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Presenter: Shanna Sorg, Safer Homes Collaborative, Missouri Institute of Mental Health/UMSL

Topic: *Suicide Prevention, Intervention & Postvention in substance use Recovery Housing*

[00:00:00] **Moderator:** Today's presenter is Shanna Sorg, co-founder and director of Madison County Recovery Allies.

[00:00:06] Shanna is a public health professional, suicide prevention advocate, and recovery support leader with nearly two decades of experience advancing community health initiatives across Missouri. She is co-founder and director of Madison County Recovery Allies, a Five Oh One C Three organization providing substance use recovery support and housing in her rural community in Southeast Missouri.

[00:00:32] An active member of the Missouri Coalition for Recovery Support Providers, Shanna is a strong proponent of the all pathways to recovery model and is especially inspired by the opportunities recovery creates for individuals and families to heal, reconnect, and thrive. Shanna also serves as a senior program coordinator with Safer Homes Collaborative, a suicide prevention research and outreach project of the Missouri Institute of Mental Health at the University of Missouri-St Louis, where she partners with community coalitions statewide to expand access to evidence-based prevention, education, and training.

[00:01:13] She holds a Master of Arts in Human Development and Family Studies from the University of Missouri-Columbia. Shanna, the floor is yours

[00:01:28] **Shanna Sorg:** Awesome. Thank you for that introduction. And thank you so much to the Fletcher Group for, um, providing this opportunity to connect with recovery, um, professionals and talk about suicide prevention. It's an important topic, and, uh, I'm happy to be here today, and thank you to everyone that was able to join us today

[00:01:48] So today's presentation Suicide Prevention, Intervention, and Postvention in Substance Use Recovery Housing. It's important that we're talking about this topic. Most of us in this recovery space we're either on our own path to recovery, um, working with folks in recovery. Mental health challenges happen suicide ideation happens, and we need to be prepared aware, prepared, and ready to respond if we find ourselves in a space where, uh, someone we're working with is thinking about suicide or has disclosed suicidal thoughts.

[00:02:29] So this work is close to home, right? As I mentioned, in this recovery space mental health struggles are common, and with that sometimes comes suicidal ideation. This is the field I work in, so I speak very openly about suicide. And that's the whole presentation. We're gonna be looking at the three different spaces in suicide prevention.

[00:02:54] The prevention piece intervention, and postvention. While we're talking about suicide today there's a possibility that you might experience some feelings you didn't think you would experience. Uh, most of us have lost someone to suicide. Most important thing in today's presentation is you take care of you.

[00:03:18] So if you, um, start getting overwhelmed or you feel like you need to step away from the presentation, or if you're halfway through and it's overwhelming, do what you need to take care of yourself, please. Um, suicide is a tough topic to talk about. The recording is gonna be on the Fletcher Group's website, so if for some reason you have to step away but you still wanna finish it circle back and access that online access.

[00:03:45] Um, and also I wanna remind everybody that support is here. Um, we've got Erica working monitoring the chat. Wanna remind everyone that 988 is an option for all of us to use. Um, it's a great resource. If you're struggling with anything 988 is there. We'll talk directly about suicide by name. We'll not discuss any specific methods today, and I'll ask you to refrain from any specific details too in this room or in the house, and we're gonna talk more about how we talk about suicide as we go through the presentation.

[00:04:25] So, um, what we're gonna get through today, what I'm hoping you guys are able to walk away with today. Recognizing those warning signs understanding that working with substance use, folks in substance use recovery is, is a high-risk population for suicide. So recognizing, asking, asking the question directly.

[00:04:47] When we're worried about somebody, when we're concerned that somebody might be thinking about suicide asking directly is the best way to communicate with them. The third takeaway is that respond takeaway. We're gonna talk about building a safety plan, choosing a level of care making decisions in the house that don't turn into a disclosure about a suicidal thought, don't turn into a, a discharge, and, um, recover.

[00:05:15] What happens if, uh, there's a suicide death in, in our recovery house? What, what does the first 24 hours look like? What do the first few weeks look like? That's that postvention space. These are all important. The, it's the whole suicide spectrum when we're talking about prevention, intervention, and postvention.

[00:05:35] Everything that we're talking about today is acceptable, uh, for peers to lean into and use these resources. We're the ones that have direct contact on a regular basis with our peers, our clients, and our residences. This, all of this information, all of the tools that are provided today, um, you don't have to be a clinician to use these tools.

[00:05:58] We're good to go on everything that's gonna be talked about How we're gonna spend our time together. Hopefully, if I stay on task we're gonna take a, a d- dive into why we're, we're talking about this population, that substance use recovery population. Um, we're gonna step into that prevention space, which is work that you are all already doing.

[00:06:22] Um, supporting those in recovery, that's a huge prevention piece. Um, we're gonna talk about that more. Intervention. What happens if someone discloses? How do we ask?

What happens if somebody says, "Yes, they're, they are thinking about suicide"? That intervention piece. Um, spend some time on that postvention.

[00:06:41] If we lose a resident to a suicide death, um, h- how does that work? What's the plan? Way better to be prepared for that situation than trying to figure out what to do in that situation. Um, we have three short case discussions built in. Um, we're gonna try to get through those, hopefully get some audience participation.

[00:07:03] But again, it's a tough topic, and we're here. We're talking about it, and I, again, appreciate y'all being here. Um, again, take care of yourselves. Do what you need to do. It's a tough topic. We talk a lot about prevention, but I do wanna throw out there that not every suicide can be prevented. Um, sometimes our best efforts, and we still lose people to suicide, and it happens, and it's sometimes out of our control.

[00:07:29] So if you've loved s- lost someone to suicide don't take that guilt on. It happens. But we're here to learn and hopefully prevent in the future. And I do wanna note everything that we learn today about suicide prevention, intervention, and postvention in recovery settings, please feel free to use these tools in your outside-of-work life as well.

[00:07:53] Right? The more we know, the more, um, we're aware of the risk factors and, and how to engage in these conversations, uh, the more we can help everybody, not just the people that we work with, but the people that are in our circles outside of work as well. So why this population? Recovery housing concentrates almost every known suicidal risk factor under one roof, um, and it adds a few of its own

[00:08:23] We lose almost 49,000... We lost 49 thou- almost 49,000, uh, folks to suicide in the US in 20- tw- uh, 2024. Um, it's, it's a pretty high rate. But if we're talking about folks in substance use recovery they're at a, a much higher rate, uh, for suicidal thoughts that 10 to 14 times higher than the general population.

