# Webinar: Suicide Prevention and Safety Planning

June 18, 2025, 12:00 – 1:30 PM ET

Transcript

## Introduction

**Jasmine Griffin:** Good afternoon and good morning to everyone. Welcome to today's webinar on Suicide Prevention and Safety Planning. We are so happy that you are here with us today.

### Today's Speakers

**JG:** My name is Jasmine Griffin, and I will be your facilitator today. I'm a licensed professional counselor with over a decade of experience in mental health, program management, and trauma-informed care. I have served in roles spanning case management, supervision, and leadership in nonprofit and government settings.

Most recently, I worked with IRC Dallas's site as health and wellness senior program manager, overseeing programs such as intensive and supplemental case management, mental health, client voice, and food security programs. During my tenure at IRC Dallas, I also stepped into a role as interim deputy director, guiding the team through significant leadership transitions while maintaining the delivery of high-quality services. I hold a bachelor's in sociology and criminology from Cleveland State University and a Master's of Professional Counseling from Grand Canyon University.

I am delighted to introduce our guest speaker today, Ashley LeBlanc. Ashley is a technical advisor for mental health and psychosocial support at International Rescue Committee, or IRC. Previously, Ashley worked as a psychiatric emergency responder in San Diego County, provided trauma and substance use counseling within community clinics, shelters, and the VA hospital, managed the monitoring and evaluation design and data collection processes with Women for Women International, and served as a Peace Corps volunteer in Eastern Guatemala, supporting the municipal government. Ashley has a Master's in Social Work from the University of Washington and a Master's in International Affairs from the University of California.

### Learning Objectives

**JG:** By the end of this session, you will be able to identify protective factors, risk factors, and warning signs of suicide, apply for practical skills to ensure your communication with clients about suicide as assertive, clear, and compassionate, implement the six questions of the suicide risk screening tool with fidelity and confidence, and finally, create effective suicide safety plans with clients, including six key elements. With that, I'm going to go ahead and pass it over to you, Ashley.

## 1. Protective Factors, Risk Factors, and Warning Signs of Suicide

**Ashley LeBlanc:** Hello. Hi, everyone. I know we have a really large group today, and that's wonderful. It shows how important this topic is, and I appreciate your openness to wanting to learn more. I do want to note, before we begin, I want to take a moment to acknowledge that discussing suicide, it can be a very emotional topic. It can be a topic that touches us professionally, it can touch us personally. Please prioritize your own well-being, take breaks, check in with yourself, and seek support if you need.

We're going to start the first section of this training, and we're going to focus on protective factors, risk factors, and warning signs for suicide. We are going to kick off with a Slido, because we'd like to hear from you. This is the interactive tool, Slido. We're going to be using this throughout the webinar quite frequently, and you can join Slido in two ways. There's a QR code on that upper left-hand side. You can scan that with your mobile device. You can also go to slido.com, and we have that code. Great, it looks like some people have figured that out very quickly.

The question we're asking are, there are often warning signs before someone commits suicide, is that true or false? I know we have a really large group, so I'm going to give it some time to have some more answers get all set up on your Slido.

Yes, the majority of answers are in line that, yes, most of the time, it is true that there are warning signs before someone commits suicide. We're going to talk about that. There we go. Suicide can be prevented, though it is really important to know that not all suicides are avoidable. That many can be prevented, and the key way to prevent that is that we're going to look at recognizing warning signs, and then we're going to determine an individual's level of risk, and then what is the most appropriate way to intervene.

Recognizing warning signs, and responding with care, and the appropriate level of support can make a critical difference, a life-saving difference to an individual. These are all things that we're going to discuss today.

## Facts

**AL:** I want to start with some statistics. These are from the latest CDC, or Center for Disease Control and Prevention report. It was released in 2023. I want you to note that in 2022, there was an estimated 1.6 million suicide attempts in the United States, and that nearly 50,000 Americans died by suicide. This impact has a ripple effect on families and communities, because when a loved one dies by suicide, that bereavement process tends to be a lot longer, much more complicated.

Over the last two decades, we have seen a 36% increase in suicide rates, and this is especially concerning for youth, because suicide is the second leading because of death for the age groups 10 to 14, and 20 to 34. These statistics are just highlighting the significant impact that suicide can have on the communities, especially those that we work in.

## Risk Factors, Protective Factors

**AL:** A key part of suicide prevention is understanding risk and protective factors, and these terms you might be very familiar with.

A risk factor is a characteristic that makes it more likely that an individual will consider, attempt, or die by suicide. On the other hand, a protective factor is a characteristic that makes it less likely. Examples of this could be increased access to mental healthcare, or having really strong social supports. When we think about these in the context of suicide prevention, we're seeking to reduce the factors that increase suicide risk, while increasing the factors that protect people from suicide. Through direct service, through the work that many of you are doing, that is what's happening.

You are increasing those protective factors, you're connecting individuals and families to resources and supports. We're going to look at these in buckets. Our first category is going to be health. What are health risk factors that we want to consider? One is substance abuse. The reason that is concerning is that substance abuse can really impact impulsivity in decision-making, something that can be really risky when someone is having suicidal ideation. Another risk factor is going to be a physical illness, especially if that's not treated, if someone doesn't have access to medical care. A chronic illness or if someone's experienced significant pain, that can be a big risk factor.

Self-harm behaviors. What self-harm is, that's a term for when someone deliberately is hurting themselves or hurting their bodies, like cutting or burning oneself. That is also a risk factor. Then there are certain mental health conditions. Things like depression or bipolar disorder do have higher risk factors. Now we're going to look at the other side. Those protective factors that we're looking to really increase. Health protective factors are someone who has optimal physical health, access to healthcare, someone where their emotional wellbeing is strong, an individual who's using positive coping skills, and that access to mental healthcare, right?

Are we able to refer people and give them access to mental healthcare? By providing any of these protective factors, so you're assisting somebody with a medical appointment, you're teaching coping skills like deep breathing or who do you go to talk to when you're having a hard time? These are all things that are decreasing risks, things you're probably already doing right now.

Our second area, social or environmental factors. Social risk factors. Examples of that could be someone who's really isolating or is just isolated because they're new to the community, there's a lack of support. One of the things we really look at in suicide prevention is any type of access to a lethal means. Are there firearms in the home? Is there a lot of medication? We want to reduce the steps that it would take in order to have access to a lethal means.

As mentioned before, any barriers to accessing care or really any support, those are going to be environmental risk factors. I think one of the more significant in suicide prevention is a recent loss. This can be loss of a loved one, it could be loss of a job that really increases financial stress, or for many of our communities, loss of identity, loss of their community. Those losses are a risk factor we want to consider. Then again, on the other side, what are the protective factors? How do we decrease risk by increasing those social protective factors?

