SUICIDE SAFE CARE FOR PATIENTS

BUILDING A FOUNDATION FOR ASSESSMENT, SCREENING, AND TREATMENT

WICHE
Western Interstate Commission for Higher Education

ZERO SUICIDE

MONTANA DPHHS

(February 2024)

RESOURCES

- Download this card and additional resources at **http://wwww.sprc.org**
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide **http://www.sprc.org/library/jcsafetygoals.pdf**
- **SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors **http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx**
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

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National Suicide Prevention Lifeline

988

http://www.sprc.org

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

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SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1

IDENTIFY RISK FACTORS

Note those that can be modified to reduce risk

2

IDENTIFY PROTECTIVE FACTORS

Note those that can be enhanced

3

CONDUCT SUICIDE INQUIRY

Suicidal thoughts, plans, behavior, and intent

4

DETERMINE RISK LEVEL/INTERVENTION

Determine risk. Choose appropriate intervention to address and reduce risk

5

DOCUMENT

Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

www.samhsa.gov

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- ✓ **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
  Co-morbidity and *recent onset of illness increase risk*
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Family history:** of suicide, attempts, or Axis 1 psychiatric disorders requiring hospitalization
- ✓ **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g, loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- ✓ **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- ✓ **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- ✓ **External**: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration—in last 48 hours, past month, and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious.
  Explore ambivalence: reasons to die vs. reasons to live

* *For Youths:* ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition

* *Homicide Inquiry:* when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

4. RISK LEVEL/INTERVENTION

- ✓ **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- ✓ **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

Saint Louis University Mental Status Examination
Form Details

Who Can Complete the Form: Social Services, Reflections/Passages Program Coordinators, Licensed Nurses, MDs, NPs, OTs, PTs, Residence Supervisors and Other Qualified Healthcare Professionals.

Purpose of the Form: To screen individuals to look for the presence of cognitive deficits, and to identify changes in cognition over time.

Instructions for Use:

1. Complete resident demographics at the top of the page.

2. We recommend that you put the date and the name of the evaluator on the bottom of the page as well (see #19).

3. Administration should be conducted privately and in the examinee's primary language. Be prepared with the items you need to complete the exam. You will need a watch with a second hand on it.

4. Record the number of years the patient attended school. If the patient obtained an Associates, Bachelor's, Master's or Doctorate degree, note the degree achieved instead of actual years of school attended.

5. Determine if the patient is alert. Do not answer "yes" or "no", but indicate level of alertness. Alert indicates that the individual is fully awake and able to focus. Other descriptors include: drowsy, confused, distractible, inattentive, preoccupied.

6. Begin by asking the patient the following:
   "Do you have any trouble with your memory?" "May I ask you some questions about your memory?"
   Then proceed with the exam questions.

7. Read the questions aloud clearly and slowly to the examinee. It is not usually necessary to speak loudly but it is necessary to speak slowly.

8. Begin by asking the patient something similar to the following:
   "Do you have any trouble with your memory?" "May I ask you some questions about your memory?" "I'd like to see how good your memory is by asking you some questions." You may need to reassure patients by telling them that this is not a test that they can fail but merely a tool much like a thermometer that takes temperature is a tool. What this does is checks for the amount of memory they have.
   Then begin to administer the exam questions.

9. Score the questions as indicated on the examination.

10. On question #4, read the statement as listed on the exam. Ask the patient to repeat each of the five objects (Apple, Pen, Tie, House, Car) that you recite to make sure that the patient heard and understood what you said. Repeat them as many times as it takes for the patient to repeat them back to you correctly.

Saint Louis University Mental Status Examination
Form Details

11. On question #5, make sure the patient is focused on you prior to reciting the information. Obtain an answer for the first part of the question ("How much did you spend") before moving on to part two ("How much do you have left?"). Do not prompt or give hints, but do give ample time to the patient to answer the questions. If the patient asks you to repeat the question you may do so once.

12. Redirect the patient's attention if necessary back to you to answer question #6. Give them one minute to complete the question. Be sure to time them.

13. Continue with the exam questions in the order that they are listed.

14. On question #8, state each number by its individual name. 87 is pronounced eight, seven; 649 is pronounced six, four, nine; 8537 is pronounced eight, five, three, seven.

15. On question #9, either draw a large circle on the back of the examination form or provide the patient with a separate piece of paper with a larger circle printed on it and attach it to the original examination form. When scoring, give full credit for either all 12 numbers or all 12 ticks. If the patient puts only 4 ticks on the circle, prompt them once to put numbers next to those ticks (12, 3, 6, and 9) for full credit. When scoring the correct time, make sure the hour hand is shorter than the minute hand and that the minute hand points at the 10 and the hour hand points at the 11.

16. You may also provide a separate sheet with larger examples of the forms listed on question #10 for those with vision impairment. This sheet should be created by enlarging the figures on the examination form and can also be attached to the original form.

17. Read question #11 as written, and provide ample time to answer each question. Do not repeat the story but do make sure they are paying attention the first time you read it to them. Do not prompt or give hints. The answer of Chicago as the state she lives in gets no credit but you may prompt them once by repeating the question.

18. Score the examination as listed at the bottom of the page, circling the level based on the score.

19. Sign and date the form.

20. Upon Completion of the Form:

☒ Record the score in the patient's record and comment on any indicated changes

☒ Depending upon office protocols, either put the sheet in the patient's record, place it in a separate identified location, or destroy the worksheet once the score is recorded in the patient record (Specify based on Office Center Policy)

21. Form Status: (Varies by office)

Mandatory for (e.g., patients with diagnoses or indicators of cognitive loss)

Mandatory for _____

Saint Louis University Mental Status Examination

Name:_____ **Age**:_____

Is Patient alert? YES NO **Level of Education:** <HS >= HS

___/1 | 1 | **#1 What day of the week is it?**

___/1 | 1 | **#2 What is the year?**

___/1 | 1 | **#3 What state are we in?**

#4 Please remember these five objects. I will ask you what they are later.

Apple Pen Tie House Car

#5 You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.

1 | **How much did you spend?**

___/3 | 2 | **How much do you have left?**

#6 Please name as many animals as you can in one minute.

___/3

0	0-4 animals	1	5-9 animals
2	10-14 animals	3	15+ animals

___/5 **#7 What were the five objects I asked you to remember?**

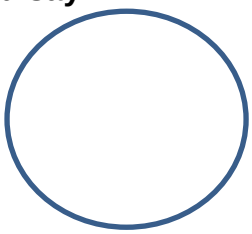
1 point for each correct answer

#8 I am going to give you a series of numbers and I would like you to give them back to me backwards. For example, if I say 42, you would say 24.

___/2

0	87	1	649	1	8537

#9 This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.



2 | Hour marker okay

___/4 | 2 | Time correct

1 **#10 Please place an X in the triangle.**

___/2 | 1 | **Which of the figures is largest?**

#11 I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

2 **What was the female's name?** 2 **What work did she do?**

___/8 | 2 **When did she go back to work?** 2 **What state did she live in?**

TOTAL

_____

Scoring

High School Education		Less Than High School Education
27-30	**Normal**	25-30
21-26	**MNCD***	20-24
1-20	**Dementia**	1-20

*Mild Neurocognitive Disorder

Office Protocol for Suicidal Patients – Development Guide

The purpose of an Office Protocol for Suicidal Patients is to anticipate and have an appropriate plan in place before a suicidal patient is identified. This office suicidal patient care management plan allows providers and office staff to be prepared when treating a patient who is assessed to be at high risk for suicide. Initial assessment of a potentially suicidal patient can be conducted by a member of the office staff or by an external consultant. An office protocol template, to simplify the process of further assessing and potentially hospitalizing a high-risk patient, can be found on the following page of this Toolkit. It will help a practice to proactively answer the logistical questions related to getting additional psychiatric care for patients before a crisis occurs, and guide providers quickly and efficiently when a patient is in need of such care.

The office protocol is an essential component of a comprehensive office strategy for suicide prevention, and may be developed during staff meetings. Once the protocol is developed, it may be useful for the office to implement a "dry run" with a mock patient to ensure that the protocol can be followed seamlessly. Suicide prevention trainings, including warning signs to look for, inquiring about suicidal ideation, and how to respond to suicidal individuals, can be provided to all office staff as an in-service. See Module 3: Effective Prevention Strategies, in the Primer section of this Toolkit, for detailed information about effective suicide prevention strategies for primary care offices. Though these strategies may require an investment of time and money, they constitute best practices for care and may save lives.

Consider involving all office staff in suicide prevention efforts. Staff members are frequently in positions to observe changes in behavior or hear patients express suicidal ideation that the patient may be reluctant to share with the provider. Office staff can play a crucial role by detecting concerning behaviors and alerting the patient's provider.

Locate specific information about your state's involuntary treatment laws and post this in the office along with contact information for mental health professionals who are responsible for making these determinations in your area.

Make sure you have information in the office about the National Suicide Prevention Lifeline, 1-800-273-TALK (8255), which also offers free materials, including posters and cards with the Lifeline number. Professionals at that number can also direct practices to community mental health service providers in their area.

Office Protocol for Suicidal Patients – Office Template

Post in a visible or accessible place for key office staff.

If a patient presents with suicidal ideation or suicidal ideation is suspected and detected with screening questions ...

- _____ should be called/paged to assist with suicide risk assessment (e.g. physician, mental health professional, telemedicine consult, etc.).
- _____ should be called/paged to assist with collaborative safety planning.
- Identify and call patient's support person in the community (e.g. family member, pastor, mental health provider, other support person).

If patient requires hospitalization ...

- Our nearest Emergency Department or psychiatric emergency center is _____
- Phone # _____
- _____ will call _____ to arrange transport.
  (Name of individual or job title) (Means of transport [ambulance, police, etc.] and phone #)

Backup transportation plan: Call _____

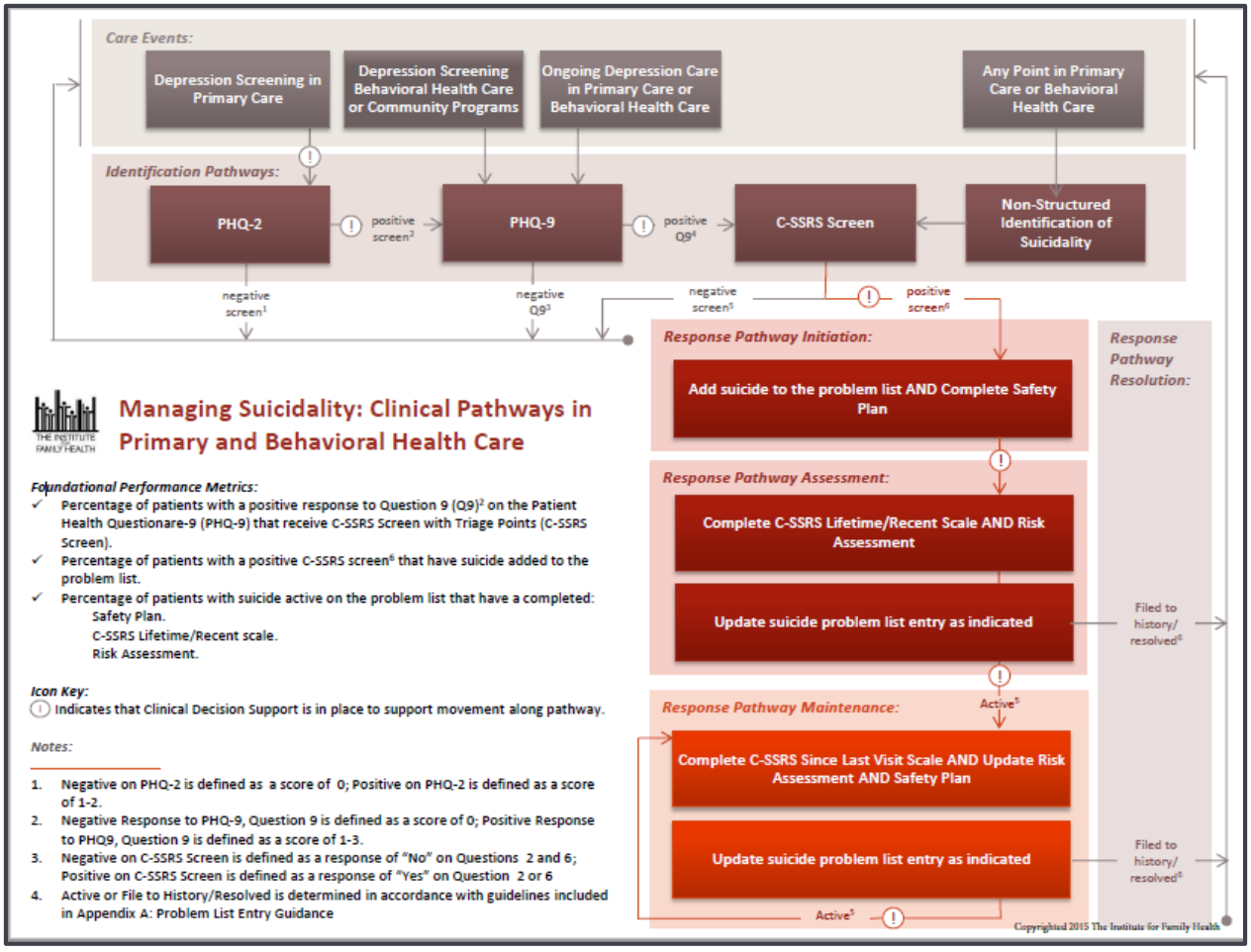
- _____ will wait with patient for transport.

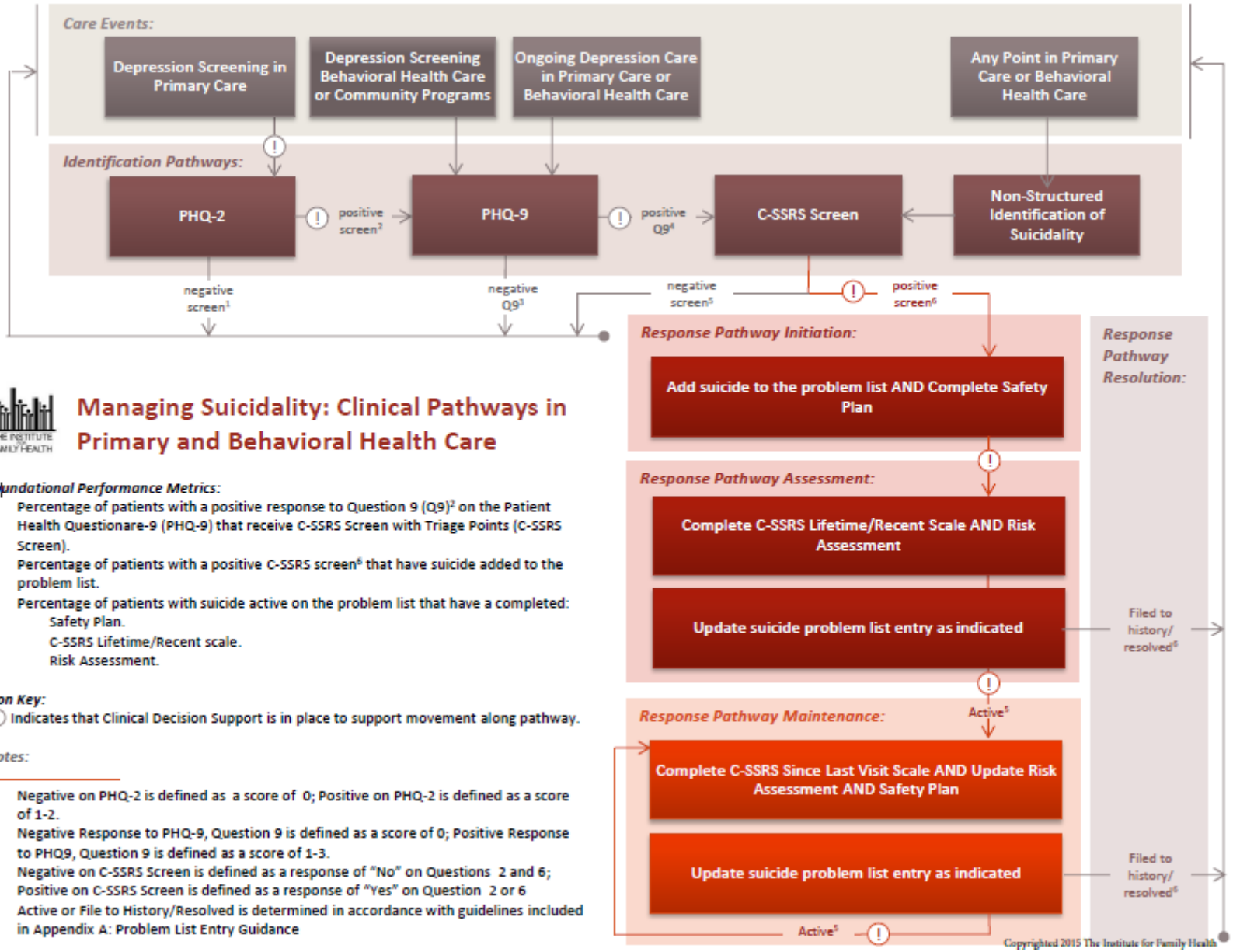
Documentation and follow-up ...

- _____ will call ED to provide patient information.
- _____ will document incident in _____
  (Name of individual or job title) (e.g. medical chart, suicide tracking chart, etc.)
- Necessary forms/instructions/chart-flagging materials are located _____
- _____ will follow-up with ED to determine disposition of patient.
  (Name of individual or job title)
- _____ will follow-up with patient within _____
  (Name of individual or job title) (Time frame)

Institute for Family Health
Clinical Pathways for Managing Suicidality

The Institute for Family Health created a Managing Suicidality: Clinical Pathways in Primary and Behavioral Health Care resource to guide staff through their organization's approach to identification and response.





Managing Suicidality: Clinical Pathways in Primary and Behavioral Health Care

Foundational Performance Metrics:

- ✓ Percentage of patients with a positive response to Question 9 (Q9)[2] on the Patient Health Questionare-9 (PHQ-9) that receive C-SSRS Screen with Triage Points (C-SSRS Screen).
- ✓ Percentage of patients with a positive C-SSRS screen[6] that have suicide added to the problem list.
- ✓ Percentage of patients with suicide active on the problem list that have a completed:
  - Safety Plan.
  - C-SSRS Lifetime/Recent scale.
  - Risk Assessment.

