ZERO SUICIDE ORGANIZATIONAL SELF-STUDY

Name of Organization

City, State

Date Study Completed

Team members completing study:

Name Role

Name Role

Name Role

Name Role

Name Role

Background:

The organizational self-study is designed to allow you to assess what components of the comprehensive Zero Suicide approach your organization currently has in place. The self-study can be used early in the launch of a Zero Suicide initiative to assess organizational strengths and weaknesses and to develop a work plan. Later in your implementation efforts, the self-study can be used as a fidelity check to determine how closely the components of the Zero Suicide model are being followed and as an opportunity to identify areas for improvement. We recommend taking the self-study at launch and then at 12-month intervals.

Staff involved in the policymaking for and care of patients at risk for suicide should complete the self-study as part of an implementation team. The team should complete this tool together during one of their initial meetings. (Information about putting together a Zero Suicide implementation team can be found on our website.) While the self-study is not exhaustive with regard to all issues that can affect patient care and outcomes, it does reflect components that define the Zero Suicide approach. For more information or clarification regarding any of the items in this self-study, please visit **www.zerosuicide.com**.

Each component of the Zero Suicide model is measured on a rating scale from 1 to 5, described below. The scale is intended to balance minimal reporting burden with measuring implementation for the most essential parts of the model. This tool should be completed by members of the implementation team who are responsible for developing and implementing the organization's Zero Suicide initiative.

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General guide to rating:

Anchors, or specific expectations, are included for most components following this guide.

Rating	Description
1	Routine care or care as usual for this item. The organization has not yet focused specifically on developing or embedding a suicide care approach for this activity.
2	Initial actions toward improvement taken for this item. The organization has taken some preliminary or early steps to focus on improving suicide care.
3	Several steps towards improvement made for this item. The organization has made several steps towards advancing an improved suicide approach.
4	Near comprehensive practices in place for this item. The organization has significantly advanced its suicide care approach.
5	Comprehensive practices in place for this item. The organization has embedded suicide care in its approach and now relies on monitoring and maintenance to ensure sustainability and continuous quality improvement.

1. Create a leadership-driven, safety-oriented culture:

What type of commitment has leadership made to reduce suicide and provide safer suicide care?

This item refers to the development of formal policies, processes, or guidelines in one or more of the following areas:

- Workforce training
- Suicide screening
- Suicide risk assessment and risk formulation
- Suicide care management plan
- Safety planning
- Lethal means reduction
- Evidence-based treatment
- Contact with patients with known suicide risk who don't show for appointments
- Follow-up with patients with known suicide risk during care transitions or following discharge

» Please select the number where your organization falls on a scale of 1–5.

○	**1**	The organization has no processes specific to suicide prevention and care, other than what to do when someone mentions suicide during intake or a session.
○	**2**	The organization has 1–2 formal processes specific to suicide care.
○	**3**	The organization has written processes specific to suicide care. They have been developed for at least 3 different components of Zero Suicide.
○	**4**	The organization has processes and protocols specific to suicide care. They address at least 5 components of Zero Suicide. Staff receive training on processes as part of their orientations or when new ones developed. Processes are reviewed and modified at least annually.
○	**5**	Processes address all components of Zero Suicide listed above. Staff receives annual training on processes and when new ones are introduced. Processes are reviewed and modified annually and as needed.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,208)

As the Zero Suicide approach relies on the formalization of several policies intended to establish guidelines and promote the adoption of safer suicide care, please consider whether you have established, written policies as well as staff training in the following areas:

	Do you have a written agency protocol specific to this component of suicide care? (yes/no)	Is this component embedded in your electronic health record or easily identifiable in your written documentation? (yes/no)	Do you provide staff training specific to this component of suicide care? (yes/no)	Additional Comments (Character limit: 126)
2. Screening				
3. Assessment				
4. Lethal means restriction				
5. Safety planning				
6. Suicide care management plan				

7. Create a leadership-driven, safety-oriented culture:

What type of formal commitment has leadership made through staffing to reduce suicide and provide safer suicide care?

