Suicide Prevention, Intervention & Postvention

In substance use recovery housing

For recovery residence staff, house managers, peer support specialists, and program leadership

Shanna Sorg,
Sr Program Coordinator
Safer Homes Collaborative
Missouri Institute of Mental Health/UMSL

- **Prevention**
- **Intervention**
- **Postvention**

988 · call or text, 24/7

GROUND RULES

Before we start

1

This is close to home

Many of us are in recovery, have lost people, or have our own history with suicidal thoughts. That is not a disqualification. It is why this room knows the material.

2

Step out if you need to

No explanation required, no penalty, and no one follows you into the hallway unless you want company. Come back when you are ready.

3

Support is here today

Names and numbers are on the last slide. If today stirs something up, tell one of us before you leave the building.

We will talk about suicide directly and by name. We will not discuss specific methods, and I will ask you not to either — in this room or in the house.

OBJECTIVES

What you will walk out able to do

1 Recognize

Name the risk factors, warning signs, and high-risk windows that are specific to recovery housing rather than generic to the population.

2 Ask

Ask a resident directly about suicide, using plain language, without fear that the question makes things worse.

3 Respond

Build a safety plan, choose a level of care, and make a housing decision that does not turn a disclosure into a discharge.

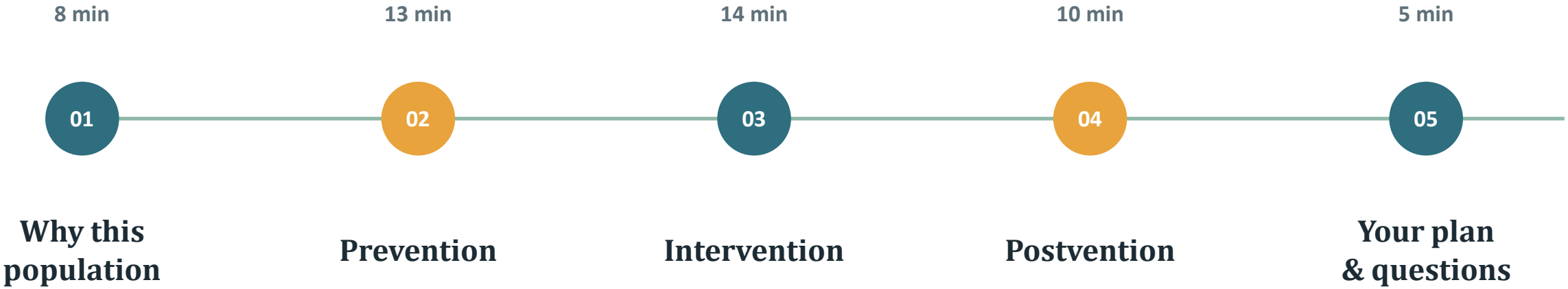
4 Recover

Run the first 24 hours, the first two weeks, and the first 90 days after a death — protecting the rest of the house while you do it.

Everything here is written for a residence, not a clinic. If your program has clinical staff, these are the steps that happen before and around them — not instead of them.

AGENDA

How we will spend the time



Three short case discussions are built in — one per section. They are the part people remember, so we will protect the time for them.

01

Why this population

Recovery housing concentrates almost every known suicide risk factor under one roof — and then adds a few of its own.

WHY THIS POPULATION

The scale of it

48,824

suicide deaths in the U.S. in 2024 — a rate of 13.7 per 100,000, down about 1% from 2023

10–14x

the general-population risk of death by suicide for people with a substance use disorder

~22%

of suicide deaths involve alcohol intoxication; opioids are present in roughly 1 in 5

An estimated 14.3 million U.S. adults seriously thought about suicide in 2024, 4.6 million made a plan, and 2.2 million attempted. In a house of twelve residents with substance use disorders, the odds that no one is carrying this are low.

Sources: CDC WISQARS / NCHS 2024 provisional data; AFSP 2024 fact sheet; SAMHSA NSDUH 2024; American Journal of Psychiatry Residents' Journal, 2018.

WHY THIS POPULATION

Risk converges here

A qualifying diagnosis

Every resident has the risk factor that carries a 10–14x multiplier. That is the admission criterion.