Strong connection to family and friends, engagement in meaningful activities, so connecting people to work when possible, school, volunteering, or a connection to faith or belief system. Having that social support, that social safety net is really important. Again, suicide prevention is seeking to reduce those social risk factors and increase the social protective factors. Connecting individuals to community supports is a key way that we can do it.

When we're evaluating risk, we're gathering information to evaluate risk, it's important to consider not only what's happening with an individual currently, but also history, as history can predict future actions. History risk factors to consider in the context of suicide prevention is a history of self-harm or suicide attempts. As we'll see in the screening tool, and we're going to talk about that later, a history of suicidal behaviors significantly increases someone's risk. It's something to be very mindful of.

Other risks, like a family history of suicide or history of trauma and abuse, are also risk factors. Then we have the protective factors. Historical protective factors would be positive attachment to caregivers and a positive childhood or absence of abuse. Then that demonstrated resilience, and that is a component we see in many of the individuals and families that we work with. We may not be able to change an individual's history, but we can be aware of the history and connect them to supports to address things like a history of trauma to help increase coping skills and resilience.

## Warning Signs

**AL:** We've looked at our risk and protective factors, and another important piece is warning signs. Warning signs are indicators that suggest potential danger, risk, or problems. I think of warning signs as often a change, especially a sudden change. Usually, there's a change, like a change in mood, a change in what people are saying, what people are doing. One of the first areas we're going to look at is mood. If they're exhibiting a shift in mood, you're noticing things like symptoms of depression, irritability, a loss of interest in things that people were interested before, anger. Shame is a big one to be aware of, feeling like you're a burden.

Then also the change in what people are saying is a warning sign. What are individuals saying to you? Are they talking about, for example, being a burden? Are you noticing people talking about feeling hopeless, being

trapped? Then certainly if an individual talks about killing themselves, saying things like, "I wish I'd never been born, I wish I'd just disappear." These are things we want to be keeping an eye out for. Then lastly, behavior. Oftentimes, we are in the position of really observing behavior. Is there a change in what people do? Is there a new behavior, or has behaviors changed?

Again, isolating is one to really think about. An increased use in drugs and alcohol or other reckless and aggressive behavior. Very concerning behaviors would be telling people goodbye, giving away prized possessions. If someone's looking for information online regarding suicide, and then we call preparatory acts. Behaviors such as collecting pills, handling weapons, writing a suicide note, those are obviously very, very concerning. Let's now, with all this information, we're going to go ahead and do a case study to try to review.

### Case Scenario: Zahra

**JG:** Awesome. For this webinar, we will be using a fake case scenario to check for understanding. The client's name is Zahra. Again, this is not a real client. We will have two follow-up questions right now. If you all can please get your Slidos ready.

The case scenario states, "You are an economic empowerment caseworker who has been working with Zahra for four months. Recently, Zahra lost her part-time job. Since then, she appears to have lost weight, looks more tired than usual, and rarely engages in classes and your individual meetings. Based on your intake assessment, you know that Zahra has no health issues, but reports a previous diagnosis of depression. She talks positively about her connection with her family. Zahra states she has made new friends and often attends community events."

### Poll Question

#### What are warning signs you notice in Zahra's scenario?

**JG:** Our first Slido question, what are warning signs you notice in Zahra's scenario? We have a multiple-choice option here. Recent job loss, withdrawal, low mood, positive connection, family and new friends, or no health issues? We're looking at warning signs. [silence] It looks like we got about half of you all responding. The first answer is correct. Great job. I'm so glad that you all understand what the warning signs are.

For Zahra, it's recent job loss, withdrawal, and low mood.

#### What are some protective factors Zahra has?

**JG:** Our second question for you, what are some protective factors that Zahra has?[silence] Family, new friends, strong connections to family. Yes. Family and friends. Connection to the community. Connection with others. Good relationships. Access to support services from the organization. That's a good one. The community. Connection to economic empowerment services. Awesome.

You all are hitting it right on the head. No health issues outside of previous diagnosis of depression. You all are doing a phenomenal job. Keep the answers coming in at identifying those protective factors. On the other hand, when we think about risk factors, those include the loss of her part-time job, the noticeable weight loss, her looking tired, and the lack of engagement in her classes or meetings, that she's also reported of having that diagnosis of depression. Great job, everyone. Back over to you, Ashley.

## 2. Communicating with Clients about Suicide

## Poll Question

### What are some key points to consider when approaching a conversation about suicide with a client?

**AL:** Hi, great job on the Slido. I was worried I went too fast, but you guys got it. We learned about risk and protective factors and warning signs. Now we're going to move to communicating with clients about suicide. We're going to go back to the Slido again, and we're going to look at what are some key points to consider when approaching a conversation about suicide with a client. What are some things you would do? What are some things to keep in mind?

Location, great. The person's mood, where are they at? Are they open to hear you? Culture, absolutely. Privacy, trauma history, yes. Ensuring safe environment. Let them know you're in a safe place. Talk openly. See the client's mood, client's body language, nonjudgmental. These are great. Empathy, listening, yes. Definitely themes of making sure there's privacy, considering where the client's at, building trust, rapport through empathy, thinking about any cultural impacts, thinking about their history.

Don't be unclear or vague in your questions. Yes, we're going to ask direct questions. We're going to talk about that more later. I'm not an expert in this. Could refer to health professional. Yes. You can say, "I'm not an expert, you're the expert," and there are experts I can refer you to. These are great. Welcoming tone. Thank you so much. These are wonderful. Do not make decisions for the client. Absolutely. Confidentiality, all right.

We're going to go to the next slide, and I'm going to say probably all of these things again. Great job, everyone.

## How to Talk about Suicide

**AL:** How to talk about suicide. It is very understandable to feel hesitant to ask about suicide, worry about saying the wrong thing. Research has shown that asking directly does not increase risk. It can actually reduce risk because you're showing that you're a safe person. If you are concerned, it's important to ask, and we'll obviously go over that more later. We're going to talk about some of the things to keep in mind. That first came up a lot in the Slido. If you're talking to someone about suicide, the first thing we want to do is really think about the space we're in.

How do we make this a private, confidential space? How can we make it a comfortable setting? If you're in a public area, you can try to gently move the person to a more private location. If you're in a virtual setting, you want to be aware of who's in the room with you, and also maybe advise, could the individual move to a more private space? If there's people around, they'd feel more comfortable. That feels safe. Yes, private, confidential, comfortable space.

The next also came up as talking openly and directly. That has a lot to do with our body language. We're going to be calm in the chaos. Even if this feels really uncomfortable, the most important thing we can do is be a safe person, have a calm tone, open body language. We want to give the individual, the person, our full attention. If we're writing notes or look hectic, that's how it's going to feel. If we have to use a computer or taking notes, we want to explain. Usually in this scenario, we really want to just be focused on that individual.