» Please select the number where your organization falls on a scale of 1–5.		
○	1	The organization does not have dedicated staff to build and manage suicide care processes.
○	2	The organization has one leadership or supervisory individual who is responsible for developing suicide-related processes and care expectations. Responsibilities are diffuse. Individual does not have the authority to change policies.
○	3	The organization has assembled an implementation team that meets on an as-needed basis to discuss suicide care. The team has authority to identify and recommend changes to suicide care practices.
○	4	The organization has a formal Zero Suicide implementation team that meets regularly. The team is responsible for developing guidelines and sharing with staff.
○	5	The Zero Suicide implementation team meets regularly and is multidisciplinary. Staff members serve on the team for terms of one to two years. The team modifies processes based on data review and staff input.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit : 1,320)

8. Create a leadership-driven, safety-oriented culture:

What is the role of suicide attempt and loss survivors in the organization's design, implementation, and improvement of suicide care policies and activities?

» Please select the number where your organization falls on a scale of 1–5.		
○	1	Suicide attempt or loss survivors are not explicitly involved in the development of suicide prevention activities within the organization.
○	2	Suicide attempt or loss survivors have ad hoc or informal roles within the organization, such as serving as volunteers or peer supports.
○	3	Suicide attempt or loss survivors are specifically and formally included in the organization's general approach to suicide care, but involvement is limited to one specific activity, such as leading a support group or staffing a crisis hotline. Survivors informally provide input into the organization's suicide care policies.
○	4	Suicide attempt and loss survivors participate as active members of decision-making teams, such as the Zero Suicide implementation team.
○	5	Suicide attempt and loss survivors participate in a variety of suicide prevention activities within the organization, such as sitting on decision-making teams or boards, participating in policy decisions, assisting with employee hiring and training, and participating in evaluation and quality improvement.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,320)

9. Develop a competent, confident, and caring workforce:

How does the organization formally **assess staff** on their perception of their confidence, skills, and perceived support to care for individuals at risk for suicide?

» Please select the number where your organization falls on a scale of 1–5.		
○	**1**	There is no formal assessment of staff on their perception of confidence and skills in providing suicide care.
○	**2**	Clinicians who provide direct patient care are routinely asked to provide suggestions for training.
○	**3**	Clinical staff complete a formal assessment of skills, needs, and supports regarding suicide care. Training is tied to the results of this assessment.
○	**4**	A formal assessment of the perception of confidence and skills in providing suicide care is completed by all staff (clinical and non-clinical). Comprehensive organizational training plans are tied to the results.
○	**5**	A formal assessment of the perception of confidence and skills in providing suicide care is completed by all staff and reassessed at least every three years. Organizational training and policies are developed and enhanced in response to perceived staff weaknesses.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,425)

10. Develop a competent, confident, and caring workforce:

What **basic** training on identifying people at risk for suicide or providing suicide care has been provided to NON-CLINICAL staff?

» Please select the number where your organization falls on a scale of 1–5.		
○	**1**	There is no organization-supported training on suicide care and no requirement for staff to complete training on suicide risk identification.
○	**2**	Training is available on suicide risk identification and care through the organization but not required of staff.
○	**3**	Training is required of select staff (e.g., crisis staff) and is available throughout the organization.
○	**4**	Training on suicide risk identification and care is required of all organization staff. The training used is considered a best practice and was not internally developed.
○	**5**	Training on suicide risk identification and care is required of all organization staff. The training used is considered a best practice. Staff repeat training at regular intervals.

Please indicate the training approach or curriculum the organization uses to train all staff on suicide risk identification and care:

- ☐ ASIST (Applied Suicide Intervention Skills Training)
- ☐ Kognito At-Risk in Primary Care
- ☐ Kognito At-Risk in the ED
- ☐ QPR (Question, Persuade, and Refer)
- ☐ QPR for Nurses
- ☐ QPR for Physicians, Physician Assistants, Nurse Practitioners and Others
- ☐ safeTALK
- ☐ Other (please name): _____

____ Please indicate the minimum number of hours of training required annually for staff in suicide risk identification and care.