Icon Key:

ⓘ Indicates that Clinical Decision Support is in place to support movement along pathway.

Notes:

1. Negative on PHQ-2 is defined as a score of 0; Positive on PHQ-2 is defined as a score of 1-2.
2. Negative Response to PHQ-9, Question 9 is defined as a score of 0; Positive Response to PHQ9, Question 9 is defined as a score of 1-3.
3. Negative on C-SSRS Screen is defined as a response of "No" on Questions 2 and 6; Positive on C-SSRS Screen is defined as a response of "Yes" on Question 2 or 6
4. Active or File to History/Resolved is determined in accordance with guidelines included in Appendix A: Problem List Entry Guidance

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005

Severity Measure for Depression—Child Age 11–17*

*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

Name:_____ **Age:** _____ **Sex: Male** ❑ **Female** ❑ **Date:**_____

Instructions: How often have you been bothered by each of the following symptoms during the past **7 days**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item score
		(0) Not at all	**(1) Several days**	**(2) More than half the days**	**(3) Nearly every day**	
1.	Feeling down, depressed, irritable, or hopeless?					
2.	Little interest or pleasure in doing things?					
3.	Trouble falling asleep, staying asleep, or sleeping too much?					
4.	Poor appetite, weight loss, or overeating?					
5.	Feeling tired, or having little energy?					
6.	Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?					
7.	Trouble concentrating on things like school work, reading, or watching TV?					
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?					
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?					
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

G4: PHQ-A (continued)

Instructions to Clinicians

The Severity Measure for Depression—Child Age 11–17 (adapted from PHQ-9 modified for Adolescents [PHQ-A]) is a 9-item measure that assesses the severity of depressive disorders and episodes (or clinically significant symptoms of depressive disorders and episodes) in children ages 11–17. The measure is completed by the child prior to a visit with the clinician. Each item asks the child to rate the severity of his or her depression symptoms **during the past 7 days**.

Scoring and Interpretation

Each item on the measure is rated on a 4-point scale (0=Not at all; 1=Several days; 2=More than half the days; and 3=Nearly every day). The total score can range from 0 to 27, with higher scores indicating greater severity of depression. The clinician is asked to review the score of each item on the measure during the clinical interview and indicate the raw score in the section provided for "Clinician Use." The raw scores on the 9 items should be summed to obtain a total raw score and should be interpreted using the table below:

Interpretation Table of Total Raw Score

Total Raw Score	Severity of depressive disorder or episode
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

Note: If 3 or more items are left unanswered, the total raw score on the measure should not be used. Therefore, the child should be encouraged to complete all of the items on the measure. If 1 or 2 items are left unanswered, you are asked to calculate a prorated score. The prorated score is calculated by summing the scores of items that were answered to get a partial raw score. Multiply the partial raw score by the total number of items on the PHQ-9 modified for Adolescents (PHQ-A)—Modified (i.e., 9) and divide the value by the number of items that were actually answered (i.e., 7 or 8). The formula to prorate the partial raw score to Total Raw Score is:

$$\frac{(\text{Raw sum} \times 9)}{\text{Number of items that were actually answered}}$$

If the result is a fraction, round to the nearest whole number.

Frequency of Use

To track changes in the severity of the child's depression over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the child's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the child that might warrant further assessment, treatment, and follow-up. Your clinical judgment should guide your decision.

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Columbia Suicide Severity Rating Scales (C-SSRS)

Answer Questions 1 and 2 *In the past month...*	Past Month
1 Have you wished you were dead or wished you could go to sleep and not wake up?	
2 Have you had any thoughts about killing yourself?	
If YES to 2, answer questions 3, 4, 5 and 6 If NO to 2, go directly to question 6	
3 Have you thought about how you might do this?	
4 Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?	**High Risk**
5 Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	**High Risk**
Always Ask Question 6 *In the past 3 months...*	
6 Have you done anything, started to do anything, or prepared to do anything to end your life? *Ex: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide notes, held a gun but changed your mind, hang yourself, etc.*	**High Risk**

Any YES must be taken seriously. Seek help from friends, family, co-workers, and inform them as soon as possible.

If the answer to 4, 5, or 6 is YES, immediately call 988 or ESCORT to Emergency Personnel for care.

DON'T LEAVE THE PERSON ALONE. LOCK UP FIREARMS AND MEDICATIONS. CALL THE MONTANA SUICIDE PREVENTION LIFELINE AT 988 OR TEXT "MT" TO 741741

THE COLUMBIA LIGHTHOUSE PROJECT
IDENTIFY RISK. PREVENT SUICIDE.

MONTANA DPHHS

Scoring the Columbia Suicide Severity Rating Scale

Ask the first 2 questions by saying, "**in the past month**…

1. **Have you wished you were dead or wished you could go to sleep and not wake up**?
2. **Have you had any thoughts about killing yourself**?

If "NO" to #2, go directly to question 6 and say "in the past 3 months…"

6. **Have you done anything, started to do anything, or prepared to do anything to end your life**?

If YES to #2, answer questions 3, 4, 5, and 6

3. **Have you thought about how you might do this**?
4. **Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them**.
5. **Have you started to work out the details of how to kill yourself? Do you intend to carry out the plan**?

If the answer to 4, 5, or 6 is "YES", immediately CALL 988 OR ESCORT THE PERSON TO EMERGENCY PERSONNEL. IF IN A HEALTHCARE SETTING, INITIATE YOUR OFFICE PROTOCOL FOR TREATING A HIGH-RISK PATIENT.

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

Brief Suicide Safety Assessment

asQ Ask Suicide-Screening Questions

What to do when an adult patient screens positive for suicide risk:

- Use after a patient **(18+ years)** screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These can be hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 Assess the patient

Review patient's responses from the asQ
Interview the patient alone; ask any visitors to leave the room

Frequency of suicidal thoughts

Determine if and how often the patient is having suicidal thoughts.

Ask the patient: "In the past few weeks, have you been thinking about killing yourself?" **If yes, ask:** "How often?" (once or twice a day, several times a day, a couple times a week, etc.) "When was the last time you had these thoughts?"

"Are you having thoughts of killing yourself right now?" **(If "yes," patient is at imminent risk and requires an urgent/STAT mental health evaluation and cannot be left alone. Notify patient's medical team.)**

Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means).

Ask the patient: "Do you have a plan to kill yourself?" **If yes, ask:** "What is your plan?" **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

Past behavior

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).

Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"

If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?" "Did you want to die?" (Intent is as important as lethality of method) **Ask:** "Did you receive medical/psychiatric treatment?"

Note: Past suicidal behavior is the strongest risk factor for future attempts.

Symptoms Ask the patient about:

Depression: "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"

Anxiety: "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"

Impulsivity/Recklessness: "Do you often act without thinking?"

Hopelessness: "In the past few weeks, have you felt hopeless, like things would never get better?"

Anhedonia: "In the past few weeks, have you felt like you couldn't enjoy the things that usually make you happy?"

Isolation: "Have you been keeping to yourself more than usual?"

Irritability: "In the past few weeks, have you been feeling more irritable or grouchier than usual?"

Substance and alcohol use: "In the past few weeks, have you used drugs or alcohol excessively or more than usual?" **If yes, ask:** "What? How much? Has this caused any legal problems or problems with more people in your life?"

Sleep pattern: "In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?"

Appetite: "In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?"

Other concerns: "Recently, have there been any concerning changes in how you are thinking or feeling?"

Social Support & Stressors

(For all questions below, if patient answers yes, ask them to describe.)

Support network: "Is there a trusted person you can talk to? Who? Have you ever seen a therapist/counselor?" **If yes, ask:** "When and for what purpose?"

Family situation: "Are there any conflicts at home that are so difficult to manage that they are causing you a lot of distress?"

Employment: "Do you currently have a job?" If yes, ask: "Do you ever feel so much pressure at work that you can't take it anymore?"

Domestic violence: "Are you worried that anyone in your life is trying to hurt you?"

Suicide contagion: "Do you know anyone who has killed themselves or tried to kill themselves?"

Reasons for living: "What are some of the reasons you would NOT kill yourself?" (e.g. belief system/faith/family/other)

asQ Ask Suicide-Screening Questions

Brief Suicide Safety Assessment

3 Make a safety plan with the patient

Create a safety plan for managing potential future suicidal thoughts. A safety plan is different than making a "safety contract"; asking the patient to contract for safety is NOT effective and may be dangerous or give a false sense of security.

Say to patient: "Our first priority is keeping you safe. Let's work together to develop a safety plan for when you are having thoughts of suicide."

Examples: "I will tell my partner/friend/sibling." "I will call the hotline." "I will call _____."

Discuss coping strategies to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).

Discuss means restriction (securing or removing lethal means): "Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (guns, medications, ropes, etc.)?"

Ask safety question: "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe; but a "yes" is a reason to act immediately to ensure safety.)

4 Determine disposition

After completing the assessment, choose the appropriate disposition plan. *If possible, nurse should follow-up with a check-in phone call (within 48 hours) with all patients who screened positive.*

- ❑ **Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts).** Send to emergency department for extensive mental health evaluation (unless contact with a patient's current mental health provider is possible and alternative safety plan for imminent risk is established).
- ❑ **Further evaluation of risk is necessary:** Review the safety plan and send home with a mental health referral as soon as patient can get an appointment (preferably within 72 hours).
- ❑ **Patient might benefit from non-urgent mental health follow-up:** Review the safety plan and send home with a mental health referral.
- ❑ **No further intervention is necessary at this time.**

For all positive screens, follow up with patient at next appointment.

5 Provide resources to all patients

- **24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454**
- **24/7 Crisis Text Line: Text "HOME" to 741-741**

asQ
Ask Suicide-Screening Questions

Script for nursing staff

Say to parent/guardian:
"National safety guidelines recommend that we screen all kids for suicide risk. We ask these questions in private, so I am going to ask you to step out of the room for a few minutes. If we have any concerns about your child's safety, we will let you know."

Once parent steps out, say to patient:
"Now I'm going to ask you a few more questions."
Administer the ASQ and any other questions you want to ask in private (e.g. domestic violence).

If patient screens positive, say to patient:
"These are hard things to talk about. Thank you for telling me. I'm going to share your answers with [insert name of MD, PA, NP, or mental health clinician] and he/she will come speak with you."

If patient screens positive, and parent/guardian is awaiting results, say:
"We have some concerns about your child's safety that we would like to further evaluate. It's really important that he/she spoke up about this. I'm going to talk to [insert name of MD, PA, NP, or mental health clinician], and he/she will further evaluate your child for safety."

asQ
Ask Suicide-Screening Questions

Parent/guardian flyer

Your child's health and safety is our #1 priority. New national safety guidelines recommend that we screen children and adolescents for suicide risk.

During today's visit, we will ask you to step out of the room for a few minutes so a nurse can ask your child some additional questions about suicide risk and other safety issues in private.

If we have any concerns about your child's safety, we will let you know.

Suicide is the 2nd leading cause of death for youth. Please note that **asking kids questions about suicide is safe**, and is very important for suicide prevention. Research has shown that asking kids about thoughts of suicide is not harmful and **does not put thoughts or ideas into their heads**.

Please feel free to ask your child's doctor if you have any questions about our patient safety efforts.

Thank you in advance for your cooperation.

Patient 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:

_____

- For methods with **low lethality,** clinicians may ask patients to remove or limit their access to these methods themselves.
- Restricting the patient's access to a **highly lethal method,** such as a firearm, should be done by a designated, responsible person – usually a family member or close friend, or the police.

WHAT ARE THE STEPS AFTER THE PLAN IS DEVELOPED?

ASSESS the likelihood that the overall safety plan will be used and problem solve with the patient to identify barriers or obstacles to using the plan.

DISCUSS where the patient will keep the safety plan and how it will be located during a crisis.

EVALUATE if the format is appropriate for patient's capacity and circumstances.

REVIEW the plan periodically when patient's circumstances or needs change.

REMEMBER: THE SAFETY PLAN IS A TOOL TO ENGAGE THE PATIENT AND IS ONLY ONE PART OF A COMPREHENSIVE SUICIDE CARE PLAN

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WICHE

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Safety Planning Guide

A Quick Guide for Clinicians

may be used in conjunction with the "Safety Plan Template"

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is **brief,** is in the **patient's own words,** and is **easy** to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are 6 Steps involved in the development of a Safety Plan.

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Implementing the Safety Plan: 6 Step Process

Step 1: Warning Signs

- Ask: **"How will you know when the safety plan should be used?"**
- Ask: **"What do you experience when you start to think about suicide or feel extremely depressed?"**
- List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patient's **own words**.

Step 2: Internal Coping Strategies

- Ask: **"What can you do, on your own, if you become suidical again, to help yourself not to act on your thoughts or urges?"**
- Assess likelihood of use: Ask: **"How likely do you think you would be able to do this step during a time of crisis?"**
- If doubt about use is expressed, ask: **"What might stand in the way of you thinking of these activities or doing them if you think of them?"**
- Use a collaborative, problem solving approach to address potential roadblocks and ID alternative coping strategies.

Step 3: Social Contacts Who May Distract from the Crisis

- Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Ask: **"Who or what social settings help you take your mind off your problems at least for a little while?" "Who helps you feel better when you socialize with them?"**
- Ask for safe places they can go to be around people (i.e. coffee shop).
- Ask patient to list several people and social settings in case the first option is unavailable.
- Remember, in this step, the goal is distraction from suicidal thoughts and feelings.
- Assess likelihood that patient will engage in this step; ID potential obstacles, and problem solve, as appropriate.

Step 4: Family Members or Friends Who May Offer Help

- Instruct patients to use Step 4 if Step 3 does not resolve crisis or lower risk.
- Ask: **"Among your family or friends, who do you think you could contact for help during a crisis?"** or **"Who is supportive of you and who do you feel that you can talk with when you're under stress?"**
- Ask patients to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.
- Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- Role play and rehearsal can be very useful in this step.

Step 5: Professionals and Agencies to Contact for Help

- Instruct the patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- Ask: **"Who are the mental health professionals that we should identify to be on your safety plan?"** and **"Are there other health care providers?"**
- List names, numbers and/or locations of clinicians, local urgent care services.
- Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- Role play and rehearsal can be very useful in this step.

Step 6: Making the Environment Safe

- Ask patients which means they would consider using during a suicidal crisis.
- Ask: **"Do you own a firearm, such as a gun or rifle??"** and **"What other means do you have access to and may use to attempt to kill yourself?"**
- Collaboratively identify ways to secure or limit access to lethal means: Ask: **"How can we go about developing a plan to limit your access to these means?"**

What Clinicians Can Do

Following is a summary of the steps, goals, and things to consider when talking with clients about reducing access to lethal means.

1. Raise the issue.

Behavioral Goal: Motivate the family to reduce access to lethal means at home.

Considerations:

- Firearms – Guns are highly lethal and irreversible (there's no time to reconsider once the trigger is pulled). Reducing access to a gun can save a life. Ask **all** clients at risk if they have access to firearms and discuss ways to reduce access.

- Medications – Medications are the most common method for suicide attempts. While medications are far less likely to result in death, some are more deadly than others.

Sample Language:

- "When someone is struggling in the ways that you are, sometimes suicidal feelings can emerge and escalate rapidly. There are a few steps we routinely recommend for the home to make things safer."

- "Guns are the most frequent method of suicide *death*, and pills are the most frequent method of suicide *attempt*, so let's start by limiting access to those."

Behavioral Goal: Assess how guns and medications are currently stored at home.

Considerations:

- Firearms – Your goal is not to make people feel interrogated or worry that their guns may be taken from them. Your goal is to let them know about voluntary steps they can choose to take. Speak to the adult who knows the most about the household's firearms which is usually the husband. Often the wife doesn't know how all of the guns are stored. If a client splits their time between homes, such as in joint custody situations, assess both homes.

Sample Language:

- "What some gun owners in your situation do is temporarily store their guns away from home with someone they trust or at a self-storage unit, gun shop, or police department. If you have guns at home, I'd like to talk over storage options like that with you."

- "Let's also talk over what types of medications are in your home and how they're stored."

2. Develop a plan.

Behavioral Goal: Safely store firearms until the client recovers.

Considerations:

- Storing firearms away from the home temporarily is the safest choice. Here are some options:
  - **Relative or friend**: Be sure they are not prohibited from possessing firearms (e.g., due to conviction for felony or domestic violence). Also, some states have laws governing temporary transfers of guns between individuals.
  - **Self-storage rental unit**: Store guns unloaded.
  - **Gun shop or shooting range**: Some offer storage services for a fee or as a free service to regular customers/members. A background check may be required to retrieve guns.
  - **Pawn shop**: For a small loan, you can leave your guns with a pawn shop in most states. Retrieving guns involves a background check in addition to repaying the loan and interest.
  - **Law enforcement**: Some police departments will hold guns on a temporary basis in an emergency. Some will even pick them up. Check their policies before bringing any guns in.
- If off-site storage is not possible, here are the second-best options for firearms:
  - **Lock the firearms in a gun safe or tamper-proof storage box** (ideally with ammunition locked in a separate location), and keep the keys/combinations away from the person at risk. Locking guns in a glass-fronted case, in a wooden case with external hinges, or with only a cable lock that can be easily cut are not as safe as locking guns in a sturdy gun safe.
  - **Disassemble the guns**, and store a key component, like the slide or the firing pin separately or away from the home.
- Quick and easy access to a loaded firearm during a suicidal crisis adds a lot of risk. If none of the off-site or on-site storage options are possible, anything that delays access can help. Here are some additional safety considerations:
  - A locked gun is safer than an unlocked gun, no matter who holds the key.
  - An unloaded gun is a lower suicide risk than a loaded gun, especially if the ammunition is stored separately or away from the home.
  - Hiding guns is not recommended. Family members, especially children and teens, often know or can find the hiding places someone else uses.
  - If a loaded gun is needed for self-defense, discuss with the client and family the short-term comparative risk of suicide versus a home invasion, as well as alternative means for self-defense.

Sample Language:

If the gun owner is the person at risk:

- "Can someone else hold the key or change the combination for now?"

If the gun owner is a family member:

- "Until [client name] is better, would storing the guns away from home work for your family?"

If the family is unwilling/unable to store guns away from home:

- "Would you be willing to lock the guns very securely and separately from the ammunition, and ensure [client name] has no access to the keys or combination?"
- "Would you be willing to ask someone who doesn't live in the home to hold the keys or to change the combination for now?"
- "Would you be willing to remove a critical component of the gun so that it can't fire?"

