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Suicide Intervention Practices: What is Being Used by Mental Health Clinicians and Mental Health Allies?

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Abstract

Objective: Implementation of evidence-based suicide prevention is critical to prevent death by suicide. Contrary to previously held beliefs, interventions including contracting for safety, no-harm contracts, and no-suicide contracts are not best practices and are considered contraindicated. Little is known about the current use of best practices and contraindicated interventions for suicide prevention in community settings.

Methods: Data were collected from 771 individuals enrolled in a suicide prevention training. Both mental health clinicians ($n=613$) and mental health allies (e.g., teachers, first responders) ($n=158$) reported which best practices (i.e., safety plan, crisis response plan) and contraindicated interventions (i.e., contracting for safety, no-harm contract, no-suicide contract) they use with individuals who presents with risk for suicide.

Results: The majority of both mental health clinicians (89.7%) and mental health allies (67.1%) endorsed using at least one evidence-based practice. However, of those who endorsed using evidence-based interventions, ~40% of both mental health clinicians and allies endorsed using contraindicated interventions as well.

Conclusion: Contraindicated interventions are being used at high rates and suicide prevention trainings for evidence-based interventions should include a focus on de-implementation of contraindicated interventions. This study examined only a snapshot of what clinicians and allies endorsed using. Additional in depth information about each intervention and when it is used would

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provide helpful information and should be considered in future studies. Future research is needed to ensure only evidence-based interventions are being used to help prevent death by suicide.

Keywords

suicide prevention; safety planning; suicide; crisis response planning

As suicide rates continue to rise, suicide prevention interventions are needed to help address this public health crisis and should not be limited to just licensed mental health providers. With over 800,000 people dying by suicide each year, suicide is the 17th leading cause of death worldwide (WHO, 2018). In United States, suicide consistently falls within the top 10 leading causes of death with over 47,000 deaths in 2019 (AFSP, 2019; Stone et al., 2018). While frontline evidence-based suicide interventions have evolved in the years since first studied, effective implementation of evidence-based interventions is equally as important as the interventions themselves. Understanding current suicide intervention practice utilization of mental health clinicians and allies is critical to the translational goal of evidence-informed care for suicide risk.

Historically, no-suicide contracts, (also known as “no-harm contracts” and/or “contracting for safety”, regularly used interchangeably), were once the primary method of suicide prevention (Drew, 2001). A no-suicide contract entails clinicians requesting or requiring a written or verbal agreement from the patient stating that they will not kill themselves. This intervention has been practiced for decades (e.g., Drye et al., 1973) and has often been widely integrated into healthcare systems. No-suicide contracts were originally thought to reduce harm, especially from a clinician’s liability standpoint (Edwards & Sachmann, 2010). More recent research suggests this is not the case (Garvey et al., 2009). In fact, no-suicide contracts have been shown to be neutral at best and harmful at worst (Edwards & Sachmann, 2010; McMyler & Prymachuk, 2008; Rudd et al., 2006). There is evidence to suggest that these interventions do not decrease liability and may do the opposite including increasing risk for suicidal behavior (Garvey et al., 2009). Training on using no-suicide contracts and similar interventions is a low burden but they do not appear to deliver the protective outcomes they were initially thought to provide.

More recently, suicide-related interventions have focused on providing the patient with a plan and skills that help them manage suicide risk (Rudd et al., 2009) that the patient can follow to reduce the risk of death by suicide. During an acute suicidal crisis, individuals often lose their ability to problem solve, regulate their emotions, and think flexibly – all of which increase suicidality (Bryan & Rozek, 2018). Two brief and effective approaches for reducing suicidality are the Crisis Response Plan (CRP; Bryan et al., 2017) and the Safety Planning Intervention (SPI; Stanley & Brown, 2012). The CRP is a multi-component intervention that begins with a narrative assessment (e.g., telling of the story of the crisis while assessing for additional risk factors in a conversational way) and develops a plan that includes five components – 1) suicide warning signs, 2) self-coping skills, 3) reasons for living, 4) social supports, and 5) professional crisis resources. The overall plan is very personalized based on the strengths of the individual. The CRP has been shown to reduce suicidal behavior by 76%, immediately reduce emotional distress, decrease days

on inpatient psychiatric care, increase optimism, and can be integrated into longer-term treatments (Bryan et al., 2017, Bryan et al., 2018, Rozek et al., 2019; Rozek & Bryan, 2020).

