TEXAS
Health and Human Services

Suicide Care in Texas Toolkit

Behavioral Health Services Department

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Statement from the State Suicide Prevention Coordinator

Zero is the Only Acceptable Number

It is a distinct honor for me to serve as the state suicide prevention coordinator for the State of Texas. Although new to this role, I have been working in suicide prevention, intervention, and postvention for many years through service in the community mental health system here in Texas. Over the years, one thing has been clear: Texas providers are dedicated to making suicide a never event in our state.

In 2012, my predecessor, Jenna Heise, started the Zero Suicide in Texas (ZEST) initiative. This initiative inspired behavioral health providers in the state to enhance screening procedures, improve risk assessments, and implement the Safety Planning Intervention (SPI). Providers began using evidence-based best practice treatments to directly address thoughts of suicide. People being discharged from hospitals received priority appointments and caring contacts. A combination of knowledge and passion fueled this initiative.

In 2019, the spark for the ZEST initiative was renewed by the Suicide Care Initiative (SCI). Additional infrastructure has been established by forming Regional Suicide Care Support Centers (RSCSCs). Training and technical assistance have been delivered to hundreds of providers of suicide care across the state. Each training has endowed suicide care providers in Texas with the skills needed to address suicide head-on.

The Suicide Care in Texas Toolkit is designed to support Texas' goal of reducing suicides to zero. The toolkit gives an overview of each element of the Zero Suicide model and steps to implement each required element. The appendices are carefully selected as examples for you to use and modify to your unique needs.

One final note, whether you are new to this work or you have been doing it for many years, self-care is one of the most important concepts to master. Work in suicide care is hard. We often talk to people on their very hardest days. Hearing the stories that bring people to their darkest hours can be heavy. Practicing self-care is a vital part of suicide care. Self-care is suicide prevention.

As we move forward in this work together, remember that aiming for zero suicides ensures that there will not only be no more suicide deaths but also no newly bereaved survivors of suicide loss; no person left behind after a suicide death to grieve. Join our state efforts now in working toward zero suicides, the only acceptable number.

Tammy Weppelman, M.S., LPC-S

Zero Suicide Statement from Texas Leadership

In 2012, Texas committed to a systematic change in our approach to suicide prevention. The goal changed from decreasing suicide deaths to eliminating suicide deaths with the implementation of the Zero Suicide framework in the public mental health system. The Texas Health and Human Services Commission (HHSC) is renewing its commitment to make suicide a never event for persons receiving care in the public mental health system with the release of the updated Suicide Care in Texas Toolkit.

The Zero Suicide framework provides guidelines, recommendations, and best practices for health and behavioral health care systems based on the notion that all suicide deaths for people in care are preventable. The core elements of the Zero Suicide framework include:

- Creating a leadership-driven, safety-oriented culture committed to making suicide a never event among people in care;
- Identifying and assessing level of suicide risk in people being served;
- Ensuring every person at risk is engaged in care through safety planning and specialized services;
- Developing a caring and competent workforce;
- Using effective, evidenced-based treatment options that address suicide specifically, not just as a symptom of another illness;
- Continuing contact and support, especially after acute care in emergency departments and psychiatric hospitals; and
- Applying data-driven quality improvement approaches to inform system changes that will lead to improved outcomes.

In 2019, the SCI began to further support the work of Zero Suicide in the public mental health system. Increased infrastructure in the form of RSCSCs has been added to provide continued training and technical assistance in support of Zero Suicide. It is through these efforts that HHSC strives to save the lives of Texans by reducing suicides to zero.

Sonja Gaines

Sonja Gaines, MBA
Deputy Executive Commissioner

Dr. Courtney Harvey

Courtney Harvey, PhD
Associate Commissioner

1. Overview of Suicide Care in Texas

History of Suicide Prevention Efforts in Texas

Texas has a long history of efforts in preventing deaths by suicide and has developed strong infrastructure to support and coordinate these activities. Texas Health and Safety Code, Chapter 533, §533.040(c), requires HHSC to designate a youth suicide prevention officer. The state suicide prevention coordinator holds this designation. The state suicide prevention coordinator is tasked with overseeing cross-agency activities intended to prevent deaths by suicide and is supported by local suicide prevention coordinators in each local mental health authority (LMHA) and local behavioral health authority (LBHA). HHSC coordinates many of the community-based suicide prevention efforts through the leadership of the Texas Suicide Prevention Council, which oversees the Texas Suicide Prevention Plan. The Texas Suicide Prevention Collaborative, an overarching non-profit suicide prevention organization, coordinates the Texas Suicide Prevention Council, as well as technical assistance following a suicide death (postvention), numerous communication activities, and community gatekeeper trainings. This infrastructure is further supported by the presence of local and regional suicide prevention coalitions in many areas of Texas.

Texas has made significant strides toward training "gatekeepers," such as teachers, university staff, and community members, to understand the warning signs of suicide risk, make appropriate referrals, and reduce the risk of subsequent deaths following a suicide through active postvention. The Texas Legislature has supported this work by requiring training in suicide prevention for school personnel and promoting evidence-based practices in school settings through state agency collaboration. Additionally, HHSC has increased the number of full-time equivalent staff working in suicide prevention from one (the state suicide prevention coordinator) to five. The State Suicide Prevention team in the Office of Mental Health Coordination now includes a youth suicide prevention project grant director, a suicide care coordinator, and a suicide data and outcomes epidemiologist. There are two additional positions, which include one person working on general suicide prevention and another person with a focus on veteran suicide prevention.

State and Local Collaboration

In 2012, following the publication of the revised National Strategy for Suicide Prevention, state suicide prevention leaders began focusing additional efforts on improving the capacity of the behavioral health system to identify, engage, and treat a person at risk for suicide. The Texas Department of State Health Services (DSHS) was the lead agency for behavioral health and suicide prevention and began collaborating with interested LMHAs to enhance workforce training to identify and treat a person at risk of suicide. Fifteen LMHAs began measuring the perceived competence of their workforce through a workforce survey and committed to training 100 percent of employees in Applied Suicide Intervention Skills Training (ASIST). DSHS contributed financial support to develop trainers in ASIST within each of the organizations. Participating organizations conducted a subsequent workforce survey in 2014, resulting in 74 percent of the workforce having been trained in ASIST, up from 2 percent in 2012. Also, most staff (86 percent) reported having the training needed to engage or assist persons with suicidal desire. Staff also reported gaining the skills (83 percent) and supervision (86 percent) needed to assist a person at risk for suicide. This initial success led DSHS to develop a plan for using the Zero Suicide framework to establish standards for safer suicide care within the LMHA public mental health system. In 2016, the responsibility for suicide prevention efforts at the state level transitioned from DSHS to HHSC following a legislative directive for consolidation. HHSC continues to partner with LMHAs on Zero Suicide efforts.

Aims of the Zero Suicide in Texas Initiative

The ZEST initiative was supported through a Garrett Lee Smith Suicide Prevention grant awarded to DSHS from 2012 to 2016 by the Substance Abuse and Mental Health Services Administration (SAMHSA). The ZEST initiative used a comprehensive public health approach to preventing deaths by suicide. Modeled after the United States Air Force Suicide Prevention Program, the ZEST initiative aimed to integrate best practices in suicide prevention, assessment, and intervention into the public mental health system in Texas. The goals of the ZEST initiative were to:

- Improve identification, treatment, and support services for high-risk youth by creating suicide safe care centers within the public mental health system;

- Expand and coordinate best practice suicide prevention activities with other youth-serving organizations and community partners to create suicide safe care communities; and
- Implement research-informed training and communications efforts to create a suicide safe care state.

Suicide Care Initiative

The SCI began in 2019. This SAMHSA-funded project's focus is to enhance suicide care in the public mental health system in Texas. The SCI has two main goals:

1. **To Establish RSCSCs:** Each RSCSC is a regional suicide care workforce development and technical assistance site that supports the suicide prevention and suicide care needs of the eight to nine LMHAs in their regions. There are four RSCSCs in Texas: The Harris Center for Mental Health and IDD, Integral Care, My Health My Resources of Tarrant County, and Tropical Texas Behavioral Health. Each of the remaining LMHAs and LBHAs is assigned to a RSCSC.
2. **For Each of the RSCSCs to Fully Implement the Zero Suicide Framework at Their LMHA:** Using first-hand experience, the regional support centers will be able to provide technical assistance and support to the assigned LMHAs to assist in the implementation of all components of the Zero Suicide framework (including fidelity).

Suicide Care Centers

HHSC has partnered with the Texas Institute for Excellence in Mental Health at The University of Texas at Austin to create Suicide Care Centers. A Suicide Care Center is committed to implementing a series of best practices intended to minimize the risk of suicide for children, adolescents, and adults accessing services from the organization.

A Suicide Care Center embraces the Zero Suicide framework, a system-wide transformation toward safer suicide care. This requires a commitment by the adopting organization's leadership and the development of an organizational culture that supports the following beliefs:

- That suicide prevention is a core role of the adopting organization;
- That all staff in that organization play a role; and

- That failures are the responsibility of the system, not any one person.

Organizations are supported through training opportunities and technical assistance related to reviewing current suicide prevention practices and policies and implementing new practices when needed. Opportunities for learning from peer organizations within the state are provided and sharing of resources encouraged. Suicide Care Centers are expected to implement best practices in the following domains:

- Workforce training and supervision;
- Screening and assessment for suicide risk;
- Safety planning and means safety protocols;
- Pathways to care for a person at risk;
- Suicide-focused interventions;
- Care transition and continuity of care practices;
- Postvention practices and support for survivors of suicide attempt and survivors of suicide loss; and
- Written policies to support suicide prevention.

A fidelity tool has been created to guide organizations in the implementation of Suicide Care Center best practices.

How to Use the Suicide Care in Texas Toolkit

The Suicide Care in Texas Toolkit was created to help organizations in Texas implement the core components of the Zero Suicide framework. Each chapter of the toolkit sets out to identify the expectations for each organization through chapter goals. These goals represent HHSC's expectations for Suicide Care Centers within the respective tenet of Zero Suicide. Within each chapter of the toolkit, the respective focus area is described in greater depth. Moreover, the toolkit includes resources for additional training and tools to assist in the change activities.

The toolkit is meant to be flexible, and each organization that aims to implement the Zero Suicide framework is likely to choose different paths toward each goal. The tools are intended to help organizations identify a starting point, select initial change targets, and plan logical steps toward accomplishing these goals. Along the way, organizations are strongly encouraged to use continuous feedback from data

to monitor their efforts. As new tools are developed, each tool will be added to the toolkit and shared with organizations.

There are many organizations in Texas working toward the goal of Zero Suicide, and learning from peers can be a powerful strategy in advancing your efforts. Each RSCSC is available to share lessons learned and provide technical assistance to organizations in their region. Also, the state suicide care coordinator is available for technical assistance.

2. Leadership and Organizational Support

Goal 1: Suicide safe care organizations have a multidisciplinary committee tasked with overseeing the implementation of the Zero Suicide framework.

Goal 2: Written organizational policies and procedures support safe suicide care practices.

Goal 3: Suicide safe care organizations have suicide care as a core mission and have dedicated staff time and resources to the sustainability of the Zero Suicide framework.

Rationale

Success in large systems that have embraced the Zero Suicide goal begins with the creation of an organizational culture that understands suicide prevention to be a core function, strives for excellence in care, and has a core belief that suicide is preventable for the people they serve. For the Henry Ford System in Michigan, this began with a goal of perfect depression care and a recognition by leadership that perfect depression care would mean that no one within their care would die by suicide.

Leaders creating a Zero Suicide culture will frequently encounter skepticism of the possibility of significant reduction or elimination of suicides. Often, this skepticism is maintained by the sense of fear and stigma associated with deaths by suicide among behavioral health providers and the community. Organizations must strive to create a just culture whereby processes and policies can be openly examined when deaths by suicide occur; however, individual staff members must feel supported and not fear blame. In other words, in a just culture, each suicide is seen as a system failure, not the failure of a single treatment provider or treatment team member.

Leadership

Leaders can take a variety of concrete steps to establish a safer suicide care culture. Organizational leaders may communicate Zero Suicide messaging in strategic plans, value statements, and staff meetings. Descriptions of the activities to bolster suicide care best practices and reduce suicides occurring within the organization can be shared through blogs, newsletters, and video messages. Examples of leadership announcements from organizations participating in the SCI in Texas are provided in Appendices A-1, A-2, and A-3. It is important for leadership to keep staff updated on the status of suicide prevention initiatives through regular communications. Timely and ongoing communications from leadership regarding suicide safe care will emphasize that suicide care is a priority and the responsibility of all staff.

Communication with external stakeholders, including referring agencies, emergency departments, psychiatric hospitals, police, emergency responders, people in care, and family members, is also critical. A video message from the early stages of the Zero Suicide framework in Texas was prepared with suicide prevention grant funds in 2012 and serves as a reference point to the beginning of this movement in Texas, as well as a glimpse at the basic message. Potential messaging supporting a Zero Suicide goal includes:

- Suicide deaths of people in our care can be prevented.
- The only goal that is acceptable in a behavioral health care system is to strive for no deaths by suicide.
- The most fundamental responsibility of health care systems is individual safety, and suicide represents a significant risk for people involved in behavioral health systems.
- "Suicide is the ultimate failure in health care outcomes" (former United States Senator Gordon Smith).
- The prevention of suicide cannot rely on one provider; a comprehensive system has the greatest chance for success.
- All staff play a role in reducing suicide risk, whether they provide direct services to a person or not.

Implementation Teams

No one person will be able to accomplish the type of organizational transformation required to create a Suicide Care Center. This will require a multidisciplinary team that includes key personnel representing different aspects of the organization. Implementation teams have been shown to increase the chance of successful implementation (from 20 percent to 80 percent) and greatly reduce the time taken to reach fidelity to practice (Fixsen et al., 2001). The implementation team needs to include personnel empowered and authorized to make changes to policies and procedures within key areas of the organization, as well as representation from a person receiving services. Survivors of suicide attempt and survivors of suicide loss are critical stakeholders in the planning, implementation, and evaluation of your change efforts. Some potential members of an implementation team are listed below, but each organization will have a unique group.

- Assertive Community Treatment (ACT) Team Lead
- Case Manager
- Clinic Manager
- Counselor
- Family Partner
- Information Technology Staff Member
- Medical Director
- Military Veteran Peer Network Member
- Mobile Crisis Outreach Team Member
- Nurse
- Peer Specialist
- Suicide Prevention Coordinator
- Survivor of Suicide Attempt
- Survivor of Suicide Loss
- Wraparound Facilitator

Implementation teams will meet regularly to identify targets for system improvement, set short-term goals, implement action steps, identify barriers, and monitor outcomes. Implementation teams may look for opportunities to link suicide care to other organizational initiatives, such as trauma-informed care. Additionally, the implementation team needs to be involved in evaluation and quality improvement efforts associated with improving suicide care and decreasing suicide attempts and behaviors. A Task Plan worksheet is included in Appendix B. Two frameworks that may assist implementation teams with their change efforts are the Rand Corporation's Getting To Outcomes® and the National Implementation Research Network's Active Implementation Framework described in the next sections.

Survivors of suicide attempt and survivors of suicide loss are critical stakeholders in the planning, implementation, and evaluation of your change efforts.

Getting To Outcomes®

Developed by the Rand Corporation, Getting To Outcomes® is an empirically supported model, which outlines key steps in establishing a program. The 10 key steps discussed in the model are listed below.

1. Identify needs and resources.
2. Set goals to meet the identified needs.
3. Determine what evidence-supported practices exist to meet the identified needs.
4. Assess actions that need to be taken to ensure the program fits the organizational context.
5. Assess what organizational capacities are needed to implement the program.
6. Create and implement a plan to develop organizational capacities.
7. Conduct a process evaluation to determine if the program is implemented with fidelity.
8. Conduct an outcome evaluation to determine if the program is getting desired outcomes.
9. Determine through a continuous quality improvement process how the program can be improved.

10. Take steps to ensure sustainability.

A brief overview of the model and the full manual are available.

Active Implementation Framework

Developed by the National Implementation Research Network at the University of North Carolina at Chapel Hill, the Active Implementation Framework identifies primary functions for implementation teams. The five primary functions discussed in the framework are listed below.

1. Assessing and creating ongoing buy-in and readiness.
2. Installing and sustaining implementation drivers.
3. Monitoring implementation fidelity and outcomes.
4. Planning for system alignment and stage-based work management.
5. Solving problems and building sustainability.

The Active Implementation Hub has more information on the framework, as well as online training modules and tools.

Quality Improvement Processes

The rapid-cycle Plan, Do, Study, Act (PDSA) model, developed by W. Edwards Deming, is beneficial for managing system change. W. Edwards Deming was an American engineer, statistician, professor, author, lecturer, and management consultant who began the quality management movement in United States business. The rapid-cycle PDSA model moves teams from planning toward implementation by using immediate feedback loops to identify, define, and resolve emergent barriers. To identify issues or barriers, an effective communication loop must be established to allow a person or group within the organization to quickly provide information to the implementation team. Using information gathered, the implementation team defines the problem, creates a hypothesis regarding the issue, and develops a plan to address the problem (Plan). The team will then work with others in the organization to implement the plan (Do), measure the impact of the intervention (Study), and determine if the goal was met or if a new intervention is needed (Act). This cycle allows teams to quickly adjust throughout the implementation phase to ensure success. A rapid-cycle PDSA worksheet is included in Appendix C.

Organizational Self-Study Assessment

The Organizational Self-Study Assessment is designed to measure the elements of suicide safe care an organization has in place at a given time. The tool can be used to assess strengths and areas for growth within the organization and provide both leadership and the implementation team with data relevant to starting an implementation plan.

Texas modified and adopted an Organizational Self-Study Assessment of the Zero Suicide framework. This assessment was based on an instrument developed by Jan Ulrich, a leader in Kentucky's Zero Suicide initiative and now a staff member for the national Zero Suicide Institute. The assessment was further developed with input from Texas and other early adopters and refined by the Zero Suicide arm of the Suicide Prevention Resource Center (SPRC), a SAMHSA-funded technical assistance center, now referred to as the Zero Suicide Institute. This instrument should be completed by a team of knowledgeable people, such as the implementation team, at the beginning of the organization's move toward safer suicide care and then completed annually thereafter. To be in alignment with the understanding of Zero Suicide as a framework used for behavioral and physical health care and to create a safer Suicide Care Center, the assessment name was broadened to: The Suicide Safer Care/Zero Suicide Organizational Self-Study Assessment. The assessment serves as a Likert scale, guiding the organization through best practices and comprehensive suicide care elements of the Zero Suicide framework. The goal is to assist in documenting a baseline and progress made over time, ensuring that minimum suicide care standards are met, as well as providing a focus for future goals. The Texas version of the assessment can be found in Appendix D.

Workforce Survey

The Zero Suicide Institute supports using an online workforce survey to assess how prepared staff in the organization feel about providing suicide care to a person at risk for suicide. Additionally, the results of the survey can help guide the implementation team in prioritizing workforce training. Completion of the workforce survey should occur prior to the implementation of the SCI and should be repeated at least every three years to assess the impact of efforts to improve workforce competency. Organizations should strive for a 100 percent return rate, surveying all staff regardless of their role. The survey is brief and takes approximately 15 minutes to complete. The workforce survey can be found in Appendix E. To request access to the online version of the workforce survey, visit the Zero Suicide

Workforce Survey Administrative Portal website or email the State Suicide Prevention team at suicide.prevention@hhs.texas.gov.

Suicide Care Policy Updates

As part of a suicide care implementation plan, it is important to review policies and procedures throughout an organization to ensure alignment with suicide care recommendations. All organizational policies should be reviewed and updated to reflect suicide care as a priority and emphasize an organization's just culture regarding suicide deaths. Just culture refers to a system of shared accountability. Specific to suicide, organizations that practice just culture view deaths by suicide as a system failure, as opposed to a failure by a single clinician or staff member. Any policy specific to the care of a person experiencing suicidal thoughts should include Zero Suicide language and tenets. Examples of suicide care policies are available in Appendices F-1 and F-2.

Moving Beyond – Community Expansion

Buy-in and leadership are also critical within the community to support suicide care programs. One strategy to develop leadership within the community is the development of and support for community coalitions for suicide prevention. A community coalition can be defined as "a formal alliance of organizations, groups, and agencies that have come together to work for a common goal" (Florin et al., 1993, p. 417).

Resources to support building local coalitions can be found in Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention, which identifies seven key elements for comprehensive community-based suicide prevention. A list of existing suicide prevention coalitions within Texas may be found on the Texas Suicide Prevention Collaborative website.

The World Health Organization's Preventing Suicide: A Community Engagement Toolkit is a step-by-step guide for people who would like to initiate suicide prevention activities in their community. It describes a participatory bottom-up process by which communities, including community leaders, health workers, parliamentarians, teachers, social workers, police, firefighters, and business leaders, can work together to identify, prioritize, and implement activities that are important and appropriate to their local context and that can influence and shape policy and services.

References

Fixsen, D. L., Blase, K. A., Timbers, G. D., & Wolf, M. M. (2001). In search of program implementation: 792 replications of the teaching family model. In G. A. Bernfeld, D. P. Farrington, & A. W. Leschied (Eds.), *Offender rehabilitation in practice: Implementing and evaluating effective programs* (pp. 149–166). John Wiley & Sons Ltd.

Florin, P., Mitchell, R., & Stevenson, J. (1993). Identifying training and technical assistance needs in community coalitions: A developmental approach. *Health Education Research*, *8*(3), 417–432.

3. Screening for Suicide Risk

Goal 4: Everyone who encounters the public behavioral health system will be screened for suicide risk using an evidence-based screening tool.

Rationale

The most effective method to identify a person at risk for suicide is to screen them by asking questions about suicide risk. A person seeking help for a behavioral health diagnosis is at a higher risk for suicide, making suicide screening at each visit to a behavioral health provider especially important. Standardized screening protocols have the following advantages:

- Effective screening identifies a person in need of more extensive risk assessment with a time- and cost-effective approach.
- Best practice screening protocols ensure organizations are meeting their obligations for high standards of care and reducing liability.
- The use of common definitions for suicide-related behaviors can lead to better communication and service planning with the provider.
- Effective screening within health care settings has led to reduced expenses through more efficient allocation of crisis response staff.

Description of the Columbia-Suicide Severity Rating Scale

The Columbia-Suicide Severity Rating Scale (C-SSRS) was developed with guidance from the Food and Drug Administration to provide further definitional clarity around the reporting of suicide-related events. The scale is available in more than 100 languages and has been used in behavioral and public health settings across the globe. The scale exhibits strong feasibility, requiring no mental health training for implementation. The C-SSRS has many versions. In line with best practices, the State Suicide Prevention team recommends completing the Lifetime Recent version at the initial intake appointment, at required reassessments, and when historical

information is not available to the provider. Subsequently, the Since Last Visit version briefly assesses suicidal thoughts, behaviors, intent, and method since the previous contact and can be used to screen a person at each appointment thereafter. Both versions of the C-SSRS are available on the Columbia Lighthouse Project website, as well as in Appendices G and H.

Training for the Columbia-Suicide Severity Rating Scale

Web-based training on the C-SSRS is available on the Columbia Lighthouse Project YouTube channel. All people who administer the C-SSRS should participate in the training; however, formal behavioral health training is not required. More information about C-SSRS training can be found in Chapter 5: Workforce Competency in Suicide Prevention.

Scoring of the Columbia-Suicide Severity Rating Scale

The following questions are the first and second questions from the evidence-based C-SSRS:

- Have you wished you were dead or wished you could go to sleep and not wake up?
- Have you actually had any thoughts of killing yourself?

If a person answers "yes" to the second question, the remainder of the questions on the screener should be completed. If a person answers "yes" to any of the questions on the screener, the below scoring key and response protocol can be used as a reference.

- **Question 1:** Mental or behavioral health referral (LMHA or LBHA)
- **Question 2:** Mental or behavioral health referral (LMHA or LBHA)
- **Question 3:** Mental or behavioral health referral (LMHA or LBHA); consider full risk assessment and safety precautions (safety planning)
- **Question 4:** Safety precautions and full risk assessment (high risk)
- **Question 5:** Safety precautions and full risk assessment (high risk)

- **Question 6:** Lifetime – mental or behavioral health referral (LMHA or LBHA); consider full risk assessment and safety precautions (safety planning)
- **Question 7:** In three months or less – safety precautions and full risk assessment (high risk)

Referral Guidelines for Risk Assessment

A person screened at high risk (see above) should receive further risk assessment by a trained provider. Research has shown that people who meet the criteria for high risk are almost four times more likely to attempt suicide within the 24-month study period (Posner et al., 2011). A person with a previous history of suicidal behaviors (prior to three months) or a positive response to Question 3 on the ideation scale should be referred for a risk assessment on a case-by-case basis. More information about risk assessment can be found in Chapter 4: Suicide Risk Assessment.

Frequency of Screening

For those in health and behavioral health care services, the C-SSRS should be utilized as a brief measure of risk at every individual contact up to once daily. The Since Last Visit version of the C-SSRS was made for frequent screening. Screening for suicide at every visit is important, as thoughts of suicide are fluid and may change from day to day. Providing a person with a suicide screening at every visit ensures the organization is making suicide care a priority. Identifying those at risk is the first step in the process of ensuring safe suicide care.

For those in health and behavioral health care services, the C-SSRS should be utilized as a brief measure of risk at every individual contact up to once daily.

Examples of Other Evidence-Based Screening Tools

- **Ask Suicide-Screening Questions:** The Ask Suicide-Screening Questions tool was developed by the National Institute of Mental Health and approved by The Joint Commission as a suicide screening tool for all ages. The screener consists of four yes-no questions and a possible fifth follow-up question. The bottom of the screening tool gives recommendations for next steps if a person screens

positive for suicide. The National Institute of Mental Health website provides a toolkit with free downloadable copies of the Ask Suicide-Screening Questions tool.

- **Patient Health Questionnaire:** Behavioral health clinics often use the Patient Health Questionnaire to gauge a person's current level of depression. Question 9 on the questionnaire is often used as a suicide screening tool, as it asks about thoughts of death and thoughts of harming oneself. While this question does ask some information about potential passive suicidal ideation (SI), it is recommended that an additional screener such as the Ask Suicide-Screening Questions tool or C-SSRS be used when a person screens positive on Question 9 because this question does not ask specifically about active SI.

There are also age- and population-specific screeners to be used alone or in conjunction with a suicide-specific screener. For this information, visit the Zero Suicide website.

Future Goals

The C-SSRS may be used efficiently by embedding it into the electronic health record. Completion of the C-SSRS should be triggered in the electronic health record in the intake, update assessment documentation, crisis notes, and all progress notes for a person receiving care. The electronic health record should contain an indicator or alert that displays on the screen to indicate someone is at high risk. This functionality could occur at a local level or regionally.

Moving Beyond – Community Expansion

The effectiveness of screening activities may be further enhanced by expansion to additional systems in which the use of the C-SSRS is warranted. The community behavioral health system can support this effort by providing leadership to community suicide prevention efforts, encouraging community partners to consider the use of the tool within their system, providing training in the use of the tool to staff within other systems, and serving as suicide prevention experts within the community. In addition, data sharing agreements and electronic data portals that allow for the communication of suicide risk screening results across partners will increase the impact of these activities. Examples of community partners who could strengthen suicide safe communities by using the C-SSRS or other screeners include:

- Civil Service Systems

- Community Behavioral Health Providers
- Detention Facilities
- Education Systems
- Emergency Departments
- Emergency Medical Services
- Federally Qualified Health Centers
- Homeless and Runaway Shelters
- Jails
- Local Suicide Prevention Coalitions and Task Forces
- Mental Health Coalitions and Task Forces
- Primary Care Clinics
- Veterans Affairs Local and Regional Offices
- Veteran-Serving Organizations
- Workforce Boards

Moving beyond traditional systems of care with new partners who are traditionally not at the suicide prevention table will expand the reach and bring suicide safe care best practices into the community. This will usher in the age of the public health approach to screening. By adapting best practices and evidence-based tools for broader use, elements such as screening everyone for suicide become actionable steps toward suicide safe communities.

Reference

Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., Currier, G. W., Melvin, G. A., Greenhill, L., Shen, S., & Mann, J. J. (2011). The Columbia–suicide severity rating scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry*, *168*(12), 1266–1277.

4. Suicide Risk Assessment

Goal 5: All children and adults within the public mental health system identified as potentially at risk during a suicide screening will receive an evidence-informed suicide risk assessment. This suicide risk assessment should include all the core components of an effective risk assessment.

Rationale

Behavioral health centers play a critical role in recognizing and intervening with a person at risk of suicide. In a study of a crisis hotline, Mishara et al. (2007a) found that callers were not asked about suicide about one-half of the time (723 out of 1,431 calls). Of the 474 callers who reported SI, 46 percent were not asked about access to lethal means. Questions about prior attempts were only asked of 104 callers. Similar findings from other settings suggest that provider behavior may not always mirror best practices in suicide risk assessment (Bongar et al., 1998; Coombs et al., 1992). Organizational policies should identify and support a risk assessment based on the most current research.