If the family is not willing to secure the guns at home, give the key/combination to someone else, or temporarily disable the gun:

- "What other options would you be willing to consider to increase safety?"
- "Would you be willing to store and lock the ammunition separately from the locked gun or not keep ammunition at home for now?"

If the reason a family member provides for holding on to the gun is self-defense:

- "For right now, while [*client name*] is at risk of suicide, that gun may be more likely to cause harm than safety."
- "Can you think of any other way to protect your home?" (Examples: outdoor lighting, a dog, or pepper spray)
- "If you have to have a self-defense gun, keeping it on you or in a lock box that [client's name] can't get into will be safer than [client's name] having access to it.

Behavioral Goal: Reduce availability of medications (even those still accessible so that they would not cause serious harm if taken all at once).

Considerations:

- Families should safely dispose of medications they no longer use.
- Provide advice on storing the medications they do need to keep on hand:

- Keep only small quantities of over-the-counter medications on hand.
- Lock up abuse-prone pills (e.g., opioids, benzodiazepines, muscle relaxants, sedatives, barbiturates, amphetamines).
- Ask their doctor or pharmacist, or the poison control center (1-800-222-1222) for help in determining safe quantities for their prescriptions (e.g., for some people, one week's worth may be safe).
- Do not lock up rescue medications such as inhalers and EpiPens.

Sample Language:

- "Now let's make sure there's nothing in the medicine cabinet that could do serious harm to [client name] if she or he took them all at once."

Behavioral Goal: Reduce access to any other method that a client's ideation has focused on.

Considerations:

- If the client has thoughts about using another method (particularly one that is highly lethal), discuss a plan for reducing access to that method.
- It is impossible to entirely "suicide-proof" a home.

Sample Language:

- "Let's talk about some ways you can stay safe and avoid [the method]."

3. Document and Follow Up

Behavioral Goal: Agree on roles and timetable.

Considerations:

- Specific steps with names and timetables work better than a general plan like "family will secure the guns."

Sample Language:

- "Let's review who's doing what and when: Dad will take the guns to his brother's house this weekend and in the meantime, he will put them in the gun safe. Mom will put a week's worth of [client's name] antidepressants in the pill sorter and lock up the rest. She will dispose of old medications and talk to a pharmacist tomorrow about safe amounts of the other medications."

Behavioral Goal: Document the plan and next steps.

Considerations:

- Note the discussion and plan in the medical record so that it is accessible to other providers.

Sample Language:

- "I've written down the plan here for you to take with you. We'll give you a call in a few days to see how things are going."

Behavioral Goal: Confirm that the plan was implemented.

Considerations:

- Follow-up contacts have been shown to increase the likelihood that a family will actually implement the plan as well as reduce the likelihood of readmission to an inpatient facility.

Sample Language:

- "Hi! I wanted to check in and see how [client's name] is doing and also ask how the plan is going that we talked about for gun and medication storage."

“Caring Contacts” Intervention

Taken from a webinar by the American Association of Suicidology entitled, “Post Treatment Caring Contacts for Suicide Prevention” by David D. Luxton, PhD., M.S., on January 15, 2015

Caring letters is a suicide prevention intervention that entails the sending of brief messages that espouse caring concern to patients following discharge from treatment.

- Simple, non-demanding, expressions of care that...
  - With multiple contacts, may contribute to a sense of belongingness (via a caring connection)
  - Reminders of treatment availability may provide route to seek help
  - May help patients to feel better about treatment and therefore motivate them to adhere to treatment
- Original *caring letters* study (Motto,1976; Motto & Bostrom, 2001)
- Sent caring letters to patients who did not continue in care
- Letters were sent monthly, decreasing to quarterly, for five years.
- Example Motto letter:

“Dear ____: It has been some time since you were here at the hospital, and we hope things are going well for you. If you wish to drop us a note we would be glad to hear from you.”

Sample caring email

Dear **[patient's name]**,
We appreciated the opportunity to get to know you while you were at the hospital. We hope things are going well for you.
We remember how you said that you enjoy hiking around the South Puget Sound. With the return of the summer weather, we hope you're getting a chance to get out there and explore some new trails. Anyway, we just wanted to send a quick e-mail to let you know we are thinking about you and wishing you well.
If you wish to drop us a note, we would be glad to hear from you.

Sincerely, Cassidy and Laura

Please note that the following resources are always available to you:
[List of resources]

Please know that I make every attempt to respond to my emails each business day. If for some reason you need immediate assistance, please reach out to the resources listed above. Also, you should refrain from replying with any sensitive personally identifiable material or confidential information to include medical information over the internet. If you choose to send such information via email, you do so at your own risk.

If you will be changing your contact information (email address, phone number, postal address), feel free to let us know so that we can stay in contact with you.

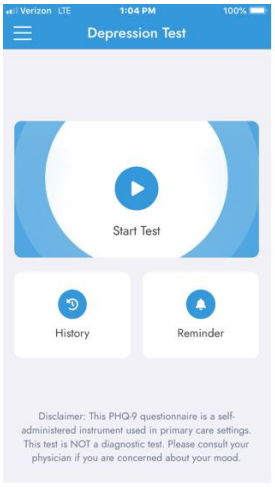
Other Caring Contact Studies

Outcomes: Self-directed violence or suicide ideation reduction (Luxton, June, & Comtois, 2013)

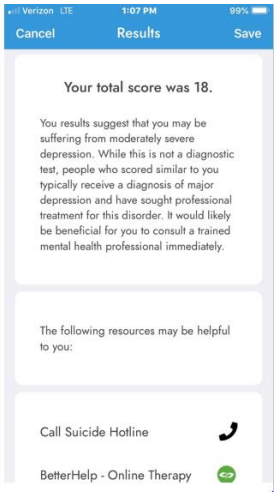
- **Postcards**(Beautraiset al., 2010; Carter et al., 2005; Carter et al., 2007)
- **Postal letters**(Motto, 1976; Motto & Bostrom, 2001)
- **SMS Texting**(Chen, Mishara & Liu,2010; Comtois, et al)
- **Email**(Luxton et al., 2012)
- **Mixed modality** (in-person, phone, etc.) (Fleischmann et al., 2008)

Ideally, contacts would be made at the following intervals

- Within 3 days of visit
- Once at two weeks
- Once at 4 weeks
- Once at 2 months and 3 months



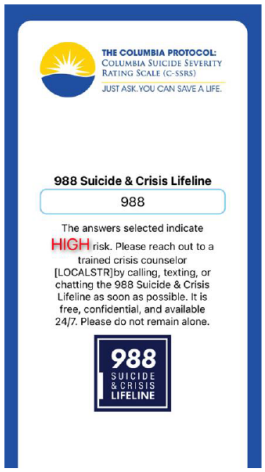
Depression Screen App

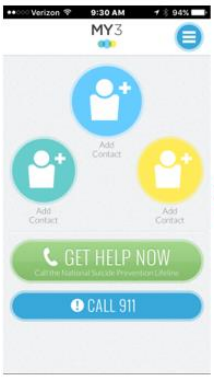


C-SSRS App search "Columbia Protocol"

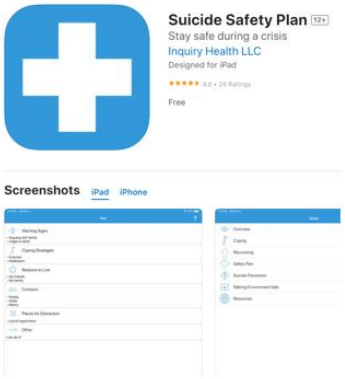
THE COLUMBIA PROTOCOL:
COLUMBIA SUICIDE SEVERITY RATING SCALE (C-SSRS)
JUST ASK. YOU CAN SAVE A LIFE.

Powered By PS Solutions





Safety Plan app



Safety Plan App

Responding After a Suicide:

A Toolkit for Communities in Montana

Table of Contents

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Montana Department of Public Health and Human Services

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Sections of the toolkit and Appendix were adapted from the following postvention resources:

Alaska Department of Health and Social Services. (2020). Preparing to Heal: The Alaska Postvention Resource Guide. https://health.alaska.gov/SuicidePrevention/Documents/pdfs_sspc/PostventionGuide-2020.pdf

American Foundation for Suicide Prevention and Suicide Prevention Resource Center. (2018). After a suicide: A toolkit for schools (2nd ed.). Waltham, MA: Education Development Center. https://www.sprc.org/resources-programs/after-suicide-toolkit-schools, AFSP.org

Black, S., Guard, A. (2016). After Rural Suicide: A Guide for Coordinated Community Postvention Response. California Mental Health Services Authority (CalMHSA). https://www.sprc.org/resources-programs/after-rural-suicide-guide-coordinated-community-postvention-response.

Introduction

What is this toolkit for?

Use this toolkit to help your community prepare for a response to a suicide before it happens. It will help you learn how to form and mobilize a Postvention Response Team, identify sources of support for anyone affected by suicide, identify warning signs, and assess for suicidal risk. Together, this series of action steps will allow your community to safely offer support and reduce the risk of additional suicides from occurring in your community. These efforts are collectively referred to as **suicide postvention** because, while planning and preparation occurs before a suicide, the actual postvention response occurs *after* a suicide has happened. This toolkit was specifically designed to be used in communities in Montana and pulls together helpful community, state-wide, and national postvention resources. Having a community-wide response has been found to be helpful in prevention efforts.

As different communities begin planning, it is critical that any statewide effort takes into account the voices of tribal and urban Indian programs. While much of the planning will be done on the local level, these voices must be included in their communities and beyond. Please refer to the addendum on page 60 for more information on enacting a postvention response in American Indian communities. Other special populations will also need culturally responsive approaches including those in LGBTQI+ communities, youth, veterans, survivors of suicide, and those in correctional settings.

When should this toolkit be used?

Suicide can happen in any community, so just as communities conduct fire drills and other kinds of disaster planning, it is best to be prepared so that you can respond effectively if the worst-case scenario does happen. While this toolkit is meant to guide the response **after a suicide occurs**, developing a response team and the overall plan called for in this guide should be **prepared in advance** so your community can respond quickly and effectively in the event of a suicide.

The steps of developing and using this plan are outlined in the following checklist, which is divided into a Preparation Phase and Action Phase. Each of these steps is described in detail starting on page 14.

Postvention Response Plan Checklist

This is an abbreviated checklist of the Postvention Response Plan. A detailed description of the tasks can be found on pages 14-23. The plan is divided into a **Preparation Phase** that should be completed prior to a suicide and an **Action Phase,** which is to be followed after a suicide occurs in your community. Within each item is a list of **Subtasks** that can be checked off as they are completed. The "**Assigned to**" column includes space to write which team member is responsible for completing each task.

Preparation Phase - *Before a Suicide*		
Item	**Brief Description of Subtasks**	**Assigned to**
1	☐ **Form Postvention Response Team and designate roles.** ☐ Make sure team members have a copy of this toolkit, read it over in its entirety, and have a clear understanding of their roles and responsibilities. ☐ Team members should also familiarize themselves with the additional resources included in the toolkit that are part of their role (e.g., social media coordinator should review linked social media monitoring documents at the end of the social media guidance on page 50).	Team Leader: _____ Team Coordinator: _____ Community Liaison(s): _____ Outreach Coordinator: _____ Media Relations: _____ Social Media Coordinator: _____
2	☐ Hold an **initial meeting with all members of the Postvention Response Team**: Review the Postvention Response Plan in detail as well as each members' roles and responsibilities, decide how often to meet, how to best communicate with the team, broad goals to accomplish, and a timeline for completion. ☐ Consider how you may enact these steps in your community. Anticipate and troubleshoot any barriers that could arise. ☐ Review sources of support and identify additional mental health support resources that could be added to this list. ☐ Identify additional stakeholders you may want to contact in the future and gather contact information for stakeholders, behavioral health centers, and local Better Business Bureau or Chamber of Commerce.	Name(s), role(s), and responsibilities: _____ _____ _____ Suggested role(s): Team Leader and Team Coordinator
3	☐ **Create memorandums of understanding/agreement (MOU/MOA) with local law enforcement, medical examiner, and/or coroner** to establish formal, clearly defined relationships and facilitate communication if a suicide occurs.	Name(s), role(s), and responsibilities: Suggested role(s): Team Leader

4	☐ **Review training options and start training Postvention Response Team members.** ☐ Consider hosting and advertising trainings to the broader community.	Name(s), role(s), and responsibilities: _____ Suggested role(s): Team Leader Trainings: _____

Action Phase - *After a Suicide Occurs*

Item	Brief Description of Subtasks	Assigned to
1	☐ **Hold a meeting with all members of the Postvention Response Team to review roles and action steps.** ☐ Ensure team members have a clear understanding of their roles and responsibilities. ☐ Decide on the frequency of meetings and confirm the best platforms for communicating with team members.	Team Leader: _____ Team Coordinator: _____ Community Liaison(s): _____ Outreach Coordinator: _____ Media Relations: _____ Social Media Coordinator: _____
2	☐ **Contact local law enforcement, medical examiner, and/or coroner** to confirm the nature of the death and any relevant details such as name, age, gender, and contact information for loss survivors and any witnesses, *only* if they agree to be contacted. ☐ Create MOUs if this has not already been established. ☐ If members learn of a suicide through social media initially, immediate efforts to contact law enforcement should be undertaken for confirmation. (Social media guidance on p. 50.)	Name(s), role(s), and responsibilities: _____ _____ _____ Suggested role(s): Team Leader
3	☐ After reviewing tips for talking about suicide and offering support to the bereaved family, **contact the decedent's family to offer condolences**. If they agree, provide information on the Postvention Response Team and inquire how you can be supportive.	Name(s), role(s), and responsibilities: _____ _____

	☐ If other loss survivors or witnesses agree to be contacted, you may reach out to them in a similar manner and provide them with **sources of support and resources designed for loss survivors.**	Suggested role(s): Team Leader
4	☐ Review safe messaging guidelines. ☐ **Create and distribute a public statement**. ☐ Contact local media to provide a public statement *and* safe messaging guidelines. ☐ Make sure the rest of the team is aware of the safe messaging guidelines and public statement	Name(s), role(s), and responsibilities: _____ Suggested role(s): Media Relations
5	☐ **Identify and contact additional stakeholders** who could play an important role in postvention. ☐ Provide stakeholders with resources from the toolkit as you see fit (e.g., safe messaging guidelines, Columbia-Suicide Severity Rating Scale [C-SSRS] recommendations for public memorial observances, Montana Crisis Action School Toolkit on Suicide [CAST-S]).	Name(s), role(s), and responsibilities: _____ Suggested role(s): Community Liaisons
6	☐ **Contact local the Better Business Bureau or Chamber of Commerce** about posting suicide prevention materials in local businesses and/or community spaces. ☐ After receiving approval, distribute and/or **display these posters** in prominent places in your community.	Name(s), role(s), and responsibilities: _____ Suggested role(s): Outreach Coordinator
7	☐ Contact your **local behavioral health center and inform them that a suicide has occurred** in your community so they can prepare for an increase in referrals. In addition, they should identify patients who may be at increased risk and direct appropriate intervention to them. ☐ Provide them with information on the **C-SSRS and Safety Planning Intervention.**	Name(s), role(s), and responsibilities: _____ Suggested role(s): Team Coordinator
8	☐ Read and follow the social media guidance found in this toolkit. ☐ **Monitor the deceased's social media sites and/or any memorial pages.** ☐ Update or create a social media page to provide links to important resources.	Name(s), role(s), and responsibilities: _____ Suggested role(s): Social Media Coordinator

9	☐ Read the **sample agenda and information on community meetings** available in the After Rural Suicide: A Guide for Coordinated Community Postvention Response guide. ☐ Set the agenda and goals for community meetings. ☐ **Host community meeting(s)** to provide the greater community with postvention information and helpful resources for coping.	Name(s), role(s), and responsibilities: _____ Suggested role(s): Team Leader and Team Coordinator
10	☐ **If possible, attend funeral/memorial services** to hand out resources such as sources of support and be prepared to look for warning signs among attendees, screen for suicide risk, and potentially refer to additional care and/or the Suicide and Crisis Lifeline (988) if needed.	Name(s), role(s), and responsibilities: __ Suggested role(s): Outreach Coordinator
11+	☐ Engage in long-term postvention activities including: ☐ Maintain **open communication with the team.** ☐ Maintain **ongoing contact with stakeholders.** ☐ Consider suicide prevention advocacy work. ☐ Be aware of **anniversaries and future memorial services** to: ☐ Remind local media of **safe messaging guidelines.** ☐ **Monitor social media.** For communities that experience multiple suicides in a relatively short period of time it may be helpful to bring in additional resources to support the postvention team. If additional support is needed, please contact the Montana Suicide Prevention coordinator.	Name(s), role(s), and responsibilities: _____ _____ Suggested role(s): All Team Members

This information in this resource was adapted from After a Suicide: A Toolkit for Schools, After Rural Suicide: A Guide for Coordinated Community Postvention Response, and Alaska Suicide Postvention Guide: Preparing to Heal.

https://sprc.org/online-library/after-rural-suicide-guide-coordinated-community-postvention-response

Why is this toolkit needed?

One suicide is estimated to affect anywhere between six and 135 people,[1] though other accounts estimate this number to be more than 400.[2] The effects of suicide are far-reaching and can lead to what is known as **suicide contagion.** Suicide contagion refers to an increase in suicide or suicidal behaviors in others occurs after witnessing or learning about the suicide of a friend, family member, classmate, community member, or even celebrities or public figures. Witnessing or learning about someone else's suicide is known as **suicide exposure.** Suicide contagion may be more likely to occur when explicit details or images of the suicide are reported.[3]

Even if not at risk of suicide contagion, many people will be faced with overwhelming emotions after the sudden loss of a loved one to suicide. Suicide grief can be both devastating and complex. Fortunately, organized community support and action can help promote the healing process. By using the postvention strategies outlined in this toolkit, you can **help others cope safely** and **prevent suicide contagion** from occurring in your community

What are some facts about suicide in Montana?

