Briefing Learning Module 5: Before, During and After a Crisis

This learning module focuses on identifying and assisting individuals who are experiencing thoughts of suicide. Providing the appropriate level of supports and services based on risk is a large undertaking but is an essential component of a comprehensive system of suicide prevention.

Striving for Zero, California's Strategic Plan for Suicide Prevention addresses the crisis response system in Strategic Aims 3 and 4. Strategic Aim 3 calls for enhancing early identification of suicide risk and increasing access to services based on risk. It includes two goals that address detection and screening and building a continuum of crisis services within and across counties. Strategic Aim 4 focuses on improving suicide-related services and supports, with three goals to increase best practices in care targeting suicide risk, continuity of care and follow-up after suicide-related services, and ongoing support following a suicide loss.

This briefing offers information on models, best practices and resources in the following:

- Identifying individuals who are experiencing thoughts of suicide
    - Asking about suicide
    - Gatekeeper training
    - Suicide risk assessment
- Continuum of Crisis Services
    - Crisis lines
    - Community crisis models (Crisis Now)
    - Mental Health Urgent Care
- Effective care and treatment
    - Safety planning (including addressing access to lethal means)
    - Crisis Response Planning
    - Follow Up Care (continuity of care)
- Ongoing support after a suicide attempt
- Behavioral health treatment

Identifying and assisting individuals who are experiencing thoughts of suicide

Asking directly about suicide

Asking someone about suicide directly is one of the most important things we do, yet it can be difficult for lay persons and professionals alike. Stigma and myths surrounding suicide and fear that introducing the topic will make the situation worse and even liability concerns often underlie this reluctance.

Asking about suicide does not cause or increase suicidal thinking or lead to a greater likelihood of suicidal behavior. Often, asking about suicide can lead to an improvement in outcomes and lower likelihood of suicidal behavior. Being asked directly promotes connection and can encourage a person to seek help and support. Talking more openly about suicide and educating people that asking about suicide can promote prevention are first steps everyone can take.

Sources

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Gatekeepers are individuals in the community who are in a position to help identify warning signs and help someone who may be at risk of suicide. Gatekeepers may include:

- Community members, family and friends
- Educators and staff on school campuses
- Co-workers, managers and supervisors in the workplace
- Human resources and Employee Assistance Program providers
- Clergy, fellow congregants and members of the faith community
- First responders (EMTs, law enforcement, firefighters)
- Health care and behavioral health care providers and office/clinic staff
- Aging services providers, volunteers, residential living and senior center staff

Gatekeeper training is designed to change factors in a person's knowledge and behaviors that will increase the likelihood that they will effectively recognize suicide risk and intervene. Training increase knowledge about warning signs, risk factors and resources available for at-risk individuals and encourage beliefs and attitudes that suicide is preventable and that seeking help for mental illness is a healthy form of self-care. Gatekeeper training can reduce reluctance to intervene by addressing perceptions individuals may have that it is not their responsibility or that it is inappropriate to intervene and mental health stigma around mental health challenges and enhancing an individual's comfort with and sense of competence around intervening.

The benefits of gatekeeper training are strongest when training is recent (e.g. every 3 years or less) and when the concepts are supported and reinforced in the gatekeeper's organization or setting. While holding gatekeeper trainings is important, being as strategic as possible in ensuring that those most likely to encounter people at higher risk is even more effective.

- Source: Gatekeeper Training for Suicide Prevention: A Theoretical Model and Review of the Empirical Literature, RAND 2015.

The Suicide Prevention Resource Center's Comparison Table of Suicide Prevention Gatekeeper Programs and Zero Suicide's Suicide Care Training Options include a more comprehensive listing of trainings and are useful resources when determining the best model for a particular audience or setting.

Assessment of suicide risk

Best practice for screening and risk assessment in (various) settings includes provider knowledge of risk and protective factors and warning signs, procedures for categorizing risk and making clinical decisions based on risk, evidence-based assessments and safety planning, documentation of risk level and action taken, and caring referral procedures. Standardization makes the entire process of identifying risk and connecting people to services transparent and collaborative for the provider and person at risk. Although it is important to note that suicide risk is still determine on a case-by-case basis and should be determined with the individual in mind.

Much of the research and theory around suicide risk agrees that there are four key components to determining suicide risk: desire, intent, capability (including behaviors), and buffers (also known as protective factors). Although suicide desire alone presents a low risk for a suicide attempt, too often individuals who are experiencing only suicide desire (low risk) are routed through the same crisis response as someone experiencing a combination of desire, intent, and capability with low levels of buffers (high risk). Linking standardized risk assessment protocols with efforts to build a continuum of crisis services in the community can help ensure that individuals receive the appropriate level of intervention and care based on the results of the assessment.

