ZERO SUICIDE

in Your Community:
An implementation guide for community organizations

Do

DO

Having a plan in place before implementation is crucial to ensure that your project is successful. Now that you have worked your way through the planning phase of the PDSA (Plan, Do, Study, Act) cycle, you are ready to move into the implementation work. During the "Do" phase of the Toolkit, you will focus on carrying out your plan, documenting your observations, and recording important data. In this section of the Toolkit we will be focused on creating, deciding, and developing and will cover the following:

- Policy and/or Procedure(s) outlining the Suicide Care Management Plan, which may include:
    - Suicide Risk Assessment
        - Suicide Screening
        - Full Suicide Risk Assessment
    - Interventions
        - Suicide Prevention Algorithm or Triage Tool
            - Community Based Crisis Resource list
        - Crisis Management and De-escalation (embed in education plan)
        - Coping Plan and Safety Plan
        - Referral to/Support Evidence Based Treatment
        - Engaging Natural and Peer Supports
        - Supporting Transitions in Care
        - Implementing Caring Contacts
        - Documentation
        - Reviewing Suicide Related Incidents
        - Postvention Support
- Implementing Suicide Prevention Staff Education
- Implementation Considerations
    - Going "Live"
    - Change Management
    - Evaluation
    - Sustainability Plan
- Building a More Suicide Safe Community

Resources to have on hand (or screen):

- A copy of the Toolkit: Plan 1.0 and Plan 2.0 sections
- A copy of your Project Plan
- Your completed Organizational Self Study & Workforce Survey
- Zero Suicide Toolkit website[1]: zerosuicide.edc.org/toolkit

Policy and/or Procedure(s) Development

In the Zero Suicide framework, the "**Lead**" and "**Improve**" elements review the importance of developing or improving policies and procedures. Suicide prevention is everyone's responsibility, and there is a role for all staff at your organization to assist in preventing deaths by suicide. Creating or enhancing a suicide prevention policy and/or procedure with a quality and safety blueprint will have a significant impact for your organization, staff, and clients.

You will recall from the Organizational Self Study (OSS) and the Workforce Survey (WFS), whether or not your organization is lacking a suicide prevention policy or procedure. We frequently hear from staff that even if they are trained in suicide prevention, they are "uncertain" about what their organizations expectations are, or how they are to enact suicide prevention in their particular workplace. A policy and/or procedure will formalize processes and help ensure that staff are:

- Aware of the importance of suicide prevention
- Clear on their role in addressing suicide
- Taking the appropriate action to ensure that clients are supported as per organizational expectations

Some organizations may be able to create one corporate policy that will meet the needs for all staff, while others may have to consider unique program/department elements and develop one or more procedures.

St. Joseph's is a multi-site, tertiary care organization with many speciality areas. To meet the needs of this organization, a corporate policy and several program level procedures were created.

Niagara Region Mental Health (NRMH) offers free counselling, treatment, and case management services for youth, adults, and seniors with serious and persistent mental illnesses across the Niagara Region. To meet the needs of this program, a policy and procedure were created.

Developing a policy and/or procedure(s) can seem like a big job, and it is! But it also adds tremendous value to the implementation process. For example, as you/others start to develop the policy and/or procedure(s), you may recognize that there are roles or aspects of the project implementation that still require some thought, or process development. Before you get started, it is important to first familiarize yourself with the policy and/or procedure development process in your organization. Some questions you may ask are:

- Who will draft the content?
- Which stakeholders need to be involved in developing the draft?
- Is there a particular template I need to follow?
- How are policies/procedures approved and how long does it take?
- Where will the policy/procedure be kept?
- At what intervals will the policy and/or procedure be reviewed? Who will be responsible for this?
- How are new/revised policies and/or procedures communicated to staff?

You may wish to review NRMH policy (Appendix N) as an example as you begin to generate ideas in developing your own.

The policy and/or procedure(s) you revise/create should include key elements, such as:

- Purpose
- Suicide Care Management Plan roles and responsibilities of staff (leaders and direct care staff) including:
    - Suicide Risk Assessment
        - Suicide screening (standardized tool, frequency, documentation)
        - Full suicide risk assessment or formal suicide risk assessment (if applicable)
    - Interventions
        - Suicide Prevention Algorithm or Triage Tool (Appendix O & P)
        - Crisis management and de-escalation
        - Coping Plan and Safety Plan
        - Referral to support/ evidence-based treatment
        - Engaging natural and peer supports
        - Supporting transitions in care
        - Implementing caring contacts
        - Reviewing suicide related incidents
        - Postvention support
        - Documentation expectations
- Required and supplemental education for staff
- Key definitions

- Supporting details
- Recommended listed appendices (if applicable):
    - Screening tool(s)
    - Suicide prevention algorithm or triage tool
    - List of local community resources (for staff and patients- both crisis and non-crisis)
    - Coping Plan and Safety Plan
    - Caring contact template

A critical component of policy and/or procedure development is diverse stakeholder engagement to elicit varying perspectives. Involving your Zero Suicide project team, leaders, and staff who will enact the policy and/or procedure(s) is important in making decisions and exerting influence. Consider who you will engage, and how you will engage them. One method is to work with a core group to develop a draft policy and/or procedure(s) that you later send to diverse stakeholders to elicit feedback. You can then collate this feedback, and address any outstanding concerns or decision points in a meeting together. Setting deadlines for policy completion (tip: give yourself more than the anticipated amount of time) will help encourage decisiveness, however, ensuring quality of completion should take priority. The policy and/or procedure(s) should be finalized and accessible to staff prior to "go-live" (approximately 48 hours) of the project implementation.

Do not be surprised if you meet challenges as you develop your policy and/or procedure(s) – thinking through the change management that accompanies the Zero Suicide framework in your organization will often spark hesitation and resistance.