According to a series of workforce survey assessments conducted from 2012 through 2016 to test behavioral health workers' attitudes and knowledge about suicide in the Texas public mental health system, less than 50 percent of those surveyed reported confidence in asking people directly about suicide. Survey results also indicate that, without concerted training and management follow-up, completing a suicide risk assessment may be one of the most challenging tasks for a behavioral health provider. It is imperative for providers to ensure the safety of a person with suicidal thoughts while referring them to receive treatment in the most clinically appropriate, least restrictive treatment environment available. Care systems are guided to consider a person's risk and protective factors when developing an overall picture of suicide risk, assigning a level of risk, and referring them to the least restrictive treatment setting.

Engagement in the Risk Assessment

There are a variety of factors that may impact the quality of a suicide risk assessment, including stigma, cultural and societal attitudes, and provider discomfort. At times, a person with suicidal thoughts may be hesitant to disclose information regarding their suicidal thoughts, methods, plans, or intent or previous suicide attempts, as they are wary of the potential response they may receive from a behavioral health provider. Research on risk assessments that were conducted on a national crisis hotline has identified some of the core characteristics of helpful interactions, as reported by people with suicidal thoughts (Mishara et al., 2007b). Approaches tied to effective outcomes include the use of collaborative problem-solving and a supportive approach, as well as the demonstration of empathy and respect. Positive results are more often yielded when the assessor approaches the interaction as a collaboration, focusing on working together to determine what to do next to keep the person safe. Providers need to be aware of any direct or indirect communication to the person being served that may indicate the provider is uncomfortable discussing suicide.

The Chronological Assessment of Suicide Events (CASE) Approach, developed by Dr. Shawn Shea, provides a strategy for enhancing the quality of the information gathered from a person during a suicide risk assessment. Dr. Shea is an internationally acclaimed workshop leader and innovator in the fields of suicide prevention, building resiliency, clinical interviewing, and improving medication adherence, having given more than 850 presentations worldwide. Dr. Shea states that:

Real Suicide Intent = Stated Intent + Reflected Intent + Withheld Intent

Dr. Shea points out that a person who is embarrassed about their suicidal thoughts and has a high level of actual intent may withhold intent, sometimes consciously and sometimes unconsciously. A person's reflected intent may be the most important component for determining real suicide intent. Reflected intent is "the quality and quantity of the patient's suicidal thoughts, desires, plans, and extent of action taken to complete the plans" (Shea, 2009, p. 3). Dr. Shea asserts that the amount of time spent thinking, planning, preparing, and practicing for an attempt may be the strongest indicator of imminent risk of a suicide attempt.

The CASE Approach is a best practice interviewing strategy designed to minimize withheld intent and maximize the likelihood that the assessor is gathering valid information about the stated and reflected intent. The CASE Approach draws on

research to identify strategies for raising the issue of suicidality while minimizing shame and stigma, as well as ways of formulating questions to maximize validity. To increase the likelihood of eliciting a truthful response when dealing with a stigmatized topic during a risk assessment, the following four validity techniques are used:

1. **Behavioral Incident:** A behavioral incident is a question or line of questioning that asks for specific details or facts about a situation. For example, one might ask, "What happened right before your suicide attempt?" followed by "What happened next?"
2. **Gentle Assumption:** A gentle assumption is a question in which the assessor assumes that the potentially embarrassing or stigmatized behavior is happening and phrases the question asked in that manner. For example, one might ask, "What other methods have you thought of to end your life?" instead of "Have you thought of any other methods to end your life?"
3. **Denial of the Specific:** Denial of the specific is a technique in which the assessor asks a series of specific questions after a person has denied a generic question regarding the same broader category. For example, one might ask, "Have you ever used any illegal drugs?" If the person being interviewed denies illegal drug use, follow up with questions such as, "Have you ever used methamphetamines?" and "Have you ever used cocaine?" and "Have you ever used heroin?" There are times people will answer in the affirmative to the specific questions even when they have clearly denied the more general question.
4. **Symptom Amplification:** Symptom amplification is based on the notion that a person will sometimes minimize their stigmatized symptomology. To keep the respondent from minimizing, the asker will provide responses that are suspected to be higher than the actual amount so that the respondent does not experience shame by sharing the true extent of their symptoms. For example, one might ask, "How much time are you spending thinking about suicide? Would you say it is 75 percent, 85 percent, or 95 percent of your waking hours?"

The CASE Approach suggests using these validity techniques while gathering information regarding a person's suicide risk in the following four chronological time frames:

1. **Presenting Events:** All suicidal thoughts and behaviors that occurred in the last 48 hours.

2. **Recent Events:** All suicidal thoughts and behaviors that occurred between two days ago and two months ago.
3. **Past Events:** All suicidal thoughts and behaviors that occurred prior to two months ago. A person may not recall past events in detail. The assessor should gather information in as much detail as possible. If the person does not recall the dates or age they were when attempts were made, the assessor should try to detail the first attempt and most recent attempt. After these details are collected, the assessor should list other attempts by number and method, as well as report that the person is unable to recall specifics. For example, one may write, "Person reports 10 additional suicide attempts all by overdosing. Person reports that these attempts all occurred between the ages of 18 and 25 but is unable to remember the details of these attempts. Person did receive psychiatric treatment at inpatient facilities after each attempt."
4. **Immediate Events:** All suicidal thoughts and behaviors that occur during the interview.

Training on the CASE Approach can be obtained through the Training Institute for Suicide Assessment.

Core Components of a Risk Assessment

As recommended by SAMHSA, The Joint Commission, and the C-SSRS, a comprehensive risk assessment should include the information below gathered from a person and their natural supports. A sample risk assessment can be found in Appendix P.

- **Presence or Absence of Thoughts of Death:** If thoughts of death are present, one might think, "I wish I could go to sleep and not wake up," or "The world would be better off without me."
    - If present, frequency (how often), duration (for how long), and when did they start? For example, "Since I was 10 years old, I have had thoughts of death two times per day that last for one hour each time."
- **Presence or Absence of Thoughts of Suicide:** If thoughts of suicide are present, one might think, "I want to kill myself."
    - If present, frequency (how often), duration (for how long), and when did they start? For example, "I have thoughts of suicide twice per week for

about 10 minutes each time, and that has been going on for about one month."

- If present, has the person considered a method? If so, what is the method? Does the person have access to a firearm? If so, discuss safe storage. Even if the person has not considered using a firearm, always assess for access to firearms and safe storage.
- If present, has the person made a plan? This includes the time, date, and location for the person's suicide.
- If present, has the person expressed intent to die by suicide?

- **Presence or Absence of Suicidal Behaviors:** Using the CASE Approach, an inventory should be made of all the person's past, recent, and present suicidal behaviors. The inventory should include all the person's suicide attempts, aborted attempts, interrupted attempts, and preparatory acts.
  - **Suicide Attempt:** A self-injurious act that was done by a person with at least some wish to die.
  - **Aborted Attempt:** When a person begins to take steps toward a suicide attempt but stops themselves before engaging in self-injurious behavior.
  - **Interrupted Attempt:** When a person begins to take steps toward a suicide attempt but is interrupted or stopped by someone else before engaging in self-injurious behavior.
  - **Preparatory Acts:** Acts made toward making an imminent suicide attempt. Examples include buying a weapon, stockpiling medications, and writing a suicide note.
- **Warning Signs:** Characteristics that are temporally related to the acute onset of suicidal behaviors (hours to a few days). Potential warning signs include:
  - Talking about or making plans for suicide;
  - Expressing hopelessness about the future;
  - Displaying severe or overwhelming emotional pain or distress;
  - Feeling intolerably alone;
  - Feeling helpless;
  - Feeling without purpose;
  - Feeling like a burden to others;

  - Arranging to divest responsibility (for children, pets, or elderly parents); and
  - Showing worrisome behavioral cues or marked change in behavior, particularly in the presence of other warning signs, including significant:
    - ◊ Changes in or withdrawal from social connections or situations;
    - ◊ Increases in anger or hostility that seem out of character or context;
    - ◊ Increases in agitation or irritability;
    - ◊ Increases in drug or alcohol use; and
    - ◊ Changes in sleep (increased or decreased).

- **Risk Factors:** Characteristics that statistically put a person at increased risk are generally static and do not change over time. Risk factors alone do not predict suicide deaths, but risk factors and warning signs should be examined together when making a risk determination. Potential risk factors include:
  - Suicide death of a family member;
  - History of a suicide attempt or suicide behavior;
  - Access to lethal means;
  - History of abuse or trauma;
  - Mental illness;
  - Physical illness;
  - Disability;
  - Impulsivity or lack of self-control;
  - Recent losses (financial, personal, or physical);
  - Current or past bullying (either the bully or the person being bullied); and
  - Recent discharge from a psychiatric hospital.
- **Protective Factors:** Protective factors are those that reduce the risk of suicide. Recognizing strengths and resiliency during the risk assessment can foster hope and set the stage for interventions to build upon protective factors and reduce future risk. However, protective factors should not supersede the importance of significant warning signs and should only be one component of the comprehensive risk assessment. Potential protective factors include:
  - Positive social support;

  - Positive coping skills;
  - Optimism for the future;
  - Sense of responsibility for family and children;
  - Spirituality;
  - Leisure activities that are enjoyed;
  - Access to effective behavioral and physical health care; and
  - Fear of death or ambivalence toward dying.

- **Determine Risk Level:** Based on all the information gathered, determine if a person is at high, moderate, or low acute risk of suicide. Develop an appropriate treatment plan to address the risk in the least restrictive environment and most culturally appropriate manner.
- **Documentation:** Document risk level, rationale, treatment plan, and follow-up.

Inquiry Around Suicide

Based on best practices, the State Suicide Prevention team recommends the use of the C-SSRS Lifetime Recent version to ensure a comprehensive, evidence-based assessment of current and previous suicidal thoughts, behaviors, plans, and intent. If the C-SSRS is not used to structure the risk assessment, the assessment should include all the information spelled out above.

Measures for Suicide-Specific Assessment

Various suicide-specific measures have been developed to assess for suicide risk across populations. Some people, especially adolescents, have been found to more openly share information related to suicidal thoughts, behaviors, and risks through self-report instruments, so these tools can be helpful components of the risk assessment. The most common evidence-supported measures are described below.

Columbia-Suicide Severity Rating Scale

The C-SSRS is a tool to measure SI and suicidal behavior, as well as the intensity of ideation, and predicts suicide risk across treatment and research settings (Posner et al., 2011). The scale has been widely used and is available at no cost. The C-SSRS Risk Assessment version includes a checklist of protective and risk factors to be used in conjunction with information about SI and suicidal behavior. C-SSRS

training is necessary to administer the scale and is not restricted to mental health professionals.

Beck Scale for Suicide Ideation

The Beck Scale for Suicide Ideation is a brief 21-item scale that assesses a person's current intensity of attitudes, plans, and behaviors to die by suicide (Beck et al., 1979). The scale examines the duration and frequency of ideation, sense of control over an attempt, number of deterrents, and amount of planning involved in a contemplated attempt. The scale is appropriate for both inpatient and outpatient settings, can be conducted through interview or self-report, and requires some interviewer training.

Beck Depression Inventory

Both the Beck Depression Inventory and Beck Depression Inventory II are moderate cost, self-report scales of depression symptoms with a suicide item that outlines ratings one through four, from passive SI to strong intent to die by suicide (Beck et al., 1988; Beck et al., 1996). Persons who rated at least a two on the suicide item (report thoughts of suicide but no intent) were 6.9 times more likely to end their lives.

Beck Hopelessness Scale

The Beck Hopelessness Scale is another brief self-report measure that has been shown to predict suicide in both inpatient and outpatient psychiatric clients and is one of the most widely used scales for hopelessness (Beck et al., 1988). The scale has 20 true-false questions that assess positive and negative thoughts about the future over the course of the past week. The tool is of moderate cost and is available in Spanish.

Documentation

Determining Risk Level

Determining and documenting risk level is a critical component of the risk assessment. No study has identified one specific factor or combination of factors that specifically predicts suicide or suicidal behavior; therefore, the determination of risk level will depend on careful consideration of the information gathered in the assessment and the clinical judgment of the assessor (see Table 1 below). The

determination of the best setting of care and course of treatment should consider not only the level of risk but also the benefits and potential risks to the person. While a more restrictive care setting may be necessary to safeguard against potential self-harm, there may also be negative effects from this course of treatment that must be weighed in the decision, such as disruption of employment, disruption of therapeutic alliance, and increased family conflict. When possible, the provider should collaborate with the person in understanding and weighing different treatment options. Information on the potential interventions and monitoring to be considered at each level of risk can be found in Chapter 6: Safety Planning and Chapter 7: Pathway to Care.

Table 1. Considerations for Each Risk Level

Risk Level	Suicidality	Risk or Protective Factors

High	• Suicidal thoughts with intent to act in past 30 days (C-SSRS Item 4)
	• Ideation with plan and intent in past 30 days (C-SSRS Item 5)
	• Any suicide behavior in past 90 days (C-SSRS Item 6)
	• Intent with access to lethal means
		• Multiple warning signs likely to be present
		• Extra concern for psychiatric diagnoses with severe symptoms, including psychosis
		• One or more risk factors likely to be present, including but not limited to:
		  ○ Recent discharge from psychiatric inpatient unit
		  ○ Lack of family or social support
		  ○ Lack of engagement in care

Risk Level	Suicidality	Risk or Protective Factors

Moderate	• Suicidal thoughts with method but no plan or intent in past 30 days (C-SSRS Item 3)
	• Suicidal thoughts with intent to act but no plan at worst ever (C-SSRS Item 4)
	• Suicidal thoughts with specific plan and intent at worst ever (C-SSRS Item 5)
	• Any suicide behavior at worst ever (C-SSRS Item 6)
		• Absence or presence of risk and protective factors may play stronger role in overall risk
		• Extra concern for the following:
		  ○ Extreme feelings of hopelessness, helplessness, or burdensomeness
		  ○ Unable to list reasons for living
		  ○ Recent discharge from inpatient hospitalization

Low	• Wish to be dead in past 30 days (C-SSRS Item 1) • General thoughts of killing self but no plan, intent, access to lethal means, or thoughts of method (C-SSRS Item 2)	• Modifiable warning signs • Strong protective factors • Available social support

Suicide risk can be examined from both an acute and persistent perspective. For example, acute risk considers a person's current and recent SI and suicidal behaviors, as well as the warning signs that indicate a person is at more immediate risk of suicide. Persistent risk occurs when a person is not necessarily at risk of suicide right now. However, a person has several risk factors that make them at risk of dying by suicide sometime in the future. When documenting risk, it is important to distinguish between warning signs and risk factors. A person can be at high acute risk but low chronic risk. Likewise, a person can be at low acute risk and high chronic risk. Each situation is unique, and the recommendations and follow-up plans need to be tailored to each person's situation.

Another way of looking at risk formulation, as taught by Assessing and Managing Suicide Risk (AMSR), is to compare a person's current suicide risk to their self at another relevant point in time or to another relevant population. This comparison is made by considering the current warning signs and risk factors being displayed by a person. For example, one might say, "Pat Doe's current risk is higher than their baseline as evidenced by (warning signs and risk factors). Pat's current risk is also

higher than people of similar age and ethnicity seen at this clinic due to (warning signs and risk factors).” From these risk formulations, a plan of action can be determined for next steps in treatment. More information regarding AMSR training can be found on the Education Development Center website and SPRC website.

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Additional Resources

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5. Workforce Competency in Suicide Prevention

Goal 6: All staff employed by the organization will receive training in suicide care that is appropriate for their role in the care of a person at risk.

Rationale

Suicide prevention is a core duty of behavioral health systems. Research published by Bachmann (2018) indicates that 50 percent of all suicides worldwide are linked to depression or another mood disorder. Additionally, between 40 percent and 85 percent of suicides occur after ingesting alcohol or another substance. Nearly 20 percent of people who died by suicide reached out to a behavioral health care provider in the month before their death. Therefore, it is important for all members of the behavioral health care workforce to be prepared to identify and treat a person at risk of suicide. In 2012, the ZEST initiative conducted a survey of more than 3,800 staff in community mental health clinics across the state and found that more than one-half did not feel they had the training or skills needed to engage and assist people at risk for suicide. Following a concerted effort to train the workforce in 15 community mental health centers using ASIST, only 13 percent to 18 percent of staff felt uncertain about their training and skills.

Core Competencies in Suicide Prevention

All staff within the organization should receive core competency training in suicide prevention. This includes direct care providers, managers, and support or administrative staff. Options for core competency training include ASIST, Suicide Alertness for Everyone: Tell, Ask, Listen, KeepSafe (safeTALK), and Ask About Suicide to Save a Life (AS+K). Each of these trainings has unique benefits for staff in various roles at the organization. Staff should receive a refresher training (generally brief) at least every three years.

Applied Suicide Intervention Skills Training

ASIST is a suicide prevention gatekeeper training that teaches how to identify a person who is experiencing immediate suicide risk and increase support for that person. ASIST trainers are certified by LivingWorks, the world's leading suicide intervention training company. LivingWorks believes suicide is preventable and everyone can learn to play a life-saving role. ASIST is used worldwide by clinical staff, non-clinical caregivers, and families. Training is provided in a two-day workshop aimed at enhancing the following skills:

- Identifying a person with SI;
- Understanding how a provider's own beliefs and attitudes impact interventions;
- Hearing a person's story for wanting to die by suicide;
- Supporting a person's turning point toward life; and
- Creating a plan to increase personal safety for a set course of time.

For a list of certified trainers in ASIST, email the State Suicide Prevention team at suicide.prevention@hhs.texas.gov. Face-to-face workshops are required for this training. More information on ASIST is available on the LivingWorks website.

Suicide Alertness for Everyone: Tell, Ask, Listen, KeepSafe

safeTALK is another gatekeeper training developed by LivingWorks. This four-hour training is appropriate for psychiatrists, primary care physicians, and non-clinical or administrative staff. safeTALK prepares staff to identify a person with thoughts of suicide and connect that person with suicide intervention resources. The goals of this training are to:

- Decrease avoidance, dismissal, or misses of suicidal thoughts or behaviors;
- Identify a person with thoughts of suicide;
- Apply the four steps of safeTALK: Tell, Ask, Listen, and KeepSafe; and
- Connect a person with suicide intervention providers.

The State Suicide Prevention team is developing certified trainers in safeTALK. For a list of certified safeTALK trainers, email the team at suicide.prevention@hhs.texas.gov. Face-to-face workshops are required for this training. More information on

safeTALK is available on the LivingWorks website. An iOS mobile application that summarizes key steps and resources is available for free download for individuals who have completed the training.

Ask About Suicide to Save a Life

AS+K is a gatekeeper training developed by Mental Health America of Texas and updated by the Texas Suicide Prevention Collaborative to be a Texas-specific suicide prevention training. This two-and-a-half-hour workshop is appropriate for suicide prevention coalition members, community members, and non-clinical or administrative staff. The goals of this training are to:

- Increase knowledge about suicide;
- Increase knowledge of basic suicide intervention skills;
- Increase confidence to ask and respond to someone in a suicide crisis;
- Increase knowledge of appropriate ways to refer a person in suicide crisis to a mental health professional;
- Increase knowledge of how to assist in the aftermath of a suicide;
- Increase knowledge of how to access local Texas crisis lines; and
- Ensure the Suicide and Crisis Lifeline has been added to cell phones.

AS+K has been approved to be provided virtually. For more information about training or a list of workshop leaders, contact the Texas Suicide Prevention Collaborative at lisa.sullivan@texassuicideprevention.org.

Recommendations for Direct Care Staff

Staff who provide direct services to people at risk of suicide should also receive best practice training in screening, assessing, means safety, and safety planning. Recommended trainings for staff providing services to people who may be at risk for suicide are described below.

Columbia-Suicide Severity Rating Scale

As discussed in Chapter 3: Screening for Suicide Risk, having an evidenced-based screening tool is imperative to suicide safe care. Ensuring all staff that will be responsible for administering the screening tool have adequate training is equally important to ensure internal reliability and validity of the tool. The Columbia

Lighthouse Project, owners of the C-SSRS, offer several training options for organizations. Visit the Columbia Lighthouse Project website for more information. Mental health training is not required to use the C-SSRS; however, it is recommended that anyone who will provide the C-SSRS screener or assessment tool receive one of the online trainings to develop proficiency and maintain reliability of the tool.

Chronological Assessment of Suicidal Events

The CASE Approach, developed by Dr. Shawn Shea, is a method of eliciting suicidal thoughts, plans, and intent. The CASE methodology is discussed in greater detail in Chapter 4: Suicide Risk Assessment. CASE Approach training is recommended for any staff responsible for risk assessment in the organization. The goal of this training is to learn and practice the seven interview techniques for enhancing validity when exploring suicidal thinking. These interview techniques are discussed more thoroughly in Chapter 4: Suicide Risk Assessment. Both live and virtual, on-demand workshop options are available for CASE Approach training. More information regarding training can be found on the Training Institute for Suicide Assessment website.

Assessing and Managing Suicide Risk

The AMSR program is a research-informed and skills-based training for mental health professionals that was created by the American Association of Suicidology and SPRC. Training workshops are either one day (for clinical staff) or one-half day (for other direct care providers) and cover 24 empirically based core competencies, some of which include how to do a risk assessment and how to generate a risk formulation from that assessment. In order to offer specialized training to people working in outpatient settings, inpatient settings, and substance use settings, five AMSR curricula are available. AMSR training is recommended for staff responsible for completing risk assessments in the organization. The goals of this training are to:

- Increase knowledge in the following core competencies: maintaining an effective attitude and approach; collecting accurate assessment information; formulating risk; developing a treatment and services plan; and managing care;
- Increase willingness, confidence, and clarity in working with people at risk for suicide; and

- Increase ability to identify how staff can better care for people at risk for suicide.

Both face-to-face and virtual workshop options are available for AMSR training. More information regarding training can be found on the Education Development Center website and SPRC website.

Counseling on Access to Lethal Means

Counseling on Access to Lethal Means (CALM) training was developed by Elaine Frank and Mark Ciocca as a way of helping a person learn how to talk about means safety with others. Elaine Frank is an injury prevention and public health professional who has focused her work for the past 10 years at the intersection of firearm safety and suicide prevention. She is the co-developer of CALM and the co-chair of the New Hampshire Firearm Safety Coalition that created the Gun Shop Project and other efforts to engage the firearm community in preventing suicide. Mark Ciocca is a consultant and trainer in New Hampshire. He has had a varied clinical career that includes working with college students and people with forensic backgrounds. Using CALM in practice is discussed in Chapter 6: Safety Planning. CALM training is recommended for any direct care staff who may work with a person with suicidal thoughts. After completing this training, staff will be able to do the following:

- Explain that reducing access to lethal means is an evidence-based strategy for suicide prevention.
- Explain how reducing access to lethal means can prevent suicide.
- Identify clients for whom lethal means counseling is appropriate.
- Describe strategies for raising the topic of lethal means, and feel more comfortable and competent applying these strategies with clients.
- Advise clients on specific off-site and in-home secure storage options for firearms and strategies to limit access to dangerous medications.
- Work with clients and their families to develop a specific plan to reduce access to lethal means, and follow up on the plan over time.

CALM has two learning options. The first is a four-hour face-to-face workshop. The in-person option allows staff opportunities to practice having means safety conversations, which may be especially helpful or necessary for staff new to the concept of means safety. For a list of approved workshop leaders in your area,

email the Texas Suicide Prevention Collaborative at lisa.sullivan@texassuicideprevention.org. The face-to-face workshop has been approved to be provided virtually. The second learning option is a two-hour on-demand training. More information about the on-demand training is available on the Zero Suicide website.

Safety Planning Intervention

The SPI is a four-hour face-to-face workshop recommended for any staff members who are working with a person who may have thoughts of suicide. The training reviews how to complete a safety plan to fidelity. For a list of approved SPI trainers, email the State Suicide Prevention team at suicide.prevention@hhs.texas.gov. SPI training has been approved by its developers to be provided virtually. More information about the SPI may be found in Chapter 6: Safety Planning.

Recommendations for Clinical Staff

Organizations should ensure the availability of at least one evidence-based treatment for suicide-related thoughts and behaviors, and providers of these practices should have appropriate training and monitoring of treatment fidelity. The three evidence-based treatments available to treat suicide directly are Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP), Collaborative Assessment and Management of Suicidality (CAMS), and Dialectical Behavior Therapy (DBT).

Cognitive Behavioral Therapy for Suicide Prevention

Traditional cognitive behavioral therapy approaches target specific disorders or symptoms, such as depression or anxiety. Although this may be a critical step for reducing distress and improving quality of life, a provider's immediate goal for a person at risk for suicide should be to keep them safe long enough to benefit from treatment. Therefore, interventions must directly target skills to prevent suicide. CBT-SP is an adaptation created to directly prevent or reduce the risk of suicide attempts. The therapy consists of a 12-week acute treatment phase that focuses on safety planning, understanding the circumstances and vulnerabilities that lead to suicidal behavior, and building life skills, followed by a maintenance continuation phase. Information on the training to become a CBT-SP therapist is available on the SPRC website. The Beck Institute for Cognitive Behavioral Therapy is another resource for training information on CBT-SP. Upcoming training workshops may be found on the Beck Institute website.

Collaborative Assessment and Management of Suicidality

CAMS is a therapeutic framework that may be utilized at the stage of assessment and may aid in organizing clinical treatment across multiple sessions. CAMS emphasizes the importance of creating a person-centered approach within the therapeutic alliance while managing suicide risk. The Suicide Status Form is used during the initial session to understand the details of the person's suicidality and then outlines a course of intervention. The form is subsequently used to track and document symptoms throughout treatment (Jobes et al., 2009). Collaboration between the person and provider is used to develop a suicide-specific treatment plan that aims to eliminate suicide as a coping strategy while increasing reasons to live. Research has demonstrated the validity of the Suicide Status Form and the effectiveness of CAMS through both quasi-experimental and experimental research (Jobes et al., 2017). CAMS trainings are available both in person and online. For more information about training, visit the CAMS-care website.

Dialectical Behavior Therapy

DBT was created as a cognitive behavioral treatment to treat a suicidal person with borderline personality disorder (Linehan, 1993). The therapy teaches a person coping skills in addition to the traditional cognitive behavioral therapy model and emphasizes the dialectics of acceptance and change. One of the core elements of DBT is teaching skills that help the person to regulate and tolerate their emotions. DBT most importantly validates the person's experience and emotional pain while ensuring safety and supports in the environment. Treatment is organized into four progressive stages, first addressing behaviors that could lead to a person's death and then addressing behaviors that could lead to premature termination. Following these critical steps, treatment addresses behaviors that negatively impact a person's quality of life and then focuses on the acquisition of alternative skills. Both online and in-person training opportunities are available on the Behavioral Tech website. This website also includes a registry of DBT providers in Texas.

Staff and Level of Training

Table 2 below lists the recommended level of training for each staff type; however, the table does not include an exhaustive list of best practice suicide prevention trainings. The trainings included in the table are currently being recommended

within the Texas public mental health system to promote consistency across agencies. For additional training resources, visit the Zero Suicide website.

Table 2. Recommended Staff Training Levels

All Staff	Direct Care Staff	Clinical Staff
• AS+K • ASIST • safeTALK	• AMSR • CALM • CASE • C-SSRS • SPI	• CAMS • CBT-SP • DBT

Training Through Peer-Led Guidance

In addition to the didactic trainings described above, it is important to implement a system of peer-led training opportunities and fidelity checks for staff members conducting this work. Ideally, after receiving the didactic trainings listed above, staff members would have an opportunity to observe a seasoned staff member or team lead complete the various processes in suicide care. At the point the new employee feels comfortable with their level of observation, they will complete the various processes of suicide care while being observed by a seasoned staff member or team lead. This process gives the new employee an opportunity to receive feedback in real time. The development of a training tool will help the observing staff member take notes on various aspects of the process and provide the new employee with strengths and areas for growth.

An example of a training tool for risk assessments is available in Appendix I. When the new employee is comfortable completing the suicide care process while being observed and the observer is confident the new employee has mastered the necessary skills, the final recommended step is to have the new employee observed by a manager or supervisor. The manager or supervisor ensures the new employee is meeting fidelity standards for the unit on aspects of suicide care using the training tool. If the new employee meets the standards, they are approved by the manager to begin suicide care work independently for the unit.

Continued fidelity checks through chart reviews and, if possible, observation at least quarterly are recommended. Develop tools to look for key elements of screening, assessment, safety planning, treatment, and other suicide care best

practices in documentation to ensure each staff member is meeting the organization's standards.

Suicide Prevention Training in Virtual Environments

Due to the complex nature of suicide, conducting in-person trainings is preferred when focusing specifically on suicide prevention, intervention, or postvention as the topic. When a virtual environment is necessary, the following recommendations should be followed to ensure a safe and effective training environment for all participants.

- Ensure all participants in the training have a clear understanding of the topics to be discussed at the event. When everyone entering the training has a clear understanding of the curriculum to be covered, it decreases the likelihood that someone may be triggered in an adverse way by the training content.
- Ensure the trainer has contact information for all participants. In the event someone leaves the training unexpectedly, it will be important to reach out to that person to make sure they are safe.
- All trainings should occur with at least two trainers. Having two people conducting the training allows for one person to monitor the participants and chat window for signs of distress while the other person conducts the training.
- Ensure the participants are aware of safe messaging guidelines. Set expectations early.
- Take frequent breaks. Breaks every 60 minutes to 90 minutes will help reduce participant fatigue. Encourage the participants to take unscheduled breaks as needed but to provide a "thumbs up" or "I am okay" in the chat window to indicate they are not in need of assistance.
- Group size should be limited to no more than 15 people. All participants should be able to be seen clearly on your platform screen.
- All participants should be asked to keep cameras on during the training session. Keeping cameras on helps to monitor the room and ensure the participants are not experiencing undue distress or being adversely affected by the training.

