EDC Education Development Center

SELF-GUIDED TRAINING MANUAL

H.O.P.E.: Suicide Prevention for Crime Victims

H.O.P.E. saves lives

Acknowledgements

Several Education Development Center (EDC) staff members worked enthusiastically to realize our vision for an innovative, cross-cutting, and relevant curriculum that would help to equip crime victim advocates with the information and skills they need to support their clients. The curriculum development team included Dr. Heidi Kar, Ms. Jennifer Myers, and Ms. Audrey Johnson. Special thanks are due to internal EDC reviewers, Dr. Jerry Reed, Ms. Terri Yellowhammer, Ms. Valda Grinbergs, and Mr. Adam Swanson, and to the project's external board members, Dr. Jackie Campbell, Dr. Kate Cerulli, Dr. Joan Gillece, and Mr. William Kellibrew, for their feedback, guidance, and wisdom. We acknowledge our master trainers, Dr. Heidi Kar, Ms. LaShawn Martin, and Ms. Jennifer Myers, who skillfully conducted regional train-the-trainer workshops developing the skills of almost 100 new H.O.P.E. trainers across the nation.

Access resources, videos, and additional information about the H.O.P.E. Suicide Prevention Training on the EDC website: https://www.edc.org/hopeforadvocates.

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Dear Advocates,

Education Development Center (EDC) is pleased to partner with the Office for Victims of Crime of the Department of Justice in presenting *H.O.P.E.: Suicide Training for Crime Victims*. EDC's staff of licensed mental health providers, public health experts, crime victim advocates, and suicide prevention specialists, as well as our Board of Advisors, which includes experts from across crime victim advocate settings, have contributed to the development of this curriculum.

This curriculum was designed to offer an effective, evidence-based, and context-specific suicide prevention training for advocates working across crime victim settings. Almost 100 trainers were trained to deliver the *H.O.P.E. Suicide Prevention Training for Crime Victims* across the nation and they have, in turn, trained hundreds of advocates in this work so far.

This training manual has been informed by feedback from advocates who have been trained in the curriculum and who have in turn used their knowledge to train other advocates and to support their clients.

This manual is designed to be used to build advocates' own skills through self-guided study. We encourage any advocate—whether in domestic violence, child protection, or any other type of violence prevention advocacy role—to use these materials to increase their skills in suicide prevention among crime survivors.

If an organization would prefer to be trained by an established trainer in the H.O.P.E curriculum, please contact Dr. Kar at the email address below for information about trainers located in your geographic area.

Thank you for making a commitment to advancing your knowledge and skills in working with crime victims who struggle with suicidal thinking or behavior. Applying best practices and evidence-based tools and fine-tuning your suicide prevention skills will have a tremendous impact on those you serve as a crime victim advocate and on providing excellent care to the clients you serve.

The U.S. Surgeon General's *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action* rightly states that we all have a role to play in advancing suicide prevention and recommends specific ways we can all get involved. Some objectives urge collaborative engagement of individuals at risk, families, and concerned others. Other objectives describe the importance of addressing the most vulnerable groups. We know that crime victims are at increased risk for suicide, and as such, it is imperative that victim advocates be equipped with the best information, skills, and resources to enable them to support those under their care.

By using the *H.O.P.E. Suicide Prevention Training for Crime Victims* curriculum materials and learning how best to recognize and support crime victims at higher risk of suicide, you are helping to achieve the goals and vision of the National Strategy. The H.O.P.E. curriculum includes this self-guided learning manual, a project website with additional resources, and a shortened, online course version designed by the Office for Victims of Crime.

Since we know that it only takes one person to offer hope, your actions make a significant difference to help reduce the toll of suicide on our nation. Thank you for all you do to best support those who are vulnerable to suicide.

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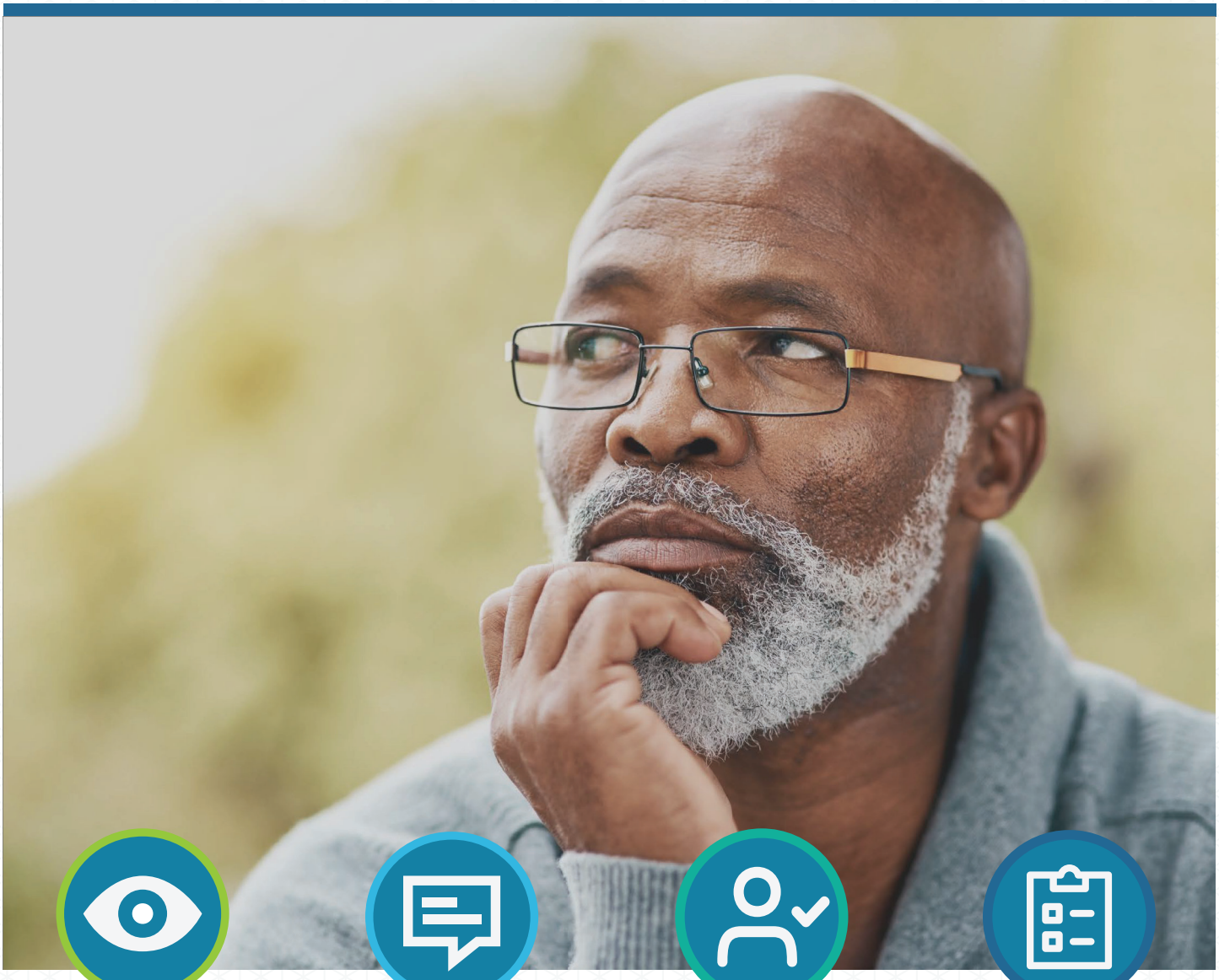
Module 1: Prepare Ourselves



Look for Hints

Ask Openly about suicide

Validate Pain

Explore reasons to live and plan to stay safe

H.O.P.E. saves lives

Module 1 Overview

Topics Covered

- Processing our own biases and reactions
- Common reactions of a crime victim advocate
- Recognition and awareness of linkages between our own reactions and the experiences and responses of those we serve
- Strategies to manage and address biases and reactions

Learning Objectives

In Module 1, participants will:

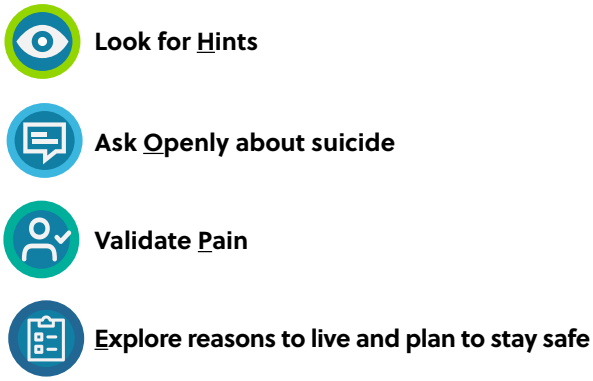
- Develop and improve skills in building self-awareness and increasing mindful processing of their own biases and reactions
- Describe common reactions when working with crime victims at risk of suicide
- Identify linkages between their own reactions and the experiences and responses of crime victims
- Outline at least two strategies to manage their own reactions and to create a collaborative and non-adversarial stance

Materials

- **Worksheet 1A:** Vignettes
- **Worksheet 1B:** Reflection Questions
- **Video:** ***The Suicide Prevention Movement*** (3:37) Dr. Jerry Reed, EDC, describes the history and ongoing needs of the Suicide Prevention Movement: https://www.youtube.com/watch?v=5N5MB-R-CrE.
- **Video:** ***Native Youth Are More Than Statistics*** (13:37) Ms. Elyssa Concha describes her own experience and that of her Native American people with suicide: https://www.youtube.com/watch?v=TMSyBmQt7iY.

Introduction

- Thank you for taking time away from your work to improve your suicide prevention knowledge and skills.
- As you go through the materials, you will see the acronym H.O.P.E. referenced to assist you in remembering the steps you can take to instill hope and to help a victim through a suicidal crisis. H.O.P.E. stands for:



- We all have a role in offering hope, supporting, and advocating for those at risk for suicide.
- We will be addressing several difficult topics throughout the training materials, including trauma, violence, victimization, and suicide risk. Suicide has likely affected many of us. Often, we know someone who has thought about suicide or attempted suicide, or we have lost someone to suicide. If you become uncomfortable, or are distressed at any point, please talk with a support person in your workplace or reach out to one of the resources listed. We have included several suicide prevention resources:
  - Call the National Suicide Prevention Lifeline at 1-800-273-8255. This is a 24/7 talk line. You can also call this line and ask for help if you are concerned about a victim you are working with, a friend, or a family member.
  - Crisis Text Line – Text "Home" to 741-741. It is not just for someone thinking about suicide.
  - You may have access to an Employee Assistance Program (EAP).

Many of us do not spend this much time reading and thinking about suicide prevention. So, we encourage you to give yourself some extra self-care.

When working with individuals who have been the victims of crime, have experienced trauma, and are going through significant distress, you will likely be working with individuals at risk for suicide due to the victimization, a prior suicide risk, or a combination of factors. We will be addressing the suicide risk for those who have been victimized and the overlap

in your work later. Before we discuss what to look for and how to respond, let's focus on ourselves and on our own reactions. These internal and external reactions could be thoughts, emotions, sensations in our bodies, and body language. The word *suicide* itself is powerful and can evoke many different reactions. Some of these responses may be useful and informative. Others may be based on myths or biases. One such bias might be what a suicidal person might look like. If a person doesn't appear depressed enough, our internal response might be to not identify the risk because the person doesn't fit our internal expectation or preconceived ideas of what a person at risk for suicide might look like, act like, or do.

The training materials will cover eight modules:

- Prepare Ourselves
- Understand Suicide
- Listen and Recognize
- Respond and Transition
- Recharge Ourselves
- Consider the Complexities
- Support the Family
- Consider the System

Throughout these modules, keep in mind your role and the resources you have in your system, and apply what we discuss to your specific setting. We encourage you to write down ideas about how these concepts apply to your work.

These self-guided training materials are designed to move suicide prevention beyond mental health. This training is intended to identify those who are at risk in their communities. Let us take a moment to hear from a suicide prevention expert about why this is so important.

Watch the video ***The Suicide Prevention Movement*:** https://www.youtube.com/watch?v=5N5MB-R-CrE.

Before moving on to Module 1, let's review the foundation for our work—the principles of a trauma-informed approach. Keep these in mind as you learn more about your role in preventing suicide as a crime victim advocate.

Principles of a Trauma-Informed Approach

- **Safety** – Staff and the people they serve feel physically and psychologically safe. Advocates consider safety as a core foundation to interactions, decisions, and responses.
- **Trustworthiness and transparency** – Decisions are conducted with transparency,

including the goal of building and maintaining trust among staff, clients, and family members of those receiving services.

- **Peer support and mutual self-help** – These are integral and are understood as a key vehicle for building trust and establishing safety and empowerment.
- **Collaboration and mutuality** – With this, there is a true partnering and leveling of power differences between staff. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.
- **Empowerment, voice, and choice** – Individuals' strengths are recognized, built upon, and validated. Advocates aim to strengthen the experience of choice for clients, family members and staff. This includes the awareness that every person's experience is unique and requires an individualized approach. A belief in resilience and in the ability of individuals, organizations, and communities to heal and recover from trauma is foundational. This is a strengths-based approach instead of a deficits-based approach.
- **Cultural, historical, and gender issues** – Advocates actively move past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, geography), offer gender responsive services, leverage the healing value of traditional cultural connections, and recognize and address historical trauma (Substance Abuse and Mental Health Services Administration, 2014).

For additional information – See *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach* (2014) at https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884?referer=from_search_result.

Vignettes

Vignettes and Reflections

- Let's start by exploring some real-life scenarios. When reading these, focus on what comes up for you. Identify any thoughts, emotions, or physical sensations that you experience.
- For this activity, focus less on exactly what you would do and focus more on what prompts you to do that. For instance, if you want to get help right away, you might identify feeling worried or fearful or having a desire to fix it. If you think the person is not really at risk for suicide, write about this.
- Now let's take several moments to focus on your reactions using vignettes. Read the vignettes in **Worksheet 1A: Vignettes** and reflect on the questions that follow.

Worksheet 1A: Vignettes

A. Lena is a 34-year-old single mom since having recently left a violent relationship. She works two jobs but barely has enough money to make ends meet. She loves her daughter Noelle but feels like she is failing as a mom because she cannot provide for her. On top of this, she lives in fear that her abusive ex-husband will find her, and she starts crying and says she can't keep Noelle safe by moving somewhere else. As you talk to Lena about this fear, she says, "I just can't do it anymore. I can't live like this." When you ask her if she is considering suicide, she says, "Yes," and that she plans to shoot herself with the gun she bought to protect herself from her ex-husband. You ask what would happen to Noelle if she killed herself. She responds, "I don't know. I love her, but I can't take this anymore. I am a terrible mother anyway. She would be better off without me."

B. Jade is experiencing suicidal thoughts. You have been working with her for about a year. During this time, you have helped her find transportation, counseling appointments, and other resources. Whenever you see her, she is unhappy to be there and says it doesn't matter because life is pointless anyway. Today you are discussing her upcoming court date to testify against the woman who sexually assaulted her. Jade seems annoyed and uninterested in the conversation. She says, "I don't see why we are even doing this. Nobody is going to believe me. Even if they do, that memory is still going to be in my head forever. She ruined everything. My life is a mess. I don't know why I even bother. I should just end it."

C. You are meeting with your client Harold, a 17-year-old member of a Native American nation. He reveals that his friend killed herself last week; the third person he has lost to suicide in the past two years. You also know he has a history of child sexual abuse from a family member. He says, "It just keeps happening. I don't think I can handle any more. It's too much—the suicides, the abuse, constantly fighting for our rights and land." When you ask him what strategies he is using to cope, he answers, "I don't know. Nothing, really. I just keep going through the motions, but I feel heavy and empty inside. Nobody will talk about it. Nobody lets you talk about the bad things, so they keep happening." You ask how it makes him feel that his community isn't discussing suicide or sexual abuse. He says, "Abandoned, lost. Sometimes I think, maybe they had the right idea—getting out."

D. Your client Albert is an 82-year-old man who has lived alone since he lost his wife Helen a few years ago. You came to know Albert a year ago when he was experiencing elder abuse from his home health aide. Recently, he's been dealing with a number of health issues, including arthritis and diabetes. These chronic illnesses make his day-to-day life difficult, and he has had to go to the hospital often. When you ask him about sources of support in his life, he quips, "Well the mail lady is very nice. Always brings me my bills. Best friend I got!" He mentioned in a previous session that he had children, so you ask him if he gets any help from them. He says, "No, they haven't talked to me in years. Who wants to hang around an old man like me?" He laughs. "Nope, don't have nobody here anymore. Sometimes I think I should just get it over with and go see Helen. Hopefully she hasn't forgotten about me up there!"

Focus on initial reactions without filtering them:

1. What did you notice in your body as you read this?

2. What are your thoughts about this person's risk?

3. What actions would you want to take?

4. What thoughts or feelings might be behind these actions?

5. Were there themes in the thoughts you had about the vignette?

- Now, let's take some time to hear from someone who has lived through a suicide attempt by watching this video ***Native Youth Are More Than Statistics***: https://www.youtube.com/watch?v=TMSyBmQt7iY
- This is one Native youth's story based on her experience. While you watch the video, be aware of your reactions, thoughts, and feelings.
- Reflect on these questions:
  - What thoughts did you have about the video?
  - What internal reactions did you notice?

Common Reactions

Introduction

You have reflected on several themes in your reactions to the scenarios.

Objectives

Participants will:

- Describe common reactions when working with crime victims at risk of suicide
- Identify linkages between their own reactions and the experiences and responses of crime victims

Key Points

- Common reactions of the advocate can lead to over-control and under-responsiveness.
- These are some common reactions that we may experience when working with a crime victim who is at risk for suicide:
  - **Fear** that we might say the wrong things, which might contribute to making things worse; that we could be sued; or that the person might die
  - **Anxiety** about the unknown; about following policies, procedures, or uncertainty; or about what to say or do
  - **Anger**, especially if the person does not seem responsive to help
  - **Confusion** if it is hard to relate to the person and why they might be at risk. For instance, maybe the individual at risk has a lot of resources, can afford to live

somewhere else, and seems to have significant support and many reasons to live. And yet, they are telling you that they are thinking about suicide. In the meantime, another victim you are working with has no or limited resources and support and is very hopeful they will get through it.

- **Helplessness**, especially if it feels like you can't help or don't know what to do. This can occur when the system isn't working well for that person, if they are considering a means of suicide that is difficult to restrict, or if they are continuing to be victimized, and you feel helpless in how to protect them from it.
- **Hopelessness**, sometimes we can relate to where a person at risk is coming from and feel hopeless also.

» If we are feeling these emotions, it is possible that we might respond in one of two ways. We become over-controlling, or we withdraw. Neither of those responses are in the best interest of the individuals we are trying to serve.

» Now, let's think about these reactions paired with the common reactions of a victim. Common reactions of the crime victim at risk can include keeping suicidal thoughts and behaviors secret, withdrawing, not showing up for or missing appointments, or not answering calls or checking in. Also, you might sense a change in rapport. This can feel like a power struggle at times. Consider that they may also be feeling many of the emotions we discussed the advocate experiencing. It is key for you in your role as an advocate to manage your own reactions to be able to fully support and respond.