Co-occurring conditions

Depression, PTSD, bipolar disorder, and chronic pain are common and frequently untreated or newly untreated.

Recent institutional exit

Residents arrive from detox, inpatient treatment, jail, or a hospital — all settings with sharply elevated post-discharge risk.

Accumulated loss

Custody, marriages, jobs, licenses, housing, and friendships lost during active use — and now fully felt without substances.

Shame and self-judgment

Early recovery returns the memory of what happened while using. Feeling like a burden is a documented driver of risk.

Precarious housing

The bed is conditional. A rule violation can mean homelessness the same day, and residents know it.

None of these are reasons to screen residents out. They are the reasons the setting needs a written protocol.

WHY THIS POPULATION

The overdose that might not have been one

What we usually assume

- An overdose after a period of abstinence is a tolerance problem
- Intent is either present or absent — you can tell which
- Overdose response and suicide response are separate protocols
- If the death certificate says accidental, that settles it

What the evidence shows

- Intent sits on a continuum — ambivalence, indifference to dying, and clear intent all exist
- Prior intentional overdose independently predicts later suicide risk
- People with opioid use disorder are many times more likely to die by suicide
- Cause-of-death classification is often uncertain in this population

Practical rule: after any overdose in your house — including one everyone calls accidental — a suicide screening happens as part of the follow-up. Naloxone and a direct question belong in the same protocol.

WHY THIS POPULATION

Language, and why it is not just etiquette

USE	AVOID
"Died by suicide"	"Committed suicide" — the word belongs to crimes and sins
"Suicide attempt"	"Successful" or "failed" attempt — nothing here succeeded
"Are you thinking about suicide?"	"You're not thinking of doing anything stupid, are you?"
General description of a death	Method, location, or note contents — never in a group setting
"He was struggling and it was treatable"	"He seemed fine — nobody saw it coming"

Any time suicide comes up in a house meeting, close the same way: this is treatable, help exists, and here is the number.

02

Prevention

The work you do before anyone is in crisis: what to look for, when to look for it, and how the house itself becomes protective.

PREVENTION

Two kinds of risk factors

Standing risk

Known at intake. Tells you who needs closer contact, not who is in danger today.

- Prior suicide attempt — the strongest single predictor
- Co-occurring depression, PTSD, bipolar disorder
- Family history of suicide; history of trauma or abuse
- Chronic pain or a disabling health condition
- Male sex; older age; veteran status
- Access to lethal means; previous intentional overdose
- Social isolation, estrangement, no visitors, no calls

Acute risk

Changes week to week. This is what staff are positioned to see and nobody else is.

- A return to use, or a positive screen
- A discharge notice, eviction, or rule violation
- Relationship ending; loss of contact with children
- A court date, sentencing, or new charge
- Job loss, benefits denial, or a large new debt
- Death of another resident or a person in the fellowship
- A stopped medication — psychiatric or MOUD

Standing risk explains why someone is vulnerable. Acute risk explains why this week. You need both, and you already collect one of them by accident every day.

PREVENTION

The five windows

Risk in recovery housing is not evenly distributed across a stay. It clusters — and the clusters are predictable enough to staff around.

1. **First 30 days**

   Arriving from detox, inpatient, jail, or a hospital. Post-discharge suicide risk is highest in the days and weeks immediately after leaving a facility — and that clock is running when they walk through your door.

2. **After a return to use**

   The shame spike, plus the belief that the one thing that was working has now failed. Compounded if a discharge decision is pending.

3. **On notice**

   Rule violation, discharge notice, or eviction. The bed and the recovery are experienced as the same thing, so losing one feels like losing both.

4. **Dates that carry weight**

   Sober anniversaries, holidays, birthdays of children, and the anniversary of a death. Predictable months in advance — put them on a calendar.

5. **Moving out**

   Even a good transition removes daily contact, structure, and the people who would notice. Successful discharges need follow-up too.

