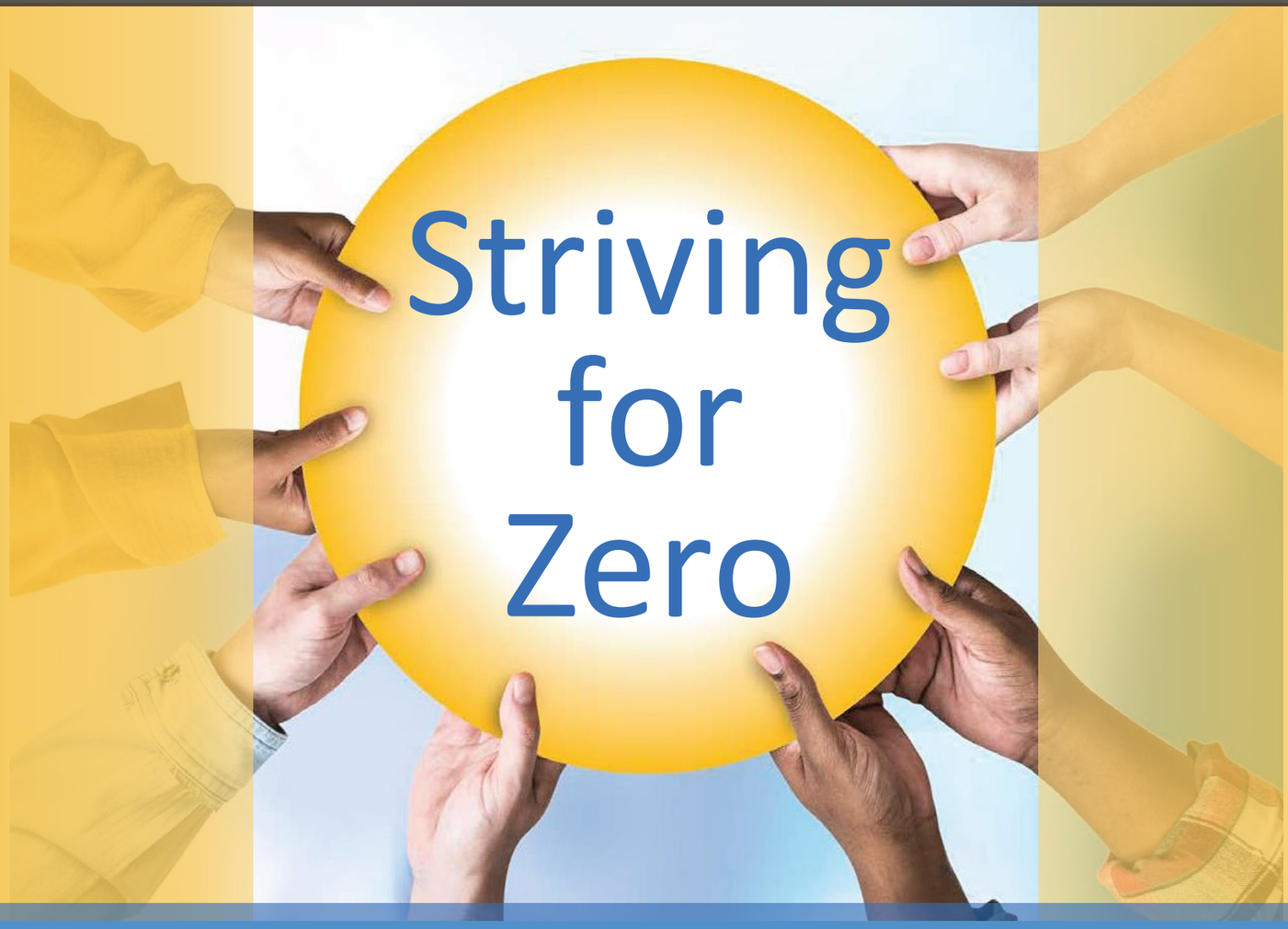

Striving for Zero Learning Collaborative

Module – Screening and Risk Assessment – October 12, 2022

Support for people at risk for suicide or those supporting people at risk is available by calling the **National Suicide Prevention Lifeline** 1-800-273-TALK (8255) or 988

Apoyo y ayuda para personas a riesgo de suicidarse o para las personas que los apoyan está disponible llamando al **National Suicide Prevention Lifeline** **1**-888-682-9454 o 988

Welcome!

Please add your county name to your display name and introduce yourself in the chat.

We will share the slides and recording with you.

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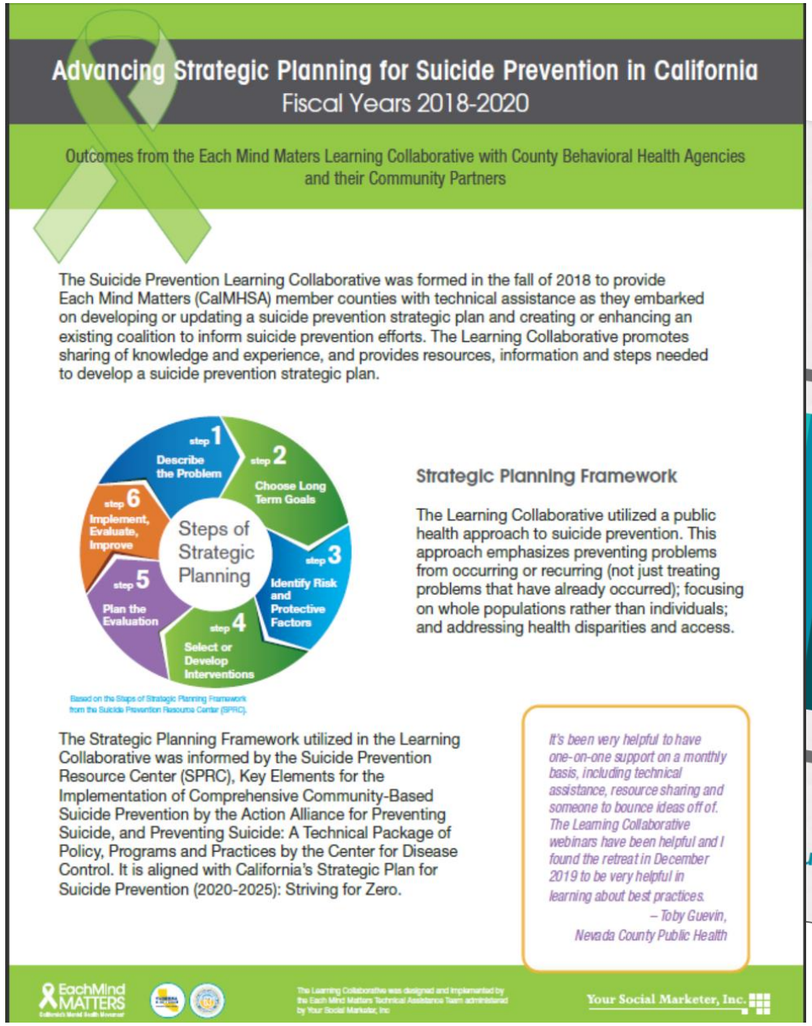
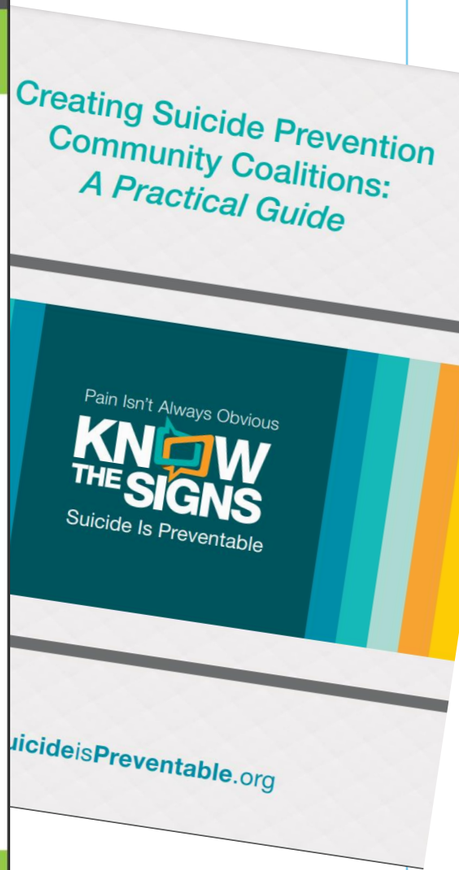
Striving for Zero Learning Collaborative

Advance local strategic planning and implementation and alignment with strategic aims, goals and objectives set forth in California's Strategic Plan for Suicide Prevention

Mental Health Services Oversight & Accountability Commission

Builds on a previous Learning Collaborative offered by the California Mental Health Services Authority





Find the Plan here: https://mhsoac.ca.gov/what-we-do/projects/suicide-prevention/final-report

Pain Isn't Always Obvious KNOW THE SIGNS suicideispreventable.org

CalMHSA California Mental Health Services Authority

Striving for Zero
Suicide Death Fatality Review Team Collaborative Meeting
November 8, 2022
10AM – 11.30PM
To register:
https://us06web.zoom.us/meeting/register/tZMpc-Ggrj4pE9YE3u1e1AKc-NiIQVRtlyuV

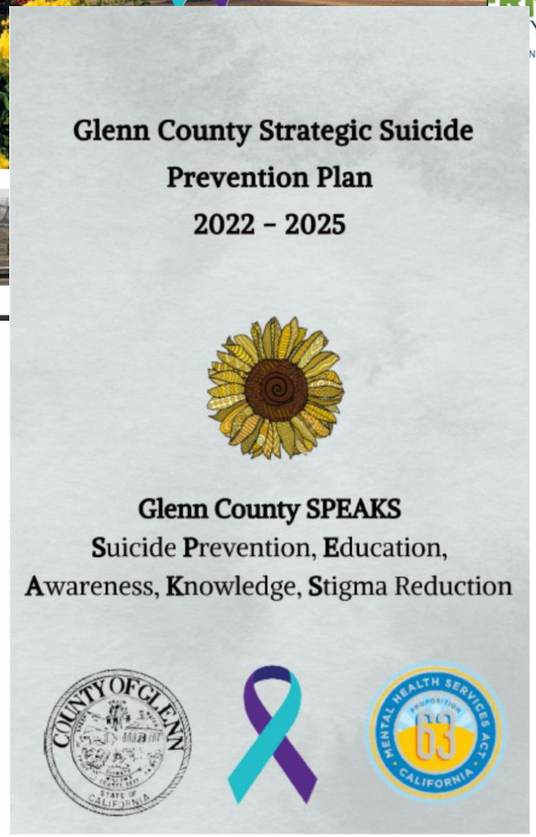
Striving for Zero Rural Cohort
November 2, 2022
12.30AM – 2.30PM
To register:
https://us06web.zoom.us/meeting/register/tZ0tdOmuqjssHdfZ9wr_BU6X4tcOUHRLhczS

Striving for Zero Collaborative Module
December 7, 2022
10AM - 12PM
To register:
https://us06web.zoom.us/meeting/register/tZUkc-morjgpHNa3UXRbBZkOEb4R8nBSAx7K

Learning Collaborative Resource Page

https://mhsoac.ca.gov/initiatives/suicide-prevention/collaborative/

Congratulations!



