Manual for Support Groups
for Suicide Attempt Survivors

Didi Hirsch
SUICIDE PREVENTION CENTER

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"It just keeps me alive." - Support Group Participant

"Our best route to understanding suicide is ... directly through the study of human emotions described in plain English, in the words of the suicidal person."
– Ed Shneidman, The Suicidal Mind

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Lead authors:
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Robert Stohr, Didi Hirsch Mental Health Services

Contributing authors:
Sandra Yi, Didi Hirsch Mental Health Services
Amy Baylis, Didi Hirsch Mental Health Services
Erin Mokhtar, Didi Hirsch Mental Health Services
Matt Meyer, Didi Hirsch Mental Health Services

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Contributing Editors:
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Effie Malley Consulting

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This manual instructs agencies how to set up structured support groups for adults who have attempted suicide, and instructs facilitators how to run the support groups.

About the Funder

The California Mental Health Services Authority (CalMHSA) is an organization of county governments working to improve mental health outcomes for individuals, families and communities. Prevention and Early Intervention programs implemented by CalMHSA are funded by counties through the voter-approved Mental Health Services Act (Proposition 63). Proposition 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

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I. Introduction

Project Background

One of the prevention and early intervention initiatives implemented by the California Mental Health Services Authority (CalMHSA) is the Suicide Prevention Initiative. The initiative was funded by the Mental Health Services Act (Proposition 63). CalMHSA is the agency leading the coordination of statewide suicide prevention efforts. CalMHSA contracted with Didi Hirsch Mental Health Services to organize suicide prevention efforts among California's diverse populations and regions. Didi Hirsch Mental Health Services established the California Suicide Prevention Network, a consortium of 10 crisis centers, to help build local capacity in suicide prevention and encourage widespread adoption of best practice programs, interventions, curricula, and protocols.

Regional task forces were implemented with representatives from state, county, and local agencies involved in mental health and suicide prevention; suicide attempt survivors; suicide loss survivors; faith communities; law enforcement; medical providers; educators; first responders; legislators; veterans; and advocates for the LGBTQ community. These regional task forces were responsible for identifying concrete steps to reduce the risk of suicide locally and for developing best practices in suicide prevention that could be replicated across the state and the nation.

Prior to the development of best practice programs, a statewide needs assessment gathered data and identified risk populations, promising local programs, and gaps and resources in each region. Regional planning committees used the findings from the needs assessment, identified priority risk populations for their regions, and selected the three programs that best addressed the needs of these populations. A diverse group of stakeholders selected one program from the three finalists for their region. After a program was selected for each region, regional Best Practices Workgroups convened to help develop the programs for eventual submission to the Suicide Prevention Resource Center's Best Practices Registry.

The Survivors of Suicide Attempts (SOSA) Support Group was developed in 2011 at Didi Hirsch's Suicide Prevention Center. Because of the value of this attempt survivors' support group, it was chosen by California stakeholders to be further enhanced into a best practice that would then be submitted to the SPRC's Best Practices Registry. The development of this manual was made possible through funding by CalMHSA and is the culmination of input from attempt survivors, suicide prevention experts, and researchers. This manual is a reflection of individual passions, organizational attention, and community collaboration.

Overview of Facilitator's Manual

The Manual for Support Groups for Suicide Attempt Survivors is primarily intended for facilitators who plan to run an eight-week support group for individuals who have survived a suicide attempt or attempts. A secondary audience is those interested in starting a group.

- Section I describes the support group and its goals
- Section II instructs the implementation team on how to set up and start a support group
- Section III provides the facilitators steps to follow before the group begins, including intake
- Section IV provides facilitators the topics and activities for each week of the support group
- Section V gives facilitators guidance about what to expect when running a support group

To establish some terminology:

Suicide Attempt - a nonfatal, self-directed, potentially injurious behavior with any intent to die as a result. A suicide attempt may or may not result in injury (U.S. Department of Health and Human Services, 2012, p.144).

Survivor of Suicide Attempt – one who makes a suicide attempt and does not die as a result of the attempt

In accordance with the safe and effective messaging guidelines, every effort has been made to present information in a way that discourages suicide and suicide contagion. However, this manual provides guidance for facilitators working with high-risk individuals who have survived suicide attempts, and at times it is instructive to include details about their experiences. However, we emphasize help-seeking and prevention as well as mental health treatment. We also provide the context that suicide attempts — although more numerous than most people realize — are uncommon. (See "Safe and Effective Messaging" from the Suicide Prevention Resource Center at **http://www.sprc.org/sites/sprc.org/files/library/SafeMessagingrevised.pdf**)

Description of DHSPC Support Group for Attempt Survivors

This manual is based on a support group developed and sponsored by the Didi Hirsch Suicide Prevention Center (DHSPC), a program of Didi Hirsch Mental Health Services (DHMHS) in Los Angeles. The group typically has six to eight adults and meets for eight weeks. Each participant must have made one or more suicide attempts. Additionally, participants are required to complete an intake interview with a facilitator prior to attending the group. The group is closed to additional participants once an eight-week cycle begins.

Since some participants continue to experience suicidal thoughts and benefit from the support they find at the group, participants can choose to repeat the eight-week cycle if desire. They know that if they are feeling suicidal, they always have someone they can reach out to who will understand their feelings without overreacting, which for many has not been the case when they have told family, friends or even professionals. In fact, in addition to finding support for themselves, participants who repeat the group often provide hope and guidance to new participants. Thus the eight-week cycles are designed to allow new participants to join the group and others to leave at a designated time.

> ***"(The group) made me not afraid to ask for help. Without this, I don't know what I would do." - Support Group Participant***

The group strives to address both the emotional and practical needs of its members. First and foremost, the group is meant to provide an opportunity for participants to connect with peers who share similar experiences. The initial weeks of the group focus on creating bonds between group participants and facilitators that allow members to feel safe in sharing their thoughts and emotions related to their suicide attempt. Once a safe group environment is achieved, the focus of the group expands to include an emphasis on tools and skills that will help members to stay safe from a future suicide attempt.

The support group is facilitated by two facilitators with a background in mental health and, preferably, suicide prevention. It is preferable but not required to have one licensed clinician. A third facilitator, usually a "peer facilitator" with lived experience, can be added when available. The role of the peer facilitator is to mirror successes and struggles with the group process by modeling their own growth through the process. The peer support person is an attempt survivor who provides support and insight from their own lived experience and has completed at least one group cycle.

The theoretical frame for support groups relies on social networks and group reinforcement, and support groups often provide peer support and psychoeducation. The model is in contrast to therapy groups, which expressly provide therapy and often exclude suicidal individuals. The support group for attempt survivors was developed based on research from the field of suicidology, including:

- The assessment principles used in the intake interview and the group outcomes are based on the Risk Assessment Standards for the National Suicide Prevention Lifeline (Joiner et al., 2007).
- Safety planning discussion and exercises are based on Barbara Stanley and Gregory K. Brown's work. (Stanley & Brown, 2008).

The support group's design embodies the core values developed by the Suicide Attempt Survivor Task Force of the National Action Alliance for Suicide Prevention. The task force participants include attempt survivors and national leaders of this work. The core values are to:

- Inspire hope and help people find meaning and purpose in life
- Build community connectedness
- Engage and support family and friends
- Respect and support cultural, ethnic, and spiritual beliefs and traditions
- Provide timely access to care and support
- Preserve dignity and counter stigma, shame, and discrimination
- Promote choice and collaboration in care
- Connect persons to peer support

These values continue to guide the implementation of the support group.

Rationale for the Attempt Survivor Support Group

People who have survived a suicide attempt are often embarrassed or ashamed about their attempt. Frequently, as a result of the crisis or mental health issues that led to their suicide attempt, they have withdrawn from their support systems. It is common for people who have survived an attempt to continue to face thoughts of suicide. Individuals trying to share a wish to die with family, friends, significant others, and even helping professionals are rarely met with empathy due to the fear and alarm these thoughts may engender in others.

> ***"But here I feel more safe." - Support Group Participant***

The rationale for this support group is that freely talking about suicidal thoughts may reduce their urgency and potency, leaving space for new alternatives to be considered. Talking about a suicide attempt within a group of peers can reduce shame and stigma. If unaddressed, the taboo and secrecy around suicidal ideation and the legacy of having made an attempt could contribute to future suicidal behaviors.

When met with empathy and mutual respect, there is important healing potential in being able to talk about what led them to their suicide attempt, to find acceptance, and to feel more empowered to ask for help should suicidal thoughts return. Members can learn how to identify when they may be at risk

of suicide again and put supports in place to help them cope with their suicidal feelings while staying safe. Having an established space of safety for members to openly disclose suicidal impulses without fear of judgment or overreaction can be very empowering.

After an attempt, people often report feeling vulnerable and raw. It may be that some members don't have the energy or will to complete tasks that could be related to their healing, such as traditional individual therapy. A support group is a non-demanding atmosphere where members can be among others who understand their experience and take small steps toward healing as they choose.

In previous support groups, when asked what they hoped to get out of the group, some participants have stressed the need for emotional support and relief such as the following:

- Connecting with peers who have had similar lived experience (having survived a suicide attempt) in order to find a safe, nonjudg mental environment where they can talk about their experiences
- Letting go of a sense of failure
- Lessening the isolation that preceded their suicide attempt and that often continues after their attempt because those closest to them are uncertain how to respond
- Being able to trust
- Having a place of "no shame"
- Letting go of the "big red label" of having made a suicide attempt
- Finding self-acceptance
- Developing a sense of hope

Other participants have expressed fear of being in a suicidal state again or of acting impulsively when feeling depressed or overwhelmed. These participants have expressed the desire to receive tools and learn skills to equip them to feel that they have more control over their behavior and ultimately their lives.

"There is community here." - Support Group Participant

Goals for the support group

The DHSPC support group serves the unique needs of survivors of suicide attempts. In offering a time-limited support group, there is a focus on short-term goals, one of the most important being reducing internalized stigma. An individual who feels fragile and vulnerable after an attempt may be more willing to make the first tentative steps of "opening the door" to their internal world with others who have been there too. In contrast to a time when participants may have felt most isolated leading up to their attempt, the group offers a timely experience of belonging, relating, and being understood.

The group environment, focused on the common experience of having survived a suicide attempt, helps survivors feel more connected, a key component in reducing suicide risk. Because the suicidal state can lead a person to withdraw from others, the group offers a corrective experience of reaching out, opening up, and encouraging connectedness.

In brief, short-term goals of the group include:

- Maintain participants' safety and manage risk
- Reduce internalized/ perceived stigma
- Increase comfort with and ability to speak about the thoughts and feelings that led to their suicide attempt and learn how to recognize and cope with these feelings if they return in order to decrease the likelihood of reattempts
- Increase coping skills as they relate to suicidal thoughts
- Increase knowledge about, and the likelihood of using, safety planning tools
- Increase connectedness, including access to peers who can support each other in times of crisis

- Creating a "built-in" safety net where members are comfortable sharing thoughts/risk for suicide without fear of how others will react
- Manage and reduce lethal means
- Increase hopefulness

Longer-term goals can be met as participants return for future cycles or as the group process starts to move in a forward direction with greater gains made over time. The seeds may be planted for growth and progress on a slower timeline than the initial eight weeks.

Long-term goals include:

- Reduce suicidal desire
- Reduce suicidal intent
- Increase protective factors
- Prevent future attempts
- Create a peer support network
- Increase in individual's ability to plan for the future

Some individuals may also choose to increase involvement in advocacy and community service, particularly in the area of suicide prevention. Many participants have reported that using their experiences related to their attempt to help others provides a sense of meaning and connectedness.

The need for services/support groups for attempt survivors

Suicide prevention efforts must address the needs of attempt survivors. Individuals who have attempted suicide form a significant high-risk group for both repeat attempts and death by suicide. Interventions can reduce this risk and keep attempt survivors from reattempting or dying by suicide. Yet services for attempt survivors are limited and often ineffective.

Suicide attempts are far more common than most people realize. In a recent U.S. survey, one in 200 adults — or approximately 1.1 million adults — reported

having attempted suicide in the past year. One in 500 adults reported that they stayed overnight or longer in a hospital as a result of a suicide attempt (Substance Abuse and Mental Health Services Administration, 2009).

While most people who attempt suicide do not attempt again, data from one study show that 37 percent of survivors repeat attempts within five years. The risk that a person may reattempt suicide is highest immediately after discharge from an emergency department or inpatient psychiatric unit and remains high over the next one to five years. For some attempt survivors, this suicide risk remains high for a longer time. Data show a higher rate of suicide deaths decades after the attempt (Knesper, American Association of Suicidology, & Suicide Prevention Resource Center, 2010).

The evidence clearly identifies this risk group, yet services often fail to move attempt survivors towards better outcomes. As Continuity of Care for Suicide Prevention and Research points out, emergency room staffs often harbor negative attitudes toward suicidal patients:

"One common attitudinal theme mentioned is: 'Suicide is a choice.' Another frequent mention is: 'Suicide attempts are willful, deliberate, selfish and attention seeking.' It is no surprise, then, that following a suicide attempt, patients very often feel invalidated, isolated and ignored by health professionals without special training in counseling for suicide" (Knesper et al., p. 30).

"Wow, thank goodness, something different outside of the hospital that can help deal with life." - Support Group Participant

Studies show that as many as 50 to 70 percent of people discharged from a psychiatric hospital or emergency department following a suicide attempt do not keep their first scheduled outpatient session for ongoing care (Knesper et al., 2010). This may stem from a sense of shame or dissatisfaction following their initial treatment in the hospital. The people who do attend therapy often drop out after a few sessions and do not complete therapy. Many people who go to

the emergency department for suicidal crises are discharged without mental health assessments. Aside from attempt survivors who are seen in emergency departments, hospitals, or doctors' offices, a number of individuals who attempt suicide do not seek treatment and remain unknown to any health or mental health provider.

There exists a gap of services for people recovering from a suicide attempt. While it is commonly agreed that therapy and support services are vital after a suicide attempt, there are very few effective programs devoted specifically to this population. Many attempt survivors don't seek any mental health treatment after their attempt, often discouraged by previous experiences in therapy where they may not have benefited. Some look for services specifically for suicide attempt survivors and are disappointed to find few exist. Other attempt survivors may feel embarrassed that they let their therapist down by making a suicide attempt. Still other attempt survivors might be angry with the mental health system because when trying to talk about their suicidal thoughts and feelings, they were prematurely involuntarily hospitalized by the outpatient mental health provider, thereby precluding their ability to explore this issue in therapy on an outpatient, and ongoing, basis.

> ***"It is different than therapy. It is a miracle in my life."***
> ***- Support Group Participant***

For attempt survivors facing significant barriers to mental health services, support groups may provide an alternative option or a first step that leads to treatment and recovery.

History of support groups for attempt survivors

Didi Hirsch Mental Health Services, a comprehensive community mental health center with 11 locations throughout Los Angeles County, has a long history in suicide prevention. In fact, the Didi Hirsch Suicide Prevention Center is

the oldest suicide prevention center in the country. In the 1960s, Dr. Norman Farberow, one of the center's founders, broke new ground by starting groups for suicide attempt survivors at the Suicide Prevention Center. He argued that while crisis intervention was an effective intervention for suicide prevention, the chronically suicidal individual needed more than that. "Essentially, the more is the development of a relationship in which the primary feature is continuing evidence of caring, interest and concern" (Farberow, 1976, p. 170).

Despite Dr. Farberow's visionary thinking, his group for suicide attempt survivors dissolved. One thought was that since his group was a drop-in group, and not a closed group with consistent members, there was not enough safety or continuity to encourage recovery from persistent suicidal ideation.

Hackel (1981) highlighted several reasons for resistance to developing support groups for suicide attempt survivors. The article describes two major themes that limit group therapy for suicide attempt survivors, including management and theoretical issues. The article does not suggests that any of the barriers mentioned are indeed reasons why there shouldn't be support groups for suicide attempt survivors, but instead lists fears or unanswered questions in relation to starting such groups. Interestingly, many of the same questions still remain unanswered today. One might ask why, in the more than 30 years since that article was published, do we still not have evidence to tell us whether a support group for suicide attempt survivors is an effective intervention for people after a suicide attempt? The founders of this support group speculate that the stigma that was present in 1981 and caused practitioners to shy away from trying innovative approaches to support those at risk for suicide is still present today, and thus without empirical evidence proving the effectiveness of these groups, groups such as the one described in this manual are not viewed as a viable treatment option.

Luckily, in recent years, some of the stigma associated with suicide seems to be lessening, and efforts in suicide prevention and attention to attempt survivors have grown. The federal government has engaged national agencies to partner with private partners to create two national strategies to prevent suicide (2001, 2012). A number of attempt survivors have become national leaders — DeQuincy A. Lezine, Terry Wise, Heidi Bryan, Eduardo Vega and Kevin Hines — and charted

new territory by telling their stories publicly and assuring that the attempt survivor perspective is included in suicide prevention and mental health efforts.

Several publications have been devoted entirely to suicide attempt survivors, including

- Lifeline Service and Outreach Strategies Suggested By Suicide Attempt Survivors (2007) at **http://www.inreachinc.org/NSPLReport.pdf**.
- A new website, What Happens Now? Exploring Life After a Suicide Attempt, a project for the American Association of Suicidology **http://attemptsurvivors.com/**
- A video story collection, Stories of Hope and Recovery, hosted online by the National Suicide Prevention Lifeline
- The After an Attempt series for attempt survivors, their families, and their caretakers, by the Substance Abuse and Mental Health Services Administration

All of these developments, along with the creation of the National Action Alliance's Attempt Survivor Task force, helped to create an environment more accepting of suicide attempt survivors. In 2010, staff at DHSPC, including Shari Sinwelski, Lyn Morris, Rebecca Hardy and Mathew Meyer, developed an implementation team to study the idea of an attempt survivors group. They agreed that the time was right to start a support group for survivors. The program's development was led by Shari Sinwelski. "We would receive calls on the hotline looking for a group for attempt survivors," she said. "Additionally, some attempt survivors would see our services advertised for loss survivors and express frustration that there was nothing for them."

Approximately one year of planning for the group included consultation with suicide attempt survivors Heidi Bryan and Eduardo Vega as well as individuals who had experience facilitating suicide attempt support groups such as Heidi Bryan, Stephanie Weber, and Norman Farberow. At the time this manual was written, the DHSPC support group has been operating for four years. Currently there are several support groups for suicide attempt survivors in the US, with interest growing.

II. Starting a support group

This section of the manual is intended for individuals who want to start a support group for attempt survivors, **the "implementation team."** It describes DHSPC's experience in starting and running the support group.

Implementation team note: Many handouts are described throughout this manual. Some of them are included in the appendices (and are indicated as such when they are included). Other handouts are not included because a facilitator would need additional training or consultation on their use. To learn more about the handouts not included in this manual, please contact Didi Hirsch Suicide Prevention Center via our website **(http://www.didihirsch.org/spc)**.

Your case and sponsor for the support group

If you are interested in starting a support group for suicide attempt survivors, start by learning as much as you can about their specific needs. Most support groups for attempt survivors are sponsored by mental health centers, crisis centers, suicide prevention programs, or hospitals (What Happens Now blog, 2014). If your community already has a support group for survivors of suicide loss, it may be worth checking with the group's leaders.

Start with a small implementation team to make initial plans. Make sure to include key stakeholders and attempt survivors on the team. The goal of the implementation team is to explore the feasibility of running a support group for attempt survivors, and then, if feasible, to move ahead with implementation. Some decisions about the group structure may vary depending on the community where the group is located and the type of organization hosting the support group.

Identify likely supporters and opponents of the proposal for a support group and try to anticipate their hopes and fears. For example, being able to offer hope for

people who have very little hope left is an incredibly rewarding aspect of this work and fits many agencies' missions. Also, the gap in services, the need for a place where people can openly share about suicide, and the program's potential to save lives can be compelling to potential sponsors.

At the same time, potential sponsors may be reluctant to begin such a group for a variety of reasons that you need to be ready to address. Supporting those at high risk of suicide can take be emotionally exhausting for staff. Additionally, some organizations will have fears about liability. DHSPC staff members did due diligence to evaluate liability concerns and determined the benefits of such a group outweighed the risks.

Put your best arguments together and make your case to a potential sponsor. DHSPC evaluated a number of outcomes such as suicidal desire, suicidal intent, and buffers. Factors such as hospitalizations and suicide attempts during the group were also measured. Participants were surveyed on their knowledge about and likelihood of using safety plans. Preliminary outcomes from groups that have been completed have been positive. Participants who complete the group show reduced self-reported suicidal desire and intent, as well as increased buffers. Additionally, participants who complete the group report increased knowledge of and likelihood of using safety planning.