PREVENTION

What it actually looks like in a house

What you hear

- "Everyone would be better off"
- "I'm done" / "I can't do this again"
- "Don't worry about me after Friday"
- Talk of being trapped, or a burden
- No future tense — no plans past this week

What you see

- Giving away possessions or money
- Sudden calm after a stretch of visible distress
- Withdrawing from meetings, chores, meals
- Putting affairs in order; goodbye messages
- Increased use, or a return to use

What changes

- Sleep — much more or much less
- Appetite, hygiene, room condition
- Irritability, agitation, restlessness
- Disconnection from a sponsor or program
- Anything sharply out of character

The sudden calm is the one people miss. A resident who has been visibly in agony and is abruptly peaceful has often not gotten better — they have made a decision.

PREVENTION

You are already doing prevention

Daily human contact

Someone notices if you do not come down for breakfast. In the suicide prevention literature this is called connectedness; in a house it is called Tuesday.

Structure and routine

Chores, curfews, meetings, and work requirements give shape to days that would otherwise be unstructured and long.

Peers who have been there

A housemate two years in is proof that the thing the resident believes is impossible is not. That is hope made concrete.

A reason to stay

Responsibility to the house, a role, a job, a sponsee. Purpose and belonging are among the strongest protective factors we know of.

The goal of the rest of this training is not to add a program on top of your house. It is to make sure the house does not accidentally strip these away at the exact moment a resident needs them most.

PREVENTION

Screening: what, when, and who

WHAT

- C-SSRS Screener — 6 questions, free, no clinical license required to administer
- ASQ (Ask Suicide-Screening Questions) — 4 items, under a minute
- PHQ-9, with attention to item 9
- Pick one. Use it consistently. A tool used every time beats a better tool used sometimes.

WHEN

- At intake, every resident, no exceptions
- After any return to use or overdose
- After a discharge notice or rule violation
- After a significant loss or a hard anniversary
- At transition out, and at the 30-day follow-up

WHO

- Trained staff and peer specialists — screening is not diagnosis
- The same person each time when possible; rapport raises disclosure
- Privately, never in a common area or in front of housemates
- With a named next step ready before you ask the question

Never screen without a plan for a yes. Decide today who gets called, who covers the shift, and where the resident goes — before anyone answers the question.

PREVENTION

Building a house where people tell you

1. **Name it first, and out loud**

   Put suicide in the house orientation, alongside overdose. If the first time the word is spoken is during a crisis, you have taught residents it is unspeakable.

2. **Separate disclosure from discipline**

   Say it explicitly and in writing: telling us you are struggling will never by itself cost you your bed. Then honor it, publicly, the first time it is tested.

3. **Ask everyone, routinely**

   Universal questions are not accusations. "How are you doing with thoughts of hurting yourself?" asked of everyone at check-in normalizes the answer.

4. **Make help visible**

   988 on the fridge, in the resident handbook, in every bedroom. Naloxone and the crisis number in the same place, treated the same way.

5. **Let staff model it**

   Staff and peers who can say "I have been there, and I asked for help" do more for disclosure rates than any poster.

PREVENTION

Reducing access, at the policy level

Putting time and distance between a person and the means of harm is one of the best-supported suicide prevention strategies that exists. In a congregate residence, it is mostly a matter of written policy rather than individual conversation.

Secure medication storage

Individually locked storage for all resident medications, prescription and over-the-counter, with a documented process for disposing of what is no longer needed.

A written weapons-free policy

Stated in the resident agreement, applied to the whole property, and enforced consistently — not case by case during a crisis.

Train supervisors in CALM

Counseling on Access to Lethal Means is a short, free, evidence-based training. Designated staff should hold it before they need it.

Enlist supports temporarily

During an identified high-risk period, family or trusted contacts can hold items off-site by agreement. Voluntary, time-limited, documented.

Pair it with overdose response

Naloxone stocked, staff trained, and the same follow-up protocol whether the event reads as overdose or self-harm.

None of this requires a conversation about specifics — and none of it should include one. Write the policy, then enforce it the same way for everyone.