St. Joseph's completed a phased approach to roll out the Zero Suicide Initiative, beginning with mental health areas, and later extending to some non-mental health care programs. Despite having implemented Zero Suicide in over 10 different program areas, developing a procedure with a non-mental health outpatient team took several months as stakeholders ventured into new territory implementing Zero Suicide in a virtual referral-based program. Developing the program-specific triage tool (i.e. expectations of clinicians working with clients at differing risk levels) created many questions as they considered organizational support and processes, staff roles and responsibilities, and broader navigation of community support.

Important note: As you develop your policy and/or procedure(s) you will need to circle back to the Plan 2.0 section of the Toolkit where you were introduced to suicide prevention elements/processes, such as: 1) suicide screening, 2) full suicide risk assessment, 3) suicide prevention algorithm or triage tool, 4) Coping Plan and Safety Plan, 5) referral to support/evidence based treatment, 6) engaging natural and peer support(s), 7) supporting transitions in care, 8) implementing Caring Contacts, 9) reviewing suicide related incidents, and 10) postvention support. During the development of your policy and/or procedure(s) you will be tasked with making decisions about these elements/processes, and adopting/adapting them as needed for your organization. The policy and/or procedure(s) in conjunction with these additional strategies and tools will serve as the structure or backbone of your project implementation.

Below are some tips and strategies for your development of each of these policy and/or procedure(s) sections. Please note that these are not exhaustive lists of what you should include, but rather some key points we felt might guide you.

Policy and/or Procedure(s) Development

Suicide Care Management Plan

When developing the Suicide Care Management Plan outline in your Policy and/or Procedure, include the roles and responsibilities of staff and leaders:

- Screening tool criteria and when the client will be engaged in a Suicide Care Management Plan
- Process for same day access to a mental health professional for a formal suicide risk assessment and risk formulation
- Requirements and protocols for safety planning, crisis support planning, and lethal means restriction
- Frequency of client interactions/visits for a client on a Suicide Care Management Plan, including what to do when a client misses a scheduled interaction/visit/service
- The process for communicating with a client about what it means to have a Suicide Care Management Plan (see Adding a Pathway to Your Treatment Plan from Centerstone)
- Requirements for continued contact with and support for the client, especially during transitions in care
- The referral process to suicide-specific, evidence-based treatment (i.e. mental health care)
- How documentation of progress and risk level reduction will occur
- Criteria and protocols for closing out a client's Suicide Care Management Plan (i.e. when there is decrease in suicide risk level and the client no longer requires suicide related care)
- Consider how management will review charts to determine that policies and protocols are being followed

Suicide Risk Assessment

Suicide Screening

Based on the planning and rationale you provided in the Plan 2.0 section of the Toolkit, identify the screening tool(s) selected for use in your organization:

Refer to the Plan 2.0 section of the Toolkit as you outline the specifics of suicide screening (e.g. who will be screened, when, frequency, etc.) in your policy and/or procedure(s). Remember all that work you did in your planning… it is paying off now! Remember, it is helpful to include screening tools in the Appendices of your policy and/or procedure(s).

Checkpoint:
Screening tool(s) selection ☐

Full Suicide Risk Assessment

Consider what your organization's expectations are in terms of staff completing a full suicide risk assessment. You will likely have thought about this as you read through the associated section of the Plan 2.0 section of the Toolkit.

What education related to a full suicide risk assessment are staff required to have? Where will they document their judgment of the client's risk? If the client requires a formal medical suicide risk assessment/risk formulation by a regulated/trained health professional, what are the expectations of staff in assisting the client to receive this? Is there someone in your organization that can do this? What will this process look like, and what care can be offered?

Checkpoint:
Full suicide risk assessment processes (if applicable) ☐

Interventions

Suicide Prevention Algorithm or Triage Tool(s)

If you have opted to create an algorithm or triage tool(s) which outline the interventions staff are responsible for, we recommend developing this now and attaching this to your policy and/or procedure(s). Ideally this a brief (e.g. 1 page), accessible, and visually appealing tool.

Further, due to the uniqueness of each client and experience, it is important to include a note on the algorithm or triage tool(s) that states something similar to: "The listed interventions are not an exhaustive list". This promotes staff critical thinking, and accounts for the reality that there can be unique situations that require unique interventions. Further, you might determine that not every area of the organization can utilize the same algorithm or triage tool, and opt to create specific triage tools based on specific areas within the organization. See Appendix O and P for examples of triage tools at St. Joseph's (note: these triage tools are based off of the risk levels outlined in the Columbia Suicide Severity Rating Scale, but recall that staff risk formulation also takes place in determining risk level).

If care is provided virtually to clients, there are other unique considerations, outlined in the resources below. Appendix P provides an example of St. Joseph's adapted triage tool for providing virtual care.

Zero Suicide Website: Telehealth and Suicide Care During COVID-19 Pandemic

SPRC Website: Treating Suicidal Patients During COVID-19: Best Practices and Telehealth

Checkpoint:
Development of the suicide prevention algorithm or triage tool(s) ☐

Creating a Community Based Crisis Resource List

Connecting both staff and clients to community-based crisis resources is essential for suicide prevention work.

For immediate risk to self or others, Emergency Medical and Police Services is necessary. If the person is at immediate risk, 911 (Canada) should be contacted. If immediate risk is managed, it may be necessary to connect the person with local crisis resources. In Niagara and London, ON., for example, COAST (Crisis Outreach and Support Team) provides outreach and support for residents in the community who are experiencing a mental health crisis. Other local crisis teams may include outreach by a Mental Health Association (e.g. Canadian Mental Health Association).

Looking for an existing list of community mental health resources or creating a list is helpful at this stage – it can be shared with staff to use as a resource, as well as with clients and their support person(s). It may be helpful to join up with a local public health agency, or use an example (see Appendix Q) and adapt it to fit the needs of your organization with resources local to you. You will want to include resources for varying risk levels (low to high risk).

Checkpoint:
Local Community Service Resource List complete ☐

Coping Plan and Safety Plan

Coping Plan

Recall from the previous section of the Toolkit that a Coping Plan is a personalized, 1-2-page document that a client can create and utilize prior to experiencing a suicidal crisis. Coping Plans can be created with input from clients, families, identified supports, or community partners.