[00:08:51] So we need to be learning these skills. We need to be aware, um... it is definitely something that we encounter as a recovery house staff and administrators. And 22% of suicide deaths involve some type of intoxication. Alcohol and opioids are pretty common in a suicide death. I do wanna point out the num- the dark bar at the bottom.

[00:09:18] So we pointed out that almost 49,000 deaths in 2024 from suicide, but look at the numbers at the bottom. Uh, 14.3 million US adults seriously thought about suicide in that same year. So as you can see, suicidal thoughts happen often. Action doesn't happen as often, right? We have to understand that in a house of 12 residents with substance use disorder, the odds that no one is carrying this, that no one is thinking about suicide, that no one is considering suicidal thoughts, those are pretty low, but action is even lower, right?

[00:09:58] It doesn't happen often, but we need to be prepared in case we find ourselves working with a client that's actively thinking about suicide

[00:10:12] And other things that we need to think about why this population is important and why this presentation, why it's so important y'all are here learning with us today. Lots of increased risk factors in this 10 to 14 time multiplier, right? That we looked at on the last screen. That shame and self-judgment on the bottom, in the middle there.

[00:10:34] Early recovery returns the memory of what happened while using. Feeling like a burden is a documented driver of risk. We talk about that feeling of being a burden frequently in the suicide prevention space. That's, it's, uh, what a lot of the research on suicide prevention is based on, is that feeling of burden, and I'm sure most of you can understand and under- uh, see how our peers and our clients have that feeling of burden sometimes.

[00:11:05] And in recovery housing, that their bed, their house, right? The roof over their head is tied to how they show up and participate in a recovery program. So if somebody is struggling with a suicidal thought, they're... M- they may also be thinking if they disclose that, they could lose their housing over it.

[00:11:27] So it kinda adds another layer in this, um, su- uh, substance use prevention space. We're gonna talk about some suicide screeners here in a little bit when we get into the prevention. Don't think about if somebody discloses suicidal thoughts in a intake, that's a reason to screen them out. It's not.

[00:11:50] It's, it's... They're expressing they're struggling. It's just another space that we need to help make sure that they're getting the care that's needed in that space, right?

[00:12:04] So overdose deaths we see them in the substance use recovery space, substance use space. And quite frequently, it's, it's hard to tell if a, a overdose was accidental or intentional. What we're gonna talk about today, uh, regarding overdose, think about your policies for your recovery program, right?

[00:12:28] How you handle overdose, and consider moving into a space where we think about every overdose as possible suicide. Could be could be something that someone did to end their life. And if we think about that nobody can reliably sort out the intentions when we're talking about an overdose death.

[00:12:52] Um, somebody might have made a comment like they didn't care if they woke up, if there's a overdose, even if there's not a death, right? That... Those are suicidal thoughts. Um, so the practical rule, that message there at the bottom for us after any overdose in your house, including one every ca- everyone calls an accident implement a suicidal screening process for everybody in the house.

[00:13:20] Don't single out anybody. And we're gonna talk about those screeners here in a little bit. And again, these are non-clinical tools. Anybody can use these. Um, and a reminder there about naloxone, and, uh, the, the direct question belong in the same protocol

[00:13:39] When we're talking about suicide and suicide deaths much like substance use disorder, there is language that is i- it's it's better used, right? Instead of committed suicide,

we, we f- are trying to shift the language to died by suicide. Um, when we have that committed piece there, we usually think about committed as a crime.

[00:14:03] Someone committed a crime or someone committed a sin. So trying to move away from using that word committed because suicide is not either one of those. Um, it's, it's a mental health struggle. A successful or a failed attempt. Neither. There's nothing successful about suicide, so we're trying to shift the language to suicide attempt, not getting the suici- the successful or the failed.

[00:14:32] To avoid, "You're not thinking of doing something stupid, are you?" Which is a question. It's, it's a way to start a conversation if we're worried about someone, but we're trying to move away from that. "Are you thinking about suicide?" Direct language when we're worried about someone is the best way to start that conversation.

[00:14:53] If we're dealing with a loss, a suicide loss, we wanna just keep a general description of the death. We don't wanna go into method, location any details. We, we wanna keep it general description of the death. And last thing we wanna try to avoid is "He seemed fine. Nobody saw it coming." We wanna try to...

[00:15:18] He was struggling and, and it was treatable. If, if we lose somebody to a suicide death we wanna acknowledge that person was struggling, and we wanna make sure that we reinforce it is treatable. That if intervention happens, usually in time we can save a life. So anytime suicide comes up in a house meeting, close the same way.

[00:15:42] That it's treatable, help exists, and there are resources. It says, "Here's the number." I would normally say 988. We don't have a slide on 988. I'm gonna jump in there real quick before we move into our prevention, 'cause I wanna make sure everybody's aware of 988 and what it is, and it's a national number.

[00:16:02] You might see 988 material branded with your state particularly, um, because each state receives funding to implement their 988 program. I know in Missouri, all the material we get from Missouri 988 has Missouri on it, right? But each state has 988. It's a national program. It's a lot like 911, right?

[00:16:25] It's that three-digit phone number. 988, we use it, though, if somebody's struggling with a mental health crisis, if somebody's thinking about suicide. If we're trying to help someone with a, a, something in the mental health space that we're not confident with, including suicide, we can call 988 and they will help us help another person.

[00:16:47] 988 does not automatically dispatch. We're all very familiar, I'm sure, with how 911 works, right? If you call, even if it's an accident, there's a good chance that police officers or some type of first responders are gonna be showing up at that location. 988 does not do that. Unless the caller is threatening to hurt themselves or hurt another person, they do not automatically dispatch.

[00:17:10] It's a good place to just connect with somebody who can help identify resources and get somebody connected with resources. Okay, I'm jumping off the 988 box, soapbox, and moving on with our presentation. I work in this space. I talk about 988 all the time, and I forget not everybody's works in this space.

[00:17:28] So I would like to give a, you know, that high-level overview and make sure everybody's aware that it's a resource for all of us. So moving into this prevention part of our presentation today. Again, we are all working in suicide prevention by being that, that connector, by being that person people talk to by helping provide that stable housing.

[00:17:54] Those are all suicide prevention resources. Um, what we really wanna talk about in this prevention sp- space is the work we do before someone's in a crisis. What to look for, when to look for it, and, um, how to move forward with helping getting that person connected with services to prevent the crisis So when we're talking about substance use recovery, we've got two different categories of risk factors that our peers, our clients are existing in.