» There are several common biases, or judgments, which a person might think about someone at risk for suicide. These include thinking the person is attention seeking, manipulative, not serious enough (such as "They are only talking about it."), and that the person may be selfish. These judgments can cloud our reactions and are almost always not true about a person at risk for suicide. If the advocate thinks the person is attention seeking, it is important to remember that a lack of connectedness may be driving the person's suicidal thinking. Therefore, it may seem as if the person is seeking attention to meet this need. However, this is a real need that is causing pain and contributing to risk.

» As advocates, we can balance and confront our judgments and biases with a genuine understanding of the experience of a person at risk for suicide. Of course, experiences are individual. Yet, research and experience has informed the field of suicide prevention.

» It is likely the person in crisis is experiencing deep and unbearable pain and despair. Unresolved psychological pain can result in suicidal behavior (Levi-Belz et al., 2019; Shneidman, 1998). This pain can stem from unmet psychological needs. There are several possible factors which might be common for a people at risk:

» **Thwarted belongingness/connectedness (Chu et al., 2017):**

- Most people who think about suicide may not feel they are connected or belong.

- **Perceived burdensomeness (Chu et al., 2017):**
  - Many persons at risk for suicide see themselves as a burden. While it may seem that they are being manipulative to get a response, they may be in crisis. This can impact their awareness and ability to change this. It can also appear as if they are doing or saying things that are selfish, when they may believe their death relieves a burden rather than causes more pain.
- **Ambivalence (Spencer-Thomas, 2017):**
  - Ambivalence is common for people in a suicidal crisis.
  - Like a teeter totter, a person's desire to live and desire to die can wax and wane. It can appear as if the person is not serious about dying, when what we know is that the person is likely very serious about ending their pain. They are struggling with how to do this in life. This balance can quickly tip towards the side of death without support and treatment.
- **Tunnel vision/Cognitive constriction (Ellis, 2006; Oltmanns, 2017):**
  - Cognitive constriction is like tunnel vision. One's thoughts can be so "tunneled" that they are only able to see the hurt, pain, and hopelessness. This is similar to a person who might see a dog and only experience this as a dog that might attack even if all of the dog's signals and behaviors are showing that it is playful or wants affection.
- For the crime victim, these suicidal thoughts can be triggered or intensified by the victimization or, what is for some, a re-victimization. The experience of the victim can include struggling to feel heard or believed and feeling blamed. This can be due to the nature of the victimization and the pervasiveness of the communication and actions by the offender blaming the victim. This can also be triggered as a result of immense stress that can be part of the criminal investigation process. Since the nature of a criminal investigation may also involve stress for the victim's family, concerns that they are a "burden" can be heightened.
- **Reflection:** Thinking back on your work, can you think of a time that your own biases may have affected the care of a client or crime victim? Potentially, a situation where you may have over-controlled or under-responded to a person's crisis?

Managing Reactions

Introduction

- There are many possible reactions to an individual that might be at risk for suicide. Some of these may be useful and assist in your work, while others may be hindrances and may contribute to you being out of sync with the individual.

- It is important to be proactive and use strategies that are helpful in increasing awareness of and managing our own reactions.

Objectives

Participants will:

- Outline at least two strategies to manage their own reactions and to create a collaborative and non-adversarial stance

Key Points

- There are several strategies we can employ to manage our reactions and moderate impacts on our work.
- In implementing these strategies, it helps if we have a culture of being able to support each other, especially when we see that a colleague may be over-responding, under-responding, or is not in sync with an individual. Some organizations have cultures that allow coworkers to hold each other accountable in a nonjudgmental way, such as being able to say, "I think this one hits really close to home, I wonder if I can help with it." Or, "It seems as if this person may be trying to tell you something. I wonder if there is something that might be blocking you from hearing it?"

Strategies to manage our reactions include:

- **Self-reflection:**
  - Integrating self-reflection into our day-to-day work is key to identifying what is occurring in our reactions. Self-reflection can be done in many ways, such as through journaling, pausing, and informal processing with others. At times, we may have blind spots or might benefit from a formal consultation.
- **Consultation:**
  - Consultation can be in the form of one-on-one consultation with a colleague, in a team, or during staff meetings, or through other means, such as another agency. Some organizations have a system through which a colleague or supervisor, typically a person with some expertise in working with a certain content area or population, can be accessed for consultation.
- **Spiritual and cultural practices:**
  - Spiritual and cultural practices can be very supportive in assisting to manage our own reactions, connect, and ground ourselves. This can be particularly relevant in some workplaces such as tribal and native organizations.

» **Professional assistance:**

- Professional assistance may be seeking therapy or medical treatment, if needed. Our reactions often have roots. There will be times when we may not be able address a root or change the fruit developed through that root system without professional help. Working with clients who struggle with suicide can amplify our own trauma reactions. There is no shame in getting professional help, especially for the many of us who have been impacted by trauma, violence, and suicide.

» **Peer support:**

- Peer support can take lots of different forms. Peers can be our colleagues, peers who work in closely related professions, or peers who have similar experiences. Peers can play an important role in normalizing our reactions while also providing a safe space for growth.

Reflection

» Take time right now to reflect on ways you can best manage your own reactions by responding to the questions in **Worksheet 1B: Reflection Questions**

Worksheet 1B: Reflection Questions

Reflection Questions

It is important to take some time to reflect on your own thoughts and feelings about suicide and talking to individuals who may be at risk for suicide. We all must be aware of our own reactions to suicide so that we can actively work to ensure the messages that we send to clients are helpful and do no harm. Please take a few minutes to respond to the following questions.

1. What thoughts and feelings do I have about suicide and death in general?

2. How do these thoughts and feelings affect my work with people at risk of suicide and/or with their family members?

3. What are the potential negative effects that my thoughts and feelings can have on my clients?

4. Who can I go to for consultation if I recognize that some of my own thoughts and feelings are affecting my work in a negative way?

5. How can I be more aware of my own reactions when working with my clients?

- In the work we do, language matters. It is best to use terminology, such as *died by suicide* or *died of suicide*, as we would say for other medical issues. *Committed suicide* comes from terminology associated with committing a crime.
- Language matters in our work. It is best to describe behavior directly rather than using phrases such as an *unsuccessful attempt*. We prefer to put the emphasis on life. Describe the actual behavior rather than labeling it as *manipulative, attention seeking,* or *a cry for help*. It is best to describe people as something other than a diagnosis. The same is true for using terminology such as *we are dealing with a person who is suicidal*. Rather, *we collaborate with, and support people who are in crisis*. Quick tips to remember regarding language (Now Matters Now, 2018):
  - Died of/by suicide vs. ~~committed suicide~~
  - Suicide death/attempt vs. ~~successful/unsuccessful~~
  - Describe behavior vs. ~~manipulative/attention-seeking~~
  - Describe behavior vs. ~~suicide gesture/cry for help~~
  - Working with vs. ~~dealing with persons at risk for suicide~~

For a digital image of Language Matters, which can be shared with colleagues or posted in an office, see Now Matters Now at https://www.nowmattersnow.org/wp-content/uploads/2018/10/LanguageMatters.pdf. Now Matters Now offers tools, resources, and videos to apply Dialectical Behavior Therapy skills for managing suicidal crises and painful moments of life.

Conclusion

Key Points

- It is common to have a variety of reactions to a person at risk for suicide.
- Some of these reactions can be useful and inform our work, while other reactions could interfere with our relationship with an individual or impede our work.
- Several strategies can be used to manage reactions. You do not have to do this work alone. A key point here is to become aware of your own reactions and use discernment regarding how they may be impacting you and your work.

Module 2: Understand Suicide

Look for Hints

Ask Openly about suicide

Validate Pain

Explore reasons to live and plan to stay safe

H.O.P.E. saves lives

Module 2 Overview

Topics Covered

- Overview of key suicide data (national and crime victim-specific)
- Signs and symptoms of suicidal thoughts and behaviors
- Risk factors for suicide

Learning Objectives

In Module 2, participants will:

- Develop an awareness of the scope of suicidal thoughts and behaviors at both the national and crime victim survivor levels
- Be able to name the main signs of suicidal thoughts and behaviors across the life span
- Be able to name the most common risk factors for suicide
- Be able to identify hopelessness as a key risk factor for suicide

Materials

- **Worksheet 2A:** Signs and Symptoms
- **Handout 2B:** Warning Signs, Precipitating Factors, Risk Factors, and Protective Factors
- **Video:** ***Older Men, Depression and Suicidal Thoughts*** (4:21): Older man describes struggles with suicide: https://www.youtube.com/watch?v=AgxrxlaeL7I.
- **Video:** ***Billingsley Teen Talks about Suicide Attempt*** (0:16 to 1:30): Madison Motley discusses suicide history: https://www.youtube.com/watch?v=ElKqvfyMQ4k.

Using Data to Understand Suicide

Introduction

Key take-home points include:

- Data can help inform our work, yet any individual can be at risk for suicide, even if they are not a member of a high-risk group.
- The purpose of looking at data and understanding warning signs and risk factors is not to predict suicide. The purpose is to plan for response, treatment, and recovery.
- Data are not representative of all persons and experiences.
- It is key to be aware of warning signs.

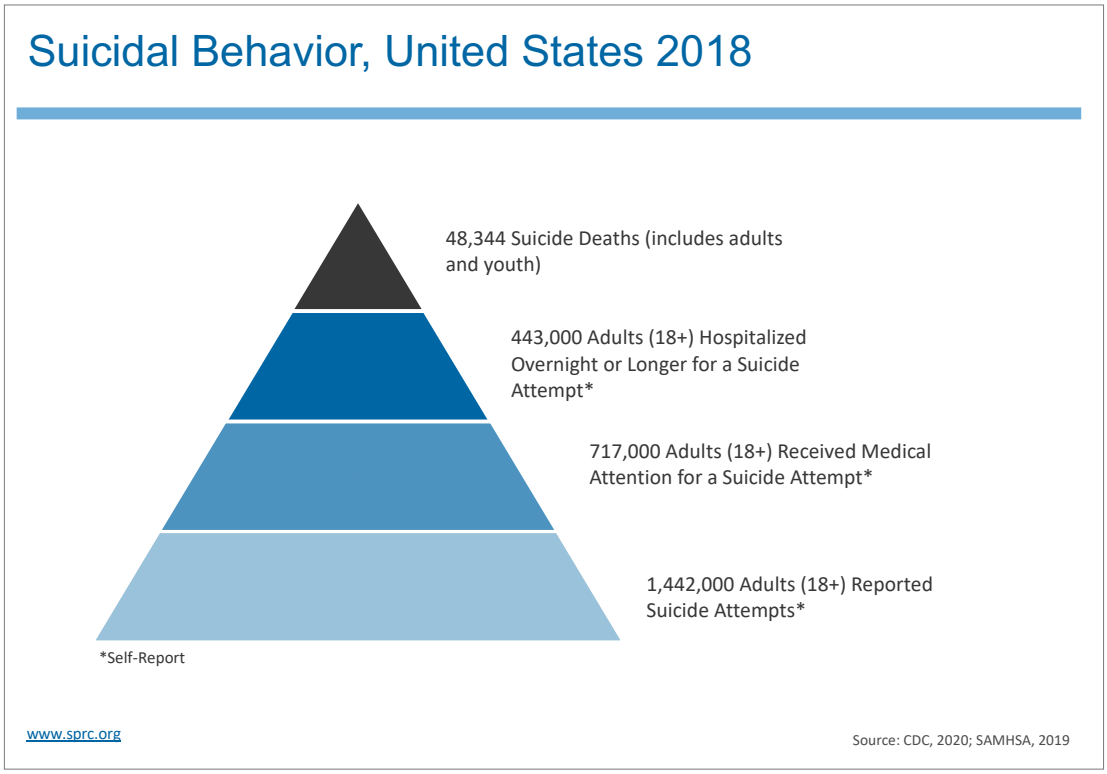
Objectives

Participants will:

- Develop awareness of the scope of suicidal thoughts and behaviors at the national and crime victim survivor levels.
- Be able to name the main signs of suicidal thoughts and behaviors across the life span.
- Be able to name the most common risk factors for suicide.
- Be able to identify hopelessness as the key risk factor for suicide.

Key Points

- We have been focusing on our reactions, common experiences of the helper and the person in crisis, and ways to manage these reactions. Now, we are shifting from responding with our heart to thinking with our head. While data and warning signs cannot predict who is at risk for suicide, this information can be useful to bring an understanding to suicide and help in planning our response.
- We may miss signs from individuals thinking about suicide and planning an attempt without the skills we will be focusing on today.

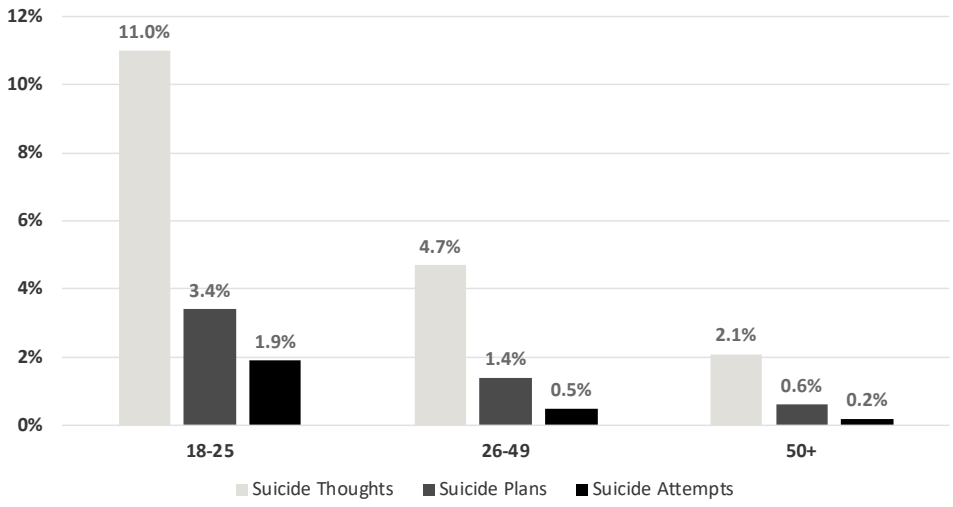


(SPRC, 2020b)

This suicide behavior pyramid image is a good representation of opportunities to intervene (Suicide Prevention Resource Center [SPRC], 2020b).

It can be helpful to understand the percentage of persons who report suicidal thoughts, plans, and attempts in the past year. This can be applied in your work, knowing those you are working with are at higher risk for suicide due to the impacts of trauma, victimization, and other factors.

Past Year Suicidal Thoughts, Plans, and Attempts Among Adults (18+) by Age, United States 2018



www.sprc.org

Source: SAMHSA, 2019

(SPRC, 2020b)

10 Leading Causes of Death by Age Group, United States—2018

Ranking	Age Groups										
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	TOTAL
1	Congenital Anomalies (4,473)	Unintentional Injury (1,226)	Unintentional Injury (734)	Unintentional Injury (692)	Unintentional Injury (12,044)	Unintentional Injury (26,614)	Unintentional Injury (22,667)	Malignant Neoplasms (37,301)	Malignant Neoplasms (113,947)	Heart Disease (526,509)	Heart Disease (655,381)
2	Short Gestation (3,679)	Congenital Anomalies (384)	Malignant Neoplasms (393)	Suicide (596)	Suicide (6,211)	Suicide (8,020)	Malignant Neoplasms (10,640)	Heart Disease (32,220)	Heart Disease (81,042)	Malignant Neoplasms (431,102)	Malignant Neoplasms (599,274)
3	Maternal Pregnancy Comp. (1,358)	Homicide (353)	Congenital Anomalies (201)	Malignant Neoplasms (450)	Homicide (4,607)	Homicide (5,234)	Heart Disease (10,532)	Unintentional Injury (23,056)	Unintentional Injury (23,693)	Chronic Low Respiratory Disease (135,560)	Unintentional Injury (167,127)
4	SIDS (1,334)	Malignant Neoplasms (326)	Homicide (121)	Congenital Anomalies (172)	Malignant Neoplasms (1,371)	Malignant Neoplasms (3,684)	Suicide (7,521)	Suicide (8,345)	Chronic Low Respiratory Disease (18,804)	Cerebro-vascular (127,244)	Chronic Low Respiratory Disease (159,486)
5	Unintentional Injury (1,168)	Influenza & Pneumonia (122)	Influenza & Pneumonia (71)	Homicide (168)	Heart Disease (905)	Heart Disease (3,561)	Homicide (3,304)	Liver Disease (8,157)	Diabetes Mellitus (14,941)	Alzheimer's Disease (120,658)	Cerebro-vascular (147,810)
6	Placenta Cord. Membranes (724)	Heart Disease (115)	Chronic Low. Respiratory Disease (68)	Heart Disease (101)	Congenital Anomalies (354)	Liver Disease (1,008)	Liver Disease (3,108)	Diabetes Mellitus (6,414)	Liver Disease (13,945)	Diabetes Mellitus (60,182)	Alzheimer's Disease (122,019)
7	Bacterial Sepsis (579)	Perinatal Period (62)	Heart Disease (68)	Chronic Low Respiratory Disease (64)	Diabetes Mellitus (246)	Diabetes Mellitus (837)	Diabetes Mellitus (2,282)	Cerebro-vascular (5,128)	Cerebro-vascular (12,789)	Unintentional Injury (57,213)	Diabetes Mellitus (84,946)
8	Circulatory System Disease (428)	Septicemia (54)	Cerebro-vascular (34)	Cerebro-vascular (54)	Influenza & Pneumonia (200)	Cerebro-vascular (567)	Cerebro-vascular (1,704)	Chronic Low Respiratory Disease (3,807)	Suicide (8,540)	Influenza & Pneumonia (48,888)	Influenza & Pneumonia (59,120)
9	Respiratory Distress (390)	Chronic Low. Respiratory Disease (50)	Septicemia (34)	Influenza & Pneumonia (51)	Chronic Low Respiratory Disease (165)	HIV (482)	Influenza & Pneumonia (956)	Septicemia (2,390)	Septicemia (5,956)	Nephritis (42,232)	Nephritis (51,386)
10	Neonatal Hemorrhage (375)	Cerebro-vascular (43)	Benign Neoplasms (19)	Benign Neoplasms (30)	Complicated Pregnancy (151)	Influenza & Pneumonia (457)	Septicemia (829)	Influenza & Pneumonia (2,339)	Influenza & Pneumonia (5,858)	Parkinson's Disease (32,988)	Suicide (48,344)

Data Source: National Vital Statistics System, National Center for Health Statistics, CDC
Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™

(Centers for Disease Control and Prevention, 2020)

Here you can see that suicide deaths exceed homicide deaths across age groups. Also, even though suicide is not listed in the 65 and up age group, this does not mean it is not a significant concern. This age group has other causes in the leading causes of death. Yet, suicide is still a significant concern in the older age group.

