Wisconsin Zero Suicide Training 2025

JULY 30 & 31, 2025

VIRTUALLY ON ZOOM

Disclaimer Language

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Housekeeping Items

Participants will be automatically muted when not speaking.

Participants are strongly encouraged to share their video.

Feel free to use the chat if you have questions during presentations.

Emotional Support

Check in with Kelsey if you need to step away for any reason.
The following resources are also available:

988 Suicide & Crisis Lifeline 24/7 Call, Text, Chat

Non-Crisis Peer-Run Warmlines in Wisconsin:

Solstice House: (608) 244-5077

Iris Place: (920) 815-3217 (Wednesday)

Monarch House: (715) 505-5641

MHA's R&R House Warmline (Veterans): (262) 336-9540

Day 1 Agenda

- 9:00-9:30am- Welcome & Introductions
- 9:30-10:10am- Belief and Attitudes Exercise
- 10:10-10:25am- BREAK
- 10:25-11:10am- Trauma Informed Care and Lived Experience
- 11:10-12:15pm- ZS Element: LEAD
- 12:15-1:00pm- LUNCH BREAK
- 1:00-2:20pm- ZS Element: TRAIN
- 2:20-2:35pm- BREAK
- 2:35-3:45pm- ZS Element: IDENTIFY
- 3:45pm-4:00pm- Closing

Day 1: Welcome!

THANK YOU FOR JOINING SYSTEMS IN WISCONSIN AND NATIONWIDE STRIVING FOR ZERO SUICIDE AMONG PATIENTS IN CARE.

ZEROSUICIDE.EDC.ORG; PREVENT SUICIDE WISCONSIN ZERO SUICIDE TOOLS

Introductions – WI Zero Suicide Faculty

Erica Steib
Kelsey Van Hoorn
Brian Michel
Sue Jungen
Andrea Nauer-Waldschmidt
Jim Salasek
Toni Simonson
Val Neff
Patty Slatter
Julianne Dwyer

Team Introductions: Delete slide

1. Team Member Names
2. Location(s)
3. Type of Organization
4. One reason for your organization’s interest in Zero Suicide

CRISIS RESOURCE CENTERS (Affiliate of Centers for Independence)

Team members:

Alyssa Starck, Marylyn Batory, Sha'Ron Maclin, Nicole Re, Alli Lane, Pa Xiong, Diana Rhyne

Locations:

3 MKE CRCs & 1 Waukesha CRC

Type of Organization:

Short-term crisis stabilization & hospital diversion program (Community-based organization w/ clinical providers)

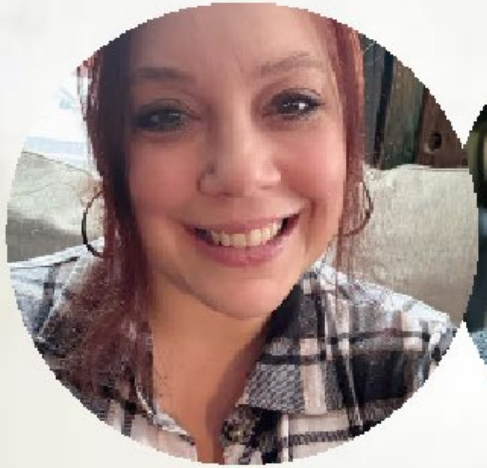
We hope to enhance our current suicide assessment via incorporation of more evidence-based tools, while maintaining our unique level of care & de-institutionalized, home-like atmosphere.

Native Collective Research Effort to Enhance Wellness (NCREW)

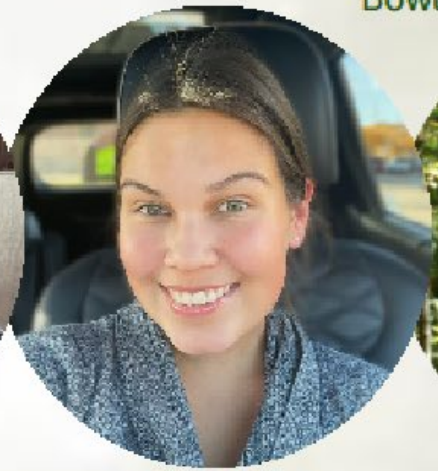
"An effort support Native American communities to lead public health research to address overdose, substance use, and pain, including related factors such as mental health and wellness."

Current Project: Adolescent Recovery and Wellness Center
Bowler, WI

We are so excited to be working with Zero Suicide to expand our knowledge and create a supportive, encouraging environment for our youth population. Currently, suicide is the leading cause of death among Indigenous youth. We are committed to exploring ways to successfully reduce these devastating statistics and work to provide our youth with a full realm of resources and services. Thank you for choosing to work with us!
-Aurora Hesse



Teresa Juga
NCREW Program Director



Aurora Hesse
NCREW Program Coordinator

Lizette Bailey
NCREW Program Assistant

GREAT LAKES INTER-TRIBAL COUNCIL INC.

Red Cliff Community Health Center

Red Cliff, Wisconsin

Mental Health America of Wisconsin

Zero Suicide Team Members

- *Diane Erickson, Health Administrator-Administrative Staff*
- *Nicole Gurnoe, MS, LPC-Lead Clinician*
- *Justin Hansen, Lead Peer Specialist*
- *Dani Montgomery-Community Partner/Information Technician*
- *Gabby Gordon, Program Evaluator-Quality Improvement*
- *Jared Blanche, Tribal School Liaison*
- *Craig Bell, Peer Specialist*
- *Lorna Gamble, Wrap Around/CCS Service Facilitator-Community Partner*

To provide Tribal wide suicide awareness and protocol trainings, implementation and continued monitoring of the need for improvements throughout the organization, community and school district.

SSM Health of Wisconsin

Team Member Names

- Megan and Rachel – Community Health
- Kim, Andrea, Jake, Miranda, and Sarah – Ambulatory Behavioral Health
- Sara and Jena – Virtual Behavioral Health Integration
- Christina – Inpatient Behavioral Health
- Brenda and Heather – Trauma
- Autum – Emergency Services
- Jodie, Sydnee and Lea - Community Representatives

Locations

- St. Mary's Hospital – Madison
- St. Mary's Hospital – Janesville
- Monroe Clinic Hospital
- St. Clare – Baraboo
- St. Agnes Hospital
- Ripon Community Hospital
- Waupun Memorial Hospital
- Dean Medical Group

Healthcare Organization

Our 2024 Community Health Needs Assessments in all service areas for the SSM Health WI Region indicated suicide prevention as a key initiative under the Mental Health priority. Further, as we continue our internal One WI model across our hospitals and markets, we strive to create a consistent, yet equitable approach to providing care to our most vulnerable patients.

ThedaCare
Behavioral Health

Mental Health America of Wisconsin

Team Member Names: Michele Crawford, Chris Matula, Paula Pedretti, Lindley Wilkerson, Kyrsten Danby, Caitlin Reider, Samantha Davies, Shastina Vang, Melissa Laughlin Holtz

Location(s): Appleton, Neenah, Menasha, New London, Waupaca, Shawano, Oshkosh, Berlin

Type of Organization: Out-Patient Behavioral Health

One reason for your organization's interest in Zero Suicide: We are interested in continuing to provide evidence based suicide prevention to our patients.

Objectives

- Explore our attitudes about suicide.
- Explore the seven elements that comprise this approach.
- Understand the perspective of those with lived experience.
- Touch on how Zero Suicide principles and practices can be extended into the community.
- Develop a realistic implementation plan.

Community of Practice

Monthly Meetings

EDC and Faculty support

Zero Suicide listserv

E-newsletter, website, and conference

Beliefs & Attitudes About Suicide Exercise

Exploring what we bring into each conversation (emotions, beliefs, teachings, etc.) is an important aspect of what it takes to have difficult conversations.

This exercise is taken from the "Alternatives to Suicide" curriculum developed by the Wildflower Alliance formerly known as the Western Mass Recovery Learning Community.

The "Alternatives to Suicide" approach represents an alternative to risk assessment, pathology, and force, and has been adopted in many settings throughout the U.S. as well as Canada and Australia. This way of being incorporates the VCVC model of Validation-Curiosity-Vulnerability-Community and emphasizes connection over control.