PREVENTION

Who needs which training

EVERYONE

All staff, all peers, all volunteers

- Gatekeeper training — QPR or safeTALK (1–4 hours)
- Overdose response and naloxone
- This session, annually, plus at onboarding

DESIGNATED RESPONDERS

House managers and on-call staff

- ASIST or Mental Health First Aid (1–2 days)
- CALM — means safety counseling
- Safety planning: Stanley–Brown format

LEADERSHIP

Directors and clinical partners

- Zero Suicide framework for the organization
- Postvention plan ownership and drills
- Policy: disclosure, discharge, documentation

Most of these are free or low-cost, and several are online. The barrier is almost never money — it is that nobody owns the calendar. Assign an owner before you leave today.

PAUSE AND DISCUSS

Case one: nine days in

THE SITUATION

Marcus is 34 and moved in nine days ago, straight from a 28-day program. He is polite, does his chores early, and has not missed a meeting.

On Tuesday he told a housemate he was "finally not going to be a burden to anybody anymore." Yesterday he gave that same housemate his work boots — good ones, and the only pair he owns.

He has a court date on Friday. When the house manager asked how he was doing, he said "honestly, better than I've been in years," and smiled.

TALK IT THROUGH

1. Which warning signs are present, and which window is he in?
2. Who asks him, when, and where — and what exactly do they say?
3. What would have to already exist in your house for this to go well?

03

Intervention

What happens in the twenty minutes after someone tells you — and in the housing decision that follows.

INTERVENTION

Ask the question, in plain words

Say this

"Are you thinking about suicide?"

"Are you thinking about killing yourself?"

Not this

- "You're not thinking of doing something stupid?"
- "You wouldn't hurt yourself, would you?"
- "Are you having thoughts of self-harm?" — vague, clinical, easy to dodge
- Any question phrased so the easy answer is no

Asking does not plant the idea.

This is the most persistent myth in the field and the research does not support it. Asking directly does not increase suicidal thinking or behavior. What it does is end the isolation — for most people it is the first time anyone has been willing to say the word out loud with them.

Then stop talking. Let the silence sit. The pause after the question is where the answer comes from.

INTERVENTION

When the answer is yes

1

Stay

Do not leave. Not to get a phone, not to find a supervisor, not for a minute. If you need someone else, call from where you are or send a third person.

2

Listen

Let them say it. Do not argue, problem-solve, or list reasons to live. "Tell me more" and "how long has it been like this" are the whole toolkit here.

3

Ask more

Have you thought about how? Do you have access to that? Have you done anything already today? Have you attempted before? These questions guide urgency.

4

Decide together

Choose a level of care with the resident, not for them. Build the safety plan now, while you are both in the room, not later.

5

Connect and follow up

Warm handoff, not a phone number on a napkin. Then check in the next day, and the day after. Follow-up contact is itself an intervention.

Not leaving is the whole first step. Most of what goes wrong in these situations happens in the four minutes a staff member spends walking down the hall to find someone more qualified.

INTERVENTION

The safety plan

The Stanley–Brown Safety Planning Intervention: six steps, written with the resident in their own words, on paper they keep. Twenty minutes, no clinical license required to complete one with someone.

1 Warning signs

How they know a bad night is starting — the thoughts, feelings, and situations that come first.

2 Internal coping

What they can do alone, without calling anyone. Music, a walk, a shower, the gym, prayer.

3 People and places that distract

Not for talking about the crisis — just for being around others. The kitchen, a meeting, a housemate.

4 People they can ask for help

Named people with phone numbers. Sponsor, sibling, a specific staff member — not "my family."

5 Professionals and crisis lines

988, mobile crisis, their prescriber, the local ED. Numbers written out, not looked up later.

6 Making the environment safer

What gets stored, held, or moved during this period, and who is holding it. Agreed with them.

Two copies: one they keep, one in the file. Review it at the next check-in — a plan written once and never mentioned again stops being a plan.

INTERVENTION

Choosing a level of care

STAY AND SUPPORT

Thoughts present, no plan, no intent, no recent attempt. Willing to make a plan and to talk again tomorrow.

- Complete a safety plan together
- Increase check-ins — name times, not "we'll keep an eye out"
- Same-day contact with their clinician or prescriber
- Notify the supervisor and document

CALL 988 OR MOBILE CRISIS

Intent is present, or a plan is forming, or you are simply unsure. Uncertainty belongs in this column, not the first one.