Moving Beyond – Community Expansion

Training community members outside of the organization in gatekeeper suicide prevention trainings will help to strengthen the overall suicide care of that community. Community members and individuals outside of the health care system are most likely to benefit from training in a suicide gatekeeper program, such as AS+K.

CALM offers a training curriculum geared toward first responders. This training is specifically intended to help police, fire, and emergency response professionals learn how to navigate conversations of means safety. This training is another key component to a suicide safe community. For more information about CALM for first responders, contact the Texas Suicide Prevention Collaborative at lisa.sullivan@texassuicideprevention.org.

Training community members outside of the organization in gatekeeper suicide prevention trainings will help to strengthen the overall suicide care of that community.

Additional training may be warranted for community agencies providing health and behavioral health care. The competency of the behavioral health workforce to assess and manage a person with suicide risk extends beyond the public mental health system. Mental health agencies with certified trainers in best practice curricula should consider expansion of these trainings to include behavioral health providers in other organizations and systems within their community. Trainings can benefit local suicide prevention coalitions and mental health task forces by informing the work they are doing in the community and offering staff opportunities to share what they have learned with others in their agency. Providing trainings that include both internal and external staff may foster networking and collaboration across agencies. Moreover, trainers may partner with technical schools, colleges, and universities to offer training within professional training programs. Many higher education programs welcome guest lecturers and opportunities for students to hear from community leaders. In addition, student interns may gain valuable experience through exposure to evidence-based interventions to prevent suicide within practice settings.

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6. Safety Planning

Goal 7: Providers will work collaboratively with children, adolescents, and adults at moderate or high risk of suicide to create an individualized safety plan.

Rationale

Many people who contact crisis hotlines or present at emergency departments or crisis centers with mental health concerns or thoughts of suicide will either not follow through with outpatient referrals or leave treatment within the first three months of care (Rudd, 2006). Therefore, it is essential providers utilize any contacts with the health care system to engage in brief interventions aimed at reducing suicide risk.

The SPI has shown to be effective in helping individuals get through crisis periods, as thoughts of suicide tend to ebb and flow. Safety planning draws from cognitive therapy interventions that utilize distraction and active coping strategies to manage thoughts of suicide. Safety planning has been tested as a component of evidence-based interventions targeting suicidal behavior and has been identified as a best practice by SPRC (Stanley et al., 2009; Wenzel et al., 2009). In a study by Stanley et al. (2018), safety planning was found to result in 45 percent fewer suicide behaviors at six-month follow-up than treatment as usual. Safety planning is notably different from no-suicide contract interventions, which do not identify how a person and their family should respond if the person has thoughts of suicide. There is minimal support for no-suicide contracts, and concerns have been raised that they may impede open communication between a person and clinicians about suicidal intent (Rudd et al., 2006). Safety contracts are not recommended as effective suicide prevention or intervention, but there is evidence that the SPI and safety planning are highly effective.

Description of the Safety Planning Intervention

The SPI is a brief 20-minute to 45-minute intervention that provides a person with a set of steps to be progressively used to attempt to reduce risk and maintain safety when thoughts of suicide emerge (Stanley & Brown, 2012). The SPI should follow a comprehensive risk assessment after strong rapport has been developed. Safety plans are to be developed within a collaborative process between a provider, the person at risk, and their close family and friends. Safety planning can be a stand-alone intervention that is utilized during crisis contacts or as part of an ongoing treatment relationship. The SPI includes the following core components, each of which is documented in a person's plan:

- Recognizing warning signs of an imminent suicidal crisis (changes in mood, thoughts, or behaviors);
- Utilizing internal coping skills that can help reduce distress;
- Using people in a person's support network as a means of distraction from suicidal thoughts;
- Reaching out to family and friends to help manage the crisis;
- Contacting mental health professionals or emergency contacts (calling hotlines); and
- Reducing access to potential lethal means.

Core Components of the Safety Plan

Each of the core components of the SPI is an important step in the process. The steps are meant to build on each other; however, it should be noted that the steps can be completed out of sequence if a person using the plan feels a particular step is warranted. The steps are described in further detail below.

- **Identifying the Warning Signs:** For a safety plan to be effective, a person must be able to recognize their own personal warning signs that a crisis may be impending. Asking questions such as, "How will you know your safety plan needs to be used?" or "What sorts of feelings or behaviors do you notice when you are headed toward a crisis state?" can open the conversation about warning signs. Some common warning signs include sadness or crying, anger or

irritability, isolation, changes in sleep, anxiety, loss of energy, and loss of interest in enjoyed activities.

- **Using Internal Coping Strategies:** Using internal coping strategies when in crisis can provide a person with a sense of self-efficacy when they are able to deescalate the crisis on their own. Ask the person, "What are some things you can do on your own to take your mind off your thoughts of suicide and help you to not act on them?" Exploring hobbies such as drawing, running, and watching a movie may be a way to find activities for a person to add as internal coping strategies. In this section of the plan, it is important to explore barriers that may keep a person from participating in a particular task. For example, if a person says they like to go for a walk for their coping strategy but going for a walk in their neighborhood is not safe, ensure that this barrier has been discussed and an alternative location has been identified or another coping strategy has been chosen. Some common internal coping strategies are watching television, listening to music, playing video games, playing with pets, reading, exercising, and cooking.
- **Using Socialization as a Distraction:** If using internal coping strategies does not work to decrease the thoughts of suicide, a person should be encouraged to move to the next step, using socialization as a distraction. In this step, a person should identify two to three people they can call to speak with to distract themselves, as well as one to two places they can go to distract themselves. These are not necessarily people and places they would seek help from but rather just casual conversation to distract themselves from their current thoughts. Asking questions such as, "Who can you talk to that may help to take your mind off your problems?" or "What are some healthy environments that you can go to for some social interaction when you are having thoughts of suicide?" Some common responses may be coffee shops, malls, gyms, parks, bookstores, and churches. When identifying healthy distractions, it is important to ensure both the people and environments chosen are healthy, encouraging, and positive options for the person. If potentially detrimental options are chosen, discuss alternatives. There may be times seeking social settings may not be a safe option for the person due to health concerns or other reasons. Consider creative options such as online support groups, online religious services, or other such activities that are social in nature.
- **Contacting Family and Friends for Help:** When social distraction does not help, the next step is to ask for help within one's own natural environment. It is important to ensure a person identifies at least one person they trust to reach out to for help with their thoughts of suicide. It is recommended that a person

share their safety plan with family and friends listed on this portion of the plan. Caring family and friends will then be ready to respond when they are called upon in times of need. When creating a safety plan with adolescents, it is important that they list trusted adults instead of other adolescents as their helpful contacts.

- **Contacting Professionals and Agencies:** If a person feels as though they cannot stay safe, they should be instructed to contact a professional for help. In this section of the plan, a person can list their own therapist, case manager, or doctor as appropriate. Additionally, all safety plans should include a crisis hotline number and information about the nearest emergency department and crisis center. Look for culturally appropriate resources. Ensure a person feels comfortable accessing these services as needed. One way to increase a person's comfort level with accessing crisis resources may be to call the resources together when a person is not in crisis, so they are able to get an idea of how the resources work while in the company of a trusted provider.
- **Means Safety:** Means safety is a crucial part of creating a safe environment for a person experiencing thoughts of suicide. As part of the safety plan, it is important to cover a person's access to firearms, as well as access to any other means the person has identified as a potential for them to use in a suicide plan. Asking questions such as, "Have you thought of how you would kill yourself?" or "Do you have access to (identified method)?" will help you determine next steps in means safety.
- **Time and Distance Between:** Once you have determined a person's identified method, it is imperative to take steps to put time and distance between the person with thoughts of suicide and their identified method. For example, if a person reports a method of taking pills and has access to those pills, look for a trusted family member who may be able to hold the pills for them. Examples of means safety include locking up identified means and having someone else hold the key, storing the identified means outside of the home, getting rid of the identified means all together, and staying with someone who can keep them company. Document on the safety plan the means safety methods that will be taken so that the person at risk will be expecting the results and not be

Document on the safety plan the means safety methods that will be taken so that the person at risk will be expecting the results and not be confused or taken off guard.

confused or taken off guard. This is another example of the powerful nature of collaborating with the person at risk to personalize their safety plan. When involving family members or friends in means safety, a phone call to discuss means safety and ensure understanding of the plan is important.

- **Reasons for Living:** Reasons for living were not part of the original safety planning document developed by Dr. Stanley and Dr. Brown. Research by Bryan et al. (2018) showed that discussing reasons for living decreased the need for psychiatric hospitalizations. The discussion of reasons for living during the safety planning process also enhanced hope. Whether or not a person can discuss reasons for living can also be a further assessment tool for clinicians. A person who is unable to discuss reasons for living may indicate a higher risk level and, therefore, need more intensive interventions to stay safe. When discussing reasons for living on the safety plan, ask questions such as, "What has kept you from making a suicide attempt?" or "What are the things you have in your life that are keeping you alive?" Allow the person to talk about their reasons for living, as building positive emotional connections is important in decreasing a person's thoughts of suicide.

Training and Resources for the Safety Planning Intervention

Training

People who conduct safety planning with a person at risk should be trained and demonstrate competency in the intervention. The State Suicide Prevention team has supported the development of in vivo SPI trainers. For a list of available trainers, email the team at suicide.prevention@hhs.texas.gov. The workshop training is four hours in length and consists of both didactic learning and role playing of safety planning steps to provide additional opportunities for practice and feedback. Follow-up coaching is recommended for providers learning the model so that they receive feedback on skills development and have an opportunity to bring questions and challenges to the trainer or their colleagues. Additional information on SPI training and resources can be found on the Stanley-Brown SPI website.

Template

A template to support documentation of safety planning is included in Appendix J and may be accessed on the SPRC website.

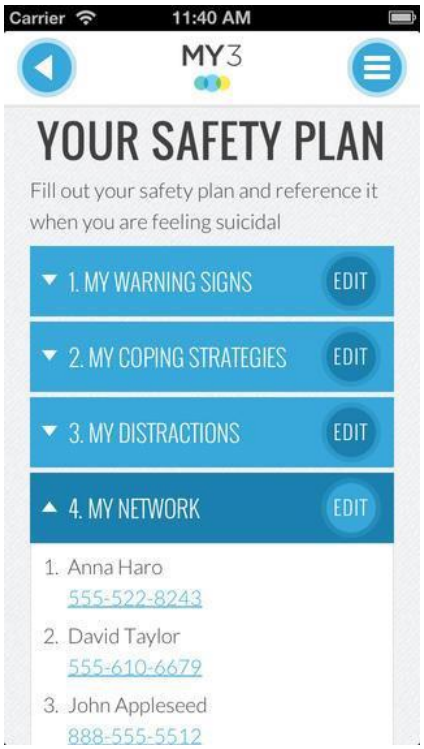
Mobile Applications

Two mobile applications have been developed to support the SPI. A person with thoughts of suicide may utilize one of these applications to keep their safety plan in a convenient location (phone or mobile device), readily available for consultation if thoughts of suicide occur. Both applications may be downloaded for free from iTunes or Google Play. Providers should keep a written copy of the safety plan and provide a copy to a person experiencing thoughts of suicide even when referring them to the mobile applications.

Figure 1. Mobile Application Screenshots

Safety Plan

MY3



Fidelity to the Safety Planning Model

To ensure the SPI is being implemented with fidelity to the best practice model, a fidelity instrument was developed by Dr. Stanley and Dr. Brown. HHSC has supported the training of a team of raters for SPI fidelity. LMHAs and LBHAs may submit a sample of SPIs via audio or videotape for review by raters. Following the analysis of ratings, a feedback report will be provided to leadership at the

organization. To discuss the process for obtaining feedback on your organization's fidelity to the SPI model, email the State Suicide Prevention team at suicide.prevention@hhs.texas.gov.

Means Safety

As previously discussed, a critical component of safety planning is counseling a person experiencing suicidal thoughts and their loved ones to limit access to lethal means. Research has shown that reducing access to lethal means can be an effective prevention strategy, as many people who attempt suicide think about their attempt for 30 minutes or less prior to making an attempt. CALM is a best practice developed by Elaine Frank and Mark Ciocca. In CALM, the provider learns how to ask a person and their families about their access to lethal means and develop a plan to reduce access, particularly around firearms and medication.

A free web-based training, CALM is available on the Zero Suicide website. The training is approximately two hours and includes didactic information and video-based examples of counseling interventions. All staff responsible for safety planning should complete this online training or a live training from a certified training provider. The developers offer master trainer certification if organizations prefer to provide face-to-face training. For information on current master trainers in Texas, email the State Suicide Prevention team at suicide.prevention@hhs.texas.gov.

In addition, the National Action Alliance has released a toolkit providing information on means safety for several commonly used means. The toolkit, titled "Lethal Means and Suicide Prevention," may be found in Appendix K.

Resources to Support Means Safety

Safety planning frequently occurs during a time of crisis for families, and it may be challenging to remember the information provided by crisis clinicians. In addition to documenting the collaborative safety plan in writing, a person and their family may benefit from written educational materials on supporting a person experiencing thoughts of suicide. Organizations should identify preferred materials based on the identified audience for the information and have materials readily available. Examples of materials include:

- Recommendations for Families
- After an Attempt: A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department

- After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department

Safety Planning in Virtual Environments

When providing a SPI on a virtual platform, there are additional considerations for a provider to keep a person safe. Most important is choosing a technology platform that is consistent with Health Insurance Portability and Accountability Act-compliant practices. Once a platform has been chosen, it is important that both the provider and person served are well-trained to use the platform. Before beginning the session, the provider should obtain a current location and phone number for the person served. In the event a person receiving a SPI needs further crisis intervention, it is important to have information about where to send help. Providers should have a plan in place for how to contact emergency services for a person while maintaining contact with them. Additionally, should the telecommunication be discontinued or disconnected, the provider will need to follow up with the person served. Finally, the provider should have a plan for providing the person served a copy of their safety plan. Discuss options for providing the plan to the person served and ensure the chosen method of transmission is secured for the person's privacy.

Moving Beyond – Community Expansion

An organization may provide leadership within the community by extending the use of the SPI to other health care providers within the community through training and consultation. Suggested targets for training are emergency departments, crisis providers, and behavioral health providers. An organization may also provide leadership by partnering with community organizations or coalitions to provide education around reducing access to lethal means within the community. This may include providing gun locks at local events, collaborating with firearm dealerships to display or disseminate suicide prevention materials, supporting the placement of barriers at high-risk locations, or other community-led efforts. Information on community strategies for reducing access to lethal means is available from Harvard University's Means Matter Campaign.

One example of a community strategy for reducing access to lethal means occurred in 2014 when state leaders partnered with the Texas Suicide Prevention Collaborative and LMHAs to provide CALM training for first responders. Several veteran-serving agencies, veteran peer network groups, and first responder agencies have had staff become trainers for their agencies. Currently, a network of

CALM trainers exists not only through the LMHAs and LBHAs but also with their partner agencies in the field such as police, firefighters, emergency medical services, and veteran groups throughout Texas.

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7. Pathway to Care

Goal 8: A person assessed to be at risk will receive care in accordance with the Suicide Care Pathway. Organizations will use quality management tools to monitor adherence to the Suicide Care Pathway guidelines.

Rationale

The Suicide Care Pathway is intended to describe best practices for a person at risk of suicide who will be monitored or treated in a community setting, as defined by the Zero Suicide Institute. The pathway is intended to support shared decision-making between providers and a person in care, as well as promote best practices during high-risk periods. At any one point in time, behavioral health organizations are likely to have only a small percentage of individuals on the pathway, but a person deserves a level of care and monitoring reflective of the importance of their safety.

Organization of the Suicide Care Pathway

In this chapter, the Suicide Care Pathway is reflected in two flowcharts: Suicide Risk Identified at Crisis Contact or Intake and Suicide Risk Identified While Engaged in a Level of Care. Both identify the paths for a person who is at risk of suicide. One flowchart focuses on a person who is not yet engaged in community-based care, while the other focuses on a person within community-based care. The flowcharts reflect standards for continued monitoring, ongoing safety planning, treatment planning, and frequency of contact. Additional guidance on each step within the flowcharts is provided in the accompanying narrative. A flowchart version of each pathway is included and may be printed and laminated for easy reference.

Education About the Suicide Care Pathway

When a person is placed on the Suicide Care Pathway, staff should educate them and any support system participating in care about pathway services. The person should be informed about what the pathway means for them, as well as what to expect from the provider, including regular follow-up. Staff providing education

regarding pathway services will need to be trained on providing education in a trauma-informed manner. When discussing pathway services, it is imperative that care and concern for a person's safety is the first priority and services provided are explained as a way to treat thoughts of suicide and monitor safety on an outpatient basis.

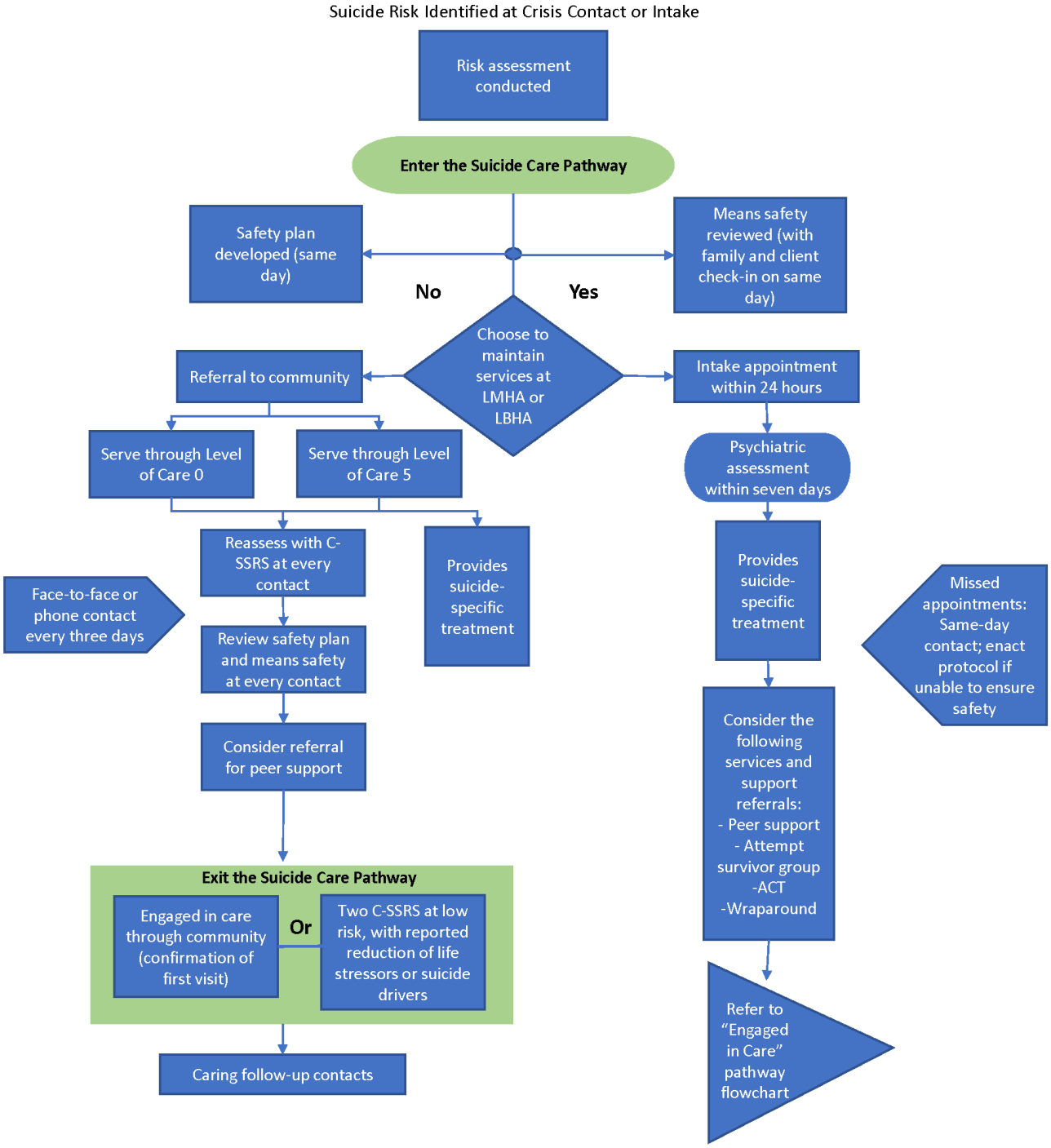
As part of the Suicide Care Pathway education, staff should encourage a person in care to call if they will miss an appointment. Additionally, if the person in care misses an appointment, they should expect the provider to reach out to them the same day for a follow-up. Providers should attempt to gather several emergency contacts, identifying people who are likely to know where the person in care may be if the provider is unable to contact the person directly. Information about services offered, frequency of contact, and follow-up efforts in the event of missed appointments should be included in the pathway education materials. A sample handout for educating clients on the pathway is available in Appendix L.

Description of the Suicide Care Pathway

Suicide Care Pathway for a Person Not Enrolled in Services

When a person is not enrolled in ongoing services with an organization and presents as moderate or high risk, the Suicide Care Pathway should be considered. Figure 2 below shows the pathway flowchart for a person who is not yet engaged in community-based care.

Figure 2. Suicide Care Pathway Crisis Contact or Intake Flowchart



Entering the Suicide Care Pathway

A person who has been assessed and determined to be at high risk for suicide (see Chapter 4: Suicide Risk Assessment) should be placed on the Suicide Care Pathway. A person at moderate risk may also be appropriate for pathway services if the moderate risk is based on recent thoughts of suicide. It is critical that the organization identify a strategy to communicate internally among providers that a person is on the pathway. The preferred method is a clear indicator within the electronic health record that is present on any screen of a person's record. Teams may also consider maintaining an electronic list of people on the pathway and reviewing the list with providers daily.

Safety Plan Developed

The provider should collaborate with the person to develop a safety plan on the same day as the risk assessment. The person should not leave the care setting without a well-developed safety plan (see Chapter 6: Safety Planning).

Counseling on Access to Lethal Means

The provider should ensure that means safety conversations have occurred with the person served (see Chapter 6: Safety Planning). After a plan is developed for means safety, the provider should follow up on the same day to ensure that the agreed-upon steps have been taken. The provider may request the person in care or their support person call the clinic, or the provider may choose to call them. Protocols should be in place to address situations in which the person or their support person cannot be reached.

Referral to Community

If the person prefers services in the community, they will continue to be served through crisis services until services in the community are confirmed. The person may be served in Level of Care 0 (Crisis Services) for up to seven days, with a focus on maintaining safety until the person is engaged in services with another provider. If engagement in care has not occurred or available care does not include best practice suicide-focused treatment, the LMHA or LBHA should consider offering the person care in Level of Care 5 (Transitional Services). This will allow staff to continue to monitor for safety during the care transition period, as well as make available a brief intervention aimed at reducing suicidal risk. Level of Care 5 services can be offered for up to 90 days.

Ongoing Monitoring of Risk

For a person on the Suicide Care Pathway, providers should continue to screen for risk using the C-SSRS or another evidence-based screening tool at every contact. This remains the most critical aspect of the monitoring role. In addition, the provider should review the safety plan with the person at every contact, asking what strategies the person has used and how helpful they have been at reducing distress or providing effective distraction, as well as identifying new strategies when needed.

Referral for Peer Support

A person could benefit from having a peer specialist provide support during transitions in care. A peer specialist may assist a person by navigating access into the preferred care system, advocating for their needs, and providing support during a period of crisis. A peer specialist may be especially impactful for a person who has limited social support.

Provision of Suicide-Focused Interventions

A person benefits from brief interventions focused on reducing suicidality. Providers should consider providing one of the evidenced-based treatments listed below to a person while they are receiving Suicide Care Pathway services.

- CAMS is a therapeutic framework used to assess and treat individual suicide risk by focusing on a person's suicide drivers. For more information on CAMS, visit the CAMS-care website.
- CBT-SP is a cognitive behavioral model of therapy developed specifically to treat thoughts of suicide. In CBT-SP, thoughts of suicide are viewed as a problematic coping skill, and this becomes the focus of treatment rather than a symptom of another diagnosis. For more information on CBT-SP, visit the Beck Institute website.
- DBT is an evidence-based behavioral therapy used to reduce suicide thoughts and behavior through teaching core coping strategies and providing support. For more information on DBT, visit the Behavioral Tech website.

Contact Frequency

While a person receives crisis services and remains on the Suicide Care Pathway, they should be contacted face-to-face or by phone at a minimum of every three

days. A person receiving services in a full level of care and on the pathway may benefit from follow-up contact at the following frequency:

- A person assessing as "High Risk" should receive face-to-face or phone contact at a minimum of every three days.
- A person assessing as "Moderate Risk" should receive face-to-face or phone contact at a minimum of every seven days.

Contact can be with any of the service or support providers, and contacts should be communicated to all providers on the treatment team.

Missed Appointments

If a person on the Suicide Care Pathway misses an appointment without notice, the provider should immediately try to contact the person to check on their safety. If the provider is unable to contact the person immediately, the organization should enact its protocol for missed appointments (see Chapter 8: Care Transitions). The organization should use various strategies to ensure either the person or an emergency contact is reached the same day.

Exiting the Suicide Care Pathway

A person being monitored through crisis services should remain on the Suicide Care Pathway until they are at reduced risk for suicide or engaged in care with another provider. A person is considered at reduced risk if they have had two consecutive C-SSRS assessments at low risk and they report a reduction in life stressors or suicide drivers after 30 days. A person is considered engaged in care when they have attended at least three appointments with the community provider. A person receiving services in a full level of care and on the pathway will remain on the pathway until they meet the following criteria:

- Two consecutive C-SSRS assessments at low risk;
- Fewer than two crisis contacts within the past two months; and
- No recent hospital discharge due to SI or suicidal behavior within the past three months.

A person exiting the Suicide Care Pathway should continue to be screened at every visit with the C-SSRS or another evidence-based screening tool, as well as continue with any suicide-specific treatments until discharge is clinically indicated. Exiting

the pathway does not indicate that the issues that contributed to elevated risk are resolved but instead indicates intensive management may not be necessary.

Caring Follow-Up Contacts

When a person meets the criteria to be removed from the Suicide Care Pathway, either due to reduced risk or engagement in services with an outside provider, the organization should provide caring contacts for a period of time established by the organization (see Chapter 8: Care Transitions).

Referral for Local Authority Services After a Crisis

For a person who is referred for services within the LMHA or LBHA, priority scheduling is important. Whenever possible, the crisis provider should provide a warm transfer to the intake provider to complete the eligibility assessment, person-centered planning, and initial service authorization. If a warm hand-off is not possible, an intake appointment should be scheduled within 24 hours. Warm hand-offs are also recommended between crisis services and case management staff in LMHA or LBHA services, whenever possible.

Referral for Psychiatric Assessment

For a person entering services within the Suicide Care Pathway, a psychiatric assessment appointment should be scheduled within seven days of entering the pathway. Processes should be put in place to allow staff to schedule priority psychiatric appointments for a person on the pathway.