Examples of Screening Tools for Suicide Risk

- Ask Suicide-Screening Questions (ASQ) Toolkit
- PHQ-9 Screening Tool; PHQ-9 Screening Tool Manual
- Columbia Suicide-Severity Rating Scale

Sources

- One Size Does Not Fit All: A Comprehensive Clinical Approach to Reducing Suicidal Ideation, Attempts, and Deaths. Jobes DA, Chalker SA. Int J Environ Res Public Health. 2019 Sep 26;16(19). https://www.ncbi.nlm.nih.gov/pubmed/31561488
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Continuum of Crisis Services

Crisis services provide assessment, crisis stabilization, and referral to an appropriate level of ongoing care. Crisis services such as those listed below can be provided individually but will

have the greatest impact when all efforts are in place and connected. Systems that deliver the right care, at the appropriate time and in the last restrictive setting will be most effective in supporting individuals who are considering suicide.

A Crisis Services Continuum of Care includes:

- Crisis lines provide immediate support and promote problem-solving and coping skills via telephone (or text or online chat) to individuals who are experiencing distress. They also facilitate referrals to medical, health care, and community support services,
- Mobile crisis teams provide acute mental health crisis stabilization and psychiatric assessment services to individuals within their own homes and in other sites outside of a traditional clinical setting. Such teams' main objectives are to provide rapid response, assess the individual, and resolve crisis situations that involve individuals who have a behavioral health disorder.
- Crisis observation or stabilization provides individuals in severe distress with up to 23 consecutive hours of supervised care to help de-escalate the severity of their crisis and need for urgent care, and to avoid unnecessary hospitalizations.
- Peer crisis services are an alternative to a psychiatric emergency department or inpatient hospitalization and are operated by people who have experience living with a mental illness (i.e., peers). Peer crisis services are generally shorter-term than crisis residential services.

The SAMHSA National Guidelines for Crisis Care – A Best Practice Toolkit advances national guidelines in crisis care within a toolkit that supports program design, development, implementation and continuous quality improvement efforts. It is intended to help mental health authorities, agency administrators, service providers, state and local leaders think through and develop the structure of crisis systems that meet community needs.

Crisis Lines

Crisis lines offer crisis interventions services using phone lines, online chat, or texting services. Most crisis lines are available 24/7 and can be especially helpful for those who may be reluctant to seek face-to-face help or who have barriers accessing mental health services. Studies and evaluations of hotline effectiveness have found that the majority of callers have reduced distress by the end of the call.

The crisis centers that operate crisis lines also offer other services to the community depending on their capacity. These may include individual or group therapy, support programs for suicide loss or attempt survivors, follow-up contacts, suicide prevention training, and community outreach. Some crisis centers provide services to support those affected by a tragedy or disaster, such as critical incident stress debriefing.

Most crisis centers are locally funded through a mix of private donations and county contracts. The majority of crisis centers are staffed by volunteers, paid staff, or a combination of the two. Crisis workers are trained in assessing suicide risk and providing counseling and facilitating

referrals to callers that may benefit from ongoing services and supports. Crisis Centers are typically accredited through the American Association of Suicidology. Crisis centers are evaluated for organizational and administrative capacity and adherence to the most current research knowledge and practice standards.

The National Suicide Prevention Lifeline (NSPL) is a network of crisis centers, not a national call center. Callers to the Lifeline are routed to a crisis center based on their area code. The call is assigned to a primary crisis center and rolls over to a series of back-up crisis centers if needed. The Lifeline network also offers web-based chat, services for the deaf and hard of hearing, and callers can choose prompts to be connected to the Spanish subnetwork or the Veterans Crisis Line.

Three-Digit Number for Suicide Prevention
Recently, the FCC recommended that 988 be designated as a national crisis hotline. Please continue to share 800-273-TALK (8255) and our chat page with anyone wishing to connect to the Lifeline. 988 is NOT CURRENTLY ACTIVE and will not connect callers to the Lifeline.