[00:18:28] Those standing risk factors we'll know those at intake, right? Usually. W-we get a pretty good picture of somebody's background during intake processes. But these, on the left, the standing risks we wanna make sure that if they're disclosing these standing risks during that intake, that we're noting that in their case, that we're making plans to keep a closer eye on them or, um, circle back with more frequent contact these standing risk factors.

[00:19:05] Acute risk factors are where a residence has an a- where we have an advantage to clinicians. We see our, our residents on a very regular basis daily usually, right? Usually way more than once a week. A clinician sees clients, peers, maybe on a weekly basis. They don't see the behavior changes that we in the house can see.

[00:19:34] Um, you see that resident every day. You know when they got that phone call from their ex or from a family member that has upset them. You know when their court date is coming up that they might be anxious about. You know when someone stopped going to their meetings. These are all things we need to be aware of.

[00:19:53] Usually suicide doesn't have one cause. Usually they are, uh, layering. Stressors build up, right? So as peers working with folks in a, in a recovery house situation, we're way more informed about what's happening in their life on a more day-to-day basis than clinicians do. We're working in, in partnership with clinicians, right?

[00:20:19] There's definitely a role for them in this space, but we have a role as well. I wanna point out that last bullet point, that stopped medication. We would see that before a, a clinician would see that, and that can really elevate somebody's risk for, um, suicidal thoughts or suicidal actions. So just be aware that we are in a very helpful space when it comes to suicide prevention and the clients, peers we work with in, in the homes.

[00:20:52] So for suicide prevention we have these five windows we really wanna think about where risk is, it could be, uh, risks can be high high elevated, right? That first thirty

days. They're coming in from a detox or inpatient or jail. They're at a elevated risk. Things are new. They're getting familiar.

[00:21:15] They're, they know that when they start a recovery program, the clock is ticking until they're expected to be moving out of the recovery program, right? So that adds a little extra stress. We wanna be aware those first thirty days. After a return to use, there's shame and it's that burden that we talked about earlier, um, and that they have...

[00:21:39] they feel like they have failed. Those can build up, right? That's, those, those stressors that build up, that can definitely be a layer. If a client or a resident is on notice, right? Rule violation, discharge notice, or an eviction. Uh, the bed and the recovery are experienced at the same, as the same thing.

[00:21:59] So, so losing one feels like losing both. Dates that carry weight. We get to know our, our clients, our, our peers that we work with. Um, think about in their file, in their calendar, marking important dates. These can be tough for some folks in recovery, right? It can add that extra layer of stress. So that's a, a high-risk window we wanna be aware of.

[00:22:28] And moving out. A good transition removes daily contact structure and the people who would notice if they were struggling. Um, successful discharge needs t- a follow-up. So we think about somebody leaving a recovery program, right? We're happy for them. We're, we know they're moving on with their recovery journey, but it can also really be, um, a stressful time in their emotional and their mental health.

[00:22:55] So just be aware. Think about those follow-up plans, a thirty-day follow-up. Contact, reach out. It's a phone call, right? I know we're all busy, but just connecting once they've left your program, um, is a great way to help reduce these risk, that risk factor.

[00:23:17] So what it might actually look like in a recovery house. There are some spaces, things you might hear, what things you might see, behavior changes we might observe when somebody is experiencing suicidal thoughts. Um, everyone would be better off. I'm done. I can't do this again. Don't worry about me after Friday, right?

[00:23:41] If they have that court date, if they have some stressful event coming up and make a comment like that, that is definitely a red flag. They feel like they're trapped or a burden. No sense, no future tense, no plans past this week. Things we might see, giving away their possessions or money. As we know, most of the residents in recovery housing, they don't have a whole lot to begin with, um, while they're staying there, right?

[00:24:08] They're usually trying to rebuild their lives and rebuild what they have, and if they're giving away what little they have, that is definitely a red flag. A sudden calm after a stretch of visible distress. This is one, and it's highlighted at the bottom as well. This is one we really need to be thinking about and keeping an eye out for.

[00:24:29] So for... We have a client, we have a peer that we've been working with, and, and they've obviously been putting out signals that they're stressed they're having some real

emotional or mental health struggles. And then all of a sudden, they're, they didn't get any resolution to that problem, but they've found some peace.

[00:24:49] There's a real possibility the peace is because they've decided to move forward with suicidal ideation. So keep that in mind. A sudden calm is not always a good thing. Yeah. Putting their affairs in orders, increased use or return to use, that could be a red flag as well. Those behavior changes.

[00:25:12] What, what I talk about in other trainings those behavior changes when it's a change from their normal, typical behavior. And as peers, again, we see them on a, a regular basis way more often than clinical staff usually. So when there's a change, anything sharply out of character, we're more likely to notice it.

[00:25:34] And those are opportunities to, to ask the question, to intervene, and get connected with additional resources if needed.

[00:25:46] As I've mentioned a couple times already, working in recovery housing is already doing prevention work, suicide prevention work. Um, it's the daily human contact, the structure and routine of a recovery program, right? It helps people, uh, feel more connected when they have that structure and that routine.

[00:26:07] Peers who've been there. A housemate two years in is proof that the thing the resident believes is impossible is not. That is hope made concrete. I love that saying. So peers, we're showing clients that we can move forward, right? That is hope made concrete. I love that. A reason to stay, responsibility to the house, a role, a job, a spons- a sponsor, right?

[00:26:35] Purpose and belonging are among the strongest prod, uh, protective factors we know. So the rest of this training is not to add to your program, not, not to try to put more work on your plate because I, I know peers are usually stretched pretty thin already, right? It's the work that we're already doing, making it more intentionally.

[00:26:58] Um, it's to make sure the house does not accidentally strip these away at the exact moment a resident needs them most. So that recovery space, it's prevention. Let's talk more about how we can keep that moving forward as a protective factor. So screening. There are screening tools out there, suicide screening tools that are available for free.

[00:27:23] There's training on how to use these screening tools. I know in the recovery organization that I'm associated with, suicide prevention screeners has, have never been part of the conversation. Um, I looked up the NARR standards. They're not required. S- and as you know, we're all busy, and the intake process is already, uh, usually a pretty long process.

[00:27:46] Adding a screener, a suicide screener, using it consistently with every client when they come in, it not only makes us as the peers peer support specialists more aware of the needs of our, our peers, our clients, but it also shows those clients, those peers that we talk about that in this space, and that's okay.

