Risk Assessment-Suicide Overdose Revention-
Suicide Response Course

RELIAS
relias.com

# Overview of Evidence-Based, Suicide-Specific Interventions



## Section 1: Introduction

### About This Course

It was once assumed that addressing underlying conditions was the best way to treat suicidality. We now know that suicidal people need interventions that directly target suicidal thoughts and behaviors. Suicide-specific interventions will give you the tools to help clients manage suicide risk.

In this course, you will learn about specific evidence-based and research-informed interventions that directly target suicidal thoughts and behaviors. Through case examples, you will gain a better understanding of ways to implement these strategies.

The goal of this course is to provide addictions, behavioral health counseling, marriage and family therapy, nursing, psychology, and social work professionals with knowledge about

evidence-based, suicide-specific interventions.

Note: This course covers suicide-specific interventions for adults. Please review the other available courses on suicide prevention in the Relias library for content on risk factors, screening, assessment, postvention, and working with specific populations.

### Learning Objectives

After taking this course, you should be able to:

- Recall the factors you should consider when determining what interventions may be needed for suicidal individuals.
- Describe three evidence-based interventions for treating individuals at risk for suicide or who have made a recent attempt.
- Summarize the process for completing a safety plan and reducing access to lethal means.

## Section 2: Treatment Considerations for Suicidal Individuals

### General Considerations

**Meet Dani**

Dani is a first-generation Asian American woman. After her first year in medical school, she decided the field was not a good fit. Unsure of what to do next, Dani moved to a new city to start a new life.

She is having trouble adjusting and has been feeling depressed for two months. She has come to your office for treatment.

"I know it was the right decision, but I just can't stop feeling like I've failed my family. They moved here to give us opportunities. I was always supposed to be a doctor and now I feel like I'm nothing."

Dani was the first person in her family to attend college and she feels a lot of pressure to continue her education. She says that her parents seem to believe that becoming a doctor is the only pathway to success.

Dani says her parents try to be supportive, but her mother insists that returning to medical school will improve her mood.

You ask Dani if she has thought about suicide.

"All the time. I tried when I was 16. Ever since then, I think about killing myself any time life is hard. To be honest, life is hard every day."

Will Dani need inpatient care? Will treating depression inadvertently address her suicide risk? How can you best help Dani?

**Engagement and the Therapeutic Relationship**

Regardless of your specific treatment model, you should prioritize the therapeutic relationship and promote engagement. Important clinical skills that cultivate trust include:

- Remaining calm and non-judgmental
- Validating feelings and showing empathy
- Being culturally sensitive
- Collaborating with clients in decision-making
- Keeping the visit conversational
- Fostering a sense of hope

**Considerations for Telehealth**
You may have to assess and manage suicide risk via telehealth. There are several adaptations you can use to support clients at risk for suicide, such as (McCord et al., 2020):

- Confirming your client's location in case you need to coordinate emergency services.
- Using screen-sharing or technological ways to collaborate while safety planning.
- Relying on verbal communication more than you would in person.
- Clarifying nonverbal communication and off-screen activities.
- Assessing any safety concerns in their specific location.
- Asking if other people are nearby, to ensure privacy and know if someone is there to help.
- Maintaining contact until emergency services arrive (in case of imminent crisis).

**Least Restrictive Setting**
While hospitalization is sometimes needed, national guidelines recommend that suicidal individuals receive treatment in the least restrictive setting appropriate to their needs (Zero Suicide, n.d.).

Inpatient treatment should only be used when:

- There is an imminent threat to the client's safety.
- The client cannot be kept safe in a less restrictive environment.

***Stepped Care Approach***
Guidelines recommend a stepped-care approach in which interventions match the client's needs. For instance, a client with chronic suicidal ideation who denies any acute or imminent suicidal behaviors would likely benefit more from outpatient rather than inpatient services (Jobes & Chalker, 2019).

Types of care lie on a continuum ranging from least to most restrictive (Jobes et al., 2018):

- Crisis center hotline support and follow-up
- Brief intervention and follow-up
- Suicide-specific outpatient treatment
- Emergency respite care
- Partial hospitalization with suicide-specific treatment
- Inpatient psychiatric hospitalization with suicide-specific treatment

You should collaborate with the client and share in decision-making about the treatment plan. Even clients who require hospitalization should be involved in the process.

***The Aftermath of an Attempt***
If your client tells you they have recently attempted suicide, you need to ensure that they are not

in any medical danger. For example, some poisons may not result in serious medical issues for several hours after ingestion. If there is any doubt, you should refer your client to the emergency department for prompt medical care.

**Where Should Dani Receive Treatment?**
Through a comprehensive suicide assessment, you learn that Dani has:

- No suicide plan or intent in the past year
- Lower suicide risk than she did as an adolescent
- Ideation that varies between mild and moderate
- A sibling who depends on her for emotional support
- Desire not to shame or disappoint her family

Does Dani need inpatient care?

A. Yes
B. **No**
   Feedback [There does not appear to be an immediate threat to Dani's safety. You consider other factors discussed in the assessment to decide on a less restrictive level of care, such as suicide-specific outpatient interventions.]

**Trauma-Informed Care**
People who seriously consider and attempt suicide often have a trauma history. Trauma-informed care is critical when addressing suicide risk. In brief, trauma-informed care assumes that clients have experienced trauma and proactively avoids re-traumatizing them (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020).

There are times when you may need to hospitalize a client involuntarily to ensure their survival. Forced treatment can disempower and retraumatize clients. Do your best to prioritize collaboration and communication when the most restrictive setting is needed.

***Trauma Sensitivity with Suicidal Clients***
Inscoe and colleagues (2021) identified strategies that promote sensitivity to trauma when working with suicidal individuals. They include:

- Having a genuine, authentic, and warm demeanor
- Recognizing, understanding, and responding to signs of traumatic stress
- Communicating and collaborating on clinical decisions
- Delivering care in the least restrictive setting
- Keeping interpersonal dynamics in mind when considering family involvement
- Emotionally supporting the people involved in your client's care
- Providing practical information and psychoeducation to your client's support system

**Culturally Responsive Suicide Care**
Your suicide risk assessment should include questions about culture so that you can develop a culturally responsive treatment plan. Consider including the Cultural Assessment of Risk for Suicide, or CARS (Chu et al., 2013).