California AAS-accredited crisis centers:

- Casa Pacifica, Centers for Children & Families (Camarillo)
- Friendship Line, Center for Elderly Suicide Prevention & Grief Related Service, Institute of Aging (SF)
- Suicide Prevention Service, Family Service Agency of the Central Coast (Santa Cruz)
- Teel Line (LA)
- The Trevor Project (West Hollywood)
- Transitions-Mental Health Association (SLO)

California Crisis centers that are AAS-accredited and also members of the National Suicide Prevention Lifeline:

- Kern Behavioral Health & Recovery Services Hotline (Bakersfield)
- Suicide Prevention of Yolo County (Davis)
- Santa Clara County Suicide and Crisis Services (San Jose)
- Crisis Support Services of Alameda County (Oakland)
- Wellspace Health (Sacramento)
- Suicide Prevention & Community Counseling (San Rafael)
- StarVista (San Carlos)
- Suicide Prevention Center, Didi Hirsch Mental Health Services (Century City)
- San Francisco Suicide Prevention (San Francisco)
- Central Valley Suicide Prevention Hotline- Kings View (Fresno)
- Optum (San Diego)
- Contra Costa Crisis Center (Walnut Creek)

Sources

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Crisis Text Line (741-741) offers 24/7 text services and responds similarly to Lifeline. When a text is sent to the number two automated messages appear while the system connects the user to a trained counselor who will conduct a similar conversation to the one described for the National Suicide Prevention Lifeline.

Population-specific crisis lines

- The Trevor Project offers several venues for LGBTQ youth (ages 25 and under) to reach out 24/7, including the Trevor Lifeline (1-866-488-7368), Trevor Chat, and TrevorText (text START to 687678).
- The Friendship Line is both an AAS-accredited crisis line and a warm line that serves adults aged 60 and older as well as adults living with disabilities. Friendship Line also offers warm line services and outreach via phone for isolated seniors. The 24/7 line can be reached by calling 1-800-971-0016. Referrals can be made via an online form or by calling the business line at 1-415-750-4111.
- Teen Line is staffed by trained volunteers who are also teens. It can be reached from 6pm to 10pm PST by calling (310) 855-HOPE or (800) TLC-TEEN, or texting TEEN to 839863. TeenLine also responds to emails during evening hours and hosts a moderated message board for teens to communicate with one another.
- Cop Line offers 24/7 peer support for crisis intervention and referrals to local mental health resources. Cop Line is staffed by retired law enforcement officers that have received additional training in active listening and peer counseling support. Cop Line is completely confidential, so callers can use the services without concern about career jeopardy.

Other Hotline Services. Many Californians may be more likely to know about or use these broader services, so strategies to enhance their capacity to manage crisis calls and develop a system of referral or warm hand-off has potential for bolstering up local crisis response systems.

- County Mental Health Access Lines assist local residents seeking assistance in a crisis to access local mental health programs. Any California resident can call 24/7 and speak with a crisis worker, including if they are concerned about someone else.
- 211 is a free and confidential service that helps people find local resources for a wide variety of needs. 211 is supported through the United Way and a mix of public and private funding. 211 can be accessed through dialing 211 or through the web site.
- Warm lines are generally not intended to provide crisis services but offer another level of support that contributes to continuity of care. The California Peer Run Warm Line offers a level of support for people who may not be in crisis, but can benefit from talking to an empathic person who understands.

Mental Health Urgent Care (MHUC) services are intended to reduce avoidable acute care (e.g. ED) usage and can help address gaps in continuity of care between inpatient and outpatient services. Similar to urgent care health clinics, the concept is to provide a level of care that is not quite at the emergency level but potentially too serious to wait to schedule an appointment with a doctor. MHUCs offer walk-in services such as screening, assessment, crisis intervention, counseling, referral and short-term treatment options including some medication management.

Reviews of the literature suggest that MHUCs are effective in reducing symptom severity and distress while improving overall functioning and mental health-related quality of life and satisfaction of care. They also have the potential to address some disparities in access to mental health care for underserved populations.

County Mental Health Urgent Care Examples:

- Santa Clara County
- Sacramento County
- Riverside County

Source: Sunderji, N., J. Tan de Bibiana, and V. Stergiopoulos. Urgent Psychiatric Services: A Scoping Review. *Can J Psychiatry*. 2015 Sep; 60(9): 393–402. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4574715/

Crisis Now Model: Transforming Crisis Services

The Crisis Now model supports delivery of effective crisis services that improve access to care while saving time and cost by reducing the need for psychiatric inpatient bed usage, emergency department visits, and law enforcement overuse. Crisis Now was developed following

recommendations from the National Action Alliance for Suicide Prevention's Crisis Services Task Force. The model advocates the following core elements of crisis care:

- Regional or statewide crisis call centers coordinating in real time
- Centrally deployed, 24/7 mobile crisis
- Short-term, "sub-acute" residential crisis stabilization programs
- Essential crisis care principles and practices that include protocols for delivering trauma-informed services for individuals with suicide risk in the most collaborative, responsive, and least restrictive setting

The Crisis Now web site offers tools to explore this approach, including:

- Rate your local crisis system using an assessment and scoring guide
- Calculate your local crisis need by understanding how your crisis system flows
- The Crisis Now Library of reports and technical assisance resources to support developing and implementing strategies.

