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>> JULIE GOLDSTEIN-GRUMET: -- .com. This will be archived in there as well after today's webinar. I'm Julie Goldstein-Grumet. I oversee the Zero Suicide Initiative for the Suicide Prevention Resource Center.

The Suicide Prevention Resource Center is federally funded by SAMHSA to build infrastructure as well as provide technical assistance, training and resources to a wide variety of audiences including both behavioral health and other healthcare providers. We provide the training and the technical assistance for the Garrett Lee Smith grantees, the state and tribal and college campus grantees. And we develop a lot of resources for different settings.

We also manage and oversee all the content development for the Zero Suicide Initiative which I'll tell you more about in just a moment.

For those of you who tweet here's our hashtag. Feel free to share content throughout today's webinar.

So what is Zero Suicide? We really see the Zero Suicide Initiative as transformative for healthcare settings. We know that many suicides take place in and around healthcare. Forty to 50% of deaths have been within a month of a primary care visit. Fifteen to 20% of suicide deaths annually are among people receiving care in the mental health system and 10% of suicide deaths are among people who have been seen in Emergency Departments in the past two months.

Just imagine if we are able to transform those systems the impact we could have on suicide rates in our country. Zero Suicide builds on the awareness that comprehensive system wide approaches have worked to reduce suicide. For example, our comprehensive approach is built on the work of the Henry Ford

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Health System and the Perfect Depression Care Approach, the United States Air Force and several others who have been able to launch full scale system wide comprehensive approaches.

Every organizational model is successful prevention and care and the pioneers of the Zero Suicide approach began with changes in the organization's core values and beliefs. The idea of transforming healthcare systems to reduce suicide is part of the National Strategy for Suicide Prevention and it's a core priority of the National Action Alliance for Suicide Prevention.

Suicide care is really the patient safety goal. Reducing suicides to zero may be aspirational but reducing suicides generally for those in your care is essential and it's a core responsibility of healthcare. So take a moment and think about do you know the number of suicides that happen for those in your care? Could you tell us? Do you have a systematic approach to collect this? We really hope that today's webinar and some of the other resources on our ZeroSuicide.com toolkit will help you to think about that and make a mission within your organization to make sure that you're tracking and aware of the suicide deaths for those who you are responsible for caring for.

Zero Suicide provides a framework for systematic clinical suicide prevention. Today's webinar will describe one component of such a comprehensive approach, the role of safety planning and lethal means counseling necessary to keep your patients safe. Additionally as I said, we have other tools to launch these efforts at ZeroSuicide.com. We are updating this online tool kit so if you were to check back in two months from today, it'll look different. The tool kit will remain live but the website itself will look different.

Zero Suicide is a framework for providing systematic clinical suicide prevention and care. I'm going to describe it very briefly but I do encourage you to look at our online tool kit. The red box really highlights the pieces that need to be in place. You need to have a leadership commitment to safety, accountability and transparency that's continuous. You can't have it during sometimes of the year and then when you think you're doing well let up and move on to other things. It has to be consistent. The workforce beyond just the clinical care teams should be competent, confident and caring. Everybody needs to accept suicide care as their mission no matter their role in the organization.

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The gray box are the components of care essential including systematically identifying and assessing for suicide risk, providing care that directly targets and treats suicidality and behavioral health disorders by using effective evidence-based treatments. You have to have contact, engagement and support especially after acute care transitions from Emergency Departments or inpatient settings. These handoffs have to be warm handoffs and you need to track where patients go and be mindful of ongoing engagements.

One effective evidence-based strategy is the use of safety planning and reducing access to lethal means for those at risk that we'll talk about today. There also should be a care pathway. Essentially these are the protocols and practices that define care management expectations for all persons with suicide risk that's taught to all the clinicians and ideally is based into the electronic health record. Of course there needs to be a review of the data and do continuous quality improvement by the leaders of your implementation efforts on a regular basis.

This is a resource that more thoroughly describes the model and the philosophy behind Zero Suicide. It's available on our tool kit and you can feel free to download it and share it with others or with people on your leadership teams. Just a brief overview of Zero Suicide. We hope you'll take a look at our tool kit to learn more.

Here's a quick look at today's presenters each of whom is a leader in suicide prevention or in systems framework.

The learning objectives. By the end of the webinar we expect that you'll be able to identify safety planning and lethal means reduction as part of a comprehensive Zero Suicide approach. To be able to discuss ways to maximize the effectiveness of a safety plan. To develop an organizational policy for lethal means reduction. Be able to explain the importance of input from people with lived experience during safety planning and means reduction policy development.

Our first speaker is Dr. Barbara Stanley. Dr. Barbara Stanley is Professor of Medical College in the Department of Psychiatry at Columbia University College of Physicians and Surgeons, Director of the Suicide Prevention Training, Implementation and Evaluation Program for the Center for Practice Innovation at Columbia University and research scientist in the Division of Molecular Imaging and Neuropathology at New York State Psychiatric Institute.

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Barbara has been a principle investigator on several NIH and foundation grants investigating clinical and neurobiological factors and intervention strategies related to suicidal behavior, borderline personality disorder and non-suicidal self-injury. She is the author or more than 200 publications and has edited or authored several books. With her colleague Dr. Gregory Brown, she developed the Safety Planning Intervention designed to mitigate suicide risk that she'll be talking about here today that is used throughout the VA and in civilian Emergency Departments inpatient and outpatient facilities. We're really thrilled to have her join us on today's webinar. Barbara.

>> DR. BARBARA STANLEY: Thank you very much. I want to thank SPRC for inviting me to give this presentation today. I thought I would start with just a little bit of brief background on safety planning but I want to just stress what Julie just mentioned that safety planning does fit into the Zero Suicide Initiative as one aspect of evidence-based care.

Okay so when we think about doing interventions with suicidal people and trying to get them to be accepted, the interventions to be accepted is system wide. The simplest way to approach this is by starting with brief interventions and so that's where we have started with safety planning. Safety planning is just one of many types of brief interventions for suicidal individuals.

I thought I would talk a little bit about the origin of safety planning and what some of the current uses are. Let me just start with where we began with safety planning. It's one of these interventions that kind of grew serendipitously as an intervention. It was originally developed as a way of keeping people safe in clinical trials until they got the real thing, the real treatment onboard and so in the context of CBT for suicide prevention the control patients were getting safety planning to help keep them safe.

And then as we were working with this we realized this was a pretty powerful intervention in and of itself and people started talking about what were the active ingredients of the treatment. They talked about safety planning. We realized that actually we should really think about this as an intervention to be utilized in and of itself that's very accessible to people.