To learn more about training in this approach, please reach to info@wildfloweralliance.org.

Activity Instructions

Head to the website by clicking this link or entering it manually: https://wzst2025.consider.it/ Insert your name, a pseudonym or “anonymous”, followed by your email and a password.

Respond to the Belief statement by selecting an opinion along the spectrum.

You may provide comments regarding your Belief anonymously by **unchecking** the box to “Sign your Name”.

“I believe that people who kill themselves are selfish.”

“I believe that suicide is linked to a mental illness for most people.”

“I believe certain thoughts and feelings are always a predictor for suicide.”

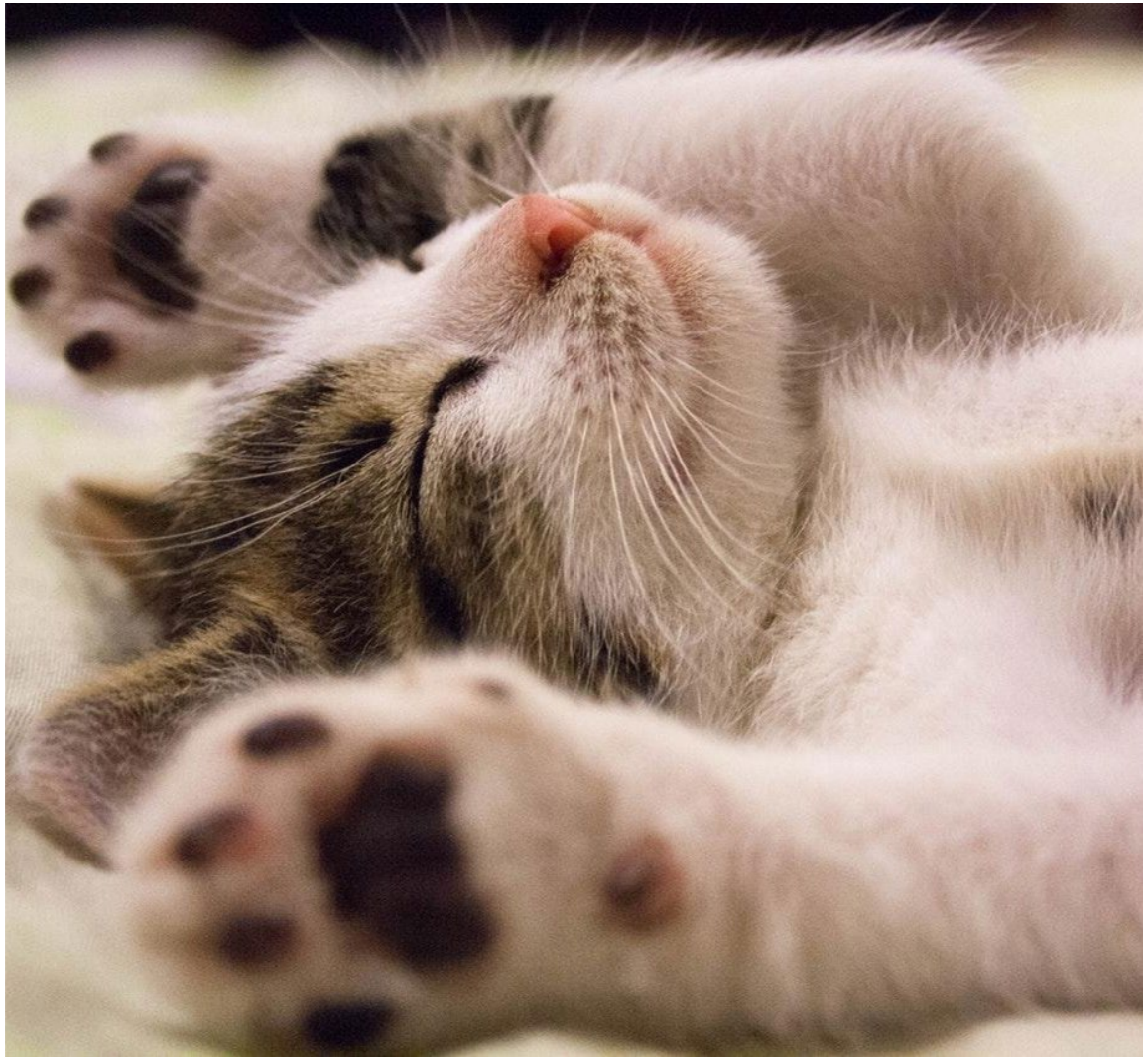
“I believe that it is my responsibility to stop people from killing themselves.”

What We Bring to the Table

What is this exercise bringing up for you so far?

What are you learning regarding your own beliefs?

How might these beliefs impact your ability to talk openly about suicide?