Current research tells us Coping Plans are an effective way to highlight the client's own abilities to cope and reinforce personal strengths. They also encourage connecting with appropriate resources and to escalate to more intensive services as needed[2].

Coping strategies: Behaviors, thoughts, and emotions that you use to adjust, minmize, or tolerate stressful situations.

Are all coping strategies helpful?
A client may identify adaptive or maladaptive coping strategies, and with consent, we an support clients in identifying helpful coping strategies.

Brainstorm:
What are some adaptive coping strategies that would be helpful for the population you work with in your organization?

What coping strategies would be considered maladaptive?

A Coping Plan should include or identify:

- Things the client can do independently to cope or strategies that have helped them overcome stressful situations in the past
- Future goals
- Personal strengths
- Actions that bring the client hope or pleasure
- People the client can talk to or spend time with that have been helpful previously
- Potential triggers such as dates/events that may interfere with wellness, past experiences, and what staff can do to help
- Potential warning signs that the client identifies such as thoughts, feelings, behaviours, and/or physical signs (e.g. headaches, or changes in sleeping patterns)
- Ways to make the environment safe (e.g. lethal-means restriction)
- Identifying professionals currently supporting the client (e.g. case worker, substance use counsellor, or psychologist)
- Crisis service information

What do you do with the Coping Plan once complete?

- Both the client and staff member should have a copy of the Coping Plan that is signed and dated by both parties
- Ensure the CopingPlan is embedded into team communication and/or documentation (e.g. client file)
- The Coping Plan should be updated with the client as needed; they may identify or learn to use new coping skills, as well as potential changes to their supports

Safety Plan

Safety planning is a critical component of suicide prevention for clients experiencing suicidal ideation or behaviour. Safety Plans are to be co-developed with the client, and your organization should determine at what risk level, a Safety Plan is encouraged. For example, at St. Joseph's, all clients complete a Coping Plan (Niagara Region Mental Health uses a Crisis Plan), and those who are high risk for suicide complete a Safety Plan.

If the client is not experiencing an imminent crisis, a staff member may work with the client (and family/support person) to develop a Safety Plan that is informed by the client's level of risk and their personal goals for recovery. It is adapted to the setting in which the client is receiving care (e.g. inpatient or community settings)[3].

The most commonly used (and validated) Safety Plan is the Stanley-Brown Safety Plan (open access on the Internet and endorsed by the Suicide Prevention Resource Centre). There are also Safety Plan apps available to support clients if this is their preferred way of accessing their Safety Plan (on their phone, tablet, or other electronic devices). Note that many of these applications are based off of the Stanley Brown Safety Plan, however they may have been adapted and have not been formally studied. See Appendix H for an example of St. Joseph's Coping and Safety Plan. You may wish to adopt an existing Safety Plan, or adapt one to meet the needs of your organization.

The Safety Plan should include:

- Client's support system
- Contact persons (including formal and informal supports)
- Self-regulation measures (coping)
- Personal warning signs
- Reasons for living (what keeps the client alive)
- List of local crisis services
- Restricting access to lethal-means

TIP:

As part of lethal-means restriction, a staff should review the client's prescribed medications to determine if there is a risk of the medications being used to overdose. Are there measures to put in place to reduce access to the medication (e.g. weekly blister pack, lock box)? It is important to engage with any formal or informal supports who can assist in these life-saving interventions. Staff are able to learn more about lethal means restriction as outlined in the education plan from the Plan 2.0 section of the Toolkit.

Checkpoint:
Coping Plan and/or Safety Plan selected/developed ☐

Referral to Support/Evidence-Based Treatment

If following suicide risk screening a client is deemed to be at high risk for suicide behaviours, same-day access to a mental health professional for a formal medical suicide risk assessment is required. This may lead to the client receiving evidence-based treatment specific to suicidality.

For continuity of care, consider if you have a Regulated Health Care Provider (RHCP) or trained Mental Health Professional in your organization who can complete this assessment within their scope of practice? If you do not have a RHCP available to complete the formal suicide risk assessment, you will need to determine a pathway to assist client's access to a formal suicide risk assessment. It is during a formal suicide risk assessment that it will be determined whether or not evidence-based treatment specific to suicide is required. Considering how you can support clients in receiving this treatment is also important. You may be able to network and collaborate with organizations that partner in mental health care and create a Memorandum of Understanding (MOU) to help support soft and caring transitions to assessment and treatment.

Your pathway to refer client to a formal suicide risk assessment and evidence-based treatment (if required) can include the following services:

- Primary Care Provider
- Emergency Department
- Crisis Centre/Mobile Crisis
- Another mental health care access point the client is already connected to service

Examples of how your organization can support evidence-based treatment specific to suicide:

- Awareness of Dialectical or Cognitive Behavioural Therapy skills and encouraging clients to use the skills to prevent further suicidal crisis
- Discussing and supporting client goals with evidence-based treatment
- Connecting with the treatment provider when necessary and with consent
- Providing support with transportation to access treatment
- Reviewing documents such as a Safety Plan created in treatment sessions

If evidence-based treatment is taking place at your organization, remember that a guiding principal to evidence-based treatment specific to suicide is providing the least restrictive care in the least restrictive environment.

Checkpoint:
Referral Pathway to Assessment and/or Evidence-Based Treatment developed ☐

Engaging Natural and Peer Supports

Connection with others is at the heart of suicide prevention. What natural resources have you identified (outside of professional services) in your community? Consider the natural supports your clients could access and the unique supports and resources the client already has.

Recall from the Plan 2.0 Toolkit section that peer support is an important component in suicide prevention. At this time, you should have identified the following:

- Is your organization going to provide peer support? If so, what does this look like?
- What peer support is available outside of your organization and what is your method for connecting clients to peer supports?
    - Referral to formalized peer support services - 211ontario.ca may be useful in Ontario
    - Informal peer support - checking in or informal connections with others
    - Self-led peer support resources - Your clients will find it helpful to have a resource list for those with lived experience with suicide

Natural supports: Refer to the support and assistance that naturally flows from the associations and relationships that are typically developed in natural environments such as the family, school, work, and community. These are different from formal or paid for supports from organizations. These unpaid, informal, and ordinary relationships and community assets are an important part of maintaining and improving mental health.[4]

Checkpoint:
Engagement with Natural and Peer Supports ☐

Supporting Transitions in Care

Transitions in care, notably from inpatient to outpatient services, can pose a high-risk time for suicide behaviours[5].