So today what I'm going to do is give you a broad overview of safety planning. You shouldn't walk away thinking that okay so now you are an expert in safety planning once you have heard my 20 minute presentation today. At the end of my talk there'll be

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additional resources that you'll see there. Really what people do is have more in-depth training and they do some practicing like we do for any kind of intervention.

One important thing that I wanted to stress here is that people of all levels of professional training can learn to use safety planning. The really interesting thing about this is that doing the safety plan with somebody is a lot easier than figuring out how to do a very, very good risk assessment. You do not need as many skills and as much knowledge base to do safety planning as you do to understand all the ingredients that go into doing a risk assessment.

Okay so if we look at the target for safety planning, we think about people who are at increased risk but not requiring immediate rescue as the candidates for safety planning. If you're on the phone with somebody and they have a gun, you're not going to talk about doing the safety plan that will help mitigate future risk. You need to do whatever you're going to do to keep them safe right now and so when the immediate risk, the imminent risk diminishes is when you should do the safety plan. I'm talking about the very imminent risk like the short-term risk is there, if they're not in danger, the point where they're not in danger of acting.

So who should we do this with? We should think about doing it with people who have made a recent suicide attempt, people who have strong active suicide ideation and then if you want to broaden the net you can think about doing it with people who have psychiatric disorders that increase risk or they're otherwise determined to be at increased risk for suicide. Sometimes people have talked about this other category when somebody has had a big loss or there's been a cluster of suicides in the school in trying to help keep people in a more broad way safe.

So the theoretical approaches underlying safety planning are threefold. I put theoretical in quotes here because we're talking about small theoretical and so the notion here is that suicide risk fluctuates over time. This in part comes from a stress diathesis model of suicidal behavior. It also clearly comes from the data that we have. We know that even for people who get extremely suicidal that acute suicidal state doesn't remain around for very long. If you look at the data in terms of how long people think about making a suicide attempt before they actually make the attempt is not that long. And so the idea of safety planning and in fact even means restriction which is part

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of safety planning is to help them through this very brief acute period.

Another theoretical approach is that we think about problem solving capacity as diminishing during crisis. You know that you can't -- when you are in an emergency you can't think clearly and so this is an approach where we either over practice to compensate or you have a specific template to enhance coping. For example, kids are taught in school if they should catch on fire you stop, drop and roll. It's a very simple thing.

The analogy that I like to think about is on an airplane. Every single time we go up we know what to do should the cabin pressure drop. We have a specific template in case of an emergency. The way we speak to suicidal individuals about this who may be resistant to doing the safety plan because they say well I was suicidal but I'm not now and I won't be again is look you go up on an airplane. We hope that the cabin pressure never drops but you want to know what to do in the rare event that it does happen.

And then finally the other theoretical approach is to use cognitive behavioral approaches including behavioral activation and distraction. We use distraction and social support in the safety plan as key techniques.

So the evidence base comes from four different places. Means restriction. There's a considerable amount of evidence to show that means restriction helps reduce suicidal behavior. Teaching brief problem solving and coping skills, enhancing social support and identifying emergency contacts and then finally we hope that safety planning increases motivation for further treatment.

The way that we think this can help, that safety planning could work, is kind of by example, by people using the safety plan, seeing that it works and then realizing that treatment may have something of use for them.

Okay so I like to use this example when I speak to people who work in emergency settings. What we think about when we think about emergency settings for psychiatric patients, the typical way that we deal with them is that we do an evaluation and then we triage them. They either go home. They don't need to be hospitalized. You give them a referral or they get hospitalized into psychiatric facility.

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But the way I think about this is like would it be okay to have the same approach to somebody coming into the ED if they had a fracture. Would we think about doing the evaluation? In other words, looking, doing a physical exam and doing an x-ray which is the equivalent of our suicide risk assessment and then simply giving them a referral? The answer is pretty much no. If they need to have surgery immediately that would be equivalent to us hospitalizing a suicidal patient who cannot go home but we don't do anything else with them that we would do with somebody who has a fracture and so that would be some kind of immediate intervention done right then and there.

And so the way that I guess I have thought about this a bit is thinking of safety planning as a cast for suicidal patients. And so it provides immediate intervention to those who do not require or need inpatient hospitalization. The other thing that it does is it fills that gap, an inevitable gap, between discharge from an emergency setting or from an inpatient hospitalization and follow-up or from somebody who you're seeing as an outpatient who is suicidal which most of us will see outpatients who are also suicidal. It fills that gap that they have some way to cope from visit to visit.

And the other thing when safety planning can be used, the other place that it can be used is as a booster, as a tool for individuals who refuse further care. If you work in the emergency setting you know that there is a good subset of individuals who come into the emergency room and who never seek follow-up care, who refuse it for whatever reason. It's not accessible. They fall between the cracks. The immediate crisis subsides and they don't go further.

Okay so just quickly to give you an overview of the steps in safety planning. We have chosen to do it in this way and it actually seems to be a way that people who use the safety plan like. It's a prioritized list of coping strategies and resources for use during the suicidal crisis. It's equivalent to on the airplane that you do this first, you do that first, you do that second, you do that third and so forth in the event that cabin pressure drops.

And so it's a prioritized list of strategies to use. What it does and we've had patients tell us this, it helps provide a sense of control. One quote that I can think of from a patient is I never thought that I could do anything about my suicidal feelings and now I have something that I can do when I get into that state.

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It uses a brief easy to read format in the individual's own words and we feel like it's really important to put it in the person's own words. This is one of the issues with having safety planning apps that are kind of like drop down menus. They're better than nothing but the problem is the patient in the emergency state has to do a bit of translation from what is there, what they choose from the list versus what would be really their own words and their own idea of what it is they would do.

It can be used as a single session intervention or incorporated into ongoing treatment. It usually takes 20 to 40 minutes. Now I will say that the 20 minutes is on the brief side and we definitely can do this if there's been a risk assessment where we have already pretty much identified the warning signs which are the first step in doing the safety plan. Often that first step, identifying the person's warning signs takes the longest to do.

Okay so what it isn't. It's not a substitute for treatment and so one of the things that I think is important is I think about suicide prevention is kind of like a wheel and there are spokes on the wheel. This kind of intervention is one of those spokes. We don't use it, as I said earlier, if the person is in imminent danger, just right then and there you have them on the phone that would be the usual time where they're at imminent risk and you need to do something right then and there to intervene to save them.