- Call from the room, with the resident, on speaker if they agree
- 988 is for staff too — you can call for consultation
- Request mobile crisis if your county has it
- Stay with them until someone takes the handoff

EMERGENCY SERVICES

An attempt has happened or is in progress, they have the means at hand, or they cannot stay safe until help arrives.

- Call 911 and say it is a psychiatric emergency
- Ask for CIT-trained officers if available
- Stay with them; send someone to meet the ambulance
- Notify leadership immediately

When in doubt, move up a column. Nobody has ever been harmed by a 988 call that turned out to be unnecessary.

INTERVENTION

Six things to stop doing

Do not use a no-suicide contract

Asking someone to sign a promise not to die has no evidence of effectiveness and can suppress disclosure. A safety plan replaces it.

Do not promise secrecy

Say it before they tell you: "I can't promise to keep this between us, but I can promise I won't tell anyone who doesn't need to know."

Do not leave them alone

Not while you find someone, not while they "get some air," not overnight while acute risk is present.

Do not debate or minimize

Reasons to live, comparisons to people worse off, and reminders of their progress all read as an argument. They stop talking.

Do not make it a performance review

A crisis conversation is not the moment for rule violations, chore charts, or the conversation about last week.

Do not handle it alone

One staff member holding a resident's suicidality privately is bad for the resident and unsustainable for the staff member.

INTERVENTION

The hardest call: use, risk, and the bed

A resident returns to use. Your policy says discharge. In the same conversation they disclose suicidal thoughts. Almost every residence faces this, and almost none have it written down in advance.

1

Separate the two decisions

The response to the use and the response to the risk are different decisions on different clocks. Handle the crisis first. The housing question can wait a day; it has waited longer for less.

2

Never discharge into homelessness during acute risk

Discharge removes every protective factor at once — contact, structure, peers, purpose — at the exact moment risk is highest. If a person must leave, they leave to a place, with a person, at a planned time.

3

A warm handoff, not a bus ticket

A confirmed bed, a named contact, transport, and a call from you to the receiving program. "We gave him some numbers" is not a transition plan.

4

Write the policy before you need it

Decide now, as a program, what happens when these collide. At 11pm with a crying resident in the office is the worst possible time to invent it.

INTERVENTION

Documentation and confidentiality

What to document

- What the resident said, in their words and in quotes
- What you observed — behavior, not interpretation
- What you asked and what they answered
- What you did, who you contacted, and when
- The safety plan, and where the copies went
- The follow-up you scheduled, and whether it happened
- Facts and times. Not your theory of why.

What you can share

- Programs handling SUD records may be covered by 42 CFR Part 2 — stricter than HIPAA
- Part 2 includes a medical emergency exception permitting disclosure to treating personnel
- Get a signed release at intake naming emergency contacts, before you need one
- Share on a need-to-know basis: the responder, the supervisor, the clinician
- Housemates are not need-to-know
- Consult your own counsel — state duty-to-warn law varies

Documentation protects the resident first — it is how the next shift and the next provider know what happened — and it protects you second. Write it the same day.

PAUSE AND DISCUSS

Case two: Sunday night

THE SITUATION

Dana tests positive on a Sunday evening. She is four months in and has been doing well — job, sponsor, the whole thing. House policy is same-day discharge for a positive screen.

When the house manager tells her, she goes flat and says: "It doesn't matter. I'm not going to be around anyway."

It is 9:15pm. Her family is out of state and not speaking to her. There is one staff member in the building. The nearest shelter stopped taking intakes at 8.

TALK IT THROUGH

1. What are the next three things the staff member does — in order?
2. What happens with the discharge tonight, and who decides?
3. What would you need in writing so this is not improvised?

Small groups, 3 minutes, then two quick reports back to the room.

04

Postvention

What you do after a death — for the family, the house, and the staff. Almost no residence has this written down. It is used on the worst day the program will ever have.

POSTVENTION

Postvention is prevention

Postvention is the organized response after a suicide death: supporting those affected, reducing the risk of further deaths, and helping a community grieve without harm. In a congregate setting it is not optional — it is the next cycle of prevention.