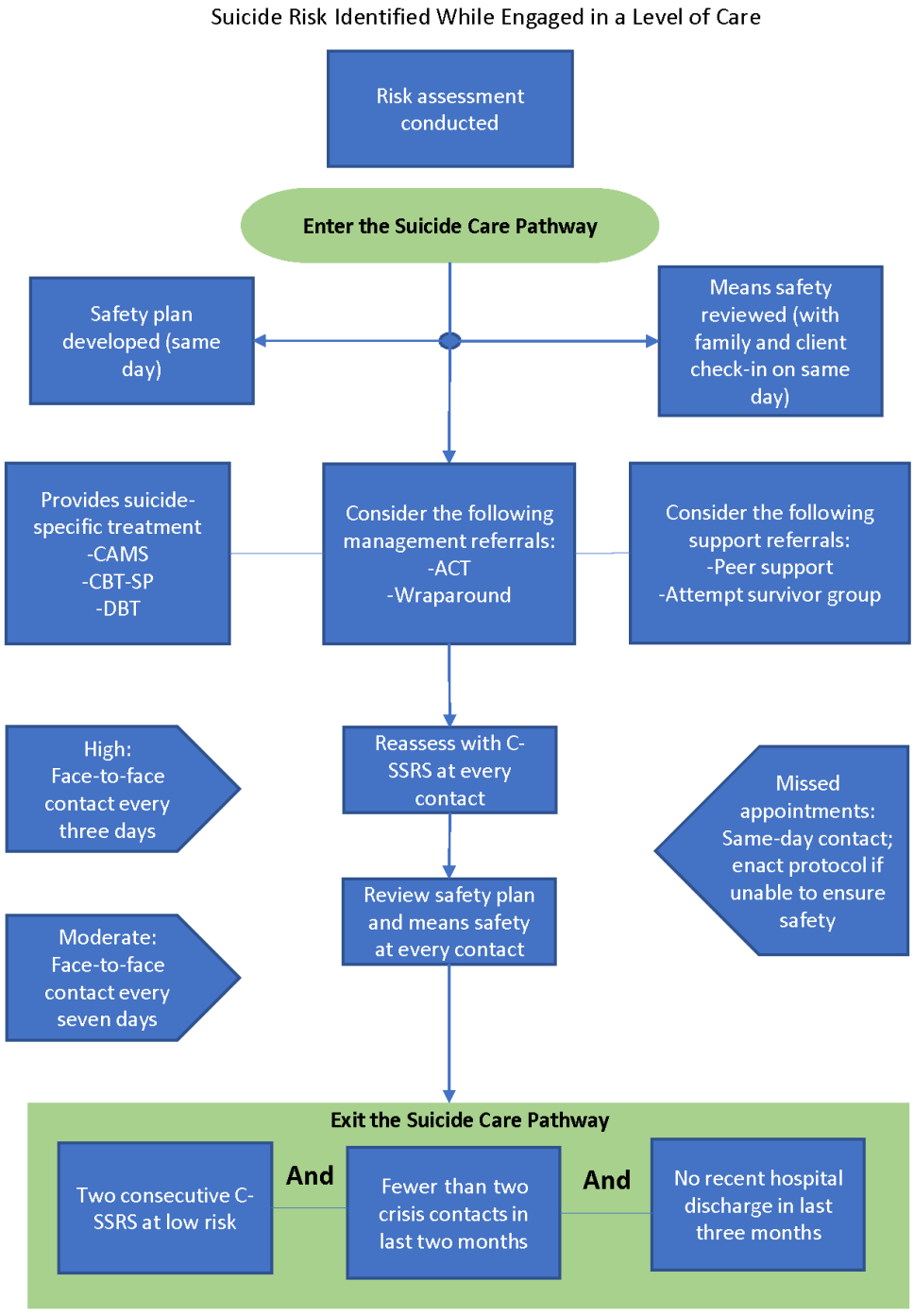
Referral for Best Practice Services and Supports

A person who enters the Suicide Care Pathway should be educated about options for services and supports that can reduce the person's risk for suicide. For a person with a history of frequent hospitalization, an evidence-based care management approach, such as ACT or wraparound, should be considered. Based on availability within the organization, suicide-focused treatments should also be considered. CAMS, CBT-SP, and DBT are evidence-supported options. Lastly, a person may benefit from peer support through a certified peer specialist or engagement in a survivors of suicide attempt support group.

Suicide Care Pathway for a Person Currently Engaged in Services

After the intake appointment, providers should refer to Figure 3 below for additional guidance on scheduling initial treatment sessions and planning for service delivery. Figure 3 shows the Suicide Care Pathway flowchart for a person receiving community-based care.

Figure 3. Suicide Care Pathway for a Person Receiving Services Flowchart



Quality Management

Organizations should create processes to monitor the extent to which staff follow the Suicide Care Pathway guidelines. Several barriers may exist to keep staff from fully engaging clients in pathway services. It is an important aspect of the pathway for supervisors to monitor and address any barriers that may arise. Organizations will need to ensure that productivity standards allow for the additional contacts required and reflect the increased demands related to monitoring and treating people on the pathway. Examples of quality management indicators that should be tracked to monitor the pathway include the percentage of:

- People correctly identified for the pathway (unless electronic);
- People with a same-day safety plan at pathway entry;
- People having means safety conversations on the same day as pathway entry;
- Contacts with documented suicide screenings at each visit;
- Contacts with a review of the safety plan;
- People in crisis services with contact every three days;
- People maintained on the pathway until engaged in care (three visits) or assessed at low risk;
- Times an initial appointment is within 24 hours of a LMHA referral;
- High-risk people with contact every three days;
- Moderate-risk people with contact every seven days;
- People reengaged in care after a missed appointment; and
- Hours to contact after a missed appointment.

Wrapping Up

Suicide Care Pathways are an important piece to engaging clients in suicide care within an organization. Having policies in place to identify those who should be placed on the pathway through screening and assessment, those currently on the pathway through electronic health record indicators, and those who are removed through further screening will ensure the organization is providing the best possible suicide-specific care to those at highest risk.

8. Care Transitions

Goal 9: Organizations should have documented continuity of care procedures to promote access to and engagement in services for people during transitions in care. Organizations should provide follow-up and bridging activities to reduce suicide risk during transition periods.

Rationale

Research has shown that a person who has made a suicide attempt or presents with a suicide crisis remains at high risk for a period of time. In fact, risk for suicide attempts and deaths is highest within 24 hours to one week after discharge and remains elevated the first month post-discharge. In a meta-analysis of 50 years of suicide death research, Chung et al. (2019) found that the suicide rate for a person was 300 times the global rate within the first week post-discharge from an inpatient psychiatric unit. Risk remains high at 200 times the global rate for the first month post-discharge. This time period is critical for ensuring continued contact with caring professionals and supportive family and friends.

Although the time following hospitalization is crucial for continued care, according to the Healthcare Effectiveness Data and Information Set (HEDIS) from 2018, only about one-third (35 percent) of this population attended a post-hospital discharge appointment within seven days of discharge and just over one-half (57 percent) attended a follow-up appointment within the first month post-discharge. HEDIS is one of health care's most widely used performance improvement tools. For more information on HEDIS measures, visit the National Committee for Quality Assurance website.

Risk for suicide attempts and deaths is highest within 24 hours to one week after discharge and remains elevated the first month post-discharge.

Ensuring organizations are using effective, evidence-based strategies to assist a person in engaging in follow-up outpatient care and provide support during this

high-risk time is critical. It is important to establish clear expectations for both inpatient and outpatient providers to ensure that the person discharging has seamless care during the transition period.

Points of Intercept

The Texas public mental health system's role is to support everyone in the community with crisis care. This includes continuity of care activities during periods of high risk. The following represent key points at which the LMHA and LBHA may serve a person at high risk of suicide:

- Discharge from an emergency department after a suicide attempt;
- Discharge from a state psychiatric hospital;
- Discharge from a local psychiatric hospital;
- Discharge from a crisis alternative setting; and
- Mobile crisis involvement.

In each of these situations, a person is less likely to follow through with mental health referrals and is at elevated risk for suicide. Additionally, each of these intercept points represents unique settings and situations that may require different strategies to support continuity of care and reduce suicide risk. Therefore, organizations should monitor the success of each identified strategy separately. Appendices M-1 and M-2 provide a care transitions worksheet and checklist. These examples can be used to plan and identify key strategies around care transitions for relevant intercept points.

In addition, strategies should also be identified to follow up with a person who is engaged in suicide care support services on the Suicide Care Pathway within the organization. One example is to call immediately if a person does not attend a scheduled appointment. This ensures a rapid response to check in with anyone known to be at risk and communicates care and concern from providers. Staff should be aware of and trained on the organization's written procedures to support care transitions.

Care Transition Strategies

The following list includes strategies that have been shown to reduce the risk of suicide or increase engagement in care following a crisis episode of care. Although a description of each strategy is included, organizations need to engage in careful planning to identify how they might implement a particular strategy. Outreach refers to the different methods used to contact a patient. Bridging is the continuous and bidirectional connection with patients following discharge.

Outreach refers to the different methods used to contact a patient. Bridging is the continuous and bidirectional connection with patients following discharge.

Memorandum of Understanding

Organizations should consider establishing a memorandum of understanding with partner organizations to outline each entity's role for screening, assessment, safety planning, discharge planning, and follow-up. Memorandums of understanding can assist in providing clear arrangements for information sharing, including establishing procedures for access to relevant assessment information and policies around warm hand-offs. Warm hand-offs between inpatient and outpatient providers increase the likelihood of an individual following through with outpatient services after an emergency room visit or a psychiatric inpatient stay due to a relationship being made with the outpatient provider. Establishing memorandums of understanding formalize the process and provide accountability for each organization in the agreement.

Warm Hand-Offs

Warm hand-offs enhance the transition by starting to build a new relationship with the receiving provider or organization. The referring provider may arrange an introduction with the new provider in person, by phone, or through telecommunication technology. The referring provider may also make linkages with other staff within the receiving organization, such as peer providers or continuity of care staff, who are responsible for maintaining care throughout the transition time. Warm hand-offs should be considered for a person who is transitioning from inpatient psychiatric treatment to outpatient care, leaving an emergency room after

a suicide attempt, transitioning from a crisis alternative setting, and transitioning from a higher to a lower level of care within organization services.

Follow-Up Appointments

Organizations should ensure that a person has rapid access to initial outpatient appointments following discharge. The first outpatient appointment should be scheduled within 24 hours of the transition in care, if possible, but within 48 hours maximum. If a person transitioning is at an emergency room, psychiatric inpatient facility, or crisis alternative setting, the follow-up appointment should be scheduled prior to discharge by way of a warm hand-off. Examples may include a phone call from the emergency room to the outpatient provider for an introduction with the person served, a direct drop-off from the inpatient unit to the outpatient provider, or the outpatient provider visiting the inpatient unit to make a connection and provide an outpatient appointment. In addition to a follow-up with a staff member within 24 hours, it is recommended that a person in transition see a psychiatrist or another designated psychiatric care provider within seven days of their transition in care. Reminder phone calls and caring contacts are also beneficial for improving attendance at scheduled appointments.

It is recommended that a person in transition see a psychiatrist or another designated psychiatric care provider within seven days of their transition in care.

Provider Communication

The care transition should be supported through effective communication between originating and receiving providers. Procedures should include gaining a release for provider communication. Providers should send documentation on the person prior to the scheduled appointment and follow up with a conversation between providers to share relevant information. It is imperative for documentation on client care to make it from one provider to the next to ensure seamless care for the person.

Psychoeducation

Providers should engage in conversations with a person to outline the roles and responsibilities of both the person and provider regarding mental health treatment, provide information and clarify misconceptions about mental health treatment, and

discuss and resolve potential barriers to attendance. Ideally, conversations should occur prior to a person's discharge from the inpatient setting, when possible.

Psychoeducation should include an understanding of the person's cultural beliefs about suicide and mental health treatment and the role these beliefs may play. Motivational interviewing techniques may also be useful in this strategy. Psychoeducation is important for caring others. Include family, friends, and other support persons in the psychoeducation process so that they are more ready and willing to support the person served when their support is needed.

Mobile Crisis Follow-Up

The mobile crisis outreach team or other crisis providers maintain regular face-to-face or phone contact with the person served until they are engaged in community-based services. Research suggests that contact between the crisis provider and person served should continue beyond the first outpatient visit until clear engagement has occurred. Contacts may include face-to-face visits, phone contacts, and caring contacts. Crisis follow-up activities include assessing risk at each contact, reviewing the safety plan, and resolving barriers to care.

Care Navigators

Care navigators have been shown to be especially helpful in providing continuity across primary care and behavioral health systems, as well as across hospital and outpatient settings. Care navigators may enhance these system relationships by serving as liaisons, improving communication across providers, and facilitating access to care. The use of motivational enhancement strategies may increase the effectiveness of care navigation and coordination. Care navigators may be housed in hospitals or outpatient settings, but their main function is to act as a bridge between the two levels of care to ensure people receiving services experience smooth transitions.

Peer Specialist Support

Organizations may engage internal or external peer specialists to assist a person in navigating behavioral health systems and provide support and encouragement during the transition period and possibly beyond. One study demonstrated that utilizing peer support organizations in the discharge process shortened the length of hospitalization, reduced the use of hospital and emergency room services over 12

months, and reduced the overall cost of care (Forchuk et al., 2005). According to the study, the intervention was most beneficial for those self-reporting as "lonely."

Engagement of Support Network

Another strategy for improving care transitions is the involvement of a person's support system. This strategy entails providing education about the elevated risk period and including supportive family and friends in the discharge and transition planning process. People in the person's support network may also be included in plans to reduce access to lethal means. Closing the loop can include post-discharge contacts with the person's support system to assess for any concerns, need for additional education and support, and barriers to accessing follow-up care.

Caring Contacts

Caring contacts are brief communications expressing care from a provider delivered in person or by phone, letter, postcard, email, or text. Caring contacts can follow a preset schedule and range from one to 24 contacts, with most lasting up to 18 months. Caring contacts are nondemanding of the person served, that is, they do not require the person to do anything when the contact is received. Several studies have examined the impact of caring contacts on suicide care. One such study by Comtois et al. (2019) compared treatment as usual to treatment with caring contacts among military personnel in mental health care. The study showed that individuals receiving caring contacts were less likely to experience thoughts of suicide between baseline and follow-up and had fewer suicide attempts between baseline and follow-up. It is best to deliver caring contacts in a person's preferred method; however, caring contacts in any method can be meaningful.

Different systems and organizational resources will require different combinations of care transition strategies. Across the various strategies described, improvement in attendance at outpatient treatment over the baseline rate ranged from 10 percent to 90 percent, with 43 percent being the average improvement over baseline (Knesper et al., 2011).

Follow-Up for a Person in Care

A person in care may also withdraw from services during times of crises. Organizations should have clear procedures for outreach to a person who has been identified as having elevated suicide risk if the person fails to attend an appointment. Electronic health records can be an important tool in notifying responsible parties of the need to engage in active outreach, as well as raising awareness among crisis hotline staff or crisis providers of elevated risk. When a person enters the Suicide Care Pathway, it is important to discuss the organization's outreach procedures. Whenever possible, allow each person to provide preferences regarding which follow-up methods they would prefer in the event outreach is needed. Allowing input from the person in care increases the likelihood of engagement in outreach efforts. More information about education for a person on the pathway can be found in Chapter 7: Pathway to Care.

Organizations should have clear procedures for outreach to a person who has been identified as having elevated suicide risk if the person fails to attend an appointment.

Following a missed appointment, staff should immediately attempt to reach the person at risk either by phone or through a home visit. Staff may also reach out to the person's support network with previously gathered consent. If staff are unable to reach the person by the end of the workday, alternative outreach strategies should be planned. Options might include:

- Outreach calls by the crisis hotline staff;
- Home or community outreach visits by the mobile crisis outreach team; and
- Home or community outreach visits by the crisis intervention team or mental health deputies.

Procedures should also include outreach by mail, preferably within 48 hours, if other outreach strategies fail to engage the person. Caring contacts scheduled at regular intervals may also be beneficial in reducing risk if the person chooses to withdraw from treatment. Consider the person's outreach preferences previously identified at intake.

Evaluating Success

Care transition strategies may range from being simple and inexpensive to intensive; however, they have been shown to be cost efficient by reducing repeated hospitalizations and emergency department use. To ensure the chosen strategies are meeting the organization's goals, staff should measure their impact and continue to identify potential gaps. Potential measures of the success of care transitions or follow-up strategies include:

- Days or hours from an initial appointment;
- Attendance rates at an initial appointment following a referral;
- Hospital readmission rates (within various time frames);
- Number of hours from a missed appointment to a follow-up; and
- Percent of individuals reengaged in care after a missed appointment.

Moving Beyond – Community Expansion

Building partnerships within the community is essential to foster effective care transitions. Creating a shared commitment for a suicide safe community can foster a willingness to address elevated risk during times of care transitions. Behavioral health centers can assist in planning effective care transition strategies for other settings in which identification of suicide risk occurs. Outlining the roles of each organization within a memorandum of understanding may be an effective way to support collaborative planning. Overlapping responsibilities while not duplicating roles can help weave together a stronger system to support the continuity of care across community providers. Technology can be another way to support communication across community partners to ensure care transitions have been provided to at-risk people. Involving other community partners, such as support groups, civic centers, faith-based communities, local suicide prevention coalitions, and mental health task forces, to increase support for a person during times of transition can also play a key role in improving outcomes for a person at high risk of suicide.

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9. Postvention

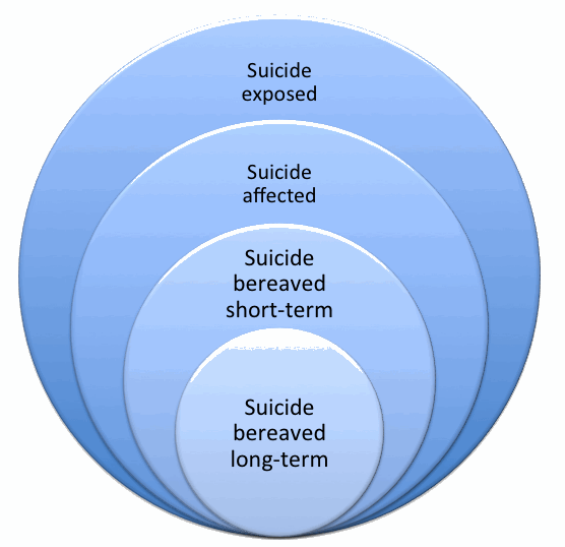
Goal 10: Organizations will develop a suicide postvention plan that addresses a person who may be affected by the suicide death of an employee or another person in care.

Rationale

Edwin Shneidman, the father of suicidology, is often quoted as having said, "Every death by suicide significantly impacts six additional people"; however, research has shown the impact to be even greater. A study by Berman (2011) found that there is an average of 4.5 to 7.5 immediate family members and around 15 to 20 extended family members, friends, and colleagues who can be considered "intimately and directly affected" by a suicide. Additional people exposed to a suicide, such as first responders, witnesses, or care providers, may not have had a personal relationship with the person who died; however, they may still be significantly impacted.

Cerel et al. (2014) categorize a person across levels of impact, including a person exposed to suicide, affected by suicide, bereaved with short-term impacts, and bereaved with long-term impacts (see Figure 4 below). This model suggests that more than six people are impacted to varying degrees by each suicide death. Moreover, Cerel et al. (2019) state that the number impacted is closer to 135 people per suicide death.

Figure 4. Suicide Levels of Impact



According to Cerel et al. (2019), the level of impact a person experiences from a suicide death is dependent on several factors. These factors include the relationship a person had with the deceased, perceived responsibility for the death, quality of a person's support system, and availability of resources. Research has clearly established that exposure to another person's suicide behaviors (ideation or attempts) or death by suicide increases the risk of suicide for the person exposed (Survivors of Suicide Loss Task Force, 2015). One large population-based study found that a person exposed to the suicide death of a spouse or child was more likely to die by suicide than the general population (Agerbo, 2005). Adolescents seem to be particularly impacted by this elevated suicide risk related to being exposed to the suicide death of a family member or friend. Research has shown that the risk of suicide is increased about threefold for men exposed to a suicide death in the workplace compared to men not exposed (Hedström et al., 2008).

Due to the increased risk that accompanies a suicide death, a comprehensive suicide prevention program must include postvention planning and strategies. Behavioral health organizations have a clear role in reducing the immediate distress following a suicide death, reducing the risk for subsequent suicides, and assisting individuals struggling with complicated bereavement in situations where a client or employee has died by suicide.

Defining Postvention Terms

The Survivors of Suicide Loss Task Force (2015), a branch of the American Association of Suicidology, defines postvention as "an organized response in the

aftermath of a suicide to accomplish any one or more of the following: (a) to facilitate the healing of people from the grief and distress of suicide loss; (b) to mitigate other negative effects of exposure to suicide; and (c) to prevent suicide among people who are at high risk after exposure to suicide." In postvention, efforts are made to encourage resilience and coping and reduce long-term negative impacts.

The term "survivors of suicide loss" refers to people bereaved by the loss of someone to suicide. In the United States, this term is sometimes shortened to "loss survivors" or "survivors." Alternatively, the term "survivors of suicide attempt" refers to people who have survived a suicide attempt. To reduce confusion, this toolkit will use the respective full term.

Postvention Planning

It is important for organizations, schools, and communities to develop a plan for postvention in advance of a death by suicide. An organizational plan should address the possible suicide death of:

- A person who is in care with the organization;
- A person formerly served by the organization;
- A staff member; and
- A person in a staff member's family.

The plan should identify the administrative official(s) tasked with managing communication and delineate a step-by-step response. Include in the response staff and shift coverage for practical and emotional needs of the organization, including short-term actions needed to facilitate recovery and long-term actions needed to reduce risk in the organization's high-risk populations. High-risk persons include those closest to the person who died, those with previous thoughts of suicide or suicide attempts, those with pre-existing behavioral health diagnoses, and those who lack social support. The organization may choose to develop a team designated to respond in the immediate and short-term aftermath, with team members prepared to serve in specific roles. Example postvention protocols are provided in Appendices N-1 and N-2. These documents were created internally by the state suicide prevention coordinator at HHSC. The organization should have a community resource list that identifies services and supports which may be helpful to survivors of suicide loss, including suicide bereavement support groups, grief counseling options, and available crisis resources. Research has shown that access to

information about available resources decreases the time before a person seeks assistance for processing their grief.

Stages of Postvention

Carson J Spencer Foundation et al. (2013) specify key phases and activities for postvention in the workforce. With minor modification, these stages can also apply to planning postvention activities for a person receiving services within an organization.

Immediate Phase

During the immediate phase, the goal is to minimize the trauma impact and provide psychological first aid to those exposed. One initial consideration is the privacy of a person and their family. If the decedent is a person served, the organization will need to determine if there is consent on file to communicate with family members. If no consent has been provided, the organization should not communicate with survivors of suicide loss unless the family reaches out. Similarly, staff members from the organization should not plan to attend memorial events or services unless permission is given by the family. If the death was of a staff member, the family may request that the manner of death be kept confidential. Privacy of the person and their family must take precedence; however, the organization may not be able to fully control information obtained in other ways.

Within the organization, one individual should be identified to coordinate communication. No official statement should be made until the death is confirmed by an immediate family member or public official, such as a police officer or medical examiner. An example death notice is provided in Appendix O. Care should be taken to notify persons who had a close relationship with the person who died by suicide prior to notifications by the organization. Having protocols in place about who will provide notifications and how notifications will occur can ensure the information is received in a caring and supportive manner. The organization's leadership should be aware that the death may trigger thoughts of suicide in vulnerable people. Care should be taken to limit information around details of the death and avoid memorializing the death in a dramatic manner. Assessing vulnerable people for risk may be necessary. Suggestions on how to honor a person who died by suicide and minimize contagion can be found on the SPRC website. Full staff meetings should be held to debrief the death and provide an opportunity for further formal or informal processing. Discretion for the privacy of the person and family members should be reiterated to staff.

During the immediate phase, practical support may be more helpful than counseling. The organizational representative may ask the family how others can help, including bringing prepared food, offering to pack belongings in the office, or communicating plans for services.

Short-Term Phase

During the short-term phase, the goal is to promote healthy grieving and provide additional support and services to those most affected. The organization should make available counseling services to a person who needs or desires additional support. If appropriate, the organization should reach out to the family for a second time, three or four weeks after the death. For family members, this may involve offering to provide counseling services or make community referrals. Survivors of suicide loss report that making connections with others who have lost loved ones to suicide can be especially meaningful, so referrals to suicide bereavement support groups or other peer-to-peer supports should be strongly considered.

For coworkers, the short-term phase may involve bringing in employee assistance program staff or other behavioral health providers and setting a culture that encourages help-seeking. Behavioral health professionals may consult with the organization's leadership to determine the best plan, which may include employee training on self-care, coping skills, and availability of support services; individual or group meetings with affected employees; and referrals of people with complicated grief responses to mental health professionals. Additionally, clinical supervisors should be aware of signs of ongoing struggles in staff and provide time for discussion during supervision. Trainees and new providers may need additional support navigating the grief process related to the loss of a person in services. Trainees should be offered a safe place to process, emotional responses should be monitored, and referrals for grief care provided as needed. Staff may be impacted both personally and professionally by the suicide. A structured yet empathic atmosphere is crucial for a healthy work environment. During this phase, management should also begin to reestablish functioning and routine within the workplace while maintaining flexibility and understanding for staff still grieving.

Long-Term Phase

Research has shown that most people show remarkable resiliency and will return to previous levels of functioning over time. However, anniversaries or major events may trigger reminders and lead to sad or traumatic memories. Organizing opportunities to remember or honor the person's life while still maintaining safe

memorial practices may be helpful for those who wish to participate. Activities with all staff are not recommended in the long-term phase. This phase also reflects the shift from postvention to prevention, with a goal of offering multiple strategies for identifying and engaging a person at risk of suicide. Providing education and gatekeeper trainings, offering universal screening for suicide, and implementing other prevention strategies within the Zero Suicide framework are intended to support both a person served and staff members within the organization.

Additional Postvention Resources

Local Outreach to Suicide Survivors Teams

The Local Outreach to Suicide Survivors (LOSS) team is a model of suicide postvention in which a trained survivor of suicide loss and mental health professional are dispatched to the scene of a suicide to meet with a person newly bereaved by suicide. The LOSS team provides support and information about community resources and begins to instill hope for the future for those who have just lost a loved one to suicide. When survivors of suicide loss meet with those newly bereaved by suicide, a connection is made. The newly bereaved recognize they are not alone in their suicide grief. Campbell (2011) found that a person who received active postvention through LOSS teams sought help for their grief on average 39 days after the death, as compared to an average of 4.5 years with passive postvention strategies. The study also found that team members had no greater risk of suicide because of their exposure to the stories of suicide death. Moreover, team members reported that the experience helped them in their own recovery. Additional information on LOSS teams and available training can be found on the LOSS team website.

Psychoeducation and Support Groups

Survivors of suicide loss frequently lack basic information about grief responses and available community resources. The American Association of Suicidology developed the SOS Handbook, which contains a practical guide to begin the grieving process. This book and other resources may be downloaded for free from the American Association of Suicidology website. The Suicide Awareness Voices of Education website offers free online resources and brief booklets on loss that may be purchased for a low cost. This website also includes a list of survivors of suicide loss support groups within Texas. The American Foundation for Suicide Prevention website offers a list of national and international suicide bereavement support

groups. For those interested in developing a survivors of suicide loss support group, the Towards Good Practice: Standards and Guidelines for Suicide Bereavement Support Groups has been identified as a best practice by SPRC and can provide guidance in the implementation of a suicide bereavement support group. Some people will also benefit from participation in online support through chat rooms or listservs, such as those offered by Survivors of Suicide and Didi Hirsch's Survivors After Suicide.

Treatments for Trauma and Complicated Bereavement

When bereaved people have been surveyed, many indicate the desire for professional assistance with grief and trauma responses. There is very limited research to identify evidence-based practices for a person with complicated bereavement. Trauma and grief interventions, such as Trauma-Focused Cognitive Behavioral Therapy, Prolonged Exposure Therapy, and Cognitive Processing Therapy, should be strongly considered treatment modalities.

Postvention Guidelines

The following postvention guidelines provide additional information and guidance:

- Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines
- A Manager's Guide to Suicide Postvention in the Workplace: 10 Action Steps for Dealing with the Aftermath of a Suicide
- After a Suicide: A Postvention Primer for Providers
- After a Suicide: A Toolkit for Schools

Moving Beyond – Community Expansion

Although initial policies and procedures will be focused on establishing a postvention plan for internal use, health and behavioral health organizations should consider ways in which crisis interventions and suicide postvention efforts may be directed toward the broader community. The development and support of a LOSS team to respond to both the immediate and short-term needs of a person exposed to suicide is one concrete strategy. Organizations may also explore avenues to provide postvention responses to community providers who are most likely to be exposed, such as health care staff, first responders, schools, clergy, and funeral

directors. Specialized resources are available from SPRC offering guidance for postvention to first responders, schools, clergy, and funeral directors. Other specialized community and cultural groups and provider relationships in each community should be considered when developing a plan.

Through community partnerships, organizations may provide guidance to other community entities to develop best practice postvention plans. Policies may be shared and important links in care may be made for those at risk, as well as those who are bereaved by suicide loss. Other groups that have resources and might benefit from postvention support are veterans, service members, and their families. Connecting with the United States Department of Veterans Affairs, American Legion, and other veteran-serving organizations may aid in postvention needs and supports. Organizations may also help ensure that local media is aware of safe messaging guidelines and that any media coverage following a death by suicide aims to inform the public about resources, support, and warning signs, as well as minimize the risk of contagion.

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List of Acronyms

Acronym	Full Name
ACT	Assertive Community Treatment
AMSR	Assessing and Managing Suicide Risk
AS+K	Ask About Suicide to Save a Life
ASIST	Applied Suicide Intervention Skills Training
CALM	Counseling on Access to Lethal Means
CAMS	Collaborative Assessment and Management of Suicidality
CASE	Chronological Assessment of Suicide Events
CBT-SP	Cognitive Behavioral Therapy for Suicide Prevention
C-SSRS	Columbia-Suicide Severity Rating Scale
DBT	Dialectical Behavior Therapy
DSHS	Department of State Health Services
HEDIS	Healthcare Effectiveness Data and Information Set
HHSC	Health and Human Services Commission
LBHA	Local Behavioral Health Authority
LMHA	Local Mental Health Authority
LOSS	Local Outreach to Suicide Survivors
PDSA	Plan, Do, Study, Act
RSCSC	Regional Suicide Care Support Center

Acronym	Full Name
safeTALK	Suicide Alertness for Everyone: Tell, Ask, Listen, KeepSafe
SAMHSA	Substance Abuse and Mental Health Services Administration
SCI	Suicide Care Initiative
SI	Suicidal Ideation
SPI	Safety Planning Intervention
SPRC	Suicide Prevention Resource Center
ZEST	Zero Suicide in Texas

Appendix A-1

Suicide Care Initiative- Survey and Training Opportunities

Timothy Stacey <Timothy.Stacey@integralcare.org>

Tue 9/8/2020 11:02 AM

To: **AllStaff <AllStaff@integralcare.org>**

Good morning,

Thank you to the 600+ people who completed our Zero Suicide Workforce survey. On behalf of the Trauma Informed Care team, we are incredibly moved by your response and appreciate all the feedback you have given us. We are excited to enter Suicide Awareness Month by offering two trainings to enhance Suicide Prevention in our community. Trainings will be held virtually via TEAMS and registration can be found in Relias.

