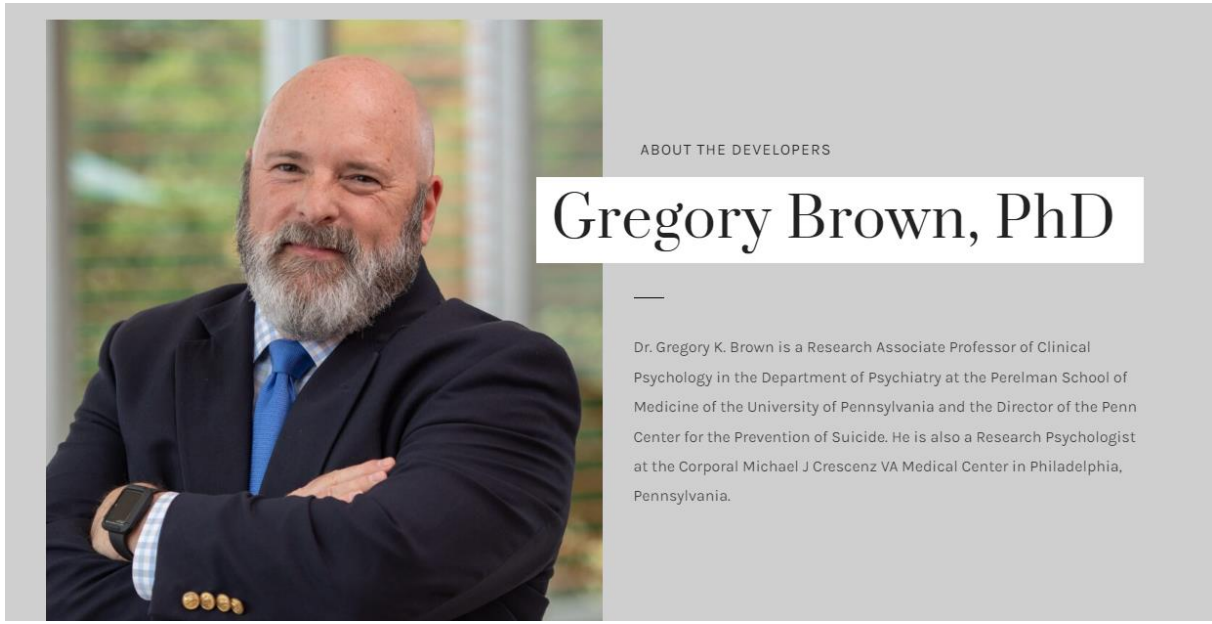
Safety Plans

What do Safety Plans achieve?

- Helps prevent a crises and prevents acting on suicidal feelings.
- Through repeated use, they help develop the capacity to ride through suicidal crises, learn techniques that reduce high distress, learn that suicidal feelings can be controlled and not simply endured, helps to increase competence.
- Using the safety plan is a form of therapy.

Stanley Brown Safety Planning Intervention Protocol

[Home - Stanley-Brown Safety Planning Intervention (suicidesafetyplan.com)]



Photos taken from: Home - Stanley-Brown Safety Planning Intervention (suicidesafetyplan.com)

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Why: Suicide Prevention Intervention

Dr. Stanley Video

https://www.youtube.com/watch?v=f4dYmWxAK_Q

Safety Planning Intervention

Barbara Stanley, Ph.D

and

Gregory Brown, Ph.D

Stanley, B. & Brown, G. K. (2012). Safety Planning Intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19,* 256-264.

Requires a comprehensive assessment of suicide risk and the crisis behavior

- Including precipitating events and antecedents in order to identify "warning signs" needed to safety plan.
- The patient DOCUMENTS, themselves, how to prevent suicide including reducing lethal means.
- Uses a collaborative stance with patient and clinician as partners.
- Incudes the point of view that "suicide" is not a solution to a problem, so the focus is on "problem solving".
- Leaves the patient with a tangible record of the problem solving they did with the clinician.

