

Understanding Suicide to Help Individuals and Their Supports Connect to the Care They Need

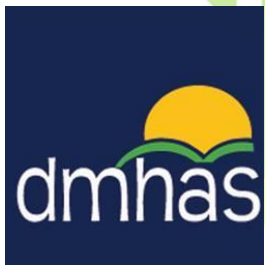
CT Clearinghouse
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Before we begin

- Suicide is complex and very personal
- We will be talking about general information about suicide. Through discussion we hope to increase understanding.
- The information that we discuss should not be applied to an individual without consideration of their unique needs and experiences.
- Please be sure to take care of yourself during our discussion

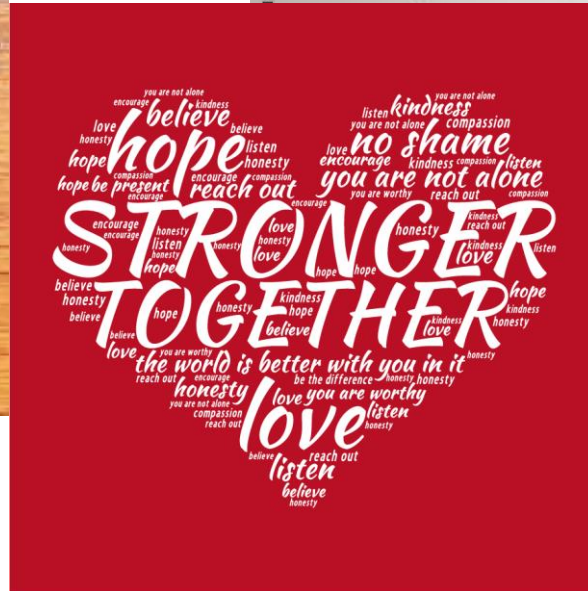


Self-Care & Peer Support



You can't
pour from an
empty cup.

Take care of yourself first.



Overview for our talk

- Data on rates of suicide and suicide attempts nationally and for CT
- Recent research on factors that impact suicide risk and the importance of clear communication about risk
- The role of risk factors, protective factors and warning signs in understanding risk for suicide
- Evidence based suicide risk screening, assessments, and suicide prevention interventions.
- How connection and communication can promote resiliency and support suicide prevention.
- How to talk to someone about suicide and support them in getting help and using resources
- Suicide Prevention in Connecticut and Resources





Data Drives Understanding, Strategic Planning & Evidence- Based Practices



Suicide is a Public Health Issue

- In 2021, suicide was the 11th Leading Cause of Death in the US (n=48,183); however, it was among the **top 2** leading causes for those age 10-34:
 - **2nd** leading cause of death for 10-14 year-olds
 - **3rd** leading cause of death for 15-24 year-olds
 - **2nd** leading cause of death for 25-34 year-olds
 - **5th** leading cause of death for 35-44 year-olds
 - **7th** leading cause of death for 45-54 year-olds
 - **9th** leading cause of death for 55-64 year-olds
- In 2021, CT ranked among the top four states with the lowest rates of suicide in the United States, but *one death is too many*.
 - *It was the 2nd leading cause of death for 10-34 year-olds.*



CT Violent Death Reporting System

Suicide Counts and Rates

- Prior to the COVID-19 Pandemic in 2020, an annual average of 403 CT residents died from suicide 2015-2019, which was a 14% increase from the annual average of 351 residents 2010-2014.
- There was a slight decrease in suicide death during 2020 due to COVID-19 Pandemic factors.
- Annual rates gradually increased through 2021; however, rates have been on a slight decline since then. The preliminary rate for 2023 is 9.48 compared to 2021 at 10.87.
- Predominantly middle-aged, non-Hispanic white males are dying by suicide.

Suicide in CT	Year		
	2021	2022	2023
Age-Group			
0-17	12	10	6
18-24	38	27	24
25-34	56	53	59
35-64	181	218	193
65+	106	83	60
Totals	392	391	342
Rate	10.87	10.84	9.48

(Source: CTVDRS 2024, CT DPH)



CT Violent Death Reporting System (2022)

CTVDRS

Top Five Known Circumstances by Specific Age Categories

Ages < 25

Ages 25 - 64

Ages > 64

Perceived to have Depressed Mood

Perceived to have Depressed Mood

Perceived to have Depressed Mood

History of Ever Receiving Mental Illness or Substance Abuse Treatment

History of Ever Receiving Mental Illness or Substance Abuse Treatment

History of Ever Receiving Mental Illness or Substance Abuse Treatment

Currently Diagnosed with a Mental Health Problem

Currently Diagnosed with a Mental Health Problem

Currently Diagnosed with a Mental Health Problem

Currently Receiving Mental Health/Substance Abuse Treatment

Currently Receiving Mental Health/Substance Abuse Treatment

Contributing Physical Health Problem*

History of Attempted Suicide

Alcohol and/or Other Substance Abuse Problem at Time of Death

Currently Receiving Mental Health/Substance Abuse Treatment



* Includes Health Problems and Chronic Pain/Illness.




The Bigger Picture

- Talking about rates of suicide does not capture the individuals who experience thoughts of suicide and may have made an attempt.
- Reports of national and state rates of suicide does not capture differences between groups.

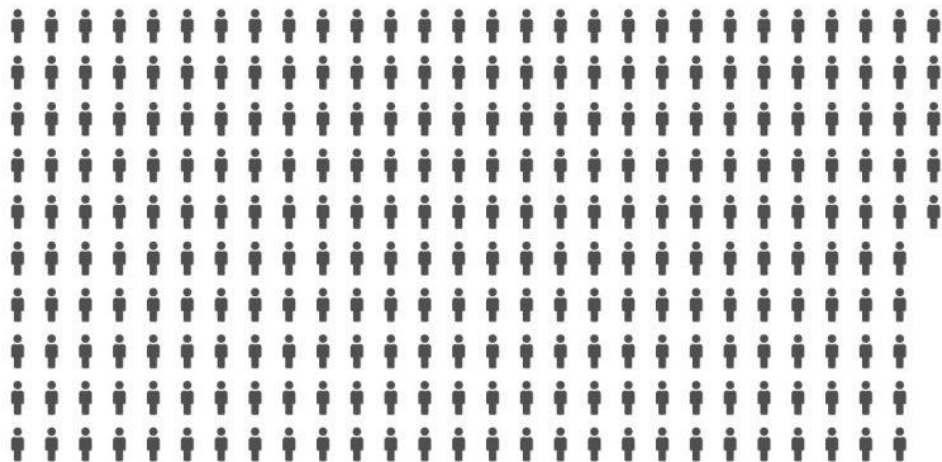


For every suicide death there are: (CDC 2020)