For resources and to see our survey results, visit Zero Suicide SharePoint.

(Questions? Connect with your Trauma Informed Care representative, or, email timothy.stacey@integralcare.org)

AS+K About Suicide to Save a Life.

This gatekeeper training is available to all staff, including staff that do not work directly with clients. AS+K About Suicide to Save a Life is a two hour workshop that provides participants with an overview of the basic epidemiology of suicide and suicidal behavior, including risk and protective factors. Participants are trained to recognize warning signs and how to intervene with a client, family member, or friend they think might be at risk for suicide.

September 29, 2020- 2:00-4:00 PM
October 13, 2020- 2:00-4:00 PM

Safety Planning Intervention Training

Despite recent use of evidence-based practices, suicide rates have continued to increase over the last 10 years. Safety planning, including the identification of resources and coping skills, has been shown to be an effective intervention, when utilized as a part of a larger system of ongoing services. This training will teach clinicians about the important elements of a safety plan, and review how to make an effective safety plan, in order to reduce the risk of harm for clients. Times and Instructors listed below!

September 15 3:00-4:30- Laurel Mollere and Bryan Camphire
October 13 -1:00-2:30 PM- Samantha Plevney and Christina Smith
November 10-1:00-2:30 PM – Samantha Plevney and Cory Clark
December 8- 1:00-2:30 PM - Bryan Camphire and Cory Clark

-Tim Stacey LPC-S

Appendix A-2

C-SSRS and Integral Care's Suicide Care Initiative

Brooke Hammond <Brooke.Hammond@integralcare.org>

Mon 6/14/2021 8:50 AM

Cc: Brooke Hammond <Brooke.Hammond@integralcare.org>

In support of Integral Care's Suicide Care Initiative as well as a global need to increase screening for risk during the current pandemic, Integral Care is committed to strengthening its use of the Columbia-Suicide Severity Rating Scale (C-SSRS) across all programs and all populations served. The C-SSRS is a simple series of questions that anyone can use anywhere in the world to prevent suicide. Answers to its plain-language questions help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs. More information on the C-SSRS can be found at https://cssrs.columbia.edu/.

While Integral Care first began using the C-SSRS in 2015, there remains opportunities to increase its use among direct care staff and across all client populations. To support these efforts, the following activities have been put into motion:

- All direct care staff are expected to complete a new C-SSRS training in Relias by June 15th and again every 12 months thereafter. You will receive e-mail reminders from Relias when it comes due in the future.
- General Documentation Training will now include more information on the C-SSRS.
- A C-SSRS is now required to be completed with every individual upon initiation of Integral Care services and at least every 12 months thereafter, or more frequently as outlined in other workflows (e.g. Waiver workflows).
- Documentation Review tools are being modified to include items focused on C-SSRS presence in the electronic health record (EHR) and appropriate frequency of completion.
- A 'Missing Assessments' report in myAvatar is available and should be actively used by Managers and Supervisors to identify individuals admitted to their programs who are missing the C-SSRS.

Thank you for your ongoing commitment to fulfilling Integral Care's vision of 'Healthy Living for Everyone.' Be on the lookout for more information and training opportunities coming soon in support of the organization's Suicide Care Initiative. For more information about this work, please contact Timothy.Stacey@integralcare.org.

Best regards,
Brooke

Brooke W. Hammond, LMSW-AP
Director of Operations
Integral Care – *Healthy Living For Everyone*
Office (direct): 512-804-3496
IntegralCare.org | Facebook | Twitter

Appendix A-3

Watch for the Suicide Care Webinar on Relias

Victoria Frias <Victoria.Frias@IntegralCare.org>
on behalf of
Dawn Handley <Dawn.Handley@integralcare.org>

Thu 5/7/2020 11:10 AM

To: **AllStaff <AllStaff@integralcare.org>**

Good morning,

We are excited to announce Integral Care's participation in the statewide Suicide Care Initiative. This initiative will help us enhance suicide prevention, intervention and postvention services here at Integral Care and it will be guided by the Zero Suicide framework.

To Learn More about This Initiative , **please login to Relias starting Friday, May 8, 2020 to review a brief webinar and complete a workforce survey.** This webinar provides an introduction to the project and how it will affect you, including your work with individuals at risk for suicide. The information gathered in the survey will be used to guide the implementation of this project.

To learn more about the project and what the Zero Suicide framework is, please visit the SharePoint page. You can also provide feedback on that page about how to best support you and the individuals we serve.

Background

In 2014, Integral Care engaged in the Zero Suicide in Texas (ZEST) initiative, working to reduce suicide deaths by individuals in our health care system. The Suicide Care Initiative will work to enhance the Zero Suicide framework throughout our agency and will have a positive impact on both our clients and staff, as we continue to work towards the goal of preventing suicides within our system of care.

Questions?

For questions regarding Zero Suicide, please contact Tim Stacey at t mothy.stacey@integralcare.org or (512) 440-4041.

Dawn R. Handley, M.Ed.,LPC
Chief Operations Officer
Integral Care-"Healthy Living for Everyone"
Ph. (512) 804-3492
[integralcare.org]IntegralCare.org | Facebook |Twitter

Appendix B

Appendix B PLANNING WORKSHEET

Zero Suicide Key Components: Possible Areas of Improvement:	
• Suicide Safe Care Policy	• Pathways to Care
• Workforce Competencies; Training	• Follow up Procedures
• Evidence-based Screening & Assessment	• Support Groups: Suicide Attempt/Suicide Loss Survivors
• Effective Interventions	• Role of Suicide Attempter/Suicide Loss Survivors in Organization
• Safety Planning; Lethal Means Restriction	• Post-vention; Attempt and Death Monitoring

Goal: *EXAMPLE: Implement CSSRS*			
Implement CSSRS as the main suicide screening tool across the entire LMHA. Make sure everyone is trained to use CSSRS accurately.			
Bench Marks: *40% trained by January 1st 2015; Used in crisis services by February 1, 2015; Used in eligibility unit by March1, 2015, etc.*			
Steps to reach goal:		**Who to complete?**	**Time/Date Completed?**
1	*Research CSSRS – length of time it takes to administer, training requirements etc. Prepare summary to give to leadership.*	*Ms. Smith*	*Complete within 2 weeks, summary by October 20th.*
2	*Get buy-in from leadership (identify who needs to know) to implement CSSRS across the site…Email/have meeting to discuss implementing CSSRS.*	*Mr. Jones – Contact key leadership within organization. Set up meeting.*	*Aim to have meeting in next 2 months.*
3	*Email all staff members (particularly intake staff) with new screening tool to use…instructions on CSSRS training…*	*Ms. Gold*	*Once leadership buy in has been successful, complete within 1 month.*

Goal:			
Bench Marks:			
Steps to reach goal:		**Who to complete?**	**Time/Date Completed?**
1			
2			
3			
4			
5			

Appendix C

Appendix C: Suicide Safe Care PDSA

PLAN – Determine the objective of the small test and plan for it.

WHY – The purpose of this change is to improve_____ by _____.

WHAT – We are planning to _____

WHEN – When will we start the plan? (date) _____

WHO – Who will initiate and monitor the plan? _____

HOW – How will we know if we are making progress toward our objective? What information will we collect?

DO – Carry out the plan and collect information about it.

End Date? _____

Was the test done as planned? ☐ No ☐ Yes

What changed? _____

Problems encountered? _____

STUDY – Analyze the information and summarize what was learned.

What feedback did we get and from whom? At what levels of the organization? What data do we have?

What lessons have we learned?

ACT/ADJUST – Reflect on what was learned and act accordingly.

What is our next step?

☐ Do another cycle (e.g., adjust, expand) ☐ Fully embed the change ☐ Discontinue (try something new)

What adjustments will we make for the next cycle?

Adapted from the Western TF-CBT Learning Collaborative; Ebert, L. NCCTS, 6/07

Appendix D

Appendix D
Form Y
Organizational Assessment for Suicide Safe Care/Zero Suicide
National Action Alliance for Suicide Prevention
Texas Version

Purpose: The purpose of this survey is to assess the organization's approach to suicide care. It is designed to be used as part of the adoption of a Zero Suicide effort in the organization. Staff involved in policy making and care for individuals at risk for suicide should complete this survey together as a team. This will likely include the organization's executive leadership, clinical managers, and suicide prevention coordinator. This survey can be used early in the launch of a Zero Suicide initiative to assess organizational strengths and needs and to develop a work plan. This survey can also be used periodically to assess progress. This survey has been adapted from the Zero Suicide Institute's Zero Suicide Toolkit. It is intended to assess the core components of the Zero Suicide framework in Texas health and behavioral health care systems. Use this as a resource to maximize impact in the journey to safer and more effective suicide safer care.

Section I: Organization Characteristics

Organization name: _____

Address: _____

Contact person: _____

E-mail address: _____

Phone number: _____

Section II: Dimensions of Suicide Safe Care

For each item, please select the most accurate description of your organization using the scale of 1-5.

1. **Developing a Leadership-driven, Safety-Oriented Culture – Suicide Safe Care Policy:** What type of formal commitment through written policies has leadership made to reduce suicide and provide suicide safe care practices among people who use the organization's services?

1	2	3	4	5
The organization has no formal policy on suicide prevention and care.	The organization has one or more formal policies that relate to suicide prevention, such as clinical risk policies, but no specific suicide safe care policy.	The organization has a formal written policy specifically addressing suicide prevention and suicide safe care. Policy addresses one or two components such as training or screening.	The organization has a formal written policy specifically addressing suicide prevention and suicide safe care. The policy addresses multiple dimensions of suicide care to include: workforce competency, identification of suicide risk, interventions tiered for risk, evidence-based treatment, follow-up during transitions.	The organization has a formal written policy specifically addressing suicide prevention and suicide safe care with all elements identified previously. Prevention of compassion fatigue is a part of the formal policy. All staff are aware that a suicide care plan and policy exist and can describe it.

2. **Developing a Leadership-driven, Safety-Oriented Culture – Staff Resources:** What type of formal commitment has leadership made through staff assignment to reduce suicide and provide suicide safe care among people who use the organization's services?

1	2	3	4	5
No staff are tasked specifically with suicide prevention practices at the organization level.	One or more staff have duties related to suicide care practices or training on suicide prevention. Responsibilities are diffuse. Staff	One or more staff are clearly tasked with leading organizational suicide prevention efforts and have authority to	A team of individuals is tasked with examining suicide prevention policies and practices. The team meets	A multi-disciplinary team is tasked with continuous quality improvement related to suicide safe care

1	2	3	4	5
	do not have the authority to change policies.	identify and recommend changes to policies and practices.	occasionally or as needed. The team does not have full authority to make policy/practice changes but can make recommendations to leadership.	practices. The team meets regularly and has the authority to make changes to policies and practices. There is a budget for suicide prevention and care training and tools.

3. Developing a Leadership-driven, Safety-Oriented Culture – Role of Suicide Attempt and Loss Survivors: What is the role of suicide attempt and loss survivors in the development and implementation of the organization's suicide care policy?

1	2	3	4	5
Suicide attempt or loss survivors are not involved in the development or implementation of suicide prevention activities within the organization.	Suicide attempt or loss survivors have informal roles within the organization, such as serving as volunteers.	The role of suicide attempt or loss survivors is limited to one specific activity, such as leading a support group.	Suicide attempt and loss survivors are part of our guidance team and provide regular input in our planning process.	Two or more suicide attempt or loss survivors participate in a variety of suicide prevention activities, such as serving on decision-making teams or boards, assist with workforce hiring and/or training, and participate in evaluation and quality improvement.

4. Suicide Screening and Risk Assessment - Systematically identifying and assessing suicide risk levels: How does the organization identify suicide risk in the people we serve?

1	2	3	4	5
There is no use of a validated suicide screening measure.	A validated screening measure is utilized at intake	A validated screening measure is utilized at intake for all individuals	A validated screening measure is utilized at intake	A validated screening measure is utilized for all

1	2	3	4	5
	for an identified subsample of individuals (e.g., crisis calls, adults only, behavioral health only)	receiving care from the organization.	and when concerns arise about risk for all individuals receiving care from the organization.	individuals at each visit when receiving care from the organization.
Name of screening instrument**:**				

5. Suicide Screening and Risk Assessment - Systematically identifying and assessing suicide risk levels: How does the organization assess suicide risk in the people served?

1	2	3	4	5
The organization has no routine procedure for risk assessments that follow the use of a suicide screen.	Providers conducting risk assessments have no specialized training and do not use a standard suicide risk assessment tool.	Providers conducting risk assessments receive specialized training. A standard suicide risk assessment is not utilized. Assessment of risk is based on clinical judgment.	A risk assessment is conducted by a trained clinician using a non-validated, locally developed tool. All clinicians in the organization routinely utilize this tool.	A comprehensive assessment of risk and protective factors is conducted by a trained staff for all individuals who screen positive for suicide risk using a validated tool. Suicide risk is reassessed or reevaluated at every visit for those at risk.
Name of risk assessment tool:				

6. Pathway to Care - Organization has a clear suicide management plan: Which best describes the organization's approach to caring for and tracking people at risk for suicide?

1	2	3	4	5
There is no formal guidance related to care for individuals at risk for suicide. Providers utilize best judgment and	Providers have some protocols or guidance for suicide care. Care plan is limited to safety planning, but it fails to	Providers have clear protocols or guidance for care management for individuals at different risk levels, including frequency	Providers have clear protocols for care management based on assessed risk and there is documented information	Individuals at risk for suicide are placed on a special suicide care management plan. Protocols for removing

1	2	3	4	5
seek consultation if needed.	address all aspects of care management.	of contact, care planning, and safety planning.	sharing and collaboration amongst all relevant providers.	someone from the pathway are clear. Suicide care management plan includes: • Use of EHR modifications to assist in identifying and preventing suicide • Specific protocols for engagement & frequency of appointments • Coordination of care within the organization for individuals of high risk

7. **Competent, Confident, and Caring Workforce – Staff Assessment:** How does the organization formally assess staff on their perception of their confidence, skills and perceived support to care for individuals at risk for suicide?

1	2	3	4	5
There is no formal assessment of staff on their perception of confidence and skills in providing suicide care.	Staff who provide direct patient care (clinicians) complete a formal assessment of confidence and skills in providing suicide care.	Assessment of perception of confidence and skills in providing suicide care is completed by <u>all</u> staff.	Assessment of perception of confidence and skills in providing suicide care is completed by <u>all</u> staff and reassessed at least every three years.	Assessment of perception of confidence and skills in providing suicide care is completed by <u>all</u> staff and reassessed at least every three years. Assessment results guide organizational changes for training and policy.

8. Competent, Confident, and Caring Workforce - Training: What basic training on identifying and managing people at risk for suicide has been provided to staff?

1	2	3	4	5
There is no organization-supported training on suicide care.	Training is available on suicide identification and care through the organization but not required of staff.	Training is available through the organization and required of selected staff (e.g., crisis staff, clinical staff)	Training on suicide identification and care is required of all organization staff. Training utilized is considered an evidence-based best practice.	Training on suicide identification and care is required of all organization staff. Training utilized is considered an evidence-based best practice. Retraining is required at least every 3 years.
Name of training curriculum:				
Minimum number of training hours required in suicide identification and care:				

9. Collaborative Safety Planning - Approach: What is the organization's approach for collaborative safety planning when an individual is at risk for suicide?

1	2	3	4	5
There is no formal protocol for safety planning.	Safety plans are required for all individuals with elevated risk, but there is no formal guidance or policy around content. Safety plan and documentation is individually developed.	Safety plans are developed for all individuals at elevated risk. Safety plans rely predominantly on formal interventions (e.g., call provider, call helpline). Safety plan does not incorporate individualization such as an individual's strengths and natural supports.	Safety plans are developed with all individuals at elevated risk and include risks and triggers and concrete coping strategies.	A safety plan is developed with each individual at elevated risk of suicide and incorporates significant others in the individual's life. The safety plan identifies risks and triggers and provides concrete strategies, prioritized from most natural to

1	2	3	4	5
		Plan quality varies significantly across providers.		most formal or restrictive. Staff utilize a standardized, evidence-based safety plan template.
Name of safety planning tool/approach:				
Frequency of safety plan review:				

10. Collaborative Safety Planning - Lethal Means Safety: What is the organization's approach to lethal means reduction identified in an individual's safety plan?

1	2	3	4	5
Safety steps are reviewed with the individual when the plan is developed. Means safety counseling is rarely documented. Organization does not provide training on counseling on access to lethal means.	Means safety is occasionally included on safety plans, but is limited to a general recommendation. Individualized planning and reducing access to means is not discussed.	Means safety is routinely included on safety plans. Family or significant others are occasionally involved. Organization provides training on counseling on access to lethal means.	Means safety is a standard component of all safety plans and families are included in means safety planning when readily available, but outreach to families is limited. Specific action is taken to reduce access to lethal means and documented.	Means safety is a standard component of all safety plans, family members are included in means safety planning. Means safety recommendations are reviewed regularly while the individual is at elevated risk. Other staff involved in care or transitions are aware of the safety steps. All staff take training on counseling on access to lethal means (CALM).

11. Effective Care Transitions: What best describes care transition approaches available in your agency?

1	2	3	4	5
The organization does not provide organized care transitions. Individuals released from inpatient settings are given follow up appointments, but little to no additional transition care is provided.	The organization has a system for providing care transitions to individuals released from the state hospital system including follow-up scheduled follow up appointments but does not have transition care established for individuals in other settings (i.e. private inpatient, respite).	The organization has policies in place to provide care transitions to individuals coming from multiple treatment settings. The policy includes a follow up appointment within seven days of discharge.	The organization has policies in place to provide care transitions to individuals coming from multiple treatment settings. The policy includes a follow up appointment within 48 hours of discharge and an appointment with a provider within seven days.	The organization has policies in place to provide care transitions to individuals coming from multiple treatment settings. The policy includes a follow up appointment within 24 hours of discharge and an appointment with a provider within seven days. The policy includes active follow up by phone and possible home visit if the individual does not come to the scheduled follow up appointment.
Care Transition provided by the organization (list all):				

12. Effective Treatment of Suicidality: What best describes the treatment/interventions specific to suicide care used for patients at risk?

1	2	3	4	5
The organization does not use a formal model for treatment for	The organization promotes evidence-based treatments for	The organization offers one or more evidence-based treatments	All individuals with suicide risk have access to evidence-based	All individuals with suicide risk have access to evidence-based

1	2	3	4	5
those at risk for suicide. Clinicians rely on experience and best judgment in treatment.	psychological disorders that increase individual's suicide risk, but do not offer specific evidence-based treatments for suicidality.	targeting suicidal thoughts and behaviors, but evidence-based treatments are not available to all individuals at risk.	treatment specific to suicide. The organization provides training in one or more evidence-based suicide treatment models. There is no assessment of treatment fidelity and outcomes.	treatment specific to suicide. The organization provides training in one or more evidence-based suicide treatment models. Fidelity to treatment and outcomes are assessed.
Suicide treatment models provided by the organization (list all):				

13. Continuing Contact and Support: What is the organization's approach to engaging hard to reach individuals or those who are transitioning in care?

1	2	3	4	5
The organization has guidelines or policies related to follow-up of individuals. There are no guidelines specific to those at elevated suicide risk.	The organization has guidelines and policies for follow up specific to individuals' suicide risk.	Organizational guidelines are directed to the individual's level of risk and address follow-up after crisis contact, non-engagement in services, and transition from ER or psychiatric hospitalization.	Organizational guidelines are directed to the individual's level of risk and address follow-up after crisis contact, non-engagement in services, and transition from ER or psychiatric hospitalization. Follow-up for high risk individuals includes active distance outreach, such as letters, phone calls, or emails.	Organizational guidelines are directed to the individual's level of risk and address follow-up after crisis contact, non-engagement in services, and transition from ER or psychiatric hospitalization. Follow-up for high risk individuals includes home or community visits when necessary. Organization works closely with community

1	2	3	4	5
				providers to conduct warm handoffs when individual transition in care.
Please list follow-up strategies identified in guidelines or policies:				

14. Support for Attempt Survivors: What access is available for support for attempt survivors?

1	2	3	4	5
The organization does not have formal strategies for the provision of support to attempt survivors.	The organization provides either individual support to attempt survivors and their families through peer services or group support for attempt survivors. The offered service is informal and does not follow an evidence-based approach.	The organization provides either individual support to attempt survivors and their families through peer services or group support for attempt survivors. Peers receive training in suicide prevention for individual support or use an evidence-supported curriculum for support groups.	The organization provides both individual support to attempt survivors and their families through peer services and group support for attempt survivors. These services are informal and do not follow an evidence-based approach.	The organization provides both individual support to attempt survivors and their families through peer services and group support for attempt survivors. Peers receive training in suicide prevention and use an evidence-supported curriculum for support groups.
Attempt Survivor Group Curriculum:				

15. Organizational Review of Deaths by Suicide: What policies are in place to examine organizational issues following a death by suicide?

1	2	3	4	5
Information is not regularly collected on deaths by suicide of individuals in care	Information on deaths by suicide is collected by the organization but	One or more staff members are assigned to review care following a death by suicide	A multi-disciplinary team is responsible for reviewing suicide deaths of	A multi-disciplinary team is responsible for reviewing suicide deaths of

1	2	3	4	5
or transitioning to care.	there is no formal policy for review.	and provide documentation regarding opportunities for quality improvement.	individuals in care or transitioning to care. The review focuses on opportunities for quality improvement with suicide safe care. No policies to protect the confidentiality of providers are in place.	individuals in care or transitioning to care. The review focuses on opportunities for quality improvement with suicide safer care. Policies are in place to ensure the confidentiality of care professionals. Action is taken, as needed, to improve the system based on this root cause analysis.

16. Use of Caring Contacts: Which best describes your agencies use of caring contacts as a form of communication and evidence-based practice?

1	2	3	4	5
The agency does not use caring contacts as a way of reaching out to individuals served.	The agency uses caring contacts but does not have specific requirements or policies regarding their use.	Caring contacts are used at the agency at the time of transitions in care. There is a policy in place regarding the use of caring contacts at transition points.	Caring contacts are used at multiple points in service delivery. These may include care transitions, discharge from services, and after a crisis contact. Agency policies are in place to formalize the use of caring contacts.	Caring contacts are used at multiple points in service delivery. These may include care transitions, discharge from services, and after a crisis contact. Caring contacts are also used to engage individuals in services. Agency policies are in place to formalize the use of caring contacts. The agency uses a variety of caring

1	2	3	4	5
				contacts including phone calls and letters/postcards, per the individual's preference, if stated.

17. Additional information: Please include below any additional information regarding the organizations suicide care approach or zero suicide model implementation not already addressed:

_____
_____
_____
_____

Appendix E

Appendix E

ZERO SUICIDE WORKFORCE SURVEY

The Zero Suicide Workforce Survey is a tool to assess staff knowledge, practices, and confidence.

This survey is part of our organizational mission to adopt a system-wide approach to caring for individuals who are at risk for suicide. Recognizing that variability exists in staff education and experience treating people at risk for suicide, we intend to use the results of this survey to help determine the training needs of our staff.

All responses are anonymous. Please answer honestly so that we can best serve both our staff and individuals in our care. Be thoughtful about your answers even if you do not work directly with individuals served by our organization. We believe that suicide prevention is a shared responsibility among everyone in our organization. Unless otherwise indicated, please mark only one answer. **It is anticipated that it will take you 10-15 minutes to complete this survey.** By answering this survey, you give your consent to participate; however, you may terminate your participation at any time.

We thank you in advance for your participation and for your dedication to this important issue!

Section 1. Your Work Environment

Thank you for participating in this survey. In the first series of questions we would like to learn more about your work environment and your role within that environment.

1. In which of the following settings do you work? [Required Item – used later for branching]
   ☐ Inpatient setting ☐ Outpatient setting ☐ Both

2. Please indicate your Department/Unit from the following list. [Customized to each organization]

2a. Is this your first time taking part in the Zero Suicide Workforce Survey at your current organization? (choose one)
   ☐ No ☐ Yes

3. Please choose the one category below that ***best*** describes your primary professional role. (choose one)
   ☐ Management (Administrators, Supervisors, Managers, Coordinators)
   ☐ Business, Administrative, and Clerical (Accounting, Reception, Human Resources, Billing, Records, Information Technology)
   ☐ Facility Operations (Dietary, Housekeeping, Maintenance, Security, Transportation)
   ☐ Behavioral Health Clinician (Counselor, Social Worker, Substance Abuse Counselor, Therapist, Psychologist)
   ☐ Adjunct Therapist (Activity, Occupational, Physical, Rehabilitation)
   ☐ Case Management
   ☐ Crisis Services
   ☐ Physical Health Care/Medication Management (Physician, Nurse Practitioner, Physician's Assistant)
   ☐ Nursing (Nurse, Registered Nurse)
   ☐ Psychiatry (Psychiatrist, Psychiatric Nurse Practitioner)
   ☐ Technician (Mental Health Technician, Behavioral Technician, Patient Care Assistance, Residential Technician)
   ☐ Patient Observer
   ☐ Support and Outreach (Outreach, Faith, Family Support, Peer Support)
   ☐ Education (Teacher, Health Educator)

4. As part of this role, do you *directly interact with individuals who may be at risk for suicide* either in person or from a distance during your day-to-day duties within the organization? This includes things such as answering phones, scheduling appointments, conducting check-ins, and providing caregiving and/or clinical services. [Required Item]
   ☐ No ☐ Yes

Please indicate how much you disagree or agree with each of the following statements. [Only for Inpatient]

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
5. I know the organizational protocols for ensuring a safe physical environment for individuals at risk for suicide (including safety precautions around entry, visitors, individuals' belongings, and physical structures in the facility).	☐	☐	☐	☐	☐
6. I know what to do when I have concerns about potential means for suicide in the physical environment in our facility.	☐	☐	☐	☐	☐

Section 2. Suicide Prevention within Your Work Environment

The next series of questions ask you to reflect on suicide prevention within your work environment.

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
7. I am familiar with the "Zero Suicide" initiative.	☐	☐	☐	☐	☐
8. I understand my role and responsibilities related to suicide prevention within this organization.	☐	☐	☐	☐	☐
9. I believe suicide prevention is an important part of my professional role.	☐	☐	☐	☐	☐
10. The leadership at this organization has explicitly indicated that suicide prevention is a priority.	☐	☐	☐	☐	☐
11. This organization has clear policies and procedures in place that define each employee's role in preventing suicide.	☐	☐	☐	☐	☐
12. I have received training at this organization related to suicide prevention.	☐	☐	☐	☐	☐
13. This organization provides me access to ongoing support and resources to further my understanding of suicide prevention.	☐	☐	☐	☐	☐
14. I feel that my organization would be responsive to issues that I bring up related to the safety of individuals at risk for suicide.	☐	☐	☐	☐	☐

15. While working at this organization, I have directly or indirectly interacted with an individual who ended their life by suicide. [Required Item]

☐ Yes, it has happened once ☐ Yes, it has happened more than once ☐ No ☐ I Don't Know

Please indicate how much you disagree or agree with each of the following statements. [Only if Yes to #15]

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
16. I felt supported by this organization when a suicide occurred.	☐	☐	☐	☐	☐
17. I felt blamed when an individual died by suicide.	☐	☐	☐	☐	☐
18. This organization has practices in place to support staff when a suicide occurs.	☐	☐	☐	☐	☐

Section 3. Recognizing When Individuals May Be at Risk for Suicide

We are interested in learning about your knowledge and comfort related to recognizing when an individual may be at elevated risk for suicide.

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
19. I have the knowledge and training needed to *recognize* when an individual may be at elevated risk for suicide.	☐	☐	☐	☐	☐
20. I am knowledgeable about warning signs for suicide.	☐	☐	☐	☐	☐
21. I know what organizational procedures to follow when I suspect that an individual may be at elevated risk for suicide.	☐	☐	☐	☐	☐
22. I am confident in my ability to respond when I suspect an individual may be at elevated risk for suicide.	☐	☐	☐	☐	☐
23. I am comfortable asking individuals direct and open questions about suicidal thoughts and behaviors.	☐	☐	☐	☐	☐

24. Have you ever received training on how to *recognize* the warning signs that an individual may be at elevated risk for suicide?..... ☐ No [sent to #26] ☐ Yes [sent to #25] [Required Item]

25. Has your current organization provided you with training on how to *recognize* the warning signs that an individual may be at elevated risk for suicide?..... ☐ No ☐ Yes

Section 4. Screening and Assessing Individuals for Suicide Risk [Only Those Who Interact with Individuals in care Q4. All Other Respondents Are Sent to #66]

These next questions are about screening individuals who may be at elevated risk for suicide.