Recall from the Plan 2.0 Toolkit section that there are recommendations for the referring staff member to complete.

What can your organization do to be an effective referral source?

- Collaboratively revise the client's Safety Plan before discharge/referral
- Ensure the client has connected virtually/in person with the staff member assuming care for the client
- Call the receiving staff member to provide pertinent documentation or communication/ report before the first appointment (within organizational/professional standards)
- Contact the client 24-48 hours after they have had contact with the new provider and document this contact
- Consider how an electronic documentation system can support client safety, such as communicating client risk status and flagging no-show appointments

Other important elements of supporting safe transitions in care include1:

- Work to promote rapid referral/access if possible (avoid long wait times or service access)
- Consider how you can engage crisis services (e.g. crisis centre) to help augment care transitions if there are resource challenges. More information about the use of crisis services to augment care is provided on the Zero Suicide Toolkit website: Transition > Role of Crisis Services.
- Brief client education about their condition and available services (system navigation)
- Encourage the support of support person(s) during care transitions if consent is provided
- Provide the client with a copy of their Safety Plan and ensure it is relevant and appropriate to the patient's suicide risk level
- Provide caring contacts

Determine what elements of supporting safe care transitions are appropriate for your organization.

Checkpoint:
Supporting Transitions in Care ☐

Implementing Caring Contacts

Having learnt and brainstormed about how caring contacts may fit within your organization, it is time to develop a method for how caring contacts will be made. Recall that caring contacts are considered as either phone calls, or "non-demanding" means such as sending a post-card or automated e-mail/text message. In your policy and/or procedure(s), you should include who will provide the caring contact, when this will be provided, the means of communication, and what the communication will entail.

If you are choosing a standardized caring contact message either by phone/non-demanding means, it is time to draft this! Ensure to include multiple stakeholders (including client input from those who will receive these contacts), and the staff who will be delivering them.

A caring contact message should include:

Phone Calls:

- Express care, concern, and encouragement
- Review discharge plan for understanding and allow the client to ask questions
- Review Safety Plan, Suicide Care Management Plan, and crisis services
- Help with problem solving for practical post-discharge challenges such as attending appointments and filling prescriptions

Refer to the Plan 2.0 section of the Toolkit to see an example of St. Joseph's caring contact phone call message

Non-Demanding caring contacts (e.g. postcards, automated text/e-mail messages, etc.):

- Postcards
- Automatic text/email messages
- Brief encouraging notes or messages

Examples and templates for non-demanding caring contacts:

- Zero Suicide Website: NetCare Caring Cards & Ideas.pdf (edc.org)
- Zero Suicide Website: nowmmattersnow.pdf (edc.org)

How do you intend to deliver caring contacts (e.g. phone call, automated e-mail)?

What will be your organizations process for delivering the caring contact?

Determine a template you will use, or draft your caring contact message below:

Checkpoint:
Caring contact process and message developed ☐

Reviewing Suicide Related Incidents

Now is the time to determine how a self-harm or suicide related incident review will take place within your organization. This information should be clearly articulated in your policy

and/or procedure(s) including who will be involved, the timeframe in which the review will occur, and how any recommendations for improvement that are an outcome of the review will be implemented.

It is recommended that a standardized process be utilized for each event. Consider adapting a current review process template within your organization, or a root cause analysis template available on the Internet. You may wish to make this template transparent to your staff by including it as an Appendix in your policy and/or procedure(s).

Example:

The Joint Commission- Root Cause Analysis & Action Plan

Appendix V: Root Cause Analysis and Corrective Actions (Non-healthcare)

Checkpoint:
Incident review process/template determined ☐

Postvention Support

The Zero Suicide framework ascribes to the aspirational goal of zero deaths by suicide, however suicide is complicated and individual to each person. Despite the policy, procedure(s), work plans, tools, and safeguards in place, we will still lose people to suicide. It is important that there is a no blame culture in the workplace for individuals doing this important work (remember: "Just Culture"). It is critical that staff know that implementing these tools, and talking to clients about suicide can be life-saving, however a death by suicide is not anyone's fault.

Identify three action items that will be implemented to improve Just Culture within your organization as you go live with your initiative:

1. _____
2. _____
3. _____

Postvention is a term that is often used when talking about suicide prevention, and refers to activities which reduce risk and promote healing after a death by suicide. Following a death by suicide, staff and other clients will need additional support to work through their grief, and an important part of a policy and/or procedure is to include how those who have been touched by a loss will be supported. Those who have lost someone to suicide are at an increased risk for suicide themselves[6], and having support and resources available/accessible to staff and other clients is critical. Postvention is prevention!

At Niagara Region Mental Health, part of the organization's postvention support includes a 'Lavender Alert' – where staff can access timely support following a critical incident or loss (Appendix R). This includes a list of the postvention support that staff can access in the policy and/or procedure(s).

Documentation

List documentation expectations of staff depending on their role within the organization. If you have an existing documentation policy and/or procedure, you may wish to refer staff to this.

Checkpoint:
Documentation expectations articulated ☐

Required Education for Staff

List all required education for staff based on their role within the organization.

Checkpoint:
Required education determined and listed ☐

Key Definitions

Clearly define all key definitions throughout the policy and/or procedure(s) to reduce ambiguity amongst staff.

Checkpoint:
Key definitions complete ☐

Appendices

Checkpoint:
Relevant appendices are attached, linked, or staff are directed to where these resources can be found ☐

You have done a lot of work in this portion of the Toolkit - namely outlining the additional suicide prevention elements/processes that your organization will adopt. Take time to integrate this information into your policy and/or procedure(s).