 **4** Hospitalizations for suicide attempts**

 **8** Emergency department visits related to suicide**

 **27** Self-reported suicide attempts***

 **275**
People who seriously considered suicide***

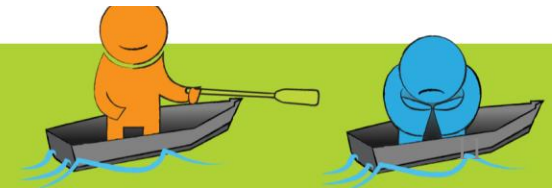
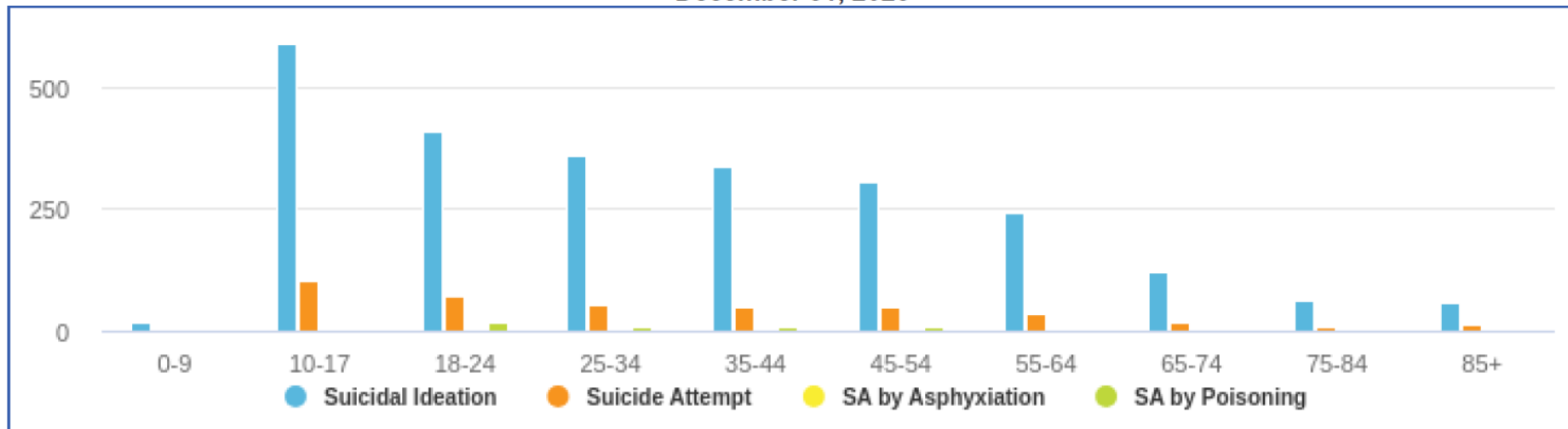
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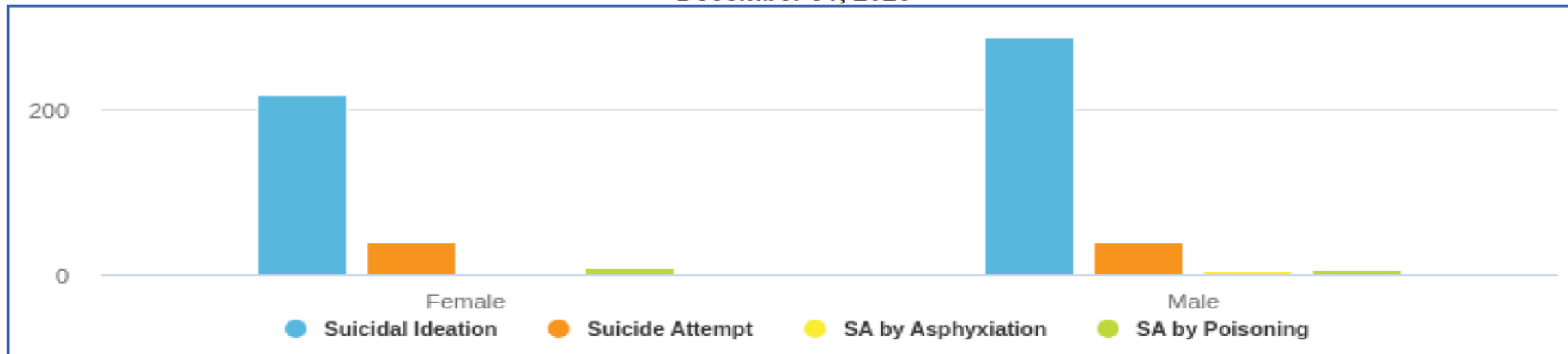
CT Syndromic Surveillance System

- In 2023, there were 42,262 ED Visits for "Suicidal Ideation and Self Harm" in CT.
- The populations with the highest rates per 10,000 visits are as follows: non-Hispanic, females, youth and young adults, and in order - Native Hawaiian or Other Pacific Islander (NH/PI), American Indian or Alaska Native (AI/AN), and Black or African American.

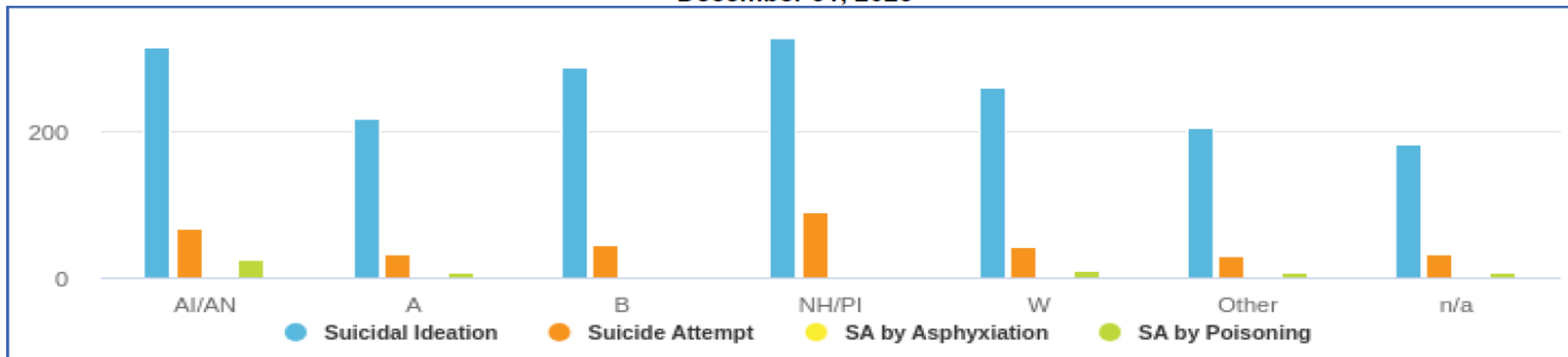
Rates of SI/SH ED Visits in Demographic Breakdown Graphs in Connecticut per 10,000 Visits by Age, January 1, 2023 - December 31, 2023



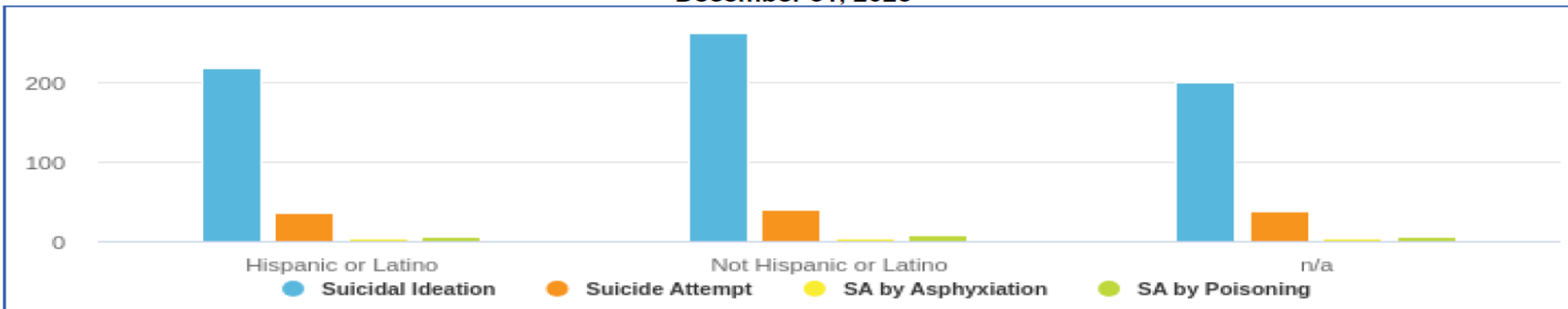
Rates of SI/SH ED Visits in Demographic Breakdown Graphs in Connecticut per 10,000 Visits by Sex, January 1, 2023 - December 31, 2023