[00:28:11] We're gonna talk about the suicide screener. We're gonna ask you some questions, just like we ask everybody that comes through the program. It lets them know that this is a space where we can talk about this. That in itself is huge in the prevention talk. Um, there are lots of different screeners out there.

[00:28:29] I believe Erica's gonna put some of those in the chat. There's a resource we're gonna share with you guys at the end of today's training. Those are out there. They're free. Whichever one you decide to use as a organization, pick one, use it con- constantly, consistently, right? A tool used every time beats a better tool used only sometime.

[00:28:50] So if we're gonna use this screener we need to have a plan if somebody says yes. If the screener helps you discover that client, that peer is having suicidal thoughts, um, we need to have a plan for what we're gonna do after that, right? A screener without a plan is a terrible situation you don't wanna find yourself in.

[00:29:13] Um, so we're gonna talk about what that looks like, that intervention piece here in just a minute. I also wanna make sure- As an organization think about when you're gonna do this screening. At intake? Yes. Every resident, no exception. If there's a return to use or an overdose think about your policies.

[00:29:33] Is that a time? It is. It's, it's a good time to do the screening again. Is that something that your organization can implement into your policy? If after a discharge notice or a rule, rule violation. Um, again, these are all things that bump up that stress in the folks that we're trying to help, right?

[00:29:53] Um, so these, these screeners, they're not long. You don't have to have that clinical training, uh, no clinical license required to do these screeners. So think about when is a- appropriate for your organization to use these screening tools. And think about who's gonna, who's gonna utilize those screening tools.

[00:30:14] Again, non-clinical tools, so it can be any peer. Every peer could, um, be made aware. It could be incorporated into your intake process and these other opportunities, these WIN opportunities. Again, never screen without a plan for yes. Um, we're gonna talk about more of that intervention piece here in just a second.

[00:30:36] But, um, I hope that this information so far has your wheels turning, right? What could you be doing in your recovery organization to be doing more suicide prevention emphasizing the work that's already being done?

[00:30:53] So, um, building that house where people wanna open up and they wanna tell you, right? Again, doing that screening tool, just letting them know that we're gonna talk about it here. E- expressing that you understand that they're going through stressful times entering this recovery, building that new life.

[00:31:16] Just making sure that they feel comfortable. That's the most important part of this, right? Building that house where they're willing to talk to you about it. Make sure. There's my

988, make it visible, right? 988 magnets w- they're avail- I know in Missouri, I don't know about other states, I can imagine that they're pretty as easy as they are in Missouri to access.

[00:31:39] I... If I go on the Missouri 988 website, there's a, a shopping cart I can fill with magnets and pins and handouts and all kinds of 988 logoed material, and they'll ship it to me for free. So making sure we're utilizing that making people aware of that. If naloxone is out, 988 should be partnered with it, right?

[00:32:05] Again, name it in that intake process, right? Um, we're, we're bringing it up there. Say it explicitly, explicitly and in writing. Tell us if you're struggling. It'll never cost you your bed, right? Make sure they understand that, um, addressing those crisises, those stressors is not a r- a program violation.

[00:32:29] It- it's an opportunity to get connected with services. Whatever that looks like in your space. Staff and peers who can say, "I've been there and I've asked for help." We all know that does more for disclosure rates than any poster can ever do. That's why, uh, peers work the magic that they work with this population so reducing access, that's specifically the space that I work in su-suicide prevention, reducing access to lethal means, uh, things that somebody might use in a suicide attempt.

[00:33:04] Those need to be in your policies if you can. A written weapons-free policy. Honestly, I'm not... I assume that our policy at the recovery organization that I, I work with, I assume that there's something in our policy that talks about weapons and firearms not being allowed on the property. Something I'm definitely gonna circle back to.

[00:33:28] The secure medication storage. I know everybody has their own practices policies on how medication is stored. They, uh, recommend that the most secure is that each resident has their own container that's locked that they can access, that only they can access. That is reducing a means. If there is something in the house or if there is something that a resident, a peer has in their possession that could be used and they've disclosed it, that they've thought about using it in a suicide attempt, it's up to them, but talk to them about possibly removing whatever that item is.

[00:34:09] See if they don't have a family or friend that they could store that pers- that item with. And, uh, again, pair it with overdose response. Naloxone is stocked, staff is trained in the same follow-up protocol, whether the event reads as an overdose or self-harm. None of this requires a conversation about specifics, and none of it should include one.

[00:34:34] Write a policy and enforce it the same way for everyone. Um, you know how that is in the recovery space. We have those policies. Um, we enforce it across the line. Nobody feels singled out that way and we're following our own rules for everybody So there are, um, a lot of different suicide prevention trainings out there in the world.

[00:34:57] The, this first column, the everyone column, all staff, all peers, all volunteers. Gatekeeper training is what we call it in suicide prevention space. Uh, QPR, which is question, persuade, refer, or safe talk I know for a fact QPR can be taught in an hour. I teach

it frequently. And that's just helping people recognize those warning signs, helping folks understand how to talk to somebody that we're worried about that might be thinking about suicide, and how to c- connect them with services.

[00:35:34] So everybody can take QPR. You can usually find it for free online. Again, there'll be information about that in the resource that Eric is gonna share. Designated responders, house managers, or on-call staff might take it to the next level, do ASIST or Mental Health First Aid. Um, I've seen those as a one to two-day training.

[00:35:53] I just myself upped, re-upped my Mental Health First Aid training recently. Um, there is a training out there that's called CALM, C-A-L-M. That's an acronym for Counseling on Access to Lethal Means. That's what my program that I work for, we teach, uh, our version of CALM, a program that was developed with the folks at CALM.

[00:36:14] And for many years, CALM was a clinician-only tool, but the folks with the CALM organization, they have re- revamped that. They have a public-facing training now for CALM. So, that helps us understand that lethal means safety, and how, uh, how important it is putting time and distance between someone who's thinking about suicide and a lethal means.

[00:36:37] Um, the more time and distance we can put between those, the safer that person's gonna be. Uh, another training, the safety planning, which we're gonna talk about here in a minute. Uh, Stanley-Brown format is the most widely used format. Again, you don't have to be a clinician to do that safety planning, that Stanley-Brown format.

[00:36:56] It'll be in the resources. And then there's, if any of... We have any directors, or if you have any meetings coming up, you wanna take some of this information back. The Zero Suicide framework, um, that's widely used in a lot of hospital settings, um, medical group, big medical groups. It might be something that if you're connected to a medical organization, you might wanna look into or you might wanna suggest.