26. You indicated earlier that you directly interact with individuals who may be at risk for suicide either in person or from a distance during your day-to-day duties within the organization. Which of the following groups do you *primarily* work with?
☐ Children ☐ Adolescents ☐ Adults ☐ Elderly

27. Are you responsible for conducting *screenings* for suicide risk? ..... ☐ No [sent to #32] ☐ Yes [sent to #28] [Req]

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
28. I have the knowledge and skills needed to screen individuals for suicide risk.	☐	☐	☐	☐	☐
29. I know our organizational procedures for screening individuals for suicide risk.	☐	☐	☐	☐	☐
30. I am confident in my ability to screen individuals for suicide risk.	☐	☐	☐	☐	☐
31. I am comfortable screening individuals for suicide risk.	☐	☐	☐	☐	☐

Individuals who screen positive for suicide risk should be assessed to inform clinical decision making. This is sometimes referred to as a suicide risk assessment.

32. Are you responsible for conducting *suicide risk assessments* for individuals who screen positive for suicide risk? ☐ No [sent to #42] ☐ Yes [sent to #33] [Required Item]

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
33. I have the knowledge and skills needed to conduct a suicide risk assessment.	☐	☐	☐	☐	☐
34. I am knowledgeable about risk factors for suicide.	☐	☐	☐	☐	☐
35. I obtain information about risk and protective factors when conducting suicide risk assessments.	☐	☐	☐	☐	☐
36. I assess the individual's access to lethal means as part of a suicide risk assessment.	☐	☐	☐	☐	☐
37. I assess the individual's suicide plans and intentions as part of a suicide risk assessment.	☐	☐	☐	☐	☐
38. I know what organizational procedures exist regarding suicide risk assessments.	☐	☐	☐	☐	☐
39. I am confident in my ability to conduct a suicide risk assessment.	☐	☐	☐	☐	☐
40. I am comfortable conducting a suicide risk assessment.	☐	☐	☐	☐	☐
41. I know the clinical workflow to follow when a suicide risk assessment indicates the individual needs additional clinical care.	☐	☐	☐	☐	☐

Section 5. Training on Screening and Risk Assessment

These next questions are about any training you may have received on screening and suicide risk assessment – even if this is not part of your current professional duties.

42. Have you ever received training on conducting suicide screenings or conducting suicide risk assessments? .....☐ No [sent to #45] ☐ Yes [sent to #43] [Required Item]

43. Has your current organization provided you with training on conducting suicide screenings or conducting suicide risk assessments?..... ☐ No ☐ Yes

44. Which of the following trainings, if any, have you taken on *screening* or *suicide risk assessment*? (select all that apply)
    - ☐ AMSR (Assessing and Managing Suicide Risk)
    - ☐ CASE Approach (Chronological Assessment of Suicide Events)
    - ☐ Commitment to Living
    - ☐ Columbia Suicide Severity Rating Scale (C-SSRS)
    - ☐ QPRT Suicide Risk Assessment and Management Training (not basic QPR training)
    - ☐ RRSR (Recognizing and Responding to Suicide Risk)
    - ☐ suicide to Hope
    - ☐ An inservice or webinar training at my organization
    - ☐ An inservice or webinar training at a former organization
    - ☐ A different training on *screening* or *suicide risk assessment* (please specify): _____

45. Do you use a standard tool, assessment instrument, or rubric for suicide screening or risk assessment?
    ☐ No [sent to #47] ☐ Yes [sent to #46] [Required Item]

46. Which of the following tools, screening and assessment instruments, or rubrics, if any, do you use? (select all that apply)
    - ☐ Asking Suicide-Screening Questions (ASQ)
    - ☐ Beck's Suicide Intent Scale (SIS)
    - ☐ Columbia Suicide Severity Rating Scale (C-SSRS)
    - ☐ National Suicide Lifeline Risk Assessment Standards
    - ☐ PHQ-3
    - ☐ PHQ-9
    - ☐ Risk Assessment Matrix (RAM)
    - ☐ Risk of Suicide Questionnaire (RSQ)
    - ☐ Risk Formulation with Risk Status and Risk State
    - ☐ SAFE-T
    - ☐ suicide to Hope
    - ☐ Suicide Ideation Questionnaire (SIQ or SIQ-JR)
    - ☐ A tool, instrument, or rubric developed by my organization
    - ☐ A different tool, instrument, or rubric (please specify): _____

Section 6. Providing Care to Individuals at Risk

These questions are for staff responsible for providing care to individuals determined to be at elevated risk for suicide.

47. Do you provide direct care to individuals who have been identified as being at elevated risk for suicide based on their risk assessment?
☐ No [sent to #52] ☐ Yes [sent to #48] [Required Item]

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
48. I have the knowledge and skills needed to provide care to individuals who have been identified as being at elevated risk for suicide.	☐	☐	☐	☐	☐
49. I am familiar with the clinical workflows at this organization related to things such as safety planning, access to lethal means, documentation, and other procedures for caring for individuals at elevated risk of suicide.	☐	☐	☐	☐	☐
50. I am confident in my ability to provide care to individuals who have been identified as being at elevated risk for suicide.	☐	☐	☐	☐	☐
51. I am comfortable providing care to individuals who have been identified as being at elevated risk for suicide.	☐	☐	☐	☐	☐

52. Have you taken a *Safety Planning Intervention for Suicide Prevention* training?
☐ No ☐ Yes

53. Have you taken the *Counseling on Access to Lethal Means* (CALM) course either online or in person?
☐ No ☐ Yes

Section 7. Use of Evidence-Based Treatments That Directly Target Suicidality

These questions are for individuals who deliver *clinical treatment* (e.g. CAMS, CBT-SP, DBT) to individuals identified as being at elevated risk for suicide.

54. Do you deliver clinical treatment (e.g. CAMS, CBT-SP, DBT) to individuals who have been identified as being at elevated risk for suicide?
☐ No [sent to #59] ☐ Yes [sent to #55] [Required Item]

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
55. I have received training on suicide-specific evidence-based treatment approaches (e.g. CAMS, CBT-SP, DBT).	☐	☐	☐	☐	☐
56. I am confident in my ability to provide treatment to individuals with suicidal thoughts or behaviors.	☐	☐	☐	☐	☐
57. I am comfortable providing treatment to individuals with suicidal thoughts or behaviors.	☐	☐	☐	☐	☐

58. In which of the following suicide-specific evidence-based treatment approaches, if any, have you received training? (select all that apply)
☐ CAMS (Collaborative Assessment and Management of Suicide)
☐ CBT-SP (Cognitive Behavior Therapy for Suicide Prevention)
☐ DBT (Dialectical Behavior Therapy)
☐ Another training (please specify): _____

Section 8. Care Transitions

These questions are for individuals responsible for ensuring that individuals identified as being at elevated risk for suicide are supported during transitions in care.

For the following questions, ***transitions in care*** include safely discharging and/or transitioning individuals following acute care admissions or changes in care.

59. Are you responsible for ensuring safe care transitions for individuals who have been identified as being at elevated risk for suicide? .....☐ No [sent to #66] ☐ Yes [sent to #60] [Required Item]

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
60. I have the knowledge and skills needed to work with individuals during their transitions in care.	☐	☐	☐	☐	☐
61. I am familiar with organizational procedures for working with individuals during their transitions in care.	☐	☐	☐	☐	☐
62. I am confident in my ability to work with individuals during their transitions in care.	☐	☐	☐	☐	☐
63. I am confident in my ability to work with family members or other support persons who may be involved during an individual's transitions in care.	☐	☐	☐	☐	☐
64. I am familiar with organizational procedures for ensuring that individuals' health information is shared during an individual's transitions in care.	☐	☐	☐	☐	☐
65. I am comfortable working with individuals during their transitions in care.	☐	☐	☐	☐	☐

Section 9. Training and Resource Needs

Staff members should have the necessary skills, appropriate to their role, to provide care and feel confident in their ability to provide caring and effective assistance to individuals with suicide risk.

66. In which of the following areas, if any, would you like more training, resources, or support? (select all that apply)

- ☐ Suicide prevention and awareness
- ☐ Epidemiology and the latest research findings related to suicide
- ☐ Identifying warning signs for suicide
- ☐ Communicating about suicide
- ☐ Suicide screening practices
- ☐ Identifying risk factors for suicide
- ☐ Suicide risk assessment practices
- ☐ Determining appropriate levels of care for individuals at risk for suicide
- ☐ Crisis response procedures and de-escalation techniques
- ☐ Supporting the care of individuals at risk for suicide
- ☐ Collaborative safety planning for suicide
- ☐ Suicide-specific treatment approaches
- ☐ Aftercare and follow-up
- ☐ Family, caregiver, and community supports
- ☐ Procedures for communicating about individuals who may be at risk for suicide
- ☐ Understanding and navigating ethical and legal considerations
- ☐ Policies and procedures within your work environment
- ☐ Staff roles and responsibilities within your work environment
- ☐ Reducing access to lethal means outside the care environment
- ☐ Creating a safe physical environment for individuals at risk for suicide

Appendix F-1

Current Status: *Active* **PolicyStat ID:** *8448701*

Origination:	*01/2019*
Effective:	*10/2020*
Last Approved:	*10/2020*
Last Revised:	*10/2020*
Next Review:	*10/2021*
Owner:	*Grace White: Chief Nursing Officer*
Area:	*Medical and Nursing Services*
References:	*Board Policy C.2.a, CCBHC Certification Criteria*

Zero Suicide

I. Purpose:

MHMR operating procedure to describe the process for screening people for suicide risk, completing a crisis/ safety plan for those identified as non-high suicide risk, and completing the Suicide Safe Care Pathway for those identified as high suicide risk.

II. Scope:

All MHMR Behavioral Health (BH) Division outpatient services.

III. Responsibility:

All MHMR BH Division staff: Wellness Navigator, Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Licensed Professional Counselors (LPC), Licensed Professional of the Healing Arts (LPHA), Licensed Vocational Nurse (LVN), Medical Assistant (MA), Prescriber, Qualified Mental Health Professionals (QMHP), and Registered Nurse (RN).

IV. Overview:

A. Columbia-Suicide Severity Rating Scale Screener

B. Non-High Risk

C. High Risk

V. Procedure:

A. Columbia-Suicide Severity Rating Scale Screener

1. The person is assessed by trained staff using the Columbia-Suicide Severity Rating Scale (C-SSRS Screener) in the electronic health record (EHR) at every visit.
    a. The C-SSRS Screener calculates a total score. A total score of six or higher indicates need for additional screening.
    b. Additional screening will be completed face-to-face by a Qualified Mental Health Professional (QMHP) or person of higher license. QMHP or other licensed staff will determine whether the person is High Risk based on patient history, presenting issues, and clinical judgment and document on a

progress note in the EHR. QMHP or other licensed staff may use the iCare Crisis Assessment in the EHR to help guide the determination.

c. A safety/crisis plan is required for any total score of six or higher regardless of whether the face-to-face additional screening deems them High Risk.

d. For people who score less than six on the C-SSRS screener, the trained staff will document this in the EHR, and no additional follow-up is needed.

B. Non-High Risk

1. If the person is determined not to be High Risk for suicide or suicidal behavior during their face-to-face additional screening for, they will not be referred to the Suicide Safe Care Pathway.
   a. A Safety/Crisis Plan will be completed with the person/legally authorized representative (LAR) and documented in the EHR.
   b. A clinician will follow up with the person/LAR within seven days to reassess for risk using the C-SSRS Screener.
   c. Documentation of completion of the C-SSRS screener, the safety planning process, and follow-up plans made will be completed on a progress note in the EHR with the appropriate clinical quality indicators selected.

C. High Risk

1. If the person is determined to be High Risk for suicide or suicidal behavior, they will be referred to the Suicide Safe Care Pathway.
   a. The Suicide Safe Care Pathway protocol will be explained to the person/LAR. The QMHP or other licensed staff will document the person/LAR response to the protocol, either voluntarily cooperating with the protocol, or refusing the protocol services, in the EHR.
   b. A safety/crisis plan will be completed with the person/LAR and documented in the EHR.
   c. The QMHP or other licensed staff will counsel the person/LAR on reducing access to lethal means using the Counseling on Access to Lethal Means (CALM) method. A family member or collateral should check-in the same day ensure that access is reduced.
   d. If the person/LAR agrees to the Suicide Safe Care Pathway, the QMHP or other licensed staff will schedule a face-to-face engagement within seven days and will contact the person/LAR by phone at least every three days.
   e. Referrals should be made to appropriate services, including Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Assertive Community Treatment (ACT), Wraparound, or Peer Support services.
   f. The QMHP or other licensed staff will screen for suicidal ideation or behaviors using the C-SSRS Screener upon every contact.
   g. The safety/crisis plan will be reviewed upon every contact in the EHR.
   h. If the person misses a scheduled appointment, the QMHP or other licensed staff should attempt telephone contact immediately.
   i. If telephone contact cannot be made with the person/LAR, emergency contact should be attempted. If emergency contact cannot be made, the provider or case manager should attempt face-to-face

contact.

j. If face-to-face contact cannot be made, the QMHP or other licensed staff should follow crisis intervention protocols and request a wellness check from the appropriate police department.

k. The person in services who is on the Suicide Safe Care Pathway will stay on the Pathway until the following criteria have been met:

   i. Two consecutive C-SSRS Screener assessments at low risk.

   ii. Fewer than two crisis contacts within the past two months, and;

   iii. No recent hospital discharge due to suicidal ideation or behavior within the past three months; OR

2. Documentation of completion of the C-SSRS screener, the safety planning process, and follow-up plans made will be completed on a progress note in the EHR with the appropriate clinical quality indicators selected.

3. If the person/LAR does not consent to the Suicide Safe Care Pathway or requests to be removed from the Pathway, the provider or case manager will follow the procedure for suicidal clients by facilitating the appropriate intervention on the person's behalf. This may involve contacting 911, an on-call clinician, or the person's doctor or treatment team. Additionally, staff may, with the person/LAR's permission, involve family members or other support systems.

VI. Definitions:

- ACT: Assertive Community Treatment
- CALM: Counseling Access to Lethal Means
- CAMS: Collaborative Assessment & Management of Suicidality
- CBT: Cognitive Behavioral Therapy
- C-SSRS Screener: Columbia Suicide Severity Rating Scale Screener
- DBT: Dialectical Behavior Therapy
- Emergent/High Risk: Individual scores a 6 or greater on C-SSRS Screener and assesses to high risk during additional face-to-face screening. Emergency services should be contacted if suicidal individual/ LAR are unable or unwilling to complete crisis/safety plan.
- LAR: Legally Authorized Representative
- QMHP: Qualified Mental Health Professional.

VII. References:

- CARF Manual 2019, Screening and Access to Services
- MHMR Operating Procedure Youth Suicide Risk Assessment
- Texas Suicide Prevention, https://texassuicideprevention.org
- The Action Alliance, https://theactionalliance.org
- Zero Suicide in Health and Behavioral Health Care, https://www.zerosuicide.sprc.org

Attachments

No Attachments

Approval Signatures

Approver	Date
Catherine Carlton: Chief of Staff	10/2020
Stacey Durr: Managing Director of Serv	10/2020
Haley Hettinger: Service Excellence Projec	09/2020
Ramey Heddins: Chief of Behavioral Healt	09/2020
Grace White: Chief Nursing Officer	09/2020
Janet Davis: Director of Electronic He	08/2020
Megan Wilcox: Service Excellence Operat	08/2020
Joshua Wheeler: Practice Imp & Consult Pr	08/2020

Appendix F-2

Current Status: *Active* **PolicyStat ID:** *8840398*

Denton County MHMR Center

Origination:	*2/24/2015*
Effective:	*12/31/2019*
Last Approved:	*12/31/2019*
Last Revised:	*12/31/2019*
Next Review:	*12/30/2020*
Owner:	*Meena Vyas: Medical Director*
Area:	*Section 03 - Consumer Service System*
References:	

3.705 Suicide Safe Care Center

I. PURPOSE:

To outline procedures for providing suicide prevention and suicide safe care to all clients of Denton County MHMR Center (DCMHMR) in line with national best practices to promote life.

II. SCOPE:

This procedure is applicable to all DCMHMR employees

III. PROCEDURE:

A. WORKFORCE COMPETENCY:

1. Denton County MHMR Center shall have a workforce competent in the recognition of and provision of suicide care. All staff will be provided ASIST training and a booster training may be required every 3 years.
2. Staff working directly with individuals in a clinical capacity will be required to take a basic crisis training course during which they will learn how to conduct a basic triage or screening, including the Columbia Suicide Severity Rating-Scale (C-SSRS) to know whether or not a full assessment is needed. This basic crisis training will also include training on safety planning using the Barbara Stanley Safety Planning Intervention.
3. Staff working in a capacity to complete full assessments will be required to take advanced crisis training to learn about full risk of harm assessments and least restrictive environment (LRE), and safety planning.
4. Any staff member working with potentially suicidal individuals in a case management setting will take case management of suicidal clients which will incorporate the philosophy of Collaborative Assessment and Management of Suicidality (CAMS).

B. IDENTIFICATION OF RISK:

1. Staff will use the Triage form (incorporating the C-SSRS since last visit) and decision tree to identify risk in the following situations:
   a. When the client scores a 2 or a 3 on the Adult Needs and Strengths Assessment (ANSA) or Child and Adolescent Needs and Strengths Assessment (CANS) on the suicidal ideation questions.

b. When the individual presents for an appointment and begins to report "at risk" behavior or concerns such as suicidal ideations, homicidal ideations, increased psychosis, manic symptoms, going off medications suddenly, a sudden significant stressor, or other clinically indicated situation/symptom.

2. Staff will work with the individual to gather all of the information on the triage form. Once the information is gathered. Staff will use the decision tree to determine a risk level of moderate or high.

C. INTERVENTIONS:

1. Individuals determined by staff to be at moderate risk will be referred to these clinically appropriate interventions: Safety planning including means restriction as needed, walk-in with med clinic for medication intervention, Applied Suicide Intervention Skills Training (ASIST) interventions, increased case management visits including CAMS interventions when appropriate, changes in level of care, and/or referrals to other outside agencies as needed.
2. Individuals determined to be at high risk will:
   a. be referred to the crisis team either Mobile Crisis Outreach Team (MCOT) or the psych triage facility for a full risk of harm assessment,
   b. Case managers will call the MCOT triage phone for other options.
   c. be assessed for risk of harm by case managers
   d. be referred to inpatient treatment if the individual has private insurance and wants to go inpatient.
   e. Staff will not leave the individual alone while transition between providers or to another level of care is being arranged.

D. FOLLOW UP DURING TRANSITIONS:

1. Denton County MHMR Center staff will make every effort to follow up with all individuals hospitalized in an inpatient psychiatric facility on the day of discharge or the next business day for aftercare.
2. If an individual is on contracted bed days, or is at the state hospital, the individual reports to Denton County MHMR Center for aftercare if they are discharged during business hours. If discharged after business hours or on the weekend, an appointment will be schedule for the next business day. Individuals known to have discharged on weekends will receive phone follow ups or face to face as needed by MCOT.
3. Staff will schedule an appointment to see the client for another appointment within 7 business days of the discharge from the hospital to follow up and ensure the client is receiving the appropriate level of care. The client's safety plan will be reviewed, and client's suicidal ideations will be assessed using the since last visit C-SSRS. At this appointment, the schedule for further follow up will be set based on client need. At least weekly face to face appointments will be kept with the individual as long as he/she is considered to be at elevated risk.
4. A client discharged from the Crisis Residential Unit (CRU) will receive a follow up with his/her case manager within 2 business days of the discharge from CRU. At this appointment, the case manager will ensure the client is receiving the appropriate level of care. The client's safety plan will be reviewed, and client's suicidal ideations will be assessed (using the C-SSRS since last visit). Staff will schedule the next appointment within 7 business days.
5. At the 7 day follow up, the case manager will review the crisis plan, assess suicidal ideations and schedule further follow up based on client need. Clients will be seen at least weekly as long as they

are determined to be at elevated risk.

6. If a client does not attend his/her appointments case management appointments, staff will immediately attempt to contact the client to reschedule the appointment.

E. COMPASSION FATIGUE:

1. All clinical staff are required to take the Center's self-care training.
2. All staff are encouraged to consult with their immediate supervisor and take personal time off (PTO) anytime he/she is struggling with burn out.
3. All staff are encouraged to debrief with their immediate supervisor following a difficult assessment/ situation for additional support.
4. Following all suicide deaths of current or past individuals served, staff members, or staff family members, a Critical Incident Stress Management (CISM) trained debriefing team of 2-3 staff members will form to meet with all effected staff to debrief the incident within 48 business hours of being informed of the incident. The group will meet again after 2 weeks to debrief again and discuss lessons learned as appropriate to the situation.
    a. The debriefing team members will always be those not directly associated with the staff member or individual who has passed away (i.e. if the individual is being served in crisis services the debriefing team will be from regular services and if the individual is from regular services the debriefing team will be made up with staff from crisis services.)
5. Debriefing team staff will follow up individually with providers as needed and will offer resources to outside agencies or providers as needed.
6. Administrators are available any time for consultation or assistance.
7. All Administers or their designees will discuss self-care and compassion fatigue in their team meetings and provide suggestions for monitoring and engaging in self-care.
8. Staff will be encouraged to download and use the provider resiliency app available for Apple and Android to monitor compassion fatigue.

Attachments

No Attachments

Appendix G

Appendix G: COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screening Version – Since Last Visit

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Since Last Visit**	
Ask questions that are bold and <u>underlined</u>	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***<u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***<u>Have you actually had any thoughts of killing yourself?</u>***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***<u>Have you been thinking about how you might do this?</u>***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u>, as opposed to "*I have the thoughts but I definitely will not do anything about them*." ***<u>Have you had these thoughts and had some intention of acting on them?</u>***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***<u>Have you started to work out or worked out the details of how to kill yourself and did you intend to carry out this plan?</u>***		
6) Suicide Behavior ***<u>Have you done anything, started to do anything, or prepared to do anything to end your life?</u>*** Examples: 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; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

Appendix H

Appendix H

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Lifetime Recent

Version 1/14/09 m9/12/17 m5/3/21

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Definitions of behavioral suicidal events in this scale are based on those used in ***The Columbia Suicide History Form****, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.]* Standardized Evaluation in Clinical Practice*, pp. 103 -130, 2003.)*

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact posnerk@nyspi.columbia.edu

SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

	Lifetime: Time He/She Felt Most Suicidal	Past 1 month
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/die by suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."* ***Have you been thinking about how you might do this?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u>, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐

INTENSITY OF IDEATION

	Most Severe	Most Severe
The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal. <u>Lifetime</u> - ***Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation*** <u>Recent</u> - ***Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation***		
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____	____
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	____	____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** *(*Self-Injurious Behavior without suicidal intent) If yes, describe:	**Yes** ☐ **No** ☐ Total # of Attempts _____	**Yes** ☐ **No** ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of interrupted _____	**Yes** ☐ **No** ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of preparatory acts _____	**Yes** ☐ **No** ☐ Total # of preparatory acts _____

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

Appendix I

Appendix I: Risk Assessment Observation Form

Trainee name	
Trainer name	
Assessment #	
Ct #	

Proficiency with EHR:

Registering Cts/finding active Cts	
Assigning programs	
Finding risk assessment note	
Saving/signing	
PDF forms	
Scanning documents	

Interviewing:

Tone/ rapport building	
Speed	
Flow with partner (if applicable)	
Ability/effort made to obtain info, explain /rephrase, define symptoms	
Use of CASE approach	

Collaborative Approach/Teamwork (if applicable):

During least restrictive environment decision making	
During staffing with supervisor (if applicable)	
During completion of additional risk assessment tasks	

Communication:

With partner (if applicable)	
With collaterals	
Professionalism	

Intangibles:

Sense of urgency before and during assessment	
Overall understanding of and proficiency in carrying out recommendations	

Safety Planning:

Explanation of purpose and each section of safety plan	
Collaborative approach with individual served	
Individualized coping skills and contacts	
Discussion of barriers and use of plan	

Additional Risk Assessment tasks:

C-SSRS filled out correctly? • Can differentiate between question 1 and question 2? • Can differentiate between all the various suicide behaviors?	
Ability to upload other paperwork correctly (if applicable)	
Completing TRR assessment accurately	

Screening Documentation:

Presenting Problem includes all of the following info (place checkmarks in left column)	
	Ct's rights were given orally before the screening
	Location
	How they got there
	Referring party info
	Reason why MCOT is called
	Insurance status
	If in hospital medical clearance status
	If applicable, UA/breathalyzer info
	If applicable, LAR consent
	If applicable, collateral present
	If applicable, translator info

Mood (place check mark in left column if covered, comment on missing info in right column)		
	Depressed	
	Anxiety	
	Irritability	
	Anger	
	Mania	
	Drastic mood changes	
	Guilt	
	Self-Esteem	
	Purposelessness	
	Trapped	
	Hopelessness	
	Withdrawn	
	Reckless behavior	
	Appetite	
	Sleep	
	Ct denies all other mood sx and risk factors	

Thought/Content/Perceptions (place check mark in left column if covered, comment on missing info in right column)		
	Command hallucinations	
	Other auditory hallucinations	
	Visual hallucinations	
	Tactile hallucinations	
	Olfactory/gustatory hallucinations	
	Paranoia	
	Other delusional thinking	
	Grandiose	
	Disorganized/ flight of ideas	
	Bizarre behaviors, complaints, speech	
	Ct denied all other hallucinations and disturbed thinking	

Substance use (place check mark in left column if covered, comment on missing info in right column)		
	Were all substances covered?	
	Was most recent episode onset, frequency, and duration of use covered?	
	Was hx of SA tx covered?	

Ct experienced abuse/neglect (place check mark in left column if covered, comment on missing info in right column)		
	Childhood abuse (who, when, how long, reported? treated?)	
	Trauma in adulthood (who, when, how long, reported? treated?	

MH tx hx (place check mark in left column if covered, comment on missing info in right column)		
	Previous/current MH dx	
	Current providers	
	Hx of MH hospitalizations	
	Family Hx of MI	
	Family/friend hx of suicides	

Social hx (place check mark in left column if covered, comment on missing info in right column)		
	Age, gender, race, marital status	
	Living arrangement	
	Support system	
	Employment/education	
	Financial status/receiving any social aid?	
	Insurance status	
	Transportation needs	
	Legal issues	
	Current stressors	
	LGBTQ/identity issues	

Health (place check mark in left column if covered, comment on missing info in right column)		
	Chronic health issues	
	Current health issues effecting MH	

Medications (place check mark in left column if covered, comment on missing info in right column)		
	List all psych and medical meds	

Suicidality/ Risk of Harm (ROH) (place check mark in left column if covered, comment on missing info in right column)		
	Thoughts of Death/going to sleep and not waking up	
	Suicidal thoughts	
	Methods considered	
	Controllability	
	Deterrents	
	Actual attempts	
	Interrupted attempts	
	Aborted attempts	
	Preparatory acts	
	Self harm behavior	
	Access to guns	

Physical/sexual aggression and HI (place check mark in left column if covered, comment on missing info in right column)		
	HI	
	Hx of assault	
	Hx of physical/sexual aggression	

Recommendations (place check mark in left column if covered, comment on missing info in right column)		
	Info from Collateral	
	Risk of Harm	
	Support system available	
	Safety plan	
	Other risk factors/protective factors	
	Willingness to participate in treatment	
	Current level of care	

Disposition (place check mark in left column if covered, comment on missing info in right column)		
	Supervisor opinion in applicable	
	Who was informed of recommendations and their response?	
	How least restrictive environment was carried out?	
	Hospitalization info?	
	Safety plan signed?	
	Means safety?	
	Any consents?	
	Transportation after screening	
	Follow-up info (date, time, location)	
	Any recommendations for ongoing	

	treatment?	
	CPS reports info	

Strengths!!!

Needed areas of improvement	Training, info, support offered for improvement

Appendix J

Appendix J: Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Place _____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name _____ Phone _____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name _____ Phone _____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services _____
   Urgent Care Services Address _____
   Urgent Care Services Phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

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

_____

Appendix K

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

Appendix K

National Action Alliance for Suicide Prevention
Lethal Means Stakeholder Group

LETHAL MEANS & SUICIDE PREVENTION:

A Guide for Community & Industry Leaders

This document advances Goal 6 of the *National Strategy for Suicide Prevention (National Strategy)*: Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk. To download a copy of the *National Strategy*, visit https://theactionalliance.org/our-strategy.

Suggested Citation: National Action Alliance for Suicide Prevention, Lethal Means Stakeholder Group. (2020). *Lethal means & suicide prevention: A guide for community & industry leaders.* Washington, DC: Education Development Center.