We're going to ask direct questions, and we're going to discuss that more when we talk about the screening. Also, which came up many times in this letter, is we're going to engage with compassion. We're going to show empathy and understanding. I am a safe person to talk to. You are not alone. I care about your well-being, and I'm competent. I know what to do. If I don't know what to do, I know how to connect you to someone. We're going to engage with compassion.

Then, always when we're working with clients who are demonstrating any type of risk, we are going to always

link to resources. That could be professional help. At a minimum, we want to provide a crisis line. We want to think, "If I wasn't here in this moment of crisis, can I make sure that I provide something?" If something changes later, if I wasn't here, do they have the resources to connect to that support? Those are essential in a moment of crisis.

Then, finally, in general, we always want to follow up. We want to ensure there's a plan. Even if the risk is really low, we want to make sure there's a plan. We want to continue support. How are we going to check in? How are we going to know if something changes? Of course, we're going to document. We're going to document the conversation and what actions we took based on the information we had.

## Reminders

**AL:** Here are just a few reminders when you're talking with individuals about suicide. First, it's better to ask than to say nothing and be mistaken. There's more harm in not asking than in asking. Listening and understanding can provide the client with relief and validation and you with more information. There's two things at once. Listening or understanding, not only are you providing that client with that sense of relief, but you're able to get more information so that you know what is the next collaborative step I'm going to take.

Asking shows the client that you care, you're willing to listen, and you can assist them with how you're feeling. Again, you're demonstrating, "I am a trusted person." Even if the client is not thinking about suicide, asking creates an opportunity to let them know you're always there to offer support—things can change—or to connect them to other support if things get worse.

Oftentimes, the same things we're doing with someone who even has a low risk or no risk for suicide is how we support individuals. We're connecting to services. What are the barriers? How can we increase those protective factors? Now we're going to return to the scenario.

## Case Scenario: Zahra

**JG:** Thank you, Ashley. Let's remember Zahra. We talked about risk factors, protective factors, and warning signs. Some of Zahra's risk factors were her loss of employment, the noticeable weight loss and fatigue, history of depression. Protective factors were strong family connections, offering emotional support, her community engagement and involvement, her friendships, and then some warning signs. Some warning signs we noted were significant weight loss and appearing more tired than usual, decreased engagement in classes, and those meetings.

This could all be possible emotional withdrawal or signs of a depressive episode coming. To add on to this scenario with Zahra, we have a second piece to add to this. Due to your concerns, you decide to meet with Zahra to learn more about how she is coping. After class, you approach Zahra and ask if she has a moment to talk.

## Poll Question

### How might you approach Zahra?

**JG:** On your phones, if you could pull up Slido again, or your computers, how might you approach Zahra in this conversation? What skills do you think that you would use? As you're thinking about this, maybe think through your demeanor, the environment, your word choice, other people in the area, access.

I statements, offer support and assistance, open-ended questions, empathy, calm, finding a private space, assertive communication, offer support and assistance. Empathy and active listening are coming really big. Eye contact, very important. Approach with respect, validate, validate, validate. Safe space, reflective listening, ask

directly, yes. Validation for why she is feeling down, cultural competency, and understanding, meeting her where she's at. Y'all are rocking this [chuckles]. Keep the answers coming in. Friendly approach, positive praise, yes.

A lot of you noted the location too and ensuring that she's in a private space. Awesome. Kindness, yes, with hope. Love these answers, you all are doing phenomenal. Next, we're going to get into how to actually have this conversation and specific questions that you would need to include. I'm going to go ahead and pass it back over to Ashley to walk us through that.

## 3. Suicide Risk Screening Tool

### Columbia Protocol

**AL:** All right. We are going to talk about a suicide risk screening tool that you can use in your work. All right, we have chosen, for this webinar, to highlight the Columbia Suicide Severity Rating Scale, also CSSRS, known more commonly as the Columbia Protocol. This is a suicide risk screening tool. It's used to determine an individual's risk; low, moderate, high. It's designed to be a series of really simple, direct, plain language questions. It's designed for anyone to use.

One of the reasons we chose this is that there are excellent resources and training materials on the Columbia Protocol because it is so widely used. We're going to put a link to the website that has all of these training materials and tools and guides in the chat. It's also going to be on the resource list at the end of the presentation. Again, it's the Columbia Protocol, and the website, I believe, is called the Lighthouse Project.

We're going to look a little bit at the history of the protocol's development. The protocol was developed by the National Institute for Mental Health in 2007, so almost 20 years ago. It was in 2011 that Center for Disease Control or CDC, they adopted the protocol and recommended this for all data collection. The next year, the FDA, or Federal Drug Administration, declared the Columbia Protocol the standard for measuring suicide ideation and behavior in clinical trials. Now, today, the Columbia Protocol is used in multiple settings across 45 nations and six continents.

Though it was originally developed in the beginning to work with adolescents, it's used with adolescents and adults in many settings. The way the protocol is organized is in sections of questions related to suicidal ideation, suicide plan, and suicidal behaviors. We want to have a really clear understanding of the definitions of each of these terms because that's how we ask these questions. Suicidal ideation. This is a broad term, and it's used to describe a range of contemplations, wishes, preoccupations with death and suicide.

These are suicidal thoughts, also called suicidal ideation. Examples are, "I'm having thoughts of killing myself." Next, we have a suicide plan. The definition is an individual's thinking about a suicide attempt that includes elements such as a timeframe, a method, and a place. We're talking about starting to think about how this is going to happen. An example could be someone stating they plan to take a bottle of pills when they return home. There's a method, there's a timeframe, there's a place. That is suicide plan.

Then finally is suicidal behaviors. Suicidal behaviors are a suicide, a suicide attempt, suicidal ideation, planning, or preparation done with the intent of dying by suicide. It is an umbrella term. An example of suicidal behaviors would be those preparatory actions I talked about, obtaining a gun, saving medications, or saving those with the intent to overdose. Those are what we think of as suicidal behaviors. Self-harm.

Now, we're going to look at the protocol. We are going to go into more detail. I just want to give an overview of all of the six questions. The Columbia Protocol, it's six questions long, so it's nice and short. It's intended to be simple and direct, and I'm going to go through and read the questions.

## Questionnaire

**AL:** Question number one, "Have you wished you were dead?" Question number two, "Have you had thoughts about killing yourself?" Question number three, "Have you been thinking about how you might do this?"

Question number four, "Have you had these thoughts and had some intention on acting on them?" Question number five, "Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?" Question number six, "Have you done anything, started to do anything, or prepared to do anything to end your life?" That is the protocol, all six questions, but we're going to go a little bit more detail.