Good Byes…

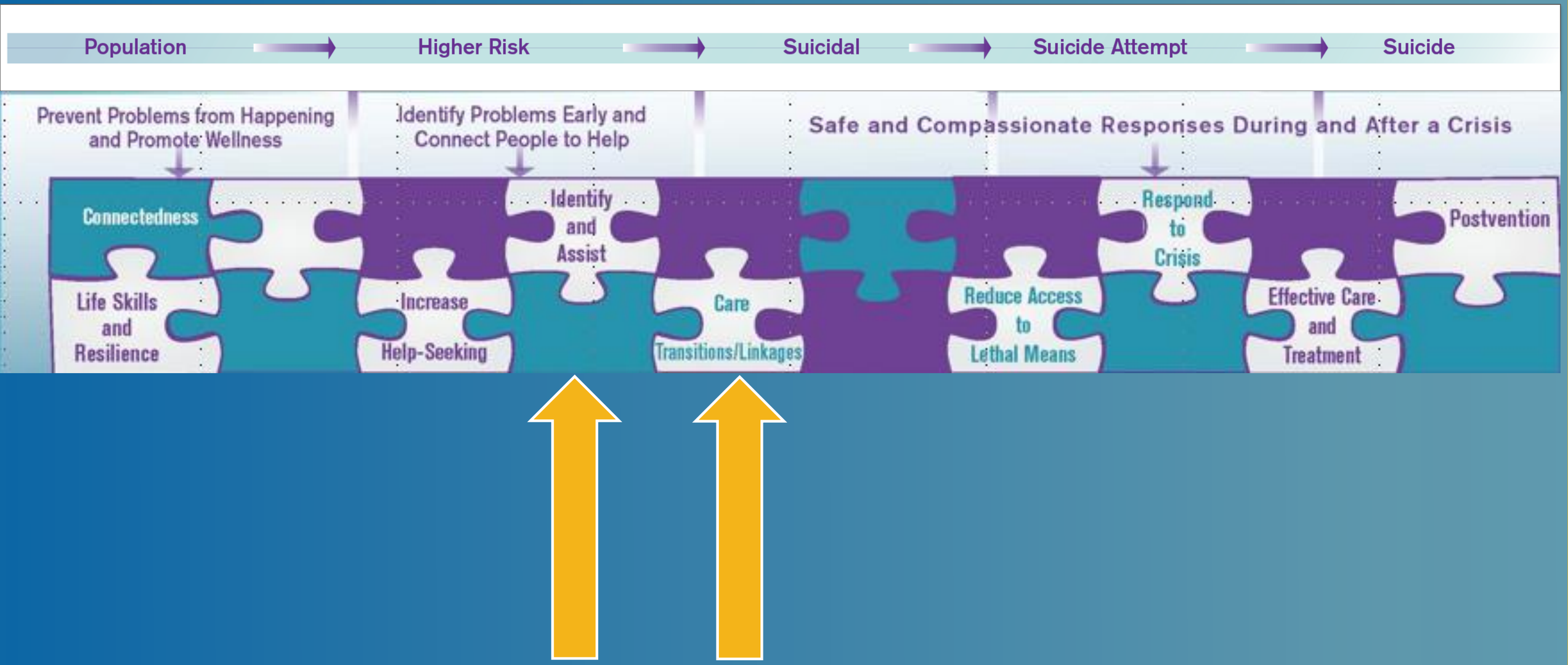
and Hellos!

Joyce Chu, Ph.D. is a licensed Clinical Psychologist whose expertise lie in the areas of suicidology, diversity and culture, and community mental health. She completed her training at Stanford University, University of Michigan, and the University of California, San Francisco, and is currently a Professor of Psychology at Palo Alto University (PAU) where she directs/co-directs the Diversity and Community Mental Health (DCMH) emphasis and Multicultural Suicide Research Center. Her work is focused around advancing the assessment and prevention of suicide for ethnic minority and LGBTQ populations, particularly in Asian Americans. She has published numerous works including a cultural theory and model of suicide and a tool that assists in accounting for cultural influences on suicide risk. Her work is community-collaborative and aims to address the need for culturally congruent outreach and service options for underserved communities.

Population → Higher Risk → Suicidal → Suicide Attempt → Suicide

“The Suicidal Crisis Path is a model that intends to integrate multiple theoretical approaches and frameworks within the context of an individual’s suicidal experience. In doing so, the purpose is to match intervention approaches with the timing, risk factors, and protective factors that would be the mechanisms to prevent a suicide from happening.” (Lezine, D.A. & Whitaker, N.J., Fresno County Community-Based Suicide Prevention Strategic Plan, 2018)

www.FresnoCares.org


Population
Higher Risk
Suicidal
Suicide Attempt
Suicide
Prevent Problems from Happening and Promote Wellness
Identify Problems Early and Connect People to Help
Safe and Compassionate Responses During and After a Crisis
Connectedness
Life Skills and Resilience
Increase Help-Seeking
Identify and Assist
Care Transitions/Linkages
Reduce Access to Lethal Means
Respond to Crisis
Effective Care and Treatment
Postvention

Striving for Zero:
California Strategic Plan

STRATEGIC AIM 3: INCREASE EARLY IDENTIFICATION OF SUICIDE RISK AND CONNECTION TO SERVICES BASED ON RISK

- Goal 8: Increase detection and screening to connect people to services
- Goal 9: Deliver a continuum of crisis services within and across counties

https://mhsoac.ca.gov/sites/default/files/Suicide%20Prevention%20Plan_Final.pdf

Identifying individuals experiencing thoughts of suicide

3 STRATEGIC AIM

GOAL 8: INCREASE DETECTION AND SCREENING TO CONNECT PEOPLE TO SERVICES BASED ON SUICIDE RISK

Desired Outcome Decrease in suicidal behavior and increase in connection to services based on risk.

Short-term Target By 2025, all people screened for suicide in health care settings are connected to services necessary to reduce risk and increase factors that protect against suicide, and receive brief interventions (if applicable).

https://mhsoac.ca.gov/sites/default/files/Suicide%20Prevention%20Plan_Final.pdf

Identifying individuals experiencing thoughts of suicide

STRATEGIC AIM 3: ENHANCE EARLY IDENTIFICATION OF SUICIDE RISK AND INCREASE ACCESS TO SERVICES BASED ON RISK

Objective 8g Screen people seen in health, mental health, and substance use disorder care settings for suicide risk and deliver best practices in suicide risk assessment and management to those who screen positive for risk. Such settings include state and local correctional facilities.

- Suicide screenings can follow positive results on other screening tools. For example, screening specific to suicide risk should follow positive screens for depression, anxiety, trauma, physical pain, and problem alcohol, drug use, and eating. Comprehensive suicide risk assessments follow screening.

- The Joint Commission recommended the use of screening and assessment tools that include the following: Ask Suicide Screening Toolkit (ASQ) by the National Institute of Mental Health; the Columbia—Suicide Severity Rating Scale (C-SSRS) Triage Version; Patient Health Questionnaire 9 (PHQ-9) Depression Scale; Suicide Behavioral Questionnaire Revised; Scale for Suicidal Ideation-Worst; and the Beck Scale for Suicide Ideation.[29]

https://mhsoac.ca.gov/sites/default/files/Suicide%20Prevention%20Plan_Final.pdf

Supporting individuals who are experiencing thoughts of suicide – Resource Mapping Questions

- What suicide risk screening/assessment tools are currently being used?
- What currently happens when someone is identified at risk for suicide? At low-risk vs high-risk?
- Is everyone aware of crisis line supports (local or national)? What crisis call center does your county utilize/promote?
- Are you promoting and supporting any population specific support lines? Do you have a need?
- Are mobile crisis response team being utilized in your county?

Polling and Reflection Questions

To your knowledge, what screening tools used routinely as part of your community's suicide prevention efforts?

Which screening tools or templates are used?