***Cultural Risk Factors that Affect Suicide Risk***
Chu and colleagues (2013, 2019) identified four cultural factors that affect suicide risk:

- **Cultural Sanctions**: Messages your client's culture conveys about suicide (e.g.,

acceptability, shame).

**Example**: "They dishonored their family. I understand why they might attempt suicide."

Interventions might:
  - Address beliefs that support suicide as an acceptable response to distress.
  - Integrate beliefs that protect against suicide into safety planning.

- **Idioms for Distress:** The ways symptoms are described or experienced by a particular culture.

  **Example:** "My head is just so heavy" to describe depression.

  It can help to:
  - Know idioms for distress common to your client's culture.
  - Humbly ask about and listen for idioms for distress so you can detect risk.
- **Minority Stress**: Distress resulting from marginalization due to social identity or position (e.g., acculturation, discrimination, social inequities, racial trauma, microaggressions).

  **Example**: "There are only two Black students in my school. We look nothing alike, yet our teachers always mix up our names. I feel like I don't matter."

  You can:
  - Assess your client's experiences with marginalization and discrimination.
  - Be aware of and check in about events that affect people belonging to their social identities.
- **Social Disorder:** Conflict, rejection, or alienation from one's community, family, or friends.

  Example: "I'm gay and the only way I can have a relationship with my family is if I don't talk about my partner. I don't think I can have them in my life anymore."

  You might use knowledge of social disorder in your client's life to:
  - Help them recognize who should and should not be part of their support system.
  - Explore whether your client wants to address unhealthy family dynamics.

***Note on Stigma***
Some cultures support stigmatizing beliefs that worsen suicide risk and discourage help-seeking. It is important to address these beliefs with your clients, their families, and the community.

***Culturally Adapted Interventions***
When considering a treatment approach, research whether it has already been adapted to your client's culture. For instance, published articles describe ways to adapt dialectical behavior therapy (DBT) to specific cultures (Haft et al., 2022). DBT is a suicide-specific treatment discussed later in this course.

When published materials are not available, you may need to adapt your approach based on your own knowledge, research, and clinical judgment. Practice cultural humility as you learn about your client's culture and identity. Consider partnering with the community to decide the best ways to address and manage suicide risk (Suicide Prevention Resource Center [SPRC], n.d).

Be sure that modifications are (Self et al., 2022):

- Based on the client's salient identities.
- Compatible with the client's beliefs and values.
- Consistent with their cultural expectations and preferences.

**Cultural Factors that Affect Dani's Risk**

Dani tells you more about her family and mental health history. She tells you about some experiences that she believes relate to cultural themes common to Asian American families. What statement BEST reflects a cultural sanction?

A. **"When I attempted suicide, my parents told me my death would have brought shame to the family."**
   Feedback [The "cultural sanctions" category can include beliefs that support the acceptability of suicide or oppose suicide. This statement reflects a cultural belief that discourages suicide.]
B. "I think my mom has depression, but you'd never know. She complains about headaches and dizziness instead of talking about her feelings."
   Feedback [This is an idiom for distress. Idioms for distress can be reflected in somatic complaints such as headaches or feeling dizzy. The statement that best reflects cultural sanctions is, "When I attempted suicide, my parents told me my death would have brought shame to the family."]
C. "My family was subjected to a lot of racism when I was growing up. It's been worse since COVID."
   Feedback [This statement reflects the concept of minority stress. The statement that best reflects cultural sanctions is, "When I attempted suicide, my parents told me my death would have brought shame to the family."]
D. "When I first dropped out of medical school, my mom wouldn't talk to me. She was so disappointed."
   Feedback [This statement reflects social disorder. The statement that best reflects cultural sanctions is, "When I attempted suicide, my parents told me my death would have brought shame to the family."]

## Long-Term Follow-Up Care and Family Involvement

### Long-Term Follow-Up Care

Long-term follow-up care will allow you to continually assess suicide risk and update treatment plans as needed. These efforts can also promote engagement and connectedness to bolster protective factors against suicide (Zero Suicide, n.d.).

You should implement follow-up care when at-risk clients:

- Transition from one provider to another

- Repeatedly miss appointments
- Experience a crisis
- Terminate services
- Discharge from an inpatient treatment setting

**Note:** It is especially important to follow up when clients are discharged from an inpatient treatment setting or emergency department. Clients are 200 to 300 times more likely to die by suicide in the month following discharge from inpatient care. Risk is highest during the first several days post-discharge (Chung et al., 2019).

***Caring Contacts***

Caring Contacts is an intervention that is used when clients transition from psychiatric crisis care (e.g., inpatient, ED) to outpatient settings. The approach consists of non-demand, brief communications that express genuine concern for the client's well-being and safety. Methods include:

- Letters
- Postcards
- E-mails
- Text messages

A recent systematic review concluded that Caring Contacts reduce suicide risk up to a year following discharge from an inpatient treatment setting (Skopp et al., 2022).

**Family Involvement**

Family relationships are important to suicide prevention. Healthy dynamics protect against suicide and people are more likely to seek help from family members if they feel supported.

However, unhealthy dynamics can worsen suicide risk and limit a person's support system. Clients are less likely to talk about suicidal thoughts if they do not feel like they belong or worry about being a burden.

Before involving family members, be sure to have the client's consent and assess whether their involvement will worsen or mitigate suicide risk. When family involvement can help with treatment, involve them early and often (Edwards et al., 2021).

***When to Involve Family***

Family involvement should be a shared decision and ultimately the client's choice. With the client's permission, consider involving family members to (Edwards et al., 2021):

- **Help Safety Plan**
  Family members can help clients with their safety plan by:
  - Monitoring safety concerns (e.g., access to lethal means).
  - Noticing warning signs and risk factors.
  - Helping clients connect with resources.
  - Offering emotional support or distractions as needed.
- **Address Beliefs**
  Family attitudes around suicide and mental illness can worsen risk or discourage help-seeking. Consider involving family to dispel myths. For instance, they should refrain from assuming that their loved one is attention-seeking when they talk about suicidal

thoughts.

- **Foster Hope**
  Family members can also lose hope that there is help for their loved one. You can foster hope by educating family members about suicide and treatment. You can also help them explore experiences or beliefs that help them maintain hope.

### Review

Dani is starting to build connections in her community but continues to lack a sense of belonging. She describes feeling conflicted about her family.

"On the one hand, I really miss them and that worsens my depression. On the other, I don't want to hear about how I should go back to medical school. It just makes me feel like even more of a failure and like I've really let them down."