Again, the protocol, it's bucketed in these areas, and the first is suicidal thoughts or suicidal ideation. Notice the timeframe at the top—whether and when in the past month. We want to be adding a timeframe. "In the past month," making sure you're adding that in the questions, and we're looking at thoughts about suicide. Question number one, "Have you wished you were dead or wished you could go to sleep and not wake up?"

Then we'd follow up with asking the second question, "Have you actually had any thoughts about killing yourself?" If an individual answers yes to either of these questions, we're going to move on to the next grouping. The next grouping is a suicidal plan. Now, we first asked about, "Do you have thoughts?" We said yes. Now we want to know, are those thoughts starting to develop into more of a plan? Again, we are asking questions to assess risk, so we know what is the appropriate action to take. We're seeking to learn more, so we know how to collaboratively move forward with the client.

We're going to ask, "Have you been thinking about how you might do this?" The fourth question, "Have you had these thoughts and had some intention of acting on them? Then question five, have you started to work out or work out the details of how to kill yourself? Did you intend to carry out this plan?" If there's a yes to these questions, we're going to move on to our last question.

That last question is focused on suicidal behaviors, both historically, so remembering that a history of suicidal behaviors is a risk factor. We want to know now and also historically. Again, examples of suicide behavior include taking more medication than was prescribed, obtaining a gun with the intention of self-harm, a history of a suicide attempt. We're going to ask the individual, "Have you done anything or started to do anything, or prepared to do anything to end your life?" If the answer is yes, we want to know, "Was this within the past three months?"

## Risk Levels

**AL:** How we assess risk and decide risk levels, if that suicidal behavior was 15 years ago, and I've done a lot to increase my protective factors, versus that was last week. That's a really big difference. We want to get a sense of that timeframe. Those are the questions. What I really like about the Columbia Protocol and what you'll notice from that link that we shared is that, in the Columbia Protocol, there's actually color-coded risk levels. If they answer yes to these questions, they're low, moderate, or high risk.

We're going to go over some examples of someone who would fall into a low-risk category. Low risk would be someone who only responds yes to those first questions, the first questions about thoughts, but not to any other questions. This is someone who has had thoughts that maybe they wanted to die or they'd not wake up, or someone who has thoughts about actually killing themselves, but they've never really thought about how to do this or taken any action.

This is someone we would consider to be a low risk. What would we do as a provider for someone who is low risk? Again, we're always looking to increase protective factors. We're going to explore what are some natural connections and supports. We'd want to know what are their other risk factors and there's ways that we can connect them to supports. Is that connection to medical care, financial support?

I would always provide a crisis line because things can change, and we cannot be there. We want to empower individuals to really take on their own care. We want to provide that. 988 is our national line. Then this is a point that we really want to be developing a safety plan. We're going to talk about that at the end. What are things that the individual can do for themselves, and how can they get support?

Now let's look at a scenario where someone has a more increased risk. They're not low risk, but there's this say moderate risk. An example would be an individual. They've indicated that yes, they're having suicidal ideation, there's thoughts, and they have been thinking about how they might kill themselves. They denied an intention to act on the thoughts. It's often referred to as a plan without intent. I want to remind you that there are lots and lots of resources and training on this. That's why we wanted to use a Columbia protocol.

Just think of this as an introduction, not that you need to remember all these scenarios as an introduction to this idea of low and moderate and high risk. Another example, someone who's moderate risk is someone who endorses suicidal ideations or having suicidal thoughts and if they have any history of suicidal behavior. Even if they didn't answer yes to question three, there's one and two, "Yes, I'm having suicidal thoughts. Five years ago, I did have a suicide attempt." That would increase someone's risk to more moderate and not just low. You'll see that in the Columbia protocol.

What actions would we take? What are we doing when we have realized someone it's not low risk, it's not high risk, we're really in that moderate area? Again, we're going to provide a crisis line. That's number one. We are going to look at how do we increase contact points? How do we increase visits? How do we really make sure there's some referrals to support services, especially mental health? How do we follow up and check in with client regularly?

We either want to review a safety plan that's in place. If there's not, we want to develop a safety plan. Part of that is really, "Is this working? Would this work? Is this realistic?" Once you have, I would say most cases you'd consult with a supervisor, but certainly if the risk has above low risk, we always want to be consulting with a supervisor, or if you have in-house staff that are behavioral health staff. We definitely want to be consulting as every situation is different.

Finally, we're going to talk about high risk. This is where there could be an immediate intervention is when we're working with clients who are at high risk. Again, we're going to give some scenarios. During the screening, someone has endorsed suicidal thoughts and a plan. They already are at moderate risk, and they're reporting that they have some intention. That question four and five is really on plan with intention. They have some intention, they've really worked out the details and have some intention of acting on that.

It could be someone who says, "I'm having suicidal thoughts and I've had a suicide attempt two weeks ago." That's someone with high risk. If there is suicidal behavior, that question number six, within the last three months, that is someone who has recently had a behavior that put their life at risk. That's someone who is going to be at high risk, and we want to really take thoughtful steps. We just want to clarify, even if someone is having suicidal thoughts, this doesn't mean we necessarily have to do a hospitalization, right? That hospitalizations are really for imminent risk of safety, right?

Definitely, at this point, we want to bring in a trained behavioral health provider to do an assessment. We want to do a consultation. That could be through a resource 988, that could be within your own setting. What other actions would we take? Someone who's at really high risk, especially if you feel like it's imminent, you're going to want to remain with a client. If you're in person, you're going to want to try to remain with that client, either yourself, if that doesn't feel safe, in a pair.

Immediately consulting, not a case consult later, immediately consulting with someone. If there really is an imminent risk, we're going to want to call first responders. Sometimes in these scenarios, you can still safety plan. Sometimes a calling of first responders is a safety plan, and that's something you would do more in more of a follow-up. Again, these are some examples of actions we would take depending on that risk level. I'm going to pass it over again to go through our scenario.

### Poll Question

What questions might you ask Zahra after her response?

**JG:** Awesome. Thank you, Ashley. During your conversation with Zahra, she sobs frequently, saying she feels guilty she can't provide for her family. She tells you she has not been answering her friend's phone calls and says, "I feel like a burden, I wish I could just disappear." Thinking through this response, what questions might you ask Zahra after her response to you?

Again, Zahra, she was crying when you approached her, she says that she feels guilty she can't provide for her family, and she tells you she hasn't been answering phone calls from family and friends, and she feels like a burden. Can you tell me more about that? How long have you been feeling this way? I am here to help you. Questions one and two. What do you mean by disappear? Validate her emotions. I'm here to listen.

You're saying you wish you could disappear, can you tell me more about that? How are you feeling right now in this moment? Asking permission—I like that one—can I ask you some questions? Are you thinking about hurting yourself? I am always here to help. I would like to gather more information. Getting that clarity on what she means by disappear and how long she's been feeling that way.