If you wish to describe or elaborate on any item, please do so in the space provided below. (Character limit: 1,054)

11. Develop a competent, confident, and caring workforce:

What **advanced** training on identifying people at risk for suicide, suicide assessment, risk formulation, and ongoing management has been provided to CLINICAL staff?

» Please select the number where your organization falls on a scale of 1–5.		
○	1	There is no organization-supported training on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management, and no requirement for clinical staff to complete training on suicide.
○	2	Training is available on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management through the organization, but it is not required of clinical staff.
○	3	Training is required of select staff (e.g., psychiatrists) and is available throughout the organization.
○	4	Training on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management is required of all clinical staff. The training used is considered a best practice and was not internally developed.
○	5	Training on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management is required of all clinical staff. The training used is considered a best practice. Staff repeat training at regular intervals.

Please indicate the training approach or curriculum the organization uses to train clinical staff on advanced suicide prevention skills:

- ☐ AMSR (Assessing and Managing Suicide Risk)
- ☐ CASE Approach (Chronological Assessment of Suicide Events)
- ☐ Commitment to Living
- ☐ QPRT Suicide Risk Assessment and Management Training
- ☐ RRSR (Recognizing and Responding to Suicide Risk)
- ☐ RRSR-Primary Care
- ☐ SuicideCare
- ☐ Other (please name): _____

If you wish to describe or elaborate on any item, please do so in the space provided below. (Character limit: 820)

12. Systematically identify and assess suicide risk:

What are the organization's policies for **screening** for suicide risk?

» Please select the number where your organization falls on a scale of 1–5.		
○	**1**	There is no systematic screening for suicide risk.
○	**2**	Individuals in designated higher-risk programs or categories (e.g., crisis calls) are screened.
○	**3**	Suicide risk is screened at intake for all individuals receiving behavioral health care.
○	**4**	Suicide risk is screened at intake for all individuals receiving either health or behavioral health care and is reassessed at every visit for those at risk.
○	**5**	Suicide risk is screened at intake for all individuals receiving health or behavioral health care and is reassessed at every visit for those at risk. Suicide risk is also screened when a patient has a change in status: transition in care level, change in setting, change to new provider, or potential new risk factors (e.g., change in life circumstances, such as divorce, unemployment, or a diagnosed illness).

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,444)

13. Systematically identify and assess suicide risk:

How does the organization **screen** for suicide risk in the people it serves?

» Please select the number where your organization falls on a scale of 1–5.		
○	**1**	The organization relies on the clinical judgment of its staff regarding suicide risk.
○	**2**	The organization developed its own suicide screening tool but not all staff are required to use it.
○	**3**	The organization developed its own suicide screening tool that all staff are required to use.
○	**4**	The organization uses a validated screening tool that all staff are required to use.
○	**5**	The organization uses a validated screening tool and staff receive training on its use and are required to use it.

If a suicidality screening tool is used, the screener used:

☐ PHQ-9 ☐ PHQ-2 ☐ Columbia Suicide Severity Rating-Scale (C-SSRS)

☐ National Suicide Prevention Lifeline Risk Assessment Standards ☐ Other tool (please name): _____

If you wish to describe or elaborate on any item, please do so in the space provided below. (Character limit: 1,416)

14. Systematically identify and assess suicide risk:

How does the organization **assess** suicide risk among those who screened positive?