Although the results were and continue to be impressive, it is worth noting that the group is not a "cure-all." During the group process, one individual was identified as an individual in imminent risk of a potential attempt and agreed to voluntarily be hospitalized for safety. Another member who was at high risk had an attempt during the group process. It is important to keep in mind that facilitators must always be vigilant about potential risk factors for attempt survivors. The group can be triggering at times, and of course there are many variables outside of the group that may affect an individual's ability to maintain their own safety. It is for this reason we recommend that facilitators, specifically new facilitators, have means of assessing risk in place for each group. If an individual is deemed at risk, the situation should be addressed immediately, either in the group or after the group. No at-risk individual should be permitted

to leave the group without some assurance that the member can maintain safety. In addition, for higher-risk individuals who are brought to safe means during or after a group, a follow-up and safety plan should be developed with the individual to monitor safety between groups. Even with these processes in place, there is no guarantee that all individuals will be able to participate safely in this group. Some individuals may need to be stepped up to more intensive controlled treatment, such as an inpatient setting. Still, with these safety issues in mind, we encourage experienced facilitators to engage even moderate-risk individuals in this group and continue to collaboratively monitor their success and safety. As one attempt survivor stated outside of the group, a physician would not stop treating a cancer patient solely on the premise that lifesaving medical treatment may not always be effective at curing the disease.

Support group facilitator qualifications

Not everyone has the wherewithal to attend to suicidal individuals. Before you start a group, you need to line up several qualified facilitators, to allow for availability and attrition. It is recommended that there are two facilitators for each support group cycle to ensure the safety of group participants and to provide support and consultation to each other.

Facilitators need a real comfort level with listening to participants' intense feelings, which often include hopelessness and ambivalence about living or dying. They must be able to be empathic and recognize the need for attempt survivors to be involved in choices related to their care. At the same time, they must be attuned to issues regarding risk assessment and safety. Some combination of mental health education and experience, and years of experience with suicide prevention are important as well. It is helpful for facilitators to have experience on a crisis line or direct experience with suicide crises. DHSPC used training in ASIST to help facilitators explore their own attitudes and beliefs about suicide, a key component in increasing comfort in working with suicide attempt survivors, but other training programs may accomplish this as well.

Additionally, it is important that facilitators have training in assessing suicide risk and confidence making intervention decisions with people at

imminent risk of suicide. Part of the success of the group is based on facilitators' comfort in assessing a person's risk for suicide and handling crisis situations in a calm, collaborative style that respects the desires of the person at risk and includes them in the process of establishing safety.

Most of the facilitators for the DHSPC group have had experience working on the Didi Hirsch Suicide Prevention crisis line, which is a member of the National Suicide Prevention Lifeline. Having this experience means the facilitators are familiar with suicide risk assessment as well as with making intervention decisions when a person is at imminent risk. The Lifeline's "Guidelines for Helping Callers at Imminent Risk of Suicide" (**http://www.suicidepreventionlifeline.org/media/7432/IR-Executive-Summary.pdf**) is a key document that provides guidance in making these decisions. Released in 2012, the guidelines were initially written for use with callers to the Lifeline; however, the approaches recommended in the guidelines can be applied in a variety of situations and are particularly helpful in working with suicide attempt survivors who, because of their attempt, may be fearful or distrustful of helping professionals. In fact, the Clinical Care and Intervention Task Force of the National Action Alliance recommends its use in behavioral healthcare settings across the country (National Action Alliance: Clinical Care and Intervention Task Force, 2012).

The Guidelines recommend using Active Engagement to make every reasonable effort to collaborate with a person at risk to ensure their safety. The Guidelines also state that the least invasive intervention should be used when working with individuals at risk and that involuntary emergency intervention should only be used as a last resort. Additionally, while the goal of the Guidelines is to involve at-risk individuals in their plan to keep safe, they also recognize that at times, people at imminent risk of suicide may not be able or willing to take measures to keep themselves safe and thus require Active Rescue, where caregivers should take all action to secure the safety of a person at risk when they are unable or unwilling to take action on their own behalf.

Often, without comfort and experience in suicide risk assessment and intervention, a facilitator's desire to keep a participant safe may cause them

to overlook collaboration with the person at risk and instead jump to a more invasive intervention to "guarantee" safety. Knowledge and experience with the aforementioned guidelines helps a facilitator to feel confident in developing a balanced plan for safety that respects the wishes of the person at risk as much as possible.

Facilitators must be available eight consecutive weeks during the scheduled group meeting time. The support group's weekly meeting lasts one and a half to two hours. (Groups with fewer participants are limited to one and a half hours, and larger groups run two hours.) However, facilitators need to allow additional time for set-up before and debriefing after the meeting. Facilitators also make themselves available for follow-up contact between group meetings. This typically requires three to six hours per week, depending on the needs and number of group participants. Facilitators are typically involved in the recruiting and screening of group participants. Additionally, facilitators will want to work with group members to make sure they are connected to outside resources, such as an individual therapist or psychiatrist.

Factors to consider in developing a group

The implementation team for the support group at DHSPC went through a yearlong development process before the group began. The team considered many factors that are important for others to consider when developing a group, including making decisions in the following areas:

- Target audience. The audience needs to be aligned with the goals and outcomes you choose. There are many factors to consider about the target audience.
    - Age. The DHSPC support group was designed specifically for an adult population (18 years and older). Because there is so little information regarding groups for suicide attempt survivors in general and even less in using such a group for youth, it was decided to focus on implementing and evaluating a support group for adult attempt survivors as a starting point. In addition, liability and contagion concerns were more significant for youth groups.

- Level of functioning. Generally, the DHSPC support group facilitators screen participants to identify their primary needs and evaluate whether a support group is appropriate for them. There are no hard and fast rules, but if an attempt survivor has more pressing concerns such as substance abuse issues or untreated mental illness that may interfere with their ability to participate in a group, this usually must be addressed prior to participating in the support group. DHSPC makes referrals for individuals with these needs, in the hope that once they are stabilized, they could attend the group.

  Participation in individual therapy is not a requirement for participation in the support group. In fact, for some, the group may encourage those who have never been in therapy to see how others have benefited and consider it for themselves. However, facilitators do ask whether an individual is in therapy during the intake interview and may suggest it for those who might benefit from additional support. Additionally, facilitators have found that individuals with certain mental health diagnoses often have had less success in the group. For example, when it comes up during the intake interview that an individual has Borderline Personality Disorder (BPD), they are usually referred to others services such as dialectical behavior therapy first, and may join the group at a later point.

- History of attempts. There is no specified amount of time that must have passed since their attempt in order to participate in the support group, and the time since attempt has varied from a couple of weeks to approximately five years. It is worth noting that if the attempt has been recent, special attention should be given to the impact of the attempt in terms of how the group might trigger the member's experience of the trauma. With this in mind, we work collaboratively with the member to insure their safety and comfort level within the group.

SUPPORT GROUP FOR PEOPLE WITH SUICIDE IDEATION

When the DHSPC support group for suicide attempt survivors began, calls from interested participants were received from people who had struggled with persistent thoughts of suicide, but had never attempted. Initially, facilitators allowed both attempt survivors as well as individuals with very strong suicidal ideation who had not attempted suicide to participate in the group. While some of those with only suicidal ideation seemed to benefit from the peer support and coping skills learned in the group, others dropped out, finding the group to be too "intense." Ultimately, based on concerns about the vulnerability of individuals who have not attempted and the possibility that hearing about others' attempts could increase their capability for suicide and heighten their risk, it was decided to limit the group to only those who had a previous attempt. Group facilitators have considered piloting a separate group to provide support and teach coping skills to this population with persistent thoughts of suicide, but have not yet initiated this group.

- Diversity. In previous groups, diversity helped to solidify the group, and people from different backgrounds were able to bond through their common experience of having survived a suicide attempt. As in any situation where diverse populations are working together, it is important for facilitators to be aware how factors such as race, ethnicity, language, religion, sexual orientation, and gender identity may impact participants' worldviews and group dynamics. To be inclusive, facilitators may wish to ask participants about these issues during intake or check-in.

I love the fact that we are different and feel very tied to each other."
"I don't feel abandoned anymore." - Support Group Participant

- Duration of group/Open or closed group. The decision to make this a closed, eight-week group was based primarily on the success of the suicide bereavement groups that have been operating for over 30 years at the Didi Hirsch Suicide Prevention Center with this structure. Participants must complete an intake and be accepted into the group before attending. The support group is closed to additional participants once the group starts.

  This model was adopted with the intention of having participants commit to attending all eight meetings whenever possible. The group has an agenda for every week, planned so that participants' skills and relationships with others in the group grow over the cycle. Since the group is closed, people are restricted from joining mid-cycle.

  It is not unusual for group participants to continue to experience thoughts of suicide after completing one eight-week cycle. Many participants have reported that the ongoing support they find with in the group is helpful. For this reason, participants of the group can choose to repeat the eight-week group cycle. In addition to finding support for themselves, repeat participants often provide guidance and hope to new participants. Repeating the group has proved popular. In fact, about 30 percent of group participants have returned for at least one additional cycle, and several participants have repeated the group more often.

  Facilitators have opted to schedule a two- to four-week break between group cycles to give both facilitators and returning participants a short break. The break after the cycle allows participants time to practice the coping skills that they learned during the group, thus fostering a sense of empowerment and independence.

- Therapist or peer-led. Peer support is very popular for a variety of issues such as addiction, mental health issues, illness or bereavement. Some have proposed that using peers to lead a group for suicide attempt survivors is the best way to reach out to a group of people who may feel discouraged or let down by therapists or other professionals they have encountered. Others have postulated that only those who have actually survived a suicide attempt can truly understand and support those with that experience. At the same time, some have argued that having a clinician lead the group is crucial to manage the intensity and risk associated with a suicide attempt survivors support group.

  The implementation team for DHSPC chose to have a therapist lead the support group. However, the team decided to also include a peer support person to work with the two facilitators. A peer support is an individual who has survived a suicide attempt and has also completed at least one previous group cycle. In addition, we also ask all of our peer facilitators to attend "facilitator training" at DHSPC. This training serves to further clarify the role of the "peer facilitator" while stressing the importance of self-care. The role of the peer support person can vary based on their comfort level and training but, as mentioned earlier, often includes providing acceptance, insight and inspiration from their own experiences and allowing participants to feel comfortable in talking about their experiences related to their attempt. The peer facilitator can model his or her own recovery process. Often, new participants find hope and comfort in seeing other attempt survivors who have progressed further in their journey of recovery. In turn, peer facilitators find inspiration in using their experiences to help others. Having a therapist working together with a peer support person has proven to be quite successful and is recommended to those considering developing their own group. Without a clinician, a peer support person may face their own thoughts of suicide and feel

overwhelmed or ill-equipped to support those who are at risk for suicide. Having a therapist as facilitator ensures that there is someone who is able to manage crises and to handle intense feelings that are present during a typical group cycle.

- Support group or therapy group. The DHSPC group is a support group rather than a therapy group. In a support group there is an emphasis on psychoeducation, information sharing, coping, and peer support, while in a therapy group the focus is on identifying individual interpersonal issues and therapeutic techniques to address them. In a support group, group participants generally take more of a lead providing thoughts, feedback, and reactions to other participants and directing conversation, but in a therapy group the therapist is responsible for treatment planning. Therapy groups often exclude suicidal individuals. For participants of the support group needing more attention, facilitators recommend individual therapy and will give referrals for therapists. In addition, we make it a point to always reinforce the fact that our crisis line is available 24 hours, seven days a week.

Schedule facilitators

Having two facilitators is recommended. It is not uncommon to have several people at risk at one time, and having a second facilitator helps handle these situations. It is also important to have a second facilitator if a facilitator needs to leave the room to attend to an individual participant. Two facilitators also allows for more flexibility to provide follow-up with participants as needed between group meetings.

Arrange a meeting place

Your sponsoring agency may provide space for the meeting, or another host may have space. Ideally this is a location that is in a safe area with adequate

outdoor lighting if meetings are to take place at night. It should be handicapped accessible and close to public transportation, with parking available if possible.

The meeting room should be private and quiet, with sufficient space for 10 people to accommodate group participants and facilitators. There should be a table big enough for the participants and facilitators to sit around. The table allows space to complete group projects and activities. The room should allow for the use of a TV/DVD player or computer and projector for showing videos. A white board or flip chart will be needed for group activities as well.

Create protocols

It is important to develop protocols for the group in advance. Protocols should include intake procedures, risk assessment, informed consent, group guidelines, and policies for handling imminent risk situations. In addition, we spent significant time looking at protocols for collecting outcome measures to further refine and monitor the effectiveness of the group.

Recruit support group participants

It is important to have a plan for publicizing the group within your community. The DHSPC group has run with as few as four participants, but having six to eight is ideal. Some attempt survivors who complete the intake may not show up for the meetings and others will cancel, so we recommend registering more than you think you will need.

Develop a flyer or brochure with basic information about the group to attract potential participants. Be sure to include facilitators' contact information and a brief mention of the group's eligibility criteria. It is important to let potential members know that there is an intake process and that the group will not be right for everyone.

Determine where to advertise the group. Contact local hospital emergency departments, inpatient programs, crisis lines, information and referral lines, community support group listings, health care practices, and counseling centers and send them information about the support group. If you belong to an

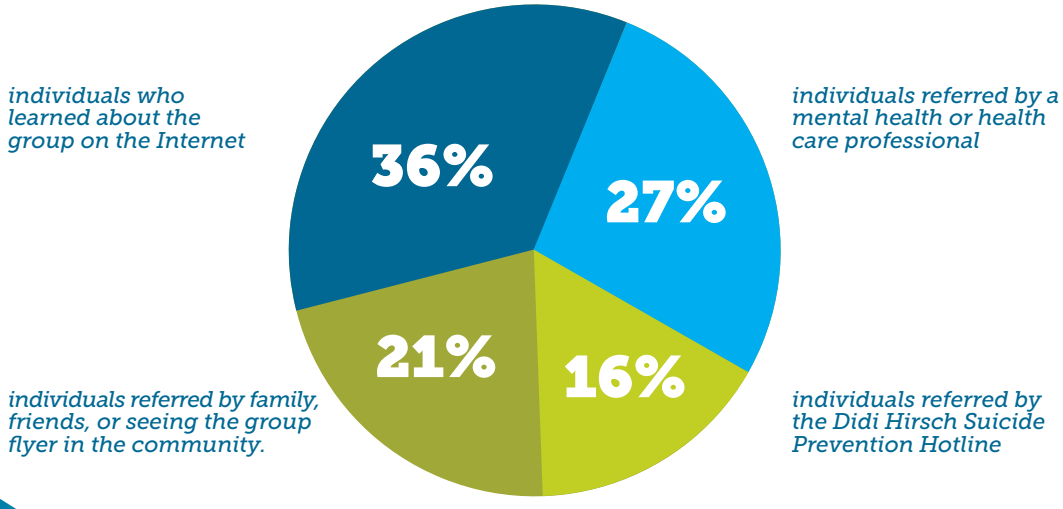
organization that regularly provides training in your community, offer to provide a training workshop and promote the support group as part of your workshop.

Promoting your support group on your website is a good way to reach attempt survivors directly. Often, they may feel more comfortable seeking services online. This being said, we discourage the use of email contact and provide a phone number instead. This is an important consideration for two reasons, unless your organization has set up a secure email channel, email is not considered a confidential form of communication. In addition, given the delicate nature of a first contact, we recommend having a conversation over the phone.

The DHSPC Support Group promotes the group in a variety of ways in the Los Angeles community and has received hundreds of inquiries about the group since it began in 2011. At the time of this writing, approximately 36 percent of inquiries come from individuals who learned about the group on the Internet, 27 percent come from individuals referred by a mental health or health care professional, and 16 percent were referred by the Didi Hirsch Suicide Prevention Hotline. Other referral sources include family, friends, or seeing the group flyer in the community.

III. Preparation Before the Group Meets

This section of the manual is intended for facilitators and addresses them directly. Statements in the manual that facilitators can use as a script to talk with potential participants are italicized and in quotation marks.



Hold the initial call with an interested survivor

When an attempt survivor calls to ask about the group, they will talk to a facilitator or other trained agency staff member. Give them an overview of the group and schedule their intake appointment. The overview includes descriptions of the following:

- Group participants. The group is for adults who have survived a suicide attempt.
- Meeting location, time, and duration. The meeting lasts one and a half to two hours (depending on group size) and is held on one weeknight/day for eight weeks. Give a general idea as to where the group meets (area of the city, etc.), especially if it is a large community, to make sure that the potential participant can attend; however, the actual meeting location is not disclosed until the caller completes the intake interview and is accepted into the group.
- Support group objectives. The group focuses on two things: a chance to meet and talk to others who have survived a suicide attempt and a chance to learn skills that may help them to cope with their suicidal thoughts and feelings in order to stay safe in the future.
- Group format and participation. The support group is a closed, confidential group. Participants all start at the same week and end the eight-week cycle together, making it more comfortable to share personal information. It is important for participants to attend all groups, if possible.
- Expectations for the group. It's a support group and not a therapy group. We recommend that group participants have additional resources outside of the group such as counselors or therapists.

In the next part of the initial call, you need to accomplish the following:

- Schedule an intake interview. It is important to schedule an intake call or visit soon after an individual initially contacts the program,

and within the same week whenever possible. An attempt survivor's readiness for joining a support group may be short-term; the energy and resolve aroused by the crisis of an attempt may not last long. Inform the individual that the intake interview will be completed by phone or in person and will take approximately one hour. If by phone, instruct them to find a quiet, private place to talk, as the intake interview will ask about their personal history and suicide attempt.

- Check for safety. Ask the potential participant if they are currently feeling suicidal. If so, a thorough risk assessment and/or intervention must be completed immediately.
- Provide resources. Inform the potential participant about the National Suicide Prevention Lifeline 1-800-273-TALK or 1-800-273-8255 and let them know it is available 24 hours a day, seven days a week if they are feeling suicidal and need to speak with a counselor. If they decide they don't want to set up an intake interview or are not an eligible candidate for the group, provide other resources when possible.
- Ask how they learned about the group. Tracking how people found about the support group is a good way to measure the effectiveness of your marketing efforts.

The intake interview: Introduction to the group and screening

Initially, intakes were done over the phone. However, as the group progressed we scheduled intakes in person. We believe that conducting the intakes in person may have led to more people joining the group. We speculate that having individuals come into the building where the group was held and meeting the facilitator in person may have worked in reducing anxiety associated with attending the first group meeting.

Purpose of the intake interview

The intake interview is meant to meet the needs of both the suicide attempt survivor and the group facilitator. The facilitator wants to determine the participant's level of safety and readiness to join the group. The participant, who may not have had a chance to discuss their experiences related to suicide, wants to feel a sense of relief and acceptance. The term "intake interview" can be misleading. Instead of the facilitator asking a series of questions and the participant giving a series of responses, the meeting ideally is more of a conversation. A skilled facilitator is able to strike a balance, gathering needed information while providing active listening and empathy.

Needs of the participant during intake

This first substantive interaction lays the groundwork for what the potential participant may expect to experience in the support group. Many suicide attempt survivors feel misunderstood and perhaps never had the chance to talk with anyone about the negative situations and emotions that led to their attempt. It is important to allow them to tell their stories and to express these emotions. However, because these feelings can be intense, some participants can get "stuck" there. As a facilitator, your role is to strike a balance, recognizing and validating the person's reasons for wanting to die while noticing and nurturing their reasons for living. Touching on these themes during the intake interview helps to get the participant thinking about them before the group begins.

For many participants, the intake interview is an important first step in their journey toward recovery. If they have spoken with someone about their suicide attempt, it likely was a difficult conversation. The participant also may be hesitant to talk to a stranger. At the same time, they may anticipate a sense of relief that can come from sharing their story with someone who is calm, patient, and non-judgmental. Creating a safe space where they feel supported will help them to see that talking about their experiences can be positive and encourage them to take the next step of attending the group.

Needs of the facilitator during intake

First and foremost, you need to be attuned to the needs of the participant. Because of time constraints or concerns about the safety of the participant, you may be tempted to ask lots of questions in rapid succession. However, you need to allow the participant time to express feelings about their attempt that they may not have had the chance to share with anyone. Additionally, the participant needs time to reflect on their experiences and ask questions. A word of caution: If you notice that a participant is unfocused or rambling you can keep the conversation productive and focused by bringing the conversation back to the questions in the intake.

Procedure for the intake interview

During the course of the interview, follow the steps below. While they are written as separate steps, in an actual intake interview some steps will likely overlap and flow naturally as part of the conversation.

1. Explain the intake interview
2. Present an overview of the group
3. Gather participant information
4. Complete the risk assessment
5. Accept participant into the group or refer to other services
6. Conclude the intake interview

1. Explain the intake interview

- Describe the purpose of the intake. "The purpose of this interview is for you and I to get to know a bit more about each other and to see if the suicide attempt survivors support group is a match for you. We are going to discuss your history to determine if the group is a good fit, and some questions may be difficult. I encourage you to let me know if anything bothers you during this process. In addition, I hope that you will ask me any questions that you have about the group."

- Gain information about the potential participant and set the group's tone. "Suicide can be a private topic, and so the questions I ask may feel very personal. The intent is not to be intrusive, but rather for you to have a chance to be honest about what you have experienced and how you are feeling. I think it is the best way for me to get to know your struggles and to help you decide if the group may be beneficial to you, or if you might do better with other resources."