Rates of SI/SH ED Visits in Demographic Breakdown Graphs in Connecticut per 10,000 Visits by Race, January 1, 2023 - December 31, 2023



Rates of SI/SH ED Visits in Demographic Breakdown Graphs in Connecticut per 10,000 Visits by Ethnicity, January 1, 2023 - December 31, 2023



Groups with higher risk

- Risk for suicide attempt is different than risk for death
- Examples:
 - youth & young adults, females, LGBTQ2S+ are at increased risk for attempts
 - middle-aged, Non-Hispanic, White, males are at increased risk for death
- Gender and Sexual Identity- females and LGBTQ2S+ (attempts), males (death)
- Race/Ethnicity- Native American, Native Hawaiian/Pacific Islander, Non-Hispanic, Survivors of Suicide Loss
- Survivors of Suicide Attempts and Chronic Thoughts of Suicide
- Mental Health, Substance Use and Gambling Disorders
- Chronic Medical Conditions or Disabilities
- Exposure to violence/trauma history
- Justice Involved, including custody and divorce
- Occupations- First Responders, Military/Veterans, Veterinarian, Farmers, Construction, Medical
- Unemployed, Uninsured/Underinsured, limited access to care (rural or cost)
- Unhoused

Groups with higher risk

- [Public Act 23-167, An Act Concerning Transparency in Education, required the Connecticut State](#)
 - Each local and regional board of education shall adopt a written policy and procedures for dealing with youth suicide prevention and youth suicide attempts. Each such board of education may (1) establish a student assistance program to identify (A) risk factors for youth suicide, based on the state-wide strategic suicide prevention plan developed by the Connecticut Suicide Advisory Board, established pursuant to section 17a-52, and shall include, but need not be limited to, youth who are (i) bereaved by suicide, (ii) disabled or have chronic health conditions, such as mental health or substance use disorders, (iii) involved in the juvenile justice system, (iv) experiencing homelessness or placed in an out-of-home setting, such as foster care, or (v) LGBTQ.



Health Equity is Central

- Health Equity is the state where everyone has a fair and just opportunity to attain their highest level of health. (CDC)
- Challenges:
- Social and Community Discrimination
- Access-transportation, child care, language
- Environment-location of services, opportunities to connect
- Education



Understanding Suicide and Supportive Responses



Suicide Myths and Facts

MYTH: Thinking about suicide is a normal reaction to extreme stress.

FACT: Suicide is caused by a confluence of factors, *not* as a result of *stress only*. It is not a common event.

MYTH: Asking a depressed person about suicide will encourage him/her to attempt suicide.

FACT: Studies have shown that patients with depression at times have these ideas and *talking* about them *does not* increase their risk of suicide.

MYTH: People who talk about suicide don't die by suicide.

FACT: Many people who die by suicide have given *definite warnings* to family and friends of their intentions. Always *take any comment* about suicide *seriously*.



Language Matters

Terms to Replace and Alternatives

Terms to Replace

- Completed Suicide
- Failed Attempt
- Nonfatal Attempt
- Parasuicide

- Successful Suicide
- Suicidality

- Suicide Gesture

Alternatives

- Suicide
- Suicide Attempt
- Suicide Attempt
- Self Injurious behavior or suicide attempt
- Suicide
- Suicidal thoughts or behavior
- Self injurious behavior, or suicide attempt



Understanding Suicide Thoughts and Attempts

- Language matters- using plain language to avoid stigma and confusion.
- Terms that don't help anymore, or might be confusing, include “successful/failed attempt”, or “commit suicide”, etc.
- There is an effort to use these terms: Suicide; Died by suicide; Suicidal thoughts or behavior; Suicide attempt; or Self injurious behavior.



Why it matters

- Clear definitions help us to understand when an individual needs help and support and provides information about possible risk.
- It helps support open discussion to increase comfort with talking honestly about experience.
- Clear definitions also help in communication about possible risk- everyone is talking about the same thing.



Definitions

- **Suicide:** Death caused by self-directed injurious behavior with any intent to die as a result of the behavior (CDC).
- **Suicide attempt:** A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury. (CDC)
 - An attempt may be interrupted or the person can change their mind



Definitions

Non-suicidal Self injurious behavior-self inflicted and self injurious behavior with no intent to die.

Example: an individual makes a cut on their wrist and describes an intention to die **vs.** an individual who states that they had no intent to die, they were just trying to feel better.

In both situations the individual needs support and intervention. Risk may be higher if someone has made a suicide attempt.



Definitions

- **Preparatory behavior**-Acts or preparation for making a suicide attempt.
 - Collecting pills
 - Buying a gun
 - Gathering information on means
 - Giving away belongings
 - Writing a note

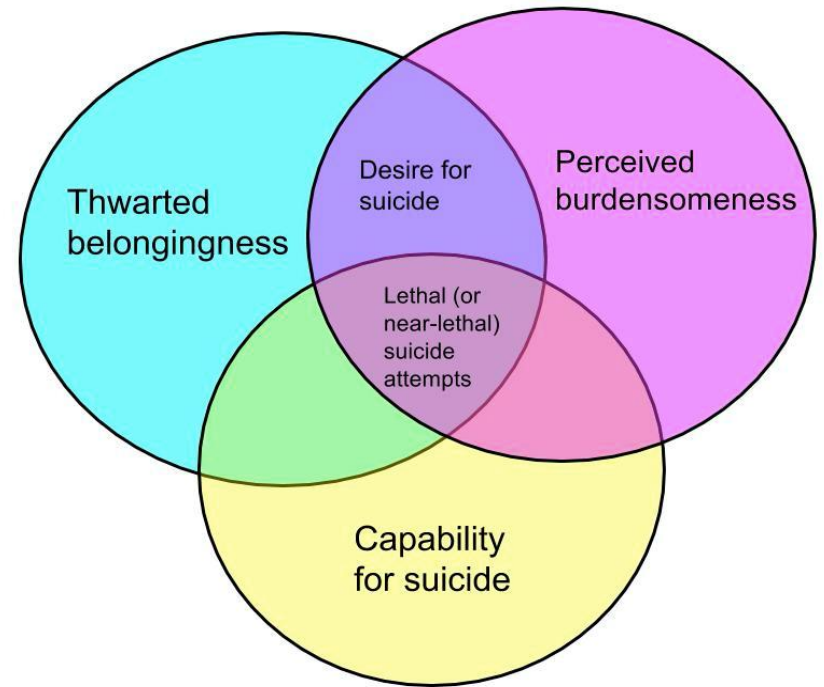
Behavior also gives us information about possible risk and the need for support and intervention.