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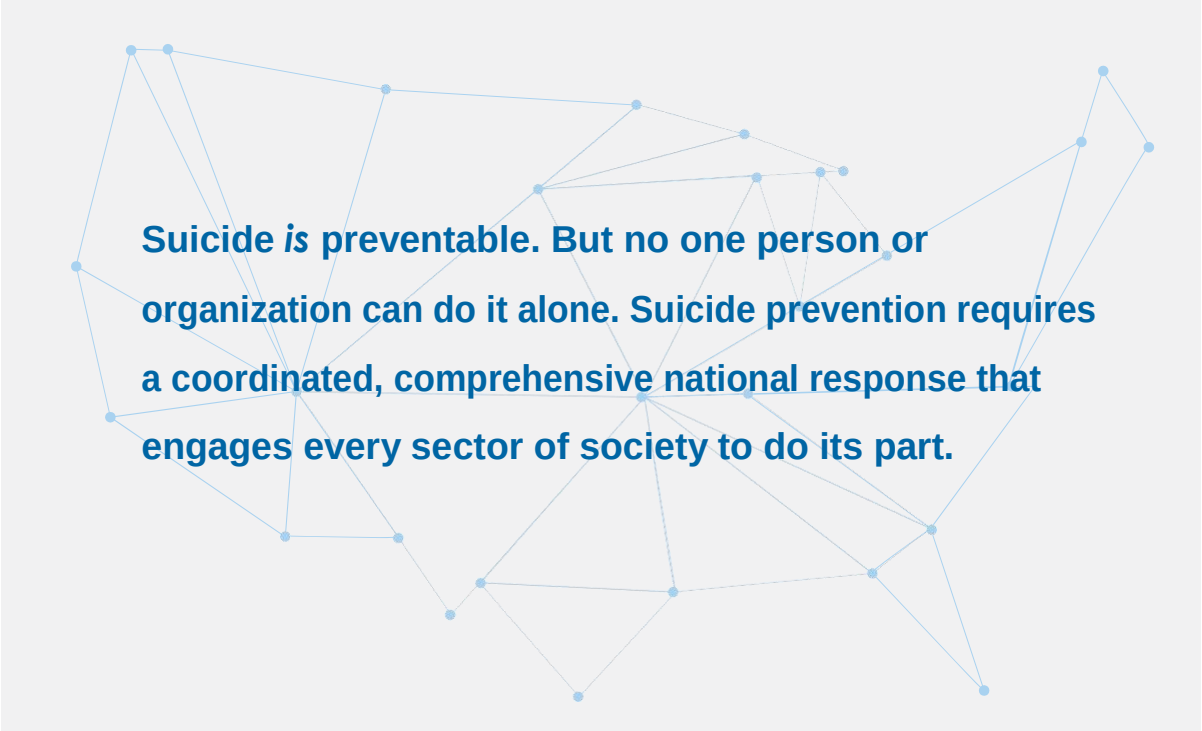
Table of Contents

Background

Suicide is a significant and tragic national health issue that affects millions of Americans each year. In addition to the more than 48,000 people in the U.S. who died by suicide last year, more than a million attempted suicide and millions more had serious thoughts of suicide (Centers for Disease Control and Prevention [CDC], 2020; Substance Abuse and Mental Health Services Administration [SAMHSA], 2019).

A suicidal crisis may be relatively short in duration—minutes to hours—and the majority of people who attempt suicide and survive do not go on to die by suicide (Harvard Injury Control Research Center, n.d.). By putting time and distance between a lethal means—"the instrument or object used to carry out a self-destructive act . . ." (e.g., firearms, medicines, illegal drugs)—and individuals who may be at risk for suicide, suicide can be prevented, and lives can be saved (Barber & Miller, 2014; Mann et al., 2005; Pirkis et al., 2015; U.S. Department of Health and Human Services [HHS], Office of the Surgeon General, & National Action Alliance for Suicide Prevention [Action Alliance], 2012; Zalsman et al., 2016).

Suicide *is* preventable. But no one person or organization can do it alone. Suicide prevention requires a coordinated, comprehensive national response that engages every sector of society to do its part. The National Action Alliance for Suicide Prevention (Action Alliance) is the nation's nonpartisan public-private partnership for suicide prevention. The Action Alliance works with more than 250 partners from the public and private sectors to advance the *National Strategy for Suicide Prevention* (*National Strategy*)—the nation's road map for a coordinated, comprehensive approach to suicide prevention. The Action Alliance focuses on innovative solutions that move forward the goals of the *National Strategy* and have the greatest potential to transform communities, prevent suicide, and save lives.



National Strategy Goal 6: Potential for Impact

Goal 6 of the *National Strategy* aims to "promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk" (HHS & Action Alliance, 2012):

- **Objective 6.1.** Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.
- **Objective 6.2.** Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.
- **Objective 6.3.** Develop and implement new safety technologies (e.g., bridge barriers, lockboxes) to reduce access to lethal means.

Recognizing this potential for impact, in 2017, the Action Alliance formed the first-ever national nonpartisan, cross-sector stakeholder group to identify innovative solutions to advance Goal 6. The Action Alliance Lethal Means Stakeholder Group does the following:

- **Serves as a national platform** for sharing and promoting creative, effective, and promising approaches for reducing access to lethal means among those who may be at risk for suicide
- **Identifies ways** to strengthen and invite cross-sector collaboration around this issue nationally and in communities
- **Offers a unified voice** that includes, reflects, and respects the unique perspectives of diverse partners around the table

The Action Alliance formed the first-ever national nonpartisan, cross-sector stakeholder group to identify innovative solutions to advance Goal 6.

Purpose and Scope of This Paper

This paper describes the role and impact of reducing access to lethal means in preventing suicide. First, it presents an overview of suicide in the United States, including data for a broad range of lethal means. Then it highlights actions, for which there is cross-sector support, that governments, organizations, and industries are taking to advance Goal 6 of the *National Strategy*. The paper concludes by discussing key recommendations for a collective path forward.

Suicide: A Leading and Preventable Cause of Death

Suicide is a significant and tragic national health issue that affects millions of Americans each year. In 2018, 48,344 people died by suicide in the United States, making it the nation's 10th leading cause of death and equating to about one suicide death every 11.1 minutes (CDC, 2020; CDC, 2017). In addition to those lives lost to suicide, 1.4 million adults attempted suicide, and 10.7 million adults had serious thoughts of suicide in 2017 (SAMHSA, 2019).

Suicide by Means

While suicide may impact groups differently, all suicides have one thing in common—a lethal means was used. Individuals who die by suicide use a variety of means (see Tables 1–3; CDC, 2020). Suffocation includes suicides by hanging and ligatures (e.g., ropes, belts). Poisoning includes suicides that are drug-related (i.e., prescription and nonprescription medicine, illegal drugs) and non-drug-related (e.g., gas, chemicals).

Table 1. Suicide Deaths by Means, 2018

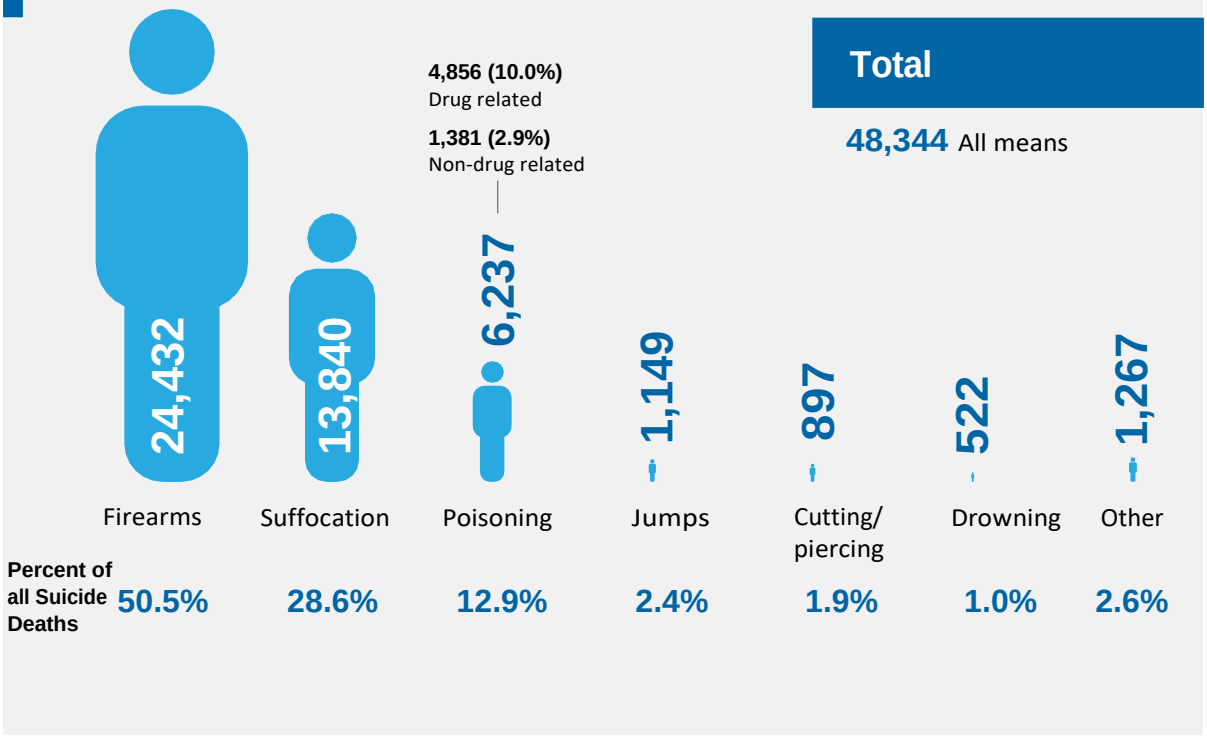
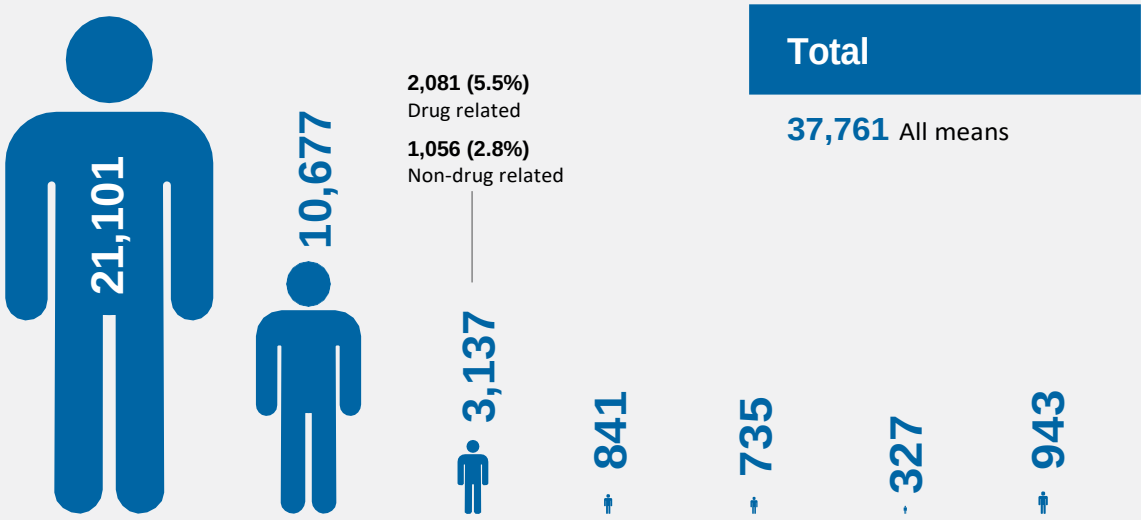
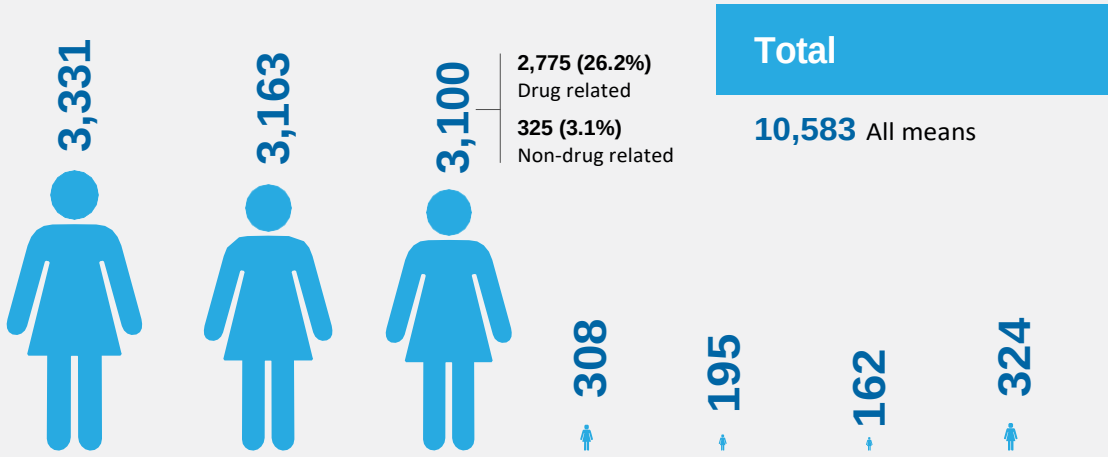


Table 2. Suicide Deaths by Means—Males, 2018



Percent of all Male Suicide Deaths	Firearms	Suffocation	Poisoning	Jumps	Cutting/ piercing	Drowning	Other
	55.9%	28.3%	8.3%	2.2%	1.9%	0.9%	2.5%

Table 3. Suicide Deaths by Means—Females, 2018

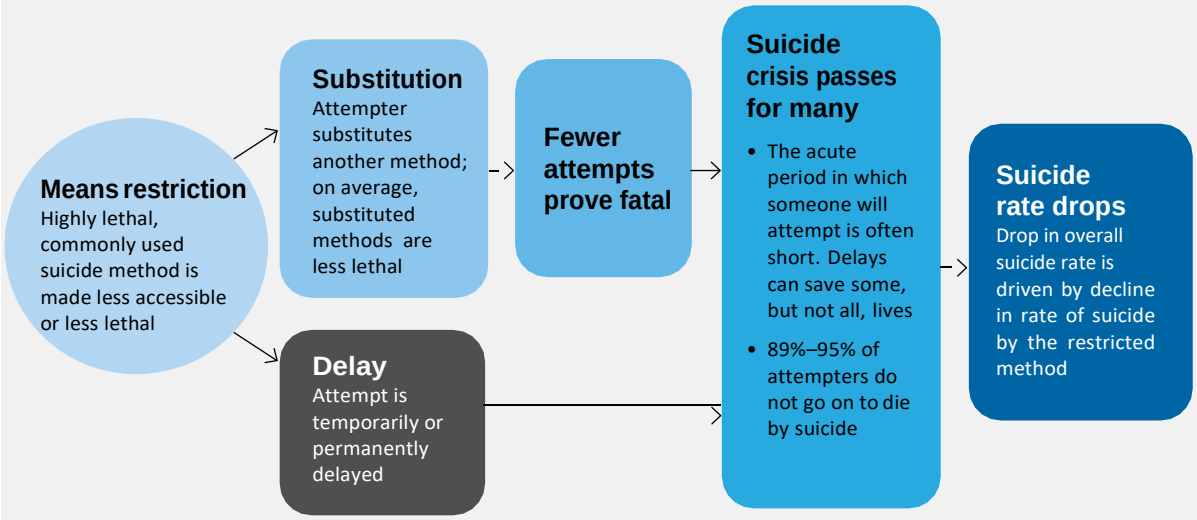


Percent of all Female Suicide Deaths	Firearms	Suffocation	Poisoning	Jumps	Drowning	Cutting/ piercing	Other
	31.5%	29.9%	29.3%	2.9%	1.8%	1.5%	3.1%

Note about Means Substitution

There is relatively strong evidence at the population level that reducing access to, or the toxicity of, a commonly used and highly lethal means is associated with reductions in the overall suicide rate driven by a reduction in the restricted method (Gunnell et al., 2007; Kreitman, 1976; Lubin et al., 2010; Reisch, Steffen, Habenstein, & Tschacher, 2013; Sinyor et al., 2017). When people's access to a highly lethal means that they would use is blocked, it creates two pathways by which lives are saved (see Figure 1): they may attempt with a method less likely to prove fatal and thus live, or they may not attempt at all.

Figure 1. Conceptual model describing how reducing access to a highly lethal and commonly used suicide method saves lives at the population level (from Barber & Miller, 2014).



Note: When a highly lethal method is made less lethal at the population level (e.g., reducing carbon monoxide content of motor vehicle exhaust), the substitution is passive. That is, people attempting suicide with the method are unaware that, in effect, a less lethal method has been substituted for a more lethal method.

The evidence regarding the effectiveness of reducing access to a low-lethality suicide method, such as most over-the-counter medicines, is less clear. There is a possibility that a certain proportion of those restricted from a low-lethality method will substitute a more lethal method. The most important reductions in suicide rates have been obtained when a method that is both highly lethal and commonly used (e.g., pesticides, domestic gas) was made less deadly or less available (Swiss and Israeli policies regarding military-issued firearms access, p. 12).

STRATEGIES TO REDUCE ACCESS TO LETHAL MEANS

Important strides have been made to reduce access to a broad range of lethal means among individuals who may be at risk for suicide. The following strategies highlight effective approaches that have been tested in the United States and other countries. Taken together, these approaches have the potential to reduce suicide and save lives.

FIREARMS RESPONSIBILITY

Firearms responsibility includes safety technologies and interventions that promote safe storage, such as gun locks and safes; equipping firearm retailers and range owners with the skills to identify individuals who may be at risk for suicide; and asking friends or loved ones to temporarily hold on to firearms during a time of crisis.

Partnering with Firearm Retailers and Shooting Range Owners

In recent years, people within the firearm industry, firearm instructors, and other firearm stakeholders have partnered with those in the field of suicide prevention to reduce access to firearms among those who may be at risk for suicide.

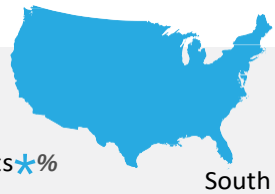
The Gun Shop Project is one example. The project aims to increase the capacity of firearm retailers to prevent suicide among customers and their friends and families (New Hampshire Firearms Safety Coalition, n.d.). The project originated in New Hampshire in 2009 as a collaboration between the New Hampshire Firearms Safety Coalition and the Means Matter campaign (Harvard Injury Control Research Center, n.d.), and it focused on educating firearm purchasers about suicide risk and associated safety precautions. Its specific objectives are to (1) help retailers avoid selling or renting firearms to new customers seeking a gun for suicide, and (2) educate existing customers in a trusted environment about the "11th Commandment of Firearm Safety" (i.e., be alert to signs of suicide risk among loved ones and help keep guns from them until they have recovered). The work has since expanded to include firearm instructors, writers for gun magazines, sportsman clubs, and other venues. A variety of training tools for instructors and retailers are available on the Means Matter gun owner pages.

The Gun Shop Project aims to increase the capacity of firearm retailers to prevent suicide among customers and their friends and families.

In 2016, the American Foundation for Suicide Prevention (AFSP) partnered with the National Shooting Sports Foundation (NSSF) to implement a program that educates firearm retailers, shooting range operators, and instructors about suicide prevention (American Foundation for Suicide Prevention, 2017). This program is planning to expand into all 50 states. AFSP launched this partnership to advance Project 2025—an AFSP initiative that aims to reduce the suicide rate by 20 percent by the year 2025 (a goal also endorsed by the Action Alliance in 2016), which includes firearm safety as one of its key strategies.

Figure 2 provides a listing of some of the firearm partnership projects currently underway that focus on increasing both responsible storage in the home and suicide prevention training for firearm retailers and shooting range operators.

Figure 2. Firearms Projects by State



Alabama*
Arkansas*
Arizona*
California*#
Colorado#
Connecticut*
District of Columbia*
Florida*
Georgia*
Idaho#
Illinois*
Indiana*
Iowa*#
Kansas#
Kentucky*
Marvland*#
Massachusetts*%
Michigan*%
Minnesota*
Mississippi*
Missouri*
Montana*
Nebraska*
Nevada*%
New Hampshire#
New Mexico*
New York#
North Carolina*
North Dakota*
Oregon*
Pennsylvania*
Rhode Island*#
South Carolina*
Tennessee #
Texas *#%
Utah %
Vermont#%
Virginia*#
Washington%
West Virginia*
Wisconsin*
Wyoming*

* AFSP Firearms and Suicide Prevention Program
\# Gun Shop Project
% Other: firearm instructor module, diner placemats, gun shows, suicide safer homes app, sportsman clubs, safe homes project

Responsible Firearms Storage

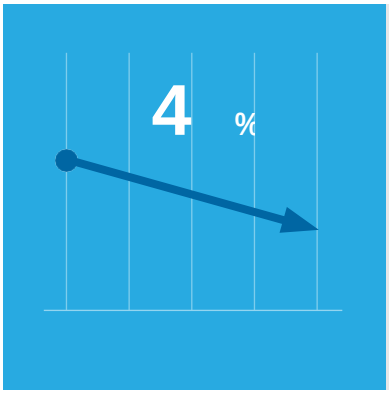
Responsible storage consists of keeping firearms locked, and preferably unloaded, and separating firearms and ammunition when not in use. Secure storage options for gun owners living with individuals who may be at risk for suicide include either storing household guns away from home (e.g., with a relative, at a gun shop, or at a storage facility) or locked at home in a secure gun safe, gun cabinet, or lockbox to which the at-risk person has no access (National Shooting Sports Foundation, 2017). For added security, portable storage devices can be secured to a wall, the floor, or both to prevent removal. In addition to locked storage, unloaded firearms can be secured with a gun-locking device that makes the firearm unusable. Firearms can also be disassembled, and the parts securely stored in separate locations.

Firearms and Veteran Suicide

According to one study, veterans are more likely than the general population to own firearms (44.95% vs. 20%, respectively; Cleveland, Azrael, Simonetti, & Miller, 2017). And the frequency of firearms use by veterans as a means of suicide remains high. Nearly 70 percent of veteran suicides involve a firearm versus 50 percent of suicides overall nationally (U.S. Department of Veterans Affairs, 2018).

Nearly 70 percent of veteran suicides involve a firearm versus 50 percent of suicides overall nationally (U.S. Department of Veterans Affairs, 2018).

For veterans and other individuals who may be at risk for suicide, putting time and distance between them and a firearm has been proven to decrease the likelihood of suicide. In their study of Israeli Defense Force members, Lubin and colleagues (2010) observed a 40 percent decline in the overall suicide rate among soldiers after a policy took effect in 2006 that limited their access to their military-issued firearms during weekend leave. The drop was driven by a decline in weekend suicides by firearms. Reisch and colleagues (2013) observed a marked decline in the overall suicide rate in Switzerland after that country instituted army reforms in 2003 that cut the size of the army in half, and thus, reduced the number of service members with military-issued firearms. It is the policy of the U.S. Department of Defense and the U.S. Department of Veterans Affairs (VA) for health care clinicians to assess access to lethal means among patients who may be at risk for suicide and take steps to limit that access (Assessment and Management of Risk for Suicide Working Group, 2013). The VA prioritizes steps that are voluntary in nature, and clinicians are trained to work collaboratively with patients around solutions.



Lubin and colleagues (2010) observed a 40 percent decline in the overall suicide rate among Israeli Defense Force soldiers after a policy took effect in 2006 that limited their access to their military-issued firearms during weekend leave.

ACCESS TO LIGATURES

Reducing access to ligatures (e.g., ropes, belts) and ligature points (e.g., beams, door knob, trees) is key to preventing suicide by suffocation. About 10 percent of suicides by hanging occur in the controlled environments of hospitals, prisons, and police custody. The remainder occur in the community (Gunnell, Bennewith, Hawton, Simkin, & Kapur, 2005), where ligatures and ligature points are all widely available. An evaluation of individuals in the United Kingdom who had survived a near-fatal suicide attempt by hanging indicated accessibility was a main factor that facilitated the attempt (Biddle et al., 2010).

Health systems, prisons, detention facilities, and jails can take action to prevent suicide by hanging. There are a number of safety technologies, including collapsible shower heads, light fixtures, door knobs, and specially designed bedding for hospitals and correctional facilities that is resistant to tearing.

The Joint Commission, an independent, nonprofit accreditor and certifier of U.S. hospitals, requires that hospitals (1) "conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide," and (2) "provide for a location for the patient that is safe, monitored, and clear of items that the patient could use to harm himself or herself or others" (The Joint Commission, 2016). In 2017, The Joint Commission announced that "its surveyors will place special focus on suicide, self-harm, and ligature observations in psychiatric hospitals and units" and will identify potential risks for suicide by ligature in the environment" (The Joint Commission, 2017).

The Joint Commission requires that hospitals (1) "conduct a risk assessment" and (2) "provide for a location for the patient that is safe, monitored, and clear of items that the patient could use to harm himself or herself or others"

ACCESS TO POISONS

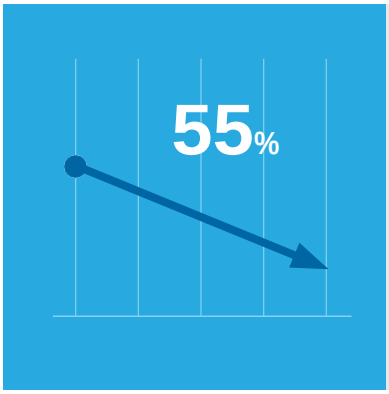
Poisons include prescription and nonprescription medicines that are used in a way other than directed as well as illegal drugs, chemicals, and gas. There are a number of different strategies that individuals, organizations, and communities can take to reduce access to poisons among those who may be at risk for suicide.

Key safety measures have been carried out in the United States and globally to make it harder for individuals in crisis to die by poisoning. For instance, in Denmark, reducing access to barbiturates and reducing the carbon monoxide content of car exhaust and household gas resulted in a 55 percent decrease in suicides between 1970 and 2000 (Nordentoft, Qin, Helweg-Larsen, & Juel, 2007).

Nonprescription and Prescription Drug Packaging, Storage, Disposal, and Prescribing

Modifying medicine packaging and reducing pack sizes also may prevent suicide. In 1998, the United Kingdom enacted legislation to modify pack sizes and adopt blister packaging of analgesics including acetaminophen. This legislation resulted in a reduction in nonfatal acetaminophen overdoses, the number of tablets taken for overdoses, large overdoses, and salicylate self-poisoning (Hawton, 2002; Hawton et al., 2001).

In January 2018, the VA led the effort to promote opioid prescription safety for veterans, becoming the first hospital system to release opioid prescribing rates. The VA began publicly posting information on opioids dispensed from VA pharmacies along with its strategies for prescribing these pain medications appropriately and safely.



In Denmark, reducing access to barbiturates and to car and household gas with carbon monoxide resulted in a 55 percent decrease in suicides between 1970 and 2000.

Safety measures available for individual storage and disposal of prescription and nonprescription drugs include drug lockboxes, drug buyback programs, and confidential drug return programs. The United States Drug Enforcement Agency (DEA) holds the National Prescription Drug Take Back Day, during which individuals can safely and conveniently dispose of prescription drugs at established collection sites. In addition, the DEA offers an online tool that locates DEA-authorized sites offering year-round collection. Many states also have similar online tools to identify local collection sites and resources, such as Washington state's www.takebackyourmeds.org. Other resources, such as www.disposemymeds.org, include a medication disposal locator that lists locations across the United States by zip code.

Pesticide Access

Pesticides are a leading cause of suicide death worldwide (World Health Organization, 2006), and efforts to reduce access to pesticides have resulted in decreases in suicide. In Sri Lanka, restrictions on the import and sales of pesticides in 1995 and 1998 were associated with a 50 percent reduction of the suicide rate by 2005 (Chowdhury et al., 2018; Gunnell et al., 2007; Gunnell et al., 2017).

Although pesticides are a leading cause of suicide death globally, they do not play such a large role in the United States and other countries that have robust regulatory environments (World Health Organization, 2006; CDC, 2016). A comprehensive regulatory system combined with guidance and other information relating to the storage, transport, and distribution of pesticides increase the safeguards around the deliberate misuse of pesticides for self-harm. Pesticide manufacturers work in cooperation with the United States Environmental Protection Agency and foreign regulatory authorities to support the safe use of pesticides in accordance with their labels. They also support and promote improved labeling, packaging, and formulations to minimize the risk of misuse and poisoning.

Government programs and stewardship initiatives are also in place to prevent deliberate misuse of pesticides for self-harm and have led to beneficial effects in several countries. These initiatives provide information and training about the importance of securely locking away pesticides, effective disposal of pesticide waste products, and increased awareness about treatments for deliberate ingestion. The pesticide industry is committed to providing information and training materials on the responsible and safe use of pesticides for farmers, agricultural extension workers, retailers, customers, and other users. These efforts have resulted in a decrease in suicide deaths from the deliberate misuse of pesticides.

Gas Exposure

Following the detoxification of domestic gas in the United States between 1950 and 1960, the suicide rate by domestic gas decreased (Lester, 1990). In the United Kingdom, suicide rates also decreased following the reduction of carbon monoxide in domestic gas (Kreitman, 1976).

The introduction of catalytic converters in vehicles has been associated with a decrease in suicide deaths from carbon monoxide poisoning (Amos, Appelby, & Kiernan, 2001; McClure, 2000; Thomsen & Gregersen, 2006). However, Strife and Paulozzi (2004) noted that catalytic converters do not completely remove carbon monoxide, particularly when a vehicle is started cold or running within a closed space, leaving suicide attempts by carbon monoxide in vehicle cabins still a high risk for death. They proposed a device that detects cabin levels of carbon monoxide, warns the driver, and automatically shuts down the engine in a stationary car if levels rise above a dangerous threshold. The device has been investigated in the United States (Galatsis & Wlodarski, 2006) and has been proposed to the United Nation's World Forum for Harmonization of Vehicle Regulations as a potential suicide prevention solution. Early models of the carbon monoxide shut-off device indicate that an estimated 600 suicide deaths could be prevented each year (National Action Alliance for Suicide Prevention, 2014).