- Explain confidentiality and exceptions. "I want you to know that this conversation, as well as what happens during the support group, is confidential. That means that anything you share during this call will remain between you and me. Additionally, whatever you say in the group will remain in the group, and we ask all participants in the group to sign a confidentiality agreement indicating that they will not disclose information to others or to group participants outside of the group meeting."

  "However, legally, there are some times when I am required to break confidentiality. This includes situations where I might hear that a child, elderly or disabled person is being abused or neglected or any situation where you or someone else's life might be in immediate danger. In these situations, I am required to take steps to ensure that everyone remains safe. This may include notifying other people and professionals about the situation."

  It is important to openly review limits to confidentiality. Since the support group is designed specifically for suicide attempt survivors, potential participants might be wondering how much they can share about their attempt or if they can disclose thoughts of suicide.

"So you may be thinking, 'This is a group about suicide, what happens if I say I am thinking about suicide?- Are you going to tell someone?' You may even have experiences where you have told someone that you were thinking about suicide and they didn't react in a way that was helpful to you. It is important for you to know that the facilitators of this support group frequently talk to people who are having thoughts of suicide, and we encourage people to share those thoughts with us. Just because someone tells us they are thinking about suicide doesn't mean that we are going to break confidentiality. In fact, it is our goal to work with you to find ways to keep you safe that are comfortable for you. That may involve getting others involved, but we would hope to contact people that you are most comfortable with. Do you have any questions or concerns about this that you would like to discuss?"

2. Discuss the overview of the group

Review the overview of the group that you provided to the potential participant on the initial call. Encourage the potential participant to ask questions and discuss concerns or fears. Asking what they hope to get out of attending the group is also an effective way of determining if the group is the right resource for them.

3. Gather participant information

During your intake interview, gather as much basic contact and demographic information as you can about your potential participant such as name, phone number, address, date of contact, age, gender, sexual orientation, ethnicity, veteran's status, and employment status. Ask for an email address if you plan on contacting participants by email. It is important to get an emergency contact; you can assure them that the emergency contact would only be used in extreme cases. This is also a good time to find out whether the potential participant is in therapy or has been in therapy in the past. If they are or have been in therapy,

ask if they found it helpful. If they are open to talking about their experiences in therapy, discuss the option of them signing a waiver to allow you to talk with their therapist.

Be attuned to the potential participant's reactions to these questions and use them to determine when and how much information to gather. For those who are comfortable discussing basic demographic information, facilitators can use the discussion as a way to establish trust and "break the ice." Others, however, may not want to share personal information, such as address, emergency contact, or experiences in therapy at the beginning. Use your best judgment when asking these questions, and if the potential participant seems hesitant you can always gather this information later in the call or even over the course of the group, if needed.

4. Complete the risk assessment

Many clinicians are skilled in suicide risk assessment; however, risk assessments for particular groups or settings often have special requirements. To complete the risk assessment that helps determine participation in a suicide attempt survivor support group, you balance two aims: completing a thorough risk assessment and building a supportive connection with the potential participant.

Most suicide attempt survivors continue to experience thoughts of suicide after their attempt. The risk assessment you do as part of intake will determine the level of safety of potential participants and identify those at imminent risk. It will also help you gauge their readiness to participate in the group. There are many suicide risk assessment instruments for clinicians working with individuals at risk of suicide; however, none of the instruments should be used without training, protocols, and supervision.

To assess a potential participant's risk level, the DHSPC support group uses the Risk Assessment Standards for the National Suicide Prevention Lifeline (Joiner et al., 2007). These standards are based on four core principles (suicidal desire,

suicidal capability, suicidal intent, and buffers/connectedness), each with a number of subcomponents:

- Suicidal Desire: Suicidal desire refers to the intense feelings and wishes for death that a suicidal person experiences. The subcomponents for this principle include suicidal ideation, psychological pain, hopelessness, helplessness, perceived burden on others, feeling trapped, and feeling intolerably alone.
- Suicidal Capability: Suicidal capability refers to a sense of "fearlessness" or "competence" in regards to making an attempt. The subcomponents for this principle include a history of suicide attempts, exposure to someone else's death by suicide, history of/current violence towards others, available means of killing self/others, current intoxication, history of substance abuse, acute symptoms of mental illness (such as recent dramatic mood change or being out of touch with reality), and extreme agitation/rage including increased anxiety or decreased sleep.
- Suicidal Intent: Suicidal intent refers to a person's resolve to die, or how likely they are to act on their thoughts of suicide. The subcomponents of this principle include attempt in progress, identified plan to kill self/others, preparatory behaviors, and expressed intent to die.
- Buffers/Connectedness: Buffers/connectedness refers to the positive things in a person's life that may be protective factors and lessen their risk for suicide. The subcomponents of this principle include immediate supports, social supports, planning for the future, engagement with the helper, ambivalence for living/dying, core values/beliefs, and a sense of purpose.

The risk assessment portion of the intake interview includes an assessment of each of the subcomponents included in the four core principles. The presence of each subcomponent is indicated via a yes/no response on the intake form. Answers may be obtained by directly asking the participant or may be revealed by the participant in the natural course of the discussion. Facilitators will develop

their own style of gathering the information in the risk assessment that allows for a conversational flow and connection with the participant. While it is not necessary to obtain direct answers to every single subcomponent in the risk assessment, the more information that is obtained, the more thorough the risk assessment will be.

The Lifeline risk assessment standards help to meet the needs of both the potential participant and the facilitator. When discussing suicidal desire, the participant has an opportunity to express the pain and emotions that led to their attempt and could be contributing to current thoughts of suicide. For the facilitator, discussions of suicidal capability and intent help them to learn more about the person's current level of risk. Finally, hearing about a person's buffers and connectedness marks a shift in the intake from a focus on pain and hopelessness to a focus on hope and resources.

Thus, even though a suicide risk assessment cannot predict suicidal behavior with certainty, it can help to determine who may be at higher risk and, more important, who may be at imminent risk, in other words, likely to act on suicidal thoughts in the near future. On occasion during an intake interview, a participant is assessed to be at imminent risk. In these cases, the facilitator works collaboratively with the participant to ensure their safety. At DHSPC we follow an agency protocol for when callers are at imminent risk, based on the Lifeline's Guidelines for Helping Callers at Imminent Risk of Suicide.

UNDERSTANDING IMMINENT SUICIDE RISK: BASIS FOR A COLLABORATIVE RELATIONSHIP

The four core principles enable the facilitator to categorize various elements of risk and evaluate a participant's overall risk. The risk assessment standards for Lifeline provide direction for how to do this. The risk assessment standards maintain that a person at the greatest risk is one who has strong suicidal desire, capability, and intent, regardless of the buffers in their life. When desire is combined with intent or capability (but not both), the risk is lower but still considerable. For these individuals, buffers may help lessen that risk. Suicidal desire alone is "best viewed as an indicator of acute distress or a symptom of a mood disorder and does not entail significant risk on its own" (Joiner et al., 2007, p. 361).

An understanding of risk assessment increases the likelihood that a facilitator will collaborate with a participant to establish a safety plan that meets their needs, rather than engaging in an overly invasive intervention. For example, a facilitator may hear a participant make statements that indicate strong suicidal desire, such as, "I just want to die," "There is no hope for me," or "I hate my life, I don't want to live anymore." A less experienced facilitator could conclude that they needed to get the participant to a hospital immediately. That is understandable, since statements such as these can feel very heavy, and one might equate them with a high suicide risk. Certainly seeking additional help is always advised, especially if one is not familiar with supporting a suicidal person.

However, this "better safe than sorry" approach treats every suicidal individual as though they are at imminent risk and often employs the most invasive intervention to try to "ensure" their safety. In a perfect world, with unlimited resources, this approach might work if the care then addressed the issues that led to the individual's suicidal thoughts and helped them determine a way to stay safe. In reality, the result of the "better safe than sorry" approach is usually a short-term hospitalization and release. The approach often leaves a person at risk feeling unempowered, with no additional tools to stay safe and decreases the likelihood that they will reach out for help if they are suicidal in the future.

However, strong statements of suicidal desire may also be a way for a person at risk to communicate the deep pain that they are experiencing. If a participant feels a strong connection with the facilitator and their previous attempts to communicate their pain went unheard, they may seek to unburden themselves. A skilled risk assessment with more information about intent and capability along with desire, will give a more complete picture of this person's risk. For example, considering statements of capability, such as, "Last week I got drunk and took an entire bottle of sleeping pills" and intent, such as, "It didn't work last week, but I've bought a gun and this time there will be no messing up" gives a much better indication of imminent suicide risk than considering only expressions of suicidal desire.

5. Accept participant into the group or refer to other services

Once the risk assessment is completed, you make a decision as to whether the potential participant is accepted into the support group. In general, most potential participants who complete an intake are accepted as long as they meet the basic eligibility requirements for the group (aged 18 years or older, residing in Los Angeles or Orange County, and survived a suicide attempt). Those not accepted into the group are provided referrals for more appropriate support services. If you decide to accept the participant into the group, you might say something like, "From what I can tell, it seems like the group might be helpful for you, and we would love for you to join us. From our discussion, does it feel like an option that you would like to try?" This allows the participant to be honest with you as to whether they intend to join the group.

When a participant is accepted into the group, they may have to wait a significant amount of time for the next group cycle to begin. In these cases, there are a few alternatives. Facilitators will make referrals to therapists or other community supports as appropriate. Additionally, facilitators can offer to stay in contact with them through email or telephone check-ins. Another option is to refer participants to a more formal follow-up program offered through the Didi Hirsch Suicide Prevention Hotline where they receive regularly scheduled calls and complete safety planning activities with a crisis line counselor.

If the person is at high risk while waiting for the group to start but is not needing emergency care, it is important to develop an individual crisis plan with them. The crisis plan may include adding the Suicide Prevention Hotline phone number in their cell phone directories and identifying situations when they would call, and talking with them about lethal means counseling, or having them check in with the facilitator on a weekly basis. Once the support group starts, their crisis plan will be augmented with additional services and incorporated into their safety plan.

6. Conclude the Intake Interview

One you have accepted the participant into the group, inform them of the next steps:

- Ask the participant, "How has it been to share with me about this today?" Asking this question helps build rapport and gives insight to the participant's readiness to join the group.
- Tell them when the next group cycle will begin and give them the location. Inform them that they will receive a reminder call (or email) a few days before the group is scheduled to begin. Request that they notify you if they change their mind and don't intend to participate in the group.
- Send them a welcome packet. In the intake interview, say, "With your permission, we would like to send you a packet with resources and information about the group." The welcome packet can contain items like a welcome letter, group schedule, crisis line and National Suicide Prevention Lifeline contact cards or magnets, group guidelines, bibliography of books recommended for suicide attempt survivors, the "Taking Care of Yourself After an Attempt" brochure from the Substance Abuse and Mental Health Services Administration, contact information for local counseling referrals, your business card, and a blank safety plan.
- Inform the participant of paperwork to be completed during the group to help them prepare. "On the first night of the group, there will be some paperwork for you to complete. Some of it is to make sure that all group participants understand the rules of the group and the importance of confidentiality. Other forms are to help us learn if the group is helping people and how we can make it better."
- Allow the participant to ask questions and provide answers as needed. "Is there anything else that you would like to know about the group?"

Facilitator note: Prior to starting the group, some participants have expressed concern that talking about suicide could be depressing and painful and might make them feel worse. You can respond that the group provides tools for coping and safety planning and is not just about talking about suicide in and of itself. In fact, the group emphasizes hope and focuses on reconnecting with things that bring participants joy. You can say that the group does not allow graphic descriptions of attempts. You can also relate that in the DHSPC group's experience, most participants have found relief in sharing their stories. Instruct the participant to be aware of these feelings and discuss them with you individually if they are still concerned about this after they have begun the group. Most find their concerns are assuaged once they attend the group. Ultimately, the group may not be the right match for all participants; in these cases you can suggest that the potential participant engage in individual therapy and consider joining the group at a later time.

- Remind the participant that the National Suicide Prevention Lifeline is always available. Give them the number and encourage them to call whenever they are feeling suicidal or they just want to talk.

IV. Support group weekly schedule

Overview of the topics for each week

This section of the manual is intended for facilitators and addresses them directly. It provides a week-by-week description of the activities that take place during the eight-week support group. Statements in the manual that you can use as a script for support group meetings are italicized and in quotation marks.

For each week, aside from the overview and objectives, there is an agenda and a list of materials you'll need for the week.

Please note that the last section of the manual (called "Facilitating the Support Group") will describe common issues that you may experience when running the support group and provides strategies to address those issues.

Week One: Group Overview/ Introductions

Facilitators and participants introduce themselves and share their experiences with suicidal thoughts and attempts. Goals and guidelines for the group are reviewed. Participants complete initial group paperwork, including outcome surveys. Informed consent is discussed in detail.

Week Two: Talking About Suicide

Facilitators and participants view a video of others who have survived suicide attempts, reinforcing the safety of discussing their experience in the group setting as well as giving examples of hope.

Week Three: Giving And Receiving Support

Facilitators and participants discuss the benefits and challenges of using other support group participants for support. Using the crisis line as support is also discussed.

Week Four: What Causes My Thoughts?

Facilitators and participants discuss causes for suicidal thoughts and automatic thinking.

Week Five: How Can I Cope With The Thoughts?

Participants begin completing their safety plans and complete a survey on the impact of safety planning.

Week Six: Resources

Facilitators and participants discuss resources for suicide attempt survivors such as websites, professional therapy, books recommended for suicide attempt survivors, and community resources. These resources can be used to complete remaining steps of their safety plans.

Week Seven: Hope

Facilitators and participants discuss reasons for living and how they brought hope into participants' lives. Participants share a personal item that represents something hopeful in their life. Hope Box activity is completed.

Week Eight: Where Do We Go From Here?

Facilitators and participants discuss closure and ways for participants to stay connected, and fill out paperwork evaluating the group process and post-group measures.

Typically in weeks one to three, as in many support groups, the focus is on allowing participants to build trust and bond with each other and with the facilitators. Participants find strength in learning they are not alone and relating to each other as suicide attempt survivors. They are able to share the experience of the suicide attempt, the challenges they have faced as a result of their attempt, and ways they have overcome these challenges. Participants see videos of attempt survivors who have found hope on their road to recovery and hear stories from peers in the group who have done the same.

As the group progresses through weeks four to six, participants continue to solidify relationships while adding a focus of learning new skills. They complete activities that help them to better understand their risk for suicide including what causes their suicidal thoughts and ways to keep those thoughts from turning into suicidal actions.

The last two weeks mark a turn towards hope. In weeks seven and eight, participants create hope boxes and share something that symbolizes their reasons for living. Ideas are shared regarding how to stay connected and safe when the group cycle ends.

There is a parallel between an individual suicide intervention and the transitions seen over the course of an eight-week group cycle. In the beginning of the group, there is a need to form a strong connection, to be able to disclose one's own pain and to attend to another's pain. As the group progresses, there are subtle transitions that typically occur as the group bonds and group dynamics come into play. Alternatives to suicide are discussed, and participants learn ways to cope with suicidal thoughts and feelings, with the hope of providing relief and ultimately opening the door to a focus on life.

While the weekly schedule provides a guide for each week's activities, the participants' needs ultimately dictate what happens in any given meeting. Be flexible when a discussion may need to supersede the planned group activity or when a participant may have a crisis that needs to be addressed immediately.

Format for weekly meeting

The first group meeting is slightly different since a number of introductory activities must take place; however, group meetings follow this format:

Arrival

The first few minutes of each group is the arrival period. It has a more social tone while people acclimate to being there. Participants choose their seats, greet each other, and gather refreshments. You lead icebreakers, and the group chats about what's going on outside or what's in the news that day.

For the first meeting, give directions to the bathroom and orienting to the facility. Encourage participants to create a nametag with their first name and wear it if they are willing. During the second meeting, continue to encourage participants to wear nametags.

Welcome and announcements

For weeks one and two, scripts for suggested welcomes are provided. For later weeks, you will provide your own welcome to the group. You make announcements, such as scheduling changes due to upcoming holidays and late arrivals or absences that participants have called in. There may also be reminders of upcoming events. Finally you will provide an overview to the planned agenda for the meeting.

> ***"It is a safe place to let it all out." - Support Group Participant***

Check-in

Each participant is given up to five minutes to check in with the group. They can use this time to share how they are feeling, how their week is going, or

something that happened during the week. Often participants share something that was negative or challenging from the week. That is acceptable; however, reframe this and ask the participant to try to share something positive as well. Other group participants will frequently point out the positive things they see in fellow participants. Reflecting their positive comments out loud is a great technique to help build group support for one another.

Note: there is no check-in at the first meeting, and a script is provided for the second week's check-in.

Weekly discussion/activity

Each week, lead the group in a topic or activity according to the weekly agenda.

Closing

For all but the first meeting, summarize any observations or themes from the meeting and, if time permits, lead the group in a closing activity. Twenty minutes prior to the end of the group meeting, remind participants to check in with themselves and do a grounding exercise if needed. Grounding may simply entail taking a few deep breaths. The process for the DHSPC group has been to allow people to get grounded in their own way by giving them a moment to check in with themselves rather than leading them through a structured exercise. However, you may instead ask participants if they wish to devote time to practicing grounding. Participants may choose this, given that dissociation can be so common with panic, trauma, suicide, and self-injury. There are various grounding exercises from dialectical behavior therapy, Seeking Safety models, or mindfulness practices if you would like to do a formal activity. This allows participants to gather themselves before leaving the group and returning to their regular activities.

After grounding, ask participants for reflections. You don't want people to leave the meeting in an uneasy state, with loose ends or unaddressed concerns,

especially if the meeting has been intense. Also, it may not be apparent when participants are struck by something that was said or that transpired. Eliciting reflections from the participants can bring important reactions that might otherwise go unspoken.

For the group's closing, consider the following or come up with another activity yourself.

- One-word check-out activity. Instruct the participants to say one word — positive or negative — that describes how they are feeling.
- Validation. Say that the meeting covered emotional territory, and acknowledge the strength it takes to belong to this group.
- Self-care plan. Ask group participants to say one small thing that they will do to take care of themselves this week to stay grounded.
- Read a poem, ring a chime, or lead a stretching exercise.

You can finish the closing by asking, "Are people okay to drive home? Does anyone need to stay after and just breathe for a few minutes before getting into their cars or on the bus?"

Facilitator note: Follow up at the end of the meeting by listing any participant you will need to check in with during the week.

Room set-up and refreshments

The set-up for the room is the same for each week:

- Quiet and private room, with soothing lighting and a comfortable temperature
- Table and enough chairs to accommodate the expected number of participants and facilitators
- Whiteboard or a flipchart placed where the group can see it
- Basket in the middle of a table which contains things like facilitators' business cards, and promotional materials for the National Suicide Prevention Lifeline and/or local crisis line such as

cards, magnets, pens/pencils, bracelets, or whatever other such items are available.
- Blank name tags and felt-tip pens are placed around the table
- Tissues on the table within easy reach of participants
- Technology for showing videos or websites.

Typical refreshments are light and may include such items chips and salsa, vegetables and dip, hummus, fruit, cookies or other baked goods, and drinks such as coffee or fruit juice.

Facilitator note about refreshments: Early in the development of the group, it was decided to provide refreshments at each group meeting. The addition of refreshments seemed to relax participants and create a more social feel, easing what could be a tense time, especially for new participants. An underlying goal of each group meeting is to help participants reconnect with things that have previously brought joy to their life. Socialization and food can be a reminder of that for many participants.

Week 1: Group overview and introductions

"It helps to come and listen to people in your situation, and you can relate to them." - Support Group Participant

Overview

- Review the group structure, expectations, and guidelines with the group, and get paperwork completed
- Create an environment that feels welcoming. To do this, the focus is on establishing rapport. Observe participants' nonverbal signals about their comfort levels around various group activities, and validate their responses and feelings

- Participants share their expectations for the group
- Participants and facilitators introduce themselves to each other

Objectives

The main objective for the first meeting:

- Participants feel safe enough to return for the rest of the group cycle. Attending the first meeting of a new group can be overwhelming for new participants who are likely wondering what to expect and what to share.

Materials

- Supplies
  - Blank name tags and felt-tip pens
  - Pens for completing surveys
  - Tissues
  - Facilitators' business cards
  - National Suicide Prevention Lifeline and crisis line promotional materials
- Participant Forms
  - Informed consent
  - Outcome Surveys
  - Group guidelines (Appendix B)
  - Support group schedule
- Facilitators' Forms
  - Attendance Sheet
  - Agenda
  - Manual

Agenda

1. ***Arrival***
2. ***Welcome***

One of the facilitators takes the lead in welcoming the group. A typical welcome might be the following:

"You've taken a big step in coming. We are glad you are here. Suicide is a topic we take seriously but are not intimidated by. This is a safe place to talk about suicide. We are here to support each other, not to judge. We want to create an environment that is safe and open to everyone. People benefit from the group differently. Some people feel relief just talking and sharing; while others want something more concrete in the way of skills. We've tried to incorporate both of these aspects into the group.