- Suicide deaths are a significant concern in Indigenous communities. Data show deaths in Indigenous populations occur more in the younger age groups. Youth aged 10–24 years accounted for 35.7% of AI/AN suicide deaths (9.8% aged 10–17 years, 25.9% aged 18–24 years). In comparison, 11.1% of suicides among Whites were in persons aged 10–24 years (2.5% aged 10–17 years, 8.6% aged 18–24 years). Almost 70 % of AI/AN decedents resided in nonmetropolitan areas, whereas most White decedents (over 70%) resided in metropolitan areas (Leavitt, et al., 2018).
  - When considering suicide-related data, it is also important to remember that there are millions of people who struggle with suicidal thoughts who will experience recovery and not go on to die by suicide.
  - Most people who think about suicide do not attempt suicide.
  - Men die by suicide more due to several factors, including their tendency to use more lethal means (e.g., increased use of firearms) and because of traditional masculinity values that translate into a lesser likelihood that they will access social support and/or treatment.
  - Data from the National Transgender Discrimination Survey indicate an increased risk for suicidal thinking and behaviors for transgender and gender diverse individuals (James, et al., 2016).
  - Lesbian, gay, and bisexual adults are at greater risk for suicide attempts than the general population (SPRC, 2012).
- Often, when we think of suicide, we don't think of younger children. Yet, young children can think about, attempt, and die by suicide. As we will discuss in detail later, abuse, trauma, and victimization can play a role in increasing the suicide risk. The suicide rate for Black children is twice as high as White children for ages 5–12 (Bridge, et al., 2018). Additionally, from 1991 to 2017, the rate of reported suicide attempts rose, especially among Black adolescent males (Lindsey et al., 2019).
- Native youth living on reservations are at a significantly higher risk for suicide and suicidal behavior, with lifetime rates of suicide and suicidal ideation much higher than the general population and American Indian or Alaskan Native youth in urban areas (Leavitt et al., 2018).
- First, let us remember that we are focusing on data regarding the intersection of victimization and suicide risk. Many people who experience victimization will experience recovery and healing, and they will thrive. Most will not think about, attempt, or die by suicide. Especially with trauma-informed approaches, survivors can be empowered and rebuild a sense of control.

- For clarity, let's define terms. The word *victim* is used to describe a person who suffers direct or threatened physical, emotional, or financial harm as a result of an act by someone else, which is a crime. This does not necessarily equate to trauma. *Trauma* relates more to the emotional and psychological response that can be related to victimization and other distressing experiences.
- There are many studies with data showing a connection between victimization and suicide risk or mental health concerns. Many of us know this and see this from our own experiences and training.
- We would be talking about statistics for this entire training if we included all the research regarding crime victims and trauma and increased likelihood of mental disorders, symptoms, and substance use. It is important to understand the research and data and keep it in mind as you look for warning signs and risk factors for suicide.

Warning Signs

Introduction

In this section, we will first cover what warning signs are and then review the warning signs.

- It can help to think of warning signs in two tiers. In the first tier are warning signs of acute risk. These are signs that we have to act immediately. Think of these as an alarm, similar to a fire alarm. If the fire alarm went off right now, we would act immediately to get ourselves to safety. The second tier includes warning signs that might indicate a suicidal crisis yet need further exploration. If we use the analogy with fire, think of these signs as smelling smoke. If we smelled smoke, it could be coming from different sources: someone could have lit a candle, there could be a barbecue outside, or it could be indicative of the start of a fire.
- We would need to investigate to find out. All warning signs need to be taken seriously and explored further.

Objectives

Participants will:

- Be able to name the main signs of suicidal thoughts and behavior across the life span

Key Points

H.O.P.E. Saves Lives


Look for Hints


Ask Openly about suicide


Validate Pain


Explore reasons to live and plan to stay safe

H.O.P.E. stands for:

- **Look for Hints** means look for the warning signs. These are hints that a person is struggling.
- **Ask Openly about suicide** – It is our role to delve deeper into difficult topics.
- **Validate Pain** – We need to meet people where they are at, in their pain, before we shift to response and safety.
- **Explore reasons to live and plan to stay safe** – Similar to what you do for creating a safety plan in regard to violence, it is important to create a safety plan specific to suicide, including eliciting reasons to live.

» We will focus on looking for hints now. If we are not attentive to these warning signs, we might miss them.

» Warning signs or hints of acute risk are signs of short-term or immediate risk. These hints need to be addressed for the safety of the victim as soon as possible:

- Talking about wanting to die or to kill oneself:
  - Talking about wanting to kill oneself can include many different statements. Some statements include "I'm going to kill myself" or "I would rather be dead and just might do something to get there" or "If such and such doesn't happen, I will kill myself."
- Looking for a way to kill oneself, such as searching online or obtaining a gun
- Talking about feeling hopeless or having no reason to live (SPRC, n.d.)

» Warning signs of suicide risk include additional hints that a victim may be at risk. These signs are like the smoke. You see them, and you need to explore further to determine if the person is at risk for suicidal behaviors.

- Warning signs of suicide risk include (SPRC, n.d.; American Foundation for Suicide Prevention, 2020):
  - Talking about feeling trapped or in unbearable pain
  - Talking about being a burden to others
  - Increasing the use of alcohol or drugs
  - Acting anxious or agitated; behaving recklessly
  - Sleeping too little or too much
  - Withdrawing or feeling isolated
  - Showing rage or talking about seeking revenge
  - Displaying extreme mood swings
- There are individual and cultural differences in the expression of distress and warning signs:
  - For instance, a military service member or a veteran may be less likely to directly disclose suicidal thinking. They may be more likely to discuss feeling trapped or like a burden, increase substance use, and have changes in mood or sleep.
  - In some native communities, talking about suicide could be an offense to spiritual traditions or to ancestors. Therefore, direct communication about suicide may be more difficult.
  - Certain spiritual beliefs and practices highly restrict the use of alcohol or other drugs. For an individual who practices these beliefs, the use of alcohol or drugs even in a very small amount could be a serious warning sign.
  - For cultures that emphasize the group over the individual, the perception of being a burden to others or shaming the family could be a very serious sign of suicide risk.
- It is important to consider the individual, their culture, and any dynamics that might impact their communication of warning signs. Imagine a crime victim who is gay and has a physical disability. Imagine if this person is used to hiding his sexuality and consistently working so others see him as capable, strong, confident, and independent. This person may not show what we might think of as warning signs for suicide risk. It is possible that hiding more, doing even more to show what is perceived as strength, and holding in any signs of difficulty or challenge may be signs of a struggle.
- We encourage you to learn more about the groups you will be working with and keep this in mind during day-to-day interactions.

Video and Reflection

» Using **Worksheet 2A: Signs and Symptoms**, write down any warning signs, including direct quotes, you notice while watching the video: https://www.youtube.com/watch?v=AgxrxlaeL7I.

» Reflect on these questions following the video:

- What warning signs for suicide did you identify?
- Tying back to managing your reactions, if you were working with a person who said, "To hell with this, I'm gone," consider if you would identify this as a suicidal statement.

» How might this type of a statement be heard differently by well-intentioned and well-educated helpers?

Worksheet 2A: Signs and Symptoms

When looking for signs and symptoms of suicide, you can use the mnemonic device "IS PATH WARM?"

Suicidal **I**deation	
Substance abuse	
Purposelessness	
Anxiety	
Feeling **T**rapped	
Hopelessness	
Withdrawal	
Anger	
Recklessness	
Mood changes	

Risk Factors

Introduction

At the end of this section, Handout 2B has a general list of warning signs, precipitating factors, risk and protective factors, and risk and protective factors for specific populations.

Objectives

Participants will:

- Be able to name the most common risk factors for suicide

Key Points

Precipitating factors are events or situations in a person's life that can trigger a suicidal crisis. This list of precipitating factors from the Suicide Prevention Resource Center is summarized from research:

- End of a relationship or serious relationship problems
- Death of a loved one
- Legal problems
- Serious financial problems (SPRC, 2020a)

You can see how a crime victim may have several of these, especially if the person has to engage a lawyer, move, or take additional steps for protection that could be costly, or if the person also has challenges working. These precipitating factors may be even more intense for someone with intersectional identities.

Risk factors are characteristics of a person or their environment that increase the likelihood that they could die by suicide. This is similar to a family history of heart disease as a risk factor for a heart attack. Some of these risk factors, such as lack of access to health care or access to lethal means, may be modifiable. Often, risk factors are not modifiable, such as a prior suicide attempt. It is important to know these risk factors and to keep them in mind. We can think of risk factors like a threshold for concern. The more risk factors, the lower that threshold might be. As a result, we might use a more immediate response to connect that person with treatment and support even if they have denied any suicidal thinking or are showing only a couple of warning signs. Combine a recent victimization with risk factors and warning signs, and you can see how a person may be at significant risk. Risk does not equal prediction. Similar to suicide risk, there are many people at risk for a heart attack who will never experience a heart attack.

Risk factors include:

- Prior suicide attempt(s)
- History of abuse
- Misuse of alcohol or other drugs
- Mental disorders, particularly depression and other mood disorders
- Access to lethal means
- Knowing someone who died by suicide, particularly a family member
- Social isolation
- Chronic disease and disability
- Lack of access to behavioral health care (American Foundation for Suicide Prevention, 2020; SPRC, 2020a)

Risk factors can vary for individuals and groups. This training would be much longer if we reviewed all groups and all possible risk factors. These are a few things to consider for certain populations. As with the warning signs earlier, it is important to know any particular risk factors in the groups you are working with.

Protective factors are characteristics that might keep a person from thinking about or attempting suicide. Protective factors include:

- Being a parent
- Effective behavioral health care
- Connectedness to individuals, family, community, and social institutions
- Life skills (including problem-solving skills and coping skills, ability to adapt to change)
- Self-esteem
- Sense of purpose or meaning in life
- Cultural, religious, or personal beliefs that discourage suicide (SPRC, 2020a)
- For crime victims, children may serve as a risk or a protective factor. Consider a victim that firmly believes her children need her and, therefore, would not act on suicidal thoughts. She may believe she does not want to add more trauma to her children's lives and wants to live for them. Now, consider if an abusive ex-partner talks about or tries to hurt the children to get back at the victim. In this situation, the victim may be more likely to think about or even attempt suicide as a way to protect the children from harm.
- Knowing the risk factors for suicide, it might make sense that some of these protective factors are opposites of those risk factors.

» A key strategy in assisting a person at risk for suicide is to increase protective factors and decrease risk factors. This is similar to increasing coping and life skills and decreasing unhealthy coping responses that might display as warning signs.

Handout 2B: Warning Signs, Precipitating Factors, Risk Factors, and Protective Factors

Warning Signs

Immediate Risk

The following three behaviors indicate that immediate action and support is needed through a crisis response or by contacting a mental health professional:

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself, such as searching online or obtaining a gun
- Talking about feeling hopeless or having no reason to live

Serious Risk

Other behaviors may also indicate a serious risk—especially if the behavior is new, has increased, and/or seems related to a painful or traumatic event, loss, or change:

- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

Precipitating Factors

Precipitating factors are stressful events that can trigger a suicidal crisis in a vulnerable person. Examples include:

- End of a relationship or marriage
- Death of a loved one
- An arrest
- Serious financial problems

Risk Factors

Risk factors are characteristics of a person or their environment that increase the likelihood that they will die by suicide (i.e., suicide risk).

Major risk factors for suicide include the following:

- Prior suicide attempt(s)
- Misuse and abuse of alcohol or other drugs
- Mental disorders, particularly depression and other mood disorders
- Access to lethal means
- Knowing someone who died by suicide, particularly a family member
- Social isolation
- Chronic disease and disability
- Lack of access to behavioral health care

Risk Factors for Specific Populations

Risk factors can vary by age group, culture, sex, and other characteristics. For example:

- Stress resulting from prejudice and discrimination (family rejection, bullying, violence) is a known risk factor for suicide attempts among lesbian, gay, bisexual, and transgender (LGBT) youth.
- The historical trauma suffered by American Indians and Alaska Natives (resettlement, destruction of cultures and economies) contributes to the high suicide rate in this population.
- For men in the middle years, stressors that challenge traditional male roles, such as unemployment and divorce, have been identified as important risk factors.

Protective Factors

Protective factors are personal or environmental characteristics that help protect people from suicide.

Major protective factors for suicide include the following:

- Effective behavioral health care
- Connectedness to individuals, family, community, and social institutions
- Life skills (including problem-solving skills and coping skills, ability to adapt to change)
- Self-esteem and a sense of purpose or meaning in life
- Cultural, religious, or personal beliefs that discourage suicide

Hopelessness

Introduction

- Hope can be a significant factor in contributing to a crime victim's will to live. It is key to identify hopefulness and hopelessness.
- This section will focus on the importance of drawing out a person's level of hope, paying attention to factors which might contribute to changes in hopelessness, and ways to ask about hopelessness.
- It is important to remember that hope is more than future orientation. A person can have plans or thoughts about the future, this does not mean that they have hope about those plans.

Objectives

Participants will:

- Be able to identify hopelessness as a key risk factor for suicide

Activity

- First, you will watch a short video of a young person talking about her experience with a suicide attempt. Fortunately, she is able to make this video and share her experience.
- **Video:** ***Billingsley Teen Talks about Suicide Attempt*** (start at 0:16; stop at around 1:28/1:30; 1 minute, 30 seconds): https://www.youtube.com/watch?v=ElKqvfyMQ4k.
- Please take note of a particular comment in this video: "I felt useless and hopeless." Madison shares this after an abusive relationship, states she felt like she couldn't talk to anybody, and that no one knew what was going on with her. Hopelessness can be a significant driver for some persons to contemplate and potentially attempt suicide.
- Let's brainstorm ways to identify hope, hopelessness, and hopefulness.
- **Reflection:** Consider these questions and write down:
  - What are some questions you can ask to identify levels of hope? Hopelessness? Hopefulness?

  - What are behaviors and nonverbal communications that you look for to know if a person is feeling hopeless?
- Social isolation often goes hand in hand with hopelessness. Referring back to the young woman in the video, her story could have been different if she had felt like she had someone to talk to that would understand.
- These are some ideas for identifying the intensity of hopelessness. It is best if you ask these questions once a rapport has been established:
  - On a scale of 1–10, with 10 being so hopeless it feels like you can't go on, where would you say you are right now?
  - When was the last time you felt like you were closer to a 1 on this scale?
  - What do you want to happen that would feel like there would be some hope?

Conclusion

Introduction

We have reviewed data related to suicide and the intersection with crime victims, warning signs, risk factors, protective factors, precipitating events, and hopelessness. Now, let's bring it all together.

Key Points

- As with violence prevention, one cannot predict when and how someone might attempt or die by suicide. All these factors come together in our planning and in our response. The purpose of learning about suicide prevention is not prediction but planning.
- Since triggering events can be sudden, it is important to look for hints and plan for safety.
- A study conducted in 2016 by several researchers at Harvard found that the median onset for certainty about the place to attempt a suicide was 30 minutes prior to the attempt, and the median time for the final decision to attempt a suicide was 5 minutes before the attempt (Millner et al., 2016). We may not be able to predict when someone might act on suicidal thoughts. Yet, we can increase our awareness to see the hints, mutually work to develop safety plans, and improve support that can be available at a time of crisis.

For background, review the study "Describing and Measuring the Pathway to Suicide Attempts: A Preliminary Study" at https://nocklab.fas.harvard.edu/files/nocklab/files/millner_2016_pathway_suicideattempts_sltb.pdf.

In the next section, we will discuss the scope of your role. Your role is a recovery-oriented, strengths-based one. It is not your role to talk someone out of suicide. With an understanding of the suicidal crisis and the impact of trauma, typically, there is not one line we can say to someone who is struggling that will pull them out of a suicidal crisis, although we may wish this were the case. Then, we will discuss the approach to listening and responding which is most helpful to those who struggle with suicidal thoughts and behaviors.

Optional Guided Meditation

Introduction

Take a few minutes, now, to step away from the material we have been discussing and give yourself a mental break. Read the text below and take a few minutes to engage in a brief meditation exercise called "Leaves on a Stream."

"Leaves on a Stream" Exercise (Harris, 2009)

1. Sit in a comfortable position and either close your eyes or rest them gently on a fixed spot in the room.
2. Visualize yourself sitting beside a gently flowing stream with leaves floating along the surface of the water. Pause 10 seconds.
3. For the next few minutes, take each thought that enters your mind and place it on a leaf... let it float by. Do this with each thought—pleasurable, painful, or neutral. Even if you have joyous or enthusiastic thoughts, place them on a leaf and let them float by.
4. If your thoughts momentarily stop, continue to watch the stream. Sooner or later, your thoughts will start up again. Pause 20 seconds.
5. Allow the stream to flow at its own pace. Don't try to speed it up and rush your thoughts along. You're not trying to rush the leaves along or "get rid" of your thoughts. You are allowing them to come and go at their own pace.
6. If your mind says, "This is dumb," "I'm bored," or "I'm not doing this right," place those thoughts on leaves, too, and let them pass. Pause 20 seconds.
7. If a leaf gets stuck, allow it to hang around until it's ready to float by. If the thought comes up again, watch it float by another time. Pause 20 seconds.

8. If a difficult or painful feeling arises, simply acknowledge it. Say to yourself, "I notice myself having a feeling of boredom/impatience/ frustration." Place those thoughts on leaves and allow them float along.

9. From time to time, your thoughts may hook you and distract you from being fully present in this exercise. This is normal. As soon as you realize that you have become sidetracked, gently bring your attention back to the visualization exercise.

Module 3:
Listen and Recognize

Look for Hints

Ask Openly about suicide

Validate Pain

Explore reasons to live and plan to stay safe

H.O.P.E. saves lives

Module 3 Overview

Topics Covered

- How and what to listen for regarding suicide risk
- Asking openly about suicide using skilled questions
- Common trajectories to suicide among crime victims

Learning Objectives

In Module 3, participants will:

- Recognize the scope of their role when working with an individual at risk for suicide
- Develop confidence to respond with both indirect and direct methods to explore suicide risk
- Be able to effectively elicit key warning signs of suicide
- Be able to identify subtle references to feelings of hopelessness and burdensomeness

Materials

- **Handout 3A:** Vignettes
- **Handout 3B:** Columbia-Suicide Severity Rating Scale
- **Handout 3C:** Role-Plays

Your Role as a Responder

Introduction

- This section moves from a focus on what to look for and begins to add how to actively listen, identify, and respond.
- Active and intentional listening for warning signs and using skilled questions are key to our role of identifying if a victim is at risk. It is especially important to use active listening and to match the victim in their style and manner of communication when someone has experienced a traumatic experience, like a violent crime. There can be many barriers to reporting a crime for some individuals, groups, and communities, such as minority, immigrant, Native, and lesbian, gay, bisexual, transgender, transsexual, queer, questioning, and two-spirit (LGBTQ2S) communities. We will outline what to listen for, how to ask skilled questions, and how to respond so as to potentially interrupt a path toward suicidal behaviors.