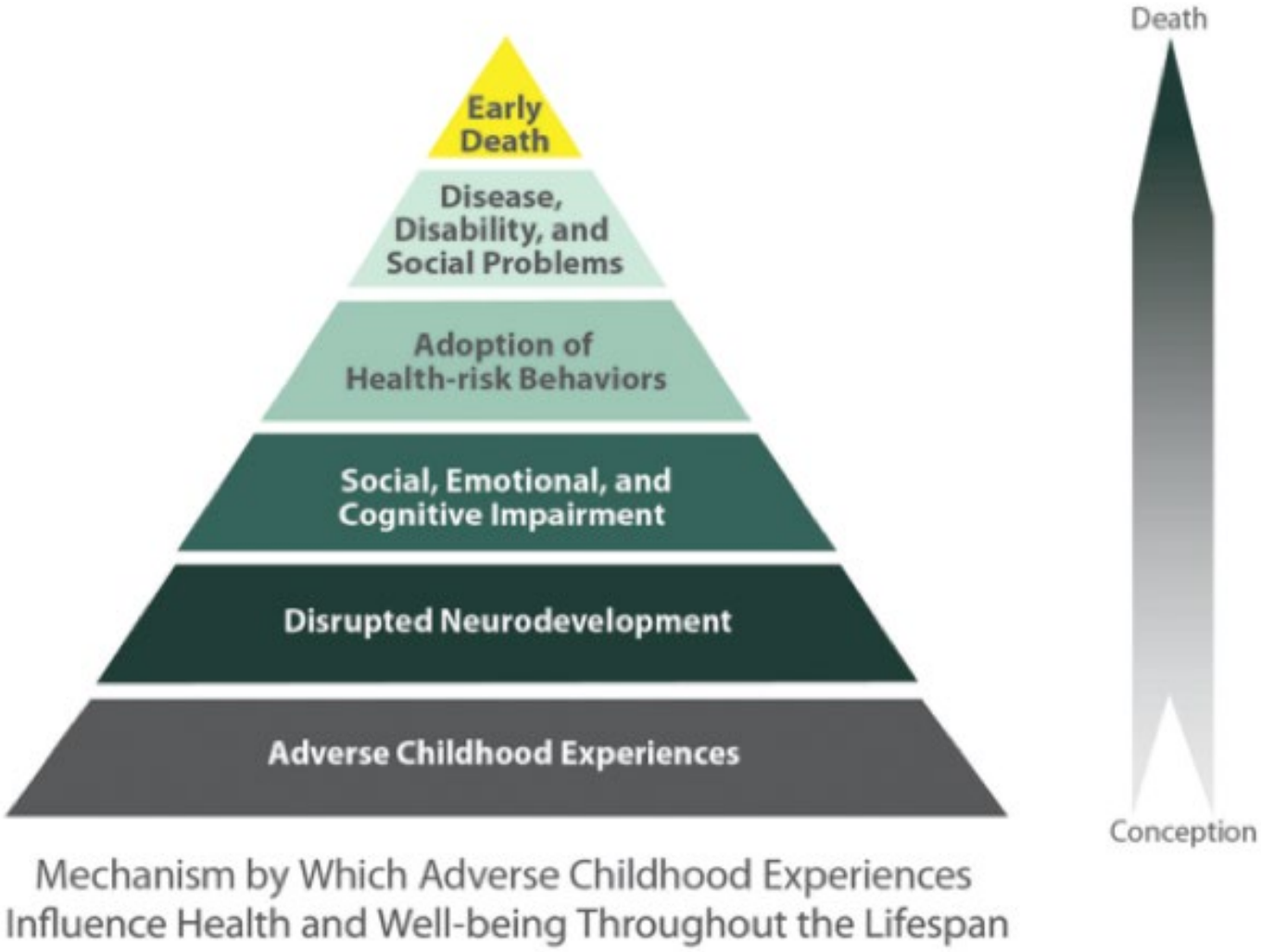


Break

15 MIN

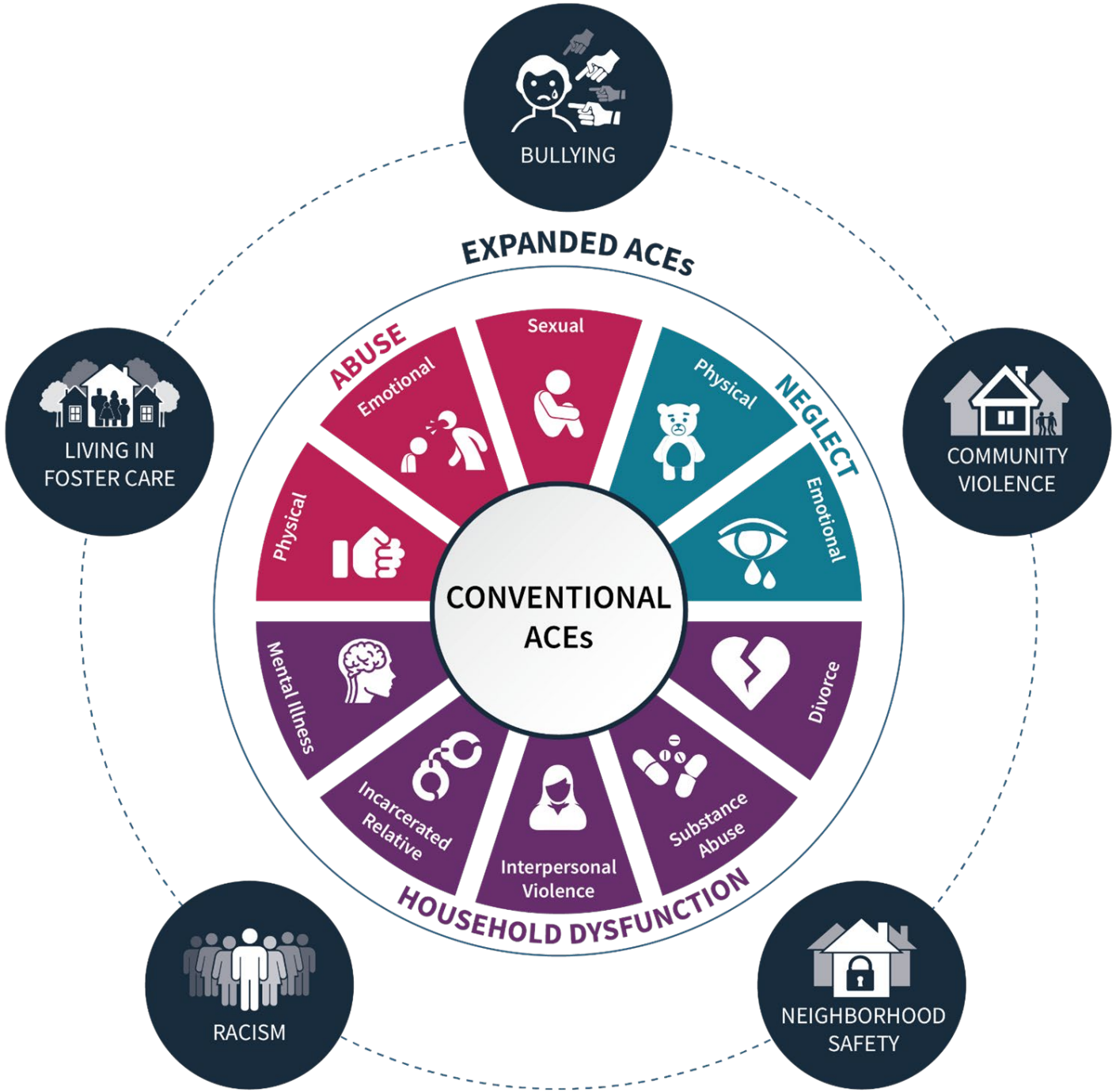
Reducing suicide through TIC

We need to integrate trauma-informed care principles into our approaches to suicide prevention.

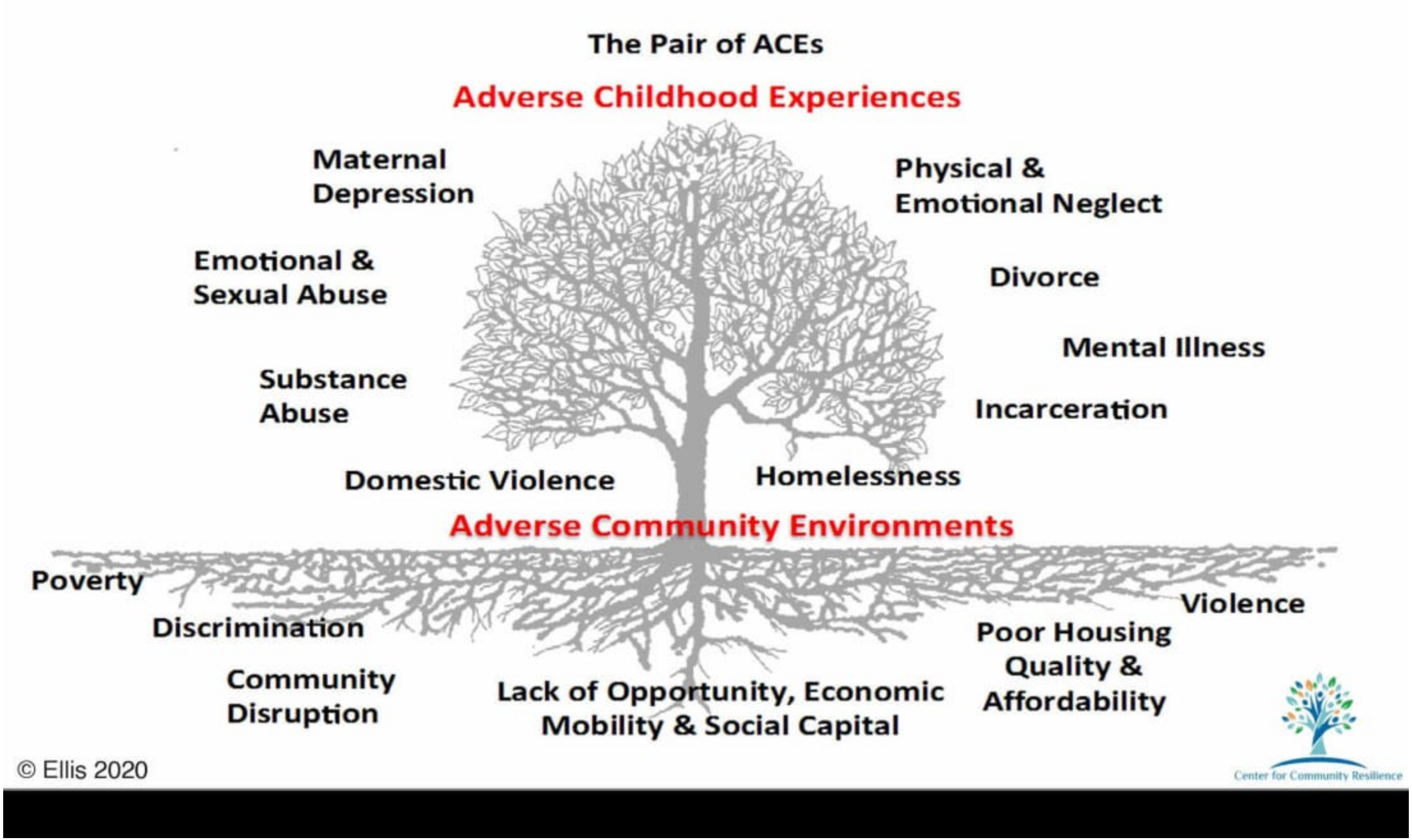


Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

https://embed.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime



Source: Cronholm, P.F., Forke, C.M., Wade, R., Bair-Merritt, M.H., Davis, M., Harkings-Schwartz, M., Pachter, L.M., & Fein, J.A. (2015). Adverse childhood experiences: Expanding the concept of adversity. *American Journal of Preventive Medicine, 49(3)*, 354-361.