Theory on Suicide Prevention

Joiner's Interpersonal Theory of Suicide (2005)

- Desire plus Capability -> Suicide attempt
- Desire = Burdensomeness and Low Belongingness
- Capability = Acquired Capability



Klonsky- 3 Step Theory (3ST) (2014)

- The combination of pain and hopelessness -> suicidal ideation
- Ideation intensifies when pain is greater than connectedness
- Connection can be: people, role, interest, job, project
- Connection provides purpose and sense of meaning



Klonsky- 3 Step Theory (3ST) (2014)

- Strong ideation leads to action when there is the capability:
 - Acquired
 - Dispositional
 - Practical



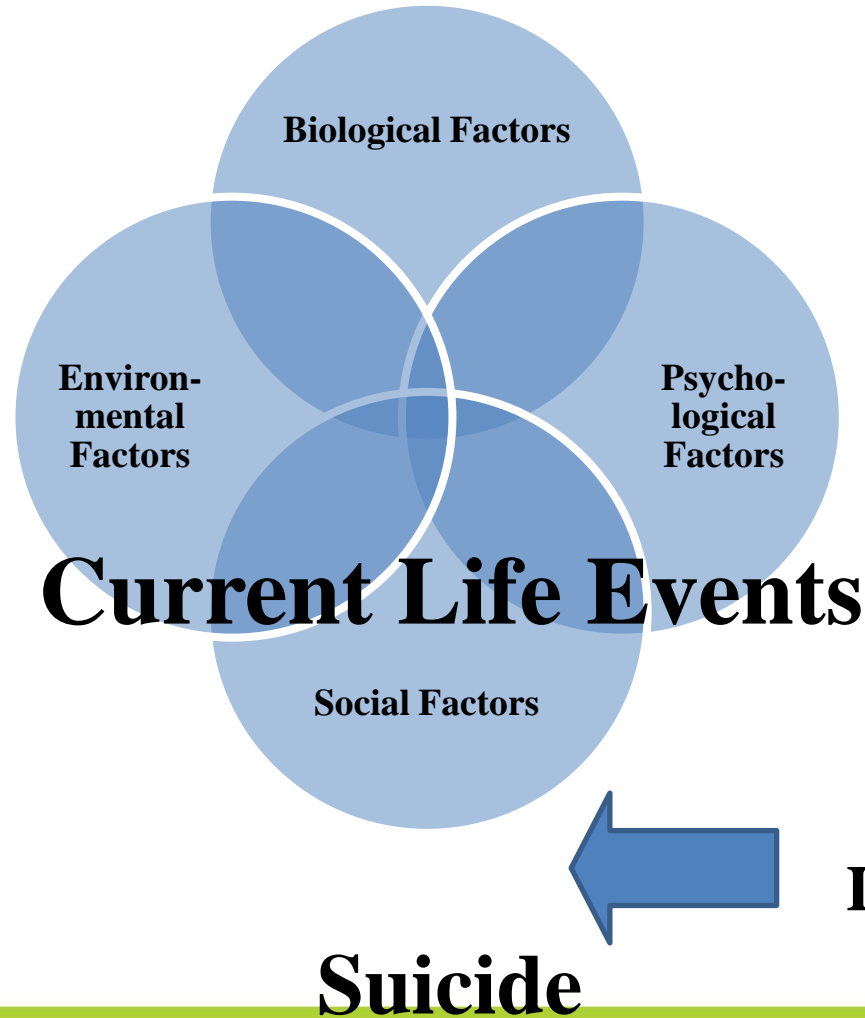
Klonsky- 3 STEP THEORY (3-ST) (2014)

Clear Targets for Intervention

- 1) Reduce Current Pain
- 2) Increase Hope for Future
- 3) Improve Connection
- 4) Reduce Capability



What We Know: Causes of Suicide



Risk Factors

- **Risk factors-** give us an idea of ongoing risk level. Characteristics or conditions that increase chance of suicide. Can lead to ideation or indicate capability. Example-History of multiple previous attempts=enduring risk.

- **Risk Factors alone do not explain or predict suicide**

Some examples:

- Biological Risk factors include ongoing illness, pain, CNS disorders.
- Social Risk Factors include feeling a lack of belonging, relationship difficulties, family conflict, bullying, difficulties at work, return from deployment, change in treatment.
- Psychological Risk Factors include emotional pain, history of adverse childhood events, depression, anxiety, substance abuse, history of suicidal behavior, multiple attempts.
- Environmental Risk Factors include social isolation, ready access to lethal means.



Protective Factors

- Protective Factors can be a source of strength, inspiration and reasons to live.
- Helpful in developing coping skills and resilience.

Some examples:

Internal: ability to cope with stress, spirituality, hope

External: connection with family, pets, relationships, positive relationship in therapy



Current Life Events

Events may interact with Risk Factors and precipitate an escalation in risk. This is a time to ask and help the individual with resources and connecting to help.

Some examples:

An event that triggers shame or despair; Loss of relationship, financial, or health status; Social isolation; Family conflict; Transitions such as return from deployment, discharge from treatment, etc.



Warning Signs

Warning signs may indicate immediate risk. This is a time to ask and help the individual connect with help.

Some examples:

Change or new behavior related to life events; Preparatory behavior; Sudden improvement in symptoms; Increased alcohol or drug use; Statements, including joking, about dying, hopelessness, burden to others, feeling trapped, unbearable pain etc.

Warning signs are unique to the individual. They are helpful to understand as part of an individualized suicide prevention intervention.



Children and Adolescents

- Mental Health Issues can increase risk.
- Children and adolescents do not see things with an adult perspective, they may not realize that things will get better.
- About a third of children and adolescents talked about suicide prior to a suicide attempt.
- Statements included: “I wish I was dead”, “I won’t be a problem to you much longer. Children as young as age nine understand that death is final and talk about death is a warning sign that needs immediate response.



Asking about Suicidal Thoughts or Behavior

"How are you?"

Confused; Betrayed
Useless
Broken

Never good Enough

Fragile; Anxious

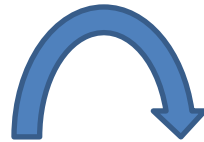
I'm falling apart and
you don't notice it

Pathetic; Annoying
Rejected
Lonely
Defeated



Asking early, Ask often

- Asking early provides an opportunity to intervene early to offer help, hope and connection to treatment to reduce risk.
- For most individuals suicide risk is like a curve, risk can increase to a crisis due to increased risk factors, life events, or other reasons.



- Under stress, or during a crisis, alternatives and resources may not seem obvious or available.

It is helpful to ask early and connect to help and intervention before the individual escalates to making an attempt.



Talking about Suicide

If you think someone is considering suicide:

- Talk with them privately
- Ask directly if they are thinking about suicide: It can help to bring it up with questions like: “Do you ever wish you could fall asleep and not wake up” and “Do you have thoughts of suicide?”
- Listen to their explanation and perspective, acknowledge their experience and feelings
- Avoid debating the value of life, minimizing their problems or giving advice
- Stay with them, help them keep their environment safe (Reduce access to lethal items over the counter and prescription medications and firearms)
- Help them access treatment.
- Stay in touch after the crisis is over, or after leaving treatment



Talking with Someone At Risk

- Individuals who are thinking about suicide are often ambivalent. Many feel exhausted by their problems, or are overwhelmed by emotional pain. They may not know how to access help, or believe that anything will help. Stigma can be a barrier in asking for help
- Listening and helping them access immediate help is an important first step.
- Call 211 in CT for mobile crisis services and guidance.



Talking to Children and Adolescents

- A conversation can start with “are you OK?” or “is there something that feels like it’s too big of a problem?”
- Important to ask about suicide directly. Keep it simple with a calm tone of voice:
 - Are you thinking about hurting or killing yourself?
 - Have you ever thought about hurting or killing yourself?
- Call 211 or call/text 988 in CT for crisis services for those under age 18.



5 Action Steps for Helping Someone in Emotional Pain



ASK

“Are you thinking about killing yourself?”



KEEP THEM SAFE

Reduce access to lethal items or places.



BE THERE

Listen carefully and acknowledge their feelings.



HELP THEM CONNECT

Call or text the 988 Suicide & Crisis Lifeline number (988).



STAY CONNECTED

Follow up and stay in touch after a crisis.