Objectives

Participants will:

- Recognize the scope of their role when working with an individual at risk for suicide
- Be able to identify subtle references to feelings of hopelessness and burdensomeness
- Be able to effectively elicit key warning signs of suicide
- Develop confidence to respond with both indirect and direct methods to explore suicide risk

Key Points

- As we go through this section, it is important to remember our roles and to have clear expectations of the advocate's core responsibility with suicide prevention: to identify risk, not to assess and treat.
- If someone seems to be in need of CPR, what is the first thing you do? Then, what are a few next steps? Let's think of this situation as similar to the fire alarm example that we discussed earlier. A person who might be in cardiac arrest is the highest level of concern, just like a fire alarm going off or seeing a fire.
- What about a person who is complaining of shortness of breath? What else would you want to know?

- It is your role as a trained responder to identify the hints and ask more questions to determine the appropriate response. Then, to initiate this response. It is not your role to treat a heart attack, install a stent, and perform cardiac rehab. Nor is it your role to determine the level of risk. Is it really a heart attack? A panic attack? Once you see the signs, the assessment by a trained medical professional is urgently indicated. Your role is to identify, support, and help a person remain safe and connect to treatment. Similarly, in victims' services, your role is supportive and empowering with an emphasis on safety.

Listen and Recognize

Objectives

Participants will:

- Be able to identify subtle references to feelings of hopelessness and burdensomeness
- Be able to effectively identify key warning signs of suicide

Key Points

- Review and practice look for hints

H.O.P.E. Saves Lives

Look for Hints

Ask Openly about suicide

Validate Pain

Explore reasons to live and plan to stay safe

Activity

- Please read over a vignette in **Worksheet 3A: Vignettes** using a different vignette than you read in Module 1. Make note of hints of suicide risk you identify in the vignette and pay particular attention to recognizing warning signs.

» Write down anything that may provide a hint someone is at risk for suicide, such as:
  - Warning signs
  - Risk factors
  - Precipitating factors
  - Hopelessness
  - Burdensomeness
  - Purposelessness

Worksheet 3A: Vignettes

A. Lena is a 34-year-old single mom since having recently left a violent relationship. She works two jobs but barely has enough money to make ends meet. She loves her daughter Noelle but feels like she is failing as a mom because she cannot provide for her. On top of this, she lives in fear that her abusive ex-husband will find her, and she starts crying and says she can't keep Noelle safe by moving somewhere else. As you talk to Lena about this fear, she says, "I just can't do it anymore. I can't live like this." When you ask her if she is considering suicide, she says, "Yes," and that she plans to shoot herself with the gun she bought to protect herself from her ex-husband. You ask what would happen to Noelle if she killed herself. She responds, "I don't know. I love her, but I can't take this anymore. I am a terrible mother anyway. She would be better off without me."

B. Jade is experiencing suicidal thoughts. You have been working with her for about a year. During this time, you have helped her find transportation, counseling appointments, and other resources. Whenever you see her, she is unhappy to be there and says it doesn't matter because life is pointless anyway. Today you are discussing her upcoming court date to testify against the woman who sexually assaulted her. Jade seems annoyed and uninterested in the conversation. She says, "I don't see why we are even doing this. Nobody is going to believe me. Even if they do, that memory is still going to be in my head forever. She ruined everything. My life is a mess. I don't know why I even bother. I should just end it."

C. You are meeting with your client Harold, a 17-year-old member of a Native American nation. He reveals that his friend killed herself last week; the third person he has lost to suicide in the past two years. You also know he has a history of child sexual abuse from a family member. He says, "It just keeps happening. I don't think I can handle any more. It's too much—the suicides, the abuse, constantly fighting for our rights and land." When you ask him what strategies he is using to cope, he answers, "I don't know. Nothing, really. I just keep going through the motions, but I feel heavy and empty inside. Nobody will talk about it. Nobody lets you talk about the bad things, so they keep happening." You ask how it makes him feel that his community isn't discussing suicide or sexual abuse. He says, "Abandoned, lost. Sometimes I think, maybe they had the right idea—getting out."

D. Your client Albert is an 82-year-old man who has lived alone since he lost his wife Helen a few years ago. You came to know Albert a year ago when he was experiencing elder abuse from his home health aide. Recently, he's been dealing with a number of health issues, including arthritis and diabetes. These chronic illnesses make his day-to-day life difficult, and he has had to go to the hospital often. When you ask him about sources of support in his life, he quips, "Well the mail lady is very nice. Always brings me my bills. Best friend I got!" He mentioned in a previous session that he had children, so you ask him if he gets any help from them. He says, "No, they haven't talked to me in years. Who wants to hang around an old man like me?" He laughs. "Nope, don't have nobody here anymore. Sometimes I think I should just get it over with and go see Helen. Hopefully she hasn't forgotten about me up there!"

» Write down anything that may provide a hint someone is at risk for suicide, such as:

- Warning signs
- Risk factors
- Precipitating factors
- Hopelessness
- Burdensomeness
- Purposelessness

Key Points

- As we look for hints, we need to **ask openly** about suicide to determine if a person is at risk for suicide. This helps us get more information so we know how to support the victim. By doing so, we can start to offer hope, and we know that hope saves lives.

  H.O.P.E. Saves Lives

  
  Look for Hints

  
  Ask Openly about suicide

  
  Validate Pain

  
  Explore reasons to live and plan to stay safe

- Indirect questions focus on understanding the context of factors that are closely linked to suicide for most people, including whether they feel hopeless, feel as though they are a burden to others, think their loved ones would be better off without them, etc.
- Examples of indirect questions:
  - Have you wished you were dead?
  - Have you wished you could go to sleep and not wake up?
  - Do you wish you could go away and never come back?
  - Have you had thoughts of harming yourself?
  - Do you feel like you are a burden to others?
- Direct questions specifically ask about the person's wish to die or plans to end their lives.
- Each of these questions will likely result in unique responses, giving you different information. For instance, a positive answer to "Do you feel like you are a burden to others?" will provide you with a significant sign. Yet, it doesn't directly ask the person if they wish they were dead.
- It is important to know if a person is thinking of harming themselves.
- Consider the difference between asking if a person has had thoughts of harming themselves and asking directly about suicide.
  - A person might say no to harming themselves but yes to more direct questions about suicide.
- A key resource for asking direct questions about suicide is the Columbia-Suicide Severity Rating Scale (C-SSRS). It is a standard, validated tool using plain language questions that anyone can ask.

The C-SSRS was developed by Columbia University, the University of Pennsylvania, and the University of Pittsburgh—supported by the National Institute of Mental Health (NIMH)—as a tool for a 2007 NIMH study. The C-SSRS is based on more than 20 years of scientific study and has helped to fill a gap in the field: to uniformly and reliably identify people who are at risk. The C-SSRS achieves accurate and comparable results by using consistent, well-defined, and science-based terminology. The Columbia Lighthouse Project website has resources, research, toolkits, and videos to assist with the use of the C-SSRS.

- The C-SSRS captures both suicidal thoughts and suicidal behaviors, allows a quicker crisis response, and reduces the burden of unnecessary steps. Using a standard screening tool enables clearer terminology across advocates and systems.
- There are multiple resources with the C-SSRS. You can find the screening versions and assessment versions on the C-SSRS website: the Columbia Lighthouse Project. We will be focusing on the Screener – Recent version. There are versions of the C-SSRS for screening frequently at every contact and for specific populations, such as younger children.
- The C-SSRS defines terms related to suicide risk. As with all our work, it is essential to consider culture and context with language. For instance, Native American cultures may use different terminology for terms related to suicide and suicidal behavior.
- Let us review the terms as they are defined in the C-SSRS:

  Suicidal ideation: Thinking about killing oneself (Columbia Lighthouse Project, 2016).

  Suicide attempt: A potentially self-injurious act committed with at least some wish to die as a result of the act. Behavior was in part thought of as a method to kill oneself. Intent does not have to be 100%. If there is any intent/desire to die associated with the act, then it can be considered a suicide attempt. There does not have to be any injury or harm, just the potential for injury or harm. If a person pulls the trigger while the gun is in their mouth, but the gun is broken so no injury results, this is still considered an attempt (Columbia Lighthouse Project, 2016).

  - **Inferring intent:** Even if an individual denies the intent/wish to die, it may be inferred from the behavior or circumstances; for example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., a gunshot to the head, jumping from the window of a high story in a building). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred (Columbia Lighthouse Project, 2016).
  - **Interrupted attempt:** When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (if not for the interruption, an actual attempt would have occurred). This includes when a person has pills in hand but is stopped from ingesting. Once they ingest any pills, the act becomes an attempt rather than an interrupted attempt. However, if a

person is poised to jump, but is grabbed and taken down from ledge, the act is an interrupted attempt (Columbia Lighthouse Project, 2016).

- **Aborted or self-interrupted attempt:** When a person begins to take steps toward making a suicide attempt but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops themselves, instead of being stopped by something or someone else (Columbia Lighthouse Project, 2016).

Preparatory acts or behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as obtaining a specific method or preparing for one's death by suicide such as writing a suicide note (Columbia Lighthouse Project, 2016).

When you look for hints and see the need to ask openly about suicide, the C-SSRS, referenced in **Handout 3B: Columbia-Suicide Severity Rating Scale**, can be used to help you ask directly.

Handout 3B: Columbia-Suicide Severity Rating Scale—Screen Version, Recent (The Columbia Lighthouse Project, 2016)

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask questions 1 and 2		
1. Have you wished you were dead or wished you could go to sleep and not wake up?	○	○
2. Have you had any actual thoughts of killing yourself?	○	○
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3. Have you been thinking about how you might do this? 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."	○	○
4. Have you had these thoughts and had some intention of acting on them? As opposed to "I have the thoughts but I definitely will not do anything about them."	○	○
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	○	○
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	○	○
If YES, ask: Was this within the past three months?	○	○

- Low Risk
- Moderate Risk
- High Risk

- Notice, we are asking about suicidal ideation and suicidal behavior with all persons. What we know is that sometimes people in crisis might say they did not want to kill themselves or might deny suicidal thinking, yet they have engaged in some suicidal behavior in the recent past. This tool is useful to ask about both ideation and behavior, which is key information when supporting a crime victim.
- When using this scale and terminology, it is important to consider age, developmental level, culture, or any language barriers. Overall, these questions are good to use with persons aged 12 and up.
- **Reflection:** What are your concerns in asking directly about suicide? What would prevent you from doing this?
- Common responses include the following:
  - Fear that they may make the person think about suicide.
    - Research shows that people at risk feel relief that they have been asked directly, and asking directly does not increase the likelihood a person will think about suicide.
  - What if they say no?
    - Connect to what you have been talking about:
      - "It is good to hear that you feel you have a good support system and don't think about suicide. Have you connected with your support system about this?"
    - Trust your instincts:
      - If warning signs and risk factors add up, it's okay to respond as if there is higher risk.
      - "I understand that right now you feel safe and aren't thinking about suicide, but I'd like to make sure you have all the support available to you since this is a really intense time in your life."
    - Connect to treatment resources:
      - "You have been dealing with some significant things and are trying to cope after being unsafe. I think connecting with counseling could help right now. I'd like to get you connected sooner rather than later."
  - What if they say yes?
    - Remember your role. You are there to listen, identify, keep clients safe, and connect them to resources. You don't have to do this alone. We will talk more about how to respond throughout the training. First, you might take a moment to center yourself, such as by taking a deep breath. Acknowledge and support their pain. Validate their pain and connect with the part of them that wants to live. Explore reasons to live and connect them to treatment.

- What if you are not sure they are being open with you?
  - It is okay to trust your gut. If you think they may still be at risk, seek consultation, collaboratively establish a safety plan, and engage in treatment.
  - In addition to the C-SSRS, it is important to use person-centered culturally appropriate language to ask direct questions about suicide. Use the client's own language and style of communicating.
- Additional direct questions include:
  - Have you felt so_____ (hopeless, ashamed, much pain) that you have thought about suicide?
  - When was the last time you thought about suicide?
  - Sometimes when a person feels _____ (intense pain, so stuck), they might think about killing themselves. Have you been thinking about suicide?

» Asking this style of questions can help to normalize these struggles. It can make it more likely for the person to give a genuine answer. By asking when the last time was the person thought about suicide, you assume they have thought about suicide. This might make it easier for the person to share suicidal thoughts.

» Now, we are going to practice with asking directly about suicide, using example scenarios in **Handout 3C: Role-Plays**. If possible, work with a colleague to role-play the scenarios provided in the text below. If it is not possible to practice right now, set an intention to practice when you are able. Take time now to read through one of the scenarios and write out how you would ask directly about suicide.

» Take about 5 minutes for each of you to role-play. Each person should ask openly about suicide in this scenario. If you are role-playing a crime victim, you can respond to being asked about suicide in any way you feel works for you.

» After you practice this exercise, discuss what went well and any difficulties or challenges. It is important to get to direct questions to ensure you understand the level of risk facing your client.

Handout 3C: Role-Plays

The person role-playing the crime victim: Read the scenario to yourself. You can give the person acting as the advocate a little bit of background such as your age and what recently happened. Then, say the statement at the end of the scenario to start the role-play.

Scenario 1

You are a 24-year-old who has recently experienced physical and sexual assault. You have experienced trauma in your childhood home in the past, have often used substances to cope, and feel as if you have very limited supports. It seems best for you to move for your safety and mental health, but you feel like you don't have any options, and you don't want to move back to your family of origin's home. You have started to use more often to cope with the symptoms of the acute stress response and the many triggers you experience throughout the day. You tell the advocate, "I just don't feel like I have any options. I don't know how to recover from this, and I am not sure it is even worth me trying. Maybe it would be best if I just didn't even bother and waste your time."

Scenario 2

You are a 72-year-old who has recently experienced elder abuse by your child, and you have connected with the victim advocate. You feel like a failure, as if you haven't raised your child well and have failed at helping him to be successful in life. You blame yourself for the recent violence. You feel guilty, ashamed, helpless, and hopeless. While you have supportive family and friends, you don't feel like you can reach out to any of them or talk to them about this because you feel too ashamed. You don't see the situation as improving, don't feel like you can cut off your child from your life, and don't think the advocate can help you. You state "Things can't get any worse. I think I would be better off dead."

Common Trajectories

Introduction

In addition to understanding data, signs, factors, and responding, it is helpful to understand some common trajectories in crime victim populations. We will review common paths to suicidal behavior. As with most things in our field, individual variations can occur, and these paths are not representative of every possible trajectory.

Objectives

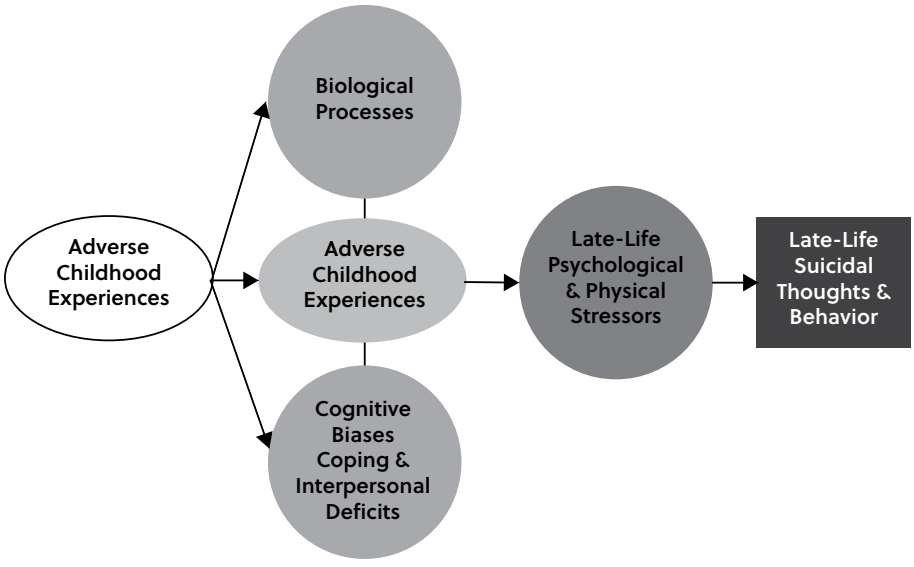
Participants will:

- Be able to identify common trajectories to suicide in crime victim populations

Key Points

- Several factors can be common in a person's path toward a suicide attempt.
- Adverse childhood experiences can affect biological factors, psychiatric and health functioning, and psychosocial development across the lifespan. The interaction of these factors with later-life stressors can lead to suicidal thoughts and behaviors in later life. There are multiple pathways towards suicidal thoughts and behaviors. Yet, we know that trauma, including the varied impacts of ACEs persist, thus, effecting suicide risk throughout the lifespan and into late life (Sachs-Ericsson et al., 2015).

Developmental Trajectories (Sachs-Ericsson et al, 2015)



- We referenced a study by Millner, Lee, and Nock (2016) earlier, which found that onset of ideation and selection of method may occur years prior to a suicide attempt. Yet, the majority of pathway steps to a suicide attempt happen very quickly. Two of the quickest steps are planning and making the decision to attempt. Approximately two-thirds of those who attempted suicide in this study reported planning steps towards their attempt happened in 12 hours (Millner et al., 2016).
- We cannot predict the if, when, and how of a suicide attempt. But we can respond in a timely manner to support a person in crisis and help prevent an attempt. When thinking about responding, it is not your role to judge or assess if a person might attempt. Keep in mind that suicidal thinking can occur for years before an attempt, or it can occur the week and even hours before an attempt. Suicide risk assessment is key to determining if someone is at risk. Your role as an advocate is to identify, support, and connect to a mental health professional for this assessment and treatment.

Conclusion

Key Points

- It is essential to recognize hints, ask openly about suicide, and stay within the scope of your role.

Module 4:
Respond and Transition

Look for Hints

Ask Openly about suicide

Validate Pain

Explore reasons to live and plan to stay safe

H.O.P.E. saves lives

Module 4 Overview

Topics Covered

- Safer suicide triage
- Responding to a person at risk for suicide

Learning Objectives

In Module 4, participants will:

- Build confidence to respond to persons at risk and connect with resources
- Develop ability to respond with both indirect and direct methods to explore suicide risk and connect with resources
- Increase awareness of the types of evidence-based interventions available for suicide to be able to describe options to clients
- Develop a framework for transitioning clients to the next level of care

Materials

- **Handout 4A:** Columbia-Suicide Severity Rating Scale – Screen with Triage Points for Victim Advocates
- **Handout 4B:** Resources
- **Worksheet 4C:** Patient Safety Plan Template
- **Worksheet 4D:** Mental Health Supports

Introduction

Introduction

- This section covers the response needed from the advocate after a person has been identified at risk.
- Now that we have discussed managing our own reactions, hints to look for, and how to ask openly about suicide, let's talk about ways to respond when working with a person that you have identified as at risk.
- We will discuss key skills and strategies in responding. Your specific role and resources in your system may allow you to do some of these things as a team. I encourage you to think about what you might do in your role and to discuss your response to the information covered in this section.

Key Points

- Develop confidence to respond to the persons at risk and connect with resources.
- Develop awareness of the types of evidence-based interventions available for suicide to be able to describe options to clients.
- Develop a framework for transitioning survivors to the next level of care.