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No-Suicide Contracts vs. Safety Planning

No-Suicide Contracts

- Written or verbal agreement to not kill themselves
- Do not include strategies for what to do to reduce risk
- No empirical support
- Not recommended

Safety Planning

- Written list of strategies to use to reduce suicide risk
- Large randomized trials supporting effectiveness
  - https://pubmed.ncbi.nlm.nih.gov/29998307/
- Recommended as best practice

Stanley-Brown Safety Plan Template

Forms - Stanley-Brown Safety Planning Intervention

Stanley-Brown-Safety-Plan-05-02-2024.pdf

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Place: _____ Address: _____
4. Place: _____ Address: _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Name: _____ Contact: _____

STEP 5: PROFESSIONALS OR PROFESSIONAL SERVICES I CAN CONTACT DURING A CRISIS:

1. Professional/Services Name: _____ Phone: _____
   Emergency Contact: _____
2. Professional/Services Name: _____ Phone: _____
   Emergency Contact: _____
3. Emergency Department: _____
   Emergency Department Address: _____
   Emergency Department Phone: _____
4. Crisis Line Phone (e.g. 988): _____

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. _____
2. _____

When is a Safety Plan Needed?

Acute Risk

Decide Yes or No for each

- Low - **No**
- Moderate - **Yes**
- High – **Follow Emergency Procedure (Complete safety plan during next visit)**

Chronic Risk

Decide Yes or No for each

- Low - **No**
- Moderate - **Yes**
- High - **Yes**

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Safety Planning Intervention Step-by-Step

With Video Examples

Step 1	Recognizing warning signs
Step 2	Using internal coping strategies
Step 3	Socializing with family members or others who may offer support or distraction from the crisis
Step 4	Contacting family members or friends who may offer help to resolve a crisis
Step 5	Contacting professionals or agencies
Step 6	Making the environment safe

Stanley, B. & Brown, G. K. (2012). Safety Planning Intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19,* 256-264.

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Recognizing Warning Signs

Step One

Recognizing Warning Signs (Step 1)

- **Warning signs immediately precede a suicidal crisis and can include personal:**
  - Situations (e.g., "stress at work")
  - Thoughts and styles of thinking (e.g., "I am a failure")
  - Styles of thinking (e.g., "having racing thoughts")
  - Images (e.g., "flashbacks")
  - Mood (e.g., "feeling down")
  - Behavior (e.g., "spending a lot of time alone")
- **Example questions to ask:**
  - "How will you know when the safety plan should be used?"
  - "What typically causes you to start thinking about suicide?"
- **Write down warning signs <u>using the patient's own words</u>.**