Safety plans are not no suicide contracts and so the way that I think about no suicide contracts is it asks them to stay alive without telling them how to do it and so safety planning is kind of one step removed from that or one step further than a no suicide contract. Actually we don't ask people to promise they won't kill themselves. We just give them tools to use to not do it.

So here are the six steps. As I said, the first step is recognizing warning signs. A person is not going to be able to use their safety plan if they don't know that they are in danger and so we work with people at the beginning to identify what their particular warning signs are, not textbook warning signs but their particular warning signs. It can be a broad range of things that are not your typical kinds of things. It's what the individual knows and if you have done a good risk assessment with them prior to doing a safety plan you will know what their warning signs are because they will have talked about it.

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The second step is employing internal coping strategies without needing to contact another person. Often people get suicidal in the middle of the night. We want them to learn to use resources that they have at their own disposal without having to contact anybody else.

Socializing with others who may offer support as well as distraction from the crisis. I'll come back to that in a minute. Contacting family members or friends who can help resolve a crisis. These two steps are distinct from each other. They both involve people but one is just using people in the same as you would use internal strategies. It's not telling somebody about the crisis. It's using people as distractions.

The next step is okay who do I reach out in my natural environment. If you look at these steps these are steps that are helping a person learn to develop strategies to cope on their own. In the same kind of way actually that we would give patients who have problems with anxiety strategies to cope with anxiety or people who have panic attacks strategies to cope with their panic attacks. We feel like we can do the exact same thing in small ways with suicidal individuals instead of just saying if you get suicidal go to the nearest emergency room.

So then the next step is contacting family members or friends who can help. And then contacting mental health professionals or agencies. And then finally what we put on the plan last, what we tackle last is reducing the potential for the use of lethal means. It isn't that we think of it as the least important step and it isn't that we're going to ask patients to implement this last. We put it on the plan as the last thing the clinician does with the person because we feel like this gives people who are suicidal a sense that okay they may be more willing to engage in a discussion of means restriction if they see that they have certain kinds of strategies.

If you work with suicidal people often you know that they often don't want to give up their means not just even because they need the gun for protection but because it gives them a sense of comfort to have those means available. And so by showing them first that we are giving them other ways of coping, we hope that they become more willing partners to engage in the discussion about the reduction of means.

Okay so the first question that we wanted to ask you is do you in your work use a safety planning template at all? I see that a lot of organizations do, more than half use safety

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planning. Okay so I'm going to let that run while I go on to the next question.

So here is the template that Graham Brown and I developed. This is one example of a form. Now I put this form up for you to see but also to let you know that although this is a form, you should never treat it as a form to be filled out. This is a clinical intervention. If you treat it as a form, it is going to lose its power. You could give this to a patient and say hey fill this out. This could help you but the idea is that this is an interaction between a clinician and a suicidal individual and they come up with strategies and approaches together that will help the person.

Okay so how many of you actually use this particular template? We saw from the last one over half the people have a safety planning template that they use or they have a safety plan they use. How many use this particular one? Okay. It seems like just under 30%, maybe a quarter of the people use this particular one. I would be curious to see what other safety planning strategies or forms that you use. If there was some way to share those with each other I think that would be terrific.

Okay so let me move on and just go through each of these very quickly. The first one is recognizing warning signs. As I mentioned before, a safety plan is useful only if the individual recognizes when they should use it, recognizes what their warning signs are. And so the way that we do this is we obtain an accurate account of the events that happened, that led up to the crisis.

The reason that we ask that is because embedded within that you are doing a risk assessment and you are also finding out what their warning signs are. And so you can once you have described the safety plan to people you can ask them okay so we're going to figure out what your warning signs are so we can know when you should be using this.

One way of starting this conversation with people is to simply ask what do you experience when you start down that path of feeling acutely suicidal. And so what you really want to do is write these down in the person's own words. So if the person says I get blue you don't put down your idea of what blue is, that the person is depressed. You put down their words so they know what blue means to them. We use their own words.

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We did a chart review from the VA of what were the kinds of things people identified. We just categorized them. It's actually mostly thoughts that people have. This does not add up to 100% because people have more than one warning sign often. It's different types of emotions not surprisingly. To a lesser extent they start engaging in certain kinds of behaviors.

Okay so once we have identified for them what their specific warning signs are, it could be something like I find that I am spending a lot of time in my room alone or it feels like nothing is ever going to get better. I think a lot about what's the point of going on. Okay so we have that down and we say okay in order to avoid suicidal feelings escalating so that you act on them you know that when you see these warning signs you should engage in using your safety plan.

The first step is to really get them to learn to cope on their own. One important thing is we don't want people okay so you must use the safety plan. You have to use your safety plan before you call me or if somebody feels acutely suicidal and they can't even think straight, they can't begin to engage in any kind of coping we would never tell them okay you must use these steps first. They need to go to the emergency room. They go to the emergency room. Most often it's not the case.

Okay so we have people list activities that they can do without contacting another person. The activities function both as a way of activating behavior and it's taking their minds off their problems temporarily. The notion here is that since suicidality that acute suicidal state lasts for only a brief period of time, time is your friend and so you get people to divert themselves for a small piece of time while the acute suicidal crisis subsides.

We know that using these kinds of coping strategies can prevent suicide ideation from escalating. And so now you might look at this and say oh somebody can do this on their own but really it takes a clinician working with the person to figure what are the best activities for them. And because the individual may think of things that are either not accessible, not healthy, or they may think of things that in the end make them more acutely suicidal.

And so we think that it's useful to have individuals try to cope on their own with their suicidal feelings even if it's just for a very brief period of time. What patients have told us is that it enhances their self-efficacy and their sense of power

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over suicidal urges. This is a simple question that we ask people. What can you do on your own if you become suicidal again to help yourself not act on your thoughts or urges?

In addition, we would ask them once we have identified a strategy for them how likely do you think it would be to take this step during a time of crisis? Or what might stand in the way of you thinking of these activities? And so we use a kind of collaborative problem solving approach to address the potential roadblocks. So you are doing a little bit of motivational enhancement along the way.

In addition, you really work with them on trying to figure out what are the kinds of things that would be helpful to them that definitely won't escalate their suicidal feelings. And so this just summarizes from our sample what are the kinds of things people identify. It's kind of simple here. This is not rocket science and it's amazing how this can be so helpful but what works for one person may not work for another.