[00:37:20] A postvention plan, that's something that needs to s- you know, originate with your director or your, um, whoever is overseeing your program. We're gonna talk more about postvention. Um, and policy Within your policy that operate your recovery organization operates under, disclosure of suicidal thoughts, discharge, documentation.

[00:37:45] We're gonna talk some more about that too here in just a minute. Again, most of these are a lot of free trainings. Ah, I'm looking at the clock and I'm talking way too much. Gonna keep moving forward. Check out some of these trainings though. It's good stuff. The more we know, the more we can help. So, uh, this prevention case study.

[00:38:04] Marcus is 34, and he moved in nine days ago. Um, he came straight from a 28-day program. He's polite, does his chores early, and he's not missed a meeting. On Tuesday, uh, he told a housemate that he was finally not going to be a burden to anyone anymore. Yesterday, he gave that same housemate his work boots, the good ones, the only ones he wears.

[00:38:25] He has a court date coming up on Friday. When the house manager asks how he was doing, he said, "Honestly, better than I've been in years," and smiled What are some warning signs we're seeing there? Feel free to drop it in the chat

[00:38:45] Warning signs for Marcus going through this right here

[00:38:49] **Moderator:** Shannon Waggoner writing on the chat, "The one that stood out to me immediately, and one I've experienced sadly in my life, is giving things away."

[00:38:59] **Shanna Sorg:** Definitely. Right? We talked about that earlier. Giving away those prized possessions. Thank you, Erica.

[00:39:05] **Moderator:** And Sandy pointed out in the chat that he was stating he, he didn't want to, he was not going to be a burden anymore.

[00:39:10] That another one, two or three more people mentioned that one, and sudden cal- sudden calmness and smiling. That was a good catch, Catherine, 'cause I didn't catch that one. Yep. Yep, and those all were things that we talked about earlier, right? Some of those warning signs. So thank you everybody who was able to share some thoughts on this situation.

[00:39:28] **Shanna Sorg:** Question two: who asks him? W- what's the next step? We- somebody's noticed. What exactly do they say?

[00:39:42] I'm trying to watch the chat. I'm also trying to watch the time. I'm so sorry. I could... This could be a, a three-hour training probably. Honest-

[00:39:49] **Moderator:** I was thinking that. I was like, "We should've, uh, this should've been a longer training."

[00:39:54] **Shanna Sorg:** So we wanna have a plan in place, right? If, if these warning signs are being noticed, we need to have a plan in place.

[00:40:02] We don't wanna be on the fly at that situation, right? We wanna make sure somebody knows that it's more than just keeping an eye on him. We wanna ask the question, "Are you thinking about suicide? Are you thinking about killing yourself?" It's okay to say these words. Um, we need to become more comfortable.

[00:40:19] They're hard words to say, but they're important words to say. Uh, what would you have to already... What would you have, uh, have to already have in place for this to go well? And those are those policy changes, those trainings the awareness that it's okay to talk to somebody about suicide when we're worried about them, and that's what we're all doing today.

[00:40:41] We're gonna move on. Thank you all so much. I see the chat number going up, so I know people are, are chiming in. Thank you.

[00:40:47] **Moderator:** Um- Yes, and they're right on track, by the way, Shana, with the questions directly asking.

[00:40:52] **Shanna Sorg:** All right. Awesome. Thank you so much. So intervention, what happens in those 20 minutes after somebody discloses that's, they might be thinking about suicide?

[00:41:01] It's important how this works, how this moves forward. So everybody but me is on silent. I'm gonna ask you to say these words out loud. Nobody's gonna hear you unless you're sharing an office. Nobody's gonna see you. Your cameras are off. We're gonna, we're gonna say them together. Both of these statements, "Are you thinking about suicide?

[00:41:22] Are you thinking about killing yourself?" when I count to three. One, two, three. Are you thinking about suicide? Are you thinking about killing yourself? They're hard words to say, but the more we practice them, the more likely we are to use them if we need them. We don't wanna say, "You're not thinking of doing something stupid, are you?

[00:41:45] You wouldn't hurt yourself, would you? Are you having thoughts of self-harm?" Self-harm is different than killing themselves. We don't wanna give them an easy out on these. If we're worried about them, the question needs to be direct. "Are you thinking about suicide? Are you thinking about killing yourself?"

[00:42:02] Big myth in suicide space, we are not planting a seed by asking those questions. We're opening a door for them to hopefully disclose and, and get some help. And there's a real possibility you may be the only one that's noticed, and you're the only one that's asking that question. Let- lets them know people care, right?

[00:42:22] So, yeah. If you find yourself in that situation, direct language is best practice. If the answer is yes, again, we wanna have a plan in place before that conversation. If the answer is yes, we wanna know what we need to do here. We're gonna stay. Stay with the person. If they answered yes to your question, don't leave them alone.

[00:42:46] We all have a cell phone within reach. If you've got to communicate at, with- outside of the office, use your cell phone. Listen. Let them say it. Don't argue with them. Don't try to problem solve or give them reasons to live. That's not the space for this. "Tell me more. How long has th- been like this?"

[00:43:05] We wanna keep that conversation moving forward. We're not there to counsel them, right? That's not what we do as peers. But we wanna keep that conversation moving forward. Ask more if you can. "Have you thought about how you would do it? Do you have access to that?" Decide together. Choose a level of care with the resident, not for them.

[00:43:25] We wanna use that safety plan that I've mentioned earlier that's gonna be in the, a handout with resources. Um, we build it with the client. We don't build it for them. And we w- just wanna make sure we connect and follow up, right? Same day if we can follow up with them. If we're not, if a crisis response situation is not needed, if we feel like we can just help talk through the suicidal thoughts we don't...

[00:43:55] We wanna make w- sure we're following up with that person. Make sure we have it in on your calendar. Whatever it takes to help you remember to follow up with that person. That safety plan that I mentioned earlier, there is the Stanley Brown Safety Planning. It is, it's a great resource. It's free.

[00:44:14] There's training on how to complete it. If you want to take the training, better understand how to utilize this tool, Check it out. Take a minute and check out the resource. When we get done helping them build the safety plan, make sure they have a copy of it. It's very specific. It's people, phone numbers specific activities.

[00:44:33] You're, you're gonna... P- preferably the client, the s- peer is writing their own safety plan, um, using their language. So you keep a copy, they get a copy, and we're making sure we're circling back to those stressful warning signs that they identify. Choosing a level of care. I, I mentioned earlier, not every disclosure about suicidal thoughts means 988 or mobile crisis or emergency services.