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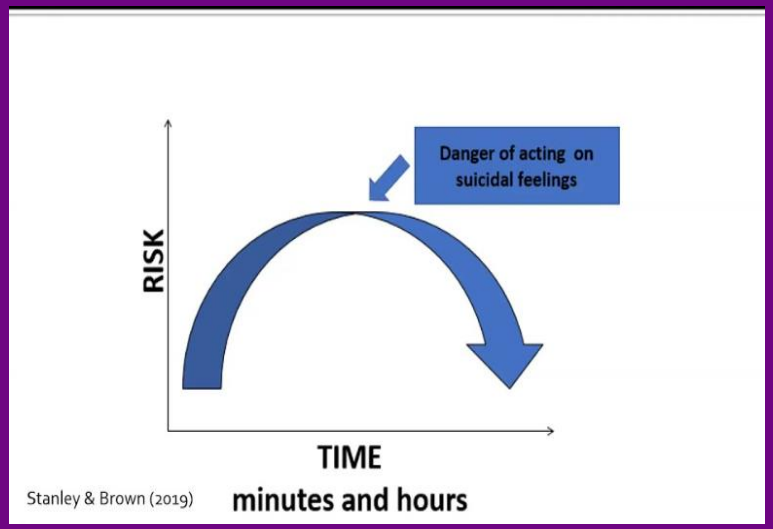
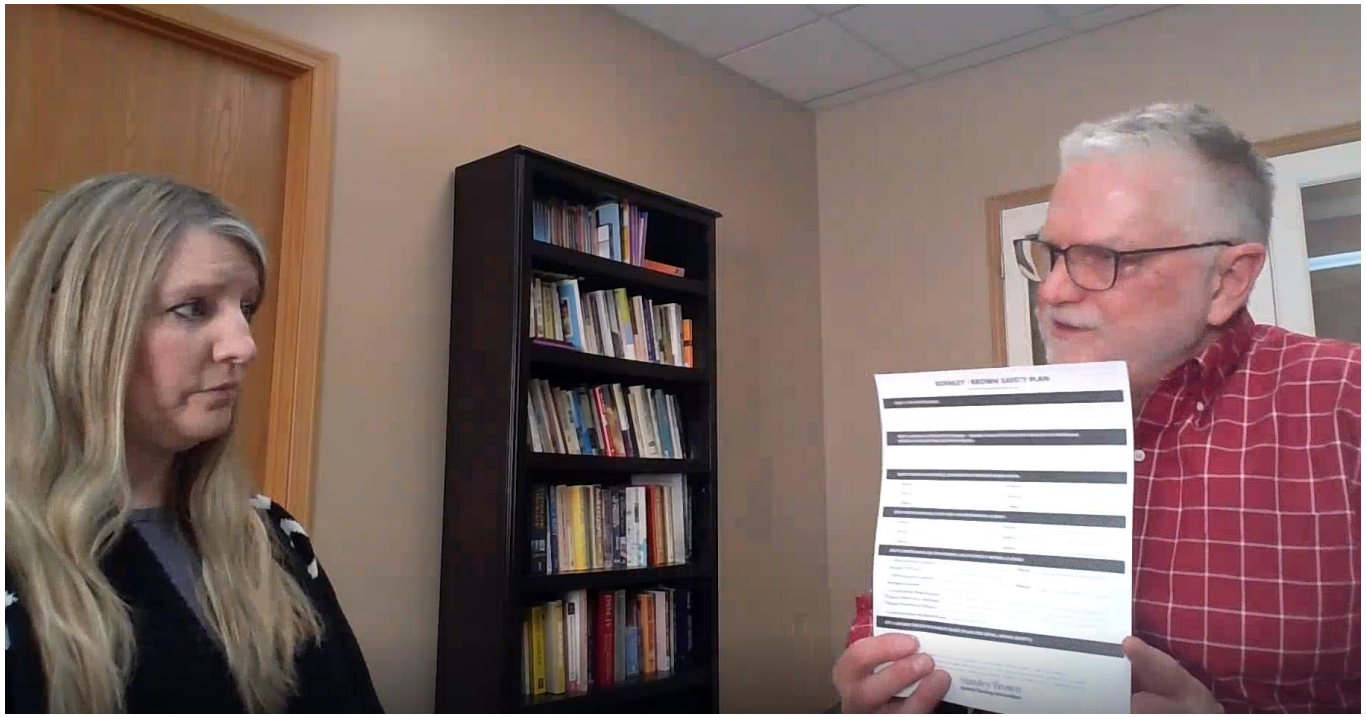
Video: Recognizing Warning Signs (Step 1)





Using Internal Coping Strategies

Step Two

Using Internal Coping Strategies (Step 2)

- Internal coping strategies can be used without needing to contact other people.
- Typically focus on activities that are distracting and can prevent suicide ideation from escalating.
- **Ask:**
  - "What can you do on your own if you become suicidal again to help yourself not act on the thoughts or urges?"
  - "How likely do you think you would be able to use this strategy during a time of crisis?" (Scale of 1-10)
  - "What might get in the way of using them? What could you do to make it more likely you would use them?"
- **Write down coping strategies (in order of priority) that the person believes they would be likely to use in a crisis.**

Video: Using Internal Coping Strategies (Step 2)

People and Social Settings

Step Three

People and Social Settings (Step 3)

- When internal coping strategies are not effective, identify people and social settings that can distract them.
  - Friends, family members
  - Coffee shops, places of religion
- **Goal is to socialize and build connection without informing people of their suicidal state.**
  - "Who helps you take your mind off your problems at least for a little while? You don't have to tell them about your suicidal feelings."
- Write down people and places, may include phone numbers and/or locations.