We have up here summarize watching television or watching a movie but we just don't leave it at that when we're working with somebody. We will say okay so what are the kinds of things that you can watch on television or what kinds of movies can you watch that will have the potential to make you feel better? More importantly what are the kinds of things that you should avoid watching that will make you feel more suicidal, more depressed?

And so I can give you another quick example. For some people an activity might be doing household chores because that's very distracting for them. For somebody else it might just make them feel really down and depressed like this is all I can do. I can't do anything else? I can't think and so forth.

These are just some examples that our patients gave us. You can see just the range here. We try to get people to identify things very clearly that they can do without a lot of resources.

We have had people that this and use this in a more confined settings like in prisons or on inpatient units and so of course some of these things have to be adapted.

Okay so the next step is -- so the idea is here if that step you try two or three internal strategies and they work great. You don't have to use -- put the safety plan away. If they don't work then we have people escalate to the next level of intervention and that is using socialization as a means of

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distraction and support. We coach individuals to use the next step if the second step doesn't resolve their crisis. Socialization is used here to take your mind off problems not to tell somebody about your problems.

And so when we do this safety planning with adolescents we will allow adolescents to use other adolescents here but not the next step where they're telling people about their problems. We have two options in this step using family friends or acquaintances who can provide support and distraction or going to a healthy social setting.

The reason we have these two options is because sometimes people will say well I have nobody. I have no one that I can use to distract myself and so we want to provide an opportunity for them to also use socialization as a means of distraction and almost everybody has a local little luncheonette or a gym or a bookstore or a library that they can go to.

Okay so these are the kinds of questions. Who helps you take your mind off your problems at least for a little while? Who do you enjoy socializing with? We try to get them to list several people in case they can't reach the first person on the list. We make sure we tell them it's amazing how sometimes you don't think of everything and this actually happened to me where somebody just kept waiting because the first person on their list wasn't available. They kept trying and trying and trying them instead of moving on so you make sure you tell people if somebody isn't available just move on and go to the next person.

To identify healthy social settings we ask them a question like where do you think you could go that's a healthy environment to have social interactions? Are there places or groups that you can go to that can help take your mind off your problems even for a little while? Some people identify going to AA meetings as a place for them. We ask them to list as many settings as they can think of.

One thing that we absolutely do not have people list here is their local bar, which is a place of interaction but we do not want people who are acutely suicidal drinking.

Okay so again here is from the RDA study this is what we found. People go to a library or bookstore, outdoors, place of worship or community center and so forth. Going shopping at a mall. Now it's really interesting here for some people going to a mall and walking around can make them feel really good. It's

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distracting. Social people. A lot of people out there. Other people it can be a very demoralizing depressing experience because they're alone or they might not have money and so this is where it's important that the clinician be involved with the person and just ask them the next question or two to make sure that what they're putting on their list has the potential of being helpful.

Okay so then we ask them to go on to the next step if this step hasn't worked. Again we want them to rely on people in their own environment. We don't want them just rushing to clinicians. We're trying to teach them the idea that suicidal feelings are feelings like anything else and we can learn how to handle them. I mean that is the basic tenant here.

And so we want them to do what is natural for somebody who isn't a psychiatric patient to cope with their feelings, their distressing feelings and so before they run to the emergency room or reach out to their clinician we want to try to have them engage their natural environment so we have them identify who would be likely candidates.

And then we ask them okay you've identified your husband as somebody who you think you would want to put on this list. How likely is it that you would actually be willing to tell him that you are feeling suicidal and you need his help? So then you identify potential obstacles, ways to overcome them. So you might have a very brief discussion about change and then you ask if the safety plan can be shared with other family members or other people who are on the safety plan. It's helpful to have that happen. In the VA often the veterans will really want their spouses involved in safety planning.

And then the next step would be if people haven't deescalated in their suicidal crisis this is when they should reach out to clinicians and then we identify which clinician should be on the plan, identify potential obstacles and develop ways to overcome them. So there are some clinicians who you know in advance do not answer emergency calls or do not take calls to readily or take a long time to return a call because of their scheduling so that might not be the right person, the right clinician to put on the list.

And so we list the names and locations. We leave nothing to chance here. We will put the lifeline number on the safety plan. Sometimes for people who have nobody in their lives we might move up the lifeline number to one of the -- instead of having

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people in their lives to reach out to like family or friends we would put the lifeline there if they have nobody.

Okay and then finally the last step that we have in terms of engaging in the discussion with the suicidal individual is we ask individuals what they would consider using during the suicidal crisis or if you're seeing them for a recent suicide attempt what they did. No matter what, we always have people ask whether they have access to firearms. The reason is because they are using a firearm in a suicide attempt is lethal 85% of the time. That is the data that I just looked at. Anywhere from 85 to 90% of the time if somebody uses a firearm they're going to die and so we always ask them about access to firearms. And I'm saying that here in a kind of off handed way but this discussion often is not an easy discussion to have with people and it's often a matter of negotiation with them like how much are they willing to do.

We have places as I said earlier at the end of the safety plan because if we give individuals a sense of alternative they're more likely to engage in a discussion of means restriction.

For low lethality means we will say to people that they can remove or restrict access on their own if they feel safe or high lethality means especially if we have somebody who we have just seen who has made a recent suicide attempt we identify ways for somebody else to limit access or to remove the access.

Okay so now we have gone through the entire safety plan and we then do kind of a briefing at the end with people. We ask them where are they going to keep it. How will they remember that they have a safety plan? What would be their queues to it? How likely is it that you will use the safety plan when you notice the warning signs are in place? Sometimes people get into kind of a resistant mindset and don't want to use it or they feel weak if they have to use it and so we would ask them something like how can you fight the urge if it's present to try to not help yourself?

Okay so there are safety plan apps available. I already gave kind of like the disclaimer of what I am not a fan of in terms of having drop down menus. The one on the left is the safety plan that was developed by Greg and me through New York State and Columbia. This one is actually simple and it takes work to use because it doesn't have drop down menus. You have to put in

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free texts. I'm actually not sure what MY3 does if it has drop down menus.

I want to just end by going through a couple resources. There is a free e-learning workshop that New York State OMH and Columbia sponsored on safety planning. You can access it on the Zero Suicide website. And then these are resources that are written resources.

Greg and I wrote an article that is really kind of like a manual in cognitive and behavioral practice. You can access the safety plan form by going to our website SuicideSafetyPlan. If you want to contact us you can contact us there. We wrote a manual for the VA that is an earlier version of what we put in cognitive behavioral practice. And there's a little quick guide for clinicians that was developed in the VA that is listed on the SPRC website.

So I think I will end there and I thank you for your attention.