Dani's suicidal ideation is affected both by missing her family and by talking to them. You recognize that family might be important to managing her suicide risk. What is the BEST way to approach family involvement with Dani?

A. Call Dani's mother to explain the ways her comments worsen Dani's suicidal ideation.
   Feedback [Even if her mother's comments worsen suicidal ideation, this approach would not be the way to address it. It can shift the focus to blame. You also should not contact Dani's family without her permission. Instead, ask if Dani thinks it would help to involve her family and then explore options.]
B. **Ask if Dani thinks it would help to involve her family and then explore options.**
   Feedback [You should humbly explore with Dani whether family involvement will meet her goals, support her mental health, and/or decrease suicide risk. If Dani is interested, you might then invite family members into treatment.]
C. Suggest Dani identify her sibling and parents as her primary support in her safety plan.
   Feedback [Dani should be the one to identify her primary support, not you. Instead, you should ask if Dani thinks it would help to involve her family and then explore options]

### Summary

Always do your best to prioritize collaboration and communication when developing treatment plans and implementing suicide-specific interventions. Family involvement should always be in the best interest of your client and with their consent.

You should also be sure to:

- Prioritize engagement and the therapeutic relationship.
- Seek care in the least restrictive setting with respect to your client's needs.
- Practice trauma-informed care.
- Use culturally responsive and humble approaches.
- Follow up with clients based on their needs and risk level.
- Share in decision-making with your clients.

## Section 3: Evidence-Based Interventions

### Directly Targeting Suicide Risk

**Meet Rene**

Rene has had several depressive episodes over the past decade. He usually manages them with a combination of strategies learned in therapy over the years. For example, he schedules pleasant activities when he notices early warning signs of depression.

Recently, Rene's husband lost his job. Rene felt uncomfortable asking for help.

"I didn't want to bother him. He's going through his own stuff. I should be there for him, not the other way around."

Rene tried to use coping strategies that had helped in the past, but his mood continued to worsen.

"I just couldn't stop thinking that I was holding my husband back. I spiraled and convinced myself the best way I could support him was to kill myself."

Rene attempted suicide by medication overdose. His husband found him in the bathroom and called 911. Rene was transported to the ED and admitted for inpatient care. He was released about 3 weeks ago.

He is starting treatment with a new clinician.

"I know a lot of ways to manage my depression, but they didn't work this time. I think I was just too lost in my head."

**The Importance of Directly Targeting Suicidality**

Historically, providers have addressed suicidal thoughts and behaviors by targeting underlying mental health conditions. They assumed that suicidality would resolve once symptoms of the primary disorder improved.

While it is important to treat any known mental health conditions, interventions that specifically target suicidal ideation and behaviors should be central to the client's treatment plan.

Three recommended evidence-based interventions that directly target suicidality include (Stone et al., 2017; The Joint Commission [TJC], 2016; Zero Suicide, n.d.):

- Collaborative Assessment and Management of Suicidality (CAMS)
- Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP)
- Dialectical Behavior Therapy (DBT)

### Collaborative Assessment and Management of Suicidality

**What is CAMS?**

The Collaborative Assessment and Management of Suicidality (CAMS) approach is a framework for evaluating and addressing suicide risk. The model is flexible and can be easily integrated with other interventions and treatment modalities. It is generally used in outpatient settings (Jobes, 2006).

### *Collaborative Tone and Functional Approach*

Two main components of CAMS are the:

- **Collaborative Relationship:** The client is an active participant who "co-authors" their treatment plan. An empathic therapeutic relationship is key to their safety.
- **Function of Suicide:** Treatment seeks to understand the problem the client believes suicide will solve. CAMS assumes suicide serves a function for the client.

The collaborative tone and functional approach to suicide treatment pave the way for more adaptive ways to manage distress. A recent meta-analysis found that CAMS (Swift et al., 2021):

- Reduces suicidal ideation
- Decreases levels of distress
- Fosters feelings of hopefulness
- Improves treatment satisfaction

### *Suicide Status Form*

The Suicide Status Form (SSF) is central to CAMS. It is an assessment tool that is initially used to identify the client's risk level and develop a treatment plan. The SSF is also used throughout treatment to inform interventions, track progress, and identify outcomes.

Core treatment components elicited from the SSF include:

- **Suicide Drivers**
  Suicide drivers are factors that cause suicidal desire. They relate to the function of suicide for the client. For example, your client might seek relief from physical or emotional pain. Once you know your client's suicide drivers, you can use suicide-specific treatment strategies (e.g., CBT-SP, DBT) to reduce risk.
- **Ambivalence**
  It is common for people to have mixed feelings about suicide. To assess ambivalence, clients list and rank their reasons for living and reasons for dying. They then identify the one thing that would help them to not feel suicidal. These strategies are intended to target ambivalence and identify specific focus areas for intervention.
- **Stabilization Plan**
  The stabilization plan is also called a safety or crisis response plan. It is a personalized guide you and the client create together to reduce the odds they will act on suicidal urges. Clients identify ways to:
  - Reduce access to lethal means
  - Cope when in a suicide crisis
  - Contact others for help or distraction
  - Address barriers to attending appointments

### *CAMS with Rene*

Rene sits side-by-side with the clinician to complete the SSF.

He rates his feelings of misery, hopelessness, and self-hate as high. He is stressed about finances and believes he is an extreme burden on his husband.

"My husband loses his job and I make everything about me. What kind of person does that?"

Rene indicates that his suicidal thoughts completely relate to the feelings he has about himself, his life, and how he relates to others.

He identifies his reasons for dying as:

- "No longer burdening my husband"
- "Ending feelings of hopelessness and stress"
- "Deserving death because I'm useless"

Rene tells you that his main reasons for living are:

- "Being there for my husband"
- "Adopting children in a few years"
- "Traveling around the country this summer"

Rene says that he would no longer feel suicidal if he knew he was not a burden to his husband.

"It would be easier to ask for help if I knew for a fact that I wasn't bothering him."

Rene and the clinician collaborate to create a safety plan. For part of the plan, he identifies:

- **Barriers to attending treatment:** Feeling fatigued and wanting to stay in bed
- **Solution to try:** Request a telehealth appointment

What are Rene's suicide drivers?