Video: People and Social Settings. (Step 3)

Contacting Personal Support Persons

Step Four

Contacting Personal Support Persons (Step 4)

- If prior steps do not help, then have individual inform family members or friends that they are in a suicidal crisis.
- **Ask:**
  - "Who do you think you could contact for help during a crisis?"
  - "Who do you think would be supportive if you tell them, you are feeling suicidal?"
- Ask about the likelihood they would contact them, identify potential obstacles, and problem solve.
- It is not mandatory that they identify a support person.
- **Write down names and contact information of identified support persons.**

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Video: Contacting Personal Support Persons (Step 4)

Contacting Professional Supports

Step Five

Contacting Professional Supports (Step 5)

- If prior steps do not help, then contact professionals or agencies that could assist in a time of crisis.
- **Ask:**
  - "Who are the mental health professionals or other providers that we should identify to be on your safety plan?"
- Assess willingness to contact, identify barriers, and problem-solve.
- **Write down list (in order of priority) of professional contacts.**

Contacting Professional Supports (Step 5)

- Mental Health Crisis Services in MN
  - 24/7 mobile mental health crisis teams by county.
  - Adults: https://mn.gov/dhs/people-we-serve/adults/health-care/mental-health/resources/crisis-contacts.jsp
  - Children: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/mental-health/resources/crisis-contacts.jsp
- Anoka County: 763-755-3801
- https://mn.gov/dhs/mental-wellness/

- National Suicide Prevention & Crisis Lifeline
  - Call, text, or online chat 988 from anywhere to reach crisis support and be connected to local crisis services.
  - Contact is routed to local or state specific resources.
  - Previously known as the National Suicide Prevention Lifeline.

Video: Contacting Professional Supports (Step 5)

Making the Environment Safe

Step Six

Making the Environment Safe (Step 6)

- **For all patients, a key component of safety planning is to eliminate or limit access to any potential lethal means in the person's environment.**
  - e.g., firearms, medications, knives or sharp objects, other household items.
- Safety planning interventions that incorporate lethal means reduction are associated with a 45% decrease in suicidal behaviors over 6 months.
  - https://pubmed.ncbi.nlm.nih.gov/29998307/
- **Ask:**
  - "What means do you have access to and are likely to use if you decide to try to kill yourself?"
  - "How can we develop a plan to limit your access to these means?"
- **Collaboratively identify ways to secure or limit access to those means.**

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Lethal Means Counseling

- **Present a menu of options to enhance the person's sense of control.**
  - Complete removal through disposal
  - Complete removal by giving to a significant other or family member
  - Restricting access by locking in a secured manner that is not accessible to the person
- **Use motivational enhancement strategies to increase willingness to remove or restrict access, but do not argue or try to coerce.**
  - Firearm Safety Counseling example: https://www.youtube.com/watch?v=-GSo1np_LUY
- Whenever possible, enlist the support of a significant other.
- **Lock to Live**: This tool can help to make decisions about reducing access to potentially dangerous things.
  - https://lock2live.org/

Bryan, Stone, & Rudd (2011)

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Means Restriction Options for Firearms

- **Safest option is storage or disposal away from home**
  - Give to a relative or friend
  - Gun shops and shooting ranges
  - Self-storage rental units
  - Local law enforcement
  - Pawn shops
- **Storage options at home**
  - Lock firearms storage and ensure the person has no access. Keep unloaded and separate from ammo.
  - Disassemble the guns and store a critical part like the slide or firing pin away from home

http://www.hsph.harvard.edu/means-matter

Video: Making the Environment Safe (Step 6)

The one thing that is most important to me and worth living for is?

Final Question of the Safety Plan

Ask “What’s the most important thing?”

Identify the “reason”, all things being equal, for staying alive even when you feel hopeless.

- The one thing that will help you no longer feel suicidal would be?
- Generate Hope: Hope is the “perceived capability” to see your way through a challenging situation.
- Join with the client: validate and affirm
- “I will help you. We will see a way through this together!”
- Be direct. Make suggestions. Generate ideas collaboratively.

Implementing the Safety Plan

- Review safety plan
- Assess for likelihood that the plan will be used
- Problem solve obstacles
- Revise safety plan as needed
- Provide person with paper copies:
  - Discuss placement of copies and review placement during follow-up
  - Have person take a photo from their cellphone
  - HAVE PERSON PUT IT ON THEIR APP!

If in ongoing treatment, review the safety plan periodically

Stanley-Brown Safety Plan App

Have patient complete Safety Plan in the app!