>> JULIE GOLDSTEIN-GRUMET: Thank you so much Barbara. So informative. We're going to turn to Becky now to talk more about lethal means reduction in a healthcare organization, so the next step in your safety plan. Becky Stoll is Vice President of Crisis and Disaster Management at Centerstone where she's responsible for the overall operation of Centerstone's crisis services as well as crisis management strategies.

Becky is a licensed clinical social worker with 16 years of behavioral health experience. Becky serves as the Chair of the Board of Directors for the International Critical Incidence Stress Foundation and is on their faculty. Becky has provided response and training nationally and internationally to professional sports, aviation industry, educational institutions, banking industry, emergency responders and civic groups.

Becky is a member of the Action Alliance and Zero Suicide Advisory Group and is an early adopter of the Zero Suicide Initiative bringing innovation and care to Centerstone. She serves as one of our faculty members and is a mentor to others launching this approach. Becky.

>> BECKY STOLL: Thanks, Julie. So to piggyback on the presentation that Barbara gave with such rich content, I'm going to turn to how paying attention and being purposeful around

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means with the clients and the patients we see and how we embedded that into a very large behavioral health organization.

So Centerstone is the largest outpatient behavioral health provider in the country. We have presence in Indiana, Tennessee, Illinois, Kentucky and soon to be in the beginning of 2015 in Florida. When we started on this journey, Tennessee and Indiana were the two locations that really adopted and kind of paved the way and we were in the process of pulling Centerstone of Illinois into our process.

So what we call our initiative it’s really a system we're trying to bake into our organization and it really is our clinical pathway for suicide prevention and how we were going to be mindful of the ways we were screening, assessing, treating and monitoring folks that were high risk for suicide. So we have implemented this pathway with all ages that we see, at all locations in all of the service lines we have so that we really make sure that we're not leaving anyone out. Even things like some of our employment programs where we're not really providing mental health treatment but maybe we're helping someone find housing or employment which also can be high risk.

So when we started the journey our goals initially were really to change the culture that we had, which I think is very similar to everyone else's. Suicide was kind of a bolt on service that was housed in crisis and within our treatment programs and our case management programs if someone was suicidal we would kind of call someone from down the hall or across town and they would come over and take that.

But we decided that really wasn't the best way to do it and that we had to figure out how we could weed out the folks that we thought truly were suicidal and put them on a pathway to care. The second piece of that being then we had to make sure our workforce was ready for this new way of thinking and that they felt confident in the work they did.

One of the big hinge pins for us and you see this in red here on the slide is not only using evidence-based care but how are we going to limit or reduce access to the means that folks could use that really could take their lives from them. What could we put in place within our system using our electronic record and some of the other functionality we had how could we do that?

And so the first thing was getting our staff trained. We developed a training program to be honest is still evolving and

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I think will continue to evolve as we get better at what we do and expand our footprint across the country making sure that all the folks that work with us have this training. But one training around means that we thought was incredibly fruitful and we got a lot of positive feedback from our staff was the SPRC's Counseling on Access to Lethal Means.

That online course really was one of the things that when I was out in the field I heard a lot from our clinicians about how much they enjoyed this training and even had seasoned clinicians, 15, 20 years that these folks could go -- these had components to it that I never had thought about.

The other nice thing about the CALM training from an organizational standpoint is it had a good price point in that it was free and so we didn't have to budget money for that. We could keep track of that in our internal training department and in our online system to make sure all of our staff that were going to work within the framework had had this training. If you have not had your staff take this training I encourage you to do it.

So this is a slide showing the location on SPRC website. At the bottom you can see how to access that for your staff.

So we developed our pathway pretty systematically and what were the components going to be of that. And it became pretty apparent in the early days for us that once we enrolled someone "in our pathway" that we were going to make sure that they understood what that meant. We only learned that because the pilots that we ran before we started the pathway we didn't do that.

I had a really I'll call it a duh moment where I kind of slapped my forehead and went gosh are we telling people that we're enrolling them in this pathway and in some locations they were and in some locations they weren't. So we thought wouldn't it be kind of a groovy idea to let people know that they're in this kind of special path?

So we developed an education sheet that you'll see in a couple of moments and it outlines some of the things that we thought were important around reducing their access to lethal means. You can see some of the other things that we did on the slide here around crisis planning like Barbara talked about and some of our follow-up work.

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So this is the education sheet that we developed and it's just called adding a pathway to your treatment plan. It does have really nice little bullet points that are pretty simplistic. It talks about a plan to get rid of the means, or the method you might want to hurt yourself, and involving your family and friends. Also asking them to follow-up with us if they're not going to make appointments so we're not worried about them.

But really sitting down and educating them about this is a sensitive time for them and that we need to make sure that we stay in touch with them. So this education sheet is embedded in our electronic health record and when a client or a patient is placed into the clinical pathway for suicide prevention this education sheet automatically pops up and it has to be tended to by the clinician or they can't proceed any further within our electronic health record.

I encourage you in your systems to involve your IT staff. They're there. They don't know a lot about mental health, behavioral health issues but they're really committed and dedicated to the mission of our organizations so often times when we would sit around the room they were the ones that would offer us suggestions on functionality of electronic health records. They would say gosh what if we could make it do this and we would get pretty gassed up about that and go gosh it could do that? They were like oh yeah, we can make it do this and this. So one of them was having this embedded in the record and making it be tended to before you could proceed into the record.

Another thing that we embedded in the beginning of our electronic health record was asking at intake at our very first appointment for any service we have one question very early on that's in the demographics page and it just asks if they have a firearm in the home so that we know ahead of time before there's a crisis, before there's a suicide issue whether this is a home that has firearms. In certain states firearms are very prominent and wanting to know how many of those houses have that.

Also and Barbara touched on this having emergency contact and support persons is just vital. Obtaining phone numbers and addresses for them is very important. One thing that we discovered was we could easily get a phone number for a family member that wasn't the hard part. Often times we would call the phone later when we needed to and it wasn't a working number or it didn't work, it was the wrong number. So we put in our

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procedures that when we write down this is the emergency contact, this is the phone number, this is the address that we're calling that number in real time as the plan is being developed to ensure that it is an actual working functioning number so that we don't have a situation where that's not a number that's working.

So we're going to turn to a poll question. We are very interested because this is kind of a rubber meets the road functionality. We're wondering how many of your staff ensure ahead of time that the phone numbers they're given for emergency contacts work? I'm not surprised with some of the information we're seeing here is the majority, over 50%, say they do not. I can tell you until somebody in a meeting got mindful about that with us we weren't either. I really encourage you to look at a system where you have your staff asking for these phone numbers and calling them in real time and make sure that they're functional numbers and that you're not kind of caught short handed when you actually need to use the number.