Responding

Introduction

In this section, we will be discussing the advocate's response and suicide safer triage.

Objectives

Participants will:

- Build confidence to respond to persons at risk and connect them with resources

Key Points

» As we addressed in an earlier module, the C-SSRS is a tool that offers guidance for identifying risk of suicide. Read **Handout 4A: Columbia-Suicide Severity Rating Scale – Screen with Triage Points for Victim Advocates**. The yellow is considered lower risk, orange is moderate risk, and red is higher risk. It is essential to trust your professional judgment. If a person seems at lower risk according to the screening triage, yet your professional judgment indicates the risk is higher, you would act upon the higher risk. This is particularly true with crime victims, as there are many factors to consider, including trauma and precipitating factors related to recent victimization. No study has identified one specific risk factor as specifically predictive of suicide or suicidal behavior. Therefore, at the end of a suicide assessment, an estimation of suicide risk is based on sound judgment. It is important to keep in mind that this is guidance for responding to screening, and screening is only one part of the process. A mental health assessment is needed to do a thorough interview and determine the appropriate level of care and a treatment plan.

Handout 4A: Columbia-Suicide Severity Rating Scale – Screen with Triage Points for Victim Advocates

Ask questions that are bolded and underlined.	Past month	
Ask questions 1 and 2	**YES**	**NO**
1. Have you wished you were dead or wished you could go to sleep and not wake up?	○	○
2. Have you had any actual thoughts of killing yourself?	○	○
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3. Have you been thinking about how you might do this? 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."	○	○
4. Have you had these thoughts and had some intention of acting on them? As opposed to "I have the thoughts but I definitely will not do anything about them."	○	○
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	○	○
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**LIFETIME**	
	○	○
	PAST 3 MONTHS	
If YES, ask: Was this within the past three months?	○	○

Possible Response Protocol to C-SSRS Screening

- Item 1 Behavioral Health Referral
- Item 2 Behavioral Health Referral
- Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- Item 4 Behavioral Health Consultation and Patient Safety Precautions
- Item 5 Behavioral Health Consultation and Patient Safety Precautions
- Item 6 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions

(Columbia Lighthouse Project, 2020)

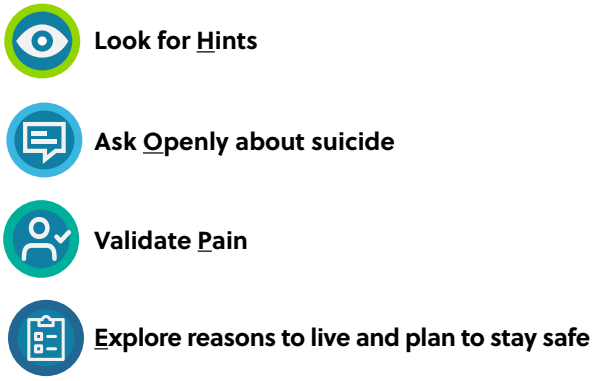
- Screening guidance:
  - Higher risk:
    - Suicidal thoughts with desire to act on it or with a plan
    - Any suicidal behavior in the past 3 months
  - Moderate risk:
    - Suicidal thoughts with no plan, desire to act on it
    - Suicidal behavior more than 3 months ago
    - Multiple risk factors and limited protections against suicide
  - Lower risk:
    - Wish to die, yet strong protections against suicide
    - Risk factors that are changeable
    - No reported history of suicidal thoughts or behavior

Understanding a judgement of levels of risk and taking actions based on them is important. For example:

- For persons who might be lower risk—remember H.O.P.E. saves lives:
  - Look for hints.
  - Ask openly about suicide.
  - Validate pain.
  - Explore reasons to live and plan to stay safe.
  - Then, make sure to help clients engage in a mental health assessment and treatment as soon as possible.
- For moderate risk:
  - Use the H.O.P.E. actions.
  - Recommend a mental health assessment within 24–48 hours.
- For higher risk:
  - Recommend a mental health assessment immediately.
- We have covered asking indirect and direct questions to explore if a victim is at risk for suicide. It is essential to ask openly about suicide. If suicidal ideation is identified, use the additional direct questions to obtain more information.
- Once you have identified risk, recommended actions include referring the person to a mental health professional to assess risk, engaging in treatment, and establishing a safety plan.

» We've looked for hints, asked openly about suicide, and now we'll focus on validating pain. Sometimes, we want to move quickly and solve the problem. But victims need to be heard. They need to know that you really understand their pain.

H.O.P.E. Saves Lives



It can be hard to know how to respond when a victim communicates that they are thinking about suicide. Often, our reactions, such as fear or insecurity about how to respond, can become our internal focus. Take a deep breath. **Validate their pain.** Communicate that you have truly understood and heard their pain. There are times this requires silence and pausing. It takes a lot of courage for clients to be vulnerable enough to share that they are experiencing so much pain that they are considering suicide. Connect with them.

Commend them for speaking up and acknowledging their suffering to another person. Validate not only the pain related to their suicidal crisis, but their experience as a victim. Then, you can offer hope and refer them to engage in treatment. For example, you might say, "Things have just been so overwhelming for you. It seems as if you really want a way out of this intense pain. Thank you for telling me how difficult things have been. I will support you through this time. You don't have to go through this alone. I think there is a way to work through this experience and gain some relief from your pain. Let's think about the part of you that wants to live and get you some support and help to decrease your pain."

These are some sample statements that you can say when communicating with a victim. It is important to connect without making overly simplified statements. These are examples, but as we all know, one line will not resolve a suicidal crisis:

» "I'm here with you and want you to get through this."

» "I know things are really hard right now and feel overwhelming."

» "I think with some help and resources we can get you support through this difficult time."

» "It sounds like you have been feeling very down and stressed. I want to make sure you get support to get you through that stress."

» As a part of the development of this training, Education Development Center asked advocates to share what they would say to victim struggling with suicidal thoughts. Take a couple minutes to watch this video: https://edc.org/hopeforadvocates. You can also share this video with others in your workplace. Think about what you would add and how you would validate pain for a person at risk for suicide.

In addition to validating pain, it is key to explore reasons to live. The person in the suicidal crisis is often ambivalent—part of them wants to live, part of them wants to die. Validating their pain lets them know you have truly heard them.

H.O.P.E. Saves Lives

Look for Hints

Ask Openly about suicide

Validate Pain

Explore reasons to live and plan to stay safe

Exploring reasons to live connects with the part of them that wants to live. This can also be a way to strengthen support and the things helping to protect them from suicide. It is important for the person struggling to know that you have heard "both sides": the part of them that wants to live and the part of them that might desire to die.

» Gently re-focusing to consider the choice of life can help to equalize emotions, remind them of choice, and open up a conversation about new types of help or support that they may not have tried or considered.

» Focus on the person's values and perspective and make linkages to areas of their life you know to be important.

» Most persons who think about suicide will not attempt or die by suicide. By using these skills, we can help victims experience recovery and healing.

After we explore and engage the part of the person that wants to live, we can begin to collaboratively **establish a safety plan**. We will be discussing the specifics of a safety plan a little later. Part of a comprehensive safety plan is engaging in a mental health assessment and treatment. This includes knowing your resources.

In **Handout 4B: Resources**, we have outlined some of the resources that you can use to create a safety net. It is best to have phone numbers and locations in your back pocket and prepared for when you need them. This could include storing them in your phone or on your computer or putting them anywhere that is accessible to you.

Handout 4B: Resources

National Suicide Prevention Lifeline National network of local crisis centers providing 24/7 free, confidential support	**Phone:** 1-800-273-8255 **For deaf/HoH:** 1-800-799-4889 via TTY **En Español:** 1-888-628-9454 **Online chat:** https://suicidepreventionlifeline.org/chat/ **Website:** https://suicidepreventionlifeline.org/
Veterans Crisis Line 24/7 free, confidential support for veterans and their loved ones (caller does not have to be registered with the VA or enrolled in VA health care.)	**Phone:** 1-800-273-8255 [Press 1] **For deaf/HoH:** 1-800-799-4889 via TTY **Text:** 838-255 **Website & online chat:** https://www.veteranscrisisline.net/
Crisis Text Line 24/7 free support from crisis counselors through text messaging	**Text:** Text HOME to 741-741 **Website:** https://www.crisistextline.org/
Man Therapy Resources about anger, stress, sadness, substance abuse, and suicide geared toward men	**Website:** http://mantherapy.org/
Local resources	Primary care provider Local psychiatric hospital Local walk-in clinic Local emergency department Local urgent care center
MY3 Suicide prevention app that allows users to add three people to talk to when in crisis, build a safety plan, and access resources	**Apple App Store:** https://itunes.apple.com/us/app/my3-suicide-lifeline/id709651264?mt=8 **Google Play:** https://play.google.com/store/apps/details?id=com.nerdery.my3 **Website:** http://my3app.org/
Now Matters Now Collection of videos that teach Dialectical Behavior Therapy (DBT) skills to address suicidality and other issues	**Website:** https://www.nowmattersnow.org/skills

Safety Planning Intervention Information about creating safety plans for those dealing with suicidal thoughts	**Website:** http://www.suicidesafetyplan.com/
The Trevor Project Free crisis line, chat, and text for LGBTQ youth (ages 13–24)	**Phone:** 1-866-488-7386 [24/7] **Text:** TREVOR to 1-202-304-1200 **Website and online chat:** https://www.thetrevorproject.org/
Trans Lifeline Hotline by and for transgender people	**Phone:** 877-565-8860 **Website:** https://www.translifeline.org/
RAINN National Sexual Assault Hotline 24/7 free, confidential support for survivors of sexual assault	**Phone:** 800-656-HOPE (4673) **Find a local service provider:** https://centers.rainn.org/ **Website and online chat:** https://rainn.org/
Love Is Respect 24/7 support for teens involved with dating abuse	**Phone:** 1-866-331-9474 Text: LOVEIS to 22522 **Website and online chat:** http://www.loveisrespect.org/
Victim Connect National hotline for crime victims	**Phone:** 1-855-4VICTIM (1-855-484-2846) Mon.–Fri.: 8:30 a.m.–7:30 p.m. **Website:** https://victimconnect.org/
National Domestic Violence Hotline 24/7 hotline for people experiencing domestic violence	**Phone:** 1-800-799-7233 **For deaf/HoH:** 1-800-787-3224 via TTY **Website:** http://www.thehotline.org/

When responding to risk, immediate referral and resources can include:

- Community mental health
- Mobile crisis
- Existing treatment provider(s)
- Emergency department
- Inpatient assessment
- Suicide prevention crisis lines:
  - Local
  - National
  - Specific populations: Veteran/military, LGBTQ
- Other crisis supports, such as RAINN and domestic violence crisis support

How do you know what the best referral is? It depends on what the problem is and the specific needs of the individual. For example, is there complex trauma, substance use issues, or immediate suicide concerns? It also depends on the person, their culture, and the situation. Knowing your resources and considering general guidance, such as that provided by the C-SSRS triage, use your judgment and consultation for what is best for the person. You can do this in collaboration with the victim and even with their support system. Collaboration is a way of empowering the victim and helping them to recover a sense of control. Healing can be facilitated through shared power and decision-making.

- We know that many of you may be in situations of responding to a person at risk in a variety of settings. For example, you can provide screening and engagement with a victim over the phone. If you are talking with someone at risk via text or email, it is important to consider the best way of continuing to engage them. This could be via electronic communication for some people. For others, it could be better to make a call or connect with them for an in-person meeting.
- A key component of responding to identified risk for suicide is engaging a person in the appropriate mental health care (Doupnik et al., 2020). It may be necessary to make a referral or a direct connection with a treatment provider or organization. If possible, make a personal connection with the provider you are referring to and provide the victim with information about the types of services provided. Engage victims regarding choices for treatment, providers, and location. Collaborate and work mutually regarding the appropriate treatment referral.
- If the person is already engaged in treatment, communicate with existing treatment providers the necessary information regarding the person's safety and suicide risk. This can be done through release of information, collaboratively engaging the person at risk to share information. It is essential to share only the information that the mental health treatment provider needs and to maintain privacy and confidentiality.

- If a person says no to engaging in care, especially if they have strong protective factors, engage support and strengthen protective factors. It is okay to trust your gut, especially if cultural considerations might indicate the person would be less likely to communicate a suicidal crisis to you. Even if a victim has things that protect them from suicide, it is still important to connect them to treatment. Remember, you do not have to do this work alone. You can seek consultation and run it past a colleague or mental health professional.
- Almost all efforts to help someone to live, reduce their pain, and not attempt suicide will usually be met with agreement and relief. Don't hesitate to get involved or take the lead. For some of you it may be your role to establish a safety plan specific to suicide with the victim. For others, you might support the safety plan that a mental health professional creates.
- A safety plan specific to suicide risk is a prioritized written list of strategies and resources that victims can use in times of distress (Stanley & Brown, 2012).

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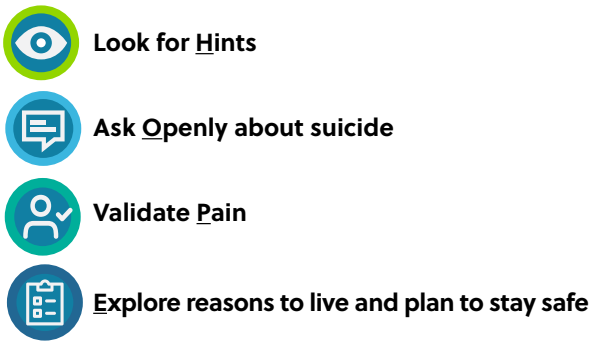


A safety plan is brief, in the person's own words, and easy to read. The process of safety planning is done through validating and engaging the person. Collaborative engagement is key to the likelihood that the safety plan will be used. There are six steps involved in the development of a safety plan.

Access the safety planning form and training manual for the suicide-specific safety planning intervention at Safety Planning Intervention: A brief intervention for reducing suicide risk: http://suicidesafetyplan.com/Page_8.html.

A similar evidence-based tool is Crisis Response Planning for Suicide Prevention, which can be accessed at https://crpforsuicide.com/.

An example safety plan for suicide risk is included in **Handout 4C: Patient Safety Plan Template**.

Handout 4C: Patient Safety Plan Template

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 _____	Phone _____
2. Name _____	Phone _____
3. Place _____	
4. Place _____	
Step 4: People whom I can ask for help	
1. Name _____	Phone _____
2. Name _____	Phone _____
3. Name _____	Phone _____
Step 5: Professionals or agencies I can contact during a crisis	
1. Clinician name Clinician pager or emergency contact #	Phone _____
2. Clinician name Clinician pager or emergency contact #	Phone _____
3. Suicide Prevention Lifeline: 1-800-273-TALK (8255)	
4. Local emergency service _____ Emergency services address _____ Emergency services phone _____	
Making the environment safe	
1. _____	
2. _____	

- For Step 1, which is focused on warning signs, you can ask: "How will you know when the safety plan should be used?" "What do you experience when you start to think about suicide or feel extremely depressed?" Then list warning signs and triggers, which can include thoughts, images, moods, and/or behaviors, using the person's own words (Stanley et al., 2009).
- In Step 2, the person outlines internal coping strategies. Ask: "If you are on your own and you become suicidal again, what can you do to help yourself to not act on your thoughts or urges?" (Stanley et al., 2009)
- Identify the likelihood that the person will use the safety plan by asking, "How likely do you think you would be to do this step during a time of crisis?" Ask about potential obstacles by asking, "What might stand in the way of you thinking of these activities or doing them if you think of them?" Use a collaborative, problem-solving approach to address potential barriers and identify alternative coping strategies (Stanley et al., 2009).
- Step 3 can be used if the coping strategies do not resolve the suicidal crisis. For this step, ask, "Who or what social settings help you take your mind off your problems, at least for a little while?" and "Who helps you feel better when you socialize with them?" Identify safe places where they can go to be around people (e.g., a coffee shop) at a time of crisis. It is key that these are accessible when the crisis typically happens. So, walking at the mall could not be used for a crisis at 2:00 a.m. Engage the person in listing several people and social settings to increase their options. The goal is distraction from suicidal thoughts and feelings. As with the other steps, consider the likelihood the victim will use these supports, identify possible barriers, and problem solve as needed (Stanley et al., 2009).
- In Step 4, the person identifies people who could offer support at a time of crisis. Ask, "Among your family or friends, who do you think you could contact for help during a crisis?" or "Who is supportive of you, and who do you feel that you can talk with when you're under stress?" As with step 3, identifying more than one person is helpful. Aim to list at least three support people, then prioritize the list. In this step, a person would share that they are in crisis to others. Again, consider the likelihood the victim will engage these supports, identify possible barriers, and problem solve. Use of role-play and rehearsal can be very useful as well (Stanley et al., 2009).
- In Step 5, the victim identifies professional supports. You can also add and educate the victim about professional and crisis supports. Ask, "Who are the mental health professionals and crisis supports that we should identify to be on your safety plan?" List specific information, such as names, numbers and/or locations of professionals or local urgent care services (Stanley et al., 2009).
- Step 6 is about making the victim's environment safe, especially if they are at a higher risk of suicide. Limiting access to lethal means, for example, can help keep a person safe in a time of intense crisis. It is a way to add some time and space for the person who might have progressed on the pathway to suicide. Reduced access to lethal objects can help to keep a person safe in a time of intense crisis (Stanley et al., 2009). However, there are unique considerations with a crime victim. For example:

- Some victims may be concerned about their physical safety and so choose to own a firearm to protect themselves from others. This very real safety concern must be balanced with the victim's safety in a time of crisis. In some situations, it may be appropriate to have the firearm in a locked safe, use a trigger lock, or store the ammunition and firearm in different locations.
- In many other situations, something like a photo of a protective factor, such as children, spiritual imagery, pets, or others, can help protect a person in a suicidal crisis.

» Ask which means the person would consider using during a suicidal crisis: "What things do you have access to and may use to attempt to kill yourself?" Then, with the person, collaboratively identify ways to secure or limit their access to lethal means. Ask, "How can we go about developing a plan to limit your access to these?" This could include storing medications in a lock box, keeping only a small supply in the home, or removing an item the person identifies. Research has shown this practice to be effective, and that often, persons don't substitute means. So, if the identified or desired method is limited or secured, the person may be safer in a time of crisis (Stanley et al., 2009).

For clients who are experiencing domestic violence, it is crucial to interweave support and resources for domestic violence with the suicide support. Both must be addressed. In addition, for clients who are experiencing domestic violence and not planning to leave their partner, offering resources for counseling/intervention for the person who is using violence against them is an important and, often, overlooked step. When these clients are referred to a mental health provider, it is important that the provider is knowledgeable of both suicide AND domestic violence.

» There is hope. And suicide deaths can be prevented. Research has shown that simply receiving a postcard from hospital staff for individuals who were treated in an inpatient hospital for a suicide attempt actually decreased suicide deaths (Stanford SPARQ, n.d.; Zero Suicide Institute, 2020a).

» Follow up in a way that is supportive and collaborative:

- Reach out and continue to show support.
- This can be through a text, a phone call, an email, or a letter.
- Caring contacts, ongoing supportive messages that don't ask for anything or remind about an appointment, have been shown to save lives (Doupnik et al., 2020).