National Institute of Mental Health

nimh.nih.gov/suicideprevention

- In CT ACTION Line (Adult Crisis Telephone and Options Network) call 1-800-HOPE-135 or call/text 988
- For those under 18 and their families call 211 or call/text 988.

Chat at www.988lifeline.org



Evidence Based Screening Tools

Screening tools are available for a variety of settings to identify those who need further assessment. They include:

- The [Columbia Suicide Severity Rating Scale](#) (C-SSRS) used in multiple settings, including community.
- [Ask Suicide-Screening Questions](#) (ASQ) for adolescents and children ages 10-24, in treatment settings.



C-SSRS in CT Legislation

- [Public Act 23-167, An Act Concerning Transparency in Education, required the Connecticut State](#)
[Department of Education \(CSDE\) to provide each local and regional board of education a list of the recommended assessments for determining the suicide risk of students who exhibit mental health distress, have been identified as at risk of suicide, or are considered to be at an increased risk of suicide. In response, the CSDE engaged the Connecticut Suicide Advisory Board chaired by the Department of Children and Families \(DCF\) and the Department of Mental Health and Addiction Services \(DMHAS\).](#)
- January 25, 2024 CSDE Letter to Superintendents.
 - Advises the [Columbia-Suicide Severity Rating Scale \(C-SSRS\)](#) be used as *the* assessment tool for determining the suicide risk of students.



C-SSRS

The Columbia

Lighthouse

Project

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
	YES	NO
Ask questions that are bolded and <u>underlined</u> .		
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan. <u>Have you actually had any thoughts of killing yourself?</u>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "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." <u>Have you been thinking about how you might do this?</u>		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u> , as opposed to "I have the thoughts but I definitely will not do anything about them." <u>Have you had these thoughts and had some intention of acting on them?</u>		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>		
6) Suicide Behavior Question: <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> 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. <u>If YES, ask: Were any of these in the past 3 months?</u>	Lifetime	
	Past 3 Months	

- Low Risk
- Moderate Risk
- High Risk

Example of sticky, tear-off sheet available via the materials page at www.preventsuicidect.org

This is often used by police and mobile crisis services clinicians in CT. Copies may be placed in files or shared with EMS or ED.

COLUMBIA SUICIDE SEVERITY RATING SCALE SCREEN WITH TRIAGE POINTS

Ask questions that are in bold and underlined.	Past month	
	YES	NO
Ask Questions 1 and 2		
<u>1) Have you wished you were dead or wished you could go to sleep and not wake up?</u>		
<u>2) Have you had any actual thoughts of killing yourself?</u>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
<u>3) Have you been thinking about how you might do this?</u> <small>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."</small>		
<u>4) Have you had these thoughts and had some intention of acting on them?</u> <small>as opposed to "I have the thoughts but I definitely will not do anything about them."</small>		
<u>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?</u>		
<u>6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u>		
<small>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.</small>		
If YES, ask: <u>Was this within the past 3 months?</u>		

Response Protocol to C-SSRS Screening

- Item 1: Behavioral Health Referral and Crisis Numbers**
- Item 2: Behavioral Health Referral and Crisis Numbers**
- Item 3: Consider Further Mental Health Evaluation**
- Item 4: Urgent Mental Health Evaluation with Escort**
- Item 5: Urgent Mental Health Evaluation with Escort**
- Item 6 Over 3 months ago: Consider Further Mental Health Evaluation**
- Item 6 3 months ago or less: Urgent Mental Health Evaluation with Escort**



**CALL 211 FOR
MOBILE CRISIS SERVICES IN CT
(FOR ALL AGES)**



PreventSuicideCT.org

NOTES: _____

Intervention

- Crisis Talk Lines
- Crisis Intervention
- Inpatient and Intensive Outpatient Care
- Specialized Psychotherapy and Pharmacology
- Brief Intervention- Safety Plan (Stanley and Brown)
- Caring contacts (call, text, cards, emails), Staying in touch



Examples of Evidence Based Psychotherapy

- Collaborative Assessment and Management of Suicidality-CAMS (Jobes) approach
- Cognitive Behavioral Therapy for Suicide Prevention-CBT-SP (for adolescents and adults) (Stanley & Brown)
- Dialectical Behavior Therapy-DBT (Linehan)

All share an approach that includes seeking understanding of the individual's experience, working collaboratively, and expanding coping skills and resources.



Brief Intervention-Safety Plan (Stanley and Brown)

- Can be completed with a crisis staff, or in the first session with a provider.
- Provides coping skills to prevent a suicide attempt even if an individual is having trouble accessing treatment, or is not in treatment.
- Is a collaborative effort between the individual and the therapist, helps an individual identify warning signs, and their own coping skills and resources.
- Provides hope and clear steps to take to avoid a crisis.
- Enhances a sense of control and social support- family can be involved.



Stanley-Brown Safety Plan

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

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:

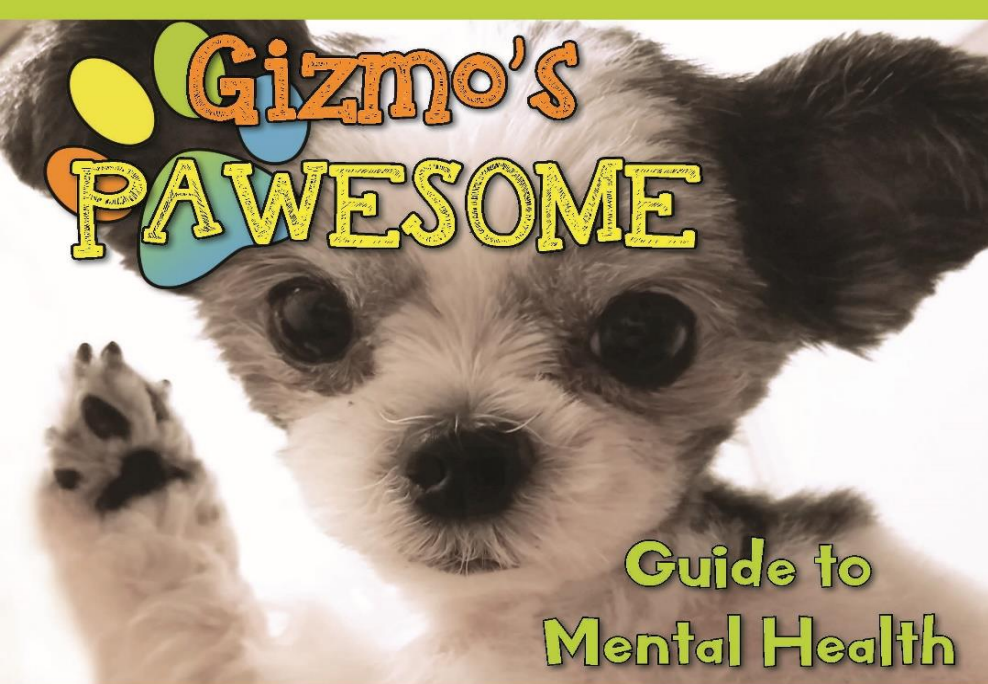
1. Clinician Name _____ Phone _____
Clinician Pager or Emergency Contact # _____
2. Clinician Name _____ Phone _____
Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services _____
Urgent Care Services Address _____
Urgent Care Services Phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

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The one thing that is most important to me and worth living for is:



Gizmo's PAWESOME

Guide to Mental Health

MY MENTAL HEALTH PLAN

Name: _____

1. Things I can do to take care of my mental health: feelings, thoughts, and actions

- | | |
|---|---|
| <input type="checkbox"/> Breathe slowly | <input type="checkbox"/> Ride a bike |
| <input type="checkbox"/> Listen to music | <input type="checkbox"/> Play outside |
| <input type="checkbox"/> Play an instrument | <input type="checkbox"/> Read |
| <input type="checkbox"/> Draw or paint | <input type="checkbox"/> Play with toys |
| <input type="checkbox"/> Take a nap | <input type="checkbox"/> Do a puzzle |
| <input type="checkbox"/> Blow bubbles | <input type="checkbox"/> Sew or knit |
| <input type="checkbox"/> Play with a pinwheel | <input type="checkbox"/> Smile or laugh |
| <input type="checkbox"/> Play dress-up | <input type="checkbox"/> Take a walk |
| <input type="checkbox"/> Write a story | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Play with pets | <input type="checkbox"/> _____ |

2. How to know if I feel mad, sad, or worried

- | | |
|--|--|
| <input type="checkbox"/> Eat less or more | <input type="checkbox"/> Want to be alone a lot |
| <input type="checkbox"/> Hard to get to sleep or stay asleep | <input type="checkbox"/> Act before thinking |
| <input type="checkbox"/> Argue more | <input type="checkbox"/> Have less energy |
| <input type="checkbox"/> Cry easily | <input type="checkbox"/> Feeling very nervous/stressed |
| <input type="checkbox"/> Feel bored with things you like | <input type="checkbox"/> _____ |
| | <input type="checkbox"/> _____ |

3. People and places that can help me think of other things

- | | |
|--|---|
| <input type="checkbox"/> Parents | <input type="checkbox"/> Friends house |
| <input type="checkbox"/> Grandparents | <input type="checkbox"/> Family member's house |
| <input type="checkbox"/> Aunt or Uncle | <input type="checkbox"/> Faith Community |
| <input type="checkbox"/> Brother, Sister, Cousin | <input type="checkbox"/> Community center or youth center |
| <input type="checkbox"/> My friends | <input type="checkbox"/> Park |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Library |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

4. Things I can do with Others to Help Me Feel Better

- | | |
|---|--|
| <input type="checkbox"/> Play a game | <input type="checkbox"/> Go to lunch |
| <input type="checkbox"/> Tell jokes | <input type="checkbox"/> Play outside |
| <input type="checkbox"/> Go for a bike ride | <input type="checkbox"/> Give and get hugs |
| <input type="checkbox"/> Go for a hike | <input type="checkbox"/> Dance and sing |
| <input type="checkbox"/> Go to the store | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Go to the library | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Watch a movie | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Play a sport | <input type="checkbox"/> _____ |

5. My trusted adults

- | |
|---|
| <input type="checkbox"/> Parents |
| <input type="checkbox"/> Grandparents |
| <input type="checkbox"/> Uncles/Aunts |
| <input type="checkbox"/> Older Brothers/Sisters |
| <input type="checkbox"/> Teachers |
| <input type="checkbox"/> Coaches |
| <input type="checkbox"/> Religious Leaders |
| <input type="checkbox"/> Scout Leaders |
| <input type="checkbox"/> School Counselors |
| <input type="checkbox"/> School Social Workers |
| <input type="checkbox"/> School Nurses |
| <input type="checkbox"/> Doctors |
| <input type="checkbox"/> Camp Counselors |
| <input type="checkbox"/> Any Others? |
| <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ |

PAWS UP
for mental health



- ❖ Introduces the characteristics of trusted adults, who may be one, how to practice talking with a trusted adult, and promotes proactive communication, social emotional learning, self advocacy, and community connectedness.
- ❖ Youth create a personal mental health plan (of action) that can be used daily, and in a time of need that can help them avert crisis.
- ❖ Resource section for trusted adults.

RESOURCES FOR TRUSTED ADULTS

In a crisis contact:

- Mobile Crisis Intervention Services for Youth: Call 2-1-1
- Crisis Line: 1-800-273-8255 (TALK) or in CT Call 2-1-1
- Crisis Text Line: Text your message to 741741



In an emergency call 9-1-1

Other resources for mental health services:

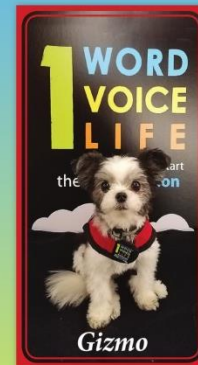
- School counselors, social workers, psychologists
- Community-based counselors
- Pediatricians



Be there to start the conversation
www.preventsuicide.org
www.empsct.org
www.gizmo4mentalhealth.org
www.suicidepreventionlifeline.org



www.211ct.org



This guide is not a substitute for treatment.



Responding to Suicide Loss is Suicide Prevention

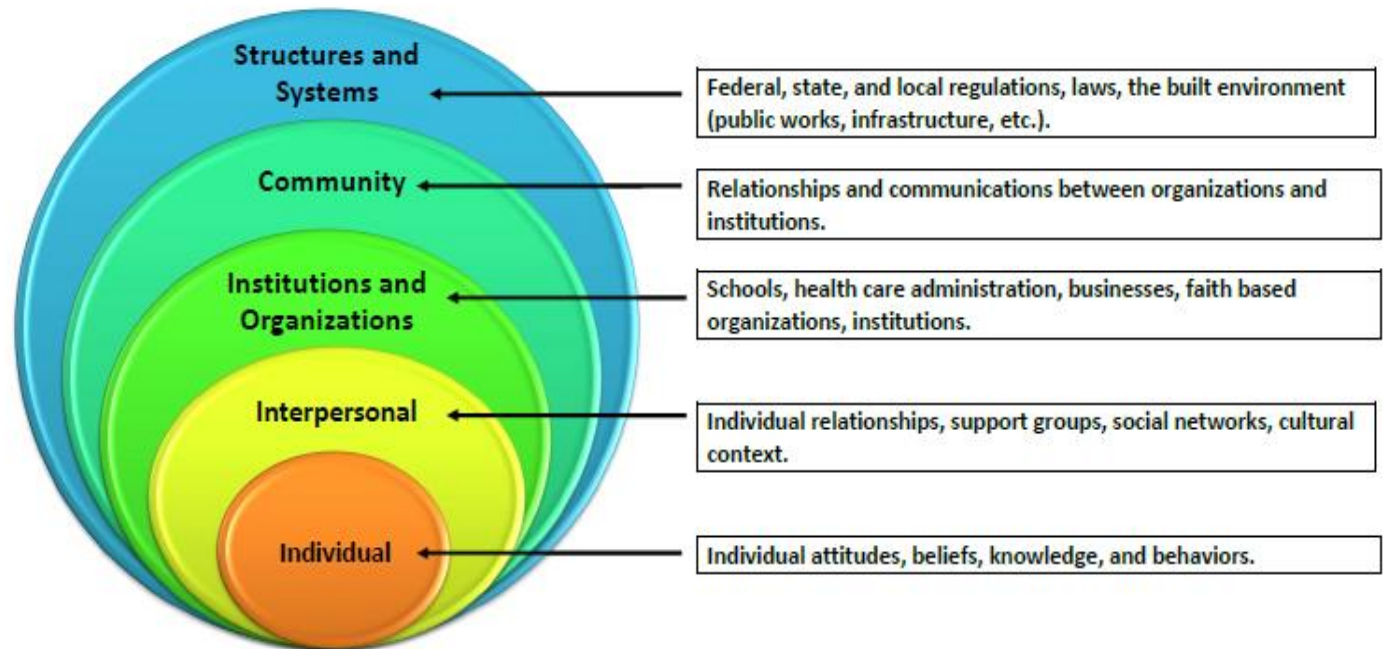


What is Postvention & Why Does It Matter?