There are many feelings after experiencing an attempt; you may be glad you survived, you may be angry you are still here. You may be feeling both of those things at the same time. You may still have thoughts about killing yourself. Most people who have personal experience with suicide are torn, confused.

Whatever you are feeling, it is okay. And don't be surprised if how you feel right now changes tomorrow. Chances are you will feel many, often conflicting, feelings as you go through your journey towards recovery after your attempt. Often people who attempt suicide are experiencing a lot of pain, and suicide seems like a way to escape that pain when it becomes too much to handle. Perhaps you felt that way. At that time, you may have felt that suicide was the only way to end your pain. But maybe there are other ways to end or live with the pain. Many are also trying to find ways to feel better, to find hope, and to keep themselves safe. Hopefully this will be a group where you can talk and learn about all of those things."

3. Agreement on group guidelines

Distribute the group guidelines and give participants a moment to read them. Group guidelines include rules related to such things as confidentiality, attendance, participation, and finding support outside of group.

"Before we begin, it is important for us to review the guidelines for the group. You received these guidelines in the packet we sent you, so you may remember them. We have found that our groups run more smoothly when everyone agrees to these guidelines."

Ask if there are any questions or concerns and address them. If no discussion arises, highlight those guidelines that you want to emphasize (perhaps attendance or confidentiality). Ask the group if there are any guidelines they think should be added. When the discussion has ended, ask the group if they are willing to agree to adhere to the group guidelines over the next eight weeks.

4. Get informed consent from participants

The informed consent form outlines what the participant can expect in terms of their participation in the support group, especially as it relates to the participant information and confidentiality. Each member of the group must read, sign and return the informed consent form. Allow the participants adequate time to read the form. Ask the group if there are any questions. Often there are questions about confidentiality, specifically the statement that says that the group facilitator may have to break confidentiality if they believe that a participant's life may be in danger. If no one asks about this, the facilitator needs to address it.

"There may be some confusion after reading the informed consent form about confidentiality. The form states that we may have to breach confidentiality for situations of harm to oneself. That statement might be confusing given we said this is a safe place where you can talk about being suicidal. As a part of the Suicide Prevention Center, we talk with many people every single day who are thinking about suicide, and we know there is a difference between thinking about suicide and acting on those thoughts. In fact, we believe that by creating a safe place for you to talk about your thoughts of suicide, you will have a greater chance of finding ways to cope with your suicidal thoughts. Our goal here is always to work together to find ways to keep you safe; and if we believe you may be in danger, we are going to do everything we can to keep you safe. However,

we will attempt to do this through collaboration. In other words, we are going to work with you to see what we can come up with together as a plan to keep you safe.

Many of you may have had experiences where others did not get your input in terms of safety. Perhaps the police were called, or you were hospitalized against your will. If we believe your life is in danger, those types of interventions would be a last resort. Are there any questions about this?"

Often, there is a peer support person present who has previous experience in the support group. If so, it is helpful for them to share their perspective on this.

5. Icebreaker (optional)

This get-to-know-you activity is optional and can be a way to allow participants to meet each other. Participants pair up and interview each other briefly, such as where they're from, places they've lived, a hobby they have or did in the past. They then take turns introducing their activity partner to the larger group. Facilitators can introduce each other. If there are a lot of participants in your group, you may have to skip this activity to save time or find a shorter icebreaker.

6. Individual introductions and expectations

Participants and facilitators introduce themselves. Facilitators begin this activity with a brief overview of the sponsoring agency. Facilitators then proceed to introduce themselves, modeling appropriate information to share, including any personal connection they have to suicide, if desired. After the facilitators introduce themselves, one should invite the participants to do the same. If your group has done the icebreaker, tell the participants that although they have already been introduced, now they can introduce themselves, giving their names and information that the group hasn't heard already.

"We would like to give each of you to the opportunity to introduce yourself to the group. Everyone is here because of a common experience, having

survived a suicide attempt. Only if you are ready, you can share what you feel most comfortable with regarding your experience with suicide and what the experience has meant to you. Sometimes it can be helpful to listen to others who have gone through similar experiences. As part of your introduction, I ask that each of you to consider sharing two things: one, what you hope to get out of your participation in this group and two, what you need in order to feel safe here."

Alternatively, if time permits, you may ask participants to generate their goals as a group and summarize on the flip chart or whiteboard. Conclude the activity by summarizing:

"Thanks for sharing your experiences and your hopes for this group. We are open to your feedback: this group is unique, and we do our best to structure the group to meet the needs of our participants. If you have concerns about the group, please let us know; you can give us a call during the week or arrange to meet with us before or after the group."

Share your expectations for the group:

"Over the next eight weeks, you will have the opportunity to get to know people who share a very profound experience with you, the experience of having survived a suicide attempt. Meeting them and seeing that you are not alone may help you to discover ways to heal after your attempt. Additionally, we will work on activities that will help you to identify what triggers in your life may have led to your suicidal thoughts, how to find relief and cope with these triggers, and how to be safe when these thoughts occur.

Today, you have seen the facilitators doing a lot of the talking in the group. That is because it is our first meeting. We have noticed, however, that participants get the most from the group when you do most of the talking, because you know the most about what you need.

Remember that this is a support group, not a therapy group. This group is only part of your support system, one of many resources available to you which

may include things like therapy, wellness activities, and church groups. If you have an expectation for more skill building than we offer here, you may want to explore a therapy group such as a dialectical behavior therapy group. I am always happy to provide referrals if you are interested."

7. Program forms and housekeeping

Briefly go over the group schedule and point out any holidays or breaks in the schedule.

8. Closing

Follow the closing format previously described. Additionally, thank the participants for coming and conclude the group.

"We want to thank everyone for coming to the meeting. It may have been a difficult decision, and we are glad that you found the strength to come. Sometimes the first group meeting can stir up a lot of feelings for you. We will be calling new participants over the course of the next week to see how you are doing. If you need more support, you can also reach out to us, or call the crisis line. You may have found that this meeting was difficult, or you may not want to come back, but we encourage you to stick with it. Most participants who stick with the group feel better as they progress."

9. Hand out program surveys that give you baseline outcome measures for your program evaluation. Ask the participants to complete the forms and submit. Explain that their information will be kept anonymous and participation will help to improve the support group and to demonstrate its effectiveness for funders and others interested in running the program in their communities. Outcome surveys are distributed after the closing to allow individuals to complete them at their own pace. You may choose to develop your own list of outcome surveys. For our

purposes we chose to use the following:

Demographics Survey (developed in-house)
Safety Plan Measure (developed in-house)
Resilience Appraisals Scale
Beck Hopelessness Scale
Beck Scale for Suicide Ideation
Please contact DHSPC for more information on establishing outcome measures.

Follow-Up

Before the next meeting, call each new participant to check in with them, process their reactions to the group, and insure their safety.

Week 2: Talking about suicide

> ***"Group opened my eyes to realize that I am not the only one going through stuff." - Support Group Participant***

Overview

- Participants view the video Stories of Hope and Recovery (National Suicide Prevention Lifeline and Substance Abuse And Mental Health Services Administration). The video features individuals who have made suicide attempts and how they have taken steps on their journeys towards recovery.

- After viewing the video, lead a discussion allowing participants to talk about their reactions to the video.

Facilitator note: In groups where there are many repeat participants who have already seen Stories of Hope and Recovery, facilitators may choose an alternate film such as Drawing from Life (National Film Board Canada), A Simple Question (The Greater Los Angeles VA Suicide Prevention Program), or even an attempt survivor video on TED Talks.

Objectives

- Further build rapport among participants and with facilitators
- Increase participants' comfort level in talking about their own suicide attempt and how that experience has affected them

Materials

- Promotional materials, name tags, felt-tip pens
- Audio-visual equipment
  - TV/DVD player, laptop with DVD player, or projector
  - Screen
  - Speakers
- Stories of Hope and Recovery or other video
- Facilitators' Forms
  - Attendance Sheet
  - Agenda
  - Manual

Agenda

1. ***Arrival***
2. ***Welcome***

Welcome everyone to week two: "Thanks to everyone for coming back. How is everyone doing? In a moment we will be checking in to hear how your week went." Ask some general questions to the group and allow participants to

respond: "How was the week? What did you think of last week? Did anything come up for anyone? Was it difficult to decide whether to return? Why?"

Review the agenda for the meeting:

"We have a variety of topics and activities planned for this meeting. You will notice that each week we have a similar structure to our meetings. At the beginning of each meeting, we will review the agenda for the night. Then we will have our check-in. This is a time for you to process how you are doing. We will discuss this a bit more in a moment. Then we usually have a topic for discussion or an activity that we will complete. Lastly, we will have some way to close the group meeting. This week, we will do a quick icebreaker, since you may not remember everyone you met last week. Then for our activity, we will watch a video that features other suicide attempt survivors and discuss it. Before we start our icebreaker, I would like to make a few announcements ..."

Make announcements to the group, such as any participants who have decided not to return or who are absent.

Describe the icebreaker as a way to allow participants to learn more about each other and to reinforce positive things in their lives by exploring talents, strengths, pleasures/likes, and life experiences. Ask each participant to introduce themselves with their name and something interesting about themselves that others might like to know. The twist is, it has to be something positive. To help generate ideas among the participants, you can ask things like, "What is your favorite thing about yourself? What do people most compliment you about?" Some participants may not be able to identify anything positive in their life at the current time, so adding options is encouraged, such as, "If you could have any kind of super power, what would it be?

3. Check-in

Since this is the first week that the group checks in, introduce the goal and guidelines for check-in.

"Many people who have survived suicide attempts find that they don't have a lot of places in their life where they can talk about how they are truly feeling, especially if they are feeling down or having thoughts of suicide. Past participants have indicated that coming to group and having a place where they can share how they are feeling is a huge benefit of the group.

At the same time, we have also gotten feedback from participants who want more from the group than just talking and listening to the bad things that people may be experiencing. We try to keep a balance in the group. We give participants a place both to talk about how they are feeling and also to learn ways to share that might help them feel better.

Each week, at the beginning of the group, we will give you a chance to check in with the group and talk about how you are feeling. You can share anything about how you are currently feeling or what has happened in your life during the past week. If you are feeling bad, that is okay. We want to give you a chance to talk about that. If you have had thoughts about suicide, share those and how you dealt with them.

But we like to balance our check-ins with both good and bad. It's hard to look at the positive sometimes, but it's important to be able to recognize and celebrate the things that went well. So when you check in, let us know how you are doing, and try to share at least one positive thing that you experienced in the past week. There must be at least one, because in fact you are here with us at group, and that in itself is positive.

Sometimes on our own we focus on all the negative things that happened during our week, but in the group other participants can help us identify some good things that they heard that we missed.

Let's be conscious of time—try to limit your check-in to five minutes. If you need more time we might not cut you off; however, we want to hear from everyone and move on to the week's activities.

When you check in you can share:

- How your week went
- Were there any significant events during the week? Any struggles or challenges and successes?
- Any thoughts of suicide? If so, how did you handle that?"

4. ***Moderate the check-in, reframing negative discussions into positive ones when possible and making sure the participants don't take too much time.***

5. ***Video and discussion***

Introduce the video. Depending on the video, say something like the following:

"Last week, many of you described your experience of being a suicide attempt survivor. Many group participants mentioned how difficult that could be. We are going to watch a video that shows several peoples' struggles to share their thoughts of suicide and how they overcame that struggle. When the video is over, we will have a chance to discuss it."

Play the video. Dim the lights, if possible, to allow for some sense of privacy. Monitor the group for reactions, as the film will likely bring up emotions.

Initiate and guide the discussion:

"Some people are eager to share their story with this group after seeing the video of other attempt survivors. Others are reluctant because it can be scary to go back to that day. Do what you are comfortable with. You will have ongoing opportunities throughout the group to share aspects of your story with others as you choose to."

Allow participants to discuss the video at a natural pace. You can choose questions from the following to help to spark conversation:

Facilitator note: Sometimes participants may feel that the video is "too hopeful," expressing that they can't imagine ever being able to recover as those in the video have recovered. Validate those feelings and the courage it has taken them to come to the group, even when feeling this way.

What were you thinking or feeling when you watched the video?

Could anyone relate to the stories? Was there anything in the video that reminded you of something in your life?

What do you remember about the time leading up to your attempt? What were you thinking? How were you feeling? Did you tell anyone? How did they respond? What did you need?

What has it been like for you since your attempt? What challenges have you faced?

Have you wondered what to say to your family? Your friends? Your job and school associates?

Who have you told about what happened? (Family, friends, work, school, etc.)

How much did you share?

What was it like to tell someone?

Have you had thoughts of suicide since your attempt?

Do you have anyone you can turn to when feeling suicidal? If not, who would you like to be able to tell? What keeps you from telling them?

What do you look for in someone who may be a supportive person in your life?

What do you want them to understand?

How do you want them to help you?

6. Closing

You follow the standard closing format and conclude by thanking the participants for sharing:

"Thanks to everyone in the group for such a rich discussion and for your willingness to be vulnerable in the group. Being able to talk about your experiences and needs is the first step in finding ways to feel better and to stay safe. Over the course of the next few weeks we will continue to build on this discussion and to learn from each other."

Follow-Up

Before the next meeting, follow up with any participants who requested it or whom you are concerned about.

Week 3: Giving and receiving support

> ***"Everyone understands each other. I feel that they are my support." - Support Group Participant***

Overview

As the group progresses, participants tend to bond quickly over their common experience of having survived a suicide attempt. Some have reported that it was easier to talk to participants because they seem like someone who understands, someone who has been there, or someone who isn't going to freak out hearing about suicidal feelings. Talking may extend beyond the group meetings.

Group participants generally feel comfortable contacting each other outside of the group when they need to talk or when they are in crisis or suicidal. Many survivors of suicide attempts feel more comfortable talking with facilitators or other group participants than with family, friends, and even therapists. This bonding is an important aspect of breaking down stigma and isolation.

In this week's meeting, participants talk about reaching out to or being a support to other participants; specifically, ways to:

- Support one another without feeling overwhelmed or incapable if a crisis arises
- Set boundaries for asking for help and giving help
- Be a healthy support system for each other
- Reach out to crisis services

Objectives

The objectives of this week's meeting are to:

- Increase participants' comfort and confidence in reaching out for support from others in the group
- Explore the benefits and challenges of being there for other participants, both in and outside of the group. Participants may not be used to supporting others who are at risk for suicide, and it is important for them to consider this before they are in a situation that is overwhelming for them, so they can establish appropriate boundaries and seek support as needed.
- Increase participants' awareness of their own needs in crisis

Facilitator note: If possible, in advance of the meeting, talk to the local crisis line or the National Suicide Prevention Lifeline about a group call. Arrange to call the line as a group (that is, putting the call on speaker phone) at the meeting time. Participants can hear firsthand what it is like to call. If you have a peer support person in the group who has called a crisis line or the National Suicide Prevention Lifeline, you may want to approach them ahead of time about participating in the group call or a role-played call. Hearing from a peer that a crisis line was helpful can encourage participants to call.

Background

The support group gives participants a safe place to test new ways of interacting, especially for reaching out for help and responding to others' reaching out. Some participants may routinely isolate and rarely or never answer their phone. Other participants may reach out to others frequently with very intense emotions. There are pros and cons to either primarily internalizing one's emotions or primarily talking and sharing communicating one's emotions; neither approach is right or wrong, and there is wisdom in seeking a balance of the two approaches.

Participants who mostly internalize may keep everything bottled up until they reach a crisis. They need to learn to get "out of their heads" and talk with others. Sharing with others may provide fresh insights or just a shift in looking at things. Letting off steam may avert the boiling point that builds from holding feelings in. These participants may need to be drawn out.

On the other hand, some participants might seem to talk endlessly, without communicating. It may not bring relief to the talker because they have not really sat with the feeling internally. Sometimes instead of talking they may need to self-soothe. They may need to choose safe listeners to share their feelings with. These participants may need help learning to communicate their needs more effectively.

One of the following activities has participants envision what it is like to be a support to a person in crisis. This has the added potential of helping participants to learn to better articulate their own needs and correlates with a later activity in safety planning. Envisioning being a crisis support person allows people to become more familiar with what they may need when they are in crisis and how they can communicate those needs to the support systems in their life.

Materials

- Whiteboard or flip chart
- Markers
- Facilitators' forms
  - Attendance sheet
  - Agenda
  - Manual

Agenda

1. ***Arrival***
2. ***Welcome***
3. ***Check-in***
4. ***Group Activities***

Introduce this week's topic, giving and receiving support:

"As we know, this is a support group. That means that everyone here has been through a similar experience and has wisdom to share as a result of that experience. In fact, your wisdom as you recover from your attempt may be helpful to other participants. I am going to list your responses to some questions as a list of advantages and challenges.

Being a support group, we are learning how to be supportive of each other."

List the ideas from the participants on the board and connect participant experiences from last week with ideas about being a support to one another. (You can ask a participant to be the scribe.)

Ask the group, "If you are in crisis, how can you use another participant in the group for support? What would be some advantages of contacting other group participants when you need support? What could keep you from reaching out, what might the challenges be?"

The following table lists typical responses for reaching out in crisis. If the group has trouble identifying responses, prompt them with responses listed below.

Advantages	*Challenges*
Other attempt survivors	*I might not feel safe being completely honest*
Understand me; I don't have to explain everything	*I don't want to be a burden to other participants*
Are not judgmental	*The unknown; I don't know how they are going to react*
Might not "freak out" because they understand suicidal thoughts	*I might wonder if they are going to tell anyone*
Empathize	*I worry that they might judge me or think differently of me later*
Helps me stay in a safe place	*It could make relationships complicated and blur boundaries*

Pose the question from the opposite perspective, "What might be the advantages to being a helper to a person in the group? What might be the challenges?"

Advantages	*Challenges*
It feels rewarding to use my experience to help others *In helping others, I might learn new ways to help myself* *Being in the role of a listener or helper might help me to learn how to better communicate my needs if I am in crisis.*	*Sometimes it can be hard to listen to others; it could be draining or stressful* *What if I am in an unsafe place myself?* *How much can I support them before I need to involve more help?* *What if someone gets mad at me if I feel the need to get additional help? It could make relationships complicated and blur boundaries* *What if a person calls me too much or wants a different kind of relationship than I do (friendship, romantic, etc.)?*

Process the groups' comments: "Now that you have heard the advantages and challenges, are you more like to reach out for help? To respond to requests for help?"

Acknowledge that many participants find it more difficult to imagine helping someone in crisis than to imagine asking for help for themselves. Lead the discussion about ways to be a good support. If the group doesn't come up with examples, suggest that the person responding:

- Can have boundaries
- Makes statements that show they understand
- Asks "What do you need?"
- Offers hope
- Reminds them to take care of themselves with the basics (eating, sleeping, bathing, exercising, perhaps taking medications)

Review what participants would do if they are helping someone and become worried that the person they are helping caller might be unsafe. The participants make lists of crisis contacts, including the local crisis line, the support group facilitators, the participant's family members, and perhaps police.

The second activity is role-playing a call to a crisis line. Begin a short discussion by asking the group whether anyone has ever called a crisis line. If participants have, ask them to describe their experiences; for example, was it helpful? Would you call it if you were in crisis?

Typical responses from the group have varied. Some participants have said they would never call a crisis line. Others have said that they have called a crisis line but were too nervous to speak and hung up. Others have shared how calling helped them. Finally, some participants have said they called and were disappointed. Be ready for any type of response and to frame each response as a valuable contribution, reframing when necessary.

If you arranged in advance with a crisis line that the group will be calling, ask the group, "Would you like to try calling the crisis line to have an experience of what it's like?" You then call as arranged. The counselor on the line questions the participants who take turns role-playing the caller. Another way to interact with the crisis line counselor is to have group members ask them general questions about how they answer the phone, or what they do to help someone who is contemplating suicide.

If this is not possible, you can stage a role-play where one facilitator role-plays calling the crisis line and the other facilitator plays the counselor on the line. The

third and final activity for the meeting is to discuss a contact list of participants.

"While we are discussing ways to be a support for one another, participants in previous support groups have appreciated having a contact list of group participants. We will pass out a sheet and if you are comfortable you can write in your phone number and/or email address to be put on the contact list. We will use first names only. The facilitators' contact information will be listed as well. If you have a preferred method of contact, you can indicate that too, whether it is text, email, or phone call.

If you don't feel comfortable, it's okay not to be a contact. We want to respect where each person is at and their comfort level. Everyone still gets a contact list, whether they are on it or not. We'll make copies and have a contact list available next week."

A separate issue is birthdays. There is a place on the contact for participants to list their birthday, but this will not be included on the contact list. "Group participants often get quite close, some mentioning that it feels like a second family. Some participants would like to acknowledge birthdays, others prefer not to acknowledge them. If it is okay for us to acknowledge your birthday, include it on the sign-in sheet. If it doesn't fall on a meeting day, we will acknowledge it the following week."