Checkpoint:
Suicide prevention policy and/or procedure(s) complete ☐

Implementing Suicide Prevention Education for Staff

In order to be comfortable and confident in suicide prevention and intervention, staff must be well trained. Thinking back to the Workforce Survey results and the Education Plan you created in the Plan 2.0 section of the Toolkit, it is now time to implement training. Note that some training will be post-dated for the future, and therefore, you may wish to "go live" with the implementation once the majority (if not all) staff are trained. From an adult learning perspective, the time between training and implementation should not extend beyond 1-2 months. For example, if you are able to register 90% of your staff for an ASIST course and organization specific training through September and October, you may be prepared to "go-live" on November 1st.

Recall that your staff may require training from both external parties (e.g., LivingWorks) and your own organization (e.g. Learning the Basics About Suicide presentation from the Toolkit - Plan 2.0 section [Appendix K]; screening tool(s), policy and/or procedure(s)).

General tips for completing staff training include:

- Create a schedule for staff training and include back up training dates for those that are unexpectedly absent
- Monitor the budget (if applicable) and timeframe for completion
- Follow up with staff on their experience (did this meet their needs?) (See Appendix S for NRMH Zero Suicide Training Evaluation)
- Revisit staff members' perceptions of confidence and comfort (does anyone require additional coaching?). Note: It is recommended that the Workforce Survey is administered at least once every 3 years, ideally once every 12-18 months, to either a sample of staff members, or the broader group of those who completed this the first time.

Tips for organization specific training:

- Identify one or more trainer(s) for organization specific training
- Consider the appropriate group size for training sessions
- Consider the length of time required - should this be in one session, or multiple?
- Create a safe space and maintain confidentiality
- Pay attention to staff who may be triggered or require support during training
- Breaks and self-care are important for staff
- How often will you offer the training? (Consider new staff onboarding)

Implementation Considerations

Go-Live Date

Your "go-live" day is typically the day in which the organization chooses to officially implement suicide prevention processes/procedures. You may have been looking at your implementation timeline and wondering if this day would ever come. During "go-live," the policy and/or procedure(s) take effect. This is a very exciting time, and is the outcome of your project team's hard work. At this point, there will also be some anticipated nerves. Despite your planning and preparation, risk mitigation, and staff training, turning processes into action can unveil unknowns and be met with change resistance. This is a normal part of every project, and the essence behind using a PDSA framework to inform your work.

Tips for a successful go live:

- Communication plan (e.g. posters to introduce the launch date)
- Prepare cheat sheets (Frequently Asked Questions [FAQ]) & quick reference guides)
- Generate energy and involve your influential staff in planning the go-live date
- Conduct a dress rehearsal prior to go-live & make system/process adjustments
- Host a meeting with the implementation team prior to the go-live date to run through final readiness and last-minute questions
- Have a forum/means for staff to be able to express feedback about the initiative once it has gone live
- Create incentive or reward/recognition for quick wins if this makes sense for your organization

Finally, it's time to implement all of your hard work. Take a deep breath, be present and available for staff if issues as they arise, and stay determined to work through them. Some challenges are to be anticipated. Stay positive and engaged in your own learning as you move through this phase of the implementation!

Change Management with Staff

Staff may have lots of questions about your established processes, especially if talking about suicide with clients is a new process for your organization. Change management can sometimes pose a challenge with staff, and essentially refers to how staff adopt new processes and use them to deliver quality services. One of the most important elements of change management is to be participatory and engage staff through the change process. This concept has been woven throughout the Toolkit, and having staff on your project team helps to include all levels of participation in decision making. Another key element of successful change management is celebrating and reinforcing what is being done well. These wins help the project gain influence, momentum, and perseverance.

Other strategies to support effective change management include:

- Effective communication and education plans
- Stay focused on the reason- "the why" for the change (i.e. client safety, organizational values)
- Engage the leadership of those with influence and close proximity to the team (e.g. change agents such as a team lead, educator, someone other staff "follow")
- Aim for standardization (equity) but acknowledge unique program differences/needs
- Help reflect on implementation processes and manage loss (e.g. familiar processes that give them confidence and security) by using open discussion sessions and 1:1 meetings
- Set and manage expectations of staff, including defining tasks well
- Be proactive to manage risk, but if issues arise, respond to them quickly
- Identify and address attitudinal barriers early on
- Build a culture of innovation and continuous quality improvement, making change the norm - consider including Zero Suicide as a standing agenda item for discussion at team meetings
- Be ready to rescue the implementation if it is starting to lose momentum (e.g. completing an in-person "blitz" or "refresh" to staff and even making these annual during September-Suicide Prevention Month)

Examples of some of these strategies in motion include hosting change management focus groups with staff and developing FAQ documents (see examples in Appendix T) to respond quickly to implementation questions.

Beginning Evaluation: Data Collection

Having a data-driven approach to quality improvement throughout your suicide prevention implementation is essential. Recall the evaluation plan you developed in the Plan 2.0 section of this Toolkit (you may have used the "Zero Suicide Data Elements Worksheet"). Depending on the specific methods and data you determined to collect, you may already be engaged in this process. For example, examining the number of suicide screening tools completed on the go-live day, the quality of screening tool completion, documents being stored in the appropriate locations, etc. You may also wish to collect implementation data. For example, what are the questions staff are asking? What are the issues that arise and how have we resolved them?

It may seem tedious, but this data collection will inform strategies for quality improvement. We will discuss this in more detail in the next section of the Toolkit entitled: Study.

Building Suicide-Safer Communities

Suicide prevention is everyone's responsibility. Your organization plays a key role, along with other health care providers, mental health workers, family members, friends, and other community organizations. We are all responsible for helping our communities to become more suicide safe, and we can all make a difference in improving suicide prevention. No action taken to prevent suicide is too small to make a difference[7].

Around the world, individuals, cohorts, and communities are working on suicide prevention at regional, provincial/state, and national levels. There are many communities of practice (e.g., Zero Suicide listserv), coalitions, and councils dedicated to improving suicide prevention. We encourage you to seek out local and national opportunities to network and learn from one another- connection is key!