A. **Hopelessness**
B. **Overwhelming stress**
C. Telehealth appointments
D. **Perceived burdensomeness**
E. Assurance from others

Feedback [Suicide drivers are factors that cause suicidal desire. Feelings of hopelessness, overwhelming stress, and perceived burdensomeness drive Rene's suicidal ideation. Telehealth appointments and assurance from others do not seem to cause suicidal desire in Rene.]

## Cognitive Behavioral Therapy for Suicide Prevention

### Goals of CBT-SP

Cognitive behavioral therapy for suicide prevention (CBT-SP) is a manualized cognitive behavioral intervention designed for people who have made a recent suicide attempt (Brown et al., 2009).

The goals are to:

- Reduce suicide risk factors
- Improve coping
- Decrease stressors that activate suicidal behaviors

### Efficacy

Evidence supports the use of CBT-based interventions to prevent suicide and reduce risk (Platt & Niederkrotenthaler, 2020). Specifically, CBT-SP has been found to (Mann et al., 2021):

- Reduce suicide behavior by 50% in people seen in the ED following an attempt.

- Decrease suicide risk in people with depression and borderline personality disorder.
- Improve the ability to cope with stressors that activate suicidal behaviors.
- Reduce impulsivity in people with recent suicide attempts.

**Core Components of CBT-SP**

The core components of CBT-SP are:

- **Psychoeducation**: The client and their family receive information about the approach. The clinician also educates them on the:
  - Nature of suicidal thoughts and behaviors
  - Role of depression and other mental health issues
  - Need to limit access to lethal means
- **Chain Analysis:** The client and clinician map out the circumstances around their first suicide attempt, such as:
  - Activating events
  - Risk and vulnerability factors
  - Thoughts, feelings, and behaviors
- **Safety Planning**: The client and clinician collaboratively develop a personalized safety plan that outlines:
  - Warning signs for suicide
  - Internal and external ways of coping
  - Social support
  - Reasons for living
  - Professional and crisis services
- **Reasons for Living:** The client explores their personal reasons for living, such as:
  - People who care about them
  - Events they hope to experience in the future
  - Activities they enjoy
  - Things they care about
- **Hope Kit:** Clients create a "hope kit" that contains reminders of their reasons for living. It should be personalized and reflect people, places, or items that may tip the balance toward living during a time of crisis. Hope kits often include:
  - Photos of friends and family
  - Keepsakes from special events
  - Inspirational phrases
  - Items they can use to distract or self-soothe
- **Case Conceptualization:** The clinician develops an understanding of their client's suicidality based on the chain analysis. The client and clinician discuss the case conceptualization to collaboratively decide specific skills training to include in treatment, such as:
  - Behavioral activation and pleasant activity scheduling
  - Mood monitoring
  - Emotion regulation and distress tolerance
  - Cognitive restructuring
  - Problem-solving and goal setting

- Ways to mobilize social support
- Assertiveness and family skills training

***Rene's Chain Analysis***

After establishing rapport, Rene and the clinician carefully analyze the chain of events that led to his suicide attempt. They start with experiences, thoughts, and feelings that made him vulnerable to suicidal thoughts:

- Hadn't slept well in days
- Started feeling depressed
- Learned my husband lost his job
- Thought I was selfish for needing support
- Drank two glasses of wine

They then identified the event that prompted thoughts and feelings that led to the suicide attempt:

- Called my husband and it went straight to voicemail
- Thought he wanted nothing to do with me
- Felt like a burden
- Believed I was better off dead
- Felt disgusted with myself
- Took all the medications I could find

Rene and the clinician also include events that occurred after the attempt, such as:

- Woke up in the hospital with my husband by my side
- Felt ashamed but loved

**Note:** The experiences that led up to Rene's suicide attempt combined to put him in "suicide mode." Suicide mode is the interaction of thoughts, emotions, behaviors, images, and situations that activate the desire to die.

***Rene's Case Conceptualization and Treatment Plan***

The clinician and Rene use the chain analysis to conceptualize his suicidality and develop a treatment plan. They explore cognitive-behavioral strategies that can target each link in the chain. For instance, they engage in problem-solving to identify ways to address sleep issues.

They also plan to practice cognitive restructuring around thoughts that drive Rene's suicidal desire, such as:

- "I'm selfish for needing support."
- "I'm a burden on my husband."
- "My husband wants nothing to do with me."
- "I'm better off dead."

The clinician helps Rene develop self-soothing and emotion regulation skills. They write coping strategies Rene can use when distressed on "coping cards." Rene will refer to these cards between sessions to practice the skills he is developing.

They also decide to involve Rene's husband in treatment. In addition to helping with safety planning, they will explore expectations and ways to address Rene's concerns about being a

burden.

***Relapse Prevention***
Relapse prevention is a component of CBT that helps the clients prepare to manage the return of symptoms. In CBT-SP, there are several ways to implement relapse prevention. For example, Rene and the clinician revisit the initial chain analysis to practice applying coping skills through guided imagery.

Other relapse prevention strategies include:
- Reviewing effective coping skills
- Identifying potential barriers to applying new skills
- Problem-solving ways to overcome obstacles
- Generating challenging future scenarios that could lead to suicidal ideation
- Using hypothetical scenarios to identify ways to practice learned skills

***Rene's Hope Kit***
Rene is working with the clinician to create a hope kit. He has decorated a box and is sharing items he is thinking of including. Which of the following should be in his hope kit?

A. **A letter from his husband describing how much he loves him**
B. **Photos from different trips he has taken with friends and loved ones**
C. A statement signed by Rene stating he promises not to attempt suicide
D. **Lyrics to a song that he finds motivational**
E. A list of reasons the clinician thinks Rene should stay alive
F. **A small coloring book and markers to distract him from suicidal urges**
Feedback [Letters, photos, song lyrics, and adaptive distractions (e.g., coloring book) are all suitable for a hope kit. The client should choose the contents, not the clinician. Therefore, a list of reasons the clinician thinks Rene should stay alive should not be included. The statement signed by Rene sounds like a no-suicide contract, which is not recommended and should not be in his hope kit.]

## Dialectical Behavior Therapy

### Description of DBT
Dialectical behavior therapy (DBT) is perhaps best known as a treatment for borderline personality disorder, although it was originally developed to treat people with chronic suicidal ideation.

DBT is a cognitive behavioral approach that incorporates the mindfulness principles of Zen Buddhism. The approach directly targets suicidal ideation through a combination of group skills training, individual therapy, and between-session support.