Continuing kind of with our protocol, we obtain the client's agreement and then we'll look at all the means that they're looking at. If they don't have a support person that's identified, we really try to assess their ability, can they independently implement this plan? That's really not best case scenario. Somebody we hope is in their circle the wagons that they have someone, a neighbor, a church member, a group member that they could get into their camp would be a good thing. If the support person is not present again we try to contact them if the family member or the friend hasn't come in to the session we try to make sure that we contact that person to make sure that they're onboard and that they're in the boat rowing the same way that we're rowing around securing and reducing access to some of these means.

Another key the we just I would say in the past six months have really pushed pretty hard with our staff on is if a support person, a family member says yes I will secure or reduce the access to these means that we really ask them to call back in the same day and confirm that was done and that we document that in the client record. We document that they've agreed to do that. We document in fact if they do that and then if they don't do it it is up to our clinicians to call the family member back and say we kind of agreed on this. Did you get the gun secured? Did you remove the medications? Whatever the means were but we're doing same day confirmation of that access reduction and documenting that for good clinical documentation.

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So the next question we wanted to pose to you all is how -- and this will be a type where you all with answer the question but if you want to type in some answers is how do clinicians in your organizations ensure that the lethal means have been removed or secured and that's not kind of left dangling out in the universe?

I can see multiple, multiple people typing so let's see what some folks are doing and maybe I'll steal some of your good ideas. Some folks talk about safety sweeps and that's definitely something with a grant that we just have looking at some of our grant staff being able to go in and do some sweeps of homes.

We have call back people. Some folks say we don't do that. We take their word for it. Lots of confirmation with support persons. Some places have police take possession of them. Others say we just take their word for it. A few people follow-up with this.

So it is a touchy difficult situation but I encourage you to make sure whatever is going to work in your system put something in place where you don't just take their word that it was put away, that you're getting some kind of confirmation that you can document in your electronic or paper record noting that the task that you trusted these folks with has actually occurred.

So we follow-up up with them again like I said. We do not direct clients or the support folks to bring weapons to our location so that definitely happens. I have a policy on that. If anyone cares to have that, I think Julie may have ours. We consulted with local and federal law enforcement about what to do if someone just goes here's my gun and it's in a clinician's office and the clinicians don't really need to handle those or get their fingerprints on them.

Again letting the support person and the patient client know that after the crisis has been resolved if we cannot return those weapons to them including ammunition that's a good thing. Maybe not allow them to have those at all in the future.

So if the client doesn't agree to have any sort of means limited or reduced we do these four steps. Talking with them why it's so important. We pull in clinical supervisors. I've been called into some of those. And then we really assess for is a higher level of care warranted? If the client just up and leaves without any kind of plan we try to do what we need to do from a crisis perspective and determine whether they're a danger to

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themselves and only at a very last resort would we do some kind of a wellness check.

Another key point in our system is we document when clients go in and out of our pathway so that we know in real time they display in red in our electronic health system. We take kind of means restriction and limiting means as probably one of the most critical aspects. We really try to work with the client and their families to assist whenever possible to make sure that during this kind of hot phase the client's don't have access to some of those things.

We try to see them face to face as much as we can and keep them on the grid is what we usually talk about. If they don't show up for appointments they automatically in our electronic health system populate onto a high risk follow-up list that's housed in our Crisis Call Center that's operational 24/7. So when a client doesn't show we make sure we're monitoring and keeping them on the grid via our Crisis Call Center.

I'll turn it back over to you Julie. Thanks.

>> JULIE GOLDSTEIN-GRUMET: Becky, thank you so much. I think people really had some good ideas going on and realized some ways they might want to think about revising their policies and protocols. We do have some information about that on the tool kit. As I said, there's the Zero Suicide list serve. We'll continue to share information with you on the list serve. If there are questions that come up for you after today please feel free to post them to the Zero Suicide list serve.

I'm going to turn over to Sarah Clingan. Sarah is a graduate student in social work and a suicide attempt survivor. She is passionate about raising awareness about mental illness and suicide and does so through her writing and her actions. We really appreciate you joining us today, Sarah, so please go ahead.

>> SARAH CLINGAN: Hi. Thank you. So what I'm going to be talking about is based on serious encounters I've had with clinicians when I was experiencing suicidal ideation.

I wanted to start with some things to be aware of when you're working with individuals who are suicidal. When it gets to the point where safety planning is necessary the person that you're working with is in a huge amount of pain. And many of the questions that need to be asked for means reduction for safety

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planning require a great deal of vulnerability on the part of the client. It can feel like a very invasive process especially when you're already very emotional.

And just to remember that talking about suicidal thoughts is not something that's easy to do. It's often accompanied by a large amount of shame. So anything that you can do to reduce that will help the person be honest with their comfort in sharing.

And then also clinicians are humans. We're all humans and so being aware of your own assumptions and biases regarding diagnosis and mental illness is really helpful. Throughout my journey, my diagnosis were changed and as they changed so did the way that I was assessed for suicidality and so did approaches to safety planning and means reduction. So having that in the back of your mind can really help you and the people that you're working with.

Language is something that had a big impact on me when I was working with providers. As much as possible using neutral, non-judgmental phrasing and avoiding things like attention seeking or suicide gesture. Those are both pretty strong negative judgments. Avoiding labeling a person. Those things are really valuable.

And then being aware also of your body language. There were times when providers were working with me using the computer to do safety planning or assessment and they didn't make eye contact with me at all. That's a little thing that makes a big difference. If the person that you're being pretty vulnerable with isn't looking at you, that is the message that what you're saying isn't valuable.

And there were also times when the anxiety of the clinician who was working with me was very apparent. Again everybody is human but if I can see that the provider is agitated and anxious because of what I'm sharing that heightens my own stress and fear and makes it a lot harder to share and be honest.

I think the most important and most helpful thing that clinicians did when they were assessing me was coming from an empowerment perspective. One of the easiest ways to do this is to share information with your clients. Things that you can say upfront like this is when you might be hospitalized or this is when I might need to break confidentiality and these are the

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people that I would share it with. All those little things are really helpful to know on the part of the person.

This goes for lethal means removal as well. Making sure that the client themselves is involved in the steps even if other people need to be incorporated into it. And kind of coming at it from almost a public safety approach. This is something that we do for anyone who is struggling with suicidal thoughts. That kind of moves it away from a punitive action.