Safer Suicide Triage

Introduction

This section focuses on the process when a victim advocate has identified a client who may be at increased risk of suicide. Some settings will have savvy clinicians on-site who can take over the care of the client, but most sites will not have these resources.

Now that we have addressed how to respond to someone who may be at risk for suicide, it is time to discuss how to figure out the next step to ensure they receive appropriate care.

Objectives

Participants will:

- Increase awareness of the types of evidence-based interventions available for suicide to be able to describe options to clients
- Develop a framework for transitioning clients to the next level of care

Key Points

- Mental health care that directly targets and treats suicidal thinking and behaviors along with the contributing and protective factors to suicide risk is essential for effective treatment. This treatment addresses the suicide risk and behavioral health disorders alongside care for trauma using evidence-based treatments. For a person in a suicidal crisis, it is not sufficient only to address behavioral health concerns such as depression, anxiety, or post-traumatic stress.
- Evidence-based suicide-specific treatments include:
  - Dialectical Behavior Therapy (DBT)
  - Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP)
  - Collaborative Assessment and Management of Suicidality (CAMS)
  - Non-demand follow-up contacts, such as letters and phone calls (Zero Suicide Institute, 2020b)
- As an advocate, your role is to be knowledgeable of who provides these evidence-based treatments in a trauma-sensitive context and make referrals, as necessary. In some regions, options might be limited, and it may be important to understand who specializes in treatment of suicide risk and trauma. As with all of our work, referrals to and the provision of treatment should be culturally appropriate and person-centered.

» Considering how you would triage when responding to a crisis or identifying a victim at risk for suicide, complete **Worksheet 4D: Mental Health Supports** with resources available in your region specific to emergency contacts and crisis contacts, routine mental health contacts, and persons to go to for consultation:

- In some areas, the mental health contacts may all be in the same agency or there may be only a few agencies. In more urban or resourced areas, there could be 24-hour treatment facilities, mobile crisis services, inpatient hospitals, and a variety of routine mental health facilities.

Worksheet 4D: Mental Health Supports

Emergency & Crisis Mental Health Contact(s)

Urgent Mental Health Contact(s)

Routine Mental Health Contact(s)

Person(s) to go for Consultation

» As you complete the contacts and processes for your organization and role, if there is something that you cannot complete right now, make a note of the person you will need to contact to find the answer to complete the process.

Conclusion

Key Points

» This section helped to bring all of the sections together. When responding, we need to be aware of our own reactions and the impact they may be having on the effectiveness of our responses and how in sync we are with the person at risk. In order to respond effectively, we need to bring together what we know about suicide, the suicidal crisis, the intersection with victimization, and hints and warning signs, and to openly ask questions to elicit information about risk. Now, we have the resources and ability to respond in a way that is collaborative, genuine, and supportive.

» We have covered a lot of content in the training at this point. In the next section, we will discuss caring for ourselves. This component is essential to support our work. It is similar to putting a plane's oxygen mask on yourself first before assisting others. Caring for ourselves allows us to be in the zone, prevents burnout, and enables us to support our teammates.

Module 5:
Recharge Ourselves

Look for Hints

Ask Openly about suicide

Validate Pain

Explore reasons to live and plan to stay safe

H.O.P.E. saves lives

Module 5 Overview

Topics Covered

- Personal and professional self-care
- Models of self-care
- Processing a suicide loss

Learning Objectives

In Module 5, participants will:

- Recognize one's professional obligation to attend to self-care
- Identify the warning signs of burnout and vicarious trauma
- Describe at least three skills that are particularly helpful in supporting self-care
- Identify personal resources for coping with a suicide loss

Materials

- **Worksheet 5A:** Self-Care Reflections
- **Handout 5B:** My Self-Care Plan

Introduction

Introduction

The work we do day to day is very different from what most people do for a living. Many of us came to this field because of our passions and experiences. We put our all into supporting those impacted by crime, working to keep people and communities safe and providing the best opportunities for recovery, healing, and thriving. Often, this means long hours and hearing difficult stories. This dedication and focus can impact our personal lives. It is demanding work, and at times, it can feel as if it is thankless work. Yet your work makes a difference. Self-care and community care are absolutely necessary for your safety, your health, the health of your relationships, the strength of your team, and the effectiveness of your work.

Commitment to Self-Care

Introduction

Often, the topic of self-care is discussed solely as something that is "good to do" for oneself. This is not the whole picture. We know that professionals who do not take care of themselves and who do not get enough rejuvenation to restore their mental flexibility can actually harm their clients. Of course, no one in this field intends to harm their clients. Yet, research shows that when we are not healthy:

- We make poor decisions with regard to maintaining boundaries.
- We ask fewer questions and do less thorough assessments.
- We can appear less empathic and caring to our clients. This can result in them losing hope that there is anyone who can help them.

So, the first thing to realize about self-care and organizational support is that it is a professional responsibility—not simply a good thing to do.

Objectives

- Recognize one's professional obligation to attend to self-care

Reflection

- Complete **Worksheet 5A: Self-Care Reflections**.

Worksheet 5A: Self-Care Reflections

Reflection Questions

1. Think back to a time when you felt like you were at the top of your game. What was your self-care and/or state of mind like at the time?

2. Think back to a time when you crossed an ethical or a professional boundary or came close. Examples can include when you became attached to a client in some way that felt too strong and/or unhealthy for you. What was your self-care and/or state of mind like at the time?

Self-care is important for:

- Your own sake
- The sake of those who care about you
- The sake of your clients
- The sake of your co-workers
- The sake of your organization

3. How does caring for yourself impact your work and the clients you work with?

4. What happens to your clients if you don't take care of yourself?

5. Why is it important for you to take care of yourself?

Vicarious Traumatization

Introduction

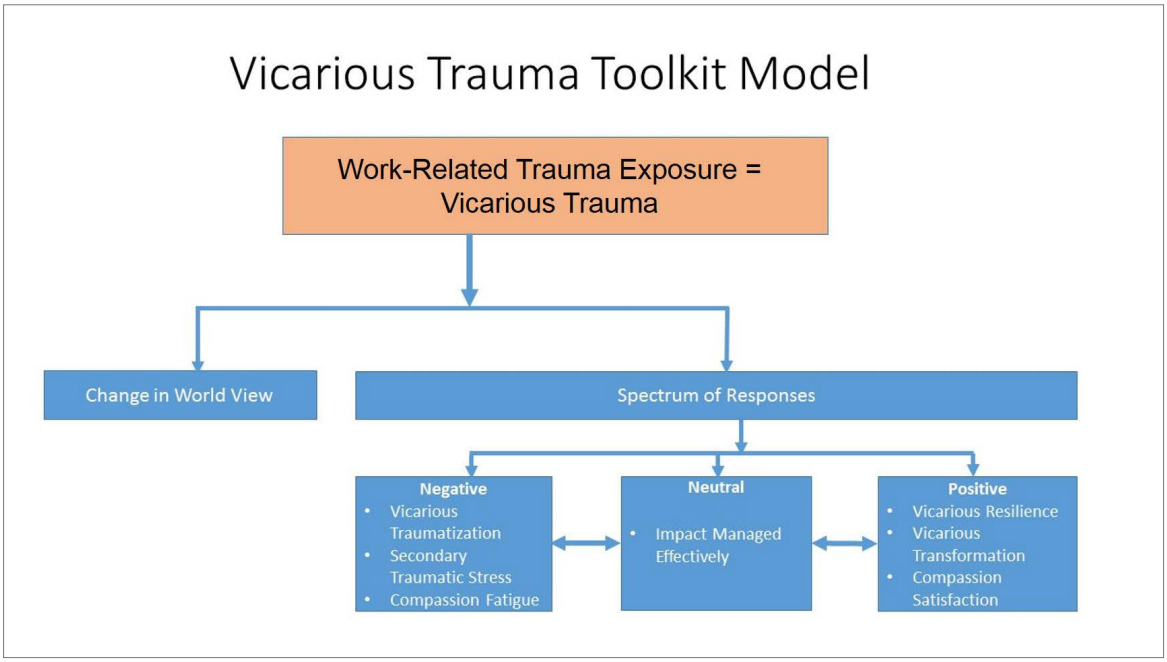
Let's review the definitions and common signs of toxic stress, burnout, and vicarious trauma. Then, we will shift to ways to care for yourself. The signs that we review are not an exhaustive list. You know yourself best. You know your team and colleagues best. Use this expertise to strengthen yourself and your team.

Objectives

- Identify the warning signs of burnout and vicarious trauma
- Describe at least three skills that are particularly helpful in supporting self-care
- Identify personal resources for coping with a suicide loss

Key Points

- Burnout is a job-related stress condition. It typically progresses over time and is often a result of chronic stress or frustration. In the fields that we are working in, burnout can occur in a shorter period due to the intensity of our work.
- Signs of burnout can be specific to an individual and can be impacted by culture. Some signs include feeling emotionally exhausted, separating oneself, and having a reduced sense of accomplishment (Institute for Quality and Efficiency in Health Care, 2017). Typically, the drive that pushes us to go above and beyond is impacted by burnout. We can find ourselves less passionate about our work and detached.
- Vicarious trauma is a state of tension and preoccupation with the stories/trauma experiences described by clients (American Counseling Association, n.d.). We work closely with trauma survivors and can empathically take on aspects of the trauma that the survivor experienced. This can result in experiencing symptoms similar to those of the trauma survivors themselves. The signs of vicarious trauma can look like post-traumatic stress disorder symptoms.
- The *Vicarious Trauma Toolkit* (VTT) was developed based on the idea that exposure to the traumatic experiences of other people is an inevitable part of the work that occurs in the field of victim services. However, organizations can reduce the impact of the negative effects of trauma exposure by becoming informed about vicarious trauma. The VTT includes tools and resources that were created for organizations to support the needs of their staff (Office for Victims of Crime [OVC], n.d.a).



(OVC, n.d.c)

- The work we do has its own inherent risk factors. Working with survivors of trauma, especially when we may have our own prior traumatic experiences, can put us more at risk for vicarious trauma (OVC, n.d.b). Other risk factors for vicarious traumatization include being socially isolated, withdrawing or avoiding feelings, having no variation in work tasks, and not having a channel for processing the content of the work. Being newer in working with crime victims can also be a risk factor as we need time to adjust to the intensity of the work and to find ways to process our work (OVC, n.d.b).
- While we can all take individual responsibility for ourselves, organizations also have a responsibility in caring for staff (OVC, n.d.b).
- Take a moment to consider: What do you think are some organizational factors that can help prevent burnout and vicarious trauma among staff?
- Several organizational factors that might prevent burnout and vicarious trauma include:
  - Having a safe environment to talk to colleagues and ask for help or support.
  - Routinely building in support and helping each other.
  - De-briefing in a timely and supportive manner.
  - Being able to take time off when needed—not just when seeing the signs of burnout, vicarious trauma, or toxic stress, but also being able to take time off for vacations, to recharge, and to take care of personal matters.
  - Being able to access professional support when needed, including Employee Assistance Programs.

- Having a balance in working hours—knowing that sometimes, work will be quite intense and may require overtime, while at other times, you may have less demands. A balance in workload is important, especially if you have been working with several particularly challenging cases:
  - For instance, if you have been working with many crime victims who have experienced intense physical violence, and you have started to feel overwhelmed by the severity of the cases, you might take on a different case, which, while still challenging, is not specific to physical violence.

» Let's talk about individual ways to support your self-care. There are many self-care strategies. Common categories for self-care include:

- Physical health promotion activities
- Spiritually oriented activities
- Leisure activities
- Seeking emotional support
- Decompression strategies/rituals
- Setting boundaries around work
- Setting boundaries about types of information ascertained from clients
- Others: _____

It's important to stress that vicarious traumatization is a normal response to doing the hard work of supporting and advocating for people who have experienced trauma and violence and is not a reflection of the advocate's competence. Just as there are individual differences in how people respond to traumatic life events, there are also individual differences in what leads to vicarious trauma in the helper (Schauben & Frazier 1995).

Resources

Introduction

It is important to take stock of the effect that a suicide loss can have on your own sense of well-being, as well as on your colleagues, your organization, and on the family of your client. We will focus the next section on taking care of yourself and on organizational strategies to implement for postvention care of a professional team. We will discuss ways to support family members in Module 7.

Key Points

If you are impacted by a suicide loss, remember everyone copes and responds in their own way. There is no right way to grieve or approach a loss that might impact your professional work. It may be helpful to:

- Take time to become aware of your needs and continue to do so
- Seek support
  - From colleagues & support system
  - Support groups
  - Professional therapy
  - Blogs, listservs, online support
- Ask for help, particularly if you are assigned a similar case
- Take the time you need
- Consult

If grief (or another emotion) is affecting anyone's work, personal relationships, or ability to sleep, eat, or engage in daily activities, likely additional support may be needed:

- Seek professional treatment.
- Add additional peer, family, spiritual, or other help.
- Leverage consultation and team support as you are able.
- Consider taking a break such as stepping back from your role for a little while or taking a vacation.
- Use Family Medical Leave Act (FMLA) time for treatment and additional support.

Remember to honor all emotions. Anger at yourself and/or anger at the client for taking their life are normal emotions, and they require time and space to work through.

Recharge Ourselves

Objectives

Participants will:

» Describe at least three coping skills that are particularly helpful in supporting self-care

Key Points

» Identify strategies for self-care.

» Focus on applying ideas to day-to-day life.

Reflection and Activity

» Let's shift to identifying and practicing how we can care for ourselves. While completing **Worksheet 5B: My Self-Care Plan**, think outside of the norm. For instance, exercising or socializing can be great strategies. Also, think about the times you struggle the most during the day. How might you use strategies during these times? Think about how you might be able to use the drive to and from work to practice strategies or how you might practice calming yourself just before you go to sleep.

» First, write personal signals of burnout or vicarious trauma.

» Then, identify personal strategies, social supports, and professional support you can use.

Worksheet 5B: My Self-Care Plan

What signals to me that I am beginning to struggle and that I need to focus on my own wellness? These include thoughts, feelings, and actions.

_____

_____

_____

What internal strategies can I use to positively impact my wellness?

_____

_____

_____

If I am "stuck" after I have tried to help myself, who can I contact among my family and friends to help me?

_____

_____

_____

If I am not able to get the support I need from my social network, what professionals are available to me?

_____

_____

_____

Now that we have identified our personal signals and self-care strategies, make plans to implement at least one of these today and several in the next week. You can take a few minutes for self-care right now.

If you would like, you can engage in this guided breathing exercise:

- Setting your guide, phone, and anything else aside, find a comfortable and upright posture that supports your body and breathing. Place both feet on the floor, arms uncrossed, if you are able to do so. You might use the back of the chair for support. You can keep your eyes open or closed for this exercise. If you keep them open, look ahead of you just a few feet.
- Start by just observing your breath wherever you feel it most predominantly. This can be in your chest, lungs, belly, or at the tip of your nose as the air moves in and out.
- You are not trying to change the breath right now. You're just taking a few moments to become aware of your breath. Put thoughts of the past or plans for what is next off to the side. Just be here, right now.
- Now, take a few deep inhales and exhales. Start by inhaling for four counts. 1-2-3-4. Make sure you fill your lungs completely to the point where you feel your abdomen is filled full of air like a balloon. Hold your breath for four counts then slowly exhale for eight counts.
- It will take a few attempts before you feel comfortable, but you will soon find a rhythm that suits you. There is no wrong way of doing this. Inhale for four counts, 1-2-3-4; hold for four counts, 1-2-3-4; and then slowly exhale for at least eight counts, 1-2-3-4-5-6-7-8. Continue doing this at your own pace.
- Repeat this exercise several times.
- Now, return to your normal breathing without trying to manipulate or change it.
- Just check in with your body, starting with your head. Scan from your head down to your feet. Notice any place you observe tightness or tension. See if you can invite that part of your body to relax. Any time you notice yourself thinking about the past or planning for the future, just return to your body and focus your attention on this.
- As you scanned your body, you may have noticed areas that need some attention. You may stand, move, or stretch in any way that you personally need it. This could be rolling your shoulders or holding your arms up and stretching to the sky. You can take a few minutes for this.

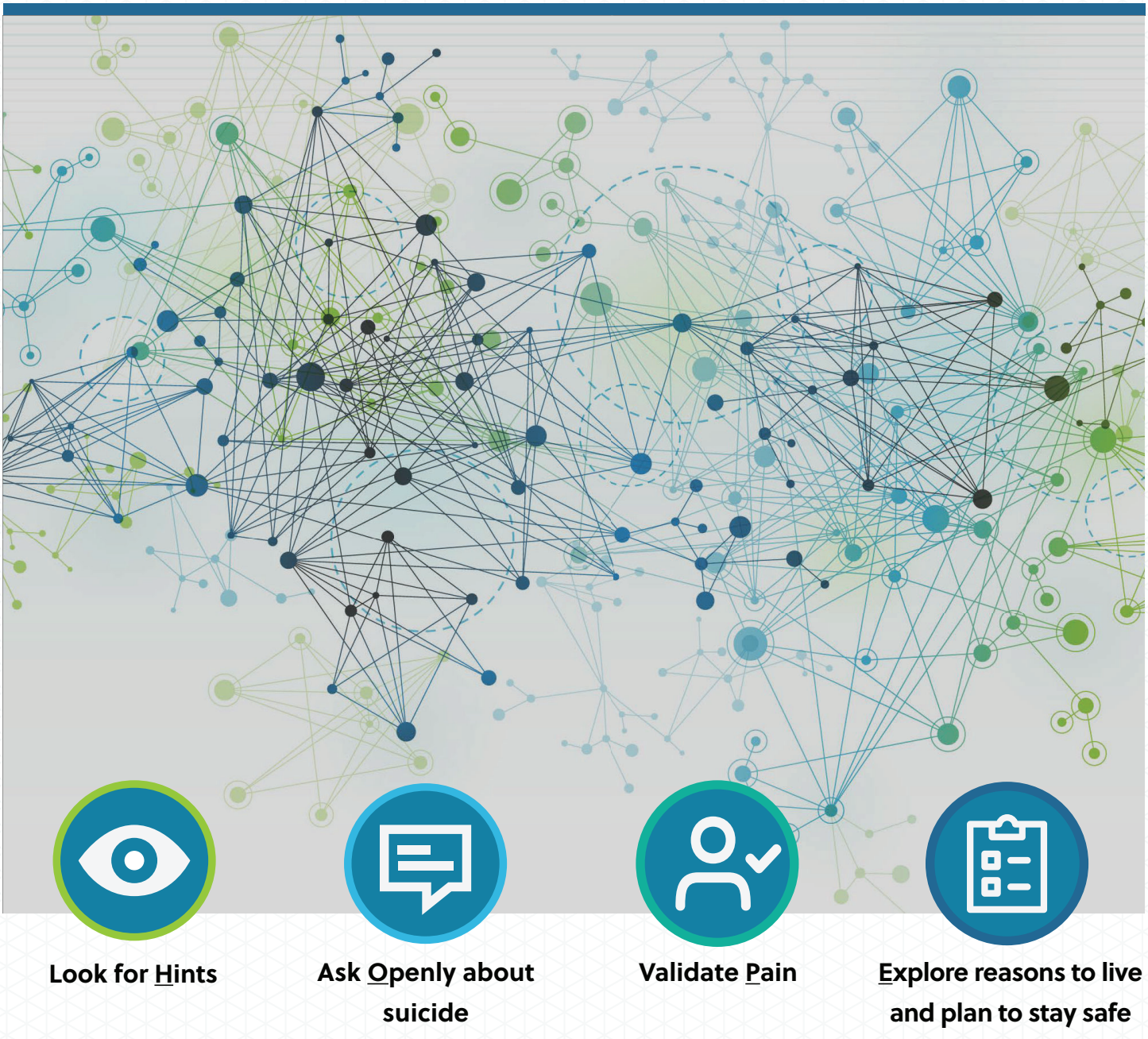
Conclusion

Key Points

Prioritizing one's own well-being and self-care is a requirement of your job. The people we serve struggle with significant concerns, and they need supportive professionals who are healthy enough to help support them in the ways they deserve.