<u>Reflection Questions:</u>

- **Are you aware of any screening being conducted routinely in key community settings or with certain populations? At what intervals**
- **Is data on the results of screening being captured, compiled, or shared? Who might you ask to find out more about this?**
- **How might you pursue this as a goal for your strategic plan?**

Screening and Assessment: The Why

Support for people at risk for suicide or those supporting people at risk is available by calling the **National Suicide Prevention Lifeline** 1-800-273-TALK (8255)

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Screening vs. Assessment

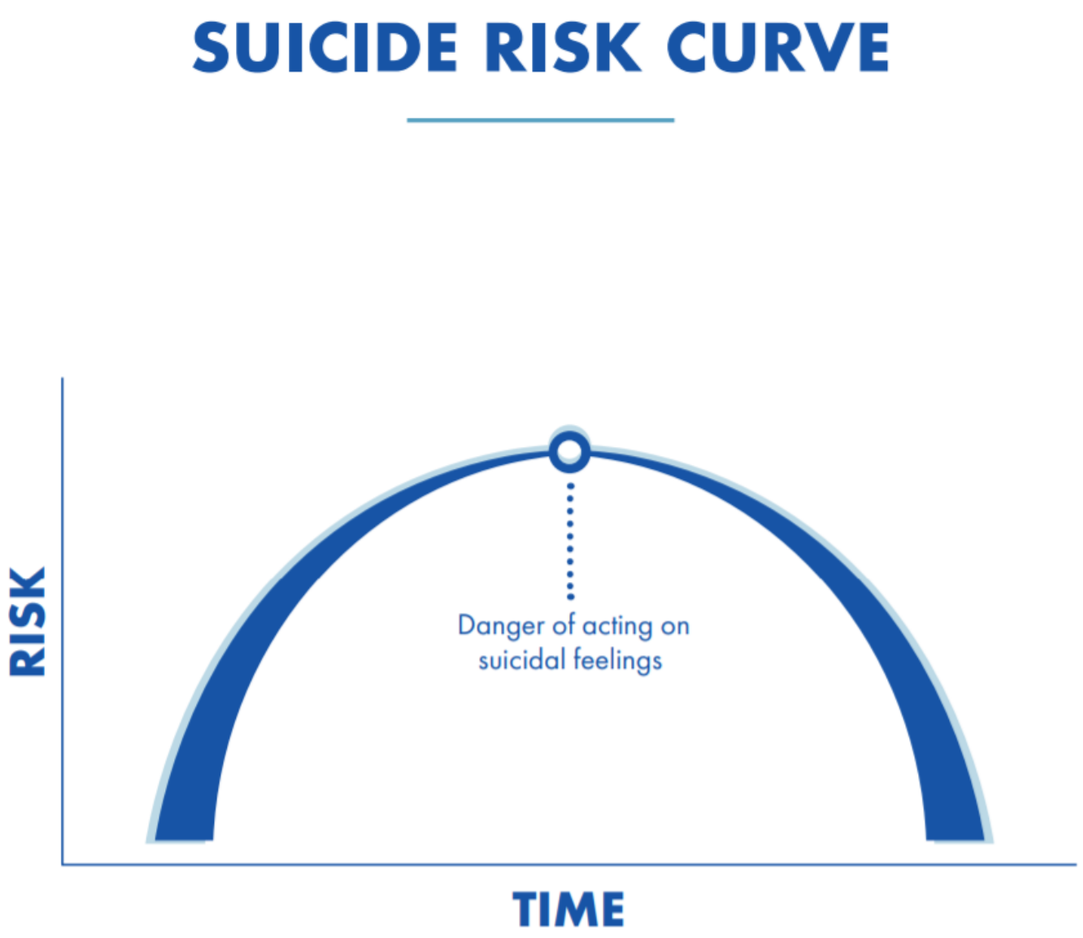
"What MOST school personnel actually conduct is a screening rather than a comprehensive risk assessment. It is important to know which is being conducted and most important is that schools have a consistent policy on how to proceed….

Many schools prefer to refer outside of school for the comprehensive assessment to determine risk AFTER conducting a brief screening. This allows the outside providers to determine if hospitalization and/or further treatment are warranted."

-Terri A. Erbacher, Ph. D.

Suicide Prevention in Schools: A Toolkit for Empowering School Districts:
https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf

Understanding Suicide Risk



Suicide risk fluctuates over time

Risk is greater when:*

- Thoughts are more frequent
- Thoughts are of longer duration
- Thoughts are less controllable
- Few deterrents to acting on thoughts
- Stopping the pain is the “reason”

-Suicide Risk Curve by Barbara Stanley, PhD and Gregory Brown, PhD
https://suicidesafetyplan.com/

**Identification, Triage and Intervention Using The Columbia Suicide Severity Rating Scale* (Adam Lesser, Deputy Director, The Columbia Lighthouse Project)

Definitions and Terminology

Suicide Attempt Definition

A self-injurious **act** undertaken with at least **some** intent to die, **as a result of** the act.

- There does not have to be any injury or harm, just the potential for injury or harm (e.g., gun failing to fire)
- Any “non-zero” intent to die – does not have to be 100%
- Intent and behavior must be linked
- Begins with the first pill swallowed or scratch made with a knife

Identification, Triage and Intervention Using The Columbia Suicide Severity Rating Scale
(Adam Lesser, Deputy Director, The Columbia Lighthouse Project)

Other Suicidal Behaviors….

Interrupted Attempt: When person starts to take steps to end their life but someone or something stops them

Aborted Attempt: When person begins to take steps towards making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior

Preparatory Acts or Behavior: Any other behavior (beyond saying something) with suicidal intent

Non-Suicidal Self-injurious Behavior: Engaging in behavior purely (100%) for reasons other than to end one's life

Identification, Triage and Intervention Using The Columbia Suicide Severity Rating Scale (Adam Lesser, Deputy Director, The Columbia Lighthouse Project)

Embracing your Role

“You do not need to be a mental health professional to screen for suicide risk, to collaborate, to follow policies and procedures…to keep (people) safe.”

- Jonathan B. Singer, PhD, LCSW,
Co-Author “Suicide in Schools”
(from stakeholder interview)

Q&A and Reflection

Screening and Assessment: The Who, What, When

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Screening

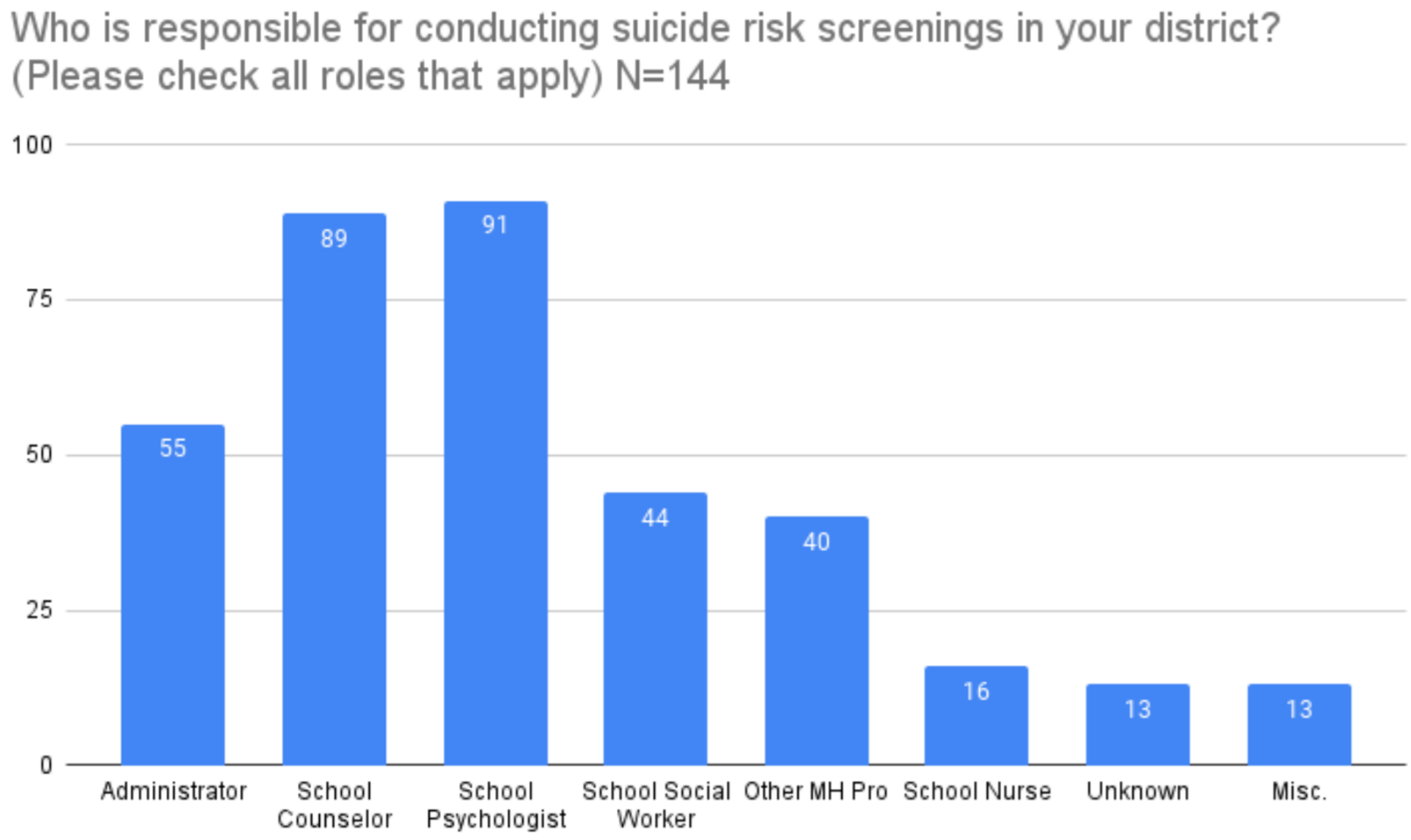
Suicide Risk Screening: Understanding your Role

A suicide risk screening should include:

- Screening by staff for suicide risk
- Determination of risk level
- Referral for assessment (if needed)
- Appropriate response to supports based on risk level (in the least restrictive setting)
- Develop safety plan
- Discussion about reducing access to lethal means
- Sharing of status with additional support network
- Documentation

**Identification, Triage and Intervention Using The Columbia Suicide Severity Rating Scale* (Adam Lesser, Deputy Director, The Columbia Lighthouse Project)