I understand that you are having a challenging time. I am so sorry that you're going through this. What can I do to help? Encouraging her to talk more about it, yes. Okay. Keep the answers coming in, y'all. I see some really great answers. Asking her, "Can we talk about your feelings? Would you be open to talking to me about this in a private space?" Going back to that, asking permission, good.

What might you do next?

**JG:** We're going to add a little bit more to this scenario. Let's think about what you might do next. You began conducting that Columbia protocol. Zahra states, yes, she has been thinking about dying, but no, she has not had thoughts about killing herself. Let's think about what you would do next based off what Ashley just taught us.

What are some things that come to mind? Safety plan, provide the crisis line. As you all are thinking about this, remember our job is to gather information to assess for risk as the service providers. We do this by going back to that screening tool and getting those first two questions asked. Providing referrals, therapy. Thanking her for trusting you, yes. Establish times and methods for continuous check-in. Ask her if she would feel comfortable seeing a therapist. Making those referrals, provide resources. Are you willing to open up and speak to someone about your thoughts and feelings?

Explore creating a safety plan, providing the crisis line, providing resources, and the contact information for a therapist or a specialist. Asking her if she's comfortable to go into that conversation. Based on the information that we gathered, we can conclude that she is low risk. You all hit it right on the head, saying safety plan, providing the resources, 988. Increasing her protective factors is also something else we can do. We know that she has strong family connections. Making sure that she's able to get to those family members or get to those community events, getting in contact with her friends, and providing a social support network for her.

Even connecting her to a community center, a local mosque, or something that may be appropriate for her. Great job. Even though she said no, it is still important that we ask about those past behaviors. I'm going to go ahead and pass it back over to you, Ashley. Thank you, everyone, for participating.

## 4. Effective Safety Plans

## Poll Question

What comes to mind when you hear the words “feeling safe”?

**AL:** Great job. Thank you. We've gone over the suicide risk screening tool, and one of the actions that we're taking in almost every scenario is creating an effective suicide safety plan. We'll go back to the Slido. What comes to mind when you hear the words feeling safe?

Great. Support, security, having someone to talk to, trusted people, peace, not feeling judged. Great. Calm, safe environment, a comfortable community that you trust, choice. Yes. Very trauma-informed. Feeling accepted, stability, consistency, able to talk in confidence, a bed to sleep in, basic needs. Yes, food, good support system. Being yourself, feeling seen and heard. Family, a lot of feeling comfortable and security, basic needs. These are all parts of feeling safe. Stability, transparency.

Great, thank you. It's important we know what feeling safe looks like. How do we create that for the individuals we're working with?

## What is a Safety Plan?

**AL:** In this context, what is a safety plan? We're saying, what is a safety plan for suicide prevention? There's lots of safety plans that we work with and lots of different scenarios. In this scenario, it is a tool that helps people manage their suicidal thoughts and provides this roadmap. A clear roadmap for seeking help when needed. That help can be internal, that help can be external.

A safety plan should always be individually tailored. That's one of our first points. When we say individually tailored, though we may have a template, we want to make sure that the components in that template really speak to that person. What does safety mean to them? What are their specific warning signs? Who are the people that they would go to? That's the first really key component. The second key component is we really need this to be practical and realistic. It's like a fire drill, right? If we don't have the doors labeled right, if we aren't going to actually take those actions, it's not going to work.

What is realistic for that individual? Would you call this hotline? Is this practical to reach out to this person? Are these supports and resources accessible to you? Are they provided in the languages that you need? We really want to make sure that this is something realistic and not just something on a piece of paper. Finally, the third point is you want it to be simple and easy to remember. One way that you could accomplish this is creating a larger safety plan. Then you could create a card with some of the major points, like, "Here's one thing I can do for myself. Here's one person I can reach out to. Here's one hotline I can call if I'm in crisis."

You can also make more simpler versions because again, thinking about when we're in crisis, we want to make sure that the road map and path we're following is very easy to follow because we're not always going to have that cognition. We're going to be feeling really overwhelmed. Finally, the most important step in safety planning is really doing this with the person. We're thinking through this situation with the person. That is how it's effective. We're going to that collaboration, choice, empowerment, all of our trauma-informed care pieces.

On the left-hand side, there's an image, and the resource should be dropped into the chat. This is one of Switchboard's resources on an introduction to safety planning that is going to have more detail. We'll talk about some of that next. There's lots and lots of resources out there on how-- trainings on how to do safety planning. We're going to take some time and talk about the six elements of a safety plan. Again, we're really going to think about this in the context of suicide prevention. There are templates that you can find that are available.

There may be some of these components, but these are the pieces you want to be thinking through when you're thinking about keeping an individual safe. The first thing is going to be warning signs. This is going to be very individual. Though we talked about lots of warning signs that you, as a provider, can be looking out for,

what are the warning signs for that individual? When do they know things aren't going well? When could other people notice? That's when we're collaborative.

Maybe we bring in friends and family members, like, "Hey, if I stop calling you for days, that's a problem. That's a warning sign for me when I'm isolating," or, "If I'm having these intrusive thoughts and they can't go away, I can't seem to make them go away," for the individual, that could be a warning sign. Essentially, when do you know things are worse? The second from that is, "Okay, I recognize warning signs. What do I do now? What are my coping strategies? How do I decrease that distress? Those are coping skills that someone may do for themselves. Those could be talking to a friend as a distraction. Essentially, what has worked in the past? That's the question I usually ask.

Has anything helped to make this better? What have you tried? Would you be open to trying something new? Could I teach you some coping strategies that you could practice? Really developing, again, things that are very individually tailored that either someone has tried and it's been successful, or that they are, it's realistic, right? I'm willing to try this. Another element to consider is the environment. That's the prevention. We want to remove any potential danger. How can we make, maybe it's home, maybe it's other places, how do we make that safer?

The first thing that comes to mind is removing access to firearms. Someone who is having suicidal thoughts that has a firearm in the home, that is extremely dangerous. Is there a friend who could hold on to that or a family member? What types of locks are on there? Is there a trigger lock? Is there a larger lock? Ideally, we're removing that out of the home. Also looking, is there someone else who could have maybe more control of medication? Can we put it in a lock box? Looking at how do we keep the home safer?

Next, we're going to talk about natural support. A lot of times in the safety plan, we're like, "These are my warning signs. This is how I know that things aren't going well. This is when I know things are getting worse. I have a coping strategy, and I've tried it. It's not working. What do I do now?" The natural supports are family, friends, community members. It could be faith-based organizations, support groups. Who can I reach out to? What's that first level of external support? Perhaps that's a friend that I just call to go for walks with, that I don't necessarily need that emotional support, but they can provide me with a distraction.