- Suicide postvention is especially important in communities in Montana as the suicide rate is nearly twice as high as the national average at 25.9 per 100,000 people; 300 suicides a year.[4,5]
- While American Indians make up 6.3% of the population of Montana, their suicide rate is even higher than the state average at 32 per 100,000.[6]
- Montana consistently ranks among the top five states with the highest rates of suicide.[5]
- Suicide was the ninth leading cause of death among all ages[7] and the second leading cause of death for those between the ages of 10 and 44.[4]
- More than half the suicides in Montana (63%) were by firearms.[4]
- Males account for 80% of all suicide deaths.[5]

*It is important to keep in mind that **suicide is preventable**. This toolkit includes research-backed steps you and others in your community can put into practice to help lower the risk of suicide in others and prevent additional suicides from occurring.*

I am not a mental health professional; can I still use this toolkit?

Yes. Everyone can play a meaningful role in suicide postvention. In fact, that is the basis for a community-based postvention effort. While mental health professionals are helpful for managing suicide risk, treating symptoms of mental illness, and providing grief counseling in a therapeutic setting, community members play a vital role in the postvention process, particularly in encouraging help-seeking and providing support and resources.

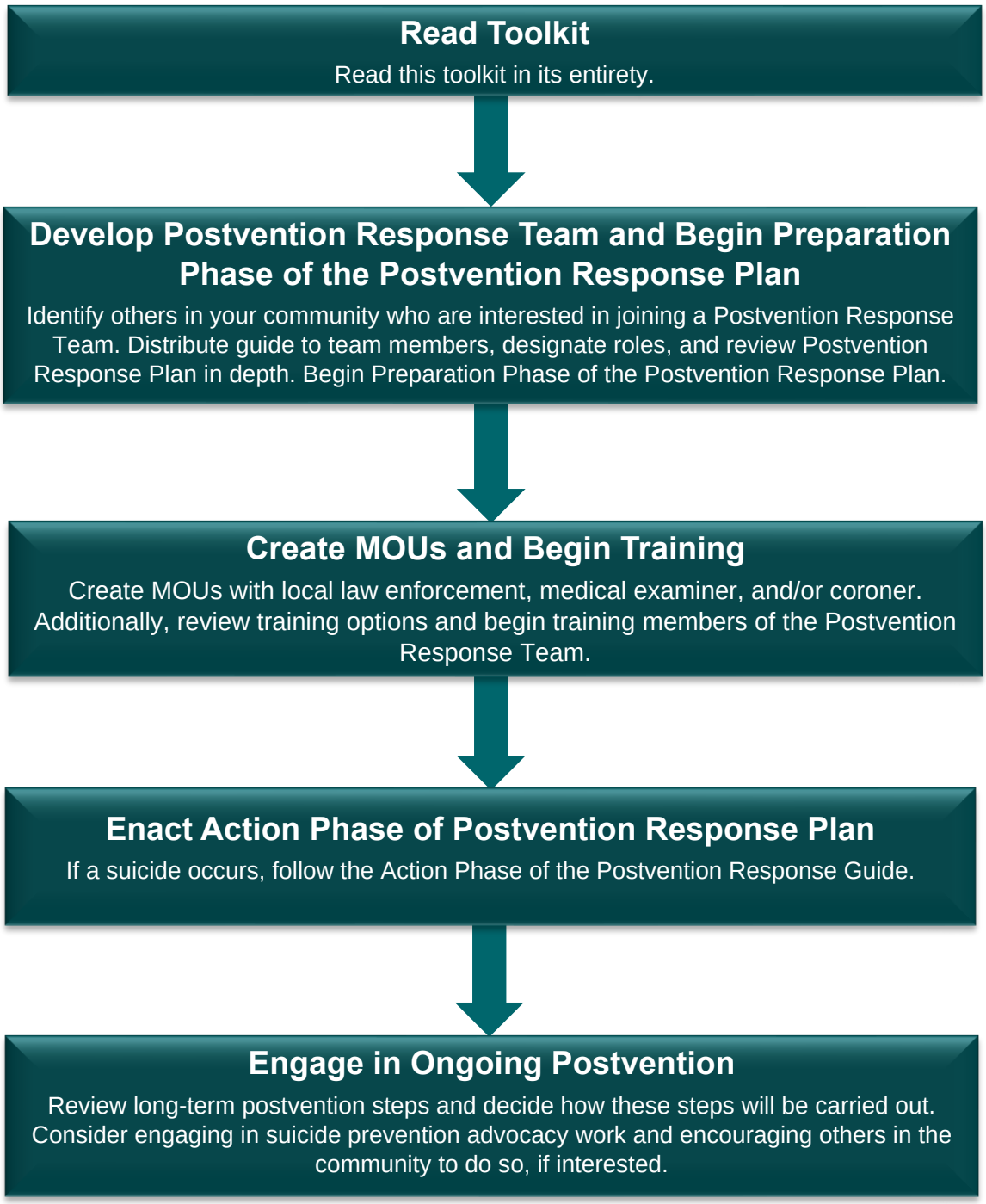
The mental health system can be overwhelming and difficult to navigate, especially those who are grieving the sudden loss of a loved one and are in crisis. Family members, friends, coworkers, and others in the community may be the first to notice changes in another's mental state and can help guide those in crisis to appropriate care. Further, everyone can play a major part in organizing

community action to promote resilience and healing. For additional guidance on these conversations please reference the Appendix.

I am a mental health or substance use treatment professional; can I still use this toolkit?

Yes. Mental health and substance use treatment professionals can play a vital role as a key stakeholder or member on the Postvention Response Team and by utilizing the Safety Planning Intervention (page 34). The Screen for Suicide Risk section (page 30) can also be used by professionals as an initial screen prior to conducting a comprehensive suicide risk assessment.

Overview


Read Toolkit
Read this toolkit in its entirety.
Develop Postvention Response Team and Begin Preparation Phase of the Postvention Response Plan
Identify others in your community who are interested in joining a Postvention Response Team. Distribute guide to team members, designate roles, and review Postvention Response Plan in depth. Begin Preparation Phase of the Postvention Response Plan.
Create MOUs and Begin Training
Create MOUs with local law enforcement, medical examiner, and/or coroner. Additionally, review training options and begin training members of the Postvention Response Team.
Enact Action Phase of Postvention Response Plan
If a suicide occurs, follow the Action Phase of the Postvention Response Guide.
Engage in Ongoing Postvention
Review long-term postvention steps and decide how these steps will be carried out. Consider engaging in suicide prevention advocacy work and encouraging others in the community to do so, if interested.

Postvention Response Team and Postvention Response Plan

Form a Postvention Response Team

The first steps to prepare your community to respond to a local suicide is to form a **Postvention Response Team** and develop a **Postvention Response Plan**. A Postvention Response Team provides immediate and long-term assistance to anyone impacted by a suicide. The overarching goals of the Postvention Response Team are to help support those who are grieving, including direct family and friends of the decedent; identify individuals who may be at increased risk of suicide contagion; offer mental health resources; and safely communicate these ideas and other important information about suicide to the larger community.

Suicide postvention work is ongoing and is more likely to be effective when you have the support of other members in your community. Ideally, the Postvention Response Team should consist of roughly six to fifteen people. Those on the Postvention Response Team should consist of community and youth leaders; village and/or tribal leaders; leaders from the faith-based community; mental health professionals; and/or anyone with a background in mental health, counseling, and/or suicide prevention, though this may not be possible in every community. At the very least, the team should consist of dedicated community members who are willing to learn and help with postvention efforts.

This section will provide more information on the different roles within a Postvention Response Team, important steps to include in a Postvention Response Plan, and other community members that would be well suited as **Key Stakeholders** in the postvention planning response.

If it is not possible to create a Postvention Response Team in your community, you can contact outside agencies for support including:

- **Tamarack Grief Resource Center (Missoula), 406-541-8472,** https://www.tamarackgrc.org/
- **Voices of Hope (Great Falls), 406-268-1330,** https://www.voicesofhopemt.org/
- **Help Center, Inc. (Bozeman), 406-586-3333,** https://www.bozemanhelpcenter.org/

If the suicide involves a youth in middle or high school, it is essential to refer the school to the **Montana Crisis Action School Toolkit on Suicide (CAST-S),** https://dphhs.mt.gov/assets/suicideprevention/cast-s2022.pdf , in addition to using the information available in this toolkit.

Postvention Response Team

If possible, a Postvention Response Team should consist of between six and fifteen members, including a Team Leader, Team Coordinator, Community Liaison, Outreach Coordinator, Media Relations Point Person, and Social Media Coordinator. Other key community members may be added to the team to provide additional support. A broad overview of the key positions follows.

Position	Overview of Role
Team Leader	• Leads and helps assemble the Postvention Response Team. • Works with team to assign roles and tasks. • Contacts and supports the bereaved family and/or organization the deceased belonged to (school, employer, etc.). • Hosts and leads any community meetings.
Team Coordinator	• Supports Team Leader in any task, as needed. • Leads Postvention Response Team meetings. • Keeps track of assigned roles and responsibilities. • Follows up with team members on outstanding tasks. • Assists with coordinating, scheduling, and advertising community meetings. • Notifies local resources of suicide prevention in the community (e.g., local behavioral health facility) to prepare to provide support.
Community Liaison(s)	• Takes lead on sharing information and coordinating with **Key Stakeholders.** • Provides stakeholders with safe messaging guidelines and other suicide. prevention and postvention materials. • Shares safety planning information with local behavioral health personnel. • Develops memorandums of understanding with stakeholders.
Outreach Coordinator	• Orients team to suicide prevention and postvention materials. • Contacts local Better Business Bureau/Chamber of Commerce requesting them to post or distribute suicide prevention and postvention materials in local businesses and community space; then posts or distributes the materials. • Shares resources at community meeting(s). • If possible, attends memorial or funeral services to offer support and help someone access emergency services if in crisis.
Media Relations Point Person	• Takes the lead creating public statements and communicating with local media and with local law enforcement. • Shares safe messaging guideline resources with media. • Creates list of talking points to give other members of the Postvention Team so everyone is on the same page if they are contacted by media. • Trains the rest of the Postvention Team on safe messaging guidelines.
Social Media Coordinator	• Monitors the decedent's social media pages and reports harmful or incorrect information and responds according to safe messaging guidelines. • Identifies existing social media platforms and disseminates important postvention information. This could include Facebook and LinkedIn pages from local hospitals, primary care practices, schools, and faith-based communities

Key Stakeholders: Stakeholders do not have to take an active role in the Postvention Response Team but can assist in developing and carrying out a comprehensive, community-wide postvention response through information and resource sharing. Stakeholders may include the following personnel: Sheriff/ first responders, coroner, medical examiner, school superintendent, clergy or religious leaders, primary care providers, members of local American Legion or VFW, village or tribal leaders, behavioral health response team (if applicable), funeral director, social services, and media. Note that personnel from these professions can also serve on the Postvention Response Team if they are willing.

Develop a Postvention Response Plan

Postvention Response Plan

This section provides a detailed description of a Postvention Response Plan. These steps can be found in an abbreviated, printable checklist starting on page 6. The plan is divided into a Preparation Phase and an Action Phase. The **Preparation Phase** includes forming a Postvention Response Team, reviewing this toolkit and additional postvention guides referenced throughout, establishing MOUs, participating in trainings, in addition to other steps.

If a suicide does occur, the Postvention Response Team should follow the **Action Phase** which involves steps such as contacting local law enforcement and the decedent's family, issuing a public statement, actively monitoring social media pages, distributing resources, among others.

Some of the steps may need to be carried out simultaneously, or in a different order. If this toolkit has not been reviewed ahead of time and the Preparation Phase has not been followed prior to a suicide occurring in the community, it is recommended that creating a Postvention Team, confirming facts about the case, contacting the surviving family, if indicated, and issuing a public statement should be prioritized ahead of the other action steps.

Further, it may not be feasible to carry out all steps depending upon the resources available in your community. If you and the Postvention Response Team decide to alter the steps outlined in this toolkit, you can consult with the Montana Suicide Prevention Coordinator to make sure your plan is in line with best practices and will not be unintentionally harmful to the surrounding community.

Montana Suicide Prevention Coordinator
Karl Rosston, LCSW
Phone: 406-444-3349
Email: krosston@mt.gov

Overall Mission Statement: The overall mission of enacting a Postvention Response Plan and forming a Postvention Response Team is to help others cope safely and reduce their risk of suicide after a suicide has occurred in your community.

Preparation Phase

❖ Preparation Item 1: Form a Postvention Response Team and Designate Roles.

Contact individuals who may be good candidates to join a Postvention Response Team. Consider the skills that are needed to implement postvention and choose members who can form a solid team. This team should consist of dedicated members of the community who are willing to learn and help with postvention efforts, especially community and youth leaders; village and/or tribal leaders; mental health professionals; and anyone with some background in mental health, counseling, and/or or suicide prevention. It will also be very helpful to have one or more members who are skilled in social media use.

Team members should read this toolkit in its entirety and familiarize themselves with the additional resources included in this toolkit. For example, the **Social Media Coordinator** should review the reference documents at the end of the social media guidance page and familiarize themselves with how to monitor different social media pages. They may also decide to develop a webpage (on Facebook, Google sites, or another platform) where they can post helpful information such as behavioral health resources, warning signs, the Suicide and Crisis Lifeline number, and/or information on upcoming trainings (this will be discussed in greater detail in the Preparation Phase).

Other examples include the **Team Leader** reviewing tips on how to talk about suicide and offering support to the bereaved (page 42); the **Media Relations Point Person** reviewing information on safe messaging (page 43); the **Outreach Coordinator** reviewing guides on how to host safe funeral and memorial services (pages 56); and gathering contact information for the Better Business Bureau, local Chamber of Commerce, and important stakeholders in the community (this will be discussed later).

❖ Preparation Item 2: Begin Postvention Response Team Meetings

Hold an initial meeting with members of the Postvention Response Team to review roles and responsibilities in detail. As a team, review the **Postvention Response Plan (both Preparation and Action Phases)**, and consider how you would begin to follow these steps in your community. Discuss any questions and barriers that may arise and come up with workable solutions. If needed, contact the Montana Suicide Prevention Coordinator to discuss questions, major revisions, or additions to the response plan.

Review the list of resources (Sources of Support on page 24) and identify additional mental health resources that would be beneficial to share with your community.

It is also helpful to identify additional stakeholders that may be important in carrying out an effective postvention response through information and resource sharing. Additional key stakeholders may include school superintendent, clergy or religious leaders, primary care providers, members of local American Legion or VFW, village or tribal leaders, behavioral

health response team (if applicable), funeral director, social services, and media. An MOU is desired between organizations participating in the postvention team as recommended.

Finally, it is recommended that you decide as a team how often to meet, how to best communicate with one another, broad goals to accomplish, and a timeline for completion.

❖ Preparation Item 3: Create MOUs with Local Law Enforcement/ Medical Examiner

The postvention team leader should **reach out to local law enforcement, medical examiner, and/or coroner** and develop an MOU, explain the role of the team, the actions that will be taken after a suicide (as outlined in the Action Phase), and what will be needed from these community members. While MOUs may not be necessary or beneficial for every community, determining if an MOU that outlines specifics of the partnership as well as what information will and will not be shared is in the best interest of all parties involved.

Guides that Include Sample MOUs

After Rural Suicide: A Guide for Coordinated Community Postvention Response
https://work.cibhs.org/pod/after-rural-suicide

Crisis Action School Toolkit on Suicide - CAST-S
https://dphhs.mt.gov/assets/suicideprevention/cast-s2022.pdf

❖ Preparation Item 4: Review Training Options and Begin Training

An effective postvention response requires that members of the Postvention Response Team are well-versed in suicide prevention/postvention best practices. The following training options are strongly recommended, at minimum, for the Postvention Response Team. You can also find additional trainings and resources at the Suicide Prevention Resource Center's (SPRC) webpage on gatekeeper trainings at https://sprc.org/sites/default/files/resource-program/GatekeeperMatrix6-21-18_0.pdf.
The Postvention Response Team may also decide to host community-wide trainings.

Recommended Training for All Postvention Response Team Members:
Free Trainings in how to use the Columbia-Suicide Severity Rating Scale
https://cssrs.columbia.edu/training/training-options/
Question, Persuade, and Refer (QPR) training: https://qprinstitute.com/
Suicide safer care training is available from approved trainers. To locate these, please contact Karl Rosston (KRosston@mt.gov).

Trainings for Mental Health Professionals:
While all members of the Postvention Response Team can view these trainings, it is recommended that the interventions are only provided by trained mental health professionals.
Safety Planning
https://zerosuicide.edc.org/resources/resource-database/safety-planning-intervention-suicide-prevention

Lethal Means Counseling
https://www.sprc.org/resources-programs/calm-counseling-access-lethal-means

Action Phase

❖ Action Item 1: Hold Postvention Response Team Meetings

Depending upon when the Postvention Response Team last met in the Preparation Phase, it will likely be helpful to host a meeting with members of the Postvention Response Team soon after a suicide has occurred in the community. During this meeting, ensure everyone has a clear understanding of their roles and responsibilities, as well as the steps of the Action Phase and any outstanding items that were not completed in the Preparation Phase. If needed, contact the Montana Suicide Prevention Coordinator to discuss major revisions or additions to the response plan.

Decide how frequently you should meet as a team during this phase and how to best keep the team informed of updates and advances on each task – whether that is through daily briefings in person or over the phone, biweekly teleconferences, and/or sharing information via email or other electronic communication. Stay consistent with the agreed upon plan moving forward and modify if necessary. In general, it is recommended that the Postvention Team meet at least yearly or more frequently, as needed, to ensure that all the functions are filled, and the team is ready to respond.

❖ Action Item 2: Contact Local Law Enforcement/ Medical Examiner to Confirm Facts

Contact local law enforcement, the medical examiner, and/or coroner (according to the MOU developed in the Preparation Phase) to confirm the nature of the death and any relevant details including the decedent's name, age, gender, where and how the body was found, and contact information for any witnesses and immediate loss survivors (family and/or close friends) if they agree to be contacted.

❖ Action Item 3: Contact the Decedent's Family and Other Loss Survivors or Witnesses

Contact the decedent's family to offer condolences. Prior to doing so, **be sure to follow tips for talking about suicide and providing support to bereaved family and friends** (page 43).

Because of the complex and unpredictable nature of suicide grief, **family members may not wish to speak with others** or may not be able to engage in a lengthy discussion. It is

important to be respectful of their reactions and not force information or resources upon them. If family members are not in a place to speak with you, simply offer your contact information and let them know that you and other caring members of the community are available to support them if they would like.