Screening in the School Setting



Screening Tools for Suicide Risk

NIMH TOOLKIT

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

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 6/13/2017

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

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

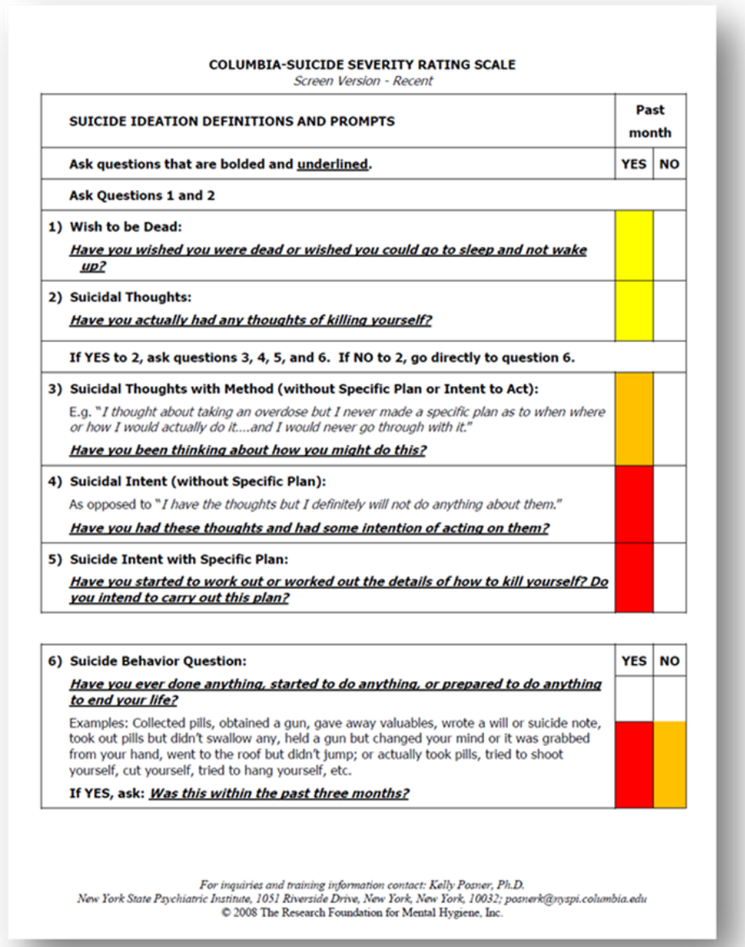
SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month YES	NO
Ask questions that are bolded and underlined.		
Ask Questions 1 and 2		
1) Wish to be Dead: ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*" ***Have you been thinking about how you might do this?***		
4) Suicidal Intent (without Specific Plan): As opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

6) Suicide Behavior Question:	YES	NO
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?***		

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

Columbia Suicide Severity Rating Scale (C-SSRS) – Screener v. Trainer

- Very brief administration time
- Versions for schools, first responders, healthcare and other fields
- Available in over 100 language
- **Age:** suitable across the lifespan for use with adults, adolescents, and young children.
- **Special Populations:** indicated for cognitively impaired (e.g. Alzheimer's, Autism)
- Developed in NIMH effort to uniquely address need for summary measure – 1st scale to assess full range of ideation and behavior, severity, density, track change
- Deemed “most” evidenced supported



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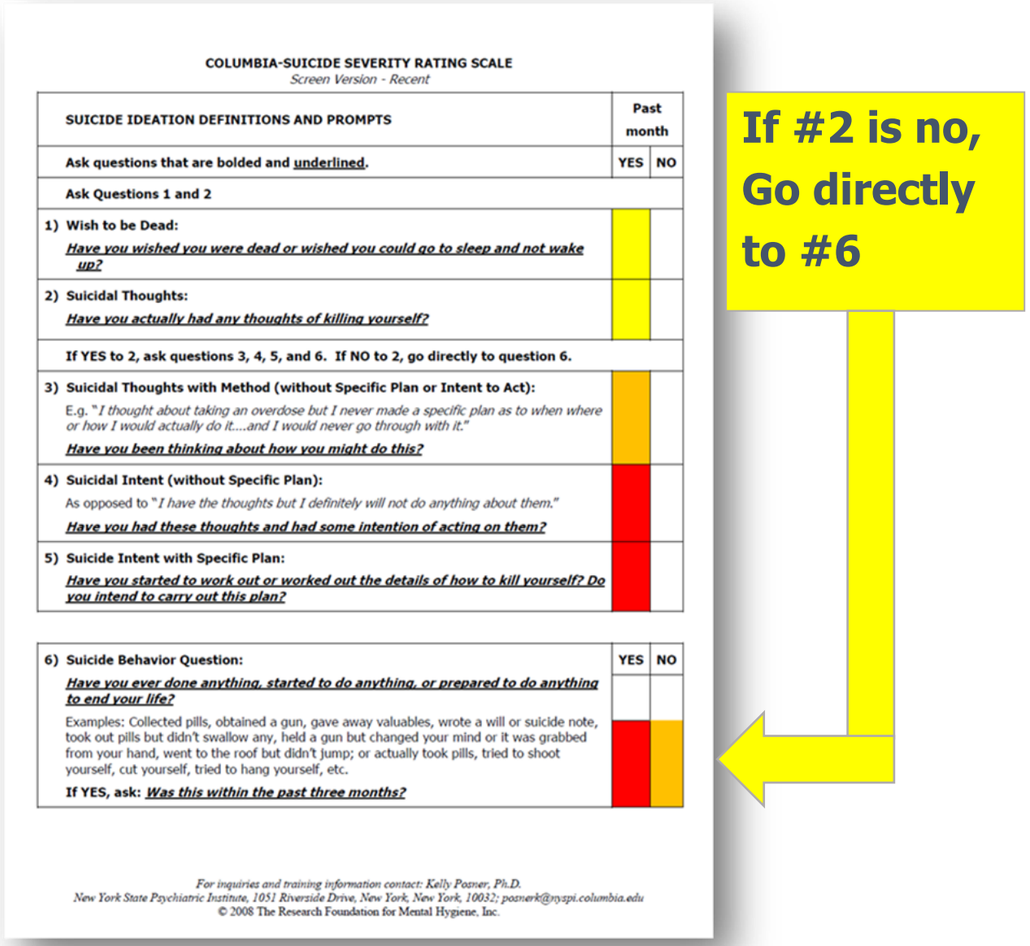
Visit the website for materials and training resources
www.cssrs.columbia.edu/

Columbia Suicide Severity Rating Scale (C-SSRS) – Screener v. Trainer

- **Ideation Severity**: 5 questions asking about increasing severity
  - From a wish to die to an active thoughts of killing oneself with plan and intent

- **Behaviors**: 1 question with all relevant behaviors assessed

NOTE: All items include definitions for each term and standardized questions for each category are included to guide the interviewer for facilitating improved identification



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If #2 is no, Go directly to #6

Visit the website for materials and training resources
www.cssrs.columbia.edu/

Guest Speaker:

Heather Nemour

Coordinator, Student Support Services and Programs Division

San Diego County Office of Education

Support for people at risk for suicide or those supporting people at risk is available by calling the **National Suicide Prevention Lifeline** 1-800-273-TALK (8255)

Apoyo y ayuda para personas a riesgo de suicidarse o para las personas que los apoyan está disponible llamando al **National Suicide Prevention Lifeline** **1**-888-682-9454

Guest Speaker:

Ivan Rodrigues, LCSW

Program Director, Visalia Youth Services

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VISALIA
Youth Services

Implementation of the C-SSRS

Ivan Rodriguez, LCSW
Program Director

About Presenter

Ivan Rodriguez, LCSW

- Parent
- Community Member
- Licensed Clinical Social Worker
- Program Director
- Adjunct Faculty
- Offensive Coordinator & Running Backs Coach

Why C-SSRS?

Why implement the C-SSRS in Visalia?

Pain of Discipline…

versus…The Pain of Disappointment

- Two Options
  - ***Pain of Discipline***
  - ***Pain of Disappointment***
- *“As if it were for our Children…because it is.”*

Tulare County SUICIDE PREVENTION Task Force

*"Unfortunately in the world of suicide prevention, people tend to **not** take action until they're **required** to…*

…or a suicide takes place."

-Noah Whitaker, Former Director

Suicide Data in Tulare County

30 Years

- 30-Year Total: 1107
- **High**: 2015 - 56 Deaths
- **Low**: 1993 - 20 Deaths
- **Average**: 37 deaths a year
- Most Suicides by Age: 25-34 (22%)

2020

- 2019: 27 Deaths
- 2020: 31 Deaths ruled as suicide
- July & September (9 deaths)
- Youth? **0-18: 0 Deaths**

Divisadero Middle School Trojans

EDHS MINERS

GREEN ACRES MIDDLE SCHOOL

“It’s about saving lives and directing limited resources to the people who actually need them.”

- Dr. Kelly Posner Gerstenhaber, Founder and Director

THE COLUMBIA
LIGHTHOUSE
PROJECT
IDENTIFY RISK. PREVENT SUICIDE.

Implementation of C-SSRS

- 2014-2020 **Joint Commission Accreditation**
  - Chair: Care, Treatment & Services (CTS)
  - Chair: Performance Improvement
  - National Patient Safety Goals
  - BHC: *Screen all individuals served for suicidal ideation using a validated screening tool.*
- **Suicide Prevention Task Force**
  - C-SSRS Research, Training, Collaboration
  - 2018: Staff Training, Pilot & Rollout:
    - Visalia Youth Services
    - Dinuba Children's Services
    - Sequoia Youth Services

The Joint Commission

"The advent of the C-SSRS and its dissemination could be seen as really a watershed moment, like the introduction of antibiotics."

Jeffrey Lieberman, Former President, American Psychiatric Association

ENDORSED, RECOMMENDED, OR ADOPTED BY:

Evidence-supported. Since 2007, Columbia University, University of Pennsylvania, University of Pittsburgh and National Institute of Mental Health (NIMH) have validated the Columbia Protocol to assess suicide risk.

- 2011, **Centers for Disease Control (CDC)** and Prevention adopted the protocol's definitions for suicidal behavior
- 2012, the **Food and Drug Administration (FDA)** declared the Columbia Protocol "*the standard for measuring suicidal ideation and behavior.*"
- The most evidence-based tool of its kind

Support for C-SSRS

Columbia Suicide Severity Rating Scale (C-SSRS)

- **Simple.** *Minutes — with no mental health training required*.
- **Efficient.** *Protocol & Resources*
- **Universal.** *Multiple settings & 100 languages*
- **Free**

"Having a proven method to assess suicide risk is a huge step forward in our efforts to save lives."