[00:45:02] If you feel like that the peer is, has expressed that they've been thinking about it, they don't have a plan, they don't ha- there's no intent, no re- re- recent attempt, um, they're willing to make a plan and they'll talk about it again tomorrow, that's acceptable. Um, you definitely wanna make sure you're connecting with your supervisor and disclosing that information.

[00:45:25] But not all suicidal disclosure has to be crisis response. Sometimes people just need to connect. Sometimes people just need to know somebody cares. However, if intent is present, or if they're been working on a plan, or they have those means if you're uncertain, call 988 or mobile crisis. Again, 988.

[00:45:48] They do not automatically dispatch. They're there to help a person or they're there to help a, a peer or a helper get through a situation. That level of care, emergency services, sometimes those are needed. If the suicidal ideation has moved into action if the person has already done something to move them into a, a suicidal death, right?

[00:46:14] Taken over- an overdose of medication or something 911 immediately, right? Ask for a CIT trained officer if available. When in doubt, move up a column. It... Call 988. It can't... No, it can't hurt to call 988, that's for sure. They're there. That's their job. Yeah. Call 988 for practice if you want to. Let them know that you're a peer support specialist and you work with a population in a elevated space for suicidal thoughts and crisis.

[00:46:43] You just wanna know what it's like to call 988. They're okay with that. They don't mind that practice call So six things to stop doing if it's happening in your recovery program.

Do not use a no suicide contract. Don't make someone promise that they're not gonna, uh, move forward with a suicidal ideation.

[00:47:05] That's not been shown to work, and it leaves a lot of weight on the peer. We don't want to add more to a peer's plate. Um, don't leave that person alone, right, until we've, uh, worked through a safety plan and identified which level of care. Don't make it a performance review, right? A crisis conversation is not the moment for rule violations, chore charts, or the conversation about last week.

[00:47:31] If they are disclosing suicidal thoughts, stay in that space. Let's not go into any other violations that may have occurred. You can't keep it a secret, right? But you are gonna only share with people who need to know. Uh, don't debate or minimize, right? We're not the therapist. We're peers. Stay in our lane.

[00:47:50] We're not gonna give them reasons to live. We're not gonna, you know, try to argue with them. This is where they're at. We're just gonna stay in that space with them, help them move into a safety plan or get them connected with, uh, additional resources. And as peers, don't handle it alone, right? We have enough.

[00:48:09] We have a lot. Our plates are usually overflowing. We do not need the stress of somebody's suicidal disclosure on our plate privately. Make sure we're sharing it with our supervisor getting support for ourselves as well. The hardest call if s- if there's a, a rule violation or a return to use and a suicidal crisis happening at the same time, your policy needs to dictate what you do here.

[00:48:36] And this presentation is suggesting that you hold on to that discharge for a minute, deal with the suicidal crisis first. Um, the last thing we wanna do is put somebody out on the street, taking away all those protective factors that a recovery house provides, um, when they're experiencing a suicidal crisis.

[00:48:58] Think about how your policy states you should handle that. Work towards putting it in your policy, how you would handle a suicidal disclosure and a return to use or a discharge happening at the same time. Like I said, w- the preferred, the safest, is deal with that suicidal crisis, even if it means finding an alternate place for that person to stay maybe bending your rules when it return, when it regards eviction.

[00:49:28] We wanna deal with that suicidal crisis first. I'm not debating with folks. I know what our policy says, in our organization, return to use is an eviction, right? They can't stay in the house anymore and be around people. But if there was also a suicide crisis involved, I would, we will deal with the suicide crisis first and return to the eviction when this is in a better space.

[00:49:53] Policy. It needs to be in the policy. I am so sorry, we are gonna run out of time. Oh my gosh. Um, so if someone discloses, we wanna make sure we're getting that documented. You wanna make sure you're putting it in their words in your documentation. Try not to be, uh, clinical. Don't use that clinical language.

[00:50:14] We wanna make sure, uh, we're putting in the documentation what the client has expressed. Uh, make sure that we're documenting that we've worked through a safety plan and dec- decided that level of care that's needed. We work under these HIPAA laws and the l- little bit stronger confidentiality rules if we're under a federal funding.

[00:50:36] So make sure you have that signed disclosure, so if you need to, uh, connect with a crisis response or your s- someone outside your organization that you have that signed disclosure already in place. Every state has different laws. Make sure you check with your state. Make sure you understand what your state guidelines are there.

[00:50:59] I'm not gonna try to override any of that. But we wanna make sure we're putting it in policy how we're gonna handle this situation

[00:51:09] Case two. Dana tests positive on a Sunday evening. She's four months in and has been doing well. Now, she has a job, she has a sponsor, and the whole thing. House policy is same-day discharge for a positive screen. When the house manager tells her she's tells her that she's, you know, she's had a, a positive te- drug screening, she has to be discharged from the program, she goes flat.

[00:51:34] "It doesn't matter. I'm not going to be around anymore," or, "I'm not gonna be around anyway," is her response. It's 9:15, uh, in the evening. Her family's out of state. She's not speaking to them anyone- anyway. Uh, there's one staff in the building. The nearest shelter stopped taking intakes at 8:00. What are the next three steps we're gonna do in that situation?

[00:51:57] We're running out of time. It's so important. The next three steps, so important that they happen in this order. We're gonna stay with Dana, right? That was step one. Don't leave them alone. Step two, we're gonna ask Dana directly, "Are you thinking about suicide? Are you thinking about killing yourself?" She has expressed that she doesn't...

[00:52:17] it doesn't matter, she's not gonna be around anyway, right? That's a big red flag. And then, and make the call, right? 988 your supervisor, whoever. Connect with somebody that can help you through this situation. What happens what happens next? On the discharge, the crisis and the housing decision are on two different clocks.

[00:52:40] The positive screen still gets addressed. Nobody is arguing that rule. But executing a same-day discharge into a night with no shelter, no family, and a stated indifference between being alive and being dead puts that person in a really bad situation. We wanna address that suicidal crisis first before we talk about the discharge.

[00:53:06] What would you need in writing so that it's not improvised? The third question, that's what we're talking about, getting it into your policy and procedures how you're gonna handle a suicide crisis, how you're gonna happen, handle a suicide crisis if it happens at the same time as a discharge. If it's in your policy and procedures, you have it there.