If the family is willing to speak further, you can inform them of the Postvention Response Team that has been created and inquire how the team can be supportive. You can also ask what they would like the public to be told regarding the decedent and the nature of their death, as well as any information on funeral arrangements or memorial services and if they are open for members of the community to attend. Further, you can provide them with a list of general mental health resources (see Sources of Support starting on page 24) and resources and tools that are specifically designed to help loss survivors (see page 44).

Identify high risk contacts. High risk contacts are people who are close to the person who died, either by familial connections or by relationship. Those with a history of depression, substance use or previous suicide attempts are at higher risk. If loss survivors or witnesses agree to be contacted, you can reach out to them a manner similar to that of the decedent's family. Be prepared to identify warning signs of suicide (page 47), assess for risk (page 30), and provide resources (page 24-25).

❖ Action Item 4: Develop and Issue Public Statements

After reviewing safe messaging guidelines and taking into consideration the wishes of the decedent's family, if you were able to speak with them, create and distribute **a public statement** (see page 46 for the information to include in a public statement); you can also access a sample public statement in the SPRC Toolkit for Schools at https://www.sprc.org/resources-programs/after-suicide-toolkit-schools.

Contact local media to provide the public statement along with **safe messaging guidelines** (page 45). Make sure the Postvention Response Team is aware of the public statement and safe messaging guidelines in case members of the media contact them. If time allows, you may also wish to offer safe messaging guidance to those in the community who are responsible for writing obituaries and death notices.

❖ Action Item 5: Contact Additional Stakeholders

Contact additional stakeholders (identified in the **Preparation Phase**) who would help support your efforts sharing information and resources. This may include the school superintendent, clergy or religious leaders, primary care providers, members of local American Legion or VFW, village or tribal leaders, behavioral health response team (if applicable), funeral director, social services, and media.

You may want to **provide stakeholders with some resources found in this toolkit** such as suicidal warning signs to lookout for in other community members (page 47), how to screen for suicide risk (page 30), mental health resources (page 24-25), the do's and don'ts of talking

about suicide (page 42), how to help someone in emotional pain, warning signs of suicide and Suicide and Crisis Lifeline posters, crisis text line posters, safe storage for firearms (pages 49), etc. It is also helpful for these stakeholders to have QPR training (see https://qprinstitute.com/).

If the decedent was a student, it is important to contact the superintendent of the school system to share information and provide important resources to prevent suicide contagion. You can also provide them with the **CAST-S** created for Montana schools (see link https://dphhs.mt.gov/assets/suicideprevention/cast-s2022.pdf)

Also provide relevant materials to **clergy or religious leaders, funeral directors** (see https://www.sprc.org/resources-programs/supporting-survivors-suicide-loss-guide-funeral-directors-2nd-ed), and any other organizations/individuals **hosting a memorial with recommendations on religious services and public memorial observances** (see https://www.sprc.org/resources-programs/after-suicide-recommendations-religious-services-and-other-public-memorial). If done incorrectly, memorial observances have the potential to put other vulnerable people in the community at risk of suicide. Therefore, it is important that these leaders are aware of this risk and provided with information on how to help prevent further tragedies from happening.

- **Action Item 6: Contact Local Better Business Bureau/Chamber of Commerce**

Reach out to the Better Business Bureau or Chamber of Commerce about **posting suicide prevention materials in local businesses and/or community spaces**. Materials you may want to post include the warning signs of suicide poster that includes the Suicide and Crisis Lifeline number, the crisis text line number poster (page 47), and the poster on how to help someone in emotional pain (page 48). After receiving approval, distribute and/or display these posters in prominent places in your community.

- **Action Item 7: Contact Local Behavioral Health Center(s)**

If there are behavioral health centers in your community, it is important to contact them and **inform them that a suicide has occurred** so they can prepare for a potential increase in referrals.

You can also **provide them with information** on how to screen for suicide risk (page 30) and how to implement the Safety Planning Intervention (page 35) along with the associated materials such as the C-SSRS on page 52 and the Stanley-Brown Safety Plan form and checklist (pages 53- 55), and any other resources in this toolkit that may be helpful.
List of Mental Health Resources Across Montana
https://dphhs.mt.gov/assets/suicideprevention/AdultMentalHealthResources.pdf

- **Action Item 8: Monitor Social Media**

Follow the Social Media Guidance starting on page 50 as well as the links for more information on social media monitoring at the end of the guidance document. If possible, you can also

create a Facebook page or other form of social media page to include links to important resources on warning signs of suicide and the Suicide and Crisis Lifeline number (page 47), how to help someone in emotional pain (page 48), the C-SSRS (page 52), as well as other resources outlined or linked in this toolkit and on the **Montana State Suicide Prevention page** (see https://dphhs.mt.gov/suicideprevention/suicideresources).

❖ Action Item 9: Host Community Meeting(s)

Host community meeting(s) to provide the **greater community with postvention information** and **helpful resources for coping**. Materials that you may want to distribute include warning signs and information on the lifeline (page 47), how to let someone know you are concerned about them if you detect warning signs (pages 47), how to screen for suicide risk (page 30), and sources of support they can provide to the community (page 25) as well as accompanying posters or resources found in the Appendix (starting on page 41). You may want to share additional resources found in this toolkit, but make sure not to overwhelm community members with too much information. You may decide to **host several community meetings to go through these materials and answer any questions**.

Whatever the Postvention Response Team decides, make certain that you have a clear agenda and goal for each meeting. A sample meeting agenda and considerations for community meetings can be found in After Rural Suicide: A Guide for Coordinated Community Postvention Response (see https://work.cibhs.org/pod/after-rural-suicide).

It is important to remember that community meetings are not memorial services. Community meetings are designed to educate the surrounding community on important postvention information. If funeral arrangements have already been made, you can inform attendees of these services where they can pay their respects to the decedent.

❖ Action Item 10: Attend Funeral/ Memorial Services

If possible, have a member (or several) from the Postvention Response Team attend the funeral and any memorial services to **distribute resources such as sources of support** (page 25) and be prepared to recognize warning signs among attendees, screen for suicide risk, and potentially refer to additional care and/or the Lifeline, if needed.

Guide For Funeral Directors
https://www.sprc.org/resources-programs/supporting-survivors-suicide-loss-guide-funeral-directors-2nd-ed

Guide for Hosting Memorial Services and Public Memorial Observances
https://www.sprc.org/resources-programs/after-suicide-recommendations-religious-services-and-other-public-memorial

❖ Action Item 11 and Beyond

The Postvention Response Team should engage in the following **ongoing action items** on an **ongoing basis:**

- Maintain **open communication** with all members of the **Postvention Response Team** to make sure everyone is on the same page, kept aware of any new information, and is following up on outstanding action items to make sure they are completed.
- Maintain **ongoing contact** and communication with stakeholders.
- Consider engaging in **suicide prevention advocacy work** in the community and with state-wide/national organizations such as National Alliance on Mental Illness-Montana and American Foundation for Suicide Prevention. Contact information is provided in the Sources of Support section of this toolkit (page 25).
- Be aware of **anniversaries and future memorials** for several reasons:
  - To inform the decedent's family members of planned memorials in case they are unaware.
  - Remind local media of safe messaging guidelines in case they cover the events.
  - Monitor social media as there will likely be an increase in posts and social media activity around the anniversary.

The information in this section is adapted from After a Suicide: A Toolkit for Schools, After Rural Suicide: A Guide for Coordinated Community Postvention Response, and Alaska Suicide Postvention Guide: Preparing to Heal.

Provide Sources of Support

Sources of Support

Losing someone to suicide is a painful, traumatic event that can have far-reaching effects across a community. Survivors of suicide (those who have lost someone to suicide) may exhibit a wide range of emotions and reactions including, but not limited to shock, despair, anger, confusion, guilt, anxiety, depression, denial, or suicidal thoughts themselves. Not everyone will react to suicide in the same way and these reactions can increase and decrease in intensity over time.

For more information on survivor grief as well as important considerations when talking to suicide survivors, please use these resources:

- *Helping Survivors of Suicide: What Can I Do?* guide from the American Association of Suicidology (AAS): https://suicidology.org/resources/suicide-loss-survivors/helping-sosl/
- *Resources for Survivors of Suicide,* also from AAS: https://suicidology.org/wp-content/uploads/2019/07/Resources-for-Survivors-of-Suicide.pdf

Survivors of suicide are at higher risk for suicidal ideation and behavior than other bereaved individuals. It is important to be prepared with a list of reputable mental health resources so suicide survivors can obtain the support they need. The following is a list of mental health and suicide prevention resources at the state and national level, as well as tools that can be used to search for local resources in your community.

National Resources

- Suicide and Crisis Lifeline
    - *Free, confidential crisis support 24/7 over the phone or via online chat. Also provides resources for you or loved ones.*
    - **Phone**: 988
        - Veterans: Press “1” after dialing 988
        - Spanish language speakers: Press “2” after dialing 988
    - **Website**: https://988lifeline.org/
    - **Online chat**: Go to https://988lifeline.org/ and select “CHAT” in the upper right hand corner of the page.

- Crisis Text Line
    - *Free support 24/7 via text or Facebook messenger for anyone in crisis*
    - **Text:** text “MT” to 741-741
    - **Website for more info and link to Facebook Messenger:** https://www.crisistextline.org/

- Veteran Crisis Line
    - *Free, confidential support 24/7 over the phone or in an online chat for* veterans in crisis. Also provides resources for you or another veteran.
    - **Phone**: Dial 988, then press “1”
    - **Online chat:** https://www.veteranscrisisline.net/get-help/chat
    - **Website:** https://www.veteranscrisisline.net

- The Trevor Project
    - *Free, confidential crisis support 24/7 via call, text, or chat for people identifying as LGBTQI+.*
    - **Phone**: 866-488-7386
    - **Online chat:** https://www.thetrevorproject.org/get-help/, select “Chat With Us”
    - **Website:** https://www.thetrevorproject.org/

- The Trans Lifeline
    - *Free, confidential crisis support for people who identify as trans.*
    - **Phone**: 1-877-565-8860
    - **Website:** https://translifeline.org/

- RAINN National Sexual Assault Hotline
    - *Free, confidential crisis support for survivors of sexual assault.*
    - **Phone:** 800-656-HOPE (4673)
    - **Online chat:** https://hotline.rainn.org/online, select “Go Chat”
    - **Website:** https://hotline.rainn.org/online

- National Domestic Violence Helpline
    - *Free, confidential crisis support for survivors of domestic violence.*
    - **Phone:** 800-799-SAFE (7233)
    - **Online chat:** https://www.thehotline.org/, select “Chat”
    - **Website:** https://www.thehotline.org/

Statewide and Local Resources

- Statewide listing of mental health resources can be found at https://dphhs.mt.gov/assets/suicideprevention/AdultMentalHealthResources.pdf.

- Mental Health America of Montana
    - **Phone:** 877-503-0833
        - Speak with a Counselor Monday-Friday: 10 a.m.-10 p.m.
    - **Website:** https://www.mhaofmt.org/
    - Offers telehealth services

The organizations that have a treatment locator feature or include lists of local resources:

- Lewis and Clark Suicide Prevention Coalition
    - **Website:** https://lcsuicideprevention.org/resources/

- National Alliance on Mental Illness - Montana
    - **Phone:** 406-443-7871
    - **Website:** https://namimt.org/, select “County Mental Health Resources”

- American Foundation for Suicide Prevention
  - **Phone:** 406-531-4728; Katie Levin, Area Director
  - **Email:** klevine@afsp.org
  - **Website:** https://afsp.org/chapter/montana
  - **Website to find local support groups:** https://afsp.org/find-a-support-group/

- Substance Abuse and Mental Health Services Administration (SAMHSA) Behavioral Health Treatment Services Locator
  - Website: https://findtreatment.samhsa.gov/

- SAMHSA Treatment Referral Hotline for Substance Abuse
  - *Provides free and confidential local treatment referrals for substance abuse*
  - **Phone:** 800-662-HELP (4357)
  - https://www.samhsa.gov/find-treatment

- American Psychiatric Association
  - **Website:** https://www.psychiatry.org/patients-families, select “Find a Psychiatrist”

- American Psychological Association
  - **Website:** https://locator.apa.org/

- National Association of Social Workers
  - **Website:** http://www.helpstartshere.org/, select “Find a Social Worker”

- Veterans Affairs
  - **Website:** https://www.va.gov/health-care/health-needs-conditions/mental-health/suicide-prevention/

- Psychology Today
  - **Website:** https://www.psychologytoday.com/us, select “Find a Therapist”

- 211
  - **Phone:** 211
  - **Website:** https://www.211.org/about-us/your-local-211

Resources for Tribal and Indigenous Communities

- Billings Urban Indian Health and Wellness Center
  - **Address:** 1230 N. 30th Street, Billings, MT 59101
  - **Phone**: 406-534-4558

- North American Indian Alliance (Butte)
  - **Address:** 55 East Galena, Butte, MT 59701
  - **Phone**: 406-782-0461

- Indian Family Health Clinic
  - **Address:** 1220 Central Avenue, Suite 2B, Great Falls, MT 59401
  - **Phone**: 406-268-1510

- Helena Indian Alliance
  - **Address:** 501 Euclid Avenue, Helena, MT 59601
  - **Phone**: 406-442-9244

- Missoula Urban Indian Health Center
  - **Address:** 830 West Central, Missoula, MT 59808
  - **Phone**: 406-829-9515

- Indian Health Services- Billings Area Office
  - **Address:** 2900 4th Avenue North, Billings, MT 59101
  - **Phone**: 406-247-7224
  - The Billings Area Indian Health Service (IHS) provides public health, environmental health, health care services, and community-based disease prevention services to more than 70,000 American Indian and Alaska Native (AI/AN) people in Montana and Wyoming. These services are delivered through six IHS-operated service units, two tribally-operated health departments, and five urban Indian health programs, administratively supported by a regional office located in downtown Billings, Mont.

- Behavioral health resources within IHS:
  https://www.ihs.gov/communityhealth/behavioralhealth/

- Contact information for regional IHS offices throughout Montana:
  https://www.ihs.gov/billings/staff/

- Indian Health Board of Billings: Substance Abuse Program
  - **Address:** 1127 Alderson Avenue, Billings, MT 59102
  - **Phone**: 406-245-7318

- The Indian Health Board of Billings (IHBB) is a non-profit, Urban Indian Clinic that offers a medical walk-in clinic two days per week along with behavioral clinic services five days a week during regular business hours.

- National Council on Urban Indian Health
  - **Address:** 924 Pennsylvania Ave SE, Washington, DC 20003
  - **Phone**: 202-544-0344
  - The National Council on Urban Indian Health (NCUIH) is a non-profit, 501(c)(3) organization devoted to supporting and developing quality accessible health care programs for all AI/AN living in urban communities through advocacy, training, education, and leadership development. NCUIH strives for healthy communities supported by fully funded and accessible health care centers and governed by leaders in the American Indian community.

- Suicide and Crisis Lifeline
  - *Free, confidential crisis support 24/7 over the phone or via online chat. Also provides resources for you or loved ones.*
  - **Phone**: 988
    - Veterans: Press "1" after dialing 988
    - Spanish language speakers: Press "2" after dialing 988
  - **Website**: https://988lifeline.org/
  - **Online chat**: Go to https://988lifeline.org/ and select "CHAT" in the upper right-hand corner of the page

- Crisis Text Line
  - *Free support 24/7 via text or Facebook Messenger for anyone in crisis.*
  - **Text:** text "MT" to 741-741
  - **Website for more info** https://www.crisistextline.org/
  - http://facebook.com/CrisisTextLine

- Mental Health Crisis Lines:
  - **Montana Warm Line**: 877-688-3377
  - **Montana Crisis Recovery**: 877-503-0833

Screen for Suicide Risk

Screen for Suicide Risk

One of the most important things you can do to prevent suicide is to ***ask*** in a clear and direct manner if you think someone is distressed and may be suicidal. Asking someone if they are thinking about suicide will not give them the idea. In fact, research has found that simply asking about suicide can **reduce the risk of attempting or dying by suicide.**

If someone is displaying **warning signs** or you are concerned for their safety, you can use The **Columbia-Suicide Severity Rating Scale (C-SSRS)** to screen their risk of suicide. Backed by more than 10 years of research, the C-SSRS guides users through a range of two-to-six questions that assess if an individual is thinking about suicide and if they need follow-up or emergency care.

No mental health training is required to use this form, though a referral to professional help should be provided if the person is at ***MODERATE OR HIGH risk. If a person is at imminent risk (has suicidal thoughts with intent to act on them and a plan for how to do it), do not leave them alone and seek emergency care.***

Before using the C-SSRS, there are a few recommendations to keep in mind:

- **Remind the person that you care about them.** Before asking about suicide, share that you are concerned, you care about them and want to help them. You may say something like: “I’ve noticed recently that you seem really down and I’m worried about you. I really care about you and want to help.”
- **Remain calm and nonjudgmental**. Doing so can help put them at ease and make it more likely that they will open up about how they are feeling, as opposed to keeping it to themselves. When suicide is asked about in a judgmental way (e.g., “You’re ***not*** thinking of suicide, ***are you***?”), people may feel a sense of shame and could be less likely to seek help now or in the future.
- **Practice**. Practice asking these questions so they feel more natural to you and you know how to respond in the moment. Practicing different scenarios ahead of time can also ease your nerves if you encounter someone who is actively suicidal.

While the C-SSRS is a quick and straightforward form that gathers a lot of information on suicidal thoughts (**suicidal ideation**) as well as behaviors people might engage in before attempting suicide (also known as **preparatory behaviors**) or during an attempt (**suicidal behaviors**).

The following provides more information on each question of the C-SSRS screener. The actual C-SSRS form can be found on page 52. It is recommended that you follow along as you review these descriptions:

1. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** This question asks about **passive ideation** where someone wishes to be dead or not alive anymore. After asking this question, **proceed to the second question.**

2. ***Have you actually had any thoughts of killing yourself?*** Question 2 asks if the person has **active ideation** of wanting to kill themself, as opposed to not being alive anymore.

    - If the person's answer to this question is **YES, you must** go on to ask the **remaining questions 3-6.**
    - If their response is **NO, skip to question 6.**

3. ***Have you been thinking about how you might do this?*** This question assesses **active ideation** that involves at least one method or **means** to attempt suicide (meaning, how they would try to kill themselves).

4. ***Have you had these thoughts and had some intention of acting on them?*** Question 4 asks about active thoughts of suicide with some intent.