–Michael Hogan, Former Commissioner, New York State Office of Mental Health

STANDARDIZE THREAT ASSESSMENT AND RESPONSE PROTOCOLS

- Provides a common language for understanding the level of risk.
- Helps first responders and others in communities determine next steps and save lives.
- Helps share information to coordinate prevention and crisis response efforts.
- Increases preparedness.
- Reduces anxiety in first responders.
- Protects against liability
- Negligence is in **NOT** asking
- Asking about suicide ***saves*** lives

THE COLUMBIA
LIGHTHOUSE
PROJECT
IDENTIFY RISK. PREVENT SUICIDE.

THANK YOU!!

VISALIA
Youth Services

Ivan Rodriguez
(559) 627-1490
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TURNING POINT
OF CENTRAL CALIFORNIA, INC.

NATIONAL
SUICIDE PREVENTION
LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org

Tulare County
SUICIDE PREVENTION
Task Force

Q&A and Reflection

Assessment

Suicide Risk Assessment

Goals of Risk Assessment:

Determine the level of risk of the individual--by doing this we can:

- Identify and **boost protective factors** (where possible)
- Identify and **minimize risk factors** (where possible)
- Provide the person with individualized care and support
- Identify environmental, personal, and other **variables** that can boost or threaten safety (e.g. managing access to means for suicide).
- Start the process of **de-escalation and stabilization**
- **Appropriately triage** the response to the identified risk (guide safety plan recommendations)
- **Effective documentation** for continuity of care

Assessing Suicide Risk

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)
- Buffers, also known as protective factors

Each of these areas likely involves a set of sub-categories to help the assessor and the individual at risk get a clear picture of the risk level for each category.

Understanding the level of risk helps us avoid over-reacting or using unnecessarily restrictive or invasive interventions. It also helps us to not leave someone in danger or under-respond when risk is present.

Considerations for Effective Assessment

- Direct language, clear and honest phrasing of questions – name what we are talking about, focus on safety as the priority right now.
- Personalizing approach and genuine communication where possible -- listening compassionately to responses
- Asking appropriate follow-up and exploratory questions
- Aim for transparency and collaboration with individual at risk where possible. Allow for choices, be flexible in pacing. Give choices where possible.
- Observing and documenting risk level beginning, during, and at the end of the assessment process
- Completing all questions and sections AND be willing to revisit some sections later, offer other opportunities for disclosure

Keeping People Safe

“It is not necessary to predict suicide with certainty to intervene effectively. Rather the evidence is clear that it is possible to identify most individuals with greatly elevated risk, allowing us to provide targeted, effective supports during the period when risk remains high.”

Recommended Standard Care for People with Suicide Risk: Mental Health Care Suicide Safe
https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf

Guest Speaker:

Sharmil Shah, Psy.D

Chief of Program Operations, MHSOAC

Support for people at risk for suicide or those supporting people at risk is available by calling the **National Suicide Prevention Lifeline** 1-800-273-TALK (8255)

Apoyo y ayuda para personas a riesgo de suicidarse o para las personas que los apoyan está disponible llamando al **National Suicide Prevention Lifeline** **1-**888-682-9454

Training

Identifying individuals experiencing thoughts of suicide

STRATEGIC AIM 3: ENHANCE EARLY IDENTIFICATION OF SUICIDE RISK AND INCREASE ACCESS TO SERVICES BASED ON RISK

Local and Regional Objectives

Objective 8f Deliver suicide prevention training to people who are in positions to identify warning signs of suicide and refer those at risk to mental health and substance use disorder services and culturally appropriate supports. Support youth gatekeepers by identifying trusted adults who can help them with next steps once a young person is identified as at risk. Provide people the opportunity to reinforce knowledge and skills acquired during training through periodic booster sessions. Build capacity and sustainability for suicide prevention training across systems using train-the-trainer models or evidence-based online trainings.

Consider the intensity of training needed and offer a variety of sessions to expand capacity and meet varied demand. For example, in a school setting, teachers, administrators, and other school personnel might receive brief trainings on suicide prevention awareness. Selected teachers, especially those who lead youth groups, and counselors might receive intensive trainings focused on how to deliver brief interventions.

https://mhsoac.ca.gov/sites/default/files/Suicide%20Prevention%20Plan_Final.pdf

Identifying individuals experiencing thoughts of suicide

STRATEGIC AIM 3: ENHANCE EARLY IDENTIFICATION OF SUICIDE RISK AND INCREASE ACCESS TO SERVICES BASED ON RISK

Objective 8i Deliver training to key action partners for conducting suicide screening in community-based settings when a person is identified as exhibiting warnings signs or communicating a desire to die. The Columbia-Suicide Severity Rating Scale has been adapted to meet the needs of diverse settings and populations and can be accessed for free here: http://cssrs.columbia.edu/.

https://mhsoac.ca.gov/sites/default/files/Suicide%20Prevention%20Plan_Final.pdf

Training on Suicide Screening or Suicide Risk Assessment

- Providing training on how to use a screening tool or conduct an effective risk assessment is a vital component of comprehensive suicide prevention efforts. Too often, people who are in the position to conduct these receive limited (if any) training on the process.

- Providing and supporting trainings can help to standardize screening activities and risk assessment procedures and streamline support processes through improving competency and reducing liability.

- Considerations for an effective training program include:
  - How this works with your strategic planning efforts
  - Participant engagement
  - Cultural adaptation and equity
  - Organizational buy-in
  - Integration, fit, communication, and sustainability
  - Trainer pool - local, remote, training for trainer options
  - One size does not fit all – the right level of training based on roles, experience, and expected level of support.

Trainings that support Screening and/or Assessment activities include…

Training on Screening Includes:

- Be Sensitive Be Brave
- C-SSRS Screener Training – Lighthouse Project
- El Rotafolio
- Kognito
- LivingWorks safeTALK
- Mental Health First Aid
- QPR – Question, Persuade Refer
- Population or setting-specific trainings, for example:
  The PSS-3, Patient Safety Screener: A Brief Tool to Detect Suicide Risk

Training on Assessment Includes:

- AMSR: Assessing and Managing Suicide Risk
- ASIST: Applied Suicide Intervention Skills Training
- CAMS: Collaborative Assessment and Management of Suicidality
- C-SSRS – Lighthouse training on the full Coumbia Suicide Severity Rating Scale
- RRSR: Recognizing and Responding to Suicide Risk
- Suicide Prevention 201

Spotlight: Select Trainings on Screening and Assessment

- **AMSR – Assessing and Managing Suicide Risk**
- **The Columbia Lighthouse Project – Remote, standardized and/or in-person customized C-SSRS Training (screener or full scale and risk assessment)**
- **Suicide Risk Screening in Schools**

AMSR

Assessing and Managing Suicide Risk

Objective: Most recent information on best practices for clinicians assessing for suicidal thoughts and attempts, ongoing treatment and interaction, and evidence-based approaches to care.

Target: Behavioral healthcare providers (master's or doctorate)

Curricula: Tailored to specific care settings and populations (outpatient, inpatient, substance use)

Training of Trainers (ToT): Available upon meeting eligibility requirements

Platform: Face-to-face or online

Duration: 3.5 hours to 6.5 hours

Offered by: Zero Suicide Institute

https://zerosuicideinstitute.com/amsr

Assessing & Managing Suicide Risk℠

General curriculum &
Additional curricula tailored to specific care settings and populations:

- AMSR-Outpatient
- AMSR-Direct Care Outpatient
- AMSR-Inpatient
- AMSR-Direct Care Inpatient
- AMSR-Substance Use Disorder

Find an open enrollment training and cost details here:
https://zerosuicideinstitute.com/amsr/trainings

Training of Trainers (ToT) options exist (in-person and online) Learn more here:
https://zerosuicideinstitute.com/sites/default/files/2021-01/ZSI-AMSR-Flyer-Training-8.5x11-v8%5b1%5d.pdf

AMSR has worked with thousands of clients nationwide and from across sectors. Learn more about sponsoring an AMSR training:
https://zerosuicideinstitute.com/amsr/sponsors

Five Areas of Competency

1. Approaching Your Work
2. Understanding Suicide
3. Gathering Information
4. Formulating Risk
5. Planning and Responding

Target

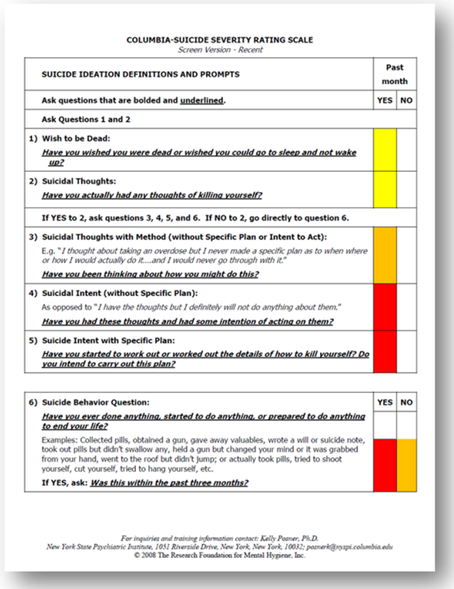
- Social workers
- Professional counselors
- Marriage and family therapists
- Psychologists
- Psychiatrists
- Psychiatric nurses

Organizational Settings

- Behavioral Health
- Healthcare
- College/University
- City/County/State Government
- Community-Based Organizations
- Children's Services/School Districts
- Military Branches

Columbia Suicide Severity Rating Scale (C-SSRS) – Screener v. Trainer

- Live Webinars occasionally
- Interactive on-line training through National Action Alliance for Suicide Prevention Zero Suicide Website
  - zerosuicide.sprc.org/toolkit/identify
- Recorded trainings on YouTube channel
- Download a recorded training from Dropbox
- The Columbia Light Project, Training Campus: https://secure.trainingcampus.net/uas/modules/trees/windex.aspx?rx=c-ssrs.trainingcampus.net



COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month YES	NO
Ask questions that are bolded and underlined.		
Ask Questions 1 and 2		
1) **Wish to be Dead:** ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) **Suicidal Thoughts:** ***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) **Suicidal Thoughts with Method (without Specific Plan or Intent to Act):** E.g. *"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."* ***Have you been thinking about how you might do this?***		
4) **Suicidal Intent (without Specific Plan):** As opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?***		
5) **Suicide Intent with Specific Plan:** ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

6) **Suicide Behavior Question:**	YES	NO
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?***		

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

Visit the website for materials and training resources
www.cssrs.columbia.edu/

The Columbia Lighthouse Project

Online Options:

- On-line training module available through the Center for Practice Innovation (CPI) here. Files for this training are also available for integration into internal Learning Management Systems by contacting the Lightouse Project team here.
- Watch a webinar on your own schedule by going to the Project's YouTube channel and selecting an archived webinar (less than 60 minutes).
- Download unlimited training videos to view or share for group training.
  - Training is available in over 30 languages and there is no limit on the number of downloads.
  - For English language training on the full and screener scales click on this link, and then click on the "download" button in the upper-right corner to download it to your desktop (do not try to watch the video within the dropbox it will end early). A video training on just the shorter C-SSRS screener is also available if by clicking on this link.
  - For training in other languages look in this folder, select the language you desire and download the training by clicking on the "download" button in the upper righthand corner.