Effective Care and Treatment for Reducing Suicide Risk

The National Action Alliance for Suicide Prevention's Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe identified several strategies that can address gaps in health care that can increase suicide risk: safety planning, lethal means reduction, and follow-up care or continuity of care after discharge from an inpatient health or mental health setting.

Safety planning is a brief intervention to help a patient develop a plan to recognize suicidal thoughts and manage them safely. Safety planning includes identifying personal warning signs as well as behaviors or actions that can help reduce risk. It also includes identifying possible means of self-harm that are available to the individual and reducing access by taking specific steps, such as self-storage of firearms. The Safety Plan Template and Quick Guide for Clinicians are useful resources. In addition, MY3 is a free app designed as a tool for a provider to work with a patient to develop a safety plan that is readily accessible on the person's mobile device. One advantage to using the app is a direct phone link to identified supportive individuals and resources.

Crisis Response Planning

Crisis Response Planning (CRP) is a strategy used to develop written steps for a person at risk for suicide to take during times of crisis or when under stress. Using an index card, people list steps for identifying personal warning signs, along with coping strategies and social and professional support. In many ways, Crisis Response Planning is similar to the Safety Planning Intervention but one of the distinguishing features is that CRP also helps the individual in distress explore and list their reasons for living, by identifying things that provide a sense of

purpose and meaning in life. The CRP is created collaboratively between a suicidal individual and a trained individual.

Results of a randomized clinical trial of high-risk active duty soldiers found that CRP was more effective than a contract for safety (contracts in which a person vows not to self-injure) in preventing suicide attempts, resolving suicide ideation, and reducing inpatient hospitalization. CRP reduced suicide attempts by 75 percent compared to using safety contracts.

Source: Bryan, Craig & Mintz, Jim & Clemans, Tracy & Leeson, Bruce & Burch, T. & Williams, Sean & Maney, Emily & Rudd, M.. (2017). Effect of crisis response planning vs. contracts for safety on suicide risk in U.S. Army Soldiers: A randomized clinical trial. *Journal of Affective Disorders*. 212. 10.1016/j.jad.2017.01.028.

Follow Up Care

Suicide risk is higher during the time after discharge from an inpatient setting or from treatment following a suicide attempt. Among those discharge from psychiatric care, the suicide death rate is 300% higher in the first week and 200% higher in the first month than that of the general population.

Bridging the transition from inpatient to outpatient care can help mitigate risk by providing continuity of care and support for individuals that have made a suicide attempt or been assessed for suicidality in the emergency department, or after discharge from psychiatric facilities. Follow-up care can be provided through phone calls, post cards, letters, or in-person visits that are intended to offer support and encouragement follow up with outpatient care.

Potential benefits to follow-up care include reduced suicidality and/or attempts, reduced hospital re-admissions and return visits to the emergency department, and cost savings to the hospital system. Some studies have also found positive results from follow-up care among patients discharged after non-suicide events.

Resources for Follow-Up Care

- Zero Suicide in Health Care, Safe Care Transitions
- National Suicide Prevention Lifeline, Follow-Up Matters
- Now Matters Now
- Suicide Prevention Resource Center, Caring for Adult Patients with Suicide Risk
- Crisis Now
- National Action Alliance for Suicide Prevention, Best Practices in Care Transitions for Individuals with Suicide Risk

Sources:

- Carter G, Clover K, Whyte I, et al: Postcards from the Edge project: randomized controlled trial of an intervention using postcards to reduce repetition of hospital treated deliberate self-poisoning. *British Medical Journal*, 2005; AND *British Medical Journal*; 2013; 202(5): 372-380.
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The majority of young people who consider and attempt suicide receive no mental health services. Ethnic minority adolescents, including Latinx and Asian American adolescents are at increased risk for suicidal thoughts and attempts compared to their non-Hispanic white peers. Yet, suicidal ethnic minority youth are even less likely than non-Hispanic white youth to receive mental health services. Although school-based services can reduce access barriers, racial/ethnic disparities persist even within school- based suicide prevention efforts.