5. ***Have you started to work out or work on the details of how to kill yourself? Did you intend to carry out this plan?*** These questions assess active thoughts of suicide with details of a plan worked out (either partially or completely) and if the person has at least some intent to carry out the plan.

6. ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Question 6 asks about **suicide behaviors** which can include 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 their mind or it was grabbed from their hand, went to the roof but didn't jump, actually took pills, tried to shoot themself, cut themself, tried to hang themself, etc.

    - **If the answer to question 6 is YES, ask*: Was this within the past three months?*** This question assesses if this behavior is more recent, which would indicate that the person is likely at higher risk of suicide.

See the next page for triage options based on C-SSRS responses.

Triage Based on C-SSRS Screener Responses

The C-SSRS is color coded to indicate whether someone may be at low, moderate, or high risk based on how they respond to each question. This information can be helpful in determining how to proceed to help keep them safe.

Note: This is a brief screener meant to provide some information about suicide risk in a short period of time. Suicide is complex and the C-SSRS screener should not be substituted for a comprehensive suicide risk assessment completed by a mental health professional.

Risk Level	LOW	MODERATE	HIGH
Responses on C-SSRS	**YES** to questions highlighted in **YELLOW**; **NO** to all remaining questions	**YES** to questions highlighted in **ORANGE** and yellow; **NO** to questions highlighted in **RED**	**YES** to ***any*** question highlighted in **RED**
Action Steps	Possibly refer to an outpatient mental health provider.	Consult should be completed by a mental health provider and **extra precautions may be needed** to help keep them safe. Extra precautions may include staying with the person at risk until you can contact a mental health professional, crisis hotline personnel, or emergency services for further evaluation. You can call the Crisis Hotline at 988, text 741741, or call 911 and **STAY WITH THEM** until they can be evaluated.	**Extra precautions are needed to help keep them safe** until they can be evaluated by a mental health professional for potential hospitalization. Extra precautions may include staying with the person at risk until you can contact a mental health professional, crisis hotline personnel, or emergency services for further evaluation. You can call the crisis hotline at 988, text 741741, or call 911 and **STAY WITH THEM** until they can be evaluated.

Links to C-SSRS screener forms and instructional documents:

- **Download the C-SSRS screener for family and friends**: https://cssrs.columbia.edu/wp-content/uploads/Community-Card-Friends-and-Family-2020-1.pdf
- **Download the C-SSRS screener for health care, law enforcement, first responder, school, and other community settings:** https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english
    - You can filter results by setting (e.g., health care, schools, military, etc.) populations (all, adult, and adolescents), and language (English or Spanish).
- **Download the C-SSRS mobile application**
    - **App store:** https://apps.apple.com/us/app/columbia-protocol/id1450966911
    - **Google Play:** https://play.google.com/store/apps/details?id=net.pssolutions.lighthouse&hl=en_US&gl=US
- **Free Online Trainings on How to Administer the C-SSRS:** https://cssrs.columbia.edu/training/training-options/

Safety Plan

Safety Plan

The Safety Planning Intervention (SPI) is a 20-to-45-minute multi-step intervention that results in a **safety plan** that can help people cope with suicidal thoughts and feelings. It is a prioritized, written list of coping strategies and sources of support. A safety plan helps prevent a suicidal crisis from escalating so the person at risk does not act on urges to self-harm. The SPI is used for individuals at **moderate** to **high risk** of suicide. It is important to remember that safety plans should be developed when the individual does not require immediate emergency care. Clinical judgment from a mental health professional may be necessary to determine who should receive the SPI.

A trained mental health professional should complete the safety plan. The process of completing a safety plan with an individual involves the following checklist:

A. Obtain a Crisis Narrative
B. Provide Psychoeducation and Introduce Safety Planning
D. Explain How to Follow Steps
C. Develop Safety Plan
E. Implement Safety Plan
F. Review and Revise

A. Crisis Narrative. It is important to obtain a detailed description of the individual's suicidal crisis (a recent suicide attempt or time when they experienced intense suicide ideation) before developing a safety plan. This is referred to as a crisis narrative and is important because it helps: 1) demonstrate how suicidal crises come and go (Part B: Psychoeducation), 2) identify warning signs that indicate a suicidal crisis is starting (Step 1), and 3) identify potential options for distraction (Steps 2 and 3) and help-seeking (Steps 4 and 5). To obtain a crisis narrative:

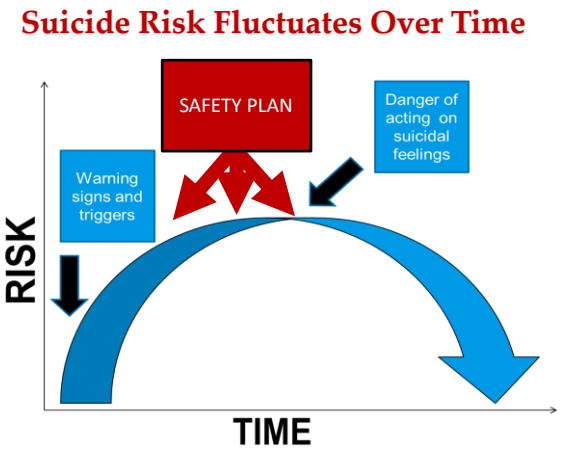
- Ask the individual to "tell their story" of the suicidal crisis, including what happened before, how the crisis escalated, how the crisis dissipated, and what happened after.

- You should mostly listen and provide empathic responses, but if they are struggling or details are unclear, you may ask clarifying questions.

- As you listen to their story, pay attention to warning signs, opportunities for distraction and lethal means reduction, and people who were supportive or to whom the client may have reached out for help. Also, be aware of how the client's suicidal urges intensified and then dissipated. Take note of these factors as they will become important for other parts of the SPI.

B. Psychoeducation and Introduction to Safety Planning. This part involves providing background information and a rationale for using the safety plan. Psychoeducation should include explanations regarding:

- **Acute suicidal crises, when people are most in danger of acting on suicidal feelings, often last only for a brief time**. While a suicidal crisis may feel like it is going to last forever, the *intensity will decrease over time*. You can use the client's crisis narrative and show them the **suicide risk curve** figure to the right to illustrate differences between the time when their suicidal thoughts and urges were at their worst to their internal experience well before and after the crisis.



- **Introduce the safety plan** as a way to help the individual recognize when a suicidal crisis may be intensifying and take action to prevent the crisis from escalating. Explain that a safety plan is a list of their preferred coping strategies and sources of support that can safely guide them through a suicidal crisis. The safety plan helps prevent them from acting on feelings, which can allow suicidal thoughts enough time to decrease and become more manageable.

- **Explain that the safety plan should be used immediately before a suicidal crisis** when the individual is experiencing warning signs or about to seriously consider suicide. You may refer back to the start of the risk curve as a time when warning signs may be present and an indication that the safety plan should be used. Explain that waiting too long to use the plan gives suicidal thoughts the opportunity to grow stronger and more intense, making them more difficult to control.

- **Ask the individual if they have any questions** now and throughout the safety planning intervention. It is important that the individual is clear on all aspects of the safety plan, why it is important, when it should be used, and how to use it. Encouraging the client to ask questions can facilitate their learning and successful use of the safety plan.

C. Explain How to Follow the Steps. The safety plan is prioritized, meaning that the steps should be completed in the order in which they appear. Explain that they should use Step 1 (Warning Signs) to identify when a suicidal crisis may be starting and when they should use the plan. Then, the individual should progress to Step 2 where they start using internal coping strategies to manage their distress. If the internal coping strategies are not helpful in reducing risk, they should go on to the next step (Step 3), and so on, until the suicidal crisis has diminished. *It is not necessary for the individual to complete all steps of the safety plan; they can stop using it whenever their suicide risk has lessened. If they are in **immediate danger** of acting on suicidal thoughts, they can **skip as many steps as they need to** and go straight to contacting a **mental health professional or emergency/ crisis services (Step 5)**.*

D. Safety Plan. There are seven steps to completing the safety plan. Creating a safety plan is a **collaborative** process, meaning that you and the person at risk work together to identify

strategies that will be *most effective for them* during a suicidal crisis. You should refrain from giving suggestions until they have had sufficient opportunity to come up ideas on their own. It is more likely that they will use coping skills they have identified on their own and may have used in the past as opposed to skills that you have identified for them.

Collaboration needs to be balanced with a directive approach, as needed. It is your job to help keep the individual safe. For example, if they suggest listing potentially harmful coping strategies (e.g., binge drinking, cleaning their gun), you should help guide them to more adaptive, healthy coping strategies.

The following are descriptions of the seven steps of the safety plan. There is also a checklist on pages 53-55 that includes these steps and prompts you can use to elicit responses.

- **Step 1. Warning signs.** Identify and list specific thoughts, feelings, thinking styles, moods, behaviors, and/or personal situations that come right before a suicidal crisis. Examples may include feeling trapped, overwhelming sense of hopelessness, or having thoughts such as, “I can’t take it anymore.”

- **Step 2. Internal coping strategies.** List what the individual can do ***without another person to distract themselves*** from suicidal thoughts and help them feel better. These strategies should be as specific and detailed as possible, as well as easy for the individual to use whenever or wherever a suicidal crisis emerges. Some examples include listening to a specific artist or music, watching their favorite movies, and practicing yoga.

- **Step 3. People and social settings that provide distraction.** List people and healthy social settings that can help ***distract the individual from suicidal thoughts***. This step is <u>not</u> intended as a way of seeking help with the suicidal crisis; therefore, the individual does not need to disclose that they are thinking about suicide in this step. The names and contact information for individuals and social settings should be written directly on the plan so that all necessary information is contained in one place, making it easier for the individual to follow this step when they are in the middle of a suicidal crisis.

- **Step 4. People I can ask for help.** List supportive people the individual can ***disclose their thoughts of suicide to*** and ***seek assistance***. Different from Step 3, this step involves explicitly revealing to supportive people that they are in crisis and need support. The names and contact information for each person should again be written directly on the plan. Only trusted adults over the age of 18 should be listed on this step.

- **Step 5. Professionals or agencies I can contact during a crisis.** List professionals, agencies, urgent care, emergency settings, and hotlines the individual can ***contact for help during a crisis***. Professionals typically include people who are formally trained in the mental health (psychology, psychiatry, social work, counseling) or medical field (primary care). Similar to other steps, the more details written on the safety plan (e.g.,

provider name, address, contact information), the easier it will be to implement this step during a crisis.

- **Step 6. Making the environment safe.** Limit access to any potentially lethal means in the individual's environment, also known as **lethal means counseling**. This is one of, if not the *most important step of the SPI*.

    - During this process, it is important to **explain** that you are not trying to limit their rights by removing possessions, you are trying to help keep them safe. You can refer back to the **suicide risk curve** on page 36 and explain that because suicidal crises are brief, people are less likely to act on their thoughts of suicide when lethal means are removed from their environment. This is because the suicidal crisis will likely dissipate in the time it would take to gain access to the lethal method.

        - Common means include: knives, glass, or other sharp objects; pills; toxic substances (e.g., bleach, pesticides); implements for hanging or asphyxiation (e.g., belts, rope, gas oven); access to a high location (e.g., unsecured rooftop, bridge without barricades); unsupervised access to a dangerous location (e.g., train tracks, construction site).

    - Because of the high lethality associated with firearms it is important to **always ask about firearm access**, even if the individual didn't specify this in their plan. Individuals may be unwilling to completely remove access to a firearm (e.g., give gun(s) to trusted person for an agreed-upon number of months), but they may be willing to *limit their access to the firearm* by having a critical part of the firearm removed (e.g., firing pin), by using a gunlock and having the gunlock key removed, or by storing the gun and ammunition in separate places.

    - Access to means can be limited for a specified period of time (e.g., several weeks or months), until a high suicide-risk period has resolved. An individual at risk may be more agreeable to this solution as they are not getting rid of their possessions completely. Suicide risk should be continuously assessed to identify if/when another high-risk period is approaching and if access to means should be limited again.

    - It is important to assess for both availability of the methods individuals have thought about using, as well as possible means in the environment that could be used more impulsively. After addressing their preferred means, ask: "What other ways might you consider hurting yourself in your environment?"

- **Step 7. Reasons for living (optional step).** This step is optional and includes listing things that are important to the individual and worth living for. The responses may serve as **protective factors** that can help prevent suicide. Examples include family members

(including pets), friends, or themselves; responsibilities to others; future goals or aspirations; and religious beliefs.

E. Implement Safety Plan. Review each step with the individual and **discuss any barriers** that may get in the way of completing each step. If the individual states they may not be able to follow through on a step, **problem-solve ways to overcome** these barriers or identify other responses they can put into practice more easily. You can discuss barriers and solutions after reviewing each step, or after you have completed the entire safety plan.

Be sure to give the individual (and family members, if appropriate) a copy of the safety plan and keep one for their records. They may also want multiple copies to keep in different locations (e.g., home, work, school, car). The safety plan should be kept where they are able to easily find and use it. Some people keep their safety plans at home and other people carry it with them in their purse, wallet, pocket, or cell phone.

They can also enter their safety plan into the **Stanley-Brown Safety Plan App** on any mobile device (see links).

F. Review and Revise. Review the safety plan regularly and revise it as needed. You can ask:

1. Have they had a chance to use the plan?

2. If yes, was it helpful?

    2a. If yes, what was helpful about it?

    2b. If no, what was unhelpful about it? *Help identify ways that the safety plan can be of use to them in the future.*

3. It is especially important to follow up on **Step 6. Keeping the Environment Safe** and confirm if they are still unable to easily access the identified lethal means. If that is no longer the case, or if they have thought about using other lethal means, work together to safely limit access.

Training Links

- **Safety Planning Intervention:**
    - https://suicidesafetyplan.com/training/
    - https://zerosuicide.edc.org/resources/resource-database/safety-planning-intervention-suicide-prevention

- **Reducing Access to Lethal Means/Keeping the Environment Safe:** https://www.sprc.org/resources-programs/calm-counseling-access-lethal-means

Links to the Stanley-Brown Safety Plan template, app, and instructional materials:

- **Safety Plan template developed by Stanley and Brown (2008, 2021)**: https://bgg.11b.myftpupload.com/wp-content/uploads/2021/08/Stanley-Brown-Safety-Plan-8-6-21.pdf

- **Safety Plan mobile application:**
  - **Available on the App Store:** https://apps.apple.com/us/app/stanley-brown-safety-plan/id695122998
  - **Available on Google Play (called "Safety Net"):** https://play.google.com/store/apps/details?id=com.twopenguinsstudios.safetyplanning&hl=en_US&gl=US

- **More information on the Safety Planning Intervention:** https://suicidesafetyplan.com/

Appendix

Do's and Don'ts of Talking About Suicide

Follow this list of "Do's" when **talking to someone who you think might be suicidal**. Be sure to avoid the behaviors and responses in the "Don't" list. For suggestions on how to talk about suicide with loss survivors and/or people who may not be suicidal, see the links at the end of this list.

Do	Don't
Take any sign of suicide seriously. Don't down-play, ignore, or try to come up with other explanations for why someone might be displaying warning signs of suicide (see list of warning signs on page 47). Take any and all indications that someone is thinking about suicide seriously.	**Ignore warning signs.** Sometimes people might feel they are overdramatizing the situation or are worried that asking a friend about suicide will offend them and negatively impact their relationship. It is always best to err on the side of caution when someone is showing signs of suicide.
Ask directly. Asking directly about suicide won't plant the thought in someone's head. Instead, being asked about suicide can lead to feelings of relief and can actually reduce one's risk. Use the C-SSRS (page 52) for examples of how to ask about suicide in a direct manner.	**Don't be vague or misleading.** Using vague language (e.g., "Do you want to end it?") or asking leading questions (e.g., "You're ***not*** thinking about suicide, are you?") makes it less likely that a suicidal person will share how they are truly feeling.
Listen. When people are in crisis, they often want to be heard and accepted. **Acceptance does not mean you agree with suicide, it means you accept that the person is in a lot of pain and want to help.** Often, people don't tell others about their suicidal thoughts for a variety of reasons including fear of how others will react. Openly listening to how the person is feeling and reflecting back or summarizing what they have told you lets the other person know you care about them. Having a supportive person listen to their pain can be a cathartic experience for someone in crisis.	**Don't make it about you or assert your advice.** Saying things like "I know how you feel," and talking about your own problems can make the suicidal person feel as if they are not being heard and may stop them from opening up to you. Additionally, telling them how they should fix their problems, that they "Have everything to live for," or how they should not have done X, Y, or Z can also make the individual feel ignored, invalidated, and/or judged.
Show compassion and empathy. Anyone thinking about suicide is going through an extremely difficult time in their life. It is important that you respond to a suicidal person with care, concern, and a willingness to try to understand where they are coming from. Open ended questions or statements like "Tell me more about what's making you feel this way," or "How can I be most helpful to you right now?" are examples of how you can show compassion and a willingness to learn about what the person is going through.	**Don't be judgmental or minimize their pain.** Arguing with or lecturing someone, trying to talk them out of it, telling them they should "get over it" or "shouldn't think like that," judging them for having suicidal thoughts, etc., is not helpful. It may make the person feel worse and reduce the likelihood that they will seek help or open up about their suicidal thoughts. Instead, be nonjudgmental and allow the person to share their thoughts and feelings without asserting your own opinions or beliefs.

Do	Don't
Offer hope and support. Let the person know that you care about them, that you are there to help them get the care they need, and that things can get better.	**Don't take on more responsibility than you should.** If you are not a licensed mental health provider, **do not take on this role.** You can offer support and hope but be sure that the person receives help from a trained professional. In addition, keep in mind that while you can use these tools to help prevent suicide, you're not responsible for other's actions or stopping others from dying by suicide.
Consult a professional. Suicide is complex. If someone is at risk, it is important that they are connected to a licensed mental health professional for long-term support. Use the resource guide on pages 25-29 for help with finding professional support.	**Don't keep it a secret**. Even if you think telling a professional will negatively impact your relationship with the suicidal person, their safety is most important. If their life is in danger and they are refusing to get help themselves, you need to inform a professional and/or emergency personnel.

For tips on how to talk to non-suicidal persons about suicide:

This toolkit provides an overview of topics to address and avoid saying when talking about suicide. It also provides concrete examples of how to convey this information.

- *After a Suicide: A Toolkit for Schools is a* guide from the Suicide Prevention Resource Center (SPRC): https://www.sprc.org/resources-programs/after-suicide-toolkit-schools.