Canadian Association for Suicide Prevention

Niagara Suicide Prevention Coalition

London Middlesex Suicide Prevention Council

As you work through your project implementation, begin to think about how you can be a leader in suicide prevention in your community. *How can you influence and support other groups and organizations to help save lives?*

References

1. Education Development Center [EDC]. (2015). *Zero Suicide toolkit*. Zero Suicide. https://zerosuicide.edc.org/toolkit
2. Stallman, H. M. (2018). Coping planning: A patient-centred and strengths-focused approach to suicide prevention training. *Australasian Psychiatry, 26*(2), 141–144. https://doi.org/10.1177/1039856217732471
3. Health Standards Ontario. (2020). *CAN/HSO 5064:2020 Suicide prevention – Public review*.
4. GADOE. (n.d.). *What are natural supports?* https://www.bing.com/search?q=gadoe+-+what+are+natural+supports&src=IE-SearchBox&FORM=IESR3N
5. Chung, D. T., Hadzi-Pavlovic, D., Wang, M., Swaraj, S., Olfson, M., & Large, M. (2019). Meta-analysis of suicide rates in the first week and the first month after psychiatric hospitalization. *BMJ Open, 9*(3), e023883. http://dx.doi.org/10.1136/bmjopen-2018-023883
6. Pompili, M., Shrivastava, A., Serafini, G., Innamorati, M., Milelli, M., Erbuto, D., Ricci, F., Lamis, D. A., Scocco, P., Amore, M., Lester, D., & Girardi, P. (2013). Bereavement after the suicide of a significant other. *Indian Journal of Psychiatry, 55*(3), 256-263.
7. London Middlesex Suicide Prevention Committee. (n.d). *A matrix of suicide prevention activities*. https://lmspc.ca/wp-content/uploads/2013/04/matrix_suicide-prevention-activities.pdf

Appendices

Appendix N: NRMH Policy and Procedure

Appendix O: St. Joseph's Triage Tool

Appendix P: St. Joseph's Triage Tool (Adapted for a virtual care setting)

Appendix Q: NRMH Mental Health and Addictions Community Resource List

Appendix R: NRMH Postvention Support: Lavender Alert

Appendix S: NRMH Zero Suicide Staff Education Evaluation Form

Appendix T: Example of St. Joseph's & NRMH FAQ documents

Appendix V: Root Cause Analysis and Corrective Actions (Non-healthcare)

Select One		Policy Number	Enter Number
Policy Title	Suicide Risk Assessment		
Revision Date(s)	July 2020		

POLICY STATEMENT

Niagara Region Public Health and Emergency services is committed to ensuring ensuring the safety and wellbeing of clients, in order to achieve maximum wellness, Niagara Region Mental Health staff who are working with clients in the community at risk for suicide will utilize a standardized, evidence based suicide risk assessment.

APPLICATION

All Niagara Region Mental Health staff providing front line support to clients will be required to complete training in Applied Suicide Intervention Skills training (ASIST) and the Columbia – Suicide Severity Rating Scale.

The Columbia-Suicide Severity Rating Scale is intended to be used by individuals who have received training in its administration.

SUPPORTING DETAILS

Suicide risk assessment should be viewed as part of a therapeutic process that creates an opportunity for discussion between the client and the clinician. A focused risk assessment can reveal the underlying factors mediating or mitigating risk and support a continued therapeutic rapport with the client to discuss his or her ideations, plans, and behaviours related to suicide; and his or her strengths and supports to moderate risk.

The suicide risk assessment tool is a source of information that is used to determine a person's risk of suicide. It does not replace clinical judgment. All assessments should remain person-focused and be incorporated within a therapeutic relationship, using empathetic, warm, and objective assessment.

Suicide Risk Assessment Tool (SAFE-T Protocol with Columbia C-SSRS Suicide Severity Rating Scale Lifetime Recent embedded:

Suicide risk assessment tools are only to be used as part of a comprehensive assessment and should not be used in isolation. The SAFE-T Protocol and Columbia – Suicide Severity Rating Scale cannot predict who will or will not attempt or complete suicide. The assessment tool helps gather information during an interview. Assessment tools can **never** replace clinical judgment.

SAFE-T Protocol with C-SSRS Lifetime Recent embedded – The SAFE-T Protocol offers a thorough assessment of the nature and extent of suicidal thoughts and behaviors.

The more extensive items contained in the SAFE-T interview are likely to yield the detailed information needed to develop a full picture of a client's suicide risk. The items include the following:

- Ideation: frequency, intensity, duration—in last 48 hours, past month, and worst ever
- Plan: timing, location, lethality, availability, preparatory acts
- Behaviors: past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self-injurious actions (clinicians to complete C-SSRS Lifetime Recent for comprehensive behavior/lethality assessment where necessary)
- Intent: extent to which the client, one, expects to carry out the plan and, two, believes the plan/act to be lethal vs. self-injurious. Explore ambivalence: reasons to die vs. reasons to live

The Columbia – Suicide Severity Rating Scale rates an individual's degree of suicidal ideation on a scale, ranging from "wish to be dead" to "active suicidal ideation with specific plan and intent." The scale identifies behaviors which may be indicative of an individual's intent to complete suicide. An individual exhibiting even a single behavior identified by the scale is 8 to 10 times more likely to complete suicide.

The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the clinician administering the scale.