Exposure is high risk

People exposed to a suicide death are themselves at elevated risk. In a house, everyone is exposed within hours.

Contagion is real

Clusters happen in connected communities. Sensational detail, method information, and glorifying accounts all raise the risk.

Your residents are vulnerable already

Everyone in the building carries the population risk factors and has just lost someone they lived with.

The response is the message

How leadership handles the first week teaches every resident whether this is a place where distress can be spoken about.

Write the plan now. You cannot build this while you are inside it.

POSTVENTION

The first 24 hours

1. Confirm the facts before anything else. Rumor moves faster than truth and is harder to retract.
2. Notify leadership and activate the response team. One person coordinates; everyone else has a task.
3. Contact the family. Ask what they want shared, including whether the cause may be named.
4. Designate one media and inquiry contact. Nobody else speaks for the program.
5. Tell the house in person, in small groups, before they see it on a phone.
6. Put support in the building the same day — counselors, peer supports, the clinical partner.
7. Identify residents at highest risk right now and assign a named person to each.
8. Increase staffing and overnight presence. Do not leave the house thin tonight.

Assign these to roles, not names — the person who would normally do it may be the person who found them.

POSTVENTION

Telling the house

How

- In person, in small groups — never a group text, an email, or a full house meeting as the first telling
- Two staff present: one talks, one watches faces
- Plain words. "Died by suicide," if the family has authorized it
- No method, no location, no details from a note
- Say clearly that this was not anyone's fault, including theirs
- Say that suicide is preventable and that help works — every time
- Name what support is available today and where it is, physically
- Then stop talking, and let them react however they react

A place to start

"I have hard news, and I want you to hear it from me. James died last night. His family has told us he died by suicide.

I'm not going to share details, and I'd ask you not to either. What I want you to know is that this is not your fault, and it wasn't inevitable.

Some of you are going to feel this hard. Sarah is here all day, 988 is on the fridge, and any one of us will sit with you. Please don't do this alone tonight."

POSTVENTION

Days two through fourteen

Who needs more, today

- The roommate and closest friends
- Whoever found them, or was last with them
- Residents in their first 30 days
- Anyone with a prior attempt or recent crisis
- Anyone who has lost someone to suicide before
- The quiet ones nobody is worried about

What the house needs

- Keep the routine — chores, meetings, curfew, meals
- Extra check-ins, scheduled and named, not ambient
- A staffed space to talk that is not a formal group
- Watch for returns to use; grief and craving travel together
- Screen again — everyone, within the week
- Watch what is circulating on phones

What to hold off on

- Large assemblies as the primary response
- Permanent memorials, plaques, dedications
- Any account that romanticizes or mythologizes
- Big program changes announced in week one
- Sending affected staff home to be alone
- Assuming silence means someone is fine

Keeping the routine is not callousness. Structure is the thing holding the house together this week, and removing it removes the floor.

POSTVENTION

Memorials, belongings, and the room

1. **Treat every death the same way**

   Whatever the house does for a resident who dies of any cause, do that. Different rituals for a suicide death send a message about shame — and identical ones send a message about dignity.

2. **Choose living memorials over permanent ones**

   A scholarship, a service project, a donation, a recovery event. Permanent fixtures in a shared living space can become a daily focal point for residents who are struggling.

3. **Involve residents in deciding**

   A response imposed from above satisfies no one. Let the house help choose, with staff holding the boundaries about method detail and glorification.

4. **Handle belongings with care and a witness**

   Coordinate with the family and law enforcement. Two staff, documented, never a resident. Ask the family before returning anything.

5. **Talk about the room first**

   Do not move a new resident in silently. Decide with the house how long it stays empty, and tell the incoming resident something true before they arrive.

Anniversaries need a plan too. Put the date in the program calendar and decide in advance who checks on whom.

POSTVENTION

The people who work here

Staff and peer workers in recovery housing are not neutral professionals at a distance. Many are in recovery themselves, many were close to the person, and some will have their own history with suicide.

Nobody works this alone

Not the notification, not the belongings, not the overnight after. Pair people up for every hard task in the first two weeks.

Peer staff need their own support

Lived experience is the reason peer specialists are effective and the reason this can hit them hardest. Supervision, not just gratitude.