Maybe there's a close family member that I really can talk to and work through some of the issues that are bothering me. We want to, on the safety plan, identify some of those safe people, natural supports in the community. Then, of course, we also want to have professional supports. Are there mental health providers that you're working with? Are there first responders or hotlines? There's a lot of warm lines that you can call to just talk. There's also crisis lines, like 988. They can call when things are more at the level of a crisis.

A lot of communities do have mobile crisis units as an alternative to first responders to law enforcement. Is there a mobile crisis unit in the community? Would the individual feel more comfortable contacting and then, again, empowering and giving that information so they can do that directly? Then finally, we want to have-- fitting into the last component that I just said is an action plan. Essentially, crisis planning. What are the specific actions that someone can do to stay safe? All of these things are not quite working yet, and the individual is feeling very unsafe, that they are in danger. What are steps that they could take?

Would they, "I will call 988," or "I will take myself to a hospital. I'll call a mobile crisis unit. I'll call a family or friend member. I'll tell them how unsafe I am and have them come to help me." Having an action plan is another really key element of a safety plan. At this point, we are working with clients. We've determined a risk level. We've decided to do a safety plan. We've done the safety plan, and we noticed there are a lot of gaps in that support side. There's not a lot of community supports. There's no professional supports.

## Making Referrals

**AL:** Another piece as a direct service provider is how do we increase those supports, right? Usually, that is done through making referrals, something that is done really frequently in your day-to-day work. How do we connect

people to those supports if we're noticing those gaps? The first step is going to be know your community resources. What are the community resources? Is there a mental health mobile crisis unit? Are there providers that have experience with suicidal ideation? Are there providers that are culturally and linguistically aligned to my client? We want to know what are the resources in your community.

Next, once we know the resources, is we want to be able to provide that information. Again, collaborative and individually tailored, right? I want to provide the information to the individual family and say, "This is what's available. What would be helpful? What's realistic as a support for you to engage in?" Then the third piece is we're going to be encouraging choice. Again, what would be helpful for you, and answer questions. If you go to this support, it looks like this, this, and this.

You're going to really want to learn about your referrals. You want to be able to have that information to be able to answer questions that clients have. Then fourth is we're always going to gain consent before we make a referral. We're not going to get nervous and make a bunch of phone calls because the client doesn't want help. We consent, consent, consent. That's your release of information. We know that the exception is imminent danger, but in this case, we're just looking to make referrals to increased support, so we're not calling first responders. We want to gain consent before making a referral. That's part of that trust between our clients.

Finally, when possible, it really does increase the likelihood of individuals connecting if we can make a warm handoff. Can you make that phone call with the client present? Can you provide some information with consent to the provider you're referring to, when possible? Warm handoff are always encouraged when we can. Then finally, if that connection is made and now they have support, especially with a mental health provider, we really want to look at what are the roles and responsibilities now? I'm a direct service provider, but now you have a mental health provider as well. Who do you go to for what concern?

I think especially when we're thinking about a mental health clinic, there's oftentimes a really robust infrastructure for dealing with crisis. They'll have a crisis hotline. They'll know the clients when you call, they'll have all the notes. They'll have a crisis clinician on staff. Maybe they have groups. They have people who are really trained in doing this work. You really want to have that conversation with the client of like, "That came up in the slide," or, "This isn't my area of expertise, and our organization doesn't really have that infrastructure to support you, but this is where you would go with those concerns."

## Case Scenario: Zahra

**AL:** Great. I think we're going to go back to our case scenario. We're going to return again to Zahra and we think through what would be those final steps now. We're going to help create a safety plan. Part of helping to create a safety plan is what are those coping strategies? What are the supports that are there? We're going to ensure if there are any gaps in supports, we're going to ensure that there's referrals to community resources. Maybe it's a support group. Maybe it's a counseling service. Provide a warm handoff if possible. We want to make sure that Zahra knows when is her next scheduled appointment with you or with a provider you're referring to and making sure we're following up.

In summary, I do want to say that suicide prevention really begins with increasing protective factors. Again, the work that is happening day to day, increasing those protective factors and supporting your client's mental health. Throughout the work, things that we can do are remind clients of their resilience and instill hope for the future. Hope for the future is a huge protective factor. We also really want to connect people to meaningful activities. How do we increase that sense of belonging? How do we increase all those social safety nets?

We really want to refer and connect as much as possible. Then, finally, of course, we want to provide information and referrals for ongoing mental health support. That could include professional support like counseling or support groups, but also psychoeducation. Providing information about what's happening and coping skills. How do we teach some basic coping skills to address some of that distress? Again, every day you are working to support individuals and families, and we hope you have more tools now to feel empowered to recognize warning signs and prevent suicide in your communities.

## Q&A Panel

**JG:** Thank you so much, Ashley. Lots of information was shared today, and you taught us quite a bit. I'm so grateful that we have some time for questions, because it was a lot of information. We did receive quite a few questions submitted when folks were registering. I hope that many of you feel that some of those questions were answered, but I did pull some that we would like to ask now as well as the Q&A is open, everyone. Please drop in any other questions that may pop up. The first question, Ashley, that I have for you:

How does suicide prevention differ when working with clients remotely?

**JG:** You're muted, Ashley. It's okay.

**AL:** Step one. I'm muted.

That is a great question. So much of our work now is virtual. We touched on it just briefly in a few examples, but let's take privacy would be a first thought. We don't really know who's in the room. If you're in an office and there's lots of people in the background, that's going to be very distracting to someone. That's not going to feel safe. Again, who's in the room with you? Then as much as you can, if it's safe and comfortable for the individual you're talking to, to prompt, "Would you want to go to a more private space in your home to talk?" I think that's one key thing.

There's pros and cons with the virtual. One of the cons, it's more difficult to observe behavior when you're in a remote setting to pick up on those warning signs. It's just going to be harder than when someone's in person. On the pro side is that I do think that people can feel more comfortable talking virtually. It's a more comfortable setting to talk about things that are uncomfortable versus in person. There could be some more openness. When you're working with low and medium risk, so again, we're talking about safety planning, providing resources, following up, that's really probably going to be pretty similar in person or virtually. You can do all that virtually.

We have some virtual programs where the provider and the client live in very different places, so you definitely want to make sure you've resource mapped all the resources for where your clients are currently living and staying, so you can refer them to the appropriate. I think where things get a bit challenging is for high risk clients. When someone's high risk, there is that potential you do need to do a welfare check. You need to call for first responders. Do you know their physical address? That's going to be one of the first things. If you needed to call for first responders, do you know where to send them?