DEFINITIONS ☐ See the bottom of this document for applicable definitions

ACCOUNTABILITIES

1.0 Suicide risk assessment is an ongoing process. Staff are expected to:

- Screen for risk and focused suicide risk assessment – using the Columbia – Suicide Severity Rating Scale C-SSRS) screening tool/s
- Integration of the information from the risk assessment into the ongoing plan of care
- Ongoing monitoring and re-assessment
- Collaborative coping and suicide management planning, including lethal means counselling

In conducting Suicide Assessments the clinician must:

- Be aware of warning signs, potential risk factors, and protective factors
- Integrate information from clinical interviews; consider other sources of information about the client, and use clinical judgment to determine overall risk
- Document all findings

The following roles will have the associated accountabilities:

ROLE	ACCOUNTABILITIES
1. Management	• Oversee the development of policy, procedures and guidelines to support the Suicide Care Management Plan • Ensure staff are oriented to this policy • Ensure communication to all staff if any changes are made to the policy

2. Implementation Team	• Ensure staff are using consistent practices within their respective services • Ensure support is provided to staff who have experienced a suicide death of a client • Ensure staff have appropriate training to talk to clients about suicide risk ie SafeTalk and/or ASIST and C-SSRS training • Ensure staff have opportunity to debrief following a suicide risk assessment or intervention with a client • Ensure suicide care planning is embedded in the electronic health record • An Implementation Team is established, with specific tasks • Each team member acts in Champion role for each service team • Provide regular input and advice on the Suicide Care Management Plan • Participate on evaluation and quality improvement efforts • Support the development of an evaluation plan to access the impact of the Suicide Care Management Plan Initiative • Support Zero Suicide training to new staff

CONSEQUENCES AND MONITORING ☒ No additions beyond the section outlined in the Public Health Policy II-070.1 Developing, Approving Monitoring and Storing of Policies, Procedures and Guidelines.

RELATED DOCUMENTS ☐ Not Applicable

Policies	•
Procedures	• Responding to suicide risk
Guidelines	•
Other	• C-SSRS screening tools

HELPFUL LINKS ☐ Not Applicable

E-Learning Module for C-SSRS – 1 hour C-SSRS Online Training Module Link

REFERENCES ☐ Not Applicable

Accreditation Canada Required Organizational Practices Handbook 2015
Registered Nurses Association Ontario (2009). Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour. Retrieved https://rnao.ca/bpg/guidelines/assessment-and-care-adults-risk-suicidal-ideation-and-behaviour

Columbia – Suicide Severity Rating Scale Web-Based Training, Dr. Kelly Posner, Kelly Posner Gerstenhaber, Ph.D. - Founder and Director of The Columbia Lighthouse Project

Chapter	Enter Chapter
Implementation Date	Select Date
Maintained By	Select One
Approved By	Select Approver Select Date

DEFINITIONS ☐ Not Applicable

Suicide: Death caused by injuring oneself with the intent to die.

Suicide Attempt/Behaviour: A self-injurious act done with at least some intent to die as a result of the act. There does not have to be any injury or harm, just the potential.

Suicide Ideation: Thoughts about suicide; thinking about, considering or planning suicide.

Suicide Intervention: A direct effort to prevent an individual from attempting to take their own life intentionally.

Suicide Risk Indicators: Refer to an individual's unique warning signs, clinical presentation, history, psychosocial factors, and reasons for suicidal ideation. Risk indicators can be associated with an increased risk for suicide at one point in time and can either be modifiable or non-modifiable.

Suicide Protective Factors: Refer to factors that may help to mitigate the risk of suicide. Assessing protective factors help to identify potential strengths that can be used to help reduce suicide risk.

Suicide Risk Assessment: Suicide risk assessment is a process of estimating the likelihood for a person to attempt or die by suicide. The goal of a thorough risk assessment is to learn about the circumstances of an individual person with regard to suicide, including warning signs, risk factors, and protective factors. The goal is not to predict suicide, but to appreciate the basis for suicidality and to allow for a more informed intervention.

Guidelines for Interventions for Columbia Risk Levels for Inpatient Mental Health

Risk Stratification	Possible Interventions
HIGH • Suicidal ideation with intent or intent with plan (C-SSRS Suicidal Ideation #4 or 5) not previously assessed **OR** • Suicidal behaviour (C-SSRS Suicidal Behaviour) not previously assessed	*Consider constant observation *Notify team of change in status *Assess with team cancellation of passes/LOA if any ordered *Consider belongings and room search in accordance with SJHC policy *Document in patient record *Ongoing suicidal assessment as needed with any clinical indicators such as: Change in treatment or medications Collateral information Team discussion Change in clinical presentation *Collaboratively develop/update Coping Plan *Psychoeducation (coping skills, stress management, symptoms management etc.)
MODERATE • Suicidal ideation WITHOUT plan, intent, or behaviour (C-SSRS Screener #2 or 3) **OR** • Suicidal behaviour more than 3 months ago (C-SSRS Suicidal Behaviour) but not currently assessed **OR** • Multiple risk factors and few protective factors	*Continue to assess daily with since last visit/shift Screener *Continue to assess q shift or as needed with any clinical indicators such as: Change in treatment or medications Collateral information Team discussion Change in clinical presentation *Notify team of change in status *Consult with team re passes/LOA privileges *Consider belongings and room search in accordance with SJHC policy *Complete Columbia Lifetime/Recent Tool if risk level increases from low to moderate or moderate to high in since last visit/shift Screener * Document on the patient record if there has been a change in risk level *Psychoeducation (coping skills, stress management, symptom management etc.) *Collaboratively develop/update Coping Plan
LOW *Wish to die (C-SSRS Suicidal ideation #1) no plan, intent or behavior **OR** *Suicidal ideation more than 1 month ago WITHOUT plan, intent or behavior (C-SSRS #2) **OR** *Modifiable risk factors and strong protective factors **OR** *No reported history of suicidal ideation or behaviour	*Complete the Columbia since last visit/shift Screener Q daily *Look for changes in presentation that may indicate need for earlier assessment *Assess environment for safety via regular environmental scans *Psychoeducation (coping skills, stress management, symptoms management etc.) * Collaboratively develop/update Coping Plan *Columbia Lifetime/Recent Tool to be used when risk level increases. This version of tool captures more information regarding severity of suicide risk
Note: This table provides *potential* interventions, but is not a mandatory or exhaustive list. It is meant as a tool/guideline only.	