Similarly, the SPI is a brief intervention and tool that utilizes a hierarchical structure to aid individuals in the management of suicidal crises (Stanley & Brown, 2012). The step-by-step components include 1) identify warning signs indicative of a suicidal crisis, 2) implement internal coping strategies (e.g., relaxation, physical activity), 3) identify social contacts and social settings that can provide distractions, 4) reach out to sources of support for help, 5) reach out to professional (e.g., therapist) or emergency sources of support (e.g., 911), and 6) reduce access to means for suicide (Stanley & Brown, 2012). Research has shown that within a sample of Veterans Affairs (VA) Emergency Department patients, those who received the SPI had 45% fewer suicidal behaviors during the following 6 months compared to patients who received the usual care of evaluation and referral (Stanley et al., 2018). The CRP and SPI have several overlapping components in terms of content and procedures and can be used for individuals at risk for suicide regardless of the diagnosis or treatment modality. Additionally, both of these interventions (i.e., CRP and SPI) have been supported in clinical guidelines (e.g., VA/DOD, 2013, 2019) and focus on developing a concrete skills based plan for individuals at risk for suicide, and can be conducted in one encounter. Still, there is limited research to support understanding of what kind of suicide practice interventions or approaches mental health clinicians actually utilize, when individuals present with suicide risk.

Mental healthcare at large, and specifically suicide prevention, has been increasingly adopted by non-mental health care clinicians in the form of peer support. This is particularly true within certain populations including military personnel and veterans (e.g., Baker et al., 2021). Formal or structured peer-support programs have been developed in various settings with the goals of reducing deaths by suicide and addressing other mental health challenges (Greden et al., 2010; Walker et al., 2009). Less structured training programs for community members, including professionals and laypersons of various fields who engage in peer support for suicide prevention (e.g., teachers, victim advocates, first responders) are in place in a variety of settings (Cross et al., 2010). These training often act as “gatekeeper” trainings, a public health approach to suicide prevention at the community level (Burnette et al., 2015). Given the brevity and overall simplicity of the SPI and the CRP it is reasonable that, with proper training, non-mental health care clinicians, or mental health allies (e.g., teachers, first responders, peer support specialists), can feasibly and effectively incorporate these interventions into peer support programming. Studies aimed at integrating current best practices into peer support programs are forthcoming (Bryan et al. 2020). However, training courses for evidence-based interventions typically target mental health professionals, which may leave mental health allies without substantial access to training in evidence-based practices for suicide prevention. Despite the array and growing popularity of peer support programs, little is known about whether mental health allies are using evidence-based practices (e.g., SPI or CRP) or contraindicated interventions.

The goal of the current study is to describe what specific suicide prevention interventions are being used by both mental health clinicians and mental health allies. Specifically, we examined the use of two evidence-based interventions (i.e., CRP and SPI) and

contraindicated interventions (i.e., safety contract, no-harm contract, and no-suicide contract). Although the study is descriptive in nature, we predicted that the majority of mental health clinicians, given their professional training, would endorse evidence-based practices in suicide prevention interventions. However, given the history and continued training which often champions contracting for safety and other now contraindicated interventions, we predicted that mental health clinicians would likely still report using these outdated interventions as well. We also predicted that mental health clinicians would be more likely endorse implementing evidence-based suicide prevention interventions more frequently and less likely to endorse using contraindicated practices than non-mental health clinicians. Additionally, descriptive analyses were used to explore differences in self-reported use of hospitalization as a suicide prevention intervention.

Materials and Methods

This was a prospective evaluation of specific suicide interventions among mental health clinicians and mental health allies enrolled in training programs for Crisis Response Plan (CRP) for suicide prevention. The Revised Standards for Quality Improvement Reporting Excellence (SQUIRE 2.0) guidelines provided the framework for this article (Ogrinc et al., 2016).