You may need to just ask directly, and you may not get that information, but it's something to consider. Then also, who is in the home with the client? Are there allies? Are there family members that can collaborate on a safety plan? Can help maybe reduce the need to actually have that call to first responders. Those are some things to keep in mind. We're always looking at the least intrusive or lowest level of care possible. Thinking about is there a mobile crisis unit in that community? You're virtual. You can't be there, but is there a mobile crisis unit that-- usually they have a peer, they have a licensed clinician, it's without law enforcement.

Really, again, being aware of what's available in the communities where your clients are. That was a long answer. [chuckles]

**JG:** Long answer, but very great. Thank you for that. A question that popped in just now:

Once a safety plan is developed, how often should one review it with the client?

**AL:** I think you want to review a safety plan when there is still ongoing risk. It's going to be really individual. I don't think we have a standard, but if something changes, that would be a time. We had this safety plan, and now you've lost your job recently. Is there more increased risk if something changes in their support networks?

That safety plan isn't really working. I think it would really depend on risk. A lower-risk client, you may be able to develop that safety plan and just check in. Has this been working? Have you tried your coping skills? Someone who's more moderate or high risk, that might be something you're reviewing more frequently.

Not just reading through, but in the last week, have you had any warning signs? If you did, did you try your coping strategies? It would probably depend on the risk level.

**JG:** Thank you. Those are some really great questions. I'm just trying to pick the next one. We have time. Someone put a question in about just asking for some tips for initiating the conversation. You went over how to have the conversation. We went through the Columbia Protocol, but case managers feel nervous, or employment staff feel nervous, because this is not their wheelhouse. We want to ensure that staff are comfortable at least asking those first two questions.

### What would you say to those staff who are having trouble asking the questions directly, especially when it comes to working with younger clients?

**AL:** The answer is never anyone's favorite. I would role-play everyone's favorite tool. Essentially, you have to practice. These questions still feel uncomfortable for me, and I've asked them hundreds of times. It is an uncomfortable thing. I think if you can really put yourself in the mindset of this person's in pain and they're in distress, and this is a way I can maybe offer relief. By asking these questions, I'm showing I can handle the answers and I'm safe. If you know that the questions are going to come out really hard and awkward, then practice. Practice with each other.

Sit down with another caseworker and say, "Let's just go over and practice," because though there's really clearly stated questions, you may have a way that you're going to ask that's slightly different. You want to get really comfortable in how you're going to ask. You might simplify. Are you having thoughts to kill yourself? Really direct. That is my recommendation, is that especially if this is not an area that comes up in your work a lot, is it will of course feel uncomfortable. As much as you can learn about the topic and practice out loud in person in front of a mirror, video, you're just going to feel--

Again, I do think that's a less intimidating way to frame it is really those first two questions. At that point, we're probably going to bring in a supervisor or someone else who can do further assessment. Just getting those first two questions to know, "Oh, wow, this could potentially not just be low risk. This could be moderate or even really high risk."

**JG:** Thank you. This gets into a question that someone else had asked early on. You answered it with this. I also want us to emphasize just a little bit more if people are still having some concerns about:

### Why is it important to be direct when asking these questions versus not asking at all?

**AL:** Versus not asking at all is that we don't want to do that, because if you have noticed any warning signs, someone is attempting to tell you what's going on. They might not be saying it directly, but they're showing you with their behaviors, right? Maybe they're saying things like, "I can't do this anymore. I'm done." People are showing warning signs, and they're giving you hints because they don't know. Are you going to be okay with this? Are you going to be able to handle this? Can I trust you? Do you also have a really strong stigma against this?

Not asking, to me as a direct service provider, working with vulnerable individuals, that's just not an option. We're always asking and asking directly, one, it's actually easier to just ask the question, especially a short, direct if you're like, "This probably isn't happening to you, and I have to ask everybody. Maybe possibly you're thinking that." You're going to lose the client, and they are not going to feel that you are a trusted, confident person who can handle this information. That's what we're trying to portray. I'm safe. I'm trusted. I can handle this. I can find you the support you need. Did that answer the question?

**JG:** It definitely did. It's so important for us to reiterate that. A question about interpretation.

### What are some tips or best practices when working with interpreters?

**AL:** Again, I think this goes to the previous question of asking directly versus softening. I think we need to be really aware of any stigma or cultural nuances around talking about suicide. I will often say, "Hey, it's really important for me to as close to word-for-word as possible what this individual is saying, because that helps me to know what to ask." Really asking to make sure that interpretation on both sides is as close to word-for-word as possible. We want to remind about confidentiality, of course. We want to make sure as a provider, we're not using any jargon. We want to think like, "Can this translate?" Again, a direct question is much easier to translate than if you're getting really wordy and not being clear.

If you have in-house interpreters, which is a wonderful thing, I would provide the suicide prevention training so that way people have that background understanding of why are they asking this question in this really specific way? There's a reason for that. Whenever I do any work that is heavy, which this is, with interpreters, I'm always going to do a debrief. Just remember that secondary trauma on you. It's also on our interpreters, so like, "Hey, can I check in with you? I know this is not normally the type of topics we talk about. Are you doing okay? Do you have any questions for me? Why I ask this?" Things like that. Those are some general when working with interpreters.

**JG:** That's helpful. Thank you. We have a question.

### Is the safety plan we have available on a Switchboard website available in other languages?

**JG:** At this time, we do not have the safety plan template in other languages. The best way to make this need known would be to submit a technical assistance request through our website, which should be dropped in the chat shortly if it's not already, and just identifying that this is a need. That request would go through our internal review process. I can also bring this up to my supervisor as well if we see that this is a need throughout. We also had a question about resources that service providers can provide to clients directly. If you all aren't familiar, SettleIn is a website that has created a plethora of resources that are client-facing. Please, check that out. You can also submit technical assistance requests through them as well if you need additional support. Let's see, Ashley. We have a few more minutes. Someone asked:

### What do you do when the caregiver or parent is suicidal and the child is also suicidal? Where would you begin as the service provider with the assessment? Should they start with the caregiver or the child?

**AL:** That's probably a very unique situation. One, I would say, if possible, bring in another staff member as soon as possible.

**JG:** A supervisor.

**AL:** It's not a one-person job. I would start with the youth. If there was, where would you start? I think that these situations are nuanced. I'd also maybe look, is there a way that we know at this point that someone is at higher risk? Maybe the caregiver is at imminent risk of doing something, and the youth is not. They're just having some of these thoughts, not just, but having thoughts. You'd also want to be very aware to not leave someone alone and to really make thinking about that imminent risk. I would say that these scenarios get very complex very quickly.

Not to not answer that question, but this is where you consult one for one person and two people at risk. In any scenario, let's get more staff. Two, consult, consut, consult. This is a huge burden to carry alone. That leads to massive burnout. You never want to feel like I made this decision alone, and it wasn't the right decision. We're consulting, we're making these decisions collaboratively with our clients, with caregivers, with our supervisors. I

would say the things I would consider it's essentially vulnerability. Your youth is more vulnerable, but also, what is the risk level of the two people in the room? I hope no one's ever in that situation.