The Pair of ACEs
Adverse Childhood Experiences
Maternal Depression
Physical & Emotional Neglect
Emotional & Sexual Abuse
Divorce
Mental Illness
Substance Abuse
Incarceration
Domestic Violence
Homelessness
Adverse Community Environments
Poverty
Violence
Discrimination
Poor Housing Quality & Affordability
Community Disruption
Lack of Opportunity, Economic Mobility & Social Capital
© Ellis 2020
Center for Community Resilience

Key Findings about ACEs in Wisconsin

Prevalence:

- Wisconsin adults report experiencing ACEs at rates comparable to other states, with over 60% reporting at least one ACE. According to the Wisconsin Behavioral Risk Factor Surveillance System, over 60% of Wisconsin adults have one or more ACEs. The more ACEs someone has, the greater their risk of poor health. Nearly 4 out of every 10 Wisconsin adults have experienced multiple ACEs.

Specific ACEs:

- Among the most common ACEs reported by Wisconsin adults are emotional abuse (nearly 30%), having a parent with a substance abuse problem (more than 25%), and parental separation or divorce (almost 25%).

Racial and Ethnic Disparities:

- While 59% of white Wisconsinites report at least one ACE, rates are higher among Black (77%), Hispanic (73%), Asian (65%), and American Indian (64%) populations.

Long-Term Impacts:

- ACEs are linked to a range of negative outcomes in adulthood, including poor physical and mental health, substance abuse, and risky behaviors, according to the Wisconsin Department of Health Services (.gov).

ACE impact on Indigenous populations

A study completed by Giano et al., (2021) used Behavioral Risk Factor Surveillance System (BRFSS) data across 34 states between 2009 to 2017.[3] It is one of the largest studies of ACES for AI/AN communities to date. Their key findings revealed:

2.32 is the average ACE score for AI/AN individuals. This is 50% higher than for White (1.53) individuals, and 40% higher than for Black (1.66) and Hispanic (1.63) individuals.

ACE scores are **higher for female AI/ANs** than for male AI/ANs (2.52 compared to 2.12).

2.55 is the average ACE score for AI/ANs with less than a high school degree, compared to 2.00 for those with a college degree.

AI/ANs who identify as **gay, lesbian, or bisexual** have significantly higher ACE scores.

AI/ANs who earn less than **$15,000** have the highest ACE scores (2.65 compared to 2.31 for individuals making $50,000+.

Younger AI/ANs tend to report higher ACE scores than older AI/ANs.

Giano, Z., Camplain, R. L., Camplain, C., Pro, G., Haberstroh, S., Baldwin, J. A., Wheeler, D. L., & Hubach, R. D. (2021). Adverse Childhood Events in American Indian/Alaska Native Populations. American journal of preventive medicine, 60(2), 213–221. https://doi.org/10.1016/j.amepre.2020.08.020

Another study by Kenney & Singh, (2016) examined ACEs among AI/AN children (aged 0-17 years) using parental responses from the 2011-2012 National Survey of Children's Health.[4] Their findings revealed that:

AI/AN children are **2-3 times** more likely to have **multiple ACEs** compared to non-Hispanic White children.

AI/AN children with **2+ ACEs** have higher rates of **anxiety or depression** compared to non-Hispanic White children.

AI/AN children are...

7 times
more likely to experience unfair treatment due to race/ethnicity

2-3 times
more likely to have an incarcerated parent, observe domestic violence, or live with a substance abuser

1.5 times
more likely to live in families with difficulty covering basics like food or housing, with a divorced or separated parent, or with a parent who died

...than non-Hispanic White children.

Kenney, M. K., & Singh, G. K. (2016). Adverse Childhood Experiences among American Indian/Alaska Native Children: The 2011-2012 National Survey of Children's Health. Scientifica, 2016, 7424239. https://doi.org/10.1155/2016/7424239

Adverse Childhood Experiences (ACE)

The signs of an adverse childhood experience can include:

Fear of other people.

Difficulty sleeping or frequent nightmares.

Bedwetting.

Changes to their mood.

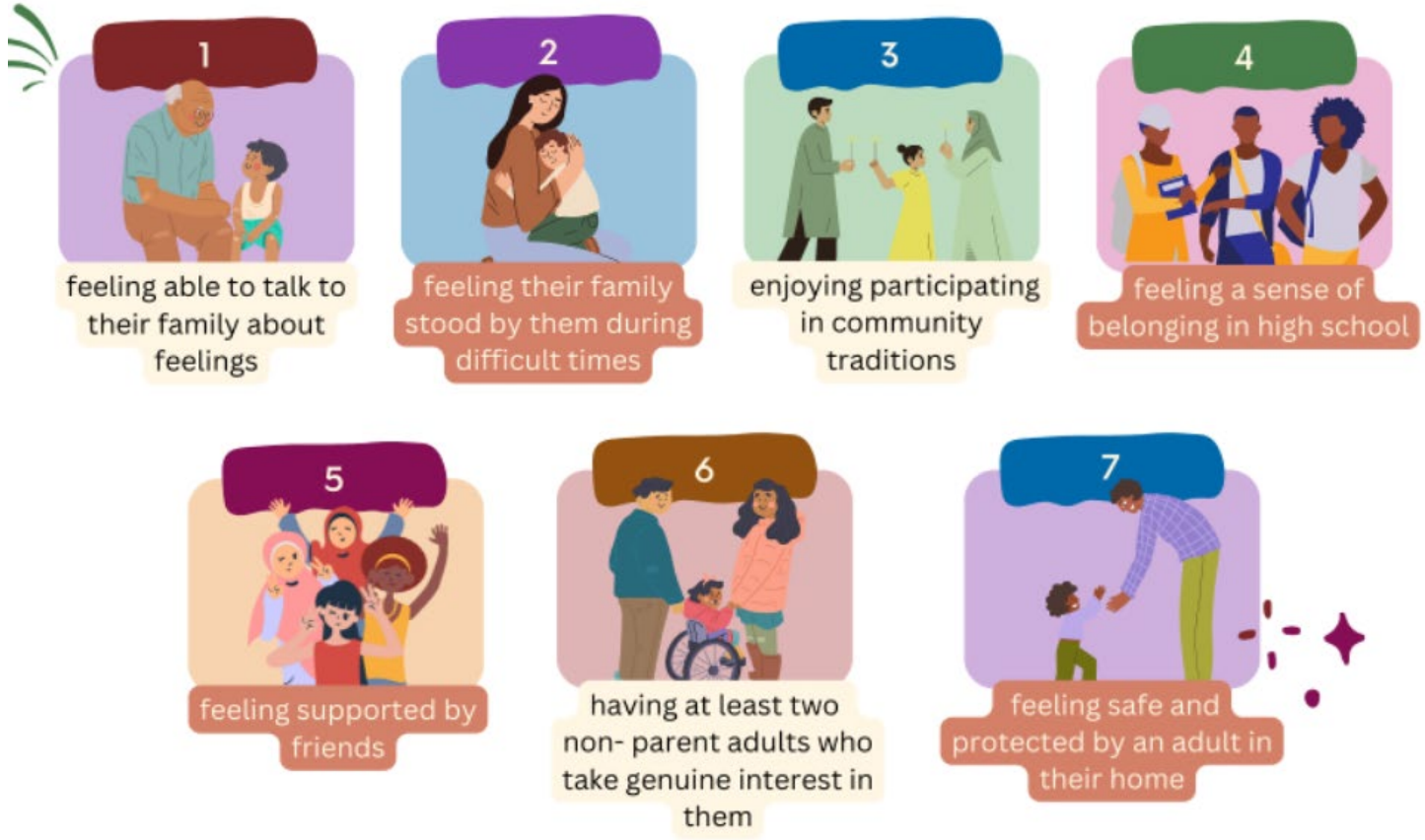
Difficulty showing affection.