[00:53:26] Turn, lean into it. If it's not there yet, work with your director, um, explain the importance of having it in place Postvention. If we lose someone to a suicide death, that's this space, postvention. And it happens. Unfortunately, it happens. We wanna be prepared way ahead of time because if you find yourself in that situation, y- you can't move forward in a good direction if you weren't prepared for that situation.

[00:53:58] Postvention is prevention. When we're, um, supporting people in this postvention space we're helping build up those protective factors. It's prevention. We're working with that high-risk exposure contagion. Clusters of suicide happen, um, so we wanna make sure we're using neutral language. We're not going into graphic detail about methods.

[00:54:21] We're not sensationalizing it. Your residents would be in a very vulnerable space, right? If they lose someone in the house to suicide, whether it's in the house or away from the house. A suicide death is a level of grief most of us know it's, it's different than normal grief. Um, so our clients our peers, they're at a increased risk.

[00:54:43] Um, 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. We need to think about our policies. It's 2:00, and I'm sorry. I know we can't hold you guys over Postvention. There will be some resources in the handout.

[00:55:04] And, uh, yeah, look into it more. See about putting policies in place for what would happen if there was a suicide death with one of your clients. So sorry I've went over.

[00:55:19] It's so worth going over for, Shayna. Yes. I'm certainly willing to stay on a few more minutes. I think this is so important.

[00:55:25] There are a couple of questions I'd like to get to. Okay. So if those of you in the- Yep ... attendance are able to stay after just a few minutes, we're gonna try to get to some of these 'cause this is I think something that's worth staying a few minutes late.

[00:55:37] **Shanna Sorg:** Thank you. I appreciate the additional time, and here we go.

[00:55:41] So if there's a suicide death, the first 24 hours, this this crisis amount time, it really matters how it's dealt with. Again, policy is the best place for all of this to reside. We need to make sure we're connecting with the family of the person that has died. And it's at their discretion how we talk about the death.

[00:56:02] If it was a suicide and the family does not want that to be disclosed, then we should not be calling it a suicide. We know how social media is. We know how everybody talks. You'll hear people using the word suicide, but as, um, the peer support specialists we don't wanna confirm or deny. It's up to the family.

[00:56:22] If the family's okay with using suicide, speaking about it, then we can. But if they're not, we're not supposed to. Um, we wanna make sure we're putting extra staff in place.

There's gonna be some people in the house. There's gonna be some people in the staff that are gonna need some additional care and attention.

[00:56:40] How to tell the house, right? We wanna do it in small groups never at a full house meeting. Two staff are present, one to talk and one to watch faces. We're gonna use plain words. "Died by suicide," if the family is okay with that. And I know this is a lot. Wanna get it in our policies so we know what our rules are.

[00:57:02] Um, no method, no location, no details that, that contributes to additional stress. We do not wanna add that at this point. Wanna make sure we're naming that additional support that has been put in place. Making sure people know how to get connected.

[00:57:23] Days two through 14, those first couple weeks. Who needs more today, right? That roommate, that closest friend. If somebody f- discovered the person r- residents that are in their first 30 days of, of recovery, they're gonna need some extra support. Um, what the house needs. When it... Don't look at it as being cold or unsympathetic if we keep routines and chores and meetings the same.

[00:57:49] Um, that routine, that schedule is huge for our peers in our programs. It's important that we keep those moving forward. When to hold a memorial. We don't wanna do that immediately. We want some time to process. We don't wanna make a me- um, a, the preferred memorial is something that gives back to the community, not necessarily a physical, uh, memorial.

[00:58:15] That's just a constant reminder to see that, and that doesn't help anyone there we go. Memorials, belongings, and the room. Treat every death the same way. Suicide death gets treated the same way as a natural cause death. We're trying to send out the same message about dignity in that person's life.

[00:58:35] Choose that living memorial over permanent ones. I mentioned that earlier. Involve residen- residents in deciding. A response imposes, imposed from above satifi- satisfies no one. Let the hou- house members help choose with the staff holding those boundaries on how we're gonna do a memorial for that person.

[00:58:55] Handle their belongings with care and a witness, just like we would with any other death. W- if it is a possible suicide death, there might be law enforcement, it might be a crime scene. We wanna make sure we're, um, adhering to all of that. Soon as the area is cleared though, go through the process just like you would with any other client.

[00:59:16] Moving a, a new person into that space, into that bed, that person that died by suicide's space hold off for a little bit if you can. Talk to your other residents about how long should we leave it empty, you know? We know it's an important bed, and it can help another person in their recovery, but we wanna also respect that person's life.

[00:59:38] And make sure if you're putting a new person into a room where somebody died by suicide, they need to be aware of that before you put them in there. It's probably gonna be

a little uncomfortable i- initially, but they're gonna find out anyway. Way better to deal with it upfront. Put this...

[00:59:58] Policies. These, these things need to be in, in your policies. The anniversary of that death, think about your staff. That's definitely gonna be there in a year, right? Hopefully gonna be there in a year. We need to be working to protect our staff's mental health in this situation as well. Make that outside help available.

[01:00:18] Expect the guilt. Suicide deaths, again we can... Hindsight is 20/20. We all know that, right? The things we could've seen, the things we, we missed. We can't w- we can't let our thoughts live there. People die by suicide. It happens. Don't let the guilt weigh you down too much. We, we can't do anything about what happened yesterday, two minutes ago.

[01:00:42] We're learning today so we can make better choices in this space moving forward. Again, policy, uh, making sure we're taking care of ourselves and our fellow peers. 30 to 90 days out, as a organization, if you can sit down with everybody, review without blame. What happened? What didn't we notice? Um, what s- the safety planning process maybe fell through, right?

[01:01:10] Think about the screeners we've talked about. Is there somewhere in your policy that a change can be made to maybe better outcome the next time, right? We're not trying to place blame. We're just taking a real honest look at how things unfolded and what policy change needs to happen

[01:01:31] Case three, resident died by suicide offsite on Thursday night. Police were notified police notified the program Friday morning. It's 7:30 in the morning, six residents have seen a post about it on social media. Two of them are in their first month of recovery. One's the roommate who is standing in the kitchen and has not said a thing.

[01:01:51] 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 can't come inside. I know that's a terrible scenario, but it, it could happen. It could happen at any of our recovery residences. Being prepared for this ahead of time, so much better outcomes.

[01:02:14] So what happens next? Who does what in this situation? When we're thinking about postvention and, in recovery housing, we wanna make sure that, uh, we're naming positions, not people, to handle this postvention work, 'cause that person may be off today, or that person, the house manager, is in their car and can't come in.