- Timely, effective Postvention Is Prevention
- Postvention - a series of planned, best practice interventions that are initiated immediately upon death notification with those affected by a suicide with the intention to:
 - Facilitate the grieving or adjustment process
 - Stabilize the environment
 - Reduce the risk of negative behaviors
 - Limit the risk of further suicides through contagion



Community Response to the Ripple Effect



Postvention Response Process in CT

- CT Office of the Chief Medical Examiner
- CT Office of the Child Advocate
- CT Department of Children and Families
- CT Department of Mental Health and Addiction Services
- CT State Department of Education
- CT Survivor Foundations (AFSP, Dagle, JPF)



Community Responsiveness

- Promote safe and best practices
- Share Information
- Promote Discussion
- Increase help seeking by promoting positive attitudes and fighting stigma through education and open discussion
- Offer programs that promote social and emotional well being such as life skill training
- Increase access to services and resources
- Care and support of those affected by suicide



RESOURCES



CT Suicide Advisory Board

The state-level suicide advisory board in legislation to address suicide prevention and response across the lifespan ([PA 22-58](#), Sec. 64).

Mission: The CTSAB is a network of diverse advocates, educators and leaders concerned with addressing the problem of suicide with a focus on prevention, intervention, response.

Vision: The CTSAB seeks to eliminate suicide by instilling hope across the lifespan and through the use of culturally competent advocacy, policy, education, collaboration and networking.



Joint Statement from Commissioners of Department of Mental Health and Addiction Services and the Department of Children and Families6

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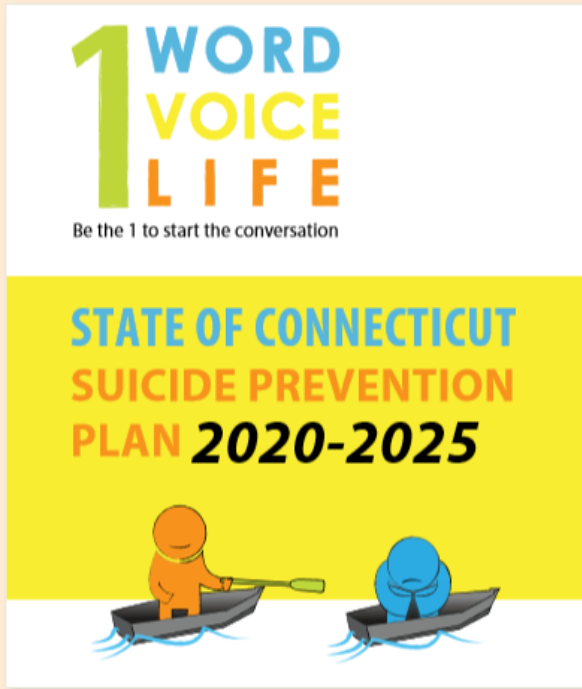
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www.preventsuicidect.org

GOAL 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings.

GOAL 2: Develop, implement and monitor effective programs that promote wellness and prevent suicide and related behaviors.

GOAL 3: Promote suicide prevention as a core component of health care services. (Adopt *Zero Suicides* as an aspirational goal).

GOAL 4: Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.

GOAL 5: Increase the timeliness and usefulness of state surveillance systems relevant to suicide prevention and improve the ability to collect, analyze and use this information for action.



CTSAB Sub-Committees

1. Armed Forces-Governor's Challenge
2. Attempt Survivor/Lived Experience
3. Data to Action
4. Education & Advocacy
5. Intervention/Postvention Response
6. Reducing Access to Lethal Means
7. Zero Suicide Learning Community for Health & Behavioral Healthcare Providers



Prevention & Response Resources

➤ CT Suicide Advisory Board/State Coalition & Regional Coalitions

- Consultation on prevention, intervention and postvention planning and response
- Training and education
- Data and surveillance
- Statewide and local networking
- Resource exchange
- Peer support
- Free print, lock boxes, educational and promotional materials
- Website with extensive resource pages
- CTSAB membership & resources:
www.preventsuicidect.org and
www.Gizmo4MentalHealth.org



- **Join the CTSAB:** <https://www.preventsuicidect.org/network-of-care/>



Regional Suicide Advisory Boards

- Support CTSAB mission and vision in respective regions.
- Engage key stakeholders to identify unique regional needs, and implement suicide prevention and response efforts.



Points of Contact:

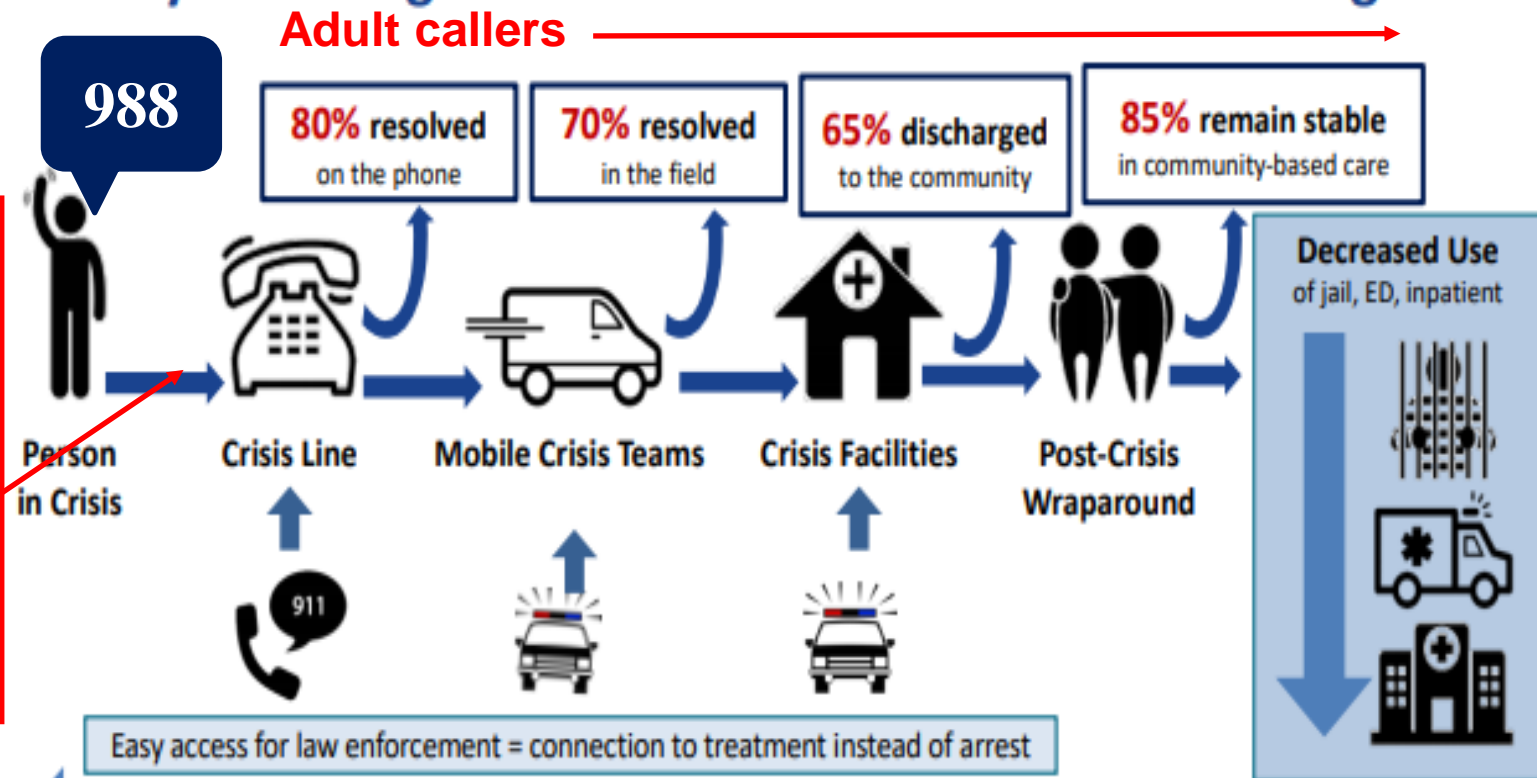
- Southern- The Hub
- Western- Western CT Coalition
- Southcentral- Alliance for Prevention & Wellness
- Northcentral- Amplify, Inc.
- Eastern- SERAC

[Regional Advisory Boards | Connecticut Suicide Advisory Board \(preventsuicidect.org\)](https://preventsuicidect.org)



Overview of 988 & Linkage to Crisis Service System*

Crisis System: Alignment of services toward a common goal



*This model refers to adults, not children. It is expected that in CT 90% of children receive in-person assessments.