Context

The Suicide and Trauma Reduction Initiative for Veterans (STRIVE, formerly the National Center for Veteran Studies at the University of Utah) and the STRONG STAR Training Initiative (SSTI) at the University of Texas Health Science Center at San Antonio have established grant-funded training programs in CRP for both mental health clinicians and mental health allies. The STRIVE program received grant-funding from the Boeing Corporation to train veteran-serving, community-based licensed mental health clinicians and mental health allies in CRP. The SSTI received grant-funding from the Texas Health and Human Services Texas Veteran + Family Alliance Grant Program to train veteran-serving, community-based licensed mental health clinicians in CRP. In this sample, mental health allies were inclusive of lay community members who registered for training in suicide prevention and who were employed in various professions including teachers, first responders, bachelors level rape crisis counselors, and certified peer support specialists. Both programs recruited training participants through advertising on professional listservs and social media posts. Trainers from both programs worked closely to develop standardize training and evaluation procedures (DCR, BAF, KAD).

This study reports on descriptive information of enrolled mental health clinicians and mental health allies as well as the pre-training methods of suicide prevention methods which were collected through the CRP training application. The STRIVE training cohorts were conducted during a 2-year period between January 2018–March 2020. The SSTI training cohorts were conducted from August 2018 to September 2019.

The Implementation Intervention

Participants in this sample enrolled in a Crisis Response Plan (CRP) Training Cohort. For these programs, the CRP training model was developed by the teams to support skill and competency development (Hepner et al., 2019). The training model consisted of a 1-day in-person training workshop which included didactics, demonstration videos, and role plays where attendees practiced skills in one-on-one settings with expert trainers observing and providing feedback. Role plays were designed to allow attendees to develop skills in narrative assessment and the collaborative development of a CRP. Following the 1-day training, trainees were offered support through 4-6 months of clinical case consultation conducted on a video teleconferencing platform with groups of up to 8 attendees. CRP expert consultants facilitated the consultation groups focused on the implementation of CRP. Each attendee presented de-identified client details and specific information about the narrative assessment and CRP. Consultants provided feedback on CRP fidelity, direction for upcoming sessions (if applicable), and conceptualization support. The goal of weekly consultation was to enhance each attendees’ technical skills in order to improve delivery of CRP. The current study utilizes data from trainees’ baseline application survey.

Measures

Trainees completed online applications in order to be considered for acceptance into a training cohort. Training applications included applicants’ contact information, demographics, and an assessment of current suicide prevention intervention practices.

Suicide Prevention Practice—Data on the trainees’ current suicide prevention practices was collected during the application process prior to the CRP training. Applicants were asked to indicate all current suicide prevention practices. Applicants were asked, “When a client presents with suicidal ideation and/or behaviors do you use any of the following (check all that apply).” Response options for immediate interventions included: Contract for safety, No-harm Contract, No-Suicide Contract, Safety Plan, Crisis Response Plan, and Hospitalization.

Statistical Analyses

Analyses were conducted using SPSS version 26.0. Descriptive statistics of individuals receiving training were run to identify demographic characteristics including self-reported gender, age, race, ethnicity, and self-identified peer support/non-mental health clinicians. Descriptive statistics were run to identify frequencies of use of evidence-based practices for suicide prevention (i.e., CRP and SPI), contraindicated interventions (i.e., contracting for safety, no-suicide contracts, and no-harm contracts), and hospitalization. Chi-squared tests were conducted to determine if there were significant differences in endorsed interventions between mental health clinicians and non-mental health clinicians.

Ethics Statement

The University of Texas Health Science Center at San Antonio Institutional Review Board reviewed the project program evaluation plan and made a non-research determination. Similarly, the University of Central Florida Institutional Review Board approved the use of

de-identified program evaluation data. Both training programs designed the original project and surveys for internal program evaluation purposes and the findings are to be used in developing targeted trainings, improve dissemination and implementation, and supporting the overall mission of the training programs. As such, trainee consent to participate was given by virtue of participation in the Training Program, which included program evaluation.

Results

Baseline Demographic and Characteristics of Training Participants

A total of 771 individuals who completed baseline surveys prior to attending trainings on suicide prevention were included in the current study. A total of 613 mental health clinicians ($n=232$ from the Strong Star Training Initiative and $n=381$ from STRIVE) and 158 mental health allies completed surveys from 2018-2021. The sample was predominately female (78.4%), White (74.3%), non-Hispanic/Latinx (76.4%) See Table 1 for detailed demographic information.