Difficulty learning in school.

Avoiding situations or events that relate to a traumatic experience.

Cleveland Clinic

What are **Positive Childhood Experiences (PCEs)**?

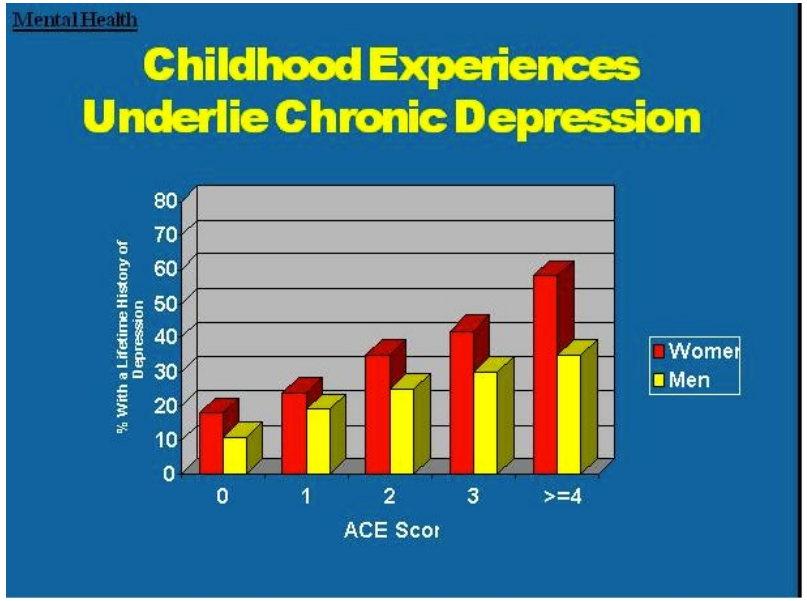


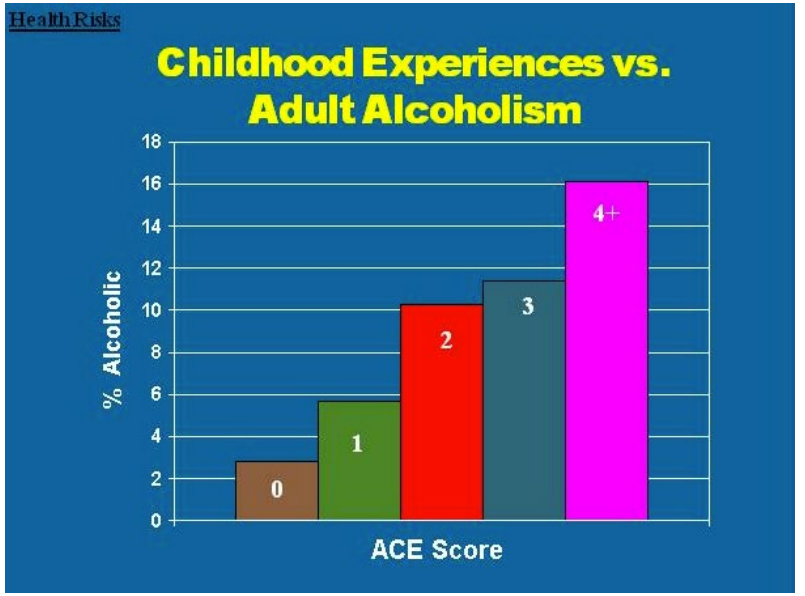
Research shows that when PCEs are **actively promoted** during early childhood, adult mental health risks are significantly **reduced**!

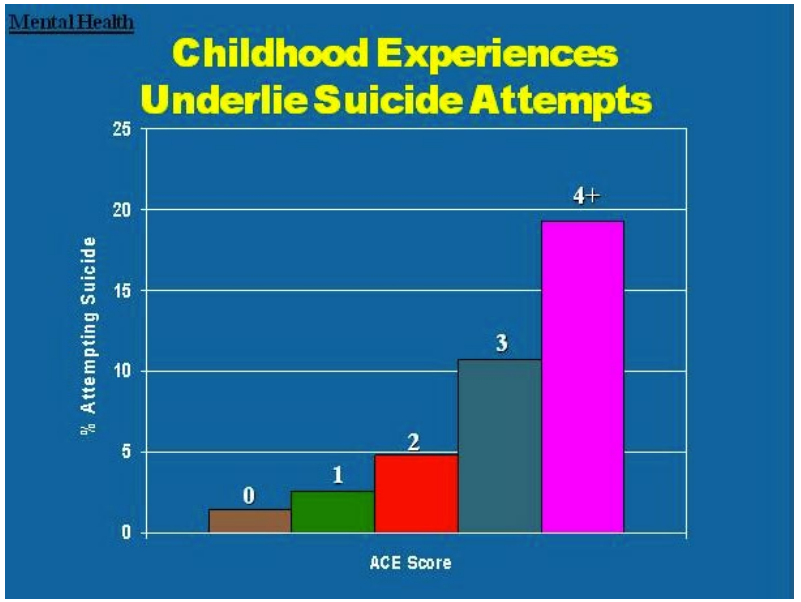
CAHMI The Child & Adolescent Health Measurement Initiative
Promoting early and lifelong health using family-centered data and tools

Scan here to read our research

www.cahmi.org


Mental Health
Childhood Experiences
Underlie Chronic Depression
% With a Lifetime History of Depression
80
70
60
50
40
30
20
10
0
0
1
2
3
>=4
ACE Scor
Women
Men


Health Risks
Childhood Experiences vs.
Adult Alcoholism
% Alcoholic
18
16
14
12
10
8
6
4
2
0
0
1
2
3
4+
ACE Score


Mental Health
Childhood Experiences
Underlie Suicide Attempts
% Attempting Suicide
25
20
15
10
5
0
0
1
2
3
4+
ACE Score

Trauma-informed care approach (Resources)

Adverse Childhood Experiences in Wisconsin

- https://www.dhs.wisconsin.gov/aces/adverse-childhood-experiences.htm
- https://www.dhs.wisconsin.gov/aces/index.htm
- https://www.americashealthrankings.org/explore/measures/ACEs_8_overall/WI

Wisconsin's Office of Children's Mental Health https://children.wi.gov/Pages/Innovate/TIC.aspx

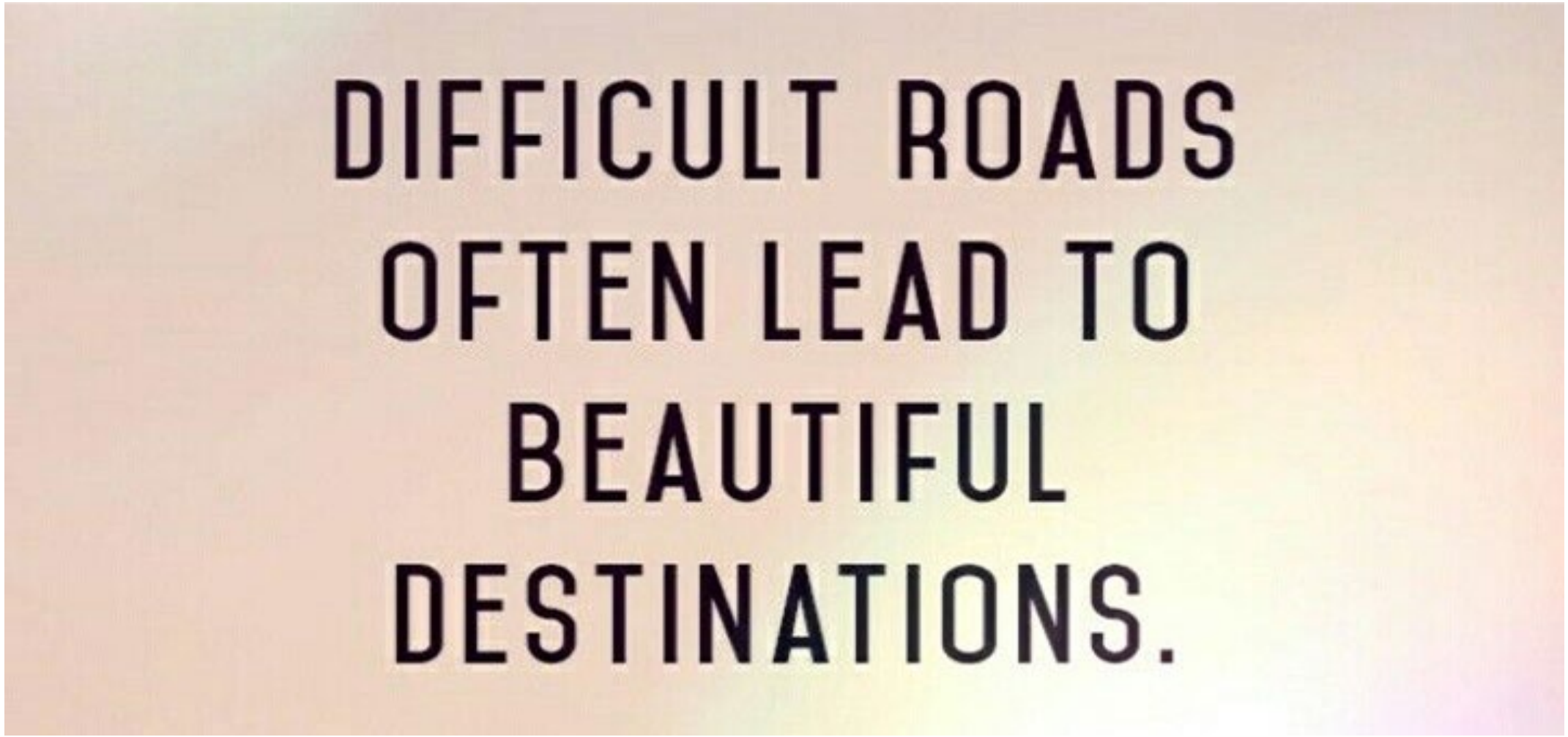
Adverse Childhood Experiences (ACEs) – Educator Resources
https://parenting.extension.wisc.edu/parenting-educator/aces-and-trauma-informed-care/adverse-childhood-experiences-aces-educator/