Risk Stratification	Triage	Possible Interventions
• Suicidal ideation with intent or intent with plan (C-SSRS Suicidal Ideation #4 or 5) not previously assessed **OR** • Suicidal behaviour (C-SSRS Suicidal Behaviour) not previously assessed	Flex up care and determine need for Suicide Management Plan Inform physician and discuss need for urgent/earlier appointment	➢ Physician to evaluate for potential hospitalization; if patient requires admission, begin admission process ➢ Collaboratively develop Suicide Management Plan ➢ Discuss sharing of Suicide Management Plan with support person(s) ➢ If patient does not show for an appointment, attempt contact within scheduled appointment time ➢ Optimize pharmacological treatment ➢ Family/significant other engagement ➢ Psychotherapy (CBT, DBT) ➢ Psychoeducation (coping skills, stress management, symptom management, etc.) ➢ Telephone follow-ups
• Suicidal ideation **WITHOUT plan, intent, or behaviour** (C-SSRS Screener #2 or 3) **OR** • Suicidal behaviour more than 3 months ago (C-SSRS Suicidal Behaviour) but not currently assessed **OR** • Multiple risk factors and few protective factors	Clinician will consider risk and protective factors and determine appropriate treatment setting	➢ Collaboratively develop/update Coping Plan ➢ Optimize pharmacological treatment ➢ Psychotherapy (CBT, DBT) ➢ Psychoeducation (coping skills, stress management, symptom management, etc.) ➢ Family/significant other engagement ➢ Utilize crisis beds
• Wish to die (C-SSRS Suicidal Ideation #1) no plan, intent, or behaviour **OR** • Suicidal ideation more than 1 month ago WITHOUT plan, intent, or behaviour (C-SSRS Screener #2 or 3) **OR** • Modifiable risk factors and strong protective factors **OR** • No reported history of suicidal ideation or behaviour	Requires outpatient mental health care (already receiving)	➢ Ensure Coping Plan is up to date ➢ Ensure Recovery Plan is up to date ➢ Continue with current management

Note: This table provides *potential* interventions, but is not a mandatory or exhaustive list. It is meant as a tool/guideline only.

St. Joseph's Triage Tool (Adapted for a virtual care setting)

RISK STRATIFICATION	POSSIBLE INTERVENTIONS *Not all possible interventions will apply in every situation, this is not an exhaustive list
HIGH • Suicidal ideation with intent or intent with plan (C-SSRS Suicidal Ideation #4 or #5) not previously assessed OR • Suicidal behaviour (C-SSRS Suicidal Behaviour) not previously assessed	**Collaborate with the patient to promote immediate safety.** **High Risk- Imminent:** • Discuss environmental safety and restriction of lethal means with the patient. • Engage personal supports who are physically with the patient, if appropriate (i.e. with consent) and not already done. Consider if the personal support can safely transport the patient to the closest Emergency Department (ED). • If the patient requires transportation to the ED, remain on the phone with the patient and call the local crisis service (note: some have mobile outreach available) or if there is a risk of violence to self or others (e.g. firearm) have another staff member call security at ext. 55555 to activate an emergency service (911) response. • Remain on the phone with the patient (See Appendix D: "Maintaining Patient Phone Contact During Imminent Suicide Risk"), providing empathic support and planning to maintain safety with the patient while waiting for crisis or emergency services. The clinician will remain on the phone with the patient until emergency or crisis services have assumed patient support (i.e. have engaged the patient on the telephone) or are physically present with the patient. **High Risk- Not imminent:** • Depending on risk formulation and clinical judgment, connect the patient to the local crisis service (with consent) or initiate emergency response. If a patient does not consent to connect (warning sign) to a local crisis service, explore this with the patient and consider initiating emergency response. • Consider completing immediate safety planning if appropriate (Appendix F: GAAT Suicide Management Plan) • Referral to the local Behavioural Support Ontario (BSO) mobile team • Contact the local BSO mobile team to provide warm handover (supportive transfer) and review GAAT initial assessment and intervention **Communication:** • Notify primary care provider/ care team of elevated risk and care plan/ outcome once patient has been transferred and/or risk is managed • Debrief with health care team and leader as needed
MODERATE • Suicidal ideation WITHOUT plan, intent, or behaviour (C-SSRS Screener #2 or 3) OR	**Discuss the immediate environment to ensure patient safety.** **Collaborate with the patient to promote immediate safety:** • Initiate referral to local BSO mobile team • Provide patient with supportive listening/ counseling • Encourage patient to make an appointment with primary care provider while waiting for initial BSO mobile team visit

• Suicidal behaviour more than 3 months ago (C-SSRS Suicidal Behaviour) but not currently assessed	• Engage family/significant other, with patient consent, as appropriate: communicate level of risk and plan of care, assist in means reduction **Communicate risk level with the Provider / Health Care Team:** • Notify primary care provider/ team of elevated risk by phone and/or fax encouraging a plan of surveillance **Provide patient with information on community Mental Health/Crisis services:** • Provide information for local community mental health/crisis services (Appendix C).
LOW C-SSRS Suicidal Ideation #1 • Wish to die - no plan, intent, or behaviour OR • Suicidal ideation more than 1 month ago WITHOUT plan, intent, or behaviour (C-SSRS Screener #2 or #3)	**Discuss the immediate environment to ensure patient safety.** **Collaborate with the patient to promote immediate safety:** • Initiate referral to local BSO mobile team • Provide patient with supportive listening/ counseling **Communicate risk level with the Provider/ Health Care Team:** • Identify risk level on the first page/ cover sheet of the triage/referral tool when referring to local BSO mobile team • Contact local BSO mobile team to provide warm handover **Collaborate with the Health Care Team to provide patient with information on community Mental Health/Crisis services:** • Provide information for local community mental health/crisis services (Appendix C)

Mental Health and Addictions

Supports & Services for adults

Niagara Region

Crisis

Canadian Mental Health Association - Safe Beds Program: A voluntary, non-medical facility that offers crisis counselling and a safe therapeutic environment for short-term stays. 905-641-5222

Community Outreach and Support Team (COAST): COAST provides services to people in the Niagara region who are in crisis and have a mental health concern. 1-866-550-5205

Distress Centre Niagara:
Provides a free, confidential, 24-hour distress line.

St. Catharines/Niagara Falls	905-688-3711
Port Colborne/Wainfleet	905-734