5. Closing

Lead the group closing activity (previously described in "Format for weekly meeting" above).

Follow-up

Before the next meeting, follow up with any participants who requested it or whom you are concerned about.

Create group contact list for distribution at next group meeting.

Week 4: What triggers suicidal thoughts?

Overview

Talking about the triggers that led to a suicide attempt is probably the most emotionally laden topic of all. It is not uncommon for group participants to become very sad and quiet as they remember the painful state they were in before they attempted to take their own life. However, it can be helpful to teach participants to become aware of what preceded their attempt in order to help them recognize when they may be at risk for suicide again. Being aware of when they may be in danger is an important element of a plan for staying safe.

Participants may find a variety of things preceded their attempt, including personal situations, events, feelings, moods, thoughts, and behaviors. Helping them to recall these events in a safe and structured way is important. We have found that many participants experience "automatic thoughts" or thinking patterns that default to an illogical or unrealistic negative theme. It is often difficult for participants to identify their triggering thoughts and especially to find positive alternative thoughts. As an example, the negative thought, "There's no reason for me to be here" might be countered with "I have a right to be here," "I matter," "My purpose is unfolding every day," or "I choose to talk to myself with kindness today." It is most helpful if the positive thoughts come from the other group participants themselves. It is not difficult for participants to intellectually accept the form of a positive thought, that is, to see that the positive alternative of "I hate myself" is "I am loveable." However, it is important for the participants to come up with the positive thoughts themselves, because it is more likely that they will believe the thoughts they generate.

The automatic thoughts exercise completed this week helps the participants to identify these thinking patterns. The exercise helps facilitators reinforce the point that suicidal thoughts don't have to turn into suicidal behaviors and that coping strategies can help participants to stay safe.

Objectives

The objectives for this week are for participants to

- Develop awareness of triggers to suicidal thinking and identify antecedents and consequences of triggers
- Prepare for the upcoming topic of safety planning

Materials

- Whiteboard or flip chart
- Markers
- Participant forms
  - Impact of Safety Planning Form (Pre-Group Outcome Survey not included)
  - Automatic Thinking Handout (Appendix D)
  - Trigger Log (Appendix C)
  - 60 Ways to Nurture Yourself (Appendix D)
  - Support group contact list
- Facilitators' Forms
  - Attendance Sheet
  - Agenda
  - Manual

Agenda

1. ***Arrival***
2. ***Welcome***
3. ***Check-in***
4. ***Group activities***

Distribute the contact list generated in the previous week.

Optional: Distribute the Impact of Safety Planning Survey. This survey was developed by DHSPC to measure participants' knowledge of safety planning and their likelihood of using its steps. Since this is the first week that safety planning is formally discussed, the participants' survey responses set a baseline to measure changes that occur between week four and the final group meeting. You may want to develop a similar survey for your outcome measures or contact DHSPC for more information. After collecting the surveys, begin discussion of triggers of suicidal thinking.

Safety plan – A prioritized list of coping strategies and sources of support for a participant to use before or during a suicidal crisis

Safety planning – Therapeutic technique that provides participants a predetermined list of coping strategies, social support activities, and help-seeking behaviors to use before or during a suicidal crisis to lower their imminent risk of suicidal behavior
(Stanley & Brown, 2008)

Trigger – Situation, reaction, or event that can precede and set off suicidal thinking

Introduce the discussion by asking about the time leading up to participants' attempts. Say to the group, "Recognizing triggers can help us to anticipate when we need additional help. Did you want help before you made your attempt? Did you even realize you needed support? What kept you from getting it?"
Review the different types of triggers for crisis or suicidal thinking, and write them on the whiteboard or flip chart with examples for each.

Types of triggers	*Examples*
Personal situations	*Stressful events, anniversary*
Thoughts	*"Things are never going to get better"*
Images	*Flashbacks, pictures*
Thinking processes	*Racing thoughts, panic, negative self-talk*
Moods	*Irritable, tired, scared, depressed, lonely*
Behavior	*Staying indoors, drinking*

Ask "How do the types of triggers relate to one another? Does one lead to another?"

Facilitator note: When participants have spoken about their triggering events, there were a variety of types. Some participants have described a personal situation, such as the break-up of a relationship, as a single defining triggering event. Other participants have described their trigger as a mood such as feeling sad, depressed, or lonely, without one specific defining event. Some participants have described the motivation for suicide as being driven by feelings of anger, rejection, humiliation, betrayal, rage, shame, and not mattering. Still other participants have related being suicidal to thoughts about themselves, their hopelessness such as

"Things are never going to get better," or longstanding states of depression and/ or anxiety. One common theme was extremely negative automatic thoughts about themselves; for example, harsh judgments of oneself, a reluctance to try new things for fear of being able to live up to one's own high standards, and perceived failure. Creating positive alternative statements will be an important step for participants.

The next activity is for the participants to complete trigger logs. This helps prepare the group for more advanced safety planning in meetings ahead. Choose one of two options based on what you feel would work best, given the degree of disclosure and closeness that has developed. Instruct the group, saying, "Although the form we are using is for current triggers, I am asking you to recall your suicide attempt and the events leading up to it."

Option #1: Participants pair up and complete a trigger log together. Pairs share the elements of their trigger logs that were most meaningful to them with the larger group.

Option #2: This activity is completed as a group exercise with you leading the discussion and writing responses on the board. Ask participants to volunteer their behaviors, events, thoughts, feelings that led up to the attempt. Or one person can respond to the log's question by telling their personal story, with you acting as scribe. Other participants may prefer to fill their logs out without sharing.

Distribute additional trigger logs for participants to bring with home with them. Encourage them to use the log throughout the next week to record any thoughts of suicide they had, what triggered these thoughts and how they coped with them.

Lead the final activity about cognitive distortions. Distribute the handout on automatic thinking and review it briefly. Ask "Are there any examples that particularly stand out to you?" and "Are there any examples that you identify with?"

Lead a discussion by asking the participants how they could change distorted thoughts. The participants may volunteer the following strategies, or you can suggest them:

- Becoming aware of thought patterns, recognizing when they are having automatic negative thoughts
- Crafting the opposite of a thought
- Asking themselves for "proof" of the distorted thought — evidence in their lives

The group participants attempt to find the automatic thoughts and substitute them with positive alternates. Help the participants in formulating them so that they can find the positive thought to be as true or truer than the negative thought. It is important to make the point that suicidal thoughts and feelings do not have to turn into suicidal behaviors. Participants may be able to find other ways to end the painful thoughts and emotions that they are having.

Refer to the positive thoughts handout for examples of positive or rational responses to hopelessness.

5. Closing

Say "How is everyone doing? Is everyone feeling ok? It can be challenging to think about reasons for dying, about triggers. We don't want to leave anyone in a bad place, but if we deal with these as a group, you might be better equipped next time you are triggered when you are alone. Remember, you can call us to check in or call the crisis line."

Lead the group closing activity. After the participants are grounded, ask the participants:

"What one activity will you do this week to feel better?"

OR,

"What is one positive coping statement that you can say to yourself this week?"

Follow-up

Before the next meeting, follow up with any participants who requested it or whom you are concerned about.

Week 5: How can I cope with thoughts of suicide?

> ***"Once I finished my safety plan, I respected myself so much more." - Support Group Participant***

Overview

Previous weeks prepared participants for this week, both in building group closeness and understanding fundamental topics including triggers and safety planning. This week, participants begin to write their safety plans. The Safety Plan used in the support group was adapted from Stanley and Brown's Safety Plan Quick Guide and Treatment Manual (2011, 2008). Adaptations came from feedback received from participants and requests that facilitators:

- Provide additional explanations for each step of the plan
- Make the form foldable. This increases privacy; others would find it more difficult to read their safety plan.
- Change the name of the form. The name "safety plan" reminded many of the participants of being hospitalized and hospital requirements to make promises before getting released. We chose to title the form "Choosing Safety Over Suicide," indicating that staying safe was a personal choice rather than an imposed situation.
- After making revisions based on participant feedback, reactions were much more positive and included statements like, "I carry it every where I go. I found it helpful" and "I have it downloaded on my iPad."

Objectives

The purpose of this week's activities is to help participants:

- Identify healthier and more effective ways of coping with suicidal thoughts and behaviors
- Begin to develop their own safety plans, which they can use when they begin to think about suicide

Materials

- Whiteboard or flip chart
- Markers
- Participants' forms
  - "Choosing Safety Over Suicide" (Safety Plan form)
  - "60 ways to nurture myself" (Appendix D)
- Facilitators' forms
  - Attendance sheet
  - Agenda
  - Manual

Agenda

1. ***Arrival***
2. ***Welcome***
3. ***Check-in***
4. ***Group activities***

You say:

"This week is important because you will explore supports and coping strategies that will help keep you safe when you get to suicidal thinking. We will fill out a form that is a lot more than a referral for crisis times, and by the end of the eight

week group I think you will find your safety plan a real resource. What do you know about safety planning? Why is safety planning important to you?"

Participants will generate responses, and the facilitator can add that safety planning is important because it:

- Gives participants a way to recognize when they may need additional help
- Empowers participants to keep themselves safe
- Encourages participants to "slow things down" and remember that there are ways to feel better other than suicide
- Gives participants a way to document and remember what we talked about in the group
- Provides a structure for participants to learn from each other

Participants work on safety plans over the upcoming meetings. By the end of the eight weeks, most participants will have plans to use when they feel suicidal; however, no participant is forced to complete a safety plan if they are not ready or unwilling.

By week five in some support groups, all the participants complete all of the safety plan's six steps. In other support groups, participants complete the form in week six. If the form for the safety plan isn't completed in one meeting, ask to hold on to the forms to be finished the next meeting.

The safety plan manual that DHSPC uses is from the U.S. Department of Veterans Affairs (Stanley & Brown, 2008). Although written with veterans in mind, the support group facilitators adapted the template for use with adults generally. Walk the group through the steps of completing a safety plan as participants fill them in. Although there are suggestions for each step below, we recommend familiarizing yourself with the full treatment manual.

Step 1: Recognize the triggers and warning signs

You say:

"Last week the group focused on triggers. A trigger is an event that can lead to suicidal thinking and serve as an indicator that you may need some additional support to stay safe. For most, thoughts of suicide come and go. It helps to know what may trigger suicidal thoughts so you can avoid these things if possible. It also helps to see these triggers as warning signs so that you are prepared to reach out for extra help. I will be asking you questions so that you will learn more about your triggers:

Why do you think it is important to be able to recognize what things make you feel overwhelmed?

What will tip you off that you need to use your safety plan?

What moves you towards dangerous behavior? Can you create a positive alternative thought to counteract that?

Step 2: Use internal coping strategies

Guide the participants through a discussion, using these questions:

1. "What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"

2. "What activities could you do to help take your mind off your problems, even if it is for a brief period of time?" (Participants might suggest going for a walk, praying, listening to music, going online, taking a shower, playing with a pet, exercising, engaging in a hobby, reading, doing chores, and volunteering. If not, you can suggest the activities.)

3. "How likely do you think you would be able to do this step during a time of crisis?"

4. "What might prevent you from thinking of these activities or keep you from doing these activities even after you think of them?"

Use a collaborative approach to address barriers and to generate alternative coping strategies (Stanley & Brown, 2008).

Review "60 ways to nurture myself" handout and ask participants questions, such as:

- "Is there anything on this list that you already do?"
- "Anything you want to try?"
- "Anything not on the list that you'd like to add?"
- "Which of these would make good coping strategies for you?"

Suggest that aside from distracting participants from troubling thoughts, many of these activities are relaxing or soothing.

Step 3: Use distraction

Say, "If using step two doesn't resolve the crisis, you go on to step three. Step three's goal is to distract yourself from suicidal thoughts and feelings. This step is not a time to disclose your suicidal thoughts. I want you to think about places you could go just to be around people. What people and social settings take your mind off your suicidal thoughts?"

Ask the participants:

- "Who helps you feel better when you socialize with them?"
- "Who helps you take your mind off your problems at least for a little while?" Remind the group that they don't need to tell them about their suicidal feelings.
- "Where is a safe place can you go where you'll have the opportunity to be around people?" Participants may volunteer ideas such as a coffee shop, a park or beach, a department store, or the library (Stanley & Brown, 2008).

Step 4: Ask family or friends for help

Say, "If the distraction in step three did not resolve your crisis, you move on to step four. What people can you ask for help when you are in crisis? Anyone in your family? A friend? These are people you can tell about your suicidal thoughts." Remind the group that they are listing several people, so that they will be able to reach someone.

In putting their lists together, participants need to consider:

- Who is supportive? Who do they feel that they can talk with when they're under stress?
- Is there anyone who knows about their struggles with suicide? If no one knows about their thoughts of suicide, who might they tell, and how would they tell them?
- How likely are they to reach out when they are struggling? What would keep them from reaching out? How likely would they be to call?
- What do they need when they are feeling suicidal?
  (Stanley & Brown, 2008)

Step 5: Contact professionals and agencies

Say, "If step four did not resolve your crisis, you'll use step five. What professionals or agencies can you contact during a crisis?" The participants generate ideas such as the National Suicide Prevention Lifeline, the local crisis line, therapists, doctors or primary care providers, clergy, and 12-step sponsors. Explore the likelihood of participants contacting the professionals or agencies, and if doubts are expressed or barriers are suggested, problem-solve ways to address them.

Step 6: Making your environment safer

Every safety plan needs to address step six. It is not easy to talk about the means that participants plan to use to attempt to kill themselves. For some participants, it

is comforting to have the means close at hand. It is important to allow participants to discuss how they feel about removing access to lethal means. As an attempt survivor, it is likely that suicide became one of the strategies they developed to end a painful situation they were experiencing. When pain is unbearable, a person needs relief and usually wants it quickly; therefore, it is important for participants to remove items that they might use impulsively when their pain feels unbearable.

Ask the participants:

"What is it like for you to be asked to remove these items or limit your access to them? While suicide may seem like a quick way to end your pain, it can have devastating consequences for you and the people who care about you. Now that you have a safety plan, you can use it to help find alternate ways of relieving your pain that don't involve ending your life. However, if you forget to use your plan, or it doesn't make you feel better, having items close to you that you could use to harm yourself can create a dangerous situation. It is important, then, to remove items that you may use impulsively, in a moment of unbearable pain. Most suicide attempt survivors indicate that their thoughts of suicide changed over time. While they had periods where the pain seemed unbearable, those times didn't last forever. Removing dangerous items gives you time to allow the way your feelings to change. For some, the thought of suicide has become a way to envision ending unbearable pain. Giving up your method may incite a feeling of being out of control, so I would like to talk about it."

Firearms are especially lethal, so the discussion about lethal means emphasizes them. Ask the participants, "What do you need to do to make your environment safer? Do you own a firearm? Guns and rifles are especially lethal, so let's talk about ways to secure them or get them out of your house."

An additional adaptation to the traditional safety plan is the addition of a place to list things that provide hope or reasons for living. Having these written right on the safety plan can a reminder why a person might want to stay safe, even when they are experiencing a crisis.

Group Discussion: Plan implementation

Acknowledge that the group did a major piece of work, going through the six steps, whether each participant's safety plan is finished or not, and reassuring the participants there will be time in upcoming weeks to add to or change their plans.

Lead a discussion about how likely it is that participants will use the safety plan when they notice warning signs. There may be additional doubts or barriers that didn't come up in discussion of the individual steps. Again, if doubts are expressed or barriers are suggested, problem-solve ways to address them.

5. Closing

Lead the group closing activity. Ask the participants:

"What one activity will you do this week for self-care or nurturing yourself?"

or

"What is one word that describes how you are feeling? "

Follow-up

Before the next meeting, follow up with any participants who requested it or whom you are concerned about.

Week 6: Resources

> ***"Books are really helpful. People that write books, if they can be successful, we can be successful too, this is uplifting."***
> ***- Support Group Participant***

Overview

The week six discussion about resources enhances the work participants have already done on safety plans; for example, some participants learn new resources that can be added to step five (Contact professionals and agencies). Some of the participants' barriers to professional therapy are countered by talk about effectiveness of therapy. Websites and books meaningful to attempt survivors may also add to internal coping strategies.

Objectives

The objectives for week six are for participants to:

- Learn about books and websites as well as resources in the community relevant to survivors of suicide attempts
- Consider how to get the most out of professional therapy
- Complete or add to their safety plans

Materials

- Whiteboard or flip chart
- Markers
- Participants' forms
  - Suicide attempt survivors website list and booklist (Appendix E)
  - A list of local resources: Support groups and counseling (Appendix F)

- Facilitators' forms
  - Attendance sheet
  - Agenda
  - Books. See Websites and books for suicide attempt survivors (Appendix E)
  - Manual

Agenda

1. ***Arrival***
2. ***Welcome***
3. ***Check-in***
4. ***Group activities***

Say, "This week is all about resources, and it may help you add to the coping strategies and professional resources in your safety plan." Hand out the list of community counseling and support groups and discuss what other resources are available for participants to gain additional help and support. DHSPC developed the counseling and support group list in Appendix F for use in the L.A. area; you will need to localize it for your area, but it gives you an idea of the kind of resources to provide. In addition, you can suggest:

- Wellness centers in the community
- Alternatives to hospitalization (for example, short-term stabilization centers)
- NAMI: National Alliance on Mental Illness, which runs support groups for family and friends of people with mental illness, as well as peer groups
  - NAMI programs can be beneficial for family to attend to get information on disorders and ways to support suicidal people
  - The programs may also give family and friends a place of re-lease and provide them their own community
- Support programs in the faith community

Ask, "What other resources have you used that have been helpful and aren't on this list? Are there any resources you can consider adding to step five of your safety plan?"

Lead a discussion, asking participants about their experiences with mental health treatment and therapy. Many participants may have had negative experiences and be less willing to get help from mental health professionals. This is an important barrier to examine and potentially reduce.

Choose from the following questions to engage the participants in the discussion:

- What has been your experience in reaching out to professionals for help?
- How much do you share with them about suicidal thoughts? Are you able to be honest in therapy? What gets in the way?
- How do you know what to talk about in therapy? Do you ever get to therapy and go blank and not know what to say? What do you think you should do about it? Do you focus on your week and day-to-day problems? How do you know when it's a good, safe time to open up about hard issues such as the past, abuse, or trauma?
- What are your fears? How can you lessen these fears?
- Who are the mental health professionals or other professionals that you could contact if needed? Are any available 24 hours?

Maintain a list of books that might be of interest to suicide attempt survivors and keep copies of these books on hand. Review the handout "Websites and books for suicide attempt survivors" and say, "Many of these are written by or for suicide attempt survivors specifically. Have any of you read any of them?" If any of the participants have read any of the listed books or visited the websites, ask them to share their experience with the group. Ask the participants if they have other books or websites for attempt survivors that they would recommend. Finally, tell the group that you have brought some of the books to the meeting and are happy to lend them out.

5. Closing

Announce that next week the focus will be on hope, and ask everyone to bring in a hope item. Describe to the group, "A hope item is something that represents hope to you, something that reminds you of your reasons for living. It could be a picture, a song, mementos, small pieces of art, something from nature, letters, awards, photographs, future plans, anything that gives you hope. We will have an opportunity to discuss these items next week."

Lead the group closing activity.

Follow-up

Before the next meeting, follow up with any participants who requested it or whom you are concerned about.

Week 7: Hope

Overview

The whole meeting for week seven is devoted to hope. The facilitators and participants discuss what provides participants with hope and reasons for living. Participants share an object that represents hope to them and create a hope box.

Participants are given a box and encouraged to personalize it with art supplies that are provided. Even "less crafty" participants enjoy this activity. It is a way to practice a distracting activity and demonstrates how just doing something to take your mind off your problems can provide relief. As participants are all working, the creative project becomes a group experience and creates another opportunity for informal bonding.

At DHSPC, facilitators have a tradition of placing a surprise gift in each participant's box; generally, it is the same item for all group participants. Typically the gift is one of the books on the suicide attempt survivors book list

that was distributed in last week's meeting. However, gifts could be anything from framed inspirational quotes, to mementos related to the group, to notebooks for journaling.

The group culminated with difficult discussions in weeks four, five, and six. This week keeps the group in the moment with a creative activity, as next week's goodbyes may be on participants' minds.

Hope box created by DHSPC support group participant

Materials

- Whiteboard or flip chart
- Markers
- Participants' forms
  - Safety Plans
  - 60 ways to nurture myself (Appendix D)
- Facilitators' forms
  - Attendance sheet
  - Agenda
  - Manual
- Hope boxes. Boxes (traditionally used to store photographs) and scrapbooking supplies like stickers and appliqués are purchased from an arts and crafts supply store.
- Items for hope boxes: blank safety plan, "60 ways to nurture myself" handout, Suicide Prevention Lifeline Promotional Materials, and "sur-prise gift"

- Art supplies: glue, stickers, scrapbooking paper, letters, appliques, markers, colored pencils, etc.