[01:02:38] It's emotionally too much for them to handle right now. We wanna make sure we're assigning roles, postvention roles to positions, not people, and we wanna make sure that there's a backup for each one of these. What do you say? How do you tell the residents? You know, they're... It- it's on social media.

[01:02:56] They're already talking about it, but the family doesn't want you to disclose it was suicide. We, we can acknowledge that they're seeing other messages than what you're getting.

We can't confirm or deny. I know that's a terrible space, but we wanna respect the family. We wanna make sure that they understand that's why we're there we're, responding the way we are if the family has said, "Don't disclose it was suicide."

[01:03:19] That's the family's choice. Who gets a named person assigned to them that day? Question three there, right? We've got the roommate standing in the kitchen not saying anything. That quiet person probably needs to have some extra attention to him that day. Those people in their first 30 days of recovery, they're at an increased risk.

[01:03:42] Staff. We wanna make sure staff's getting taken care of, too. Gonna keep moving here. Eight things we can take away from this today to help move our program in a better space for suicide prevention. Those screening tools, take a look at them. Work with your, uh, director. Figure out which one would be best for your organization.

[01:04:05] Get it in policy that that's to take... done at intake maybe at return to use, uh, maybe at other stressful times. Those gatekeeper trainings, that's gonna be in that resource that's shared with you. I know trainings are hard to find time to do. Some of them are as little as an hour. They just help you understand, um, suicide risk factors better, what to be looking for, and how to have that conversation, and why it's so important to use direct language.

[01:04:31] Your medication storage practices, um, and a weapons-free policy in the resident agreement. Um, that one-page postvention plan with roles and backup plans for everybody. A written answer to what happens when a disclosure and a discharge happen in that same space. Are we gonna discharge them even though they're in a suicidal crisis?

[01:04:54] Are we gonna deal with that suicidal crisis, give them one night, somehow, some way make it happen so we can get them connected with some resources to help move through that suicidal crisis? That CALM training that was mentioned earlier, Counseling on Access to Lethal Means, it'll be in the resource packet.

[01:05:12] That release signed at intake naming emergency contacts, so important. I'm, I'm 100% positive everybody's getting that signed release. I know how important it is for us in our organization. Local numbers. Who do you call in your area? Uh, I don't know where all y'all are joining me from on this call today.

[01:05:30] Find out who your mobile crisis, if you have mobile crisis in your area. Uh, make sure you're aware of those phone numbers. 988-988-988. They would be able to connect you with your mobile crisis. They will know for sure if you have one. Pick something here. There's lots of options. Choosing one of these is moving your program in a better direction when it comes to suicide prevention.

[01:05:52] Work towards getting all eight of them implemented. Resources, there we are. Erica's gonna share some resources with you guys. Three things to carry out of here. Ask the question, be direct. I know it's hard, but that's our best outcome. Don't let a crisis become a discharge, and write it into your plan, get it into your policy.

[01:06:13] Thank you all so much for learning with us today. Again, it'll be recorded. It'll be on the website. Reach out to Erica if you've got questions. She'd be happy to connect you with me. I'm happy to answer any questions you got. Thank you so much for your time today.

[01:06:27] **Moderator:** Shana, before we go, couple things really quick.

[01:06:30] Carmen- Yep ... asked if you could go back to the resource slide again. And Carmen, I don't know if you saw it, but I've got a resource list in there as well. Right there. I've got a resource list. I'll upload it again just here at the very end to make sure everybody got it. It's downloadable. And Carmen, email me if you don't see it.

[01:06:47] I'm happy to send it to you through email too. Two really quick questions, and some people stayed on, and some people even shared personal experiences. Gerard, I hope I pronounced your name correctly, thank you for sharing in the chat. And back to where you talked about... 'Cause I, when I was doing counseling and therapy, we did a, a suicide contract.

[01:07:06] So that's why training is so important to stay up to date on what is the most current and latest and greatest practices. And you... He had asked what about a promise to call? Like, just a sort of acknowledgement from them that they will call and get help or support. I think that's what you were referring to.

[01:07:24] That's how I read it. And if not, please clarify in the chat. I'm happy to

[01:07:30] **Shanna Sorg:** So that safety plan it, they're really simple. American Foundation for Suicide Prevention has a downloadable one that we had a client we were worried about here recently, and it's more than them agreeing or promising to make a phone call.

[01:07:46] It helps identify when they're stressed. It helps identify things they know they can do to help decompress themselves. It identifies places they can be socially so they're connecting. Not necessarily talking about their suicidal thoughts, but being around other people, right? Um, but then it, it moves into if that doesn't help, who do you call?

[01:08:07] So I recommend that safety planning process. 10 minutes and a good solid safety plan can be developed.

[01:08:15] **Moderator:** Perfect. Thanks, Shana.

[01:08:17] **Shanna Sorg:** Yep.

[01:08:17] **Moderator:** Um, and the other question was if you know somebody who has been having suicidal thoughts how can you continue to check up on them? You know, is there, you know, is there a time interval?

[01:08:28] What does that look like for maybe that first few months or even ongoing?

[01:08:34] **Shanna Sorg:** If someone has expressed suicidal ideation frequent. Often. We wanna make sure, um, we're connecting and re- re- revisiting the question, you know? Uh, you've disclosed, you've talked about suicide before. I care about you. I'm worried about you.

[01:08:52] Is that something that you're still thinking about? Are there some resources we can try to get connected with so we can get that out of your rotation, you know? Just frequent, and be direct.

[01:09:06] **Moderator:** Thanks, Shanna. Um, and for everybody who stayed over, I'm just looking through the chat to see if there's anything else.

[01:09:13] I had to literally restrain myself from unmuting just to encourage you, 'cause you... This was, I think this is one of the best webinars we've had. I think that all the time, but I mean, this was so helpful, and I think it took a lot of the fear out things that I experienced as a counselor when I would have to ask these questions.

[01:09:30] So, and the fact that you pointed out that peers can do this. You do not have to be credentialed to talk to somebody to get a safety plan in place. So I think that's critical for this space. And all, you are getting all kinds of, um, very positive feedback, and well deserved, Shanna, in the chat. So thank you so much for taking the time, for even staying late with us.

[01:09:51] Yeah. And for all the attendees today who were so, helpful in the chat and just stayed with us late, we thank you, and we hope you join us next time. Thanks, Shanna.

[01:10:00] **Shanna Sorg:** Yeah.