Wellpoint Care Network Tim Grove, Senior Consultant tgrove@wellpointcare.org

- Trauma Informed Care https://wellpointcare.org/ https://wellpointcare.org/mission/our-approach/trauma-informed-care
- Seven Essential Ingredients of Trauma Informed Care https://wellpointcare.org/mission/our-approach/trauma-informed-care/seven-essential-ingredients-of-trauma-informed-care

Wisconsin ACE-Interface Network Across the state of Wisconsin, professionals are trained to educate on the effects of Adverse Childhood Experiences (ACEs) and the long-term effects on life-long health. Our network of trainers are available to give free trainings to anyone in the state that is interested in learning more about this important topic.

https://www.carrollu.edu/academics/health-sciences/majors/public-health/wisconsin-ace-interface-network


DIFFICULT ROADS
OFTEN LEAD TO
BEAUTIFUL
DESTINATIONS.

Zero Suicide Element: Lead

LEAD SYSTEM-WIDE CULTURE CHANGE COMMITTED TO REDUCING SUICIDE

Zero Suicide Element: Lead

- Implementation Team
- Top down
- Organizational Self-Study
- Workforce Survey
- Zero Suicide Work Plan Template
- Policies, procedures, and training
- Ongoing communication with Management and Staff

Zero Suicide Element: Lead

- Safety-oriented culture
- Just Culture
- Action plan around clinical leadership, establishing target dates for implementation
- Connect to and exchange with other leaders and organizations

Zero Suicide Element: Lead

Two Types of Leadership – Effective Leaders Combine Both

TECHNICAL LEADERSHIP

- Deal with immediate concerns
- Focus on the next thing
- Problems are easily defined
- Restore order
- Maintain norms
- Authority for problem solving

ADAPTIVE LEADERSHIP

- Big picture; vision for change
- Maintain focus on change
- Change is complex with no easy answers
- Expose conflict; help staff regulate distress
- Challenge norms
- Give the work back to staff

Zero Suicide Element: Lead

- Committed Leadership/Champions
- Include people with lived experience
- Introduce idea of community-level Zero Suicide work

Zero Suicide Element: Lead

County Human Service perspective

- Choosing our implementation team and changes over time
- Rolling it out across the Human Services Agency
- Champions

Lived Experience

"Personal knowledge about the world gained through first-hand involvement in everyday events rather than through representations constructed by other people."

It is also defined as "the experiences of people on whom a social issue or combination of issues has had a direct impact." (SPRC)


Peer support
Lived expertise
Personal lived experience of suicide
Lived experience
Relational lived experience of suicide
Peer specialist

Lived Experience: What It Is and How to Include It

Leah Harris

Zero Suicide Element: Lead

Lived Experience

- **P**assion
- **A**ble to receive positive or constructive feedback
- **S**upport from treatment providers
- **S**upportive environment
- **I**nvolvement in the community
- **O**pen to telling their story
- **N**AMI, MHA, other organizations

Implementation Planning: Lead

- Who else should be on the implementation team, how often should you meet? Including critical membership: IT, lived experience, finance/budget
- Who else needs to be involved/informed? How can you communicate this? How will you respond to resistance?
- Who are the champions across the organization?

BREAK

45 MINUTES

Zero Suicide Element: Train

TRAIN A COMPETENT, CONFIDENT, AND CARING WORKFORCE

Zero Suicide Element: Train
Step 1- Organizational Workforce Assessment

- Staff are assessed for the beliefs, training, and skills needed to care for individuals at risk of suicide.
  - Effective distribution methods are efficient and keep staff anonymous
  - Generate staff buy-in by providing incentives like an all-staff raffle or lunch for the team with the highest response rate
- Conduct an assessment of staff knowledge, practices, and confidence in providing safe suicide care, this assessment should be conducted at least every three years
  - Assess staff skills using the Workforce Survey (general version)
  - Workforce Survey for Indigenous Populations

Zero Suicide Element: Train
Step 2 - Organizational training

All staff, clinical and non-clinical, receive suicide prevention training appropriate to their role in providing safer suicide care

- Ensure that training contains the following elements for ALL staff:
    - The fundamentals of the organization's Zero Suicide philosophy
    - Policies and protocols relevant to the staff member's role and responsibilities
    - Basic, research-informed **training on suicide identification for all staff**

Suicide Care Training Options-

https://zerosuicide.edc.org/sites/default/files/2020-11/2020.11.18%20Suicide%20Care%20Training%20Options_0.pdf

Zero Suicide Element: Train
Step 3 - Organizational training

Additional training for all clinical staff ensuring:

- Basic level in skills related to assessment,
- Managing,
- Treatment planning for patients at-risk especially focused on safety planning and assessment of lethal means safety
- Advanced training to deepen skills and increase confidence and effectiveness

Consider Community level training and support so stakeholders are aware of your processes

Zero Suicide Element: Train

Examples of trainings available for non-clinical (and clinical) staff:

- Mental Health First Aid (MHFA)
- Question, Persuade, Refer (QPR)
- Applied Suicide Intervention Skills Training (ASIST)
- Connect Program
- Counseling on Access to Lethal Means (CALM)
- AMSR - Assessing and Managing Suicide Risk https://solutions.edc.org/solutions/zero-suicide-institute/amsr/amsr-services/amsr-training

Counseling on Access to Lethal Means (CALM)

A course primarily for mental health, medical social service providers and clergy

Two components:

1. who needs lethal means counseling, teaching practical skills on when and how to ask suicidal clients about their access to lethal means,

2. how to work with people at risk for suicide and their families to reduce access to lethal means

Can be completed in about 2 hours and in more than one session as needed.

Training Resources

- Zero Suicide website
- Suicide Prevention Resource Center
- Prevent Suicide Wisconsin: Webinars & Conference Calls
- YouTube or TedTalks utilizing key words for search
- Wisconsin Zero Suicide Virtual Training 2025 Resources and Trainings, handout

Involving Lived Experience

ZS Institute of Australasia Series: Train Video

Zero Suicide Element: Train

Human Service Agency perspective:

Workforce Survey

- Direct feedback on:
  - Self-perception of comfort
  - Opportunities

Zero Suicide Training Opportunities

- Increase confidence, competence, and compassion of workforce
  - Offering trainings for a variety of expertise (clinician staff, certified peer specialists, etc.)
  - Contracted providers

Implementation Planning: Train

- What are the logistics of implementing the workforce survey in your organization?
  - Who needs to be involved?
  - How will you collect workforce survey data?
  - How will you share results with staff?
  - What will your capacity be to implement training?
- What factors must be addressed to facilitate additional training; e.g., training budget, scheduling time? How can this be incorporated into new employee training?
- How do you maintain healthy and compassionate staff? What type of supervision is offered to those working with people at risk?