And then for safety planning, again emphasizing that it's specific to the person that you are working with. It involves coping skills and steps that they are willing to use and that they're capable of implementing during moments of intense emotional distress.

And finally emphasizing help throughout this process. Recognizing and validating that the person had the courage to seek help and is there and willing to be honest with you and acknowledging that there is possibility for change and for help.

>> JULIE GOLDSTEIN-GRUMET: Sarah, thank you so much. I think it's so important that we have the perspective of people with lived experience and we really appreciate you sharing experiences to that. We can learn what will improve the care for people at risk for suicide so thank you for sharing with us.

Our last speaker is Dr. Ursula Whiteside. She's a licensed psychologist with over 15 years working in the field of treatment for suicidal individuals. She's currently a research scientist with Forefront: Innovations in Suicide Prevention working on grants from the American Foundation for Suicide Prevention and the National Institute of Mental Health. She's a member of the Action Alliance Zero Suicide Advisory Group and serves as a faculty member and mentor to organizations adopting this approach.

She's an advocate for the consumer voice in suicide prevention and has developed an online resource based on dialectical behavior therapy. You can see that at NowMattersNow.org. Ursula.

>> URSULA WHITESIDE: Thank you so much, Julie. Just before I jump into things real quickly we were having a conversation among a number of clinicians here and the organization that serves adjudicated youth. The question about what no harm contracts or no suicide contracts are came up because from the

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dialectical behavioral treatment perspective we're often working with individuals to come to agreement, to come to a commitment to not harming themselves and that is actually different than what is being sort of cast out of clinical practice this no harm contract. So I want to be very clear we're not suggesting that you should not get a commitment from your client to not harm themselves. What you should not do is create a coercive environment where the patient or client is not involved in that decision making process.

So moving along, you see here I've got my twitter handle and I've been tweeting seriously throughout this talk. There is a growing online community among those with lived experience. This is a group that I consider myself part of and I'll speak of it a bit more in a moment.

So moving on to the next slide. It looks like maybe my slides are -- oh there we go. Just bringing the perspective of where I'm coming from. I trained extensively with Marsha Linehan. I essentially grew up in her research laboratory. She's a developer of dialectical behavior therapy. This is an environment where clients and therapists are treated as equals.

It was not until I got to my clinical internship a yearlong in Seattle Hospitals that I realized that was ultimately not the case in a lot of environments in the ways that people were treated who were struggling with mental health difficulties. This year quite painful as it was because of this experience helped sort of direct the next steps of my career. Out of it I created an organization or a group of individuals all with lived experience who were interested in changing the way that suicide was talked about.

Again Julie mentioned the NowMattersNow.org. You can go there to see members of this organization, this group. Sarah Clingan is one of my co-founders. I call her my co-pilot in hacking suffering.

So moving on to the next slide. What I wanted to do was pay attention to the ways that people might fall through the cracks. That means that we must approach suicide in the healthcare system from a wraparound approach. Each of these four things that Becky Stoll spoke to are incredibly important and also at the same time very difficult to do.

I want to ultimately on this slide just point out creating checks and balances. This is the idea that we create a feedback

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loop for our clinicians such that they receive feedback about the number of times they're completing a suicide risk assessment and a safety plan when it was indicated for example. That in itself maintains the behavior of clinicians. Left to our own, we really often think that we're doing this when we actually are not necessarily doing that.

The next slide is again to this idea of who we might miss, who might fall through the cracks. For myself related to safety planning and lethal means reduction, I created a series of videos that will be shared with you in a moment. I included people like myself who because I was a clinician and experiencing suicidal thoughts at the same time I do not think that clinicians asked me about it because I'm not a high profile in a sense of celebrity but high profile in another way. Those are people that you need to pay attention to. One of the videos in the series is one that I created so high profile, high functioning. Then also people in settings where resources are limited and time is limited. Additionally finally we might miss people when we ourselves are afraid or stressed.

Sarah Clingan alluded to this and this ultimately comes from my four years working in a healthcare setting in Seattle called Group Health Cooperative and ultimately trying to wrap our head around how do we make the issue of lethal means and reducing at risk to firearms something that we can really talk about together. Ultimately we came down to this description. I'm really asking that people consider this when they're having a discussion about lethal means.

So me asking you about guns is a public health safety issue. It's just like wearing motorcycle helmets and knowing the signs of a stroke. We universally recommend that people who are experiencing depression and/or significant stress and especially those experiencing suicidal thoughts do not have easy access to guns. I'm assuming that you might want this just as we would recommend for your mother, your brother, your sister or other people experiencing these symptoms.

So this is really language that we can ask that you kind of potentially keep in the back of your mind when trying to have this discussion, the public health approach.

Finally moving on to current slide, I've put together a list of different pieces of feedback or recommendations from my team members. These are what clients want from providers in situations where they are acutely suicidal. I've highlighted in

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red and underlined those that are specific to lethal means and safety planning.

These fit really well with what Sarah Clingan was discussing. I won't read them all but I want you to just have them. This first slide is specifically about being fully present. The next slide has a real emphasis on including family and friends in the plan, as Sarah mentioned and empowering oneself as Sarah Clingan also mentioned.

And finally this last slide of advice from Team Now Matters Now is to ask me would you tell me if you did have a gun and then pause and watch for my response and nonverbals. So this is really allowing them an opportunity to sit with the response and then what follows the response that pause can allow you to follow-up again if you read nonverbals that maybe indicate that otherwise an individual said.

I guess there's a couple more of these. Another advice was knowing that when I'm telling you about my suicide it is because I want to live. I want to help and I want to work together. So sometimes there is an assumption that this is not otherwise true and our group wanted you to know that's the opposite.

The final slide here is a specific advice on how to encourage clients to be most open in the process of lethal means removal and safety planning. This advice comes from Kelly Koerner and ultimately it supports the idea that in order to move forward, in order to be on the same page, validation is important. We often struggle with validating our client's experience when maybe it involves drug use or self-injury and this really gives a suggestion to pay attention to the emotion behind that and the suffering itself. I would also like to balance this validation advice with direct advice in the case of lethal means removal.

And that is my final slide.

>> JULIE GOLDSTEIN-GRUMET: Thank you, Ursula. Thank you to all of our presenters. What an exceptional webinar and opportunity to learn about really how to integrate this important evidence-based approach and the use of policies and protocols to make sure that it's well integrated into your systems.