### Skills Training Component of DBT
The skills training component of DBT includes:
- **Mindfulness**: Being fully aware of the present moment without judgment
- **Distress Tolerance**: Tolerating distress or discomfort, rather than trying to change it
- **Interpersonal Effectiveness**: Learning assertiveness and other interpersonal skills
- **Emotion Regulation**: Applying adaptive techniques to change distressing emotions

It may appear that some skills components contradict each other. The term dialectical refers to the emphasis on striking a balance between seemingly opposite poles, such as acceptance and change.

**Note:** DBT certification requires extensive training. For more information, see the Resources section of this course.

**Efficacy**
Research shows that DBT effectively reduces the intensity, frequency, and duration of suicidal ideation. The approach can decrease feelings of sadness as well, which further lessens overall suicidality (Rizvi & Fitzpatrick, 2021).

DBT is also effective in decreasing suicide attempts. For instance, two independent trials showed that adolescents who completed DBT had fewer suicide attempts and were less likely to engage in non-suicidal self-injury than those who did not receive the intervention (McCauley et al., 2018).

People do not need to be diagnosed with borderline personality disorder to benefit from DBT. The approach has transdiagnostic applicability (Ritschel et al., 2015).

**Mindfulness with Rene**
Rene continues to feel depressed and like a burden when relying on his husband for support. He and the clinician have completed many cognitive restructuring exercises around burdensomeness.

He identifies alternative beliefs that sometimes help, but mostly leave Rene feeling invalidated and frustrated.

"You can't tell me I'm not a burden. He lost his job because he had to spend so much time taking care of me. That's all the evidence you need to see that I am in fact a burden!"

The clinician suggests that mindfulness might help Rene cope with perceived burdensomeness.

Before learning about how Rene uses mindfulness, it can help to understand how mindfulness differs from other techniques like cognitive structuring.

***What Mindfulness is NOT***
Mindfulness differs from other interventions in that:

- **It is NOT cognitive restructuring.** Rene does not learn to examine the accuracy of his assumptions or recognize biased thought processes.
- **It is NOT a positive affirmation.** Rene does not try to make himself feel better by substituting a positive thought (e.g., "you are wanted") for his negative assumption.
- **It is NOT a distraction.** Rene does not try to ignore or distract from his thoughts and emotions by focusing on something else.

***Types of Mindfulness***
There are different approaches to mindfulness. Some of these include:

**Formal Mindfulness**
Formal mindfulness skills include interventions like meditation.

Rene might learn to meditate by focusing on his breath and allowing thoughts to come and go without judging or attaching to them. His clinician could record a script or refer him to an app he can use in between sessions.

**Informal Mindfulness**
Informal mindfulness skills are ways of being present in daily activities.

When washing dishes, Rene actively:

- Sees the suds that form as he cleans a plate.
- Hears the water pouring from the faucet and splashing into the sink.
- Feels the warmth of the water and softness of the sponge.
- Tastes the remnants of the meal he just ate.
- Smells the fresh scent of the soap he uses.

***Approaching Rene's Beliefs with Mindfulness***
The clinician helps Rene approach his beliefs with mindfulness. They acknowledge how difficult it can be for Rene to believe he does not burden his husband and then introduces ways Rene can apply mindfulness to his thoughts.

The clinician teaches Rene to shift into the role of a non-judgmental observer when he assumes he is a burden. Rather than trying to make those thoughts and feelings go away, Rene simply notices them.

He refrains from judging the thoughts as good or bad. He puts words to the ways he is being aware of his thoughts.

"I am having the thought that I am a burden. I am noticing a feeling of disgust and queasiness in my stomach."

Shifting to an observer stance creates space between Rene's automatic thoughts and his tendency to act on them immediately.

The clinician teaches Rene other ways he can simply notice versus react. For example, Rene learns to attend to where he feels emotions in his body and then:

- Describes them more fully.
- Considers them with gentle kindness.
- Watches how they shift in intensity from moment to moment.

Over time, Rene comes to recognize the idea that he is a burden as "just a thought." It is not necessarily true. It not demanding any sort of action or response. It can pass through his mind as any other inconsequential thought might.

### Review

Rene learns a skill from DBT called "opposite action" when working with his clinician. This technique has clients behave in a way that is incompatible with their feelings. For instance, when Rene feels disgust toward himself and wants to withdraw from others, he makes plans with his husband or other friends. The technique causes his feelings to change and thus reduces suicide risk.

What term BEST applies to the type of strategy Rene learned?

A. Mindfulness
   Feedback [Mindfulness involves being aware of the present moment without judgment. Rene is learning an emotion regulation strategy used in DBT. Emotion regulation skills are adaptive techniques to change distressing emotions.]
B. **Emotion regulation**
   Feedback [Emotion regulation is one of the skills people learn in DBT. Emotion regulation skills are adaptive techniques to change distressing emotions.]
C. Cognitive restructuring
   Feedback [Cognitive restructuring is a CBT strategy to identify and challenge unhelpful thoughts that underly emotions. Rene is learning an emotion regulation strategy used in DBT. Emotion regulation skills are adaptive techniques to change distressing emotions.]
D. Identifying suicide drivers
   Feedback [This intervention is focused on changing Rene's feelings, not identifying factors that cause suicidal desire. Rene is learning an emotion regulation strategy used in DBT. Emotion regulation skills are adaptive techniques to change distressing emotions.]

### Summary

There are three main evidence-based treatments that directly target suicidal thoughts and behaviors:

- Collaborative Assessment and Management of Suicidality (CAMS)
- Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP)
- Dialectical Behavioral Therapy (DBT)

You can use CAMS to identify suicide drivers and then implement strategies from CBT-SP or DBT to reduce their risk. Tailor treatment to meet your client's needs. Some people might benefit from cognitive and behavioral strategies used in CBT-SP. Others might prefer DBT skills, such as mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation.

## Section 4: Safety Planning and Lethal Means Counseling

### Safety Planning

**Meet Wendy**

Wendy was in a car accident that resulted in long-term injuries. She experiences severe chronic pain and memory issues due to a traumatic brain injury. She can no longer drive or work. Wendy now lives with her sister, who helps with finances and various daily tasks.

Wendy is grieving her loss of independence. She also has posttraumatic stress disorder resulting from the accident.

You are meeting with Wendy following a suicide attempt that was interrupted by the police. An officer saw her standing on a highway overpass intending to jump.