Organizations have responsibility in creating a culture of support and protections against vicarious trauma and burnout. We must think beyond self-care and prioritize the well-being of all staff.

Module 6:
Consider the Complexities



H.O.P.E. saves lives

Module 6 Overview

Topics Covered

- Linkage between suicide and trauma, suicide and substance use, and substance use and trauma
- Understanding these linkages through real-life scenarios
- Implications of understanding these linkages, including distinguishing between some substance use behaviors and suicidality

Learning Objectives

In Module 6, participants will:

- Identify the linkages between suicide, trauma, and/or substance use
- Recognize the complexity involved in distinguishing some substance use behaviors from suicidal thoughts and feelings
- Identify strategies to resolve unclear situations

Materials

- **Handout 6A:** Reflection – Case Examples
- **Worksheet 6B:** Unclear Situations

Introduction

Introduction

Too often, we in the crime victim arena talk in silos. We have gotten much better at drawing connections between someone's trauma history and their risk for victimization, and in understanding that violent victimization can lead to mental health issues. However, we are often not discussing the linkages between crime victimization, trauma, suicide, and/or substance use. If we are not aware of the interconnections, we will miss hints and opportunities to help our clients address their underlying pain. Far too often, we become sidetracked by sending someone to substance use treatment or thinking someone doesn't want to change because they continue to abuse substances when, in reality, their underlying emotional pain is so great that substance use is the only way they know to cope. Alternatively, sometimes we send someone to the emergency department (ED) because we are afraid of suicidality and do not take the time to understand how the experience of trauma and/or substance use is related to their current suicidal crisis. As such, those pieces of the puzzle never get documented. Thus, once the ED staff believe the person is stable from a suicide perspective, they are released, and there is no follow up to the underlying issues. This module focuses on the interconnections between trauma, suicide, and substance use.

Key Points

- Identify cyclical and reinforcing linkages between suicide and trauma and/or substance use.
- Recognize the complexity involved in distinguishing some substance use behaviors from suicidality.
- Identify strategies to resolve unclear situations.

Consider the Complexities

Objectives

Participants will:

- Identify the linkages between suicide, trauma, and/or substance use
- Recognize the complexity involved in distinguishing some substance use behaviors from suicidal thoughts and feelings

Key Points

- The American Psychological Association defines *trauma* as "an emotional response to a terrible event like an accident, a rape or a natural disaster" (American Psychological Association [APA], 2020). Responses to trauma may include shock, denial, flashbacks, physical symptoms, and unpredictable emotional reactions (APA, 2020). Two people may experience the same event differently—one may experience it as a trauma, and another may not. There is a subjective element to defining a traumatic event.
- **Reflection:** Think about the difference between stress and trauma. What do you see as the differences between stress and trauma? Everyone experiences stress. Not everyone experiences a trauma.
- Even among those that experience an event, a set of events, as harmful or life threatening, many people don't have lasting adverse effects, and many people heal on their own.
- Some types of traumas are associated with a higher likelihood of mental health disorder and/or substance use—usually the more personal and the more severe the type of violent experience, the more debilitating the consequences.
- **Individual trauma:**
  - Individual trauma includes common traumatic events, such as witnessing a death; being threatened with death, injury, or sexual violence; or experiencing a natural disaster. Only a small percentage of people who experience a trauma develop clinical symptoms or a disorder.
- **Historical and intergenerational trauma:**
  - Historical or intergenerational trauma occurs as a result of decades and centuries of discrimination, violence, and victimization. It happens to populations, often paired with other adversities. Think of families living in high-crime neighborhoods or Native people who have experienced decades of trauma that have, over time, shaped family dynamics and health for generations.
- **Suicide and trauma:**
  - Adverse childhood experiences (ACEs) include stressful or traumatic events that can lead to social, emotional, and cognitive impairment, which, in turn, can lead to high-risk behaviors, disease, and early death. Felitti and his colleagues first identified the term *ACEs* when looking at risk factors for chronic disease in a sample of hospital patients (Felitti et al., 1998). Since their initial work, interest has grown in understanding which adverse experiences have what types of long-term health effects. Individuals who reported four or more ACEs had a 12-fold increased risk for attempting suicide (Ports et al.,2017).

- ACEs scores may not fully reflect additional traumatic experiences such as racism and discrimination. So, as we consider the adverse childhood experiences that are measured with an ACEs score, we also need to keep in mind that there could be other complicating factors.
- Individuals diagnosed with PTSD have been found to be at higher risk for suicide attempts even after controlling for physical illness and mental health disorders (U.S. Department of Veterans Affairs, 2007). Some studies indicate PTSD is a precipitating factor of suicide. This data emphasizes the intersection of suicide risk and trauma. Victimization that results in physical, sexual, and emotional impacts and develops into PTSD symptoms can lead to a higher risk for suicide.
- People who do experience early adversity are not fated to experience problems. We know from both experience and research that with the right kinds of support, most people can heal.

» **Suicide and substance use:**

- Research indicates there are clear linkages of trauma leading to substance use, substance use leading to trauma, and the circular nature of both existing together. Substance use disorders may come before trauma exposure. ACEs have a dose-response relationship with many health problems. As researchers followed participants over time, they discovered that a person's cumulative ACEs score had a strong relationship to numerous health, social, and behavioral problems throughout their life span, including substance use disorders (SAMHSA, 2018).
- Preventing suicide death will also require an understanding of the complexities with substance misuse (Oquendo & Volkow, 2018). At times substance overdose deaths are ruled intentional and may actually have had suicidal underpinnings. It can often be very difficult, at times impossible, to determine the difference between an unintentional drug overdose and a suicide attempt. Yet, making a distinction can have impacts on treatment decisions. Often, staff may be quick to label "overdoses" and thus may inadvertently ignore suicidal behavior or ambivalence about living.
- Substances affect thinking and emotional processes and can contribute to a suicidal crisis. In 2011, approximately 230,000 ED visits resulted from drug-related suicide attempts, with almost all involving a prescription drug or an over-the-counter medication. One of the reasons that alcohol and/or drug misuse significantly affects suicide rates is the reduced inhibitions that occur when a person is intoxicated (Pompili et al., 2010). Alcohol and opioids can be a dangerous combination. Currently, less is known about the relationship between suicide risk and other drug use. We know that the number of substances used seems to be more predictive of suicide than the types of substances used (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012).

Also, we know that substances are involved in suicide deaths. Of those who died by suicide, 28.3% had problematic substance use; 17% had problematic substance use with alcohol; and 16% had problematic substance use with other substances. It has been documented that alcohol was present in about 30%–40% of suicide attempts (SAMHSA, 2015).

A recent study found that persons using opioids regularly were at greatest risk. They were about 75% more likely to make suicide plans and twice as likely to attempt suicide as persons who did not report any opioid use (Oquendo & Volkow, 2018).

Children Witnessing Domestic and Suicide Risk

A child witnessing domestic violence is linked to suicide risk. Children exposed to chronic domestic violence have a significantly higher lifetime prevalence of suicide attempts. When violence is chronic in a home even when the child is not directly abused themselves, there is a risk for long-term negative outcomes (University of Toronto, 2016). It is important to remember this when considering the risk for children and early intervention for suicide prevention.

The ways that exposure to violence as a child affects our brain development is important to remember when working with victims and understanding the neurological factors that be contributing to their mental state and even to their suicide risk. We recommend watching the video *First Impressions: Exposure to Violence and a Child's Developing Brain* to gain a more comprehensive understanding of the impacts of witnessing domestic violence on a child's developing brain: https://www.youtube.com/watch?v=brVOYtNMmKk. This video developed by the California Attorney General's office highlights the impact of chronic exposure to violence on a child's developing brain.

Case Examples and Reflection

- Trauma can manifest in different ways. Depending upon the trauma experienced and individual factors, individuals may be drawn to different substances, and the hopelessness related to suicide may play out in a variety of ways. We are going to discuss several examples. As you read these, think about the linkages between trauma, substance use, and suicide risk.
- **Example:** If someone experiences abuse from a close family member, they may have a hard time attaching to others and creating new, close relationships. They may be overly alert and on guard at all times. Social situations may feel very intense. That person may move toward a substance that allows them to relax and experience less anxiety in social situations. These substances, which can worsen depressive symptoms, may facilitate suicidal behavior.
- **Reflection:** How can these substances facilitate suicidal behavior? Consider the interconnected and cyclical nature of how trauma history, substance use, and suicide can occur together.
- If a person is thinking of attempting suicide, alcohol may supply the motivation to act on suicidal thoughts or to complete the steps to die. The victim may believe that alcohol will assist in making dying by suicide painless.
- This becomes a cycle at times, with suicidal behavior or thinking contributing to additional stress and symptoms for the person and serving as a driver to continued substance use.
- Consider clients you have worked with who have struggled with all three of these issues. Think of these examples in relation to the linkages and how suicide, trauma, and substance use are intertwined.

Case Example

- Imagine John – John grew up in an affluent, suburban home engaging in public high school and excelling at academics and athletics. He went on to attend college, played Division I sports, and is now a successful businessperson.
- John experienced domestic violence with his partner Matt, and you are meeting with John regarding the physical violence, emotional abuse, and worries about being safe as his partner is continuing to harass him.
- Using **Worksheet 6A: Reflection – Case Examples**, write down some ways you would work with John and things you might do.

Worksheet 6A: Reflection – Case Examples

What are some ways you might work with some of the case examples discussed?

- **Reflection:** How does your response change if you know that John experienced physical abuse as a child and witnessed his father murder his mother?
  - John has been experiencing symptoms of PTSD for a long time and has never received treatment. He used alcohol in high school and college to cope. Most people in John's life saw this as average male athlete drinking. Now, he uses benzodiazepines, primarily Xanax and Klonopin, and alcohol at night to cope. His primary social connections are through drinking with buddies and coworkers.
- **Reflection:** How does your response change given this information?
  - Now consider that John experienced a significant change in his business investments.
  - Several years ago, he lost a lot of money and planned to kill himself. He began to take action in killing himself when he met his current partner. He had felt lonely and disconnected, and meeting Matt helped him to feel hopeful, like life was worth living, and that he could get back on his feet again financially.
- **Reflection:** How does your response change given this information?

Historically, the fields of trauma, suicide, and substance misuse have been separate. Often, if you seek treatment for substance misuse and are struggling with suicidal thoughts, you might be asked to be stabilized with the suicidal crisis first before being able to get focused substance misuse treatment, and likewise, you might be asked to get clean first before you receive treatment for your trauma. Many professionals trained in trauma and mental health have no substance use training and vice versa. Given this reality, it can be easy for trauma survivors to feel hopeless, increasing the risk present in their lives. Crime victim advocates should be skilled at finding coordinated or integrated care, or helping the client engage with specific service systems as a part of the client's safety plan.

- The best practice is combined, integrated, holistic, person-centered treatment.
- These topics are important to bring together because it is clearly established that people with unresolved trauma histories are much more likely to abuse substances, and that among those with the harder to manage substance use disorders, the vast majority have trauma histories.
- Also, it is clear that those with suicide susceptibility are much more likely to have trauma histories.
- Our support and help-giving approaches need to align with the evidence and need to address the trauma, substance use, and/or suicide together.
- If the underlying trauma and substance use aren't considered or addressed, we could invest resources in sending people again and again to ineffective treatment. Meanwhile, they are losing hope in themselves and blaming themselves for not being able to stay clean when we are giving them the wrong treatment. It isn't fair to ask someone to give up their coping strategy if we haven't helped the huge problem that they are trying to cope with.

» Continue to use **Worksheet 6A: Reflection – Case Examples** to write down strategies you would use to support John as you learned more about him.

Unclear Situations

Introduction

Some cases may be particularly challenging and unclear. While we cannot review or discuss every possible scenario in this training, we will outline some general strategies for you to use with unclear situations.

Objectives

Participants will:

» Identify strategies to resolve unclear situations

Exercise

» Let's take a moment to reflect on what we have discussed. Use **Worksheet 6B: Unclear Situations** and take what we have gone through so far, and think of persons that you have previously worked with or are working with currently or of a situation you imagine you may come across. Take a moment to write down several things that would make a case unclear. For example, consider an individual who has a past history of suicidal crises, yet has denied suicidal ideation and, currently, has a strong support system.

Worksheet 6B: Unclear Situations

What are some things that might make a case unclear?

- Strategies to include for responding to situations that feel unclear:
  - Consult, internally or externally.
  - Refer, such as for further assessment, treatment, or assistance.
  - Develop a safety plan and contingency plan, including crisis resources and reducing access to lethal means if possible.
  - Involve support, mutually engaging the person's identified support network.
  - Follow up in a supportive and collaborative manner, using trauma-informed approaches and honoring safety.

Conclusion

Key Points

- It is important to be cognizant of and identify linkages in suicide risk, trauma, and substance use.
- While it may be complex and complicated to distinguish suicidal behavior and substance misuse, it is important to consider a holistic integrated treatment approach.
- When situations seem less clear, strategies such as consultation, additional assessment, creating an expended support network, and follow-up are particularly useful.

Module 7: Support the Family

Look for Hints

Ask Openly about suicide

Validate Pain

Explore reasons to live and plan to stay safe

H.O.P.E. saves lives

Module 7 Overview

Topics Covered

- Typical family reactions to a family member in crisis
- Importance of maintaining a nonjudgmental stance
- Types of family interventions across the spectrum of resource intensity

Learning Objectives

In Module 7, participants will:

- Recognize the full range of normal reactions to a suicidal person and the importance of maintaining a nonjudgmental stance
- Identify interventions to support children and adult family members of a person struggling with suicidal thoughts and feelings

Materials

- **Handout 7A:** How to Talk about Suicide with a Loved One

Introduction

Introduction

Now, we will be focusing on how to support the community and family that might be concerned about a person at risk for suicide or who have been impacted by a suicide loss. As we go into this section, let's keep in mind the importance of self-care and organizational support, leveraging all your resources, and staying in your role. You do not need to be all things to all people, and sometimes, it is actually harmful to be so.

Common Family Reactions

Objectives

Recognize the full range of normal reactions to a person at risk for suicide and the importance of maintaining a nonjudgmental stance

Key Points

- When a person you know and care about is thinking about suicide, it can evoke feelings of fear, anxiety, and helplessness. Often a family member's own need for that person to live can impact their ability to respond in a rational manner. Some family and friends may be able to work past this initial fear and tap into empathy, compassion, and concern.
- There are some common thoughts that a concerned family member may have. These include thoughts such as:
  - "Don't they know I love them and would be devastated without them? How could they even think about this?"
  - "They are always saying they want to kill themselves."
  - "Suicide is selfish."
  - "Suicide is cowardly."
  - "Suicide is a sin."
  - "You don't mean that. You don't really want to die."
  - "They've had so much going on. I hope I can support them through this."

- We are going to unpack these a little more.
- Remember from our first section that a perception of being a burden is a common thought for the person in crisis. The tunnel-vision of the suicidal mind can make the person think they are negatively impacting loved ones more in life than they would in death.
- It can be invalidating and dismissive to think that a person who talks about suicide often is not going to act on it. The mind of the person in crisis can become used to thinking about suicide. Suicide can become the mind's go-to solution or a rut it gets stuck in. But this does not mean they will not act on these thoughts at some point.
- Saying that suicide is selfish to someone struggling with suicidal thoughts can be a guilt- or shame-inducing response. If you think about crime victims, they may be feeling a lot of guilt and shame already connected to the trauma they have experienced. For persons who have lost someone to suicide, especially family members, this can be particularly hard. Thoughts such as "You know what we went through before. Why would you do this to us?" can surface. These can evoke anger and distance the supporter and the person struggling.
- Saying that suicide is a sin to someone struggling with suicidal thoughts can increase alienation and hopelessness. It is not your job to change their belief, but you can help them to recognize that communicating this belief can be alienating to the person at risk. Connecting to beliefs such as compassion and love could help.
- Read **Handout 7A: How to Talk about Suicide with a Loved One**, which provides a number of examples for how to talk about suicide with a loved one. This can be used as tool. It is best to meet the person where they are at, using their language.

Handout 7A: How to Talk about Suicide with a Loved One

There is more than one way to respond to a person struggling with a suicidal crisis. The following is a list of statements that may be helpful. It is essential to consider the individual, culture, and context and to use responses that are more natural to you. It is key to ask openly about suicide, connect with their pain, offer hope, and explore reasons to live while maintaining a collaborative approach.

1. "I'm so glad you told me that you are thinking about suicide. I want you to be able to share whatever pain you are feeling."

2. "Help me understand what is going on that makes you want to die."

3. "How long have you been feeling bad/sad?"

4. "When did you start to lose hope that things could get better?"

5. "I care about you, and I would be so sad if I lost you to suicide."

6. "What can I do to help?"

7. "Are there things you have tried to do that didn't help?"

8. "What has been helpful to you during times when you have felt like you can't get through this? "

9. "Would you be willing to try some sources of help that you may not have tried before?"

10. "Have you thought about specific ways that you could kill yourself? What ways do you think are most likely?"

11. "I hear the intense pain you are in. I also hear that you would like to find a way through this pain. While I may not have all the answers, let's explore some ways to help you through this."

12. "You are such an important part of many peoples' lives and losing you would be very painful and a deep loss for all who know you."