Family Intervention for Suicide Prevention (FISP) is a multicomponent cognitive-behavioral family intervention designed for use in emergency departments, but that has been adapted for use in other settings (e.g. homes, inpatient, residential, outpatient, school, other community programs). The goal is to reduce suicidal behavior and improve rates of follow-up care by for youth ages 10-18 through enhancing family motivation. The FISP is delivered by mental health providers or health providers with some mental health training. Follow-up contacts begin within the first 48 hours after discharge and continue until the youth is linked to care. This intervention has also been adapted for use in the homes of youth and in non-ED settings.

Sources

- Husky, M. M., Olfson, M., He, J. P., Nock, M. K., Swanson, S. A., & Merikangas, K. R. (2012). Twelve-month suicidal symptoms and use of services among adolescents: results

from the National Comorbidity Survey. *Psychiatric services*, *63*(10), 989–996. https://doi.org/10.1176/appi.ps.201200058
- Pirkis J.E., Irwin C.E. Jr., Brindis C.D., Sawyer M.G., Friestad C., Biehl M., Patton G.C. Receipt of psychological or emotional counseling by suicidal adolescents. *Pediatrics*, 2003 Apr; 111 (4 Pt 1): e388-93. https://www.ncbi.nlm.nih.gov/pubmed/12671157
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- Suicide Prevention Resource Center. Family Intervention for Suicide Prevention

Ongoing Support After a Suicide Attempt

A prior suicide attempt is one of the primary risk factors for a second attempt. The weeks and months following a suicide attempt are frequently ones with elevated risk, yet only about half of patients receive follow-up care after a suicide attempt.

Studies estimate that fewer than half of suicidal patients admitted to inpatient psychiatric units or treated in emergency departments receive aftercare. A review of the literature suggests multiple contacts with patients discharged from psychiatric hospitalization or emergency departments after a suicide attempt or ideation may prevent future suicidal behaviors.

Sources

- Luxton, D.D., June, J.D., & Comtois, K.A. (2013). Can post discharge follow-up contacts prevent suicide and suicidal behavior? A review of the evidence. *Crisis 34*(1): 32-41.
- Burstein B, Agostino H, Greenfield B. Suicidal Attempts and Ideation Among Children and Adolescents in US Emergency Departments, 2007-2015. *JAMA Pediatr.* 2019;173(6):598–600. doi:10.1001/jamapediatrics.2019.0464

Individuals who have survived a suicide attempt often have a difficult time talking about their attempt with family members, friends, and even helping professionals. It is not common for attempt survivors to continue to have thoughts of suicide. Talking openly and connecting with others who understand and have been there can help reduce the stigma and shame around suicide and can also reduce future risk.

Attempt survivor support groups are facilitated by individuals with a background in mental health and suicide prevention (preferably including a mental health clinician) and a peer, or someone who has also survived a suicide attempt. The groups provide an opportunity for people to connect with others that share the experience, a safe place to share thoughts and emotions about the suicide attempt, and the chance to work together to develop skills and tools to stay safe from future attempts.

Attempt survivor support groups typically meet in 8-week sessions that cover such topics as talking about suicide, giving and receiving support, what triggers suicidal thoughts, coping Mechanisms, safety planning and resources to find help.

Source: Didi Hirsch Mental Health Services Suicide Prevention Center. 2014. Manual for Support Groups for Suicide Attempt Survivors. Los Angeles, CA: Didi Hirsch Mental Health Services

Behavioral Health Treatment

Several treatments have proven success in reducing to suicidal ideation and behavior. Not all mental health professionals may be trained to provide these interventions. Increasing the availability of training as well as directories of providers who are trained in these interventions can help ensure individuals who can benefit from treatment are able to find it. Effective treatments include:

- Cognitive Therapy for Suicide Prevention (CT-SP)
- Brief Cognitive Behavior Therapy (BCBT)
- Collaborative Assessment and Management of Suicidality (CAMS)
- Dialectical Behavior Therapy (DBT)
- Attempted Suicide Short Intervention Program (ASSIP)

Several trainings are also available for mental health clinicians that include best practices for treating suicide risk. Zero Suicide's Suicide Care Training Options includes a more comprehensive listing of trainings, such as:

- Assessing and Managing Suicide Risk
- Recognizing and Responding to Suicide Risk
- Collaborative Assessment and Management of Suicidality
- Suicide to Hope: A Recovery and Growth Workshop
- Question, Persuade, Refer, Treat (QPRT)

Conclusion

Creating an effective crisis response system requires partnership and connectivity at multiple levels: from individual members of the community to a range of health and behavioral health care providers and others that are in a position to help. Having a crisis response plan in place

within key community settings can help weave together a safety net throughout the community that can support individuals along the suicide crisis path.