» Please select the number where your organization falls on a scale of 1–5.		
○	**1**	The policy is to send clients who have screened positive for suicide to the emergency department for clearance AND/OR there is no routine procedure for risk assessments that follow the use of a suicide screen.
○	**2**	Risk assessment is required after screening, but the process or tool used is up to the judgment of individual clinicians AND/OR only psychiatrists can do risk assessments.
○	**3**	Providers conducting risk assessments use a standardized risk assessment tool, which may have been developed in-house. All patients who screen positive for suicide have a risk assessment. Suicide risk assessments are documented in the medical records.
○	**4**	All individuals with risk identified, either at intake screening or at any other point during care, are assessed by clinicians who use validated instruments or established protocols and who have received training. Assessment includes both risk and protective factors.
○	**5**	A suicide risk assessment is completed using a validated instrument and/or established protocol that includes assessment of both risk and protective factors and risk formulation. Staff receive training on risk assessment tool and approach. Risk is reassessed and integrated into treatment sessions for every visit for individuals with risk.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,440)

15. Ensure every person has a suicide care management plan (pathway to care):

Which best describes the organization's approach to caring for and tracking people at risk for suicide?

A suicide care management plan should include the following:

- Screening
- Assessment and risk formulation
- Safety planning
- Lethal means restriction
- Evidence-based treatment
- Supportive contacts with patients who don't show for appointments and during care transitions

» Please select the number where your organization falls on a scale of 1–5.		
○	1	Providers use best judgment in the care of individuals with suicidal thoughts or behaviors and seek consultation if needed. There is no formal guidance related to care for individuals at risk for suicide.
○	2	When suicide risk is detected, the care plan is limited to screening and referral to a senior clinician.
○	3	All providers are expected to provide care to those at risk for suicide. The organization has guidance for care management for individuals at different risk levels, including frequency of contact, care planning, and safety planning.
○	4	Electronic or paper health records are enhanced to embed all suicide care management components listed above. Providers have clear protocols or policies for care management for individuals with suicidal thoughts or behaviors, and information sharing and collaboration among all relevant providers are documented. Staff receive guidance on and clearly understand the organization's suicide care management approach.
○	5	Individuals at risk for suicide are placed on a suicide care management plan. The organization has a consistent approach to suicide care management, which is embedded in the electronic health records and reflects all of the suicide care management components listed above. Protocols for putting someone on and taking someone off a care management plan are clear. Staff hold regular case conferences about patients who remain on suicide care management plans beyond a certain time frame, which is established by the implementation team.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 702)

16. Collaborative safety planning:

What is the organization's approach to collaborative safety planning when an individual is at risk for suicide?

» Please select the number where your organization falls on a scale of 1–5.		
○	1	Safety planning is neither systematically used by nor expected of staff.
○	2	Safety plans are expected for all individuals with elevated risk, but there is no formal guidance or policy around content. There is no standardized safety plan or documentation template. Plan quality varies across providers.
○	3	Safety plans are developed for all individuals at elevated risk. Safety plans rely on formal supports or contact (e.g., call provider, call helpline). Safety plans do not incorporate individualization, such as an individual's strengths and natural supports. Plan quality varies across providers.
○	4	Safety plans are developed for all individuals at elevated risk and must include risks and triggers and concrete coping strategies. The safety plan is shared with the individual's partner or family members (with consent). All staff use the same safety plan template and receive training in how to create a collaborative safety plan.
○	5	A safety plan is developed on the same day as the patient is assessed positive for suicide risk. The safety plan is shared with the individual's partner or family members (with consent).The safety plan identifies risks and triggers and provides concrete coping strategies, prioritized from most natural to most formal or restrictive. Other clinicians involved in care or transitions are aware of the safety plan. Safety plans are reviewed and modified as needed at every visit with a person at risk.

Please indicate whether or not the organization uses the Stanley/Brown safety plan template: ☐ YES ☐ NO
If no, identify the safety planning tool or approach the organization uses:

_____

How frequently is the safety plan reviewed with the individual? _____

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 851)

17. Collaborative restriction of access to lethal means:

What is the organization's approach to lethal means reduction?