← LEAST Restrictive = LEAST Costly

Balfour ME, Hahn Stephenson A, Winsky J, & Goldman ML (2020). *Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies*. Alexandria, VA: National Association of State Mental Health Program Directors. <https://www.nasmhpd.org/sites/default/files/2020paper11.pdf>





CT Calls to the 988 Suicide & Crisis Lifeline

Calendar Year 2023

Key Performance Indicator 95% answered in 15 seconds

Month	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Total number of Lifeline Calls Received	3924	3243	3459	3666	3798	3458	3867	3,911	3,725	3,703	3,740	3,806
Total Number of Lifeline Calls Answered	3830	3163	3384	3570	3675	3351	3655	3,716	3,539	3,510	3,542	3,622
Answer Rate for Lifeline Calls	0.98	0.98	0.98	0.97	0.97	0.97	0.95	0.95	0.95	0.95	0.95	0.95
Avg Speed Of Answer (seconds)	5	5	4	4	5.72	5.46	7.91	6.94	5.29	5.6	5.65	5.11
Avg Handle Time (Minutes)	10.71	11.12	11.72	10.94	12.25	12.05	11.5	9.6	13.1	10.53	13.6	14.34

Comprehensive Suicide Prevention Grant

(08/31/20-08/30/25; Total funding = \$3,500,000)

- The DPH-directed Comprehensive Suicide Prevention (CSP) grant is Co-Directed by DMHAS and DCF and is funded by the Centers for Disease Control and Prevention. The CSP is advised by the CT Suicide Advisory Board. The purpose of the CSP is to expand upon the state's cross-sector efforts to implement a comprehensive public health approach to suicide prevention to reduce suicide attempts and deaths among two key vulnerable populations in the state: middle-aged adults (ages 35-65), in particular men, with serious mental illness or substance use disorder (SUD); and adolescents and young adults (ages 10-24), a group disproportionately represented in ED data for a suicide attempt or reported suicide ideation.
- CSP activities include, but are not limited to: Promoting the CT Comprehensive Suicide Prevention Plan 2025 (PLAN 2025); Identifying vulnerable populations using existing data; Performing an inventory of suicide prevention programs in CT; Using the CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* to guide the selection and implementation of community-based, healthcare-related, and upstream primary prevention strategies using a regional approach; Developing and disseminating a communication plan for stakeholders; and Performing ongoing evaluation to guide efforts and ensure outcomes.
- Partners: UCONN Health, United Way of CT, 5 Health Depts/Districts- Bristol-Burlington, East Shore, Torrington, Norwalk, Uncas

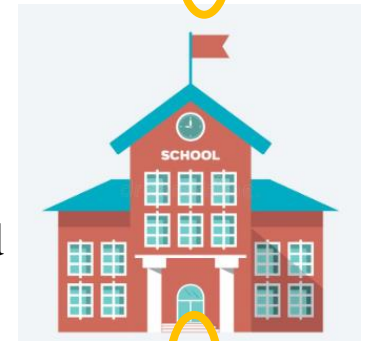
CT Garrett Lee Smith Youth and Young Adult Suicide Prevention Grant: Partnerships for Hope & Healing (PH2)

(09/30/23-09/29/28; Total funding = \$3,675,000)

- DMHAS Directs, and DCF and DPH Co-Direct the CT Partnerships for Hope and Healing (PH2) funded by the Substance Abuse and Mental Health Services Administration, and the CT Suicide Advisory Board advises the grant. The PH2 supports the CT Comprehensive Suicide Prevention Plan (PLAN 2025), and is working to enhance statewide and community-level mental health promotion and suicide prevention, intervention and response capacity and readiness to utilize comprehensive, equitable, public health approaches and evidence-based practices, frameworks and strategies (EBPs) to address gaps and reduce suicide attempts and deaths among youth age 24 and under.
- Planned enhancements to the state's suicide prevention resources include, but are not limited to: a Training Collaborative to increase workforce education; a Data to Action Website to guide prevention practices; 988 Suicide and Crisis Lifeline co-promotion with the state's suicide prevention campaign to increase awareness and access; development and release of the CT Comprehensive Suicide Prevention Plan 2030 (PLAN 2030) to guide future efforts; and development of informed, coordinated and sustainable partnerships within five prioritized communities among schools, campuses, community organizations and clinical services to ensure at-risk youth are services using best practices for their identification, connections to care and treatment, are provided with lethal means counseling and safety planning support and family engagement, and receive timely follow-up services and supports.
- Partners: UCONN Health, United Way of CT, 5 Regional Behavioral Health Action Councils-Regional Suicide Advisory Boards, Education Development Center

What Providers, Schools and Community Partners Can Do Together

- Promote resource materials/media among faculty/staff, youth/patients and parents/caregivers.
- Ensure youth/patients and parents/caregivers know how and where to get help for themselves and others. Practice how to call 211 or 988, text 988 or 741741, or chat www.988lifeline.org when experiencing mental health distress, just like contacting 911 for police, fire or EMS.
- Host and take Gatekeeper Training for faculty/staff, patients/youth and parents/caregivers to learn how to recognize and respond to youth in crisis, and help them get assistance.
- Use the ZS approach and evidence-based strategies to screen and assess for risk, refer, treat, support safety planning and reduce access to lethal means, facilitate continuity of care, and provide follow-up services to ensure connections.



What Providers, Schools and Community Partners Can Do Together – *Continued*

- Collaborate to provide mental health and suicide prevention EBP education, and peer advocacy programs.
- Have protocols in place that guide staff to help youth/patients and parents/caregivers in mental health distress, and to support them during treatment and care transitions.
- Develop and activate suicide prevention and response planning with key community partners (e.g. municipal offices, mobile crisis, first responders).
- Continue education of EBPs, many are available at no or low cost.
- Stay in touch: join the CT Suicide Advisory Board and/or your Regional Suicide Advisory Board – www.preventsuicidect.org



Messaging to Share

- **There is “no wrong door” in CT.** To reach the CT crisis contact center for telephonic support or mobile crisis services, people can call 211 and press 1 for crisis and then 1 for children or 2 for adults, or they can call 988 to be routed to the CT contact center. They will not have to press any other numbers when they call 988 to get services, and call, text and chat services are all functioning.
- **Youth in crisis?** In CT, call 211 (press 1 for crisis, 1 for youth), Call/Text – 988 or Chat www.988lifeline.org; Text CT to 741741
- **Adults in crisis?** In CT, call 800-HOPE-135 or 211 (press 1 for crisis, 2 for adults), Call/Text – 988 or Chat www.988lifeline.org; Text CT to 741741



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