So I know we've been taking some questions. You can continue to write the questions in the chat box. As I said, there's a Zero Suicide list serve if additional questions come up for you

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after today. You can join that list serve on the ZeroSuicide.com homepage. There's a button at the bottom that says join the list serve. It's a peer to peer list serve that you can post questions and we've had a lot of great conversations.

So a couple of questions I'll start with. The first one I'm going to start with you, Becky. The question is what do you do, how do you get staff to buy into and see the value of a safety plan so they don't see it as just another piece of paperwork that they need to do?

>> BECKY STOLL: I think a couple of ways that we did that. I'll talk quickly so we can get to some other questions. One of them has been training and culture for sure. Some of that has been talking about doing things in a purposeful way to decrease liability and that they need to make sure when we -- it's easy sometimes to forget how serious these situations are and that we really are putting ourselves at risk in terms of liability.

And so I think culture training, some talk about needing to own that if you're going to do this kind of work, and to be honest some of the sell for us is in making certain things in our electronic record mandatory and saying to the staff when we make it mandatory it's really serious and kind of game on and these are the things. If we made it mandatory in the record realize how important this is and be mindful and purposeful for those little pieces of this puzzle that we're trying to complete.

>> JULIE GOLDSTEIN-GRUMET: Great. Thank you. And Barbara, do you want to say anything else about that?

>> DR. BARBARA STANLEY: No but I would like to address the question that somebody asked about if it's okay about no suicide contracts.

>> JULIE GOLDSTEIN-GRUMET: Sure, please, go ahead.

>> DR. BARBARA STANLEY: My take on it. So I guess what I would say is Ursula made the point about commitment to life. No suicide contract is a very different kind of thing than the kind of commitment that you get from patients who are in DBT. I've been DBT trained. I do DBT. I'm a trainer and so it's quite a different thing. A no suicide contract is actually a piece of paper typically that the patient signs and that the clinician signs that says I promise I won't kill myself or that if I get suicidal I will go to the emergency room.

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When you talk with patients about this it kind of one of two things that people say. Number one, it makes the clinician feel better and number two it means nothing to them unless it's in the context of a long standing relationship where they feel like they want to keep a promise to somebody. And so that's a very different kind of thing than the kind of commitment to treatment and staying alive that you would put as a priority in a psychotherapy.

And so I just think that it's kind of like even though we're talking about a commitment to life it's really kind of apples and oranges.

>> JULIE GOLDSTEIN-GRUMET: Great. Thank you.

>> DR. BARBARA STANLEY: Oh and the other thing I would just mention is a no suicide contract is not a contract because if you're doing a contract, a real contract, both parties have to have skin in the game. The only person that has skin in the game for a no suicide contract is the patient because the patient is promising to stay alive, to give their life. The clinician is promising and giving nothing. And so I just think that it's really important to remember we're talking about something quite different than the kind of commitment that we would ask in a treatment like DBT.

>> JULIE GOLDSTEIN-GRUMET: Great. Thank you. Becky, any thoughts about what you do when a client doesn't return to the session or the phone call and that was part of their safety plan? Any best practices that you might have to offer?

>> BECKY STOLL: Yeah the thing that's been most helpful for us and besides the CALM training our staff kind of flipped out about two things. CALM training was one. The second was if you can set up some kind of system and it's easier if you have electronic health records but when our clients don't show for appointments and they kind of fall off the radar, they automatically within our system as I said earlier populate onto our Crisis Call Center's high risk follow-up list.

They kind of display in a different way. We know it's all hands on deck for these. And then they are really very good at hunting them down in terms of trying to find them through. We've prepared the client and the patient for this ahead of time to say when we did the education sheet please call us if you can't make your appointment because if you don't it's really going to make us worried about you. And then we were trying to get all

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the releases of information we can on the front end so when in fact that does happen and they don't show up that we can try to track them down. Sometimes they're at I-Hop having pancakes and they forgot and sometimes it’s not. We've had to do some rescues but it pushes.

And then our clinicians can go back and take care of the rest of their patients and our Crisis Call Center who is 24/7, 365 anyway take over that really trying to track down where the client is and is it a crisis? Is it a dangerous situation? They do that for a period of days. We just got a grant that we'll implement next year where we'll actually be able to deploy some face to face resources out for some of these clients.

If we just all fail and we just try and try and try and we put the best effort and we can't, we developed a letter. I think we call it a caring letter that we were pretty purposeful about giving lived experience input into what the language is. I'm glad to share it. I'll send it when I send -- I forgot what else I was going to send. I'll send it also. It basically says we're worried about you. We haven't heard from you. We want to work with you and partner with you. We care about you. We want you to recover. We send that out and that's really the last ditch effort if we just can't find somebody and track them down.

>> JULIE GOLDSTEIN-GRUMET: And Sarah Clingan, we have about one minute left. I just think as somebody with lived experience it would be great to hear from your perspective how a provider an organization could handle this. If there's a commitment made and if they do plan that the client doesn't live up to, what suggestions might you have. Other people talked about how do you know when you're making progress when you could change the safety plan for the person? Do you have any final thoughts in the last minute?

>> SARAH CLINGAN: I think in terms of when you know if you can change the safety plan just asking that very question to the client is a great place to start. I know I have several safety plans that just kind of stayed latent because they were drawn up and then never revisited. So just checking in with people and seeing where they're at, seeing if they've actually used it, how many times, if it needs to be altered is a great place to start.

>> JULIE GOLDSTEIN-GRUMET: Any thoughts about what to do if somebody doesn't keep up with their end of their safety plan? You can't reach them. They don't follow-up on the lethal means or making the phone call that they said they would.

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>> SARAH CLINGAN: Well what Becky said was wonderful. And then also when trying to get in touch with people that you can't get in touch with as much as you can emphasizing that you're doing it because you care. Somebody is not in trouble. It's not a punitive thing but that you care about them. You want to know how they're doing. That's really helpful.

>> JULIE GOLDSTEIN-GRUMET: Thank you, Sarah. Thank you to all of our presenters for today's webinar and sharing this important information and your experiences. We really appreciate it.

Today's webinar will be archived. I will share some of your questions on the list serve in the coming week. You can feel free if you have additional questions to post them there as well. The webinar will be posted to the ZeroSuicide.com tool kit sometime in the next few days. Both the webinar and the slides will be available.

We appreciate you joining us. Our next webinar will be the first week in February on evidence-based treatment. We'll send information out through the list serve and many other list serves as well. Happy Holidays and thank you again for joining us. Take care.

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