**JG:** We're getting quite a few people with very specific client scenarios.

**AL:** [crosstalk] The specific scenarios we could—

**JG:** We couldn't address. I was just—

**AL:** That's when you come to someone like me in your organization and do a one-on-one case consult. [chuckles] If you have someone in your organization, you really want to do those because the questions we ask, we need to gather more information or ask you to gather more information, so we can do a much more thorough assessment of what's happening.

**JGL** Yes. Absolutely.

**AL:** There's no--

**JG:** No worries.

What about if you ask someone the first two questions and they say no, but you suspect they're not being honest? What would you say your next step would be? What would you encourage a staff person to do if they are stuck on, "This person is not being honest? I know that they're suicidal. I see the warning signs, but they're telling me no."

**AL:** I think you could do the full assessment. You don't need to just stop at question one and two because someone said no, especially if your instincts—you could go through and ask questions. If someone's denying all aspects and you still have concerns about their safety, I'd want to know why do you have those concerns. What is happening in your gut that's telling you, or what information do you have that is increasing that risk? Also, being sure that that's not your own discomfort, that that really is the risk you're picking up.

Again, you want to consult, but you want to try to—I wouldn't stop the assessment. You don't have to stop it at the first two questions. You can continue asking all the way through. We always want to ask that last question on past suicidal behaviors. I would continue the assessment, see what information you can gather. The screening tool, if someone is denying all things and you still have concerns, then you're going to need to talk to someone and see what other actions can we take.

**JG:** Thank you.

What are some tips you would give to a service provider who is addressing suicide prevention with several clients? How does one protect their own mental health?

**AL:** I know I already said this once, but I'd go back to share the burden. Consulting, what often leads to that burnout? One, it's the content. It feels very high-stake, and it's the content. We're going to take care of ourselves the same way we are with any other distressing content. What are your coping skills, what supports? I think, especially around suicidal behavior, that sense of feeling responsible, that I might do something wrong and the stakes are really high, that can be very heavy on-- if we're sharing that, we're always consulting, these are decisions that are made in collaboration with other people, then you don't feel as much of that weight of that burden that this was a choice that I made.?

That is one of the reasons we consult. The other is the situations are often nuanced, and if you can have more minds thinking about the situation. Not all the minds, we still want to think about confidentiality. The other is, I think, trying to be more comfortable with the uncomfortable. If you are direct service provider and all of a

sudden suicidal thoughts are coming up a lot and it's really new to you, you're attending this webinar, so that's a good start, but you want to get comfortable with what's uncomfortable. Can I learn more about this? Can I read more about this? Can I practice this? How do I gain more skills?

Generally, when we're in a situation with a client, the stress comes when we don't know what to do. That's a helplessness we don't want to be. If you feel like I do know what to do, I know I have these questions to ask, and I have this person I consult with, and I do X, Y, Z if this happens. The more you have that process and tools, the less there is that sense of like, "This is happening, I have no idea what to do." That's really, I think, where that heaviness can come from in that burnout. Great question.

**JG:** Yes, great answer. Thank you. I think we have time for one more question, and I'm just skimming through. So many have popped in, and I'm so grateful that many of you are still with us. Let's see.

What do you find are the most common mistakes that providers make when trying to connect with a client in an active suicidal crisis who isn't engaging?

**JG:** That's a really deep and good question.

**AL:** There's a lot of things happening in that question, which is a great question.

**JG:** It's a great question.

**AL:** Read the scenario part again. I get the, what are some of the mistakes that a provider could make? We're looking at maybe—if a client's actively suicidal—and they're not engaging. Again, I want to ask so many follow-up questions about the scenario because that's how this works. What we said many times, the biggest mistake is not asking and not acting. It's like, "All right, well, they're not engaging, but they're actively suicidal. I'll just let it be." No, we're going to take action. If someone is actively suicidal, I want to know that definition. Like we said, if someone's actively suicidal, meaning they have stated they have suicidal thoughts, they have a plan, and they're taking steps on that plan. They're now at imminent risk. Most people at that point are not engaging in help, right? At that point, that's the definition.

That is when we would be able to break confidentiality, and we would need to make a call to mental health providers. Maybe at this point, we're calling in first responders. If we're saying actively suicidal, meaning they're having suicidal ideation, just thoughts. We've asked the questions, I'm actively suicidal. I think that's where we went through all those definitions because you're like, "What do you mean by that?" [chuckles] I'm having suicidal thoughts. I'm thinking I don't want to be here. I'm thinking I want to die, but no, I don't have a plan. I haven't thought about a plan. I've never done anything in the past, but I'm having these very intrusive thoughts.

For some people, those intrusive thoughts are very distressing. If someone's not engaging, at that point we are trying to safety plan, trying to referrals, but there's not imminent risk. There's not really a lot you can do at that point. You want to go through all those action steps. You want to ask the questions. In that scenario, that's just increasing check-ins, asking again, maybe reviewing a safety plan. Again, you want to follow your organization policies.

For some organizations, a client that's not engaging at all is a client that might not be appropriate for care there, but we always want to provide, "Here's where you can go. Here's where you can go for a crisis if things get worse. If you change your mind and you do want to get help," you want to make sure that people always have that information.

## Conclusion

## Reviewing Learning Objectives

**JG:** Thank you, Ashley. We fired those questions at you pretty fast, so thank you so much. [laughs] We appreciate you. Now we hope that you all are able to identify protective factors, risk factors, and warning signs of suicide. You are also able to apply the four practical skills to ensure your communication with clients about suicide is assertive, clear, and compassionate. You're able to implement these six questions of the Suicide Risk Screening Tool with fidelity and confidence, and you're able to create effective suicide safety plans with clients, including those six key elements.

Before we share our recommended resources, we'd like to ask you all to help us help you. If you could please scan this QR code, the link will also be in the chat. The survey is extremely important to help us improve our future trainings. Our survey is three questions and should take you about 30 seconds to complete. If you can take 30 seconds now to complete the survey, we would really appreciate that.

## Recommended Resources

**JG:** All right, awesome. Here are our recommended resources for you all. We are also sharing these in the chat. Several of you asked about the slides being shared. You will receive the slides with these links that will be live for you to click directly on. Please visit our website. We shared some additional resources as well throughout the webinar.

## Stay Connected

**JG:** If you have any questions that come up, don't hesitate to reach out to Switchboard through our technical assistance link as well. Please stay connected with us. For more training and technical assistance, you can go to our website, you can visit us on LinkedIn. We also have our YouTube. You can send us an email or just click on our social media. On behalf of all of us here at Switchboard, we want to thank you for learning with us, and we hope to see you all again soon.

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