Note:
Specialized training and certification are available and required for use of the C-SSRS in research and clinical trials. Click here for more information.

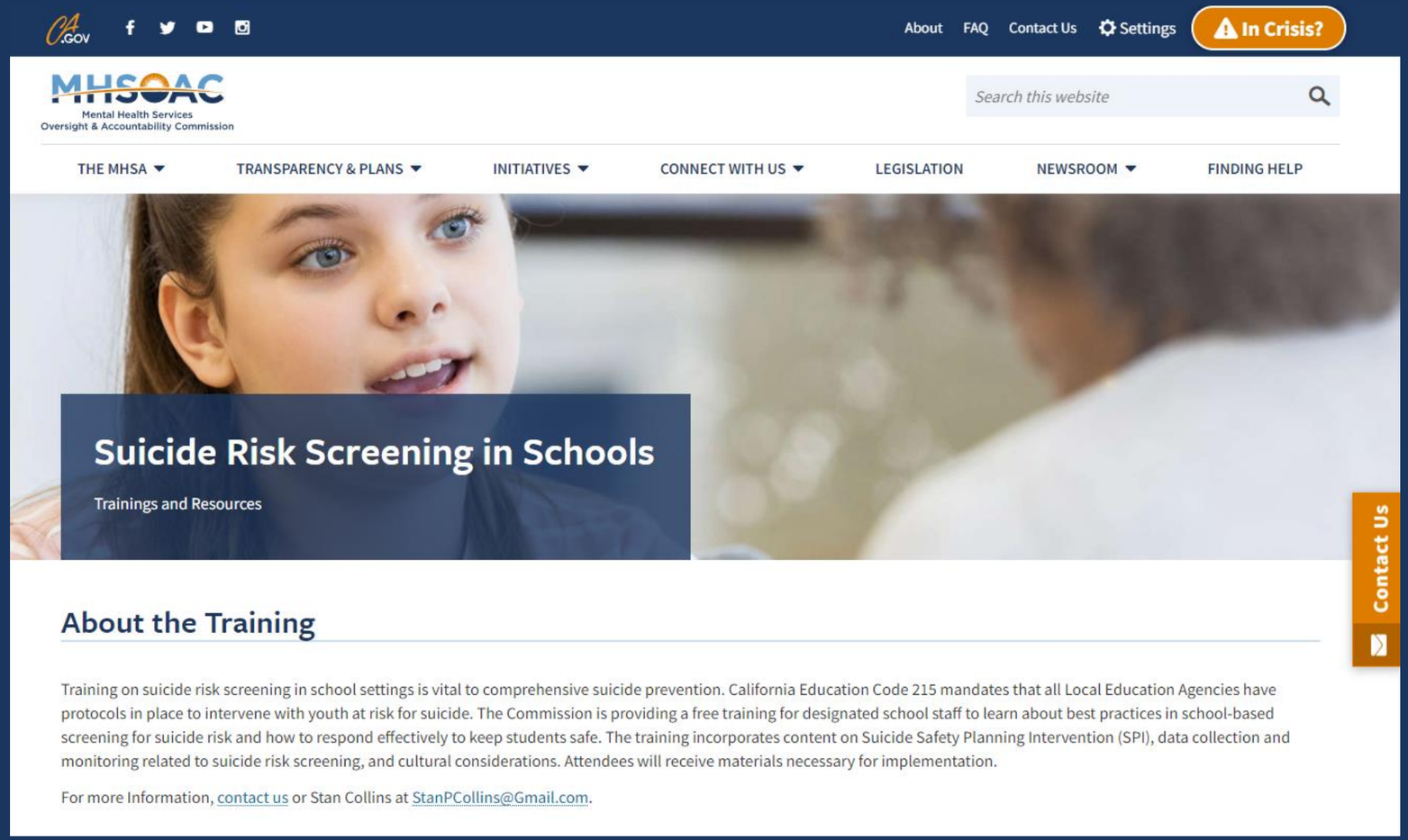
THE COLUMBIA LIGHTHOUSE PROJECT
IDENTIFY RISK. PREVENT SUICIDE.

Training Considerations

Use of the Columbia protocol does not require prior knowledge or training; however, training is shown to be helpful for individual, organization, and community-wide use.

Trainings are not setting specific. Choose the method that works best for you or your group.

Suicide Risk Screening in Schools



For more information, resources, and links to future trainings, please visit:

mhsoac.ca.gov/initiatives/suicide-prevention/school-suicide-risk-screening/

County Spotlight:
Monterey County
Behavioral Health Department

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Identifying individuals experiencing thoughts of suicide

STRATEGIC AIM 3: ENHANCE EARLY IDENTIFICATION OF SUICIDE RISK AND INCREASE ACCESS TO SERVICES BASED ON RISK

Objective 8h Integrate best practices in suicide risk assessment and management in health, mental health, and substance use disorder care settings and workflows. Create uniform policies and procedures to make screening, assessments, and decision-making routine. Clarify billing methods for services.

https://mhsoac.ca.gov/sites/default/files/Suicide%20Prevention%20Plan_Final.pdf

MONTEREY **C**OUNTY **H**ELPING **O**NE ANOTHER **P**REVENT AND **E**LIMINATE **S**UICIDE

Coalition and Community Focus

MC HOPES

www.mtyhd.org/MCHOPES

Workforce Education and Training on Suicide Assessment and Intervention:

- Thoughtful, patient process, “throttle” model
- What training or tools were already being used
- Integration into Avatar/Electronic Health Records System
- Discussion and decisions amongst leadership teams – who should complete screening or assessment? Where should this be documented? To whom can service providers go for a second opinion or support?
- Discussion and decision on appropriate interventions and resources
- Discussion and decisions to balance C-SSRS/Safety Plan data/suggestions with clinician or provider guidance
- Stages of initial training, training to use tool in EHR system, refresher training, and/or coaching sessions, amongst others
- Continuum of training opportunities by role, expectations, previous experience, etc.

Screening and Assessment: What Next?

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Apoyo y ayuda para personas a riesgo de suicidarse o para las personas que los apoyan está disponible llamando al **National Suicide Prevention Lifeline** **1-**888-682-9454

We're Good at Keeping People Safe

"We aren't very great at predicting suicide risk… but we are really good at helping keep people safe."

-John Draper, PhD, Executive Director
National Suicide Prevention Lifeline
(from stakeholder interview)

Identifying individuals experiencing thoughts of suicide

3 STRATEGIC AIM

GOAL 9: PROMOTE A CONTINUUM OF CRISIS SERVICES WITHIN AND ACROSS COUNTIES

Desired Outcome Increase in linkage to community-based services for people experiencing suicidal behavior and their families and caregivers.

Short-term Target By 2025, 80 percent of all crisis services providers are trained in suicide prevention and are referring people in distress to community-based services based on risk assessments.

Objective 9e Promote the use of crisis services as alternatives to hospitalization and as a resource to support people in distress, by advertising crisis hotline and warmline numbers and other methods. Deliver suicide prevention training to all providers of such services.

Objective 9f Disseminate information on available crisis service resources to health, mental health, and substance use disorder care partners. Encourage these partners to include crisis services in safety plans developed through an alliance between partners and people at risk.

https://mhsoac.ca.gov/sites/default/files/Suicide%20Prevention%20Plan_Final.pdf

Respond to Crisis

Although the term crisis services is often used to refer to hotlines or helplines, it also encompasses other programs that provide assessment, crisis stabilization, and referral to an appropriate level of ongoing care.

Continuum of Care:

- **Crisis hotlines** provide immediate support and facilitated referrals to medical, health care, and community support services, and promote problem-solving and coping skills via telephone (or text or online chat) to individuals who are experiencing distress.
- **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.
- **23-hour 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). Services are intended to last less than 24 hours but may extend up to several days, if needed. Peer crisis services are generally shorter-term than crisis residential services.

Polling and Reflection Questions

To your knowledge, are safety planning tools used routinely as part of your community's suicide prevention efforts?

Which safety planning tools or templates are used?