For tips on talking to and providing support to bereaved family and friends:

These guides provide information on common reactions to losing a loved one to suicide, as well as how others can be supportive during this difficult time. The guides also provide links to helpful resources and support groups.

- *Helping Survivors of Suicide: What Can I Do?* is a guide from the American Association of Suicidology (AAS): https://suicidology.org/resources/suicide-loss-survivors/helping-sosl/
- *Resources for Survivors of Suicide,* also from AAS: https://suicidology.org/wp-content/uploads/2019/07/Resources-for-Survivors-of-Suicide.pdf

Resources and Self-care Strategies for Loss Survivors

This section provides different resources, websites, organizations, and guides for those who have lost a loved one to suicide. These resources provide background information on suicide and common grief reactions for the bereaved. Included are strategies for coping with suicide loss as well as loss survivor support groups that are conducted both online and in-person.

Coping with Suicide Loss
https://save.org/find-help/coping-with-loss/
Suicide Awareness Voices of Education

Friends for Survival
https://friendsforsurvival.org/
Friends for Survival

Healing Hearts and Restoring Hope
https://www.heartbeatsurvivorsaftersuicide.org/
Heartbeat: Survivors After Suicide

Hope After Suicide
http://www.allianceofhope.org/
Alliance of Hope

I've Lost Someone
https://afsp.org/ive-lost-someone
https://afsp.org/find-a-support-group/
American Foundation for Suicide Prevention

Loss Survivors
https://988lifeline.org/help-yourself/loss-survivors/
Suicide and Crisis Lifeline

SOS: A Handbook for Survivors of Suicide
https://suicidology.org/wp-content/uploads/2019/07/SOS_handbook.pdf
Jeffrey Jackson, American Association of Suicidology

Safe Messaging Guidelines

These guidelines were developed by Suicide Awareness Voice of Education (SAVE) in collaboration with several leading suicide prevention organizations. These guidelines can be found at https://reportingonsuicide.org/recommendations/#dodonts. The website also includes additional resources as well as example statements on how to report on suicide safely and effectively.

AVOID...	INSTEAD...
✗ Describing or depicting the method and location of the suicide.	✓ Report the death as a suicide; keep information about the location general.
✗ Sharing the content of a suicide note.	✓ Report that a note was found and is under review.
✗ Describing personal details about the person who died.	✓ Keep information about the person general.
✗ Presenting suicide as a common or acceptable response to hardship.	✓ Report that coping skills, support, and treatment work for most people who have thoughts about suicide.
✗ Oversimplifying or speculating on the reason for the suicide.	✓ Describe suicide warning signs and risk factors (e.g. mental illness, relationship problems) that give suicide context.
✗ Sensationalizing details in the headline or story.	✓ Report on the death using facts and language that are sensitive to a grieving family.
✗ Glamorizing or romanticizing suicide.	✓ Provide context and facts to counter perceptions that the suicide was tied to heroism, honor, or loyalty to an individual or group.
✗ Overstating the problem of suicide by using descriptors like "epidemic" or "skyrocketing."	✓ Research the best available data and use words like "increase" or "rise."
✗ Prominent placement of stories related to a suicide death in print or in a newscast.	✓ Place a print article inside the paper or magazine and later in a newscast.

Sample Public Statement

We recently learned that a _____(e.g., disclose age and gender) in our community has died. The cause of death was suicide.

OR

(if cause of death is unknown at this time)

We were informed that a _____(e.g., disclose age and gender) in our community has died unexpectedly. We ask that people in the community do not spread rumors about the cause of death as this can not only be hurtful to the deceased and [his/her/their] family, it can be harmful to those in the surrounding community.

AND

Our support goes out to [his/her/their] family and friends during this difficult time.

Additional information to consider including in the media statement:

- If hosting a community meeting(s), indicate the date, time, and location of the event(s) as well as who is able to attend (e.g., all community members).
    - State if members of the Postvention Response Team and/or mental health providers will be in attendance and if so, how they will support the community (e.g., provide resources, information on mental illness and suicide, address concerns).
- Provide information on how community members can receive updates regarding the community meeting as well as other events such as memorial services. Some examples include a Facebook page, Twitter, or website.
- Share if trained counselors are available to meet with members of the community and if so, how to contact these counselors
- Provide sources of support (pages 25-29)
- In addition to the information included above, you can also include the following posters:
    - Warning Signs with the Suicide and Crisis Lifeline information from Montana Department of Public Health and Human Services (DPHHS) and the Crisis Text Line (page 47).
    - How to Help Someone in Emotional Pain from the National Institute of Mental Health (NIMH) (page 48).

The statement is adapted from the After a Suicide: A Toolkit for Schools, Second Edition

Warning Signs of Suicide and Suicide and Crisis Lifeline

This infographic from Montana DPHHS depicts warning signs of suicide and the number of the Suicide and Crisis Lifeline. **Download the poster**: https://dphhs.mt.gov/assets/suicideprevention/Warningsignsposter.pdf

This tool may be helpful to share in public places so others can have a basic understanding of how to identify warning signs and the appropriate numbers to contact if someone they know is in distress.

- The Montana DPHHS has another **Suicide Prevention Poster**: https://dphhs.mt.gov/assets/suicideprevention/suicidepreventionposter.pdf and a **Crisis Text Line poster**: https://dphhs.mt.gov/assets/suicideprevention/crisistextlineposter.pdf
- NIMH also provides another warning signs poster which can be accessed and downloaded at: https://www.nimh.nih.gov/health/publications/warning-signs-of-suicide

How to Help Someone in Emotional Pain

This fact sheet from NIMH provides clear, easy-to-follow steps to respond to someone who may be thinking of suicide and/or is in emotional pain. This tool may be helpful to share in public places so those who do not have access to this toolkit or other resources can still have a basic understanding of how they can help someone in crisis.

Download the fact sheet: https://infocenter.nimh.nih.gov/nimh/product/5-Action-Steps-for-Helping-Someone-in-Emotional-Pain/OM%2021-4315

5 Action Steps for Helping Someone in Emotional Pain

Suicide is a major public health concern and a leading cause of death in the United States. Suicide affects people of all ages, genders, races, and ethnicities.

Suicide is complicated and tragic, but it can be preventable. **Knowing the warning signs for suicide and how to get help can help save lives.**

Here are 5 steps you can take to #BeThe1To help someone in emotional pain:

1. ASK:
"Are you thinking about killing yourself?" It's not an easy question but studies show that asking at-risk individuals if they are suicidal does not increase suicides or suicidal thoughts.

2. KEEP THEM SAFE:
Reducing a suicidal person's access to highly lethal items or places is an important part of suicide prevention. While this is not always easy, asking if the at-risk person has a plan and removing or disabling the lethal means can make a difference.

3. BE THERE:
Listen carefully and learn what the individual is thinking and feeling. Research suggests acknowledging and talking about suicide may in fact reduce rather than increase suicidal thoughts.

4. HELP THEM CONNECT:
Save the National Suicide Prevention Lifeline number **(1-800-273-TALK)** and the Crisis Text Line **(741741)** in your phone so they're there if you need them. You can also help make a connection with a trusted individual like a family member, friend, spiritual advisor, or mental health professional.

5. STAY CONNECTED:
Staying in touch after a crisis or after being discharged from care can make a difference. Studies have shown the number of suicide deaths goes down when someone follows up with the at-risk person.

For more information on suicide prevention:
www.nimh.nih.gov/suicideprevention
www.bethe1to.com

National Institute of Mental Health

NIMH Identifier No. OM 21-4315
Revised 2021

Safe Storage for Firearms

The time between an individual thinking about and acting on suicidal thoughts can be a matter of minutes. Research has found that limiting access to highly lethal means, such as safely storing firearms when not in use, can help prevent suicides.[8] The following resources provide information on how to safely store firearms:

Infographic on different safe firearm storage options:
https://projectchildsafe.org/wp-content/uploads/files/PCS_SafeStorage_19.pdf

Basic tips on safe firearm storage from the U.S. Department of Veterans Affairs (VA):
https://www.va.gov/reach/lethal-means/#safe-gun-storage

Toolkit on safe firearm storage from the VA:
https://www.mentalhealth.va.gov/suicide_prevention/docs/Toolkit_Safe_Firearm_Storage_CLEARED_508_2-24-20.pdf

How to obtain free safety kits from local law enforcement in Partnership with Project ChildSafe, a firearms safety education program:
https://projectchildsafe.org/safety_kit_site/?safety_kit_state=montana

Safety kits from Project ChildSafe include a cable gun lock and instructions for storing firearms safely.

Social Medial Guidance

Social media refers to websites and applications that allow content sharing and social networking. Some examples include Facebook, Twitter, Instagram, YouTube, and SnapChat, among others. In the days following a suicide, social media can be used in both helpful and unhelpful/potentially harmful ways.

- Examples of **helpful ways** to use social media include posting information on community meetings, religious observances, or memorials for the deceased; sharing mental health resources; providing information on preventing suicide by identifying warning signs, screening, and referrals for mental health care.
- Examples of the **unhelpful/ harmful ways** social media may be used is through users commenting on explicit details about the suicide (both actual and rumored); making statements that unfairly blame others for the person's death; and glorifying or romanticizing suicide. These examples have the potential to be **harmful** to others in a number of ways including increasing the risk of **suicide contagion**.

To minimize the unhelpful/harmful effects of social media, social media sites including the decedents' personal social media pages should be monitored for others posting:

  - Explicit details about the suicide.
  - Rumors or misinformation.
  - Statements that are derogatory, harmful, intimidating, or involve victimizing others.
  - Information indicating that someone may be at risk of suicide.
  - Information that goes against safe messaging guidelines (page 45).
- Monitoring may include deleting or flagging inappropriate posts, blocking users, responding with accurate information, and promoting helpful resources.
- In some cases, it may also involve contacting those who may be at risk or reaching out to local emergency services to help ensure their safety.

How to report if suicidal messages are being communicated on social media

If you are worried about someone on social media, you can contact safety teams that will reach out to connect the user with the help they need.

- **Facebook** – https://www.facebook.com/help/contact/305410456169423
- **Twitter** – https://help.twitter.com/en/forms/safety-and-sensitive-content/self-harm
- **Instagram** - To report posts about suicide or self-harm on Instagram: Tap "…" below the post, Tap Report Inappropriate, Select This Photo Puts People at Risk > Self-Harm.
- **Snapchat** – https://support.snapchat.com/en-US/i-need-help?start=5153567363039232
- **YouTube** - To report suicide or self-harm, click "More." Highlight and click "Report" in the drop-down menu. Click "Harmful dangerous acts," then "Suicide or self-injury." YouTube will review the video and may send a message to the uploader with the Lifeline number.
- **TikTok** - To report for self-harm on TikTok, tap the arrow at the bottom right-hand corner of the video. Tap the report icon, select "Self-injury" and follow the prompts.

To maximize the benefits of social media, consider creating a Facebook page or other social media page to disseminate information regarding:

- Community meetings.
- Memorial or religious services.
- Local, state, and national mental health resources (pages 25-29).
- Reputable suicide prevention websites including American Association of Suicidology: https://suicidology.org/, Suicide and Crisis Lifeline: https://988lifeline.org/, American Foundation for Suicide Prevention: http://www.afsp.org, Suicide Prevention Resource Center: http://www.sprc.org.
- Warning signs and information on the Suicide and Crisis Lifeline (page 47) and how to talk to someone in distress (see page 48).

Helpful considerations:

- Utilize community members as "cultural brokers" to help the community understand the social media that is currently most used by community members.
- Train community stakeholders in gatekeeper roles and specifically identify what suicide risk looks like when communicated via social media.
- Monitor social networks and provide safe messaging. Safe messaging stresses that suicide is preventable and largely the result of mental illness and that evidence-based treatments exist for mental illness.
- Encourage community members to monitor their family's social media.
- Psychoeducation: Make use of social media to post prevention messages, crisis support lines, and community mental health resources.
- Direct community members to the suicide-prevention information posted on the district website.
- Provide the community with specific helpful language to include when making use of social media.
- Work with social media sites to take down messages with disturbing images or language.
- Utilize the Facebook application to report concerns or issues with content.

For more information on social media monitoring, please consult:

- *Support for Suicidal Individuals on Social and Digital Media:* https://988lifeline.org/wp-content/uploads/2020/04/Lifeline-Social-Media-Toolkit-2020.pdf
- *After a Suicide: A Toolkit for Schools, Second Edition* https://sprc.org/sites/default/files/resource-program/AfteraSuicideToolkitforSchools.pdf
- *The Lifeline Online Postvention Manual* https://www.sprc.org/sites/default/files/migrate/library/LifelineOnlinePostventionManual.pdf
- *A Guide to Using Facebook to Promote Suicide Prevention and Mental Illness Stigma Reduction* https://www.sprc.org/resources-programs/guide-using-facebook-promote-suicide-prevention-and-mental-illness-stigma

This information is adapted from After a Suicide: A Toolkit for Schools, Second Edition

Columbia-Suicide Severity Rating Scale

Screen Version - Recent

	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* Example: "*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.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them*."		
5) *Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*		
6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* *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.* **If YES, ask: *Was this within the past three months?***	**YES**	**NO**

Low Risk
Moderate Risk
High Risk

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

This form was retrieved from https://cssrs.columbia.edu/

Stanley-Brown Safety Plan Form

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

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

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

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

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

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

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
2. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
3. Local Emergency Department: _____
Emergency Department Address: _____
Emergency Department Phone : _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

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

1. _____
2. _____

Stanley-Brown
Safety Planning Intervention

Note: This Safety Plan has the old Lifeline number. While callers will still be redirected to the new number, be sure to write the new number (988) directly on the plan as it is easier to remember.

Safety Planning Intervention (SPI) Overview Checklist

This checklist (adapted from Stanley & Brown, 2012) is meant to be used by **licensed mental health professionals** who are trained in the Stanley-Brown Safety Planning Intervention. Before using this checklist, please first review the Safety Planning section in this toolkit including the free online Safety Planning training, starting on page 35, as well as the Safety Planning template, found immediately before this page.

A. Obtain a Crisis Narrative

__ Ask client to "tell the story" of the suicidal crisis, including what happened before, how the crisis escalated, how the crisis dissipated, and what happened after.
__ Ask follow-up questions as needed.

B. Provide Psychoeducation and Introduce Safety Planning

__ Explain that suicidal crises come and go and describe/draw the suicide risk curve.
__ Introduce the safety plan and explain that it should be used immediately before a crisis.
__ Ask the client if they have any questions.

C. Explain How to Follow Steps

__ Explain to the client that if one step is not helpful in reducing risk, they should go on to the next step, and so on, until their risk has subsided.
__ Inform the client that not all steps need to be completed as they can stop whenever the suicidal crisis has resolved.
__ Explain that if the client is in imminent danger of acting on suicidal feelings, they can skip steps and go straight to contacting mental health professionals.
__ Discuss how Step 6 (means restriction) should be completed as soon as possible.

D. Develop Safety Plan

__ Develop safety plan. (See next page for details.)

E. Implement Safety Plan

__ After completing the safety plan, ask, "*What are barriers that might get in the way?*"
__ Problem-solve solutions. Say, *"Let's discuss some ways to deal with this problem(s) so you can use the plan when it will be most helpful for you."*
__ If appropriate, ask *"How do you overcome reluctance to help yourself?"*
__ Give the client hard copies of the safety plan. Offer multiple copies and/or suggest downloading the Stanley-Brown Safety Plan mobile app.
__ Keep a copy of the client's safety plan for their records.
__ Document that you completed the SPI and gave client a copy of the plan.

F. Review and Revise (for later sessions, remember these should be routinely reviewed with client)

__ Ask if there has been an opportunity to use the safety plan and if it was used.
__ If yes, determine what has been helpful or ask what worked well regarding the plan?
__ Ask what, if anything, hasn't been helpful and what was unhelpful about it?
__ Routinely follow up on means restrictions, if they are still unable to access the lethal means specified and if changes need to be made.
__ Revise the plan together as indicated.
__ If changes were made, give client a copy of the newly revised plan.
__ Document that you reviewed (and revised) the safety plan and that you gave the client a copy of the revised plan.

Safety Plan Checklist

Step 1: Recognizing Warning Signs

__ Remind client the purpose of this step.
__ Ask *"What do you experience when you start to think about suicide or feel distressed?"*
__ List specific and personalized warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using clients' own words.
__ Ask the individual if the warning signs will be helpful in recognizing that a suicidal crisis is starting and that it is time to use the safety plan.

Step 2: Using Internal Coping Strategies

__ Explain to client the purpose of this step.
__ Ask *"What can you do, on your own, if you become suicidal again, to help yourself not act on your thoughts or urges?"* or *"What activities could you do to help take your mind off your problems, even for a brief period of time?"*
__ Ask *"How likely do you think you would be able to do this step during a time of crisis?"*
__ If doubt about using coping strategies is expressed, ask *"What might stand in the way of you thinking of these activities or doing these activities even after you think of them?"*
__ Use a collaborative, problem solving approach to ensure that potential roadblocks are addressed and/or that alternative coping strategies are identified.

Step 3: Social Contacts Who May Distract from the Crisis

__ Explain to client the purpose of this step and that suicidal thoughts and feelings are not revealed.
__ Ask *"Who helps you take your mind off your problems at least for a little while? or "Who helps you feel better when you socialize with them?"*
__ Ask *"Where can you go to be around people to distract you from your suicidal feelings?"*
__ Ask clients to list several people and social settings, in case the first option is unavailable.
__ Assess both the likelihood of the client using and the safety associated with implementing each response.
__ Use a collaborative, problem solving approach to ensure that potential roadblocks are addressed and/or that alternative coping strategies are identified.

Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis

__ Explain to client the purpose of this step and that unlike Step 3, clients reveal they are in crisis.
__ Ask *"Who do you think you could contact for help during a crisis?"* or *"Who is supportive of you and who do you feel you can talk with when you're under stress or feeling suicidal?"*
__ Ask clients to list several people in case they cannot reach the first person on the list. Prioritize the list.
__ Ask *"How likely would you be willing to contact these individuals*?"
__ If doubt is expressed about contacting individuals, identify potential obstacles and problem-solve ways to overcome them.