BRIDGE BARRIERS

Adding barriers (e.g., fencing, safety nets) to bridges can prevent suicide by making it harder for jumps to occur, while removing bridge barriers can lead to increases in suicide. In spring 2017, construction of a stainless steel safety net began on the Golden Gate Bridge, a location associated with at least 1,300 suicide deaths (Blaustein, M., & Fleming, A., 2009). Although it is too soon to know the impact of this construction on future suicide attempts, there are already a number of examples that highlight the effectiveness of bridge barriers in preventing suicide.

Bloor Street Viaduct, Toronto, Canada

The city of Toronto erected a barrier at the Bloor Street Viaduct in 2003. In the 11 years prior to the barrier, there was an average of nine suicides per year at the site. In the 11 years following the barrier, the number of suicides dropped to almost zero (Sinyor et al., 2017).

Memorial Bridge, Augusta, Maine

For the Memorial Bridge in Maine, the number of suicides decreased from 14 before the installation of an 11-foot barrier in 1983 to zero during the 22 years following the installation of the barrier (Pelletier, 2007).

Bridge Barriers in Australia and New Zealand

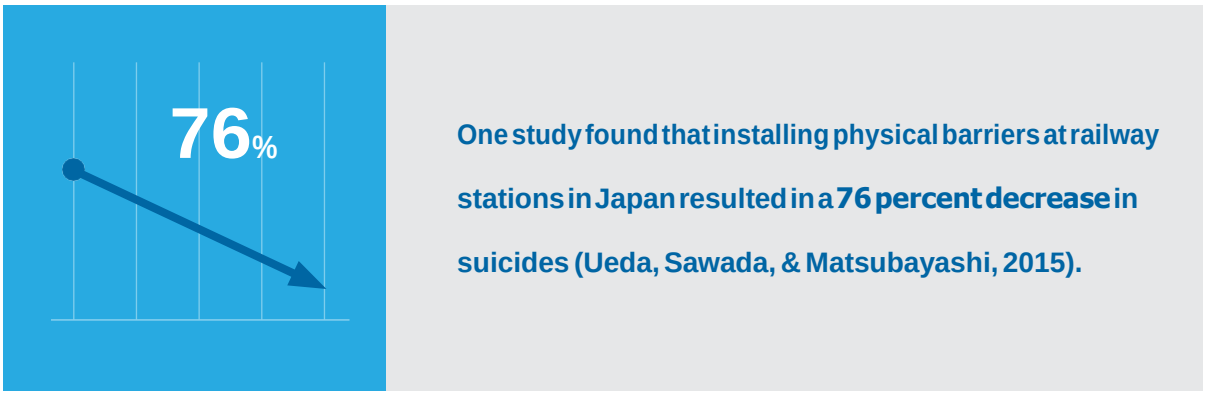
Suicides decreased by 50 percent at the Gateway Bridge in Australia after barriers were installed in 1993 (Law, Sveticic, & De Leo, 2014). At another Australian bridge, which was a suicide hot spot, suicides increased after safety barriers were removed in 1996 (Beautrais, 2001). A similar study in New Zealand found that suicides at a bridge increased five-fold after barriers were removed. But after the barriers were reinstalled, there were no reported suicides at the site (Beautrais, Gibb, Fergusson, Horwood, & Larkin, 2009).

RAILWAY BARRIERS

Suicide related to railways can be prevented with the installation of barriers blocking access to the tracks. The Federal Railroad Administration has identified two types of barriers: fencing that restricts access to the tracks and platform edge or screen doors. The agency stresses that while completely blocking off access to the tracks is not feasible, it may be feasible to focus efforts on reducing access to known locations where many suicides have occurred (i.e., suicide hot spots; Federal Railroad Administration, 2014).

One study found that installing physical barriers at railway stations in Japan resulted in a 76 percent decrease in suicides (Ueda, Sawada, & Matsubayashi, 2015). Chung and colleagues (2016) found that suicides at Seoul Metro subway stations in South Korea decreased by 89 percent after the installation of platform screen doors. Further, Law et al. (2009) found that suicides decreased by 59.9 percent following the installation of platform screen doors at rail stations in Hong Kong.

In the United States, there was an average of 284 suicide deaths per year from 2012 through 2016 on U.S. rails (Federal Railroad Administration, 2017). However, Berman and colleagues (2013) found that the majority of suicides on U.S. railways have occurred on freight rails rather than transit systems. Thus, the use of platform edge doors or screen doors in transit systems may not fully prevent all railway-based suicides. While they are not commonly used in the United States, these barriers are seen in some airport transit systems, and some communities are considering them. For instance, in 2017, the Southeastern Pennsylvania Transportation Authority (SEPTA), which already had posted signs for the National Suicide Prevention Lifeline, was asked "to consider platform barriers as part of City Hall Station's ongoing renovation" to prevent accidents and suicide (Saksa, 2017).



HEALTH CARE STRATEGIES TO ADDRESS LETHAL MEANS

The majority of people who die by suicide had a health care visit in the weeks and months before their death (Ahmedani et al., 2014; Luoma, Martin, & Pearson, 2002). Thus, the health care system can play an enormous role in preventing suicide by creating safe environments, screening for suicide risk, assessing level of suicide risk, conducting safety planning and counseling on access to lethal means, and providing follow-up care and caring contacts (National Action Alliance for Suicide Prevention, 2018).

Creating a safe environment within health care facilities can include reducing access to ligatures and installing safety technologies, such as collapsible shower heads. Health care systems can also ensure that their providers counsel patients who may be at risk for suicide on access to lethal means, including how to make their home safer.

Training for health care providers on how to reduce access to lethal means among patients who may be at risk for suicide is now widely available. The Suicide Prevention Resource Center offers the free online course Counseling on Access to Lethal Means (CALM) for primary care and behavioral health care providers. CALM focuses on how to (1) identify people who could benefit from lethal means counseling, (2) ask about their access to lethal means, and (3) work with them and their families to reduce access (Suicide Prevention Resource Center, n.d.).

Training for health care providers on how to reduce access to lethal means is now widely available. The Suicide Prevention Resource Center offers the free online course.

Considerations for the Way Forward

Reducing access to lethal means is an effective way to prevent suicide and is critical for reducing the nation's rising suicide rate. This paper demonstrates that significant progress has already been made to save lives by putting time and distance between lethal means and individuals who may be in crisis. The Action Alliance recommends the following ways community and industry leaders can build on these successes and continue to advance Goal 6 of the *National Strategy*:

1. **Launch or get involved in innovative cross-sector partnerships designed to advance Goal 6: promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk (HHS & Action Alliance, 2012).**
2. **Support, promote, or invest in local, state, or national efforts that seek to advance Goal 6 through a multi-sector approach.**
3. **Promote and expand access to widespread training for health care providers in clinical settings on ensuring counseling on access to lethal means is conducted.**
4. **Encourage the inclusion of a wide range of perspectives in any effort to advance Goal 6 and the use of shared language that conveys the concept of reducing access to lethal means in terms that appeal to diverse audiences.**
5. **Invest in the evaluation of efforts to advance Goal 6, in order to help build the evidence for what works in preventing suicide by reducing access to lethal means among those who may be at risk for suicide.**

Suicide is preventable. But no one person or organization can do it alone. Suicide prevention requires a coordinated, comprehensive national response that engages every sector of society, including leaders from suicide prevention, health and behavioral health care, business and industry, communities, public safety, and public policy. Continued progress will rely on cross-sector collaboration that brings together the best thinking and the best resources to advance goal 6 of the *National Strategy.* Working together, we can help those in crisis and turn the tide of the nation's rising suicide rate.

Suicide is preventable.

But no one person or organization can do it alone. Working together, we can help those in crisis and turn the tide of the nation's rising suicide rate.

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Appendix A: Contributors

Catherine Barber
Senior Researcher, Harvard Injury Control Research Center

Joe Bartozzi
President and CEO, National Shooting Sports Foundation

Jack Benson
Partner, Reingold

Bill Brassard
Senior Director of Communications, National Shooting Sports Foundation

Alex Crosby
Chief Medical Officer, Division of Injury Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Keita Franklin
Chief Clinical Officer, PsychHub

Bob Gebbia
CEO, American Foundation for Suicide Prevention

Mark Jones
General Director of Health and Medical Services, Union Pacific

Stephen Kaminski
President and CEO, National Propane Gas Association

Doreen Marshall
Vice President of Programs, American Foundation for Suicide Prevention

Richard McKeon
Chief, Suicide Prevention Branch, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Emily Mannel
Director, Reingold

Matt Miller
Acting Director, Suicide Prevention Program, U.S. Department of Veterans Affairs

Jane Pearson
Chair, Suicide Research Consortium, National Institute of Mental Health

Jerry Reed
Senior Vice President for Practice Leadership, Education Development Center

Stephanie Rogers
Senior Vice President of Communications and Marketing, American Foundation for Suicide Prevention

Adam Walsh
Director, Research and Program Evaluation, Defense Suicide Prevention Office, U.S. Department of Defense

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Staff

Colleen Carr
Director, National Action Alliance for Suicide Prevention

Farah Kauffman
Operations Manager, National Action Alliance for Suicide Prevention

Appendix L

Name: _____ Case Number: _____ Date: _____

Appendix L: Gulf Bend Center
Adding a Pathway to your Treatment Plan

We care about your recovery and want to help you work through this difficult time and find hope. Based on your appointment today, we feel it is important to offer you extra care and attention over the next few weeks. To do so, we are placing you in a special program we offer to assist people who are having thoughts about suicide. We call it a Pathway. We strongly believe behavioral health services can provide you with useful tools to understand your current suicidal thoughts and help you create changes to where your life seems "livable" again. This Pathway is meant to help keep you safe while you are working on these life changes.

The following is a list of supports or activities we want to provide for you:

- A plan to get rid of the means or method you might use to hurt yourself. Your family members or a friend may need to help with this.
- Regular check-ins. We hope to have contact with you every few days to make sure you are feeling safe. To do this, we will need your current phone number(s) and an address. Additionally, we would like to have your permission to contact a family member/friend/parent/LAR in case we cannot reach you so we will need their phone and address information as well. By signing this agreement, you agree to allow us to contact individuals on your Pathway.
- Notification to your psychiatrist and/or your primary care physician of the change to your treatment plan. We would also be notifying your treatment team at Gulf Bend Center that you are on the Pathway.
- An appointment or consult with one of our medical staff may be to discuss your current medications or adding/changing medications that could help during your recovery.
- An appointment with a licensed counselor may be indicated. Gulf Bend Center will assist you with setting this up.
- If you do not keep an appointment, we will try to call you. If we cannot reach you immediately, we will continue to call you and your emergency contact/LAR/parent. If we still cannot reach you, we may ask someone from our mobile team or a law enforcement officer to check in on you at your residence.
- Information about how to get help 24 hours a day, 7 days a week.
- Most importantly, we want to help you see there is hope; you can feel better, and suicide is not the answer. We will want to involve people close to you - with your permission - so they can understand better what is going on with you and learn how to help. This information was reviewed with me on _____ (date).

_____ _____ _____
Signature of Client or Client's Legally Authorized Representative Date LAR Relationship to Client

_____ _____
Staff Signature Date

The Suicide Safe Care Pathway has been explained to me. I am refusing the Pathway at this time. I understand that if I change my mind, I can ask for the Suicide Safe Pathway at any time. I also acknowledge that staff may need to obtain an emergency detention warrant to ensure my safety.

_____ _____ _____
Signature of Client or Client's Legally Authorized Representative Date LAR Relationship to Client

_____ _____
Staff Signature Date

If you are in crisis, call 1-888-SAFE GBC * Adapted from Centerstone "Consumer Handout for Pathway", personal communication

REC: 280 (6/28/21) QM: jg

Appendix M-1

Appendix M-1

Care Transitions Best Practice Strategies

1. Identify your key stakeholders - As a first step, it is imperative to identify the state or private psychiatric hospitals and emergency departments (ED) in which individuals in your area seek care, and the respite/residential units they go to when experiencing a psychiatric crisis. Obtain and maintain a point of contact for each of these stakeholders.
2. Establish relationships with the key stakeholders - Share with key stakeholders the statistics on high suicide risk upon discharge from an inpatient psychiatric unit and/or ED. Open the lines of communication to form a good working relationship to reduce suicides in your area.
    a. Negotiate a Memorandum of Understanding (MOU)- Important areas to consider in the MOU:
        i. Can the hospital notify someone at the outpatient facility anytime an individual is seen in the ED for a suicide attempt?
        ii. Can the private psychiatric hospital provide transport of the individual directly to the outpatient office for aftercare upon discharge?
        iii. Can the inpatient provider call the outpatient provider at least 24 hours prior to discharge to schedule an outpatient appointment?
        iv. Can the outpatient provider speak to the client on the phone prior to discharge from the inpatient facility to schedule the aftercare appointment?
        v. Can the outpatient provider send a staff member to the inpatient facility daily to meet with individuals scheduled for discharge in the next one to two days to explain outpatient services and schedule aftercare appointments?
    b. These are a few ideas for setting up an MOU with hospitals in your catchment area to improve care transitions. The warm hand-off between the hospital and the outpatient provider increases the likelihood that the individual at risk will follow through with outpatient services.
    c. Ensure MOUs address record transfers from the hospital or ED to outpatient provider to ensure continuity of care.
3. Narrow the transition gap - The sooner an individual can be seen for a transition appointment, the less likely the individual is to die by suicide. Transition appointments include discharge from psychiatric hospitalization, discharge from ED due to psychiatric crisis, discharge from respite/residential treatment, and

interaction with Mobile Crisis Outreach (MCOT). Transition appointments within 24 hours is ideal.

a. If the individual cannot be seen within 24 hours, reach out with caring contacts in the days leading up to the transition appointment.

b. Engage family and/or friends to provide support to the individual during the transition period.

c. Connect the individual with peer support

4. Follow up on missed appointments - immediately follow-up on missed appointments by calling the individual, trying emergency contacts (e.g., family member), and finally initiating a welfare check if an individual cannot be reached by any other means.

Appendix M-2

Appendix M-2

Care Transitions Best Practice Strategies

1. Identify your key stakeholders:
    - Psychiatric Hospital Partner(s):
      _____
      _____
      _____
    - ED Partner(s): _____
      _____
      _____
      _____
      _____ _____
    - Crisis Unit (Crisis Residential Unit /Crisis Stabilization Unit) Partner(s):
      _____
      _____
      _____

2. Establish relationships with the key stakeholders:
    - _____Schedule meetings with stakeholders to discuss importance of care transitions. _____
      _____
      _____
      _____
    - _____Negotiate a Memorandum of Understanding (MOU) with each stakeholder.
        - _____MOU with Psychiatric Hospital Partners_____
          _____
          _____
          _____

- _____MOU with ED Partners _____

  _____
  _____
  _____

- MOU with Crisis Unit Partners: _____

  _____
  _____
  _____

- ___Set up protocols to obtain records containing relevant information for your agency from your stakeholder partners.

3. _____Narrow the transition gap
   - ___Create agency policies and procedures for care transitions. In the policies address:
     - Length of time until first appointment
     - Caring contacts
     - The role of natural supports
     - The role of peer support
4. _____Follow up on missed appointments
   - ___Create agency policies and procedures for follow up on missed appointments. In the policy address:
     - Time frame for follow-up (immediate)
     - Methods for staff follow-up (calling the individual, trying emergency contacts, home visit, etc.)
     - Number of follow-up attempts to be made in what time frame (e.g., staff to call individual three times within two hours of missed appointment as well as his/her emergency contact two times within the following one hour).
     - Protocol for when an individual is not able to be reached by phone after a missed appointment (e.g., welfare check).

Appendix N-1

Appendix N-1

Guidelines for Suicide Death of an Agency Client

1. Notifications:
   a. Care must be taken to notify individuals in a sensitive manner that respects the deceased and protects against potential contagion.
   b. Outline in your protocol who is to be notified first and how various people in the organization will be notified and in what time frame. When a client dies by suicide, often quality management departments must be notified first or second in the chain; however, it is important to remember that the individual's treatment team should be notified as soon as possible.
   c. It is recommended, when possible, an early point of contact be an individual with experience in grief/trauma/suicide debriefing. This individual will have skills to help deliver the information to others and debrief the treatment team as information as disseminated.
   d. Whenever possible, individuals that worked directly with the person who died by suicide (i.e., his/her treatment team), should be told about the suicide face-to-face. The purpose of this is two-fold. First, it allows for the people being told about the tragic death to debrief the situation. Secondly, it allows the people telling of the death to assess the group for any potential vulnerable individuals that may need screening for suicidal thoughts.
   e. All notifications to staff should be made within eight business hours and face-to-face by an individual with debriefing skills unless business necessity prevents it from happening.

2. Responses:
   a. The supervisor for each individual on the treatment team will follow-up with that individual to determine what, if any, response will be offered regarding follow-up, employee assistance program, etc.
   b. Individual will be allowed to go home if needed.
   c. Supervisor will check in with employee again daily for two to three days. Each agency will incorporate into their protocols what additional action will be taken if an individual appears to be having a traumatic grief reaction, and/or expresses suicidal thoughts themselves.
   d. At least one large group (treatment team) debrief session will be scheduled to allow for processing during the first week after the suicide death. Whenever possible, it is recommended that this debriefing be led by an individual with grief/trauma/suicide debriefing experience.
   e. During the death review process, lessons learned need to be shared with the treatment team. It is important that all communications about lessons learned and recommendations about future operations be in a blame-free environment.

Appendix N-2

Appendix N-2

Guidelines for Suicide Death of an Agency Employee

These steps are intended to guide agencies in setting up protocols before a death by suicide occurs within the agency.

1. Notifications:
   a. Care must be taken to notify individuals in a sensitive manner that respects the deceased and protects against potential contagion.
   b. Sharing the manner of death (i.e., suicide) is preferred. It helps to break down stigma and shows that there are people at the agency willing to talk about suicide. Sharing the cause of death (method used) is not advised. Sharing how people can seek help for suicidal thoughts is best practice.
   c. Outline in the protocol who is to be notified first and how various people in the organization will be notified and in what time frame. In the days of social media, rumors and information spread quickly, so to ensure employees receive the information in the most sensitive and life-affirming way possible, a quick notification is best.
   d. It is recommended, when possible, the first point of contact be an individual with experience in grief/trauma/suicide debriefing. This individual will have skills to help deliver the information to others and debrief the groups as information is disseminated.
   e. Whenever possible, individuals who worked directly with the person who died by suicide (i.e., his/her manager, individuals on his/her team, etc.), and known friends of the individual should be told about the suicide face to face. This allows for the people being told about the tragic death to debrief the situation. More importantly, it allows the people telling of the death to assess the group for any potential vulnerable individuals that may need additional counseling and/or screening for suicidal thoughts.
   f. If the individual who died by suicide worked with clients, consider how to notify those individuals of the death as soon as possible.

2. Responses:
   a. Day one:
      i. Supervisor or manager will check-in individually with all the severely affected individuals, especially known friends, people with close office proximity, and those on the same team with the deceased individual.
      ii. Have a strong management presence with administrators without a direct connection to the deceased employee walking through the halls checking in with people and excusing them to go home as needed. Assessing risk is important.
   b. Days two-four:
      i. Individuals with grief debriefing experience will have a list of the most vulnerable individuals on which to follow up. Managers continue frequenting the hallways looking for signs of distress.

ii. Consider sending an agency-wide email from the executive director.
iii. Management begins to check on the peripheral staff (staff without a known connection to the deceased). Arrange coverage for staff who can't focus. Allow for frequent breaks.
iv. Begin planning for coverage to allow staff to attend the funeral if staff want to attend.
v. Schedule a group debriefing for the first few days for any agency staff that wishes to attend.
vi. Schedule a managers group debriefing session to allow those who are checking on others to debrief.

c. After the funeral
i. Continue to check in on the most vulnerable staff members.
ii. Schedule another group debrief for about three weeks out from incident.
iii. Allow individuals with grief debriefing experience to keep the list of most vulnerable and keep following up as needed.

Appendix O

Appendix O: SAMPLE INTERNAL NOTIFICATION MEMO

[WHEN CAUSE OF DEATH REVEALED]

Date:

To: Staff

From: [Name of CEO]

Re: Death of [name of employee]

[Our workplace] is saddened to learn of the reported suicide of [employee]. The tragic and sudden circumstances of [employee's] death may cause a range of reactions among our workplace, so with the family's permission we are sharing the facts as we know them and are offering support for those who might need it.

[Employee] worked for [workplace] for the last [number] years. On [Saturday night] [s/he] died around [11:00PM] [DO NOT MENTION PLACE OR METHOD USED FOR SUICIDE]. We may never know all the factors leading to this tragedy; however, experts agree that in nearly all suicides there is no single cause or simple explanation.

[Employee's] memorial service will be held on [January 7 at 11:00AM], and all employees who wish to attend may be excused. The family would like to welcome all of [his/her] friends and colleagues who wish to share in the celebration of [his/her] life.
Some of you may be having difficulty coping with the sudden loss of one of our workplace family. We have arranged for the Employee Assistance Program (EAP) professionals to facilitate a debriefing on [January 8th at 5:00PM]. During this group meeting, counselors will be on hand to support us and answer any questions we may have. Others may prefer individual support at this time. If so, please contact our EAP program by calling [1-800-123-4567].

The family has requested that instead of flowers, those who wish to do so may donate to [a local suicide prevention center or other charity as shared by the family] in [employee's] memory.

For those who would like to talk about what has happened, our HR team is available to you.

SAMPLE INTERNAL NOTIFICATION MEMO

[WHEN CAUSE OF DEATH WITHHELD BY FAMILY]

Date:

To: Staff

From: [Name of CEO]

Re: Death of [name of employee]

[Our workplace] is saddened to learn of the death of [employee]; the family has requested that the cause of death be withheld. The tragic and sudden circumstances of [employee's] death may cause a range of reactions among our colleagues, so with the family's permission we are sharing the following information and are offering support for those who might need it.

[Employee] worked for [workplace] for the last [number] years. On [Saturday night] [s/he] died around [11:00PM] [DO NOT MENTION PLACE OR METHOD USED FOR SUICIDE]. [Employee's] memorial service will be held on [January 7 at 11:00AM], and all employees who wish to attend may be excused. The family would like to welcome all of [his/her] friends and colleague who wish to share in the celebration of [his/her] life.

Some of you may be having difficulty coping with the sudden loss of one of our workplace family. We have arranged for the Employee Assistance Program (EAP) professionals to facilitate a crisis counseling session on [January 8 at 5:00PM]. During this group meeting, counselors will be on hand to support us and answer any questions we may have. Others may prefer individual support at this time. If so, please contact our EAP program by calling [1-800-123-4567].

The family has requested that instead of flowers, those who wish to do so may donate to [a local suicide prevention center or other charity as shared by the family] in the [employee's] memory.

For those who would like to talk about what has happened, our HR team is available to you.

Appendix P

Appendix P. Sample Risk Assessment

Presenting Problem:

(Include what prompted the risk assessment to be completed.)

Client came in today for their weekly face-to-face appointment with case manager. During the appointment, staff completed the C-SSRS screening tool. Client indicated that they had thoughts of suicide with method and intent since last visit. Staff will complete the full risk assessment.

Risk of Harm:

(Include the frequency, intensity, and duration of SI and suicidal behaviors using the CASE Approach.)

Client reports a long history of thoughts of suicide, and their most recent thoughts of suicide were yesterday. Client reports yesterday they overslept for work and the day went downhill from there. Client reports they had to call in sick for work when their car did not start and the suicidal thoughts began. Client reports thinking about suicide most of the day yesterday. Client reports considering the methods of hanging self with a rope they have in their garage and overdosing on psychiatric medications. Client reports the thoughts started as fleeting and became more intense throughout the day, but they did not act on the thoughts because, "I did not want my family to find me." Client reports they have had suicidal thoughts off and on since they were 15 years old (for 10 years). Client reports at age 15 they had thoughts of suicide daily for approximately four hours per day. After one month of this, client had their first suicide attempt by overdose. Client reports receiving psychiatric treatment at an inpatient unit after that attempt. Client reports not having SI again until approximately age 18. Client reports having SI off and on approximately one time per week for about one hour from ages 18 to 20. At age 20, client had an interrupted attempt when they were in college. Client failed a class and decided to overdose; however, their roommate came in and stopped them. Client did not receive treatment for the interrupted attempt. After age 20, client reports having occasional fleeting SI but denies considering a method or having further attempts, interrupted attempts, aborted attempts, or behaviors. Client denies current suicidal thoughts (most recent last night). Client denies current, recent, and past homicidal ideations. Client denies access to firearms.

Warning Signs:

(Include information regarding any warning signs not captured in the Risk of Harm section.)

Client endorses the following warning signs: purposelessness, anxiety, burdensomeness, hopelessness, and withdrawing.

Client reports they have felt like they do not have a purpose for "most of my life." Client reports most recently feeling this way earlier today. Client reports feeling like a burden to their family. Client reports they began feeling like a burden yesterday when their car did not start because they were going to have to ask for a ride or miss work and have to ask for money. Client reports they have felt like a burden off and on for several years, but the feeling is most intense when things go wrong in their life. Client denies having hope for the future. Client reports things have never "quite gone my way." Client states hopelessness comes and goes but is most intense at night when they are alone. Client reports yesterday the hopelessness was a "10 out of 10." Client reports they have been withdrawing from friends and family for the last two months. Client reports they have not gone out with friends when asked and have spent most days and nights in their room when not working. Client reports experiencing anxiety almost daily since age 15. Client reports anxiety is most noticeable when they have to participate in an activity they do not want to do or when they become overwhelmed. Client describes their anxiety as racing thoughts, general motor agitation, difficulty concentrating, and sweaty palms. Client reports anxiety typically lasts several hours to all day. Most recently, client reports feeling anxious during this assessment. Client denies all other warning signs.

Risk Factors:

(Include information regarding any risk factors or chronic risk.)

Client endorses the following risk factors: history of trauma, suicide death of a family member, mental health diagnosis, and previous suicide attempt.

Client reports they lost their 20-year-old cousin to suicide three years ago. Client reports they were somewhat close to their cousin but had not seen their cousin in the four years preceding their death. Client reports they are diagnosed with major depressive disorder and generalized anxiety. Client has one previous suicide attempt (see Risk of Harm section). Client reports a history of verbal and physical abuse as a child. Client reports their stepfather was the perpetrator of the weekly

abuse from ages 10 to 15. Client reports at age 15 their mother and stepfather divorced. Client denies all other risk factors.

Protective Factors:

(Include all protective factors that the client may report.)

Client reports they have a supportive family including a mother and younger sister. Client reports enjoying drawing and writing and feels these positive coping strategies are protective. Client reports having a strong faith that is important to them and helps them cope when things are especially difficult.

Current and Past Psychiatric Treatment:

(Include inpatient and outpatient psychiatric treatment history per the client's report and documentation history.)

Client is currently receiving services at XYZ Clinic in ABC, Texas. Client has received services for approximately two years. Client reports taking medication as prescribed "most of the time." Client attends case management appointments and participates in skills training. Client has received psychiatric treatment including medication and counseling off and on at various outpatient clinics since they were 15 years old. Client has one previous psychiatric hospitalization at QRS Hospital after a suicide attempt at age 15.

Psychotic Experiences:

(Include hallucinations and delusions regardless of diagnosis.)

Client denies all hallucinations and delusions.

Substance Use:

(Include the type, amount, frequency, and duration of all substances.)

Client reports drinking approximately six beers per week for the last three to four years. Client reports they will drink one to two beers on most nights. Client denies drinking to intoxication now but would do so on occasion when they were a teenager.

Client reports smoking approximately one marijuana joint per month for the last six months. Client reports marijuana helps with their anxiety. Client denies all other drug and alcohol use.

Biopsychosocial Factors:

(Include any factors that may be contributing to or mitigating the crisis such as the client's employment, housing, access to care, and support system.)

Client is 25 and lives with their mother and younger sister. Client graduated from college two years ago; however, they have been unable to find work in their field of study. Client currently works part time at Starbucks. Client reports their mother and sister are both supportive; however, they feel like a burden to their family because they should be "out of the house and on my own." Client reports having a diagnosis of depression and anxiety.

Risk Formulation:

(Include the determination of risk level and rationale for this determination. Include information regarding risk or protective factors and risk of harm to self and others.)

Client is at moderate risk for suicide due to the following:

- Client had active thoughts of suicide most recently yesterday that involved considering the methods of hanging and overdosing on pills.
- Client has access to means (rope and pills) they considered using.
- Despite the risk reported as recently as yesterday, client denies current thoughts, plans, or intent to carry out a suicide plan.
- Client is willing to actively engage in safety planning including means safety.
- Client's family is supportive and willing to participate in safety conversations.
- Staff recommend outpatient treatment with a safety plan and a referral to the suicide care pathway as the least restrictive treatment option for this client at this time.

Disposition:

(Include all pertinent information about how the risk assessment ended. Where did the client go? How did the client get there? What resources were given? How was means safety conducted?)

Staff and client worked together to complete a collaborative safety plan. Client agreed to a means safety plan with the rope and psychiatric medications. Staff and client engaged with client's mother to assist in the means safety plan, which included client's mother removing the rope from the home, locking all household medications in a lock box, and dispensing client's psychiatric medications to them

at the appropriate times. Staff and client agreed to a follow-up appointment tomorrow at 1:00 p.m. Staff provided client with the clinic crisis line number and the 988 Suicide and Crisis Lifeline number in case the situation worsens overnight. Client agrees to utilize the safety plan and return for the follow-up appointment tomorrow.