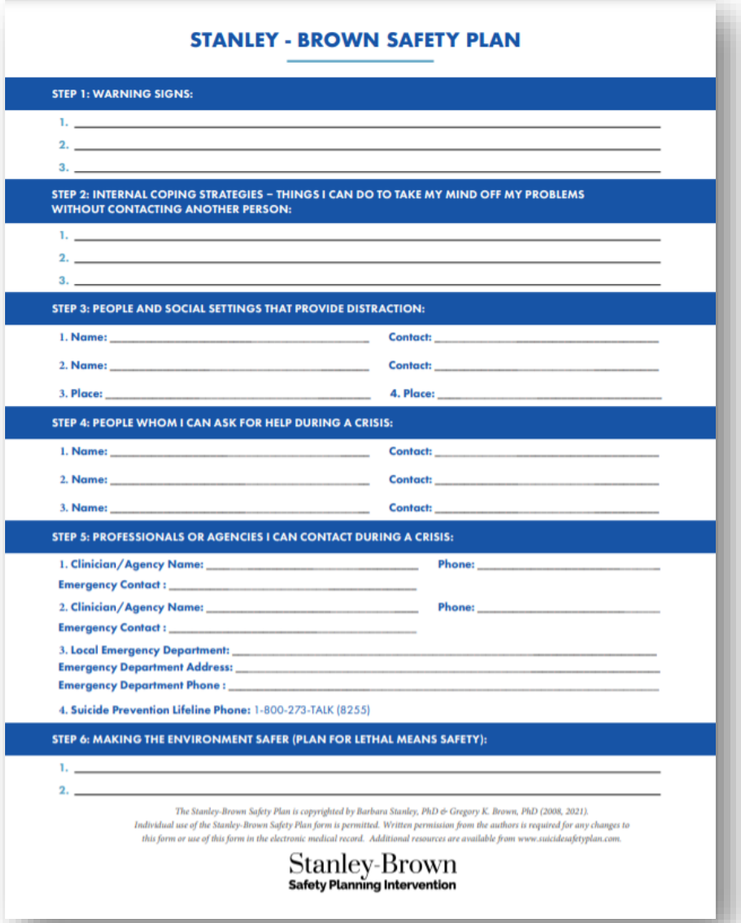
Reflection Questions:

Is one of your goals to promote the consistent use of safety planning tools across service providers and key community settings (schools, behavioral health providers, healthcare, etc.)? How can you highlight your successes right now?

Wat's one small or powerful way you could move this forward? For example-- surveying providers on what tools are used and what tools or training are currently used? Could you feature a spotlight on a provider who has had experience with this in your coalition meeting or with your planning team?

Safety Planning Intervention

- Stanley-Brown Safety Planning Intervention:
  - https://suicidesafetyplan.com/
- Stanley, B. & Brown, G. (2011) Safety planning intervention: A brief intervention to mitigate suicide risk. Cognitive and Behavioral Practice, 19(2), 256-264.
- Collaborative Safety Planning to Reduce Risk in Suicidal Patients: A Component of the Zero Suicide Model
  - http://suicideprevention-icrc-s.org/sites/default/files/sites/default/files/events/17_7_26_icrc-sslides.pdf
- Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version
  - http://www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.pdf



STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

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

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

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

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

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

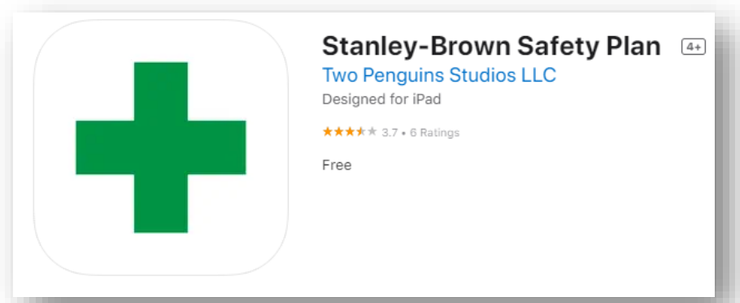
STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

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



SAFE-T: Suicide Assessment Five-step Evaluation and Triage

Identify Risk Factors

Note those that can be modified to reduce risk

Identify Protective Factors

Note those that can be enhanced

Conduct Suicide Inquiry

Suicidal thoughts, plans, behavior, and intent

Determine Risk Level/Intervention

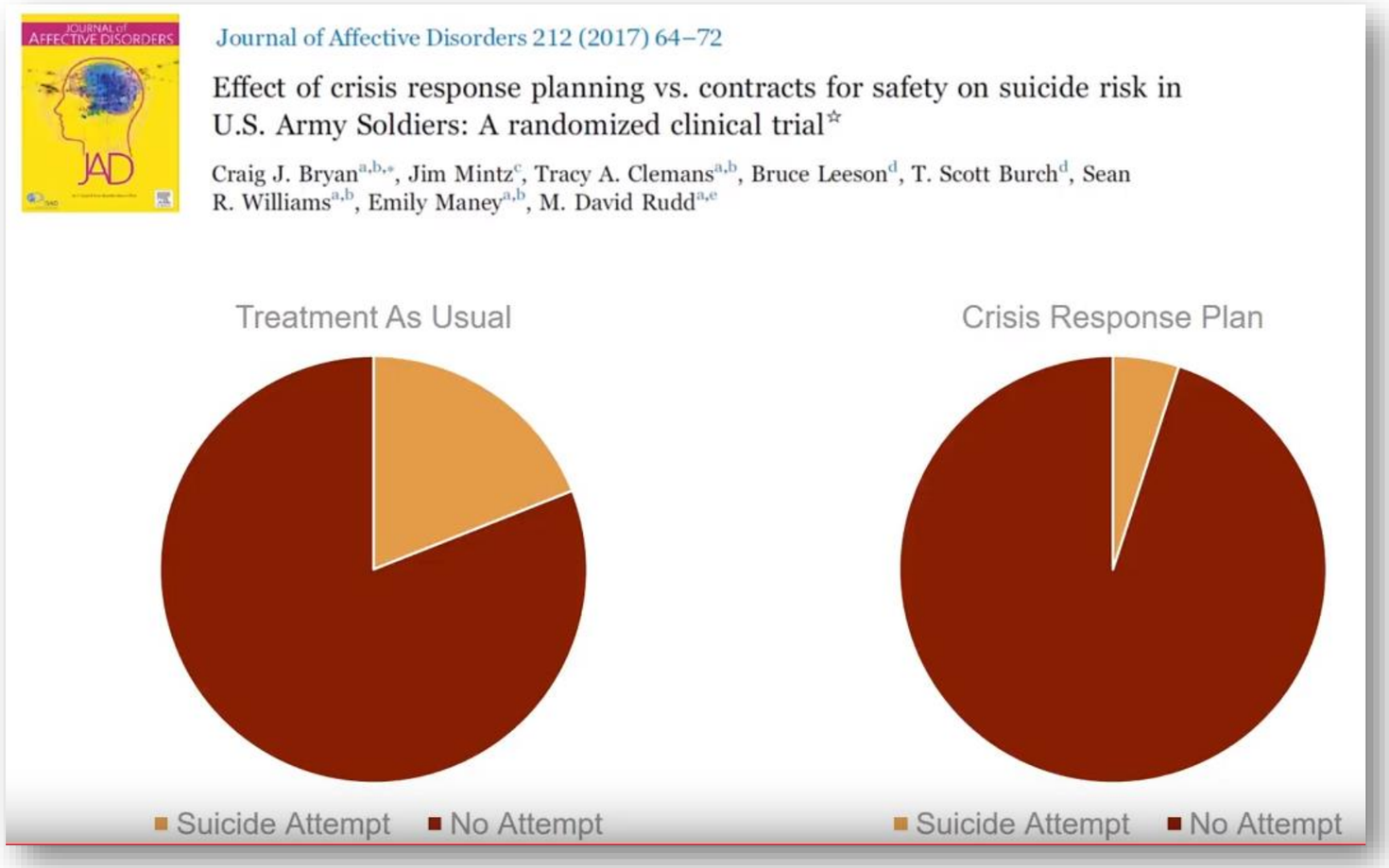
Determine risk. Choose appropriate intervention to address and reduce risk.

Document

Assessment of risk, rationale, intervention, follow-up

Crisis Response Plan (CRP) Tool

The Crisis Response Plan (CRP) is a brief procedure used to reduce an individual's risk for suicidal behavior. The CRP is created collaboratively between a suicidal individual and a trained individual and is typically handwritten on an index card for easy, convenient access during times of need.



Elements addressed:

- **Personal warning signs**
- **Self-management strategies**
- **Reasons for living**
- **Social support**
- **Professional crisis support**

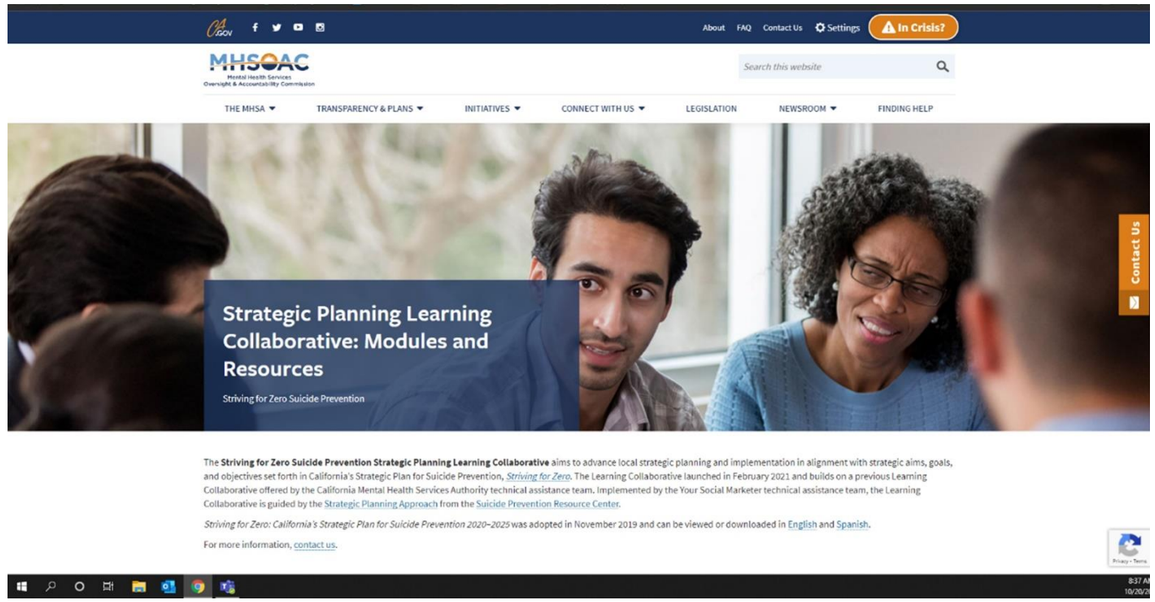
https://crpforsuicide.com/about

Module 3: Strategic Approaches to Training - October 20, 2021
Recording: https://www.youtube.com/watch?v=0Qu0I6-0b-I
Slides:
https://us06web.zoom.us/meeting/register/tZMpc-Ggrj4pE9YE3u1e1AKc-NiIQVRtlyuV