"I just wanted to end it all. I can't live like this anymore."

Wendy says that she is grateful she did not jump because she could have hurt a driver or passengers in a car.

An interrupted suicide attempt like Wendy's is serious. While she no longer intends to attempt suicide using this method, she still needs a safety plan.

**What is a Safety Plan?**
A safety plan is a personalized guide you develop collaboratively with the client to help them manage suicidal thoughts and urges.

As you may have noticed, most suicide-specific treatments include safety planning as a core component. Safety planning is also an effective standalone approach that improves (Ferguson et al., 2022):

- Suicidal ideation and behaviors
- Hopelessness and depression
- Treatment adherence

***Involvement of Others***
With their permission, it can help to involve supportive family members, clergy members, or other supportive people. These individuals may have insight into the client's warning signs and symptom patterns associated with past suicidal crises. They may also play a role in your client's safety plan.

The involvement of others can depend on several factors, including the client's:

- Age and development
- Cognitive functioning
- Willingness to participate
- Relationship dynamics

You might not involve family members when initially developing the plan if it impacts your client's comfort or if another person is likely to take over the process.

Do not include people who compromise your client's safety or contribute to suicide risk.

**Wendy's Family Involvement**
You introduce Wendy to safety planning and ask whether and when her sister should be involved.

"I'd rather not include her when we make the plan. I've had a lot of memory issues since the accident though. Can we bring her in at the end?"

Like Wendy, many people like to retain their autonomy when developing the plan but recognize they may need help implementing it. Wendy's cognitive functioning is important to consider when deciding to involve family.

Anyone listed as a support person should be made aware of their role in helping the client manage suicide crises.

***Caution about Safety Contracts***

Safety contracts (i.e., no-harm or no-suicide contracts) are written agreements in which the client promises not to attempt suicide or harm themselves. They are different from safety plans. They do not include strategies to manage urges or steps the client should take during a developing crisis.

Safety contracts provide a false sense of security while offering little in the way of concrete, effective approaches the person can use to lower their risk.

Studies have found that safety contracts can involve a degree of coercion and compromise the working alliance, leading people to (Bloch-Elkouby & Barzilay, 2022):

- Feel uncomfortable or unsafe discussing suicide.
- Avoid talking about suicidal thoughts, urges, or plans.
- Provide minimal or vague responses to suicide screening questions.
- Shift the conversation away from anything that might lead to suicide inquiry.

Safety contracts are ineffective and should be avoided. Instead, you should develop a collaborative and personalized safety plan with the client.

**Developing a Safety Plan**

Safety planning is a collaborative process. You do not develop it for your client. You are a resource who helps your client develop their own unique plan based on their experiences. Even if you are physically writing the plan, it should be written using your client's words.

The best time to develop a safety plan is before your client is in a crisis, not while a crisis is happening.

If your client is experiencing a crisis, it may be difficult for them to think clearly or identify the kind of information needed to develop a safety plan. In a crisis, your priority is ensuring your client's immediate safety.

***Components of a Safety Plan***

A safety plan generally includes several components to help individuals manage a suicide crisis. Consider each element when reviewing parts of Wendy's safety plan (Rogers et al., 2022):

- **Warning Signs:** Identify specific warning signs that suggest your client may be considering suicide.
  - Thinking, "I can't live like this anymore"
  - Overwhelming sadness, frustration, or physical pain
- **Coping Strategies:** Describe activities the client identifies that they can do on their own to manage the building crisis.
  - Self-soothing activities (e.g., listening to music, deep breathing, taking a bath)
  - Physical activity (e.g., go for walk, stretch, doodle)
- **Social Distractions:** Indicate settings that the client can easily access to distract themselves and keep them safe from a developing crisis.
  - Coffee with my friend Lorena
  - Go for a walk and sit at the park alone or with my sister
- **Supportive People:** Include contact information for family members and other supports who may help to resolve the crisis. The individuals listed should be people who are likely

to help and be available.
    - My sister
    - My friend Lorena
- **Professional Support:** List contact information for any service providers your client can access if they need help during a developing crisis. You should also include hotline numbers and any other emergency contacts they may need.
    - My therapist
    - 988 to access the National Suicide Prevention Lifeline
- **Environmental Safety:** Identify steps the client and involved support people can take to increase safety in the client's environment. Efforts should include lethal means counseling and strategies to reduce access to alcohol or drugs.
    - Avoid walking across the highway overpass
    - Call 911 if in immediate danger

Your client should be given a legible copy of their safety plan. Safety plans should be reviewed periodically and updated as needed.

## Lethal Means Counseling

**What is Lethal Means Counseling?**
Lethal means counseling is an approach where you (Anestis et al., 2021; Weinberger et al., 2015):

- Assess the client's access to firearms, medications, and other deadly suicide methods.
- Develop a plan to safely store or remove lethal means until the risk subsides.

The goal of lethal means counseling is to keep at-risk people alive.

**Why Lethal Means Counseling?**
Suicide crises intensify quickly and can be unpredictable. Most acute suicidal urges last 20 minutes or less. If someone can access lethal means during this time, they are more likely to die (Anestis et al., 2021).

You can decrease the odds a client will attempt or die by suicide by limiting their access to potentially lethal means, such as:

- Firearms
- Lethal doses of medications
- Chemicals
- Any means they have specifically identified in a suicide plan

**How Lethal Means Counseling Prevents Suicide**
Providers sometimes assume that suicidal people will simply replace one method with another when they want to die by suicide. However, people usually do not seek other means when their preferred methods are blocked. Instead, they often find other ways to cope with the distress (Berman et al., 2022; Conner et al., 2019).

If your client does seek another method, lethal means reduction will give them a better chance of survival because (National Action Alliance for Suicide Prevention, 2020):

- Their suicidal urges will likely abate as they are looking for or securing another method.

- The new method will likely be less lethal, allowing them to survive the attempt.

**When Is Lethal Means Counseling Needed?**
At a minimum, you should counsel clients on reducing access to lethal means when they have current suicidal thoughts or past suicidal behaviors. People with behavioral health or substance use issues should engage in lethal means counseling if they are experiencing major life stressors or significant distress (SPRC, 2019).

Lethal means counseling should happen long before your client is in an acute suicidal crisis.