Use of Evidence-based Practices for Suicide Interventions

Descriptive statistics were run to examine the self-reported frequency of use of evidence-based interventions (i.e., SPI and CRP) for mental health clinicians and mental health allies (see Table 2). Mental health clinicians endorsed using the SPI at 84.8% and CRP at 47.6% with a combined rate of 89.7% of participants using at least one evidence-based practice suicide prevention intervention. Mental health allies reported using the SPI at 57.0% and CRP at 40.5% with a combined rate of 67.1% using at least one evidence-based practice suicide prevention intervention. For mental health clinicians who endorsed using at least one evidence-based practice, 41.8% also reported using at least one contraindicated intervention. Similarly, for mental health allies who endorsed at least one evidence-based practice, 41.5% also reported using at least one contraindicated intervention.

Use of Contraindicated Practices for Suicide Interventions

Parallel descriptive statistics were run to examine the self-reported frequency of contraindicated interventions for suicide prevention (i.e., contract for safety, no-harm contract, and no-suicide contract) (see Table 2). Over one third of mental health clinicians (35.6%) endorsed using the contract for safety, while 15.0% reported using no-harm contracts, and 13.7% reported using no-suicide contracts. Overall, 39.5% of mental health clinicians using at least one contraindicated intervention. Nearly a quarter (24%) of mental health allies reported contracting for safety, while 12.7% reported using no-harm contracts, and 8.2% reported using no-suicide contracts, with a combined rate of 28.5% of mental health allies using at least one contraindicated intervention. Of note, ~2% of mental health clinicians and <1% of mental health allies reported using only contraindicated interventions.

Comparing Mental Health Clinicians to Mental Health Allies

Chi-square tests were conducted to examine differences in suicide intervention use between mental health clinicians and mental health allies. Mental health clinicians were more likely to report using evidence-based interventions compared to mental health allies ($X^2(1, N=771) = 50.71, p < .001$). However, mental health clinicians were also more likely to report

using contraindicated interventions compared to mental health allies ($X^2(1, N=771) = 6.50, p=.01$).

Hospitalization

Descriptive statistics were run to examine the self-reported frequency of use of hospitalization as a means of suicide prevention among both mental health clinicians and mental health allies. Mental health clinicians were more likely to endorse using hospitalization as for suicide prevention than mental health allies (70.1% compared to 31.6%). Chi-square tests were conducted to examine differences in self-reported use of hospitalization as an intervention for individuals expressing suicidal ideation and/or behavior. Mental health clinicians endorsed higher rates of hospitalization compared to mental health allies ($X^2(1, N=771) = 79.25, p<.001$).

Discussion

This study provides useful data concerning the current utilization of first line evidence-based practices and contraindicated suicide prevention practices among community-based mental health clinicians and mental health allies. An overwhelming 89.7% of the community-based mental health clinicians endorsed using at least one evidence-based practice of SPI and/or CRP. The majority of community-based mental health clinicians indicated that they used evidence-based practices including SPI (84.8%) and almost half of the respondents used CRP (47.6%). The majority of mental health allies (67.1%) also endorsed using evidence-based practices for suicide prevention, but at lower rates compared to mental health clinicians. Over half of mental health allies reported using SPI (57.0%) and many reported using the CRP (40.5%). Although these results demonstrate the promising reach and implementation of evidence-based practice to prevent suicide, over 40% of the same mental health clinicians (41.8%) and mental health allies (41.5%) who use SPI and CRP also engaged in contraindicated interventions. These endorsement rates are somewhat offset by the results that show only ~2% of mental health clinicians exclusively used contraindicated interventions. Interestingly, mental health clinicians were more likely to endorse the use of contraindicated suicide prevention interventions than mental health allies.