» Please select the number where your organization falls on a scale of 1–5.		
○	**1**	Means restriction discussions and who to ask about lethal means are up to individual clinician's clinical judgment. Means restriction counseling is rarely documented.
○	**2**	Means restriction is expected to be included on safety plans for all patients identified as at risk for suicide. Steps to restrict means are up to the individual clinician's judgment. The organization does not provide any training on counseling on access to lethal means.
○	**3**	Means restriction is expected to be included on all safety plans. The organization provides training on counseling on access to lethal means. Steps to restrict means are up to the individual clinician's judgment. Family or significant others may or may not be involved in reducing access to lethal means.
○	**4**	Means restriction is expected to be included on all safety plans, and families are included in means restriction planning. The organization provides training on counseling on access to lethal means. The organization sets policies regarding the minimum actions for restriction of access to means.
○	**5**	Means restriction is expected to be included on all safety plans. Contacting family to confirm removal of lethal means is the required, standard practice. The organization provides training on counseling on access to lethal means. Policies support these practices. Means restriction recommendations and plans are reviewed regularly while the individual is at an elevated risk.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,062)

18. Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors:

What is the organization's approach to **treatment** of suicidal thoughts and behaviors?

» Please select the number where your organization falls on a scale of 1–5.		
○	**1**	Clinicians rely on experience and best judgment in risk management and treatment for all mental health disorders. The organization does not use a formal model of treatment for those at risk for suicide.
○	**2**	The organization may use evidence-based treatments for some psychological disorders, but it does not use evidence-based treatments that specifically target suicide.
○	**3**	Some clinical staff have received specific training in treating suicidal thoughts and behaviors and may use this in their practices.
○	**4**	Individuals with suicide risk receive empirically-supported treatment specifically for suicide (CAMS, CBT-SP or DBT) in addition to evidence-based treatments for other mental health issues. The organization regularly provides all staff with access to competency-based training in empirically supported treatments targeting suicidal thoughts.
○	**5**	The organization has invested in evidence-based treatments for suicide care (CAMS, CBT-SP or DBT), with designated staff receiving training in these models. The organization has a model for sustaining staff training. The organization offers additional treatment modalities for those chronically or continuously screening at high risk for suicide, such as DBT groups or attempt survivor groups.

Please indicate if clinicians in the organization receive formal training in a specific suicide treatment model:

☐ CAMS (Collaborative Assessment and Management of Suicidality)

☐ CBT-SP (Cognitive Behavioral Therapy for Suicide Prevention)

☐ DBT (Dialectical Behavior Therapy)

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,057)

19. Provide continuous contact and support:

What is the organization's approach to engaging hard-to-reach individuals or those who are at risk and don't show for appointments?

» Please select the number where your organization falls on a scale of 1–5.		
○	1	There are no guidelines specific to reaching those at elevated suicide risk who don't show for scheduled appointments.
○	2	The organization requires documentation by the clinician of those individuals who have elevated suicide risk and don't show for an appointment, but the parameters and methods are up to individual clinician's judgment.
○	3	Follow-up for individuals with suicide risk who don't show for appointments includes active outreach, such as phone calls to the individual or his or her family members, until contact is made and the individual's safety is ascertained.
○	4	Follow-up for individuals with suicide risk who don't show for appointments includes active outreach, such as phone calls to the individual or his or her family members, until contact is made and the individual's safety is ascertained. Organizational protocols are in place that address follow-up after no-shows. Training for staff supports improving engagement efforts.
○	5	The organization may have an established memorandum of understanding with an outside agency to conduct follow-up calls. Follow-up and supportive contact for individuals on suicide care management plans are systematically tracked in electronic health records. Follow-up for high-risk individuals includes documented contact with the person within eight hours of the missed appointment. The organization has approaches, such as peer supports, peer-run crisis respite, home visits, or drop-in appointments, to address the needs of hard-to-reach patients.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,309)

20. Provide continuous contact and support:

What is the organization's approach to following up on patients who have recently been discharged from acute care settings (e.g., emergency departments, inpatient psychiatric hospitals)?