**Priorities in Lethal Means Counseling**
Experts have analyzed several factors to determine how to have the most impact through lethal means counseling. When examining different suicide methods, they studied (SPRC, 2018):

- Accessibility to the method
- Reversibility if an attempt is made
- Cultural and/or individual acceptability of the method
- Overall fatality rates
- Feasibility of reducing access
- Total number of deaths caused by a particular method

Based on their analysis, SPRC (2018) recommends prioritizing lethal means counseling around:

- **Firearms**
  Death by firearm is the most common and deadliest suicide method in the U.S.

  In 2020, 52.8% of people who died by suicide used a firearm and 54% of all U.S. gun deaths were suicides (Centers for Disease Control and Prevention [CDC], 2020). Firearms result in death in 90% of cases where the person attempts suicide with a gun (Anestis et al., 2021).
- **Medications**
  Medication overdose is the most common means of attempting suicide (64%) but results in fatality 1.5% of the time (Harvard T. H. Chan School of Public Health, n.d.).

  Medication overdoses can be medically reversed, interrupted, or aborted more easily than an attempt by firearm. However, some medications can be highly lethal when taken in large quantities or when taken in combination with other substances.

You should also prioritize counseling around any methods your client has specifically mentioned as part of their suicide plan.

**Wendy's Lethal Means**
As you might recall, Wendy is distressed by her loss of independence and chronic pain. She has also been diagnosed with posttraumatic stress disorder. She recently engaged in suicidal behavior (i.e., an interrupted attempt). Wendy denies current suicidal thoughts or desire.

"I don't want to die. I just want the pain to stop."

Does Wendy need lethal means counseling?

A. **Yes**
B. No

Feedback [Wendy's current distress, behavioral health condition, and history of suicidal behavior suggest she needs lethal means counseling. A lethal means reduction plan will lessen the likelihood she will die if she has suicidal urges again.]

**Principles of Effective Lethal Means Counseling**

Key elements to effective lethal means counseling include (SPRC, 2018):

- **Direct:** You should directly and specifically ask about access to firearms, medications, and other lethal means.
- **Conversational:** The client should not feel interrogated. A conversational approach encourages engagement.
- **Collaborative:** Do not dictate how a client should reduce access to lethal means. Decisions should be made together.
- **Respectful:** Work within the client's culture and personal values. Respectful dialogue can be important when your client identifies with firearm culture.
- **Temporary:** In order to preserve autonomy and encourage engagement, it can help to emphasize that the lethal means reduction plans are temporary.
- **Voluntary:** Participation in lethal means counseling is voluntary. You can emphasize this point by avoiding words like "restrict," "surrender," and "get rid of."
- **Specific**: Lethal means counseling should result in a specific and feasible plan with clearly defined steps.

**Steps for Lethal Means Counseling**

There are six basic steps to lethal means counseling (SPRC, 2019):

1. Raise the issue
2. Assess for lethal means
3. Motivate participation
4. Develop a plan
5. Review and document
6. Follow up

As you learn more about these, consider the kinds of questions you might ask Wendy as you implement lethal means counseling.

**Step 1: Raise the Issue**

You should start by informing the client about the reason you are asking about lethal means. Your introduction will vary based on the situation that prompted the assessment. It is important to be non-confrontational and direct.

You raise the issue with Wendy by saying:

- "You mentioned that you had planned to die by jumping off a highway overpass. Thoughts of suicide can escalate quickly. It would help if we could talk about anything else that might affect your safety."

**Step 2: Assess for Lethal Means**

Assessing for lethal means includes asking directly about potentially dangerous items in the

home that could be used for suicide.

***Involving Others***
When your client is not the person in charge of storing firearms or other lethal means, you should involve the person who is. Family involvement is especially important when working with youth. You should have the client's permission and authorization to engage others in lethal means counseling.

In Wendy's case, you learn that her sister owns a firearm and helps her manage medications due to memory issues.

You might say:

- "It sounds like it might help to include your sister in this part of the process. Could we invite her in to make sure we have a clear idea of what's in the home and how we can best keep you safe?"

***Asking about Firearms***
Because gun ownership can be a polarizing topic in the U.S., it is especially important to use a non-judgmental and collaborative approach when assessing access to firearms. Allow your client's body language and responses to guide the conversation.

You briefly introduce yourself to Wendy's sister and explain that you have invited her to join the session to figure out ways to keep Wendy safe. Both Wendy and her sister seem willing to participate and open to your questions.

One way to ask about firearms is:

- "Many people have firearms in their homes. Can you tell me about any guns in the home and the ways they are stored?"

***Asking about Medications***
When assessing access to medications, also ask about unused or old prescriptions. You should also inquire about other substances the person may use since certain combinations can have more lethal outcomes.

Wendy will likely have concerns about losing autonomy if her sister must manage even more of her medical care. Respect her concerns when conducting the assessment.

One way to ask about medications is:

- "We should also talk about the different types of medications you have in your home and how they are stored."

**Step 3: Motivate Participation**
Motivation for participation in lethal means counseling varies. Some people worry about judgment, and others worry about being controlled. Your client's body language and responses to initial questions about lethal means will suggest the extent of conversation needed to promote motivation.

Help clients identify their own reasons for (or against) reducing access to means through motivational interviewing principles and techniques (Anestis et al., 2021; Britton et al., 2016).

You learn that Wendy has access to her medications. She uses a pill sorter to ensure that she takes them as prescribed. She says she has access to lethal doses of opioids and other medications.

After talking more about Wendy's access to medications, you summarize the conversation by:

- **Providing Affirmations**
  "It sounds like your current approach to managing medications helps you retain some independence. It shows strength and creativity to use strategies that work for you."
- **Reflecting Ambivalence**
  "You also said you might be tempted to take them if you're suicidal again and agreed your approach might not always be safe."

**Step 4: Develop a Plan**
Remember that the plan should be collaborative and the client should share in decision-making. Do not take a directive approach. Instead, explore options to reduce access to lethal means.

The plan should identify specific ways to reduce access to (SPRC, 2019):

- Firearms
- Possibly lethal medications
- Other suicide methods the client has considered

***Reducing Access to Firearms***
The safest way to reduce a person's access to firearms is to store guns outside of the home. You might consider a friend, family member, or third-party network (e.g., police department, gun retailer, pawnshop).