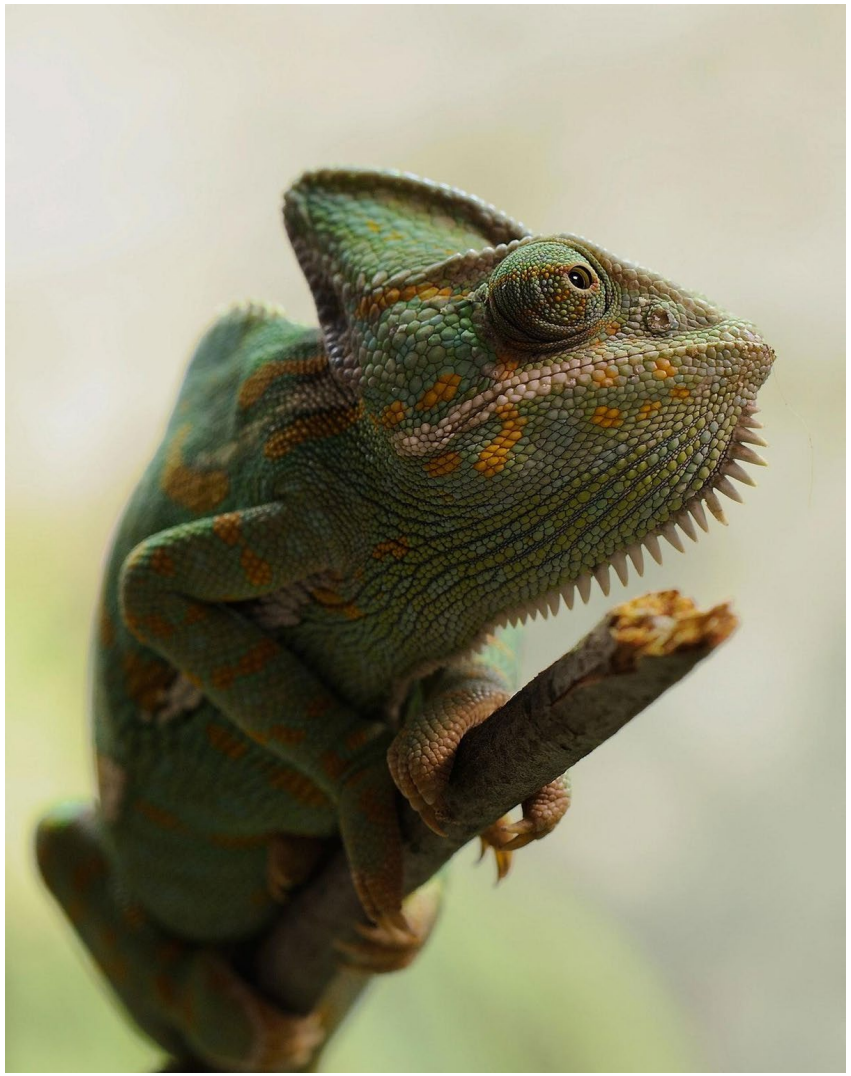
Training Reflection

How are feeling at this point during the training?

Please add a word or phrase to the word cloud about how you are feeling at this point in the training

There are no right or wrong answers!

Follow this link or QR code:
https://www.menti.com/al7m4bc8gbs9



Break
15 minutes

Zero Suicide Element: Identify

IDENTIFY INDIVIDUALS AT RISK OF SUICIDE VIA COMPREHENSIVE SCREENING AND ASSESSMENT

Zero Suicide Element: Identify

All persons receiving care are screened for suicidal thoughts and behaviors at intake.

Positive screen => risk assessment

Zero Suicide Element: Identify

Standardized screening

Assessment

Policies and procedures to provide direction and guidance

Zero Suicide Element: Identify

Screening for Suicide Risk

- Formulating a Risk Assessment
- Inpatient settings
- Screening tools available

Attempts

No complete count is kept of suicide attempts in the U.S.; however, each year the CDC gathers data from hospitals on non-fatal injuries from self-harm.

Approximately **one million** people in the U.S. each year engage in intentionally inflicted self-harm.	Females attempt suicide **3** times more often than males.	Males are **4** times more likely than females to die by suicide.

Risk factors

- Previous Suicide Attempt
- Trauma or Abuse
- Family History
- Social Isolation

Risk factors (continued)

- A pattern/history of aggressive or antisocial behavior
- Discharge from inpatient psychiatric care
- Access to lethal means
- Acute or enduring unemployment
- Stress (job, marriage, school, relationships, etc.)
- Physical health problem

Signs of concern

Many people who die by suicide show one or more of the behaviors listed below. The risk of suicide is greatest when the behaviors listed below are the result of a painful event, loss, or change.

- Talking about wanting to die or to kill themselves
- Looking for a way to kill themselves, like searching online or buying a gun
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated
- Sleeping too little or too much
- Withdrawing or isolating themselves
- Showing rage or talking about seeking revenge
- Extreme mood swings

Screening Follow-Up

***A history of a prior attempt is the strongest predictor of future suicidal behavior*.**

Always ask if the patient has **attempted suicide in the past**, even if there is no evidence of recent suicidal thinking.

Screening Follow-Up

After discussing the character of suicidal thoughts, providers should inquire about planning. Ask whether the patient has a plan and, if so, get the specifics.

Sample questions to assess suicidal planning:

- Do you have a plan, or have you been planning to end your life? If so, how would you do it? Where would you do it?
- Do you have the (drugs, gun, rope) that you would use? Where is it right now?
- Do you have a timeline in mind for ending your life? Is there something (an event) that would trigger the plan
- Do you see yourself dying? If so, how?

Zero Suicide Element: Identify

Human Service perspective

- Choosing a screener and assessment tool
- Speaking the same language with community partners
- Program efficacy