In the field of suicide prevention, there is a unique responsibility to ensure clinicians are aware of contraindicated practices as well as trained in evidence-based practices. With this study's finding of such high percentages of clinicians and allies using outdated and contraindicated approaches, additional training in the evidence-based practices to reduce and prevent suicide seems necessary. Based on these findings, a specific emphasis on de-implementation of contraindicated prevention methods, rather than just education on the evidence-based practices, is warranted. De-implementation is a complex strategy aimed to halt the practice of interventions that have shown to be either ineffective or harmful (Prasad & Ioannidis, 2014) and is recommended when an alternative approach, like CRP and SPI, have been identified as evidence-based alternatives. For example, at the clinician level it is recommended that trainers of evidence-based suicide prevention practices be explicit about not combining or incorporating contraindicated practices with SPI or CRP. De-implementation at the organizational and environmental levels may be more difficult

to achieve, given that change in practice depends on the level of connection with system leaders (Pinto & Park, 2019). Although contracting for safety and engaging in no-harm or no-suicide contracts are likely a vestige of prior training and/or even organizational practice, specific efforts to de-implement these practices are imperative in comprehensive suicide prevention policy and programs.

Mental health allies represent a substantial subset of individuals who work to prevent suicides in the population at large. It is promising that non-mental health care providers in our sample use evidence-based interventions at over 50%, compared to the 28.5% use of contraindicated practices, though even these numbers can and should be improved. Providing mental health allies with additional skills and training for implementing evidence-based practices is an important avenue for the improvement of care for suicidal individuals and, ultimately, for the reduction of suicides. While mental health allies are already using these brief and relatively simple evidence-based tools (i.e., SPI and CRP), we should seek to expand their abilities to support high-risk individuals by increasing access to trainings in evidence-based intervention and prevention programs. Additional research should focus on how to best adapt trainings for mental health allies in order to provide support for implementation of these interventions with high fidelity.

Overall, many individuals endorsed hospitalization as an option (i.e., 62.3% of total sample). Mental health clinicians endorsed hospitalization as an option at higher rates (70.1%) compared to mental health allies (31.6%). Although data suggests that hospitalization may increase risk of suicidal behavior in the months following the stay, it is still an option that many use and may be clinically indicated (Chung et al., 2017). Although hospitalization is an option, it is important to follow clinical guidelines and determine the risk level of an individual through assessing suicide risk (e.g., access to means, recent behavior, suicidal thoughts, plan, intent). Additionally, spending the time assessing and providing an intervention like the CRP or SPI allows for the individual in crisis to manage with the support of a mental health provider or mental health ally prior to the decision to hospitalize or not. More research is needed on understanding the decision process of determining when and how hospitalization is used when working with individuals who present with risk for suicide to see if alternative models can be used to prevent the potential overuse of hospitalization. The differing rates of endorsement should be investigated further as for some mental health providers, protocols, policies, and laws may require hospitalization for certain patients. These limitations or training in hospitalization utilization for suicide risk may not be in place for many mental health allies. Although hospitalization may be a life-saving intervention, data may not support its use, especially as frequently as many use it (Ward-Ciesielski & Rizvi, 2020). Mental health allies may have additional reasons for not endorsing the use of this intervention that may help understand suicide prevention (e.g., lived experience). Future research should examine this closer with a lens towards understanding when and why both mental health clinicians and mental health allies use hospitalization as an intervention.

This study had a number of strengths as well as limitations. The strengths include that the data collected were across two training institutes and from trainings in many different states with various backgrounds. Additionally, all of the data was collected at baseline,

which shows mental health clinicians and mental health ally data at baseline prior to a suicide specific intervention training (i.e., CRP). In terms of limitations, the current study did not provide specific definitions for each category of interventions. This left respondents to choose what they believed was accurate. Additionally, the frequency of each intervention was not measured and was dichotomized to used or not used. This does not give a clear picture of when each intervention was used or how often. Because the original data was for program improvement, the survey was not set up as a specific research question nor were standardized measures used. Last, it is worth noting that our training programs did not specifically target mental health allies and therefore those allies who attended may have already been familiar with and/or using evidence-based practices and were potentially drawn to our training due to having prior knowledge of the CRP and SPI. This study also included many military-serving mental health clinicians and allies, which might not be generalizable to those not serving military personnel. Future research should examine this topic longitudinally to see how trainings on evidence-based suicide interventions impact behavior and reported interventions as well as in a wider sample of both mental health clinicians and mental health allies.