Ongoing Patient Treatment and Follow-up Care

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Ongoing Patient Treatment

When suicide risk is indicated from the start

- If a safety plan was completed, continue to address throughout services.
- Complete suicide risk screening and assessment ongoing.
- When utilizing PHQ-9 during services, consider further suicide assessment if patient answers 2 or 3 to question 9 then utilize C-SSRS again.

When suicide risk is indicated after treatment has started

- Utilize the C-SSRS to assess for suicide risk and severity.
- Follow it up with the Safe-T and Safety Plan intervention when indicated.
- Continue to address safety plan throughout services as needed.

Things to Consider

Telehealth

- Non-verbal indicators may be limited or body language limited
- Always know location, emergency contacts for the direct area, how to assist with immediate need and ask at the beginning of the session
- If unable to complete appointment due to patient location (patient located outside of state of licensure), you should still complete a safety assessment
- Be aware of privacy, ability to talk without people around them
- Address confidentiality and supports

Minors

- It is important to screen for suicide risk for all ages
- Be aware of privacy, feeling able to talk with parents or others in session
- Address confidentiality and supports
- If there is any risk of harm to self or others, then parent/guardian is informed
- Educate families on recognizing behavioral changes, risk factors, and effective support strategies
- Encourage open communication about mental health and provide resources for family support

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Additional Resources

North Metro Round Table will be sharing a website with the training materials as well as other resources.

Other Apps:

- Suicide Safe by SAMHSA: https://apps.apple.com/us/app/suicide-safe-by-samhsa/id968468139
- Columbia Protocol App: https://apps.apple.com/us/app/columbia-protocol/id1450966911

Websites:

- The Columbia Lighthouse Project: https://cssrs.columbia.edu/
- Stanley-Brown Safety Planning Intervention: https://suicidesafetyplan.com/
- NowMattersNow.org – Real stories and research-based solutions for suicide prevention. For people experiencing suicidal ideation. https://nowmattersnow.org/

Follow-up Care Recommendations

Have a plan for next connection whenever possible.

Make sure the patient has a copy of their Safety Plan and numbers for crisis resources.

- Individuals have reported that sometimes it is helpful to have multiple copies of their safety plan to keep in different places (e.g., different rooms of house, car, etc.)

Caring Contacts as a Follow-up Intervention

Messages of support for those at risk for suicide.

Evidenced Based Intervention – phone call or letter of concern

Indicated for use along with Safety Planning Intervention

Reach out to patient after completing safety planning intervention to express concern and review safety plan

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Support for Caring Contacts Intervention

Original Caring Letters Study (Motto,1976; Motto & Bostrom, 2001)

- "Caring letters is a suicide prevention intervention that entails the sending of brief messages that espouse caring concern to patients following discharge from treatment."
- In the first two years, the suicide rate was nearly twice as high for those not getting caring messages.
- No other experiment had ever been able to show a reduction in suicide deaths.
- Link: A Randomized Controlled Trial of Postcrisis Suicide Prevention

Support for Caring Contacts Intervention

Research has continued into the use of caring contacts as an effective intervention

- 2022 study - Caring contacts for suicide prevention: A systematic review and meta-analysis – PubMed
- 2024 study - Comparative effectiveness of two versions of a caring contacts intervention in healthcare providers, staff, and patients for reducing loneliness and mental distress: A randomized controlled trial – PMC
- 2025 study - JMIR Research Protocols - Exploring the Impact of the Caring Contacts Intervention on the Stress and Distress of Veterans and Service Members: Protocol for a Randomized Controlled Trial

Examples of Caring Contacts

Format

- Postcards, letters, text messages, home visits
- Phone calls made by trained clinical or non-clinical staff
- Brief, personalized, non-demanding, repeated
- Give in session to take with them