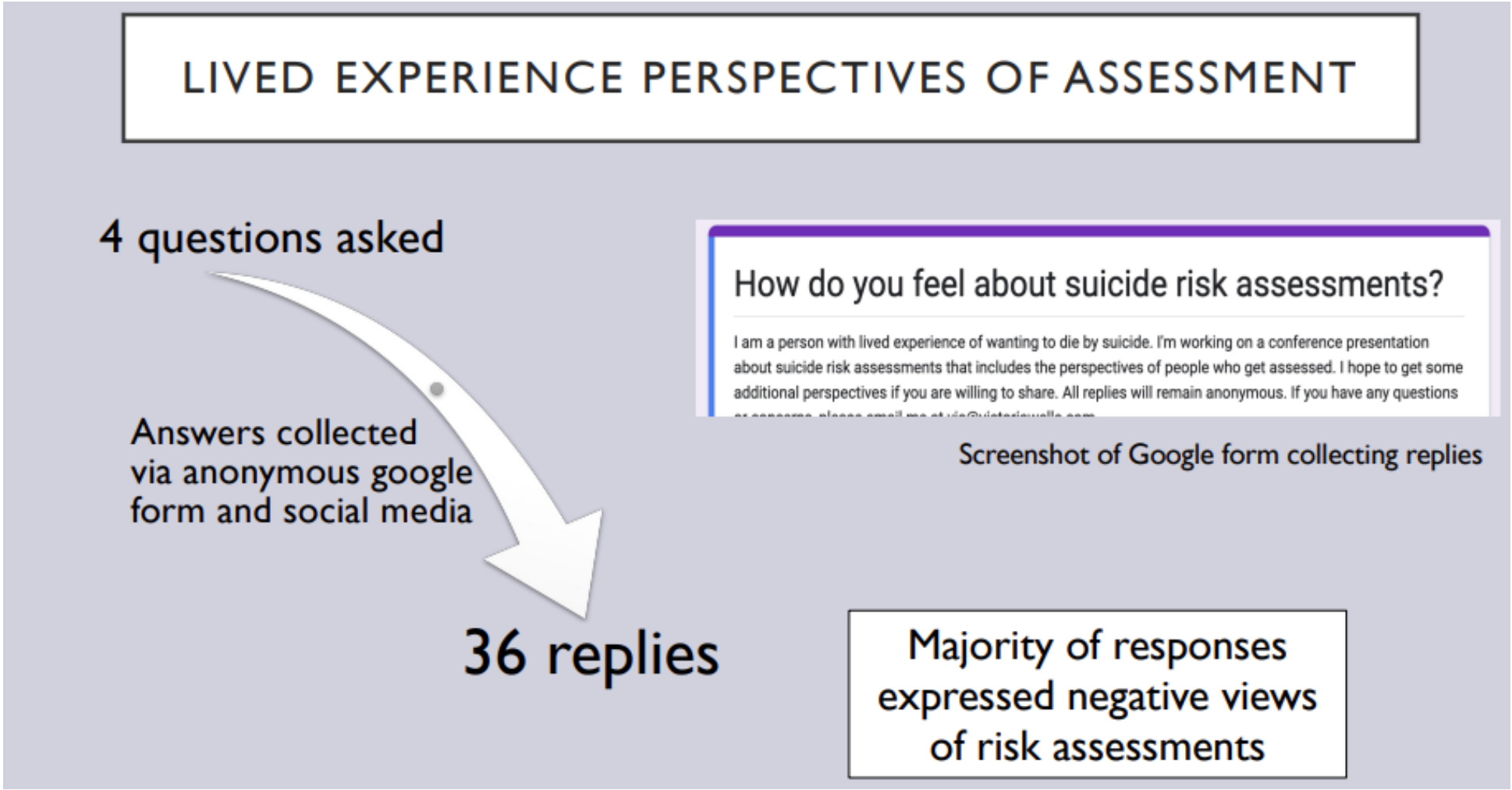
Lived Experience Perspective: Columbia (CSSRS) vs. PHQ9

	In the Past Month	
Answer Questions 1 and 2	YES	NO
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If YES to 2, answer questions 3, 4, 5 and 6 **If NO to 2, go directly to question 6**		
3) Have you thought about how you might do this?		
4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?		
5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?		
Always Ask Question 6	In the Past 3 Months	
6) Have you done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		

		Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Zero Suicide Element: Identify History

"Authenticity Not Assessing: Peer Support Models For Talking about Suicide" by Vic Welle



Zero Suicide Element: Identify History

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LIVED EXPERIENCE PERSPECTIVES OF ASSESSMENTS

SURVEY QUESTION:
If you are someone with personal experience of suicide attempts or wanting to die, how you feel when you get asked risk assessment questions?

"I feel heightened and anxious. I am afraid that honest answers can lead to involuntary institutionalization or contacting the police."

"Conversation has gone from seeing me to seeing risk."

"I feel anxious and like I cannot trust them. Overwhelmed because I have to figure out how to lie enough to stay free but not so much as to not access any help."

"i feel weird, like i cannot truly be honest"

"Annoyed, frustrated, invaded, judged"

Zero Suicide Element: Identify History

"Authenticity Not Assessing: Peer Support Models For Talking about Suicide" by Vic Welle

IMPACT OF ASSESSMENT QUESTIONS IN EVERYDAY LIFE

SURVEY QUESTION:
Does it matter if the person asking these questions is a mental health professional or a loved one? Why or why not?

"I hate the questions whether it's professional or a loved one. They feel cold and like they've been taught to ask the questions rather than just hold space and be more curious about what I'm going through."

"Depends - if I trust the person won't over react and [d]o something that causes me more harm"

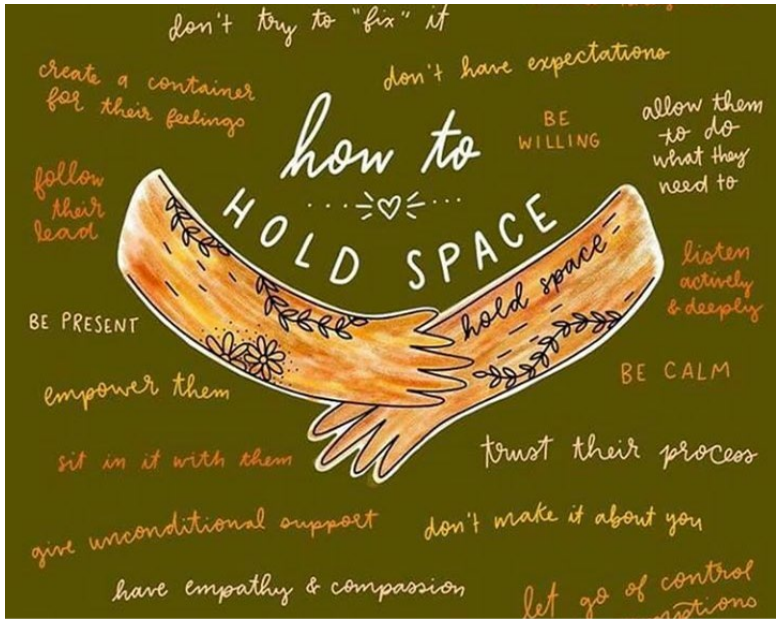
"yes because loved one isn't a mandated reporter"

"Is even more annoying when people I know/love do it.

Zero Suicide Element: Identify History

Mental Health America of Wisconsin

- Past suicide ideation
- Past suicide attempts
- Past Hospitalizations
- Past History with the Police
- Self-Injury History
- “Can I trust this person asking me these intimate questions?”
- “Will that happen to me again if I answer Yes?"



Holding Space for the Individual

Conversations vs. Questions

Empathy vs. “I have a task to do”

Identify

Learn the questions to ask and get comfortable asking them

PRACTICE, PRACTICE, PRACTICE,

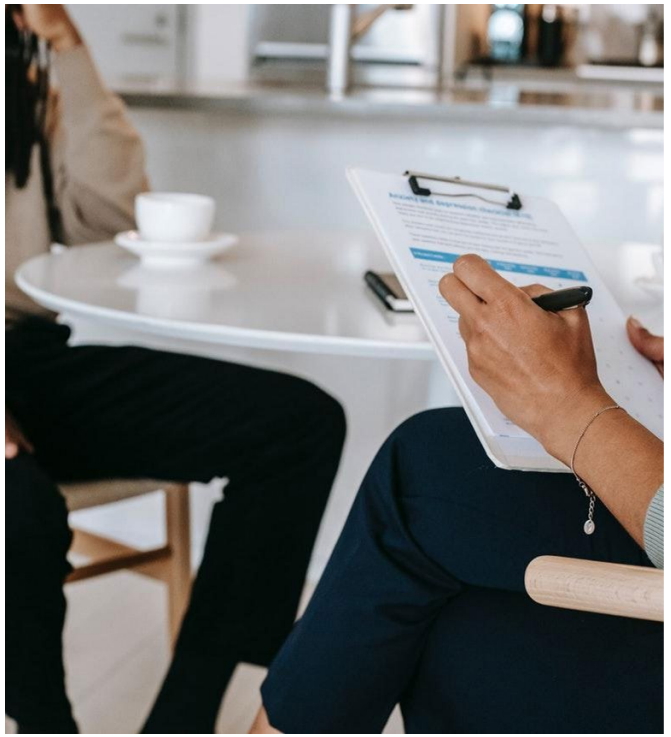
Role play with co-workers, friends and/or family

Practice in front of the mirror

Pick an assessment tool that you are comfortable with

You might make mistakes just be willing to learn

Listen to your clients and who you are screening and take their feedback



Follow-Up: What are the next steps?

- Talk with the client what they would like to do
- Talk with their therapist, Doctor, etc.
- Peer Respite Centers
- Have them call a friend
- Stay with them and talk to them

Implementation Planning: Identify

- What screening tools do you use now? Are these evidence-based screening tools?
- Should all staff use the same screening and assessment tools? Why or why not?
- How often should you screen clients? How might that differ among programs or specific clients?
- What types of policies does your organization have around screening?

Day 1 Closing Questions?