- Family and friends may respond in a variety of different ways. Responses to a person at risk for suicide by family and friends might include withdrawing, ignoring, dismissing, controlling, lecturing, listening, and supporting. It can help to find ways to tap into the more useful responses. Providing assistance and professional help to the support person may help them to be able to remain in a fully collaborative and supportive role.
- Consider the variety of relationships and dynamics people have with those in crisis. Responses can vary depending on the relationship. For instance, a parent may feel guilty, like they have failed their child if their child doesn't want to live. This can impact their response.
- Think of a partner that may be suspected of interpersonal violence reporting that their spouse is thinking of suicide. At times, this "concern" can be used as a way to manipulate, control, or punish. This could be used to get the person in the hospital. It can also provide an opportunity to engage in other controlling behaviors, such as going through their phone or email or installing video cameras or monitoring devices in their car.
- It is key to consider the context. It is important to keep in mind the concerned person's relationship and role, especially for the crime victim in the context of this trauma. Also, consider if the accused or perpetrator is making suicidal comments. These can still be serious suicidal comments. Yet, the victim is not in a position to support or respond and likely needs to be protected from this. Suicidal ideation, statements, and behaviors by the perpetrator could be triggering to the victim, or they could potentially cause the victim to be more concerned about the perpetrator than about themselves. This could compromise their safety. For instance, imagine someone has a protective order against their spouse, and they read a suicidal comment that the spouse made on social media. They might go to the spouse's house in the interest of helping that person remain safe from themselves. This could potentially jeopardize their own safety.
- At the same time, what we know about persons who engage in violent, abusive, or harassing behaviors is that they may also have experienced trauma, adverse childhood experiences, and victimization. They can be at risk for suicide, as well. It is important to take suicidal statements and behaviors seriously while at the same time maintaining the safety of the victim. This is when a team approach is often best.

Supporting the Family

Introduction

We've been focusing on increasing our understanding and awareness of what the family or support persons might be experiencing. Understanding the complexities, background, and dynamics can help us maintain a nonjudgmental collaborative stance. In this next

section, we will focus on ways you can support the family. Front and center is maintaining a collaborative, empathic relationship with the victim you are advocating for. At any time, you can establish a boundary and engage resources to support the family if the situation calls for this.

There can be a full range of reactions to a person at risk for suicide. This can be particularly challenging for family members, supporters, and others. While we can work to put ourselves in the shoes of another person, it is not possible to see fully and only from their perspective. It is also important to maintain the foundations of trauma-informed approaches in working with those impacted by suicide.

Objectives

» Identify interventions to support children and adult family members of a person struggling with suicidal thoughts and feelings

Key Points

» There are many ways to respond to a family member concerned about a person at risk for suicide. Be prepared ahead of time. Provide resources, make referrals, take action together when possible and appropriate, and engage the person's safety net. It may be helpful to consult with your team, and at times, you may need to take immediate action by initiating a crisis response.

» You might respond directly to the person at risk, or you might only provide resources. It depends on the situation and your role. It is often useful to expand the safety net, provide crisis and treatment information, and consult. If you have a close relationship with the victim and it would not escalate their risk, you might consider reaching out directly. If the support person is concerned, the victim is in the process of a suicide attempt, or the safety of the victim is in question, you might initiate an emergency response. Similar to the resources available to you, the family member can call the National Suicide Prevention Lifeline or a mental health professional to seek consultation. There are also resources from the C-SSRS, including community cards that list the questions of the screening tool. The cards can be easily accessed through the Columbia Lighthouse Project, printed, and given to a concerned support person.

» If a child is concerned their parent is at risk for suicide, consider how to expand their support system, create a crisis response plan through emergency contacts, and help to identify a key adult who can support the parent. You might assist the child in setting boundaries, so they are not taking responsibility for the safety of their parent—both with suicide risk and protection from victimization. Helping the child to get support can be very useful.

» It can be challenging for a spouse or partner to support a victim of trauma and through a suicidal crisis. Providing information about crisis support and treatment options and expanding their safety net can be useful responses. It can be helpful to problem solve

together, educate the person that is concerned, and validate their limits encouraging a safety net that is more than one person.

- If a parent is concerned about a child at risk for suicide, consider how to expand their support system, provide crisis and emergency resources specific to youth, create a crisis response plan through emergency contacts, and help them think about how to meet their own needs. Set boundaries around your role and how you can assist them. Remind them who to contact for treatment and a mental health emergency. If the parent is having difficulty understanding the intensity of risk, provide support, educate, and engage a mental health professional as family therapy may be beneficial.
- It can be good to refrain from assuming that a parent is a "safe" or "helpful" presence. We recommend suggesting to the parent(s) that they should offer their child an opportunity to meet with a professional, and you can offer to be the go-between, if appropriate. Remember, you may not know the trauma history of this family.

Safer Suicide Care Within the Family

It may be helpful to prepare family and friends in how to support and recognize a crisis. These are key things to educate the family about:

- Warning signs of suicide risk and how to respond:
  - If an attempt is in progress, call 911 for an emergency response.
  - If the victim has made a direct suicidal statement and cannot be reached or found to determine their safety, a welfare check may be needed.
  - If the person is not following their safety or treatment plan, a mental health crisis line or emergency mental health treatment may be needed.

Supporting Suicide Loss Survivors

- At times, we lose someone to suicide. The warning signs may not have been clear, or we may lose someone to suicide despite everyone's best efforts. This can contribute to deep hurt and pain for those impacted. If someone you are supporting or the crime victim loses someone to suicide, use your resources. Support them in the way that works for your role, in a way that is collaborative and supportive. Suicide loss survivors can struggle with a range of feelings and reactions including guilt, fixated thoughts on past interactions and their own behaviors, and questioning of reasons for the suicide death. You can listen without trying to have the answers. You might need to problem solve regarding specific tasks, such as who to contact or what needs to be addressed now and what can wait.
- If a crime victim has died by suicide, your role may be particularly useful in helping to know how to handle an offender or an accused who may want to know, might start showing up, or might come to the funeral. If certain conditions exist, the offender may have rights to certain property. The family may need a lawyer, and you will likely need to

use your team and consult. As this may be a challenging time, you may need to access your own support and professional assistance.

It is vital that all advocates be aware of the appropriate VOCA, VAWA, and/or FVPSA confidentiality requirements, depending on the funding source for their work. All of these funding organizations require that advocates have a signed, time-limited, written authorization for release of information from a victim who is served with funds from one of those funding streams before they can discuss what's going on with the victim, with the family, or with another third party.

- How we respond to a suicide loss in a community can impact the potential ripple effect of suicide. Good support following a suicide loss can serve as suicide prevention. It is important to maintain safe messaging and not memorialize a person more than you would with any other loss. Those impacted can be at higher risk for suicide themselves. There are many resources for responding after a suicide loss, including:
  - A postvention toolkit for schools: http://www.sprc.org/sites/default/files/resource-program/AfteraSuicideToolkitforSchools.pdf
  - A toolkit for workplaces: https://theactionalliance.org/sites/default/files/managers-guidebook-to-suicide-postvention-web.pdf
  - Resources for personal support for survivors of suicide loss, including finding a support group after suicide loss: https://afsp.org/ive-lost-someone
  - Resources for safe messaging: http://suicidepreventionmessaging.org
  - *Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines:* https://theactionalliance.org/resource/responding-grief-trauma-and-distress-after-suicide-us-national-guidelines
- Follow best practices outlined in the safe messaging guidelines. It is also best to follow the postvention best practices described in the toolkits.
- If the crime victim is impacted by a suicide loss, there can be many complicating factors. Consider adding the intense grief of this type of loss to all of the experiences and impact of trauma. This can be overwhelming, can impact the victim's ability to function, and can stunt healing and recovery. The loss would be a precipitating event that might trigger a suicidal crisis or other crises for the victim. This would be a time to screen for suicide risk. In addition to identifying any risk, do the other things that you do so well, such as increasing contacts, connecting with support and treatment if needed, and using trauma-informed approaches. Additional complications can occur if the offender dies by suicide. This can have many possible reactions and impacts, including increased feelings of shame, guilt, blame, anger, and fear.
- Losing a close support person to suicide can leave a victim feeling as if they don't have support or shouldn't burden others with their needs. They might feel guilty for having used the person for support. There can be many possible reactions that could complicate grief and healing in this situation.

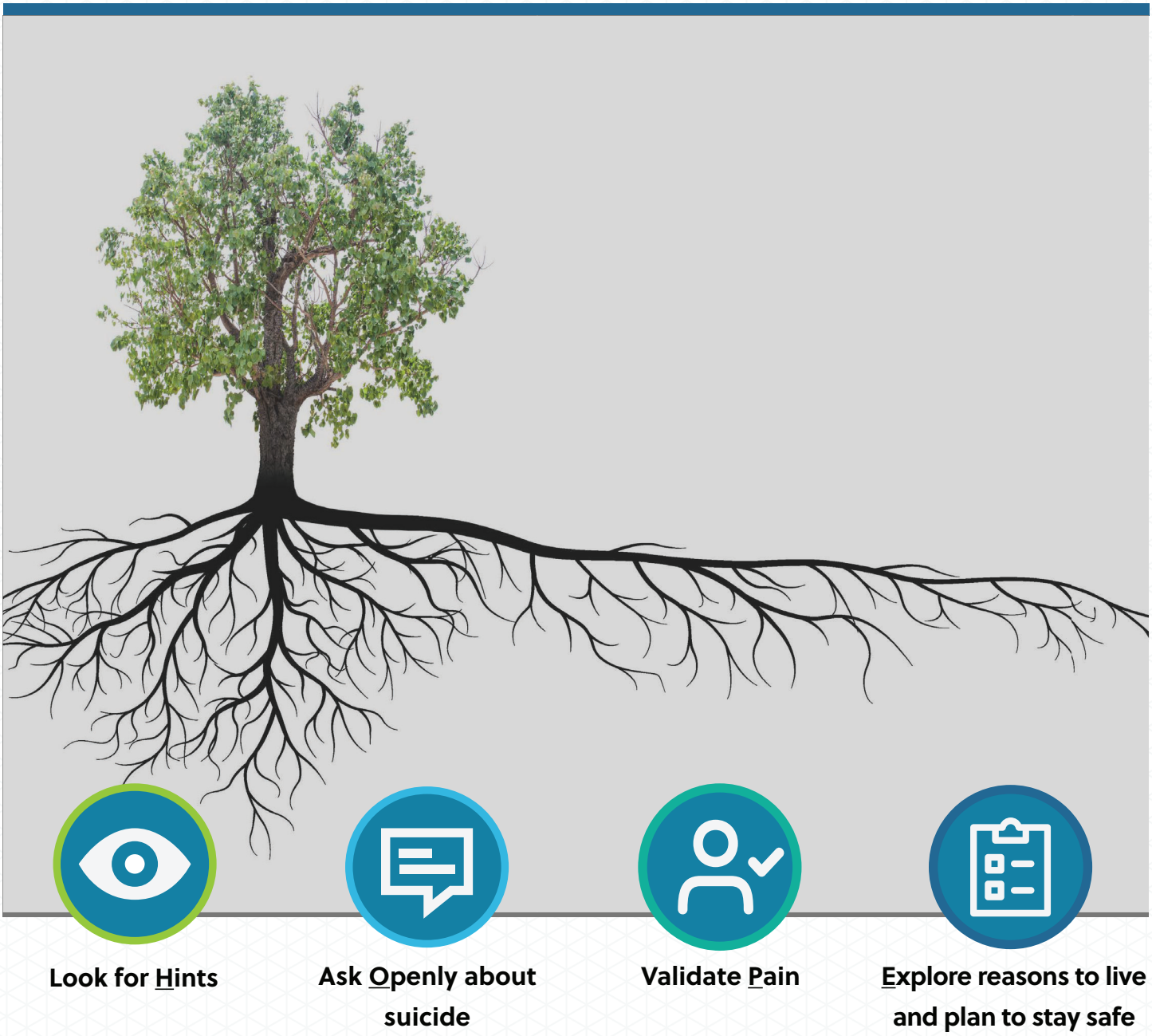
- It is important to keep in mind the many complicating factors for crime victims if they lose a person to suicide.

Conclusion

Key Points

- We have outlined possible reactions of those who might be concerned a victim is at risk for suicide and ways to support them. We have also discussed ways to support the family, community, and victim if they are impacted by a suicide loss.
- Knowing that you are one person, leverage your team and resources. Stay in your role, engage in self-care, and get support for yourself when needed.
- Let's remember most people who attempt suicide go on to live without dying by suicide. The support makes a difference for those impacted, and you are not alone in this work.

Module 8: Consider the System



H.O.P.E. saves lives

Module 8 Overview

Topics Covered

- Specific challenges and strengths of each crime victim setting
- Strategies and considerations in developing suicide triage care policy

Learning Objectives

In Module 8, participants will:

- Identify recommendations to enable settings to better support suicide prevention and care
- Identify key champions within the facility and larger system to partner with for suicide prevention

Materials

- **Worksheet 8A:** Systems

Introduction

Introduction

We have focused on supporting the victim, family, and community and your own self-care. Now we are moving on to discuss the systems in which each of you work. We encourage you to channel solution-focused brainstorming on this final section. It is okay to identify challenges, limits, and gaps. Yet, we can't stop there.

We need to use our energies and collective wisdom to strengthen our organizations. Trainings such as this can serve as an impetus for changes to be embedded in a system.

Systems

Objectives

- Identify recommendations to enable settings to better support suicide prevention and care.

Key Points

- We will focus on the first competency of developing recommendations to enable each setting to better support those at risk for suicide and each of you doing this work. We'll identify challenges, outline possible solutions, and standardize practices.
- Let's review some common challenges. While these challenges are not specific to your community or organization, as you read through them, think of which apply more to your specific area.
  - Often, leaders and systems may not have established clear standards, processes, or policies.
  - At times in systems, the "who to go to" person is identified. Yet, those on the ground aren't trained or provided the appropriate information to do this. For instance, the "who to go to" person might be a crisis mental health professional, but the information for how to reach them, what to communicate, and options for their response may not be in the hands of the advocate when needed.
  - Insufficient training can emphasize differences in individual responses. For instance, an untrained advocate might mistakenly judge that a victim is not at risk for suicide or missing hints.

- Poor documentation can occur when previous action steps, including safety planning, or previous identification of risk is not clearly documented. Imagine a survivor communicating signs of suicide risk, but the advocate responding in that specific moment doesn't have the documentation that the person attempted suicide previously.
- Gaps in communication can refer to internal, external, and between-system communication.
- Many systems do not consider resources for suicide loss until after suicide occurs.

» There are several strategies to improve structure and consistency related to suicide prevention in crime victim advocate agencies:

- Create standard training and protocols specific to roles. Be intentional to create this structure across the continuum of prevention, intervention, and postvention.
- Clearly define roles and scope.
- Outline standard processes and procedures, including who to go to, who to inform and consult with, crisis policies, and standardized screening and triage, as possible.
- Be specific about documentation within legal and ethical requirements. Yet, work to ensure that if many staff provide services to a person at risk, information is appropriately shared and, specifically, only the information that addresses risk and works to improve safety.
- Use memorandums of understanding or memorandums of agreement to clearly outline partnerships.

Activity: Writing Exercise Focused on System Policies

» Using **Worksheet 8A: Systems**, focus on identifying three things:

1. What type of policies exist for your system?
2. What do these policies communicate about your role in addressing and/or preventing suicide?
3. Where are the opportunities for improvement in these policies?

» If you don't know this information, then others in your system don't know. This means there is a need for standardization in policies and/or procedures, improved communication, and training.

Worksheet 8A: Systems

What type of policies do you know exist for your system?

What do these policies communicate about your role in addressing and/or preventing suicide?

Where are the opportunities for improvement in these policies?

Identifying Champions

Introduction

Systems changes typically do not happen overnight and by one person alone. System improvements occur more effectively and efficiently with engaged champions.

Objectives

» Identify key champions within the facility and larger system to partner with for suicide prevention

Key Points

Focus on strengths and ways to leverage strengths.

» Build on what works well in your systems and cultures. If you all do a great job supporting each other, consider what organizational supports and cultural changes made this happen and build on these approaches. Often, it is useful to build on trauma-informed, substance misuse, or violence prevention approaches. An organization may have made progress in one area that can serve as momentum in another area.

» A just culture is an organizational culture where the focus of reducing errors and preventing adverse events is on the system and not the individual. A just culture is a model of shared accountability, where feedback is sought at all levels, with no deference to rank or position, to progress toward what is best for the client and safety. Errors are seen as learning opportunities to improve the system. A just, safety-oriented culture can be a foundation for suicide prevention with crime victims while taking the pressure off of the heroic efforts of you as an advocate. You have a system that is built to reduce gaps and support safety, healing, and recovery.

» Champions don't have to have a certain credential. Yet, it is helpful to engage those who have some power and influence to change a system.

» Engage those who are passionate about the issue or improvement you are seeking. Also, work to engage key leaders who have the power to impact change. Use both stories and data to leverage champions. Work to get those with expertise or lived experience on board. People with lived experience are those who have been through a crisis and can use their experiences to inform systemic changes.

» If it is too challenging to seek systems change and still care for yourself and others, consider how to have a voice in a way that works best for you and your system.

Reflection

- Reflect on the strengths of your current organization.
- Identify: Who are the champions are in your organization? Who are the key leadership, staff, and other champions in your site/system whom you can get on board?

Conclusion

Key Points

- Suicide prevention requires an organizational commitment and a systematic approach.
- The work of supporting the safety and recovery of those we are supporting must be a team effort and not on the heroic efforts of individual advocates.
- Organizations need to review training, policies, procedures, and referral networks to develop a comprehensive approach to suicide prevention.
- Leveraging the energy and passion of champions can create momentum for systemic change.

Training Wrap-Up

We have come to the end of our training program. To pull it all together, we have discussed the specific suicide risk data that crime victims face and have discussed that certain communities are at higher risk than others. We have also discussed the following topics:

1. The role of the crime victim advocate
2. The kinds of hints to listen for that may signal suicidal ideation and risk and how to listen and openly communicate that you are listening and unafraid of discussing suicide
3. The best ways to address suicidal statements and to screen for suicide risk
4. The importance of addressing suicide directly and openly after indirect questions
5. Strategies to validate pain, explore reasons for living, and establish a safety plan
6. Important issues that may co-exist with suicide risk, including trauma and substance use, and the ways that co-occurring issues can exacerbate or inform suicide risk

7. The best ways to help family members and close supports who may be within the suicidal person's social network
8. The importance of taking care of our own mental health and well-being through intentional self-care
9. The importance of recognizing and working to improve the systems we each work within, so that our advocacy can be most effective and so that we can be the most effective.

» This training, developed by Education Development Center with support and in close collaboration with the Office for Victims of Crime, is just one foundational step in the learning available to you.

» Access resources, videos, and additional information about the H.O.P.E. Suicide Prevention Training on the EDC website: https://www.edc.org/hopeforadvocates.

» There are resources available, including training and technical assistance, through the Office for Victims of Crime.

» Education Development Center, including its Suicide Prevention Resource Center and Zero Suicide Institute, is available for consultation and questions. We offer a large array of publicly available webinars, resources, and training that you and your organization are welcome to take advantage of. If your organization is interested in having a H.O.P.E Trainer organize a training for your staff, please contact Dr. Heidi Kar at hkar@edc.org.

» In addition to these resources, the Substance Abuse and Mental Health Services Administration has many resources regarding substance misuse, suicide prevention, trauma-informed practices, and more.

» The National Action Alliance for Suicide Prevention is the nation's public-private partnership focused on suicide prevention.

» The National Suicide Prevention Lifeline (1-800-273-8255) provides crisis services for people in distress, their loved ones, and best practices for professionals.

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