» Please select the number where your organization falls on a scale of 1–5.		
○	1	There are no specific guidelines for contact of those at elevated suicide risk following discharge from acute care settings.
○	2	The organization requires follow-up for individuals with suicide risk, but the parameters and methods are up to the individual clinician's judgment.
○	3	Organizational guidelines are directed to the individual's level of risk and address one or more of the following: follow-up after crisis contact, transition from an emergency department, or transition from psychiatric hospitalization.
○	4	Organizational guidelines are directed to the individual's level of risk and address follow-up after crisis contact, non-engagement in services, transition from an emergency department, or transition from psychiatric hospitalization. Follow-up for high-risk individuals includes distance outreach, such as letters, phone calls, or e-mails.
○	5	Organizational guidelines are in place that address follow-up after crisis contact, no-shows, transition from an emergency department, or transition from psychiatric hospitalization. Follow-up for high-risk individuals includes in-person or virtual home or community visits when necessary. Follow-up and supportive contact for individuals on suicide care management plans are tracked in the electronic health record. Policies state that follow-up contact after discharge from acute settings occurs within 24 hours.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,309)

21. Apply a data-driven quality improvement approach:

What is the organization's approach to reviewing deaths for those enrolled in care?

» Please select the number where your organization falls on a scale of 1–5.		
○	1	At best, when a suicide or adverse event happens while the client is in treatment, a team meets to discuss the case.
○	2	Root cause analysis is conducted on all suicide deaths of people in care.
○	3	Data from all root cause analyses are routinely examined to look at trends and to make changes to policies.
○	4	Root cause analysis is conducted on all suicide deaths of people in care as well as for those up to 30 days past case closed. Policies and training are updated as a result.
○	5	Root cause analysis is conducted on all suicide deaths of people in care as well as for those up to 6 months past case closed, and on all suicide attempts requiring medical attention. Policies and training are updated as a result.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,309)

22. Apply a data-driven quality improvement approach:

What is the organization's approach to measuring suicide deaths?

» Please select the number where your organization falls on a scale of 1–5.		
○	1	The organization has no policy or process to measure suicide deaths for those enrolled in their care.
○	2	The organization measures the number of deaths for those who are enrolled in care based primarily on family report.
○	3	The organization has specific internal approaches to measuring and reporting on all suicide deaths for enrolled clients as well as those up to 30 days past case closed. Deaths are confirmed through coroner or medical examiner reports.
○	4	The organization annually crosswalks enrolled patients (e.g., from a claims database) against state vital statistics data or other federal data to determine the number of deaths for those enrolled in care up to 30 days past case closed.
○	5	The organization annually crosswalks enrolled patients (e.g., from a claims database) against state vital statistics data to determine the number of deaths for those enrolled in care. The organization tracks suicide deaths among clients for up to 6 months past case closed.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,327)

23. Apply a data-driven quality improvement approach:

What is the organization's approach to quality improvement activities related to suicide prevention?

» Please select the number where your organization falls on a scale of 1–5.		
○	1	The organization has no specific policies related to suicide prevention and care, and it does not focus on suicide care other than care as usual. Care is left to the judgment of the clinical provider.
○	2	Suicide care is discussed as part of employee training and by those in supervision in clinical settings.
○	3	Early discussions about using technology and/or enhanced record keeping to track and chart suicide care are underway. Suicide care management is partially embedded in an EHR or paper record.
○	4	Suicide care is partially embedded in an electronic health record (EHR) or paper record. Data from suicide care management plans (using EHRs or chart reviews) are examined for fidelity to organizational policies, and discussed by a team responsible for this.
○	5	Suicide care is entirely embedded in EHR. Data from EHR or chart reviews are routinely examined (at least every two months) by a designated team to determine that staff are adhering to suicide care policies and to assess for reductions in suicide. EHR clinical workflows or paper records are updated regularly as the team reviews data and makes changes.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,202)

Once your implementation team has completed this organizational self-study using this document, the results can be entered online at http://zerosuicide.sprc.org/what-organizational-self-study.
Should you have additional questions, please email zerosuicide@edc.org