Expect the guilt

Almost everyone will replay the last conversation. Name it before it festers: hindsight manufactures signals that were not visible at the time.

Cover the shifts

Someone who cannot work should not be working. Build the coverage plan into the postvention plan, before you need it.

Watch the long tail

The hard week is often week three, when the crisis response has ended and everyone else has moved on. Check in then, deliberately.

Make outside help easy

EAP numbers, a therapist list, a peer support line. Handed to people, not posted on a wall.

POSTVENTION

Thirty to ninety days out

Review, without blame

- What did we know, and when did we know it?
- Where did our own protocol not get followed, and why not?
- What did the protocol not cover at all?
- What information existed but never reached the right person?
- What do we change in writing as a result?

A systems review, run by leadership, oriented to the process rather than to individuals. If it turns into a search for who failed, you will never get an honest one again.

Close the loop

- Update the policy and re-train on the parts that changed
- Put the anniversary on the program calendar now
- Keep checking on the residents who were closest — well past the point people stop asking
- Follow residents who have since moved out; exposure does not end at discharge
- Tell staff what changed, so the review visibly mattered
- Return to prevention — this is where the cycle restarts

Postvention ends where prevention begins. Everything you learn in this review belongs in section two of this deck.

PAUSE AND DISCUSS

Case three: Friday morning

THE SITUATION

A resident died by suicide off-site on Thursday night. Police notified the program at 6am Friday.

By 7:30am, six residents have seen a post about it on social media. Two of them are in their first month. One is his roommate, who is standing in the kitchen and has not said anything.

His mother has asked the program not to tell anyone how he died. The house manager, who knew him for two years, is in the parking lot and cannot come inside.

TALK IT THROUGH

1. What happens in the next two hours, and who does each piece?
2. What do you say, given what the family has asked?
3. Who gets a named person assigned to them today?

Small groups, 3 minutes, then two quick reports back to the room.

BEFORE YOU LEAVE

Eight things, each with a name and a date

- [ ] A screening tool chosen, and the moments it gets used written down
- [ ] A written answer to: what happens when a disclosure and a discharge collide
- [ ] Gatekeeper training scheduled for every staff member and peer
- [ ] CALM training completed by designated responders
- [ ] Medication storage and a weapons-free policy in the resident agreement
- [ ] Releases signed at intake naming emergency contacts
- [ ] A one-page postvention plan, with roles and backups for every role
- [ ] Local numbers filled in: mobile crisis, the nearest psychiatric ED, your clinical partner

Pick the one that would have mattered most in the three cases we just discussed. Start there, this week.

TAKE THESE WITH YOU

Resources

Crisis

- 988 Suicide & Crisis Lifeline — call or text 988, 24/7
- Crisis Text Line — text HOME to 741741
- SAMHSA National Helpline — 1-800-662-4357
- Your county mobile crisis team: _____

Training

- CALM: Counseling on Access to Lethal Means — free, online
- QPR, safeTALK, ASIST — gatekeeper trainings
- Mental Health First Aid
- Zero Suicide framework — organizational model

Tools & guidance

- Columbia Protocol (C-SSRS) screener — free
- Stanley–Brown Safety Planning Intervention
- SAMHSA TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment
- SPRC — Suicide Prevention Resource Center

Postvention & loss

- AFSP / NAS: After a Suicide — postvention toolkits
- Responding to Grief, Trauma, and Distress After a Suicide — national guidelines
- Survivors of Suicide Loss support groups
- NARR — recovery residence standards

Fill in your local numbers before you deliver this deck. A resource slide with a blank line on it is the one nobody uses at 2am.

Three things to carry out of here

1

Ask the question

Directly, in plain words, out loud. It does not plant the idea, and it is the one thing every single person in this room is qualified to do.

2

Do not let a crisis become a discharge

The bed, the routine, and the people are the protective factors. Separate the housing decision from the crisis,and make it in daylight.

3

Write the plan before you need it

Screening moments, the disclosure-and-discharge policy, and one page of postvention with roles and backups.

988 · call or text, 24 hours a day · for residents, and for you

Questions