You should familiarize yourself with (American Public Health Association, 2018):

- Federal and state regulations
- Categories of individuals who can legally possess a firearm
- Rules about the temporary transfer of firearms between individuals

If your client refuses or is unable to store their firearm outside of the home, explore in-home options such as:

- Gun safe or lockbox
- Trigger, cable, or internal locks
- Storing ammunition separately and keeping the gun unloaded

For instance, you could support Wendy in asking her sister:

- "Would you be willing to lock your guns in a safe that I cannot access and then store the ammunition in another location?"

Hiding guns is not a recommended approach. An unloaded gun will be safer than a loaded gun. A locked gun will be safer than an unlocked gun.

***Reducing Access to Medication***
If your client has unused or old medications, you can help them locate a medication take-back program in your area. If no such program is available, they or a loved one might dispose of the medication. One strategy is to mix medications with an inedible substance (e.g., used coffee

grounds, kitty litter) and place them in the trash.

If your client uses or has access to opioids, ensure that the household has access to the opioid reversal agent naloxone (Narcan®).

Other methods of reducing access to medications include (Miller et al., 2020; SPRC, 2018):

- Limit the amount of medication your client can access.
- Store medications with high overdose potential in a steel, locked storage box.
- Enlist family members to store and dispense medication doses.
- Collaborate with the care team to reduce risk through prescribing choices.
- Prescribe smaller quantities of medications or use blister packaging (if applicable).

After talking more about Wendy's access to medication, you might say:

- "Would you be open to a temporary plan that limits your access to anything that could do serious harm if you took it all at once?"

***Reducing Access to Other Means***

Your client should have described any suicidal plans or past attempts during the suicide risk assessment. Review the information to identify any other means they might consider.

When working with Wendy, you might say:

- "You said you almost jumped off a highway overpass near your home. Let's talk about ways you can stay safe and avoid that bridge."

**Step 5: Review and Document**

During this step, providers should (SPRC, 2019):

- Agree on everybody's role.
- Identify when each step will occur.
- Detail the plan in your client's chart.
- Provide the written plan to your client.
- Review the plan to ensure everyone agrees.
- Inform the client you will follow up in a few days.

Toward the end of the session, you might say to Wendy and her sister:

- "Let's review the plan we've developed together. When you get home, your sister is going to store her unloaded guns in a safe and keep the ammunition in another part of the house unknown to you.

  She will also dispense your meds in the morning, afternoon, and at night. All medications will be locked in a storage container.

  When you go for walks, you'll avoid that overpass. We mapped out a few routes earlier in the session that take you to a nearby park.

  We will keep with this plan for the next two months and then re-evaluate. Does that sound good for now?

I wrote everything down and will make you each a copy. I'll follow up in 3 days to see how the plan is going. How does that sound?"

Bear in mind that your summary should be conversational. Pay attention to your client's body language. Include check-in questions (e.g., "does that make sense?") and pauses to allow for engagement.

**Step 6: Follow-Up**
Research shows that follow-up contact reduces the likelihood of hospitalization and increases the odds the plan will be implemented (SPRC, 2019). Strategies for effective follow-up include:

- Be direct
- Confirm the plan is implemented
- Troubleshoot obstacles if necessary

You call Wendy and say:

- "Hi, Wendy! I was just checking in to see how the safety plan is going."

You would then reinforce Wendy's adherence to the plan and troubleshoot any parts where she needs help.

### Review

When you follow up with Wendy about the lethal means reduction plan, you learn that her sister has been limiting Wendy's access to knives and has told her to leave the door open when in the bathroom. Wendy is upset.

"She's afraid I'm going to kill myself. I feel like a child, and we are arguing a lot because I refuse to use the bathroom with the door open. Can you talk to her?"

You agree to meet with Wendy's sister. What is the MOST important point to emphasize in your conversation?

A. Tell Wendy's sister she will be removed from the lethal means reduction plan if she continues this behavior.
   Feedback [This strategy will likely come across as threatening and may not help Wendy. Wendy should share in decision-making about updates to her lethal means reduction plan. Wendy's sister should be reminded that the plan is supposed to be voluntary and collaborative.]
B. **Remind Wendy's sister that the plan is supposed to be voluntary and collaborative.**
   Feedback [Any changes to the lethal means reduction plan should be decided by Wendy, not her sister. If Wendy's sister has new concerns, there are ways to discuss them and collaborate to update the plan.]
C. Ask Wendy's sister if she thinks the lethal means reduction plan should be updated.
   Feedback [Wendy should share in decision-making about updates to the lethal means reduction plan. You should remind Wendy's sister that the plan is supposed to be voluntary and collaborative.]

### Summary

Safety planning and lethal means counseling are brief interventions that reduce the risk someone will die by suicide.

A safety plan is a personalized guide to help clients manage suicidal thoughts and urges. Lethal means counseling specifically assesses your client's access to deadly suicide methods and then results in a specific plan to store or remove lethal means until risk subsides.

These plans should be developed in collaboration with the client so that they share in decision-making. The best time to develop a safety plan is before a suicidal crisis.

## Section 5: Conclusion

### Course Summary

Now that you have finished viewing the course content, you should have learned the following:

- The factors you should consider when determining what interventions may be needed for suicidal individuals
- Three evidence-based interventions for treating individuals at risk for suicide or who have made a recent attempt
- The process for completing a safety plan and for reducing access to lethal means

### Course Contributors

**The content for this course was written by Bridgett Ross, PsyD.**
Bridgett Ross, PsyD. received her bachelor's degree in Psychology and Philosophy from Boston College and then her doctoral degree in Clinical Psychology from Alliant International University. She is a licensed psychologist in California and was in private practice for 13 years treating various issues including trauma, anxiety and mood disorders, grief/loss, and issues around self-concept, identity, and attachment. Having supervised pre-licensed and licensed clinicians, she maintains an interest in professional issues in the field of psychology. Dr. Ross' training and work history include Children's Hospital Chadwick Center for Children and Families, Kaiser Permanente, Alvarado Parkway Institute, and the Department of Veterans Affairs, which informed her focus on providing evidence-based trauma treatment to diverse populations.

**Acknowledgment:** Monique Kahn, PsyD was the previous author of this educational activity but did not participate in the revision of the current version of this course.

### Resources

**Caring Contacts**
https://zerosuicide.edc.org/resources/resource-database/nowmattersnow-caring-contacts

**Safety Planning**
https://suicidesafetyplan.com/

**Lethal Means Counseling**
Websites with information and training on lethal means counseling:

***Free Counseling on Access to Lethal Means (CALM) Course***
https://zerosuicidetraining.edc.org/enrol/index.php?id=20