Room Set-Up

- Note: Hope boxes are placed on the table with surprise gift and other items inside. Art supplies are also out.

Agenda

1. ***Arrival***
2. ***Welcome***
3. ***Check-in***
4. ***Group activities***

Say, "This week we have a chance to create something meaningful and useful, our hope boxes. We'll start by giving everyone a chance to share their hope item and to talk about why it gives them hope."

A hope item shared by a DHSPC support group participant. Participant stated that coming to the group gave her the key to talk about her "secret" (that she had tried to kill herself), allowing her to take steps towards healing from her attempt.

After participants have shared their hope items, summarize the sharing, then say,

"This box is a physical reminder of all of the work you have done in this group and all that you have learned. You can use it to store your Safety Plan, crisis line materials, contact list for the group participants, and whatever you find hopeful. You can continue to add to it and fill it with things that make you feel good. If you are having a bad day, you can take it out, review your safety plan and reflect on the things in your life that give you a reason for living. "

- The participants decorate their hope boxes.
- Some participants may be a bit uncomfortable decorating a box. If

so, you can make the project less about craft work and more about cognitive work by following some exercises, such as writing different hopeful thoughts on index cards to place in the box.

- Lead a discussion about reasons for living by asking the group, "What gives you hope? What makes you feel more connected or gives you a sense of purpose?" Suggest that participants add reasons for living to their boxes. They can write each reason on an index card, and decorate the card if they like.
- Suggest that group participants can place are items for self-care and self-soothing in the hope box, items that generate positive thoughts, feelings, and memories. Many of these items, such as candles or chimes, can be purchased inexpensively.
- Give the participants the opportunity to show and talk about their completed hope boxes if they desire, but make it clear that this is optional.

5. Closing

- Inform the participants that next week is the group's last meeting, and it will be a celebration, for which facilitators will supply special refreshments.
- Encourage the participants to bring a potluck item to share if they like.
- Lead the group closing activity. After the participants are grounded, ask the participants either:
  - "What one activity will you do this week for self-care or nurturing yourself?" or
  - "What is one word that describes how you are feeling? "
- Ask "Does anyone want some follow-up?" and "Are people okay to drive home? Does anyone need to stay after for a few minutes and breathe before getting into their cars or on the bus?"

Follow-Up

Before the next meeting, follow up with any participants who requested it or whom you are concerned about.

Week 8: Where do we go from here?

Overview

The week eight meeting ends the group and prepares participants for the absence of the weekly support.

Objectives

The objectives for week eight are for participants to:

- Discuss closure of group, fears, ways to cope, and how to stay connected
- Help participants to plan for the end of group/break between cycles
- Say goodbye

Materials

- Whiteboard or flip chart
- Markers
- Pens
- Art Supplies: glue, stickers, scrapbooking paper, letters, appliques, markers, colored pencils, etc.
- Participants' forms
  - 60 ways to nurture myself (Appendix D)
  - Safety Plans
  - Ways to Stay Connected (Appendix G)
  - Outcome surveys
- Facilitators' forms
  - Attendance sheet
  - Agenda
  - Manual

Room Set-Up

- Note: Refreshments are provided, and participants can share any potluck items they brought.

Agenda

1. ***Arrival***
2. ***Welcome***
3. ***Check-in***
4. ***Group activities***

Lead a group discussion about closure, asking:

- "The ending for the group is coming up, how do you feel about it?"
- "This is a place where you felt safe talking about suicide. Previous participants have expressed anxiety when the group ended. Is any one concerned that if you don't have this weekly space, it will be scary?"

Lead the discussion to ways of coping by asking, "What can you do to cope? What are some ways you can practice what we learned here in the last eight weeks?" If the participants don't generate the following, suggest that the participants can:

- Stay connected with group participants
- Meet up at other community events throughout the year
- Attend other groups
- Call the crisis line on Lifeline

Describe how other participants found it difficult at particular dates or events, and ask the group if they anticipate difficulties at anniversaries, holidays, or events that mark life transitions, such as births, weddings, and graduations. Ask "Will the coping strategies we just talked about work for you at these challenging times? Are there other strategies you could add?"

For the next activity, review the handout "Ways to Stay Involved," ask, "What other ways can you think of to stay connected?" and lead the discussion.

Depending on the group, you may lead a closing ritual, start the potluck meal, or suggest a group activity. One group activity you can consider is to make cards for one another. Each participant and facilitator has a card, and other group members write positive, descriptive words describing how they see them. All the participants in the group as well as the facilitators will have a card at the end of the activity. Some participants may add the card to their hope boxes.

Distribute your program's outcome surveys and ask participants for their feedback. Describe how their feedback will drive improvements to the program for future participants.(Contact DHSPC for more information about outcomes for this group).

5. Closing and goodbyes

- Instruct participants to share a wish that they have for other group participants.
- Be aware of anyone who seems to linger after the group ends and check in with them individually about how they are feeling.
- Make notes of whom you want to follow up with.
- Check with the participants whether they are okay to drive home.
- Model saying goodbye to the group.

V. Facilitating the support group

The DHSPC support group has been in operation for a few years. During this time, there have been many common issues, questions, and themes that facilitators have noted. This section of the manual outlines these areas and strategies for handling them.

The section is intended for facilitators and addresses them directly. Statements that you can use as a script for support group meetings are italicized and in quotation marks.

Common reactions after a suicide attempt

Often, after a suicide attempt, a person has many conflicting emotions. They may be grateful that they survived and be eager to find help to recover. They may be angry that they survived or feel like a failure after their attempt did not result in death. They may feel embarrassed and ashamed, wondering what to say to their family and friends about what happened. They may feel numb. They may still have thoughts of suicide. Likely, they don't even know where to start to pick up the pieces of their life. Remember, they weren't planning on being here.

It is common to see an attempt survivor vacillate through all of these stages and emotions during the course of their recovery. A person may present as very hopeful, even stating, "I am so happy I am still here," at one point during the group cycle and later feel deflated: "I wish I would have died." It's important not only to accept the survivor wherever they are at, but also to reinforce that it is normal for them to feel different emotions at different times. Suicidal people and survivors of suicide attempts face a quandary: They may want to ask for help but are afraid of alarming others or finding themselves hospitalized.

Approaches to maintaining safety and managing risk

A key objective of the support group for attempt survivors is to maintain safety and reduce the tendency of the group's participants to opt for suicide under duress, not only during the meetings but also during the weeks between meetings. Safety takes precedence over all other issues. By definition, this group is exclusive to high-risk participants. The following describes our approaches for maintaining safety.

Building collaborative process

One of the core values we hold for working with individuals who have survived suicide attempts is that it be a collaborative process between the facilitator and the attempt survivor. As facilitator, you emphasize the capability of the attempt survivor to make safe choices when given proper support. To this

end, a careful process of informed consent, beginning with the screening and intake on the phone, is important. Facilitators must convey non-judgment and neutrality about the desire to die, while clearly communicating the legal and ethical requirements to break confidentiality in cases of danger. Facilitators allow participants space to give voice to the desire to die and empathize with the desire, while assessing for imminence of risk. If there is not an imminent risk, facilitators allow participants the space to express the desire to die and to share self-talk about suicide, which is usually hidden. For an attempt survivor, this is a very rare moment indeed, and it is accorded its priority as an intervention.

Collaboration refers to more than the relationship between the facilitator and the group participant. At the outset of group, you may consider requesting the participant's written consent to collaborate with the contact person for their treatment team; for example, the therapist or psychiatrist. After a group meeting, you may ask a participant for verbal consent to share specific content with their treatment team. For example, if you feel intensified concern for a participant's safety, you will want to get consent to share this. It is important to take care when asking for the participant's consent for you to collaborate with their therapist. This may feel scary or intimidating before a trust is developed between the participant and the facilitator. If consent is given, it is important for you to sign a consent form specifying what information can be shared and with whom.

Collaboration may also include helping participants to reach out to their family or friends for support. Some participants have supports in their life who want to help them, but they are unsure how to express their needs. Sometimes, with their permission, a phone call or meeting with a family member can be helpful for the participant.

Identifying sources of support

Other important interventions are assisting the participants in identifying sources of support in their own lives and heightening awareness around their ability to choose to reach out for support in times of crisis. Sources of support

may include therapists, psychiatrists, family and friends, the suicide prevention crisis line, and community resources.

Focusing on safety

You can keep the focus on safety by introducing and modeling the following strategies:

- Ongoing awareness of triggers to and warning signs of suicidal thoughts and suicide attempts
- Coping skills that provide an alternative to thoughts of suicide and suicide attempts
- Ongoing risk assessment
- Safety planning

For some participants, focusing on death has become a recurrent theme and coping style which does not shift quickly. Given the persistence of some participants' strong will to die and their weak will to live, the focus of the group needs to stay on safety, without ignoring the strong feelings some participants may be feeling.

Limiting the means of suicide

When group participants have the means to injure themselves, such as firearms or a quantity of medications, develop a plan with the client to remove those means. The participant can enlist family members and friends to support their efforts and heighten accountability. For more information about lethal means counseling, see **http://www.hsph.harvard.edu/means-matter/lethal-means-counseling/**.

Stressing attendance at all meetings

When reviewing the group guidelines in the first group meeting, it is important to reinforce the importance of attending all meetings. If a participant has to miss a meeting, they miss a lot that happens in the group that week and it can impact

group dynamics. If a participant has to miss a meeting, it is crucial that they call a facilitator in advance to notify them that they will be absent. Due to the sensitive nature of this group, having a participant absent without advance knowledge can cause anxiety for both the facilitators and the participants. If a participant misses a meeting without notifying the facilitator, a follow-up call is warranted.

Checking in before leaving

Toward the close of each group meeting, check in with all participants, being sensitive to whether it has been an especially intense group meeting. Allow time for participants to get grounded, and keep track of who needs follow-up.

PARTICIPANT SAFETY AND IMMINENT RISK OF SUICIDE

Perhaps the biggest challenge to maintaining safety and managing risk for the support group is when a participant is at imminent risk. For example, a group participant may reveal to the group their plans to take their own life.

The National Suicide Prevention Lifeline has helped thousands of people at imminent risk: Lifeline connects callers with trained crisis center staff and is available 24/7. In 2012, Lifeline released the Policy for Helping Callers at Imminent Risk of Suicide. While this policy addresses the risk of Lifeline callers, the recommended approaches can be applied in a variety of situations and are particularly helpful in working with suicide attempt survivors.

The policy recommends using the following approaches in cases of imminent risk of suicide:

- Active engagement to make every reasonable effort to collaborate with a person at risk to ensure his or her safety

- Active rescue to take all action to secure the safety of a person at risk when they are unable or unwilling to take action

- Collaboration with other community crisis and emergency services to assure safety

The policy also states that the least invasive intervention should be used when working with individuals at risk and that involuntary emergency interventions should be used only as a last resort.

Some examples of imminent risk and how you could work with the participant to maintain safety follow:

- In a group meeting, a participant revealed that they were at imminent risk and didn't think they could keep themselves safe. The facilitator and the participant made a plan for them to drive themselves home, call the facilitator when they got home safely, and for family members to stay with them until their therapy appointment the following day.

- Another participant revealed during a group meeting that they were at imminent risk and didn't think they could keep safe over the weekend. The facilitator made a plan with the participant that they would communicate with their therapist and that the participant would remain safe that evening. The plan also included that the participant would then voluntarily hospitalize themselves the following day. This exemplifies working collaboratively in situations involving imminent risk. The next day the participant agreed to a safety plan that included checking themselves into a supportive housing facility that they felt would be a more helpful option than a visit to the emergency room.

- Additionally a participant was at imminent risk in the meeting. The facilitator worked collaboratively with the sister and the participant to develop a safety plan. It is important that your protocols list procedures and roles like these for imminent risk situations.

Helpful tips for facilitators

Helping participants articulate needs and monitor boundaries
You can draw participants out by using questions, such as:

- "What do you need from us?"
- "Would you like us to check in with you?"
- "It seems you had a strong reaction to what I said. Can you describe what you are feeling?"

Encourage participants to get in touch with strategies that would help them get through challenges. To illustrate with an example, a participant revealed to a facilitator that they had suicidal ideation and their therapist did not know. The facilitator asked them what they needed, and they jointly decided that they would come early to the next group meeting and that they would call the therapist together. The facilitator offered to help them make this difficult disclosure.

An example of a group participant struggling with boundaries had to do with strong romantic feelings for another participant. After working with the participant to understand the nature of transference during group sessions, the romantic feelings lessened. It was decided after this to make the establishment of boundaries and discussions around transference a part of the group discussion on giving and asking for support in week 4.

Several other members said phone calls are difficult, but email is OK. Although we do not use email, it is perfectly acceptable for participants to email or text one another for support. We encouraged each participant to establish boundaries around communication that suited their comfort level. Some participants set boundaries around certain hours that they were willing to receive calls. Others would not release their phone number but only wanted to respond to an email or text.

Each participant also discussed what they would say to a caller or someone who text them if they were not wanting to talk or text at the moment. We asked what it would feel like if different participants didn't offer help or were not willing to talk when called. Would members feel rejected and if so how could they handle it? It was important to spend time in this area as many members had difficulty reaching out, and many had been rejected or judged when they had.

Noticing participants' growth

A large part of the facilitator role is watching for participants' growth. There is a tendency for people to identify with a label, and being part of a group for attempt survivors has the inherent risk of over-identification with that label. For instance, one group member almost apologized for sharing that they were feeling good.

Therefore, we stress how important it is to listen for and highlight points participants make around utilizing resources and coping. You can use a participant's strategy as an example: "What Jennifer just said about calling a friend to meet for coffee really demonstrates what we have saying about using distraction." Often, after seeing the facilitator model this skill, participants start to observe and point out growth they see in each other.

As the group progresses, you will also notice group members offering support to one another between sessions. It is at this point that the facilitator's job will move more into the background, and examples of participants' support for one another should be noticed and acknowledged.

Balancing light and dark

Another important job of the facilitator is shifting the focus of subject matter. Talk of heavy thoughts and feelings around suicide is perfectly normal in the group setting, but it can lead to a downword spiral if each participant stays with only these thoughts. You can model using self-disclosure, small talk (such as talk about pets, food, and light current events), and humor to balance the dark nature of talking about death and suicide. Levity helps avoid the group's becoming uniformly heavy and encourages the participants' getting to know each other better. Look for opportunities to be positive by validating participants' progress and pointing out strengths. Participants do need to air their reasons for dying and to express their nihilistic, angry, and dispirited side, but they also have a need to learn how to balance these thoughts with more positive hopeful thoughts. The goal is for the facilitator to find a balance between the light and the dark and to reflect the client's ambivalence: the part that wishes to live and the part that wishes to die. Modeling effective cognitive techniques such as thought reframing can give them tools to maintain hope.

Other communication tips for facilitators are as follows:

- Modeling the philosophy of safety planning, i.e., finding ways to help yourself feel better when experiencing tough emotions
- Promoting participants' shifting their focus out of the "tunnel vision" and darkness inherent in suicide and broaden their

focus to include small pleasures, laughter, and the lighter side of life

- Helping participants to socialize and bond. When participants are in a dark place internally, it may be hard to socialize. The facilitator's modeling of light and positive statements and affect may help them access the lighter side of themselves and reach out for more support.
- Practicing the "skill" of socializing in the group can translate to reconnecting with supports outside of the group setting.

Encouraging group participants to respond to one another

In a support group of this nature, the role of the facilitator is to resist offering all the help for members and instead look for opportunities to encourage participants to support each other. The support group can be a place for participants to practice giving and receiving support. Make space for this to happen by encouraging participants to comment and give feedback when it is appropriate.

Assessing risk in the moment

Participants will most often bring up their own risk during check-ins and group conversation. For example, during check-in a participant may bring up that they have been crying all week, thinking about not wanting to be alive anymore, or saving up prescription pills. It is important that facilitators take these disclosures of risk as invitations to engage with the participant at that moment in the group. It is vital to address the issue of suicide directly and compassionately while they are present and feel the support of their peers. They have the door "open" which may close again during the week. If there are concerns about the safety of a participant, a plan for safety needs to be established, either in the group meeting or by asking the participant to stay after the meeting to speak with a facilitator. Often, new facilitators will establish weekly check-in calls where they are able to talk to participants outside of the group and get a clear picture of any risk.

Being aware of your role

As in any support group, the focus is on the participants. Facilitators avoid playing roles like lecturer, adviser, entertainer, or expert. We like to say that "the answers are within, and within the group," meaning each person has what they need to know, and the group's wisdom surpasses any individual's.
Ideally, as a support group, the participants should have a sense of ownership of the group. As the group cycles unfold, you continue to empower participants to speak up and share their opinions and needs. Do this by using open-ended and/or Socratic questions, such as "What is an example?" or "How does that relate to our topic?" and turning things back to the group. Ask:

"What do other participants of the group think about this?"

"What are your thoughts about that?"

"Does anyone else relate to this?"

In order to avoid a debate or a polarizing disagreement, take care to qualify statements; for example, "Sometimes, for some people, isolating at home will strengthen suicidal thoughts. What do you think?"

Using time to de-escalate feelings

A support group for attempt survivors is bound to stir up strong feelings.
Once, a participant stormed out in the middle of a meeting, highly agitated. A facilitator escorted them to the lobby and asked to hold their car keys until the end of group, when they would get a chance to speak privately. By the end of the meeting, the participant agreed to call a family member who was waiting to support them upon their arrival home. The participant had de-escalated and was able to drive themselves home. Additionally, they agreed that the facilitator could call them in one hour to confirm that they had arrived safely at home.

It is not uncommon that participants may become overwhelmed during the meeting and may need to step out. This is accepted and even encouraged. The two facilitators should have a plan for who will step out and should be trained to work with the individual to assist them in calming down and returning to the group whenever possible. If someone struggles consistently with staying calm in the group, they may need more intensive care. Knowing these things in advance helps facilitators stay calm and helps group members stay safe. This can be openly discussed at the beginning of group one. We at DHSPC always felt that the more transparent and honest we were with members about these situations, the more they became comfortable when they occurred.

Contact with individual participants between group meetings

You may decide to be available to participants who wish to talk during the week, or you may decide to make outgoing calls. Depending on your support group's size, you can spend several hours a week following up with participants. It's a good idea to call participants who have an anniversary or difficult event coming up that week or who indicated that they are at higher risk and need safety checks.

It is important not to create a dependency or give the impression of overprotecting participants by checking up on them. Whenever possible, it is best to encourage the participant to take an active role in their own recovery and to reach out to the 24-hour crisis line when feeling unsafe. If a person is not at high/imminent risk, the facilitator does not need to initiate contact but can be available to receive calls.

Our support group staff decided to put a protocol in place for when a participant's risk of suicide was clearly more elevated. We would collaborate with a participant who indicated a need for more support by setting up a time for a weekly call for a safety check. Our protocol requires that the participant agree up front to returning our calls within 24 hours. If we don't hear back within the allotted time, we will call their emergency contact or initiate a welfare check.

Using e-mail for communication with participants

Your sponsoring agency will have its own policies about the use of e-mail. It is recommended to check with your organization regarding legal concerns around confidentiality and HIPAA requirements.

Contact with participants after the group finishes

Toward the end of the eight-week cycle, facilitators can ask participants if they are amenable to ongoing contact. It is important to be clear about what this contact includes. We ask permission to follow up with them after the group to get their feedback on the group and to gather information about our outcomes. We also offer to put them on an e-mail list if they would like to receive periodic e-mails about group activities or items of interest to suicide attempt survivors. Facilitators are not available for individual support, check-ins, or counseling except to participants who are attending the next group cycle. All participants are encouraged to use the National Suicide Prevention Lifeline and their safety plans if they need additional support after the close of the group.

Group participants can opt to repeat the eight-week group cycle. Many past participants of the support group have repeated the cycle; one repeated the group 12 times and became a strong peer support person for other group members. Many participants benefit from repeating the curriculum; however, we realize that there are pros and cons to this. Advantages are that participants stay connected to this very unique community and we have found that returning participants have been a tremendous inspiration to new participants. They have added valuable insight and motivation to group discussions. Disadvantages are that the curriculum can get repetitive and that participants may need to grow beyond it.

As a facilitator, you may opt to follow up with past participants in any number of ways, from offering a weekly drop-in group, hosting biannual potlucks, forming teams at annual suicide prevention events, joining fun community events, doing

quarterly follow-up phone calls, sending quarterly postcards, sending out e-mail blasts. Or you may decide not to follow up at all, depending on the capacity and interest of your sponsoring organization.

Facilitator's self-care

You support participants by listening to their reasons for dying, their wishes to die, and their ongoing expressions of despair over many weeks. The wish to die may not relent over the course of the entire eight-week support group. Some participants are very high risk and have strong suicidal ideation.

You carry your own feelings of loss or feared loss. Statistics show that about one in five counselors lose a client to suicide during their career. Clearly, facilitators know that the support group participants are at higher risk, and they have to live with the daily possibility of losing a participant to suicide.