Module 4: Crisis Response – February, 2022
Recording:
https://www.youtube.com/watch?v=_sEr1IOeQ2w
Slides:
https://mhsoac.ca.gov/wp-content/uploads/2.16.22-Crisis-Module-FINAL_ADA.pdf

Module 5: Supports after an attempt – April, 2022
Recording:
https://www.youtube.com/watch?v=x37E_8AbEls
Slides:
https://mhsoac.ca.gov/wp-content/uploads/Module-5_After-a-Suicide-Attempt-FINAL-CM-4.20.22.pdf

Learning Collaborative Resource Page – Recent Modules To Review and Utilize…



https://mhsoac.ca.gov/initiatives/suicide-prevention/collaborative/

Crisis Centers & Crisis Lines

988 SUICIDE & CRISIS LIFELINE

In Crisis?
Text HELLO to 741741

CRISIS TEXT LINE | Free, 24/7, Confidential

www.thetrevorproject.org

988 LÍNEA DE PREVENCIÓN DEL SUICIDIO Y CRISIS

THE TREVOR lifeline
866.488.7386
YOU ARE NEVER ALONE
TheTrevorProject.org

WE'RE HERE FOR YOU
USA: (877) 565.8860
CAN: (877) 330.6366
TRANS LIFELINE

Best practices for continuity of care

Recommendations for Inpatient Providers	Recommendations for Outpatient Providers
Collaborative protocols and procedures for seamless transfer	Consider the inpatient provider as part of the care team
Involve family members and other natural supports.	Connect with the patient and their family and/or other natural supports.
Collaboratively develop a safety plan.	Narrow the transition gap.
Follow up with the patient.	Maintain good communication.

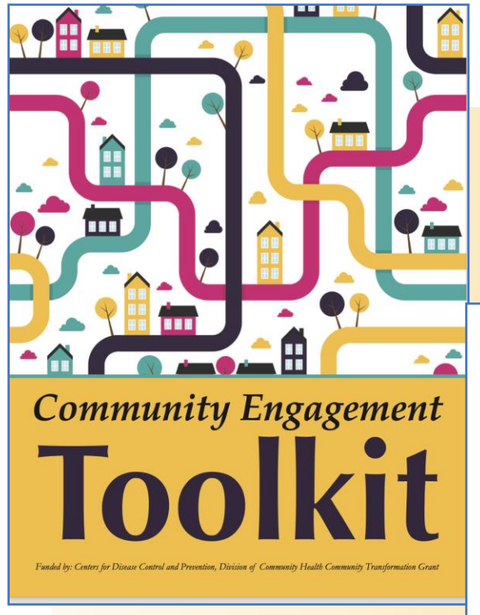
Source: National Action Alliance for Suicide Prevention, "Best Practices in Care Transitions for Individuals with Suicide Risk".

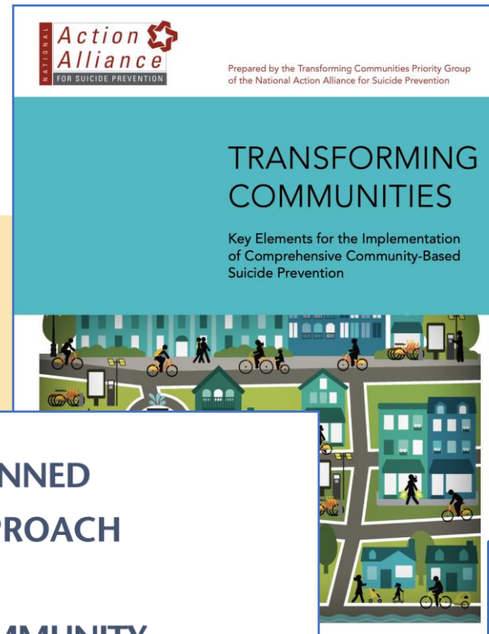
Considering how to prioritize and approach this in your work.

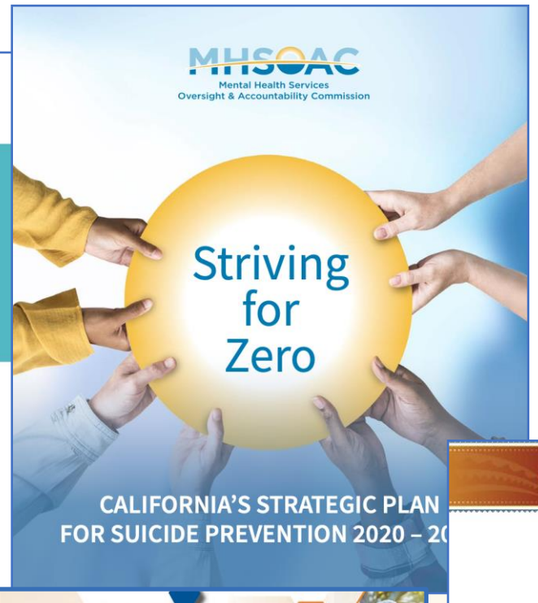
Let's revisit where we might begin.

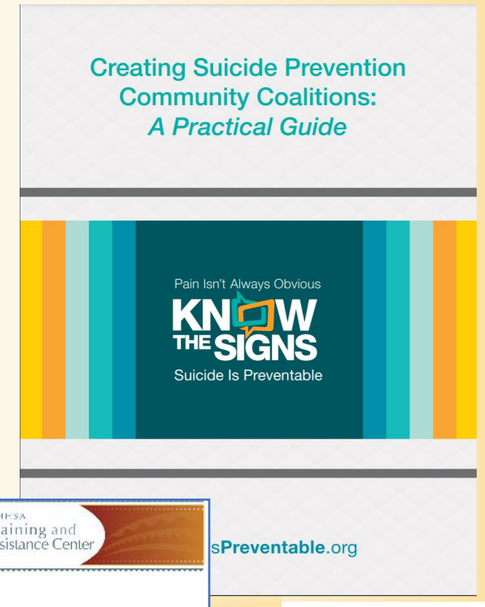
- What suicide risk screening/assessment tools are currently being used?
- What currently happens when someone is identified at risk for suicide? At low-risk vs high-risk?
- Is everyone aware of crisis line supports (local or national)? What crisis call center does your county utilize/promote?
- Are you promoting and supporting any population specific support lines? Do you have a need?
- Are mobile crisis response team being utilized in your county?

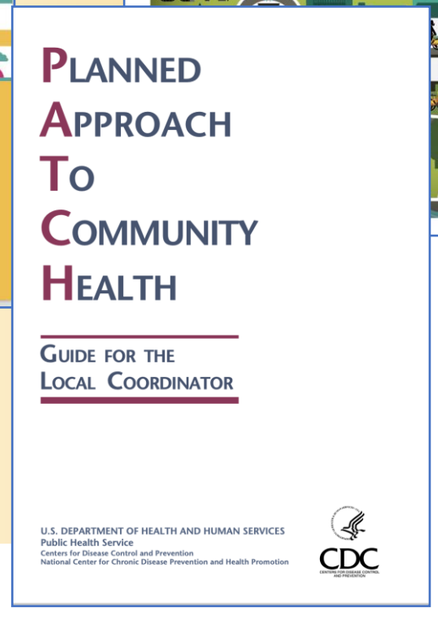
Guiding Resources

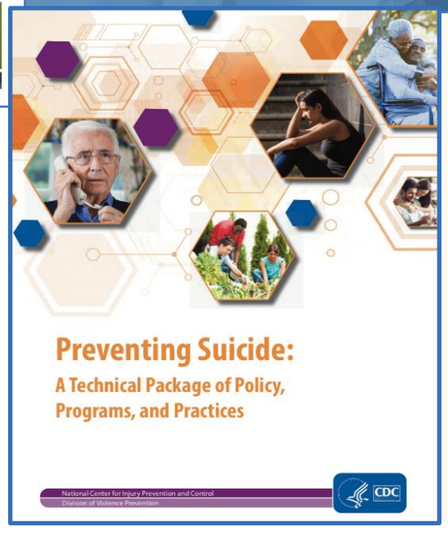


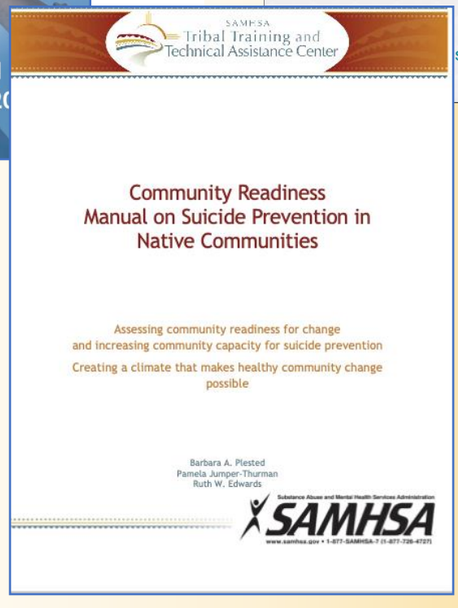












Thank you for your time

For more information please contact: jana@yoursocialmarketer.com

Support for people at risk for suicide or those supporting people at risk is available by calling the **National Suicide Prevention Lifeline** 1-800-273-TALK (8255) or 988

Apoyo y ayuda para personas a riesgo de suicidarse o para las personas que los apoyan está disponible llamando al **National Suicide Prevention Lifeline** **1-**888-682-9454 o 988