Message Content Examples

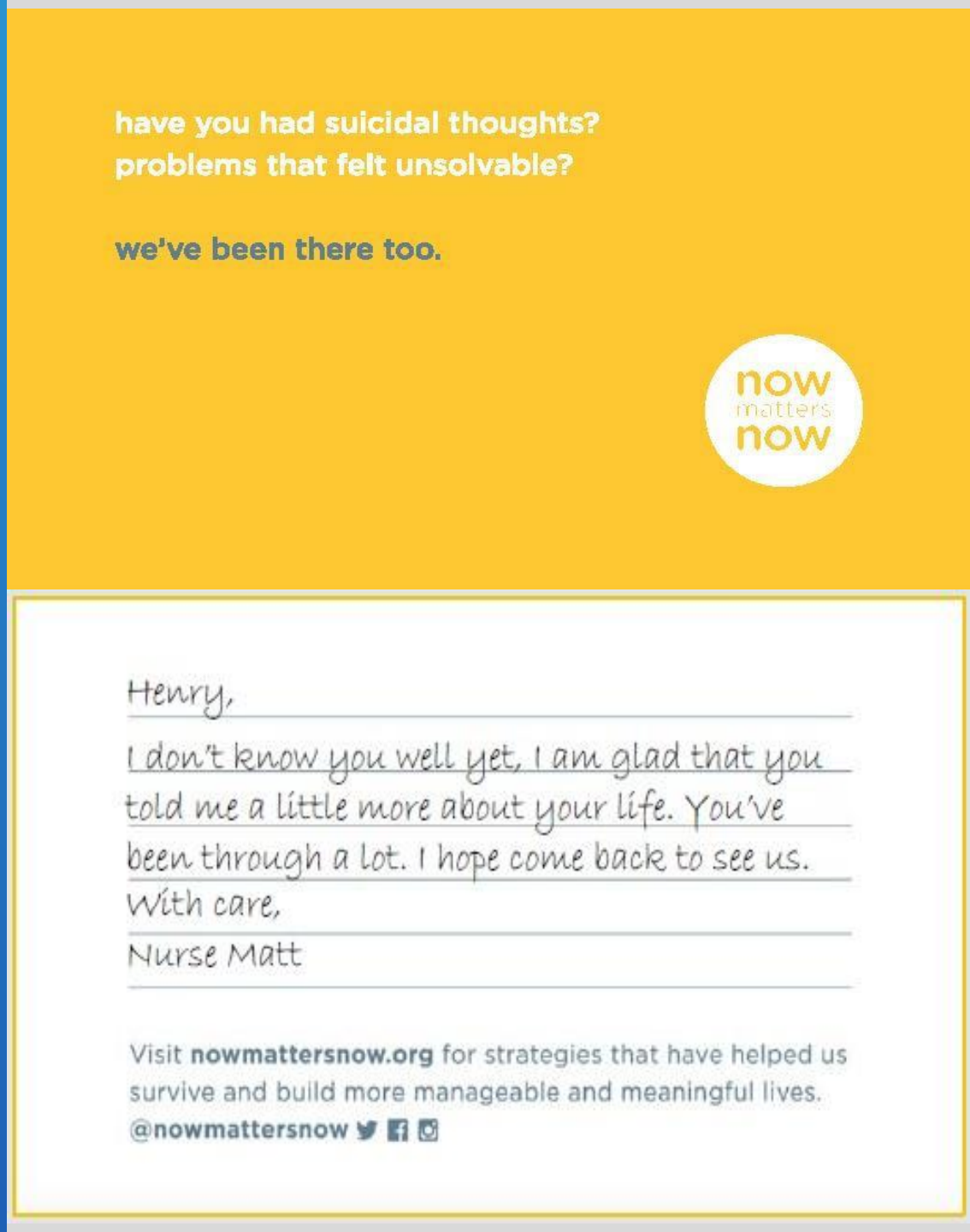
- I see you know how to do hard things.
- I look forward to seeing you again
- I enjoy our interactions
- Reference a memory with them
- “Dear __: It has been some time since you were here at the hospital, and we hope things are going well for you. If you wish to drop us a note we would be glad to hear from you.”

“Caring Contacts” Intervention: Luxton, et. al., and nowmattersnow.org

NowMattersNow.org Templates

Printable cards redirecting recipients to resources on their website. Templates include example text for composing and distributing caring contacts.

https://nowmattersnow.org/wp-content/uploads/2018/10/nmn_cards.pdf



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Thank you.

We would like to thank you all for attending this training. Sagent Behavioral Health is honored to partner with Anoka County and the North Metro on this training. Lastly, a special thanks to Dan Nelson and Becca Gardner for creating the role-play videos!

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