Working with suicidal individuals can take its toll, so it is imperative for you to have space in your life and work life for adequate self-care and a caring environment among staff and colleagues. Administrators can support a group like this best by allowing staff adequate time and resources to foster ongoing care and communication with one another, training opportunities, and experienced clinical supervision. A group will function best when group facilitators respect and trust one another.

It is important for facilitators to converse with one another before and after each group meeting. Before the meeting, facilitators discuss planned activities for the group meeting and touch base regarding any contact they may have had with participants throughout the week, especially if the content may be relevant for the group meeting. Additionally, after the meeting has concluded, facilitators debrief and make plans for any needed follow-up. Facilitators should also allow time after each group meeting to check in with each other regarding their reactions to what they have experienced and need for support and self-care.

Evaluation

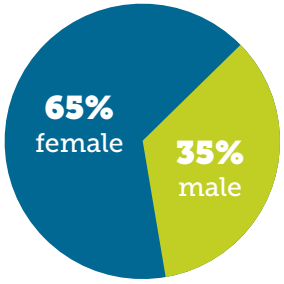
> ***"I am thankful I came to group. If not, I do not know where I would be right now." - Support Group Participant***

Because there are very few groups for suicide attempt survivors and even fewer evaluations of their effectiveness, DHSPC staff knew it was important to establish a plan to measure the effectiveness of this group in meeting our objectives. A variety of methods were used to do this, including focus groups with suicide attempt survivors and pre- and post- surveys to collect both qualitative and quantitative information. This feedback obtained from participants was part of an iterative process and was used to make changes to improve the group from cycle to cycle.

Outcome measures used in the group include:

- Self-rated measures of suicidal desire, intent, and buffers at intake, at first group meeting and last group meeting
- Beck Scale for Suicide Ideation at first and last group meetings
- Pre- and post- survey that asks about participants' use of mental health supports, medication usage, suicide attempts, hospitalizations, and demographic information, as well as qualitative information regarding participant expectations and reactions
- A pre- and post- survey to measure the impact of safety planning, which measures the participants' knowledge and likelihood of using a safety plan
- A focus group where participants were asked about the positive and negative aspects of the group (See appendix H for focus group summary).

Demographic summaries for the first two years of the group show approximately 65 percent of participants were female and 35 percent were male. Of the partici-



pants, 7 percent were 18 to 19 years old, 25 percent 20 to 29 years old, 36 percent 30 to 39 years old, 14 percent 40 to 49 years old and 8 percent 50 to 59 years old. The age for 10 percent of participants was unknown. Participants included 39 percent white, 32 percent Hispanic, and 29 percent black, multi-racial, or unknown.

Preliminary outcome reports from the first two years of the group show positive post-group results when compared to pre-group measures. Group participants reported decreased suicidal desire and intent and increased perceived connectedness. Additionally, group participants indicate increased knowledge about safety planning, as well as an increased likelihood of using a safety plan when having suicidal thoughts. In a focus group conducted with participants who had completed an eight-week group, one participant commented, "The fact that I can get through another year is astounding." Another participant said, "It (the group) just keeps me alive."

The National Suicide Prevention Lifeline suicide risk assessment standards are used as outcome measures to help assess the effectiveness of the DHSPC support group. During the intake interview, all participants are asked to self-rate their feelings in regards to suicidal desire, intent, and buffers/connectedness using the questions below. Suicidal capability was excluded because many of the subcomponents of this principle are fixed and won't change over time (i.e., history of a suicide attempt or exposure to a suicide) or are more difficult for a participant to self-rate (i.e. increased symptoms of mental illness or extreme agitation). Participants are asked the questions from the intake interview again at the first meeting of the eight-week group cycle and again at the last meeting to identify changes from the intake baseline measures. Preliminary outcomes on these measures have been positive.

Suicidal Desire:
On a scale of 1-5 how much do you want to die? (1= low – 5= high)

Suicidal Intent:
On a scale of 1-5 how likely are you to kill yourself? (1= very unlikely – 5= very likely)

Buffers/Connectedness:

On a scale from 1-5, how connected to others/how supported do you feel?
(1= very unconnected/supported – 5 =very connected/supported)

For more information about the outcome measures used during the support group, please contact DHSPC. Didi Hirsch Suicide Prevention Center:
http://www.didihirsch.org/spc

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VI. APPENDICES

Appendix A: Check-In After Meeting #1

Attempt Survivors Support Group

Name: _____

Phone: _____

Date of Contact: _____

- Is this a good time for you to talk? Schedule another time?
- How was the first group meeting for you?
- Did it bring up anything that you need to process?
- Do you have any questions or concerns about the group?
- How are you in terms of your thoughts of suicide?
- What can you do to stay safe?
- Do you plan to continue with the group? It can be hard in the beginning, but it does get easier.
- Reminder: You can always call any of the facilitators if you have questions or concerns. If you are in crisis and need to speak to someone immediately you can call the crisis line at 877-727-4747

Notes:

Didi Hirsch
MENTAL HEALTH SERVICES

Appendix B: Guidelines for Support Groups for Survivors of Suicide Attempts

Didi Hirsch Mental Health Services Suicide Prevention Center
Revised April 14, 2013

Attendance

- Attend all meetings if possible. Group participants depend on each other and will be concerned if other participants are absent. If you need to miss a meeting, notify the group facilitator of your absence.
- Arrive on time.
- Avoid drugs (excluding prescription drugs) or alcohol use before attending a group meeting.
- Be respectful of other group participants by wearing appropriate attire. Revealing clothing should be avoided.
- Turn off cell phones before the group begins.

Confidentiality

- Whatever is shared within the group remains confidential (except in cases where there may be reportable abuse or neglect or someone's life is in immediate danger).

Participation

- Participants are welcome to ask questions, make suggestions or just listen.

- The atmosphere is one of sharing, but no one is put on the spot or forced to talk.
- While no one is required to share, the more you share, the more everyone is likely to gain from the group.
- There are no right or wrong answers or feelings. Each person's feelings are their own and important to them. Respect their decision to share.
- The group is a safe place to share experiences and feelings. There is no pressure to do or see things a certain way.
- It is important to allow everyone who wishes to talk the opportunity to do so. Try not to monopolize the group.
- Avoid "side" conversations; they are distracting and disrespectful to the person who is talking.
- Be considerate of others' feelings. Don't be judgmental or pry.
- People are making themselves vulnerable in group, so we recommend avoiding romantic relationships with other group participants.

Support

- The Suicide Prevention Center Crisis Line is available 24 hours a day: **1-877-727-4747**
- You can call the group facilitators with questions or concerns about the group; however, if you are in an immediate crisis, you should call the crisis line, as your facilitators work normal business hours and may not be available immediately.

- It is OK to e-mail group facilitators for a quick check-in or question or if you are going to miss a meeting, but if you are in crisis, be sure to call the crisis line.

- Group participants often use each other for support outside of the group. It is important for each group participant to consider their role in supporting other group participants and find balance between taking care of their own needs as well as supporting others.

Healing Commitment

- Although we try different tools in the group, we do not endorse specific ones. We encourage you to identify small goals that you have and seek to take small steps toward them in the frame of mind of; "What would I be willing to try today?" Easy does it.

- Be willing to experiment with new behaviors and new ways of doing things. Try the homework. Keep an open mind.

- If you can, explore voicing your opinions, thoughts, and feelings honestly and openly with the facilitators. You may find it most comfortable to do this by phone or one-on-one. We ask that while you are participating in group that you return our phone calls. Consider the group a safe place to put out your requests, reactions, and feedback.

- This is your group. We have a topic of the night, but we are very open to your needs as well. If there are things you want to see discussed or focused upon, send us an e-mail, call us, or just bring it up in check-in. No request is too minor.

- Give yourself time. It is possible to live with less unhappiness and learn new ways to manage distress.

Appendix C: Week Four - Trigger log

When you notice your mood worsening or thoughts of suicide occurring, fill in the chart below to help you identify triggers.

Remember, you may experience suicidal thoughts as a result of uncomfortable emotions or unbearable pain.

Recognizing what caused these emotions and finding other ways to cope with them can help keep your suicidal thoughts from escalating into suicidal actions.

Date/ Time	Was there a situation or event that led to your thoughts of suicide?	What were you experiencing when these thoughts occurred? (Thoughts, images, thinking processes, moods, behaviors)	What feelings did you have?	Did you experience any automatic negative thoughts? What were they?	Were you able to discover any ways to counteract those thoughts? What were they?	List the internal/ external coping skills you tried to take your mind off of your suicidal thoughts.	How effective was the coping skill you used? Did it help in decreasing your thoughts of suicide?

"To get through the hardest journey we need take only one step at a time, but we must keep on stepping." – Chinese Proverb

Don't hesitate to reach out for help!
Crisis line: (877) 727-4747

Appendix D: Week Five - "60 Ways to nurture myself"

PHYSICAL	EMOTIONAL	MENTAL	SPIRITUAL
Take a walk	Listen to music you like	Say an affirmation	Connect with nature
Ride a bike	Share feelings about an experience with a friend	Read a book or magazine article	Concentrate on the flame of a candle
Soak in a hot bath, with candles and music	Deep breathe and think, 'I am calm and peaceful'	Express your thoughts and feelings in a journal	Meditate
Exercise at the gym	Sing or make sounds	Make a 'to do' list	Pray
Stretch and move to music	Hug someone, ask for a hug	Write a poem	Talk to your guardian angel
Practice yoga postures	Pet your dog or cat	Write a letter	Listen to a guided meditation tape
Take a course in Tai Chi, water aerobics, or Yoga	Feel your fear and take a positive risk for change	Listen to tapes	Write about your spiritual purpose
Sit in the sun for 15 minutes	Affirm yourself daily	Email a friend	Visualize yourself in a peaceful place
Change one thing to improve your diet	Notice what you are feeling several times a day	List things you will do to improve your life	Do something of service for another or for your community
Watch birds and animals interact in nature	Write a letter to someone who has hurt you, but do not send it	Update negative beliefs that limit your life	Join a church group
Go swimming	Talk to someone by pretending they are facing you in an empty chair	Journal daily about your reactions, thoughts, and feelings for a month	Learn about a religion different from your own
Sit in a garden or park	Smile at a stranger and send them thoughts of peace, acceptance and joy	List your traits, needs and wants	Study with a spiritual teacher
Take a nap	Telephone a long distance friend or relative	Make a list of short-term and long-term goals	Study ancient esoteric wisdom teachings
Get a massage	Watch children play, talk to your inner child in a loving, joyful way	Preview your day upon awakening. Review upon retiring	Practice unconditional love and forgiveness with self and others
Eat healthy for one day	Acknowledge yourself for accomplishments you are proud of	Work on your family tree	Practice a daily quiet time, a routine to connect spiritually

Suzanne E. Harrill, LPC, LMFT, Author, Counselor, Teacher:
www.innerworkspublishing.com/news/vol1/selfcare.htm

EXAMPLES OF AUTOMATIC NEGATIVE THOUGHTS (ANTs)

One of the basic assumptions of the cognitive model that underlies much of the broader positive psychology model is that the way we think about things is important in determining how we feel. Further, there are times when are thoughts are unhelpfully negative. Recognising these ANTs is the first step in learning to change them (see Managing Automatic Negative Thoughts). Here are some of the more common types of negative thoughts.

(1) Overgeneralisation: Coming to a general conclusion based on a single event or one piece of evidence. If something bad happens once, you expect it to happen again and again. Such thoughts often include the words "always" and "never".

E.g. I forgot to finish that project on time. I never do things right. He didn't want to go out with me. I'll always be lonely.

(2) Filtering (Selective Abstraction): Concentrating on the negatives while ignoring the positives. Ignoring important information that contradicts your (negative) view of the situation.

E.g. I know he [my boss] said most of my submission was great but he also said there were a number of mistakes that had to be corrected...he must think I'm really hopeless.

(3) All or Nothing Thinking (Dichotomous Reasoning): Thinking in black and white terms (e.g., things are right or wrong, good or bad). A tendency to view things at the extremes with no middle ground.

E.g. I made so many mistakes. If I can't do it perfectly I might as well not bother. I won't be able to get all of this done, so I may as well not start it. This job is so bad...there's nothing good about it at all.

(4) Personalising: Taking responsibility for something that's not your fault. Thinking that what people say or do is some kind of reaction to you, or is in some way related to you.

E.g. John's in a terrible mood. It must have been something I did. It's obvious she doesn't like me, otherwise she would've said hello.

(5) Catastrophising: Overestimating the chances of disaster. Expecting something unbearable or intolerable to happen.

E.g. I'm going to make a fool of myself and people will laugh at me. What if I haven't turned the iron off and the house burns down. If I don't perform well, I'll get the sack.

(6) Emotional Reasoning: Mistaking feelings for facts. Negative things you feel about yourself are held to be true because they feel true.

E.g. I feel like a failure, therefore I am a failure. I feel ugly, therefore I must be ugly. I feel hopeless, therefore my situation must be hopeless.

(7) Mind Reading: Making assumptions about other people's thoughts, feelings and behaviours without checking the evidence.

E.g. John's talking to Molly so he must like her more than me. I could tell he thought I was stupid in the interview.

(8) Fortune Telling Error: Anticipating an outcome and assuming your prediction is an established fact. These negative expectations can be self-fulfilling: predicting what we would do on the basis of past behaviour may prevent the possibility of change.

E.g. I've always been like this; I'll never be able to change. It's not going to work out so there's not much point even trying. This relationship is sure to fail.

(9) Should Statements: Using "should", "ought", or "must" statements can set up unrealistic expectations of yourself and others. It involves operating by rigid rules and not allowing for flexibility.

E.g. I shouldn't get angry. People should be nice to me all the time.

(10) Magnification/Minimisation: A tendency to exaggerate the importance of negative information or experiences, while trivialising or reducing the significance of positive information or experiences.

E.g. He noticed I spilled something on my shirt. I know he said he will go out with me again, but I bet he doesn't call. Supporting my friend when her mother died still doesn't make up for that time I got angry at her last year.

NB: The good news is these unhelpful thoughts can be changed. See the "Managing Unhelpful Thoughts" tip sheet for some ideas about where to start.

And if you think you'd benefit from a more detailed explanation of unhelpful thinking and how to manage it, consider Dr. Sharp's "The Happiness Handbook"

www.thehappinessinstitute.com
ph. 02 9221 3306

Antianxiety Affirmations

The following affirmations and script are intended to help you change your attitude and respond constructively to the kinds of negative self-talk that can feed anxiety. Reading through them once or twice probably won't make much difference. Rehearsing some or all of them daily for a few weeks or months will begin to help you change your basic outlook about fear in a constructive direction. One way to do this is to read through one of the three sections below slowly once or twice each day, giving yourself time to reflect on each affirmation. Even better, record one or all three sections on an audiotape, leaving a few seconds of silence between each affirmation. Then listen to the tape once daily, when relaxed, to reinforce a more positive and confident attitude about mastering your anxiety.

Negative Thoughts and Positive Affirmations to Combat Them
(Use only the affirmations if you make a recording.)

This is unbearable. What if this goes on without letting up? I feel damaged, inadequate relative to others. Why do I have to deal with this? Other people seem freer to enjoy their lives. Having this condition seems unfair. I don't know how to cope with this. I feel so inadequate relative to others. Each day seems like a major challenge. I don't understand why I'm this way-why this happened to me. I feel like I'm going crazy. I have to really fight this. I shouldn't have let this happen to me.

I can learn how to cope better with this.

I'll deal with this one day at a time. I don't have to project into the future.

Some of us have steeper paths to walk than others. That doesn't make me less valuable as a human being-even if I accomplish less in the outer world.

Life is a school. For whatever reasons, at least for now, I've been given a steeper path-a tougher curriculum. That doesn't make me wrong. In fact, adversity develops qualities of strength and compassion.

Life can appear unfair from a human perspective. If we could see the bigger picture, we'd see that everything is proceeding according to plan.

I can learn to cope better-with this and any difficulty life brings.

Let people do what they do in the outer world. I'm following a path of inner growth and transformation, which is at least equally valuable. Finding peace in myself can be a gift to others.

I'm learning to take things more slowly. I make time to take care of myself. I make time to do small things to nurture myself.

The causes are many, including heredity, early environment, and cumulative stress. Understanding causes satisfies the intellect, but it's not what heals.

When anxiety is high, I feel like I'm losing controL But that feeling has nothing to do with going crazy. Anxiety disorders are a long way from the category of disorders labeled "crazy."

Struggling with a problem won't help so much as making more time in my life to better care for myself.

The long-term causes of this problem lie in heredity and childhood environment, so I didn't cause this condition. I can now take responsibility for getting better.

Antianxiety Affirmations

- I am learning to let go of worry.
- Each day I'm growing in my capacity to master worry and anxiety.
- I am learning not to feed my worries-to choose peace over fear.
- I am learning to consciously choose what I think, and I choose thoughts that are supportive and beneficial for me.
- When anxious thoughts come up, I can slow down, breathe, and let them go.
- When anxious thoughts come up, I can make time to relax and release them.
- Deep relaxation gives me the freedom of choice to move out of fear.
- Anxiety is made of illusory thoughts-thoughts I can let go of.
- When I see most situations as they truly are, there is nothing to be afraid of.
- Fearful thoughts are usually exaggerated, and I'm growing in my ability to tum them off at will.
- More and more, it's becoming easier to relax and talk myself out of anxiety.
- I keep my mind too busy thinking positive and constructive thoughts to have much time for worry.
- I'm learning to control my mind and choose the thoughts that I think.
- I am gaining more confidence in myself, knowing I can handle any situation that comes along.

Choosing Safety Over Suicide: Using a Safety Plan

A safety plan is a written list of personalized coping strategies and resources that you can use to feel better when you are feeling suicidal.

Many suicide attempt survivors report that during the time right before their attempt, they were experiencing unbearable emotional pain and they saw suicide as a way to find relief from this pain.

A safety plan is a way to identify other options of relieving your pain, before you are in crisis, when it may be difficult for you to think of them. By writing them down ahead of time, you will always have the set of coping strategies available even if you are upset or not thinking clearly, to help to ease your pain, rather than feeling trapped or tempted to act on the suicidal thoughts you may experience.

You can complete your plan by yourself or with the help of a counselor, family member, or friend. This pamphlet will help you to brainstorm elements of your safety plan.

Creating a safety plan can feel intimidating at the beginning, but don't let that discourage you. Many people have felt anxious about using a safety plan, but have found it to be a very useful tool for them once they have completed it.

"Once I finished my safety plan, I respected myself so much more."
- Suicide Attempt Survivor

Resources

- National Suicide Prevention Hotline
  1.800.273.8255/1.888.628.9454 (Spanish)
  www.suicidepreventionlifeline.org

- Emergency: Dial 911
- Community Information and Referrals: Dial 211
- Survivors of Suicide Attempts Website:
  www.suicidesurvivor.org
- American Association of Suicidology Website:
  (includes a suicide attempt survivors blog)
  www.suicidology.org
- Trevor Line (LGBTQI)
  1.866.488.7386
  www.thetrevorproject.org
- Suicide Awareness/Voices of Education
  www.save.org
- American Foundation for Suicide Prevention
  www.afsp.org
- SAMHSA
  (Substance Abuse and Mental Health Services Administration)
  www.samhsa.gov

  SAMHSA publishes several After An Attempt pamphlets for suicide attempt survivors and those who support them.

Feeling Suicidal? Worried About Someone Who is?
Call 1-800-273-TALK

The Safety Plan in this brochure was developed by Shari Sinwelski, Sandra Yi and Amy Baylis at the Didi Hirsch Suicide Prevention Center and was adapted from the Safety Plan Treatment Manual to Reduce Suicide Risk:

Keeping Yourself Safe

Step 1: Know the Warning Signs.

Many suicide attempt survivors indicate that their suicidal thinking became almost automatic over time. When something negative occurred, they start to have negative thoughts. These thoughts include, "Nobody cares about me," "I can't take it anymore. I wish I were dead." These warning signs can include personal situations, thoughts, images, thinking styles, moods, or behaviors and can help you know when to use your plan.

What triggers your suicidal thoughts?

_____

_____

_____

Step 2: Internal Coping Strategies

One way to do take your mind off your suicidal thoughts is to do something that helps you feel better. What can you do when you're alone and you start to have thoughts of suicide? What can you do to take your mind off of your problems and help yourself feel better? Examples include reading a book, playing computer games, exercising, playing with your dog, shopping, or writing down your thoughts and feelings in a journal.

_____

_____

_____

Step 3: External Coping Strategies

Another way to take your mind off of your suicidal thoughts is through external strategies like talking to certain people or visiting places that improve your mood. Finding places that make you feel better or people who cheer you up are

good ways to keep your thoughts from escalating. Where can you go to be around other people in a safe environment? Who can you be around that makes you feel positive? Examples include the coffee shop, the gym, church, friends, or family.

_____

_____

_____

Step 4: Who can you ask for help?