Step 5: Contacting Professionals and Agencies

__ Explain to client the purpose of this step and that they should use Step 5 if Step 4 does not resolve the crisis **or if they are at imminent risk**.
__ Ask *"Who are the mental health professionals that we should identify to be on your safety plan?"* and *"Are there other health care providers you could contact?"*
__ Ask, *"Where is the hospital or urgent care setting you can go to in an emergency?"*
__ List names, numbers, and/or locations of clinicians, local urgent care services, and the Suicide Prevention Hotline (988).
__ Assess the likelihood that the client would contact each professional and agency in a crisis.
__ If doubt is expressed about contacting individuals, identify potential obstacles and problem-solve ways to overcome them.

Step 6: Reducing the Potential for Use of Lethal Means

__ Ask which means they would consider using and identify ways to secure or limit access to them.
__ For methods with low lethality, ask clients to remove or restrict their access to these methods themselves.
__ Restricting access to a highly lethal method should be done by a designated, responsible person—usually a family member or close friend, or the police.
__ Ask about firearm access.
__ If doubt is expressed about limiting access, identify obstacles and problem-solve ways to overcome them.
__ Make sure the client knows to implement the means reduction action plan as soon as possible.

Additional Postvention Guidance

A Journey Toward Health and Hope: Your Handbook for Recovery After a Suicide Attempt

https://store.samhsa.gov/product/A-Journey-Toward-Health-and-Hope-Your-Handbook-for-Recovery-After-a-Suicide-Attempt/SMA15-4419

Gallup, Inc,. and Shari Sinwelski, M.S./Ed.S., and the Didi Hirsch Suicide Prevention Center's Suicide

This guide is designed to help individuals who have attempted suicide heal and recover. Included are suggestions for re-establishing social support, finding professional support, and cultivating a hopeful future.

After Rural Suicide: A Guide for Coordinated Community Postvention Response

https://work.cibhs.org/pod/after-rural-suicide; scroll down to download "After Rural Suicide Guide"

California Mental Health Services Authority (CalMHSA)

This guide provides a wealth of information on engaging in postvention activities in rural areas including Postvention Response Plans, checklists, sample public statements, sample memorandums of understanding, and a loss survivors brochure. There is information on Considerations for Community Meetings and a sample agenda for Community Meetings in the Tools section of the guide.

After a Suicide: Recommendations for Religious Services and Other Public Memorial Observances

https://www.sprc.org/resources-programs/after-suicide-recommendations-religious-services-and-other-public-memorial

American Foundation for Suicide Prevention (AFSP) and Suicide Prevention Resource Center (SPRC)

This manual provides detailed information on common reactions and grief following suicide as well as how to best support survivors. The guide also provides best practices for hosting memorial and religious services including how to reduce stigma and contagion while utilizing appropriate language.

Crisis Action School Toolkit on Suicide - CAST-S

https://dphhs.mt.gov/assets/suicideprevention/cast-s2022.pdf

Drs. Poland and Poland in collaboration with Montana OPI, SAM, DPHHS, Big Sky Regional Council of Child and Adolescent Psychiatry and NAMI Montana

This toolkit is designed help prevent and respond to suicide within the Montana school system. There are over 100 pages of helpful information, resources, and links for schools to engage in effective suicide prevention, intervention, and postvention.

Montana DPHHS

https://dphhs.mt.gov/suicideprevention/suicideresources

The state suicide prevention website hosts numerous suicide postvention and prevention resources for different populations (Veterans, American Indians, LGBTQI+ youth) and organizations (schools, primary care, college).

Postvention

https://sprc.org/comprehensive-approach/postvention; scroll to the bottom for "Recommended Resources"

Author: Suicide Prevention Resource Center (SPRC); various authors

This website includes links for additional postvention resources, including those designed specifically for **middle school** and **high school**, **college campuses**, and **workplace settings**.

Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines

https://www.sprc.org/resources-programs/responding-grief-trauma-and-distress-after-suicide-us-national-guidelines

Survivors of Suicide Loss Task Force, National Action Alliance for Suicide Prevention

Includes background information and research on suicide and suicide postvention as well as helpful resources and organizations for communities and individuals bereaved by suicide.

SAMHSA Tribal Training and Technical Assistance Center

https://www.samhsa.gov/tribal-ttac/resources/suicide-prevention

SAMHSA

This site includes links and resources for suicide prevention and postvention efforts that are designed for AI/AN Communities.

Supporting Survivors of Suicide Loss: A Guide for Funeral Directors

https://www.sprc.org/resources-programs/supporting-survivors-suicide-loss-guide-funeral-directors-2nd-ed

Education Development Center, Inc. (EDC) and Samaritans, Inc.

This guide provides information and suggestions for funeral directors caring for those bereaved by suicide. Included are suggestions on talking with and supporting suicide loss survivors, providing services as a funeral director, and self-care support for funeral directors.

Additional Resources and References Used to Develop this Tool

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Montana Tribal Postvention Addendum

Montana Tribal Postvention Addendum

Tribal members in Montana continue to suffer high numbers of suicide- and mental health-related issues that stem from systemic policy, trauma, and lack of resources and supported services connected to reservations and urban centers. The history of trauma is all too familiar for American Indians, whether cultural, historical, intergenerational, or present trauma. Understanding these characteristics is key to developing effective prevention and postvention practices and approaches. This addendum's primary purpose is to support those who are organizing postvention teams in understanding the unique factors influencing the incidence of suicide in American Indian families and communities.

This addendum is designed to accompany the Suicide Postvention Toolkit, Responding After a Suicide: A Toolkit for Communities in Montana. It provides specific steps and best practices in approaching and engaging with tribal and urban community members who have experienced a suicide in their community. Successful engagement in postvention care can help reduce suicide clusters and provide needed support to families and communities that have lost a loved one to suicide, thereby helping to prevent more suicides among American Indians.

This addendum follows the structure of the full Postvention Toolkit and is designed as a bridging tool to help recognize the differences and nuances that take place when creating community-based actions in Native communities while working with Indigenous populations throughout Montana. A critical piece of that approach is to identify and support community strengths and individual resilience to counteract the negative stereotypes that are often present in and placed upon Native populations. Please refer to the full Postvention Toolkit for complete information on developing a Postvention Response Team before a suicide occurs, review your postvention plan in detail, enact a postvention plan, and review sources of support along with warning signs and suicide screening tools.

Montana Tribes

There are 11 distinct tribes in Montana, including the Bitterroot-Salish, Kootenai, Blackfeet (Amskapiipiikaani), Chippawa Cree, Little Shell Cree, Aanii (Gros venture), Nakoda (Assinboine) – Canoe paddler and Red Bottom Bands, Yankton and Sisseton Sioux Bands, Northern Cheyenne, and Crow (Apasoolooka). In Montana there are 7 federally recognized reservations. which include the Confederate Salish and Kootenai Tribe (CSKT), Blackfeet, Rocky boy, Fort Belknap, Fort Peck, Northern Cheyenne, and Crow. The Little Shell tribe is now a federally recognized tribe but has no Reservation. There are also five urban Indian Centers which provide services to all tribal members living off the reservation in Montana.

Overview

Within the tribal context there are recommended adaptations to the postvention team planning and development as well as general considerations for tribal contexts.

Develop Postvention Response Team before a Suicide Occurs

Identify others in your community who are interested in joining a Postvention Response Team. Distribute guide to team members and designate roles. If it is not possible to create a Team in your community, contact outside agencies for support. See Resources for Tribal and Indigenous Communities beginning on page 28.

Individuals within a community where one suicide has taken place may be more likely to attempt suicide themselves, especially if they were particularly close to the person who took their life. Youth and family members appear to be especially vulnerable to this dynamic. This “suicide contagion” (when losing someone to suicide can cause an increase in suicidal behavior in others) may be decreased by involving Elders and youth in decision-making processes, the presence of adult role models, and inclusion of traditional healing practices.

Review Postvention Response Plan In-depth And Begin Preparation Phase

Discuss any barriers that may get in the way of carrying out the response plan and problem-solve solutions. If needed, modify the plan and consult with the Montana Suicide Prevention Coordinator to ensure the plan adheres to best practices. Begin the Preparation Phase of the Postvention Response Plan (beginning on page 17).

Enact the Action Phase of Postvention Response Plan

After a suicide occurs, follow the Action Phase of the Postvention Response Guide (beginning on page 19).

Things to consider when assessing communities after a suicide is assessing protective factors. Protective factors have been found to mitigate the long-term risk for suicide and can serve as foundations when engaging in safety planning with a families and communities. The Postvention Team should understand the value of the strengths as mitigation and build crisis plans that highlight or boost the protective factors for patients at risk of suicidal behavior. Understanding the community's strengths are as important as understanding individual strengths.

Protective factors include:

- Community and family support.
- Positive peer support.
- Cultural beliefs that emphasize reasons for living and future roles as tribal leaders.
- Access to a variety of clinical interventions mental, physical, and substance abuse disorders, along with ongoing support from medical and mental health professionals, although many tribal communities lack some or all these resources.
- Coping skills and conflict resolution skills.
- Restricted access to lethal means of suicide.
- Strong tribal spiritual and religious beliefs. A study of American Indian community members living on reservations found that individuals with a strong tribal spiritual orientation were half as likely to report a suicide attempt in their lifetime. Previous research shows that religion is a protective factor in the general population, and tribal spiritual and religious beliefs are protective factors.
- Social Connectedness. Research shows that one of the most significant protective factors against suicide attempts in American Indian individuals is feeling connected to family, feeling able to discuss problems with family or friends, and general positive emotional health.

Review Sources of Support, Warning Signs, and Suicide Screening

Review mental health resources (beginning on page 25) and identify any others in your community that can be added to the list. Also, be sure that you have a clear understanding of warning signs (page 47) and screening for suicide risk (page 30).

General Recommendations for the Tribal Postvention Team:

1. Create safe and culturally inclusive norms for every postvention meeting to support a context where honest dialog can exist to support the postvention actions.
2. Develop a sense of trust, confidence, and comfort between all team members by creating inclusive cultural safe spaces. Help each other understand that it is OK to ask questions and to continue to check in with each other while creating and implementing the Postvention Toolkit. It is important to ask for clarification on technical terms that one does not understand. Taking time to clearly define all technical terms with your

postvention team will help them understand that it is OK to ask questions or to ask for clarification on technical terms to best support the families and communities.

3. It is critical for the postvention team to be sensitive to the family, engage them to the extent they feel comfortable, and always consider the needs of the family and community.
4. Seek to understand your postventions practices, team and cultural values, beliefs, and build on those that can have positive impacts within your team and community outreach.
5. Treat all members as unique individuals.
6. Search for cultural ways to connect your postvention team so it can relate to the families, communities, and resources they are serving and using in your community.
7. This toolkit is well-written. However, terms are far too technical for some Indigenous families and require patient and clear explanations. Many explanations in the toolkit are not only technical but also cumbersome and families and team members may quickly lose patience when having to deal with them. Someone from the team can be designated to helping families go through the steps and create connectedness.

Suicide Trainings and Evidence-based Practices for Tribal and Urban Communities

Question, Persuade, Refer (QPR): A two-hour gatekeeper training that provides attendees with the ability to recognize the warning signs, basic intervention strategies, and guidance for referrals.
Website: https://qprinstitute.com/

Applied Suicide Intervention and Skills Training (ASIST): A two-day workshop designed to provide participants with gatekeeping knowledge and skills. Gatekeepers are taught to recognize the warning signs of suicide and intervene with appropriate assistance.
Website: https://www.livingworks.net/asist

Mental Health First Aid and teen Mental Health First Aid: These public education programs are designed to improve participants' knowledge and modify their attitudes and perceptions about mental health and related issues, including how to respond to individuals who are experiencing a crisis.
Website: https://www.mentalhealthfirstaid.org/population-focused-modules/teens/

Gathering of Native Americans (GONA): A culture-based planning process where community members gather to address community-identified issues. It uses an interactive approach that empowers and supports AI/AN tribes. The GONA approach reflects AI/AN cultural values, traditions, and spiritual practices. The GONA focuses on the following four themes:

- Belonging. The GONA ensures that everyone feels welcomed in an inclusive, open, safe, and trusting environment.
- Mastery. The GONA allows participants to take stock of how historical trauma impacts their communities and what fosters their resilience and holds them together.
- Interdependence. The GONA initiates the planning process to assess resources and relationships, and to experience and strengthen interconnectedness.
- Generosity. The GONA exercise of creating gifts to share with other participants symbolizes each participant's larger gift to their families and communities in helping to address and prevent mental and substance use disorders, prevent suicide, and promote mental health.

The GONA is a journey of healing and transformation. It is as much about healing the past as it is about building the future. The GONA is a road map for the journey. The journey itself will need to be traveled by all members of the community. Ultimately, this journey is about reestablishing a safe, supportive, and nurturing community so AI/AN youth can thrive and grow up in balance.
Website: https://www.samhsa.gov/tribal-ttac/resources

Peer-mentoring, Sources of Strength (SOS): Adults and peer mentors trained in the Sources of Strength Youth Suicide Prevention program help enhance protective factors and

connectedness among at-risk youth to prevent suicide. Trained peer leaders use their network of friends to:

1. Have one-on-one conversations.
2. Develop a hope, help, strength poster and/or PSA program using local faces and voices.
3. Present peer-to-peer presentations.
4. Develop video, internet, or texting messages.

The program often starts as three-to-six-month project but is designed as a multi-year project with ongoing peer messaging and contacts growing over time.
Website: https://sourcesofstrength.org/

Peer-to-Peer Services: Peers provide group supports, assistance navigating the mental health care system, and follow-up/follow-along contacts.
For more information: https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers

Resources and References Used to Develop Addendum

Additional references used to develop the addendum and those that are not cited throughout the toolkit.

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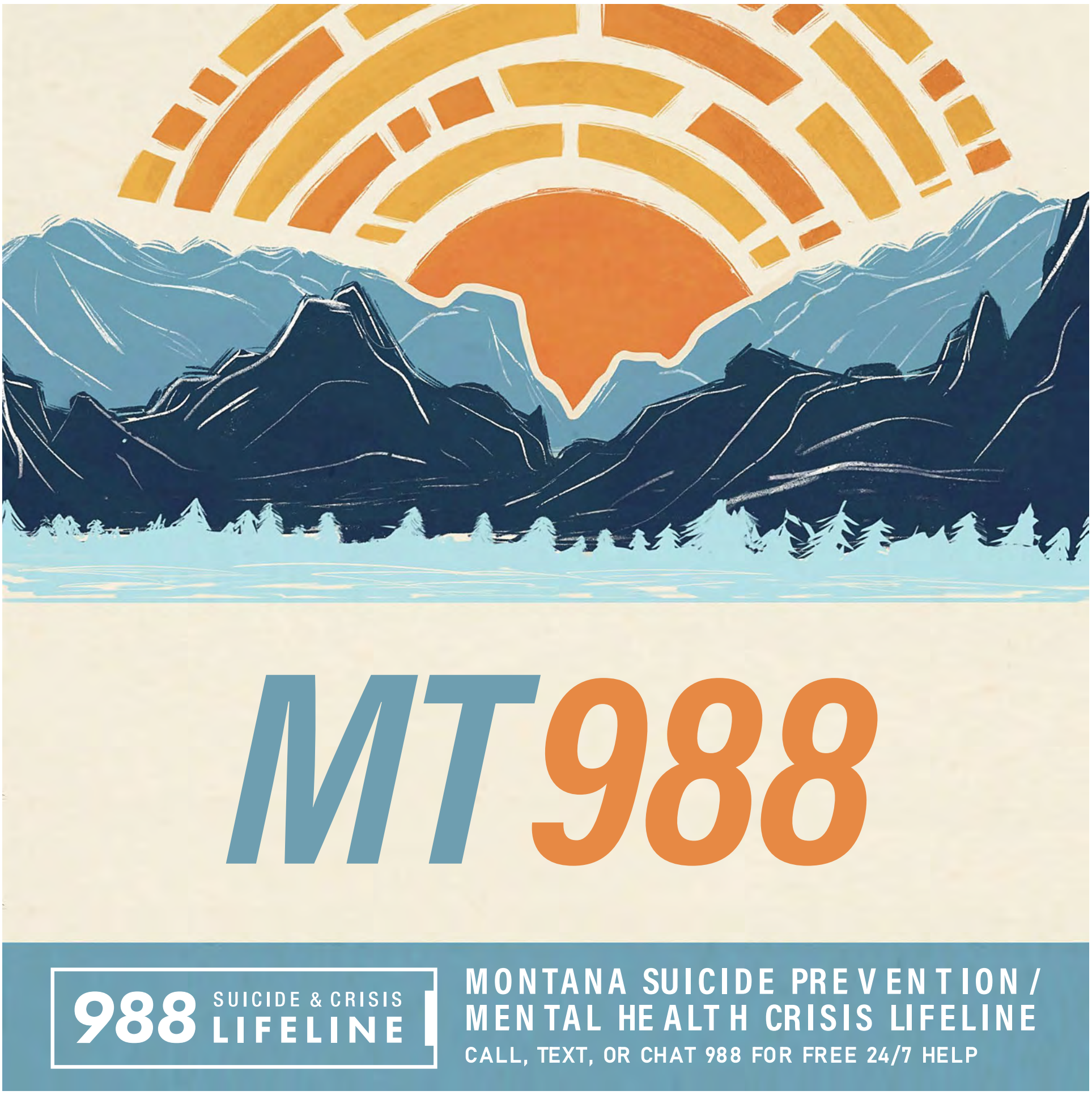

Montana Department of Public Health and Human Services | www.dphhs.mt.gov

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Montana 988 Suicide Prevention and Mental Health Crisis Lifeline

Montana's 988 Suicide Prevention and Mental Health Crisis Lifeline provides free and confidential emotional support to people in suicidal crisis or emotional distress, 24 hours a day, 7 days a week, across Montana. The MT 988 Suicide & Crisis Lifeline is an effective, life-saving safety net for those experiencing a mental health crisis, especially those with nowhere else to turn.

Connect

All calls to the MT 988 Suicide & Crisis Lifeline are answered by trained crisis workers at three regional call centers around the state. All Montana crisis centers are accredited, provide training for counselors, and disseminate best practices. Local counselors at crisis centers are familiar with community mental health resources that are part of the Montana 211 referral network.

Resources

For more information on how the MT 988 Suicide & Crisis Lifeline can help you or someone you know who is in crisis, or to find out how to spread the word about MT 988 in your community, go to https://dphhs.mt.gov/suicideprevention/

MONTANA DPHHS

https://dphhs.mt.gov/suicideprevention/