Overall, both mental health clinicians and mental health allies endorsed using evidence-based practices for suicide prevention at high rates. Unfortunately, contraindicated suicide interventions are also still being endorsed at high rates as well. This likely indicates that these interventions are being used in some combination, suggesting a larger problem in suicide prevention efforts. Evidence-based suicide prevention training should focus not just on teaching the evidence-based practices, but also on de-implementation of contraindicated interventions. This focus on reducing the use of contraindicated interventions will likely improve the impact of evidence-based suicide prevention and potentially improve suicide prevention efforts.

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Highlights:

- The majority of both mental health clinicians and mental health allies use evidence-based practices for suicide prevention. This indicates good implementation rates of evidence-based interventions for suicide prevention.
- Approximately 40% of both mental health clinicians and mental health allies who endorsed using evidence-based practices for suicide preventions also endorsed using contraindicated interventions.
- A focus on de-implementation of contraindicated suicide interventions is warranted and should be part of the focus on suicide prevention efforts.

Table 1

Demographics

Participant Demographic Characteristic	Total sample (n = 771)	Mental Health Clinicians (n = 613)	Mental Health Allies (n = 158)
Age			
20-30	130 (16.9%)	89 (14.6%)	41 (25.9%)
31-40	275 (35.9%)	227 (37.3%)	48 (30.4%)
41-50	167 (21.8%)	139 (22.8%)	28 (17.7%)
51-60	125 (16.3%)	95 (15.6%)	30 (19.0%)
61-70	57 (7.4%)	50 (8.2%)	7 (4.4%)
70+	13 (1.7%)	9 (1.5%)	4 (2.5%)
Gender			
Female	601 (78.4%)	479 (78.7%)	32 (20.3%)
Male	159 (20.7%)	127 (20.9%)	122 (77.2%)
Prefer not to Answer	7 (0.9%)	3 (0.5%)	4 (2.5%)
Ethnicity			
Hispanic/Latinx	147 (19.3%)	123 (20.3%)	24 (15.2%)
Non-Latinx	582 (76.4%)	461 (75.9%)	121 (76.6%)
Unknown	33 (4.3%)	23 (3.8%)	10 (6.3%)
Race			
White	568 (74.3%)	455 (75.0%)	113 (71.5%)
Black or African American	68 (8.9%)	57 (9.4%)	11 (7.0%)
Asian	21 (2.7%)	19 (3.1%)	2 (1.3%)
American Indian/Alaskan Native	13 (1.7%)	9 (1.5%)	4 (2.5%)
More than one race	52 (6.8%)	37 (6.1%)	15 (9.6%)
Unknown	40 (5.2%)	28 (4.6%)	12 (7.6%)

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Table 2

Interventions Endorsed

Endorsed Practices	Total sample (n = 771)	Mental Health Clinicians (n = 613)	Mental Health Allies (n = 158)
Evidence-Based Interventions	656 (85.1%)	550 (89.7%)**	106 (67.1%)**
Crisis Response Plan (CRP)	356 (46.2%)	292 (47.6%)	64 (40.5%)
Safety Plan Intervention (SPI)	610 (79.1%)	520 (84.8)	90 (57.0%)
<i>Any Evidence-Based Intervention + Any Contraindicated Intervention¹</i>	<i>274 (41.8%)</i>	<i>230 (41.8%)</i>	<i>44 (41.5%)</i>
Contraindicated Interventions	287 (37.2%)	242 (39.5%)*	45 (28.5%)*
Contracting for Safety	256 (33.2%)	218 (35.6%)	38 (24.1%)
No-harm Contract	112 (14.5%)	92 (15.0%)	20 (12.7%)
No-suicide Contract	97 (12.6%)	84 (13.7%)	13 (8.2%)
Hospitalization	480 (62.3%)	430 (70.1%)**	50 (31.6%)**

Note. Differences were tested using chi-square analyses for only the overarching categories (i.e., Evidence-based Interventions, Contraindicated Interventions, and Hospitalization). Differences are noted by * = $p < .05$ & ** = $p < .001$.

¹This subset sample was 656 individuals who endorsed using at least one evidence-based intervention and at least on contraindicated intervention. This included 550 mental health clinicians and 106 mental health allies.

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