It can be helpful to have someone with whom you feel comfortable sharing your thoughts of suicide. Ideally, this is a supportive person who already knows about your suicidal thoughts before a crisis occurs and is aware of his/ her role as a resource in your plan. Having several people listed here, if possible, is best in case your primary support person is unavailable.

Who do you feel comfortable talking to when you're in crisis?

_____

Name Phone #

_____

Name Phone #

Step 5: Professional Resources

What professionals or agencies can offer assistance if the other parts of this plan don't seem to be helping you to stay safe? Ideally, you want to have resources that are available 24 hours a day, seven days a week. Look at the back of this pamphlet for more resources!

_____

Clinician's Name Clinician's Phone #

_____

Local Emergency Dept. Phone #

Suicide Hotline (LA/OC): 1.877.727.4747
National Suicide Prevention Lifeline: 1.800.273.8255

Step 6: A Safer Environment

At times, if you forget to use your plan, or it doesn't make you feel better, having items close to you that you could use to harm yourself can create a dangerous situation. It is important to remove items that you may use impulsively.

What items do you have nearby that you may use to harm yourself? How can you safely remove them for the time being? Examples include pills, guns, knives, poison, or rope. To whom can you give them?

_____

_____

_____

Appendix E: Week 6 Websites and books for suicide attempt survivors

RECOMMENDED ATTEMPT SURVIVOR WEBSITES

www.suicidesurvivor.org
This site is a hub for suicide attempt survivors with information on resources, support groups and what to expect when recovering from a suicide attempt.

www.suicidepreventionlifeline.org
This site provides information about the National Suicide Prevention Lifeline.

www.my3app.org
https://itunes.apple.com/us/app/safety-plan/id695122998?mt=8
These sites feature downloadable safety planning apps.

www.attemptsurvivors.com
This site features essays and videos by people who speak openly about having been suicidal.

www.talkingaboutsuicide.com
This site features over sixty interviews so far with attempt survivors who are open about their experiences.

http://www.suicidology.org/suicide-attempt-survivors
This site has downloadable brochures for family members and consumers about self-harm and surviving a suicide attempt.

http://www.suicideanonymous.net/
A 12-Step online support group is offered by Suicide Anonymous.

http://www.suicideispreventable.org/
This is an interactive site which teaches people how to recognize warning signs, communicate about suicide, and help a suicidal person. Can be a great resource for family members.

www.livethroughthis.org
This is a site with stories of people who have attempted suicide and survive. Hopeful messages of recovery.

http://www.nami.org/
NAMI offers support groups in many communities for friends and family of individuals with a mental illness.

http://www.helppro.com/SPTF/BasicSearch.aspx/
HelpPRO was developed to help people find individual counseling, family counseling, couples counseling and therapy groups

SUICIDE PREVENTION ORGANIZATIONS

www.suicidology.org
American Association of Suicidology

www.afsp.org
American Foundation for Suicide Prevention

www.actionallianceforsuicideprevention.org
National Action Alliance for Suicide Prevention

http://actionallianceforsuicideprevention.org/task-force/suicide-attempt-survivors
National Action Alliance Suicide Attempt Survivors Task Force

OTHER HELPFUL WEBSITES

www.nmha.org
Mental Health America

www.nami.org
National Alliance on Mental Illness

www.samhsa.gov
Substance Abuse and Mental Health Services Administration (SAMHSA)

www.DBSAlliance.org
Depression and Bipolar Support Alliance

RECOMMENDED BOOKS FOR SUICIDE ATTEMPT SURVIVORS

Children of Jonah: Personal Stories by Survivors of Suicide Attempts; Clemons, James T.; Capital Books; 2001.
This book was written by James Clemons, a Methodist minister who tells the stories of several individuals who survived a suicide attempt.

Choosing to Live: How to Defeat Suicide Through Cognitive Therapy; Ellis, Thomas & Newman, Corey; New Harbinger; 1996.
This workbook, written by two psychologists contains exercises suggesting practical skills to help those who are struggling with thoughts of suicide using a cognitive approach to change suicidal thoughts and behaviors.

Conquering the Beast Within: How I Fought Depression and Won...and How You Can, Too; Irwin, Cait; Times Books; 1998.
Readable book capturing the author's journey through depression and recovery starting at age 13 in graphic cartoons and writings.

The Dialectical Behavior Therapy Skills Workbook for Biopolar Disorder; Van Dijk, Sheri; Raincoast Books; 2009.
Day to day tools for coping with manic depression.

Eight Stories Up: An Adolescent Chooses Hope Over Suicide: Lezine, DeQuincy. Oxford University Press; 2008.
As a teenager, DeQuincy Lezine nearly ended his own life, believing it was the only way to escape the emotional pain that was overwhelming him. Instead, Lezine was able to find expert psychiatric care, and went on to found the first university campus-based chapter of the Suicide Prevention Action Network USA.

Hello Cruel World; 101 Alternatives to Suicide for Teens, Freaks, and Other Outlaws; Bornstein, Kate; Seven Stories Press: 2006.
This is an inspirational book written by an attempt survivor about self-acceptance and transcending rules, gender, and societal norms.

How I Stayed Alive When My Brain Was Trying to Kill Me; Blaumer, Susan Rose; Harper Collins; 2002.
After surviving 18 years of suicidal thoughts and multiple attempts, and having been diagnosed with PTSD, depression, and borderline personality, this woman chronicles the tools that she used in the beginning of her recovery and the ones she still uses today to find happiness and peace of mind again.

Night Falls Fast, Understanding Suicide; Jamison, Kay Redfield; Alfred A. Knopf; 1999.
A personal account of suicide by a prominent professor of psychiatry at John Hopkins University who has struggled with bipolar disorder and her own suicide attempt.

The Noonday Demon; Solomon, Andrew; Touchstone; 2001.

Secrets of Suicide; Tullis Ken M.D.; AuthorHouse; 2007.
A follow-up to Seduction of Suicide, this book explores how traumatic events can lead to suicidal thoughts and actions.

Seduction of Suicide; Taylor, Kevin M.D.; 1st Books Library; 2002.
Written by an award-winning psychiatrist who himself has attempted suicide, this book presents suicidal thoughts and behaviors as an additction.

Step Back from the Exit: 45 Reasons to Say No to Suicide; Arena, Jillayne; Zebulon Press; 1995.
Written by a woman who struggled with her own suicidal thoughts and attempts, this book presents 45 practical "reasons to live."

Struck By Living; Hersh, Julie; Brown Books; 2010.
An honest and hopeful look at clinical depression punctuated by suicide attempts and a recovery path including electroconvulsive therapy, or ECT. This debut non-fiction narrative by Julie Hersh traces her search for identity through her career, interfaith marriage, motherhood and clinical depression. Her book details her recovery from suicide attempt. She writes a blog for Psychology Today about recovery and stigma.

Suicide: The Forever Decision; Quinett, Paul G., The Crossroad Publishing Company; 2004.
This book is written by a caring psychologist written as if the reader were his personal client in his psychotherapy office, having a one-on-one conversation about suicidal thoughts and emotional pain.

Suicide Why: 85 Questions and Answers About Suicide; Wrobleski, Adina; Afterwords; 1994.

Undoing Depression; What Therapy Doesn't Teach You and Medication Can't Give You; Richard O'Connor; 2010
The author writes from the perspective of having experienced anxiety and depression personally and being a psychologist treating depression. He also survived the suicide of his mother. His book focuses on a holistic approach for recovery with an emphasis on skills (but as a shorter version than David Burn's classic Feeling Good).

An Unquiet Mind; Jamison, Kay Redfield; Vintage Books; 1995.
A personal account of examining manic-depression from the perspective of "the healer and the healed" by a prominent professor of psychiatry at John Hopkins University who has struggled with bipolar disorder.

Waking Up Alive; Heckler, Richard. Ballantine Books; 1996.
The author interviewed 50 suicide attempt survivors and through a representative selection of stories describes their common experiences of loss and subsequent pain. They talk about the steps they took after the attempt on their path toward healing.

Waking Up: Climbing Through the Darkness; Wise, Terry, L. Pathfinder Publishing; 2003.
The writer focuses on her therapy sessions (and progress!) over several years as she struggled with grief, self-destructive substance use, and a serious suicide attempt and how she grew in identifying her emotions and sharing them with other people, particularly around childhood abuse.

Appendix F: Week Six - Community Resources: Support Groups and Counseling

Individual or Family Counseling/ Psychotherapy

I. Insurance

If you have Medi-Cal

Call the ACCESS line for referrals to a private counselor or counseling center in your area: 1-800-854-7771.
Note: If you have a child with Medi-Cal, you can sometimes be seen under their insurance as part of Family Counseling.

If you have private insurance

Call the phone number on the back of your insurance card for referrals.
The customer sevice representatives can tell you how much your copays and deductibles are.

If you are uninsured or can't afford the copays of your plan

Call 211 for referrals or the ACCESS line at 1-800-854-7771.

II. Types of therapy

Dialectical Behavioral Therapy and Cognitive Behavioral Therapy

These are two kinds of therapy that have been researched to be effective for suicide prevention; you can find groups and/ or private counseling by searching a therapist finder. One resource for finding therapists who say they are comfortable working with suicidal clients is HELPpro, which has been endorsed by the American Association of Suicidology and other groups:

http://helppro.com/SPTF/BasicSearch.aspx

III. Support Groups

Recovery International at **www.lowselfhelpsystems.org**

This is a free peer support group started in the 1930s for people to tap into their "rational side" to cope with the stresses of daily life and internal symptoms. The tools use some old-fashioned language but really represent the first cognitive behavioral approach to recovering from emotional symptoms. Many people have found it helpful for PTSD, panic attack, or depression. There are meetings throughout L.A.

Wellness Recovery Action Plan (WRAP) at **www.mentalhealthrecovery.com**

This is a personalized tool to feel better and live better long-term that was developed by a group of people with serious mental health diagnoses who wanted to improve their quality of life and stay out of the hospital through their own efforts rather than relying on professionals only. You can join a local group to put together the plan over time, develop one online, or buy the mini-book and do it with a friend. This site offers webinars as low as $10 to take you through the plan.

Al-Anon at **www.al-anon.alateen.org**

This is a free, 12-step group for people who are affected by the dysfunction that can occur in families with drinkers and/or substance abusers; either in their family of origin or with significant others or social circles. The 12-step programs are a spiritual, but not religious, way of approaching life and offer a close-knit community for those who decide to get involved, participate, and get to know other participants but people are also free to simply attend the meetings and listen. There are numerous meetings daily in every part of L.A.

Other 12-step programs

Other 12-step programs that may be of interest include Alcoholics Anonymous, Sex and Love Addicts Anon, and Suicide Anonymous. Most 12-step programs have meetings and online forums.

Other support groups

NAMI (National Alliance on Mental Illness); DBSA (Depression and Bipolar Support Alliance); and locally the SHARE network all offer ongoing support groups.

Appendix G: Week Eight - Ways to stay connected: Opportunities for support and involvement

- Keep your safety plan updated and nearby and use it when needed (it fits nicely in your hope box).

- Attend another support or therapy group in the community (Dialectical Behavioral Therapy, Depression and Bipolar Support Alliance, Al-Anon, Recovery Inc., Wellness Recovery Action Plan groups, Alcoholics Anonymous, National Alliance on Mental Illness or others). Information about local support groups can be found by looking online at NAMI (**www.namila.org**), or SHARE **http://www.shareselfhelp.org/finding.aspx**, or calling the local information and referral crisis line at 2-1-1.

- Consider joining a Wellness Center.

- Visit **www.suicidesurvivor.org** for more information and resources for suicide attempt survivors.

- Try the 12-step online support group offered by Suicide Anonymous **http://www.suicideanonymous.net/**

- Get connected with a therapist or counselor. Local county referrals can be found at: **800-854-7771**

- Get educated on the ways to receive help, give help, and prevent suicide:

    - National Suicide Prevention Lifeline **http://www.suicidepreventionlifeline.org**
    - American Association of Suicidology (AAS) **http://www.suicidology.org**
    - The AAS suicide attempt survivors website at **http://attemptsurvivors.com/**

- Share your story of survival by joining our SPC speaker's bureau *
- Share your story or learn about others by visiting websites for attempt survivors:
    - Portraits and interviews at **www.livethroughthis.org**
    - Interviews at **http://talkingaboutsuicide.com/**
- Attend our annual fundraiser in September, Alive and Running. Create a team to support suicide prevention! Visit **www.aliveandrunning.org** for more information.
- Join the Didi Hirsch mailing list to receive the agency newsletter or learn about the latest events within the agency and DHSPC

And remember, you can always call the crisis line whenever you need to talk at

1-877-7-CRISIS (1-877-727-4747)

or the Suicide Prevention Lifeline at 1-800-273-TALK or 1-800-273-8255

Chat counselors are also available by visiting the National Suicide Prevention Lifeline Website at
http://www.suicidepreventionlifeline.org

* You will receive additional training before becoming an agency speaker. If you are thinking about sharing your story, you may want to review Best Practices for Presentation by Suicide Loss and Suicide Attempt Survivors on the American Association of Suicidology website at
http://www.suicidology.org/web/guest/suicide-attempt-survivors
Didi Hirsch Mental Health Services cannot monitor the websites and blogs listed above. They are suggested as a means of additional support.

Appendix H: Survivors of Suicide Attempts Support Group Focus Group Results

Didi Hirsch's Survivors of Suicide Attempts (SOSA) Support Group was created in 2010 to help reduce the stigma associated with mental health and suicide and to reduce reattempts by attempt survivors. SOSA is an eight-week support group that was created for people who have had a suicide attempt or who are struggling with chronic and persistent thoughts of suicide. Through this peer-led support group, survivors address triggers of suicide ideation, identify positive coping skills, and learn how to develop safety plans.

A focus group was conducted with former and current SOSA clients to explore their perspectives, opinions and suggestions about ways Didi Hirsch could enhance care and provide better services to SOSA clients. Staff from the Didi Hirsch Best Practices Department conducted the focus group on August 6, 2012. During the focus group, participants responded to a series of broad questions (indicated in bold below) posed by the facilitator that were intended to generate open discussion on issues relevant to the SOSA support group. There were seven former and current SOSA support group participants who participated in the focus group. Of these seven, 71 percent were female and 29 percent were male. Participants' ages ranged from 21 to 50 years old. All participants were given a small monetary incentive for their time and participation in this focus group. The dialogue from the group were transcribed, coded into categories and grouped into themes. Patterns and themes were noted, and illustrative quotes were identified and presented in the findings below.

KEY FINDINGS

What do you like most about being a part of this support group? What about this group did you find most helpful?

- One of themes that we found among the participants was that they felt a connection with other group members who also attended the group. It was stated among participants that if they were struggling

with something and could not make contact with the Didi Hirsch facilitators, they could always call others in the group to help talk through their struggles.

- Another theme that emerged was that participants found the group environment provided a safe and comfortable space to share their thoughts and feelings because other group members understood what they were struggling with. Participants stated that they felt that they could express their opinions and thoughts with group members without being stigmatized. A few participants shared that they feared that they would get hospitalized if they shared true suicide thoughts and feelings with their loved ones.

"Group opened my eyes to realize that I am not the only one going through stuff." (Male, 21)

"There is community here." (Female, 48)

"It was something that I looked forward to." (Female, 48)

"I just love it ... it is such a release, and it calms your thoughts at this point of my life, and I just love it." (Female, 34)

"But it helps to come and listen to people in your situation, and you can relate to them." (Female, 35)

"So I feel that they are my support." (Female, 50)

"It helped me a lot." (Female, 21)

"It is a safe place to let it all out." (Female, 50)

"But here, I feel more safe." (Female, 50)

"You feel comfortable in here." (Male, 21)

"I promised them that I would see them again." (Male, 21)

"You meet new people and make friends." (Female, 35)

"It is different than therapy. It is a miracle in my life." (Female, 21)

"Even to come back and get hugs today, I felt the love." "You have the connections, nice to know you can call." (Male, 21)

"Everyone understands each other." (Male, 35)

"This group gives you life." (Female, 35)

"It's more like a family thing." (Female, 21)

What are some things you would like to see changed in this group? What did you like least about the group?

- One aspect of the group that participants wish to see changed is the name of Safety Plan. Adjectives such as "insensitive", "impersonal" and "insulting" were used by participants to describe how they felt about the document's name. A few participants felt as though the name did not make it sound personal to them. Alternative suggestions for names included "My Respect Plan" or "My Plan."

- Another aspect that participants would like to see changed is the number of days the group is held. There was an overwhelming response from participants to have group sessions held twice a week instead of once every week. Participants expressed that there was a struggle to wait until the next week to meet again for group, especially if they were going through something and needed to talk.

- Providing more books to participants and showing more videos in group are things that participants mentioned that they would like to

see more of. Participants found that books were really uplifting, and it gave them a sense of hope because they saw that if the author of the book was able to make it through their own struggles, they themselves (participants) may be able to one day get through their struggles as well.

- One last thing to note is that the female participants stated that the new time that group is held (5:30pm) works well for them because of transportation issues. A few women expressed that they have to take the bus, and traveling late at night is unsafe for them.

"Books are really helpful." (Female, 48)

"Waiting for the next week to come and go to group." (Female, 35)

"People that write books, if they can be successful, we can be successful too, this is uplifting." (Female, 21)

"Change the name; it (safety plan) does not make it personal." (Female, 35)

"It felt intimidating and insulting (Safety Plan). The name is insulting." (Female, 48)

Can you explain what is more helpful, sharing about how your week went (checking in) or learning about skills (self-care, safety planning), what do you think about the balance between the two?

- Participants stated that they liked the combination of skill building and check-in as long as there is equal time dedicated to both.

If you were not able to attend group regularly, can you share some reasons why?

- The three main reasons that participants were not able to make it to group regularly were because of personal illness, family issues and transportation issues.

For those who have stopped attending the eight-week cycle, what are some reasons you have stopped coming?

- The main reasons that most participants were not able to continue on with the cycle was because of personal illness, family issues, and job/school responsibilities. One person did express that he was devastated because he was not able to make it back to group because of his distance.

"To not make it back here was devastating; I was living for this group." (Male, 21)

Have you used the safety plan that you created during the group meetings?

- Participants mentioned that at first they found the safety plan a bit scary, and they could not relate to it. They said that once the facilitator discussed it in detail, they understood what it was and how to use it. Participants did find the safety plan very useful, and some mentioned that they still continue to carry it around today. One participant stated that she finds herself constantly adding to it, the more she learns.

"What I found over time is that I would add things to it." (Female, 48)

"I carry it everywhere I go. I found it helpful." (Female, 50)

"I have it downloaded on my iPad." (Male, 21)

"I like the fact that we can talk about it." (Female, 48)

Has being a part of this group stopped you from trying to kill yourself?

- Participants expressed that the group has stopped them from trying to kill themselves. One thing that the group helps group participants do is empower them to ask for help, especially when they feel like they want to act on their suicidal thoughts. The group provides a sense of connection to others. Group members feel that they can turn to each other in a state of crisis.

"Wow, thank goodness something different outside of the hospital that can help deal with life." (Female, 48)

"It has been helping me, I asked for help, so without this, I do not know what I would do." (Female, 50)

"This group definitely made me promise that they will see me again." (Male, 21)

"I am thankful I came to group. If not, I do not know where I would be right now." (Female, 21)

"Made me more not afraid to ask for help." "Without this, I don't know what I would do." (Female, 50)

"The fact that I can get through another year is astounding." (Male, 35)

"It just keeps me alive." (Female, 50)

"This group is the reason I am here." (Male, 21)

"Without this group, I probably would not have made it." (Male, 21)

"I love the fact that we are different and feel very tied to each other." "I don't feel abandoned anymore." (Female, 48)

"I feel sorry for people who are struggling and do not have this group to go to." (Female, 48)

What are some reasons that you continue to come back to group?

- The participants mentioned that the group helps keep them alive because they are able to share their thoughts and feelings without being stigmatized.
- Participants expressed that if this SOSA group did not exist, they are not sure where they would be.

"Thought I was cured but was not, so I am back." (Male, 35)

"It just keeps me alive." (Female, 50)

After the end of each cycle, there is a short break before the next cycle begins. What is this break period like for you when group is not in session?

- There was an overwhelming response from participants that scheduled breaks were very difficult for them, especially the Christmas break. One participant stated that she was finding that a couple of days after the end of a group cycle, she was going into crisis. Some other participants stated that it was hard to cope without the weekly group sessions.

"That break is not good." (Female, 21)

"What was happening over break, I was going into serious crisis 48 hours after group." (Female, 48)

What are some things that Didi Hirsch can do to help you during this time?

Participants stated that to help ease their struggles about not being in group, the Didi Hirsch staff should give them a take-home project or activity that they could work on during the break (coloring pencils, journaling, etc). Participants also thought that talking about plans or particular anniversaries prior to the end of group cycle would also help deal with their anxieties during break.

Ways of being connected

- One way participants stated that they would like to stay connected to the group would be through a blog created by Didi Hirsch where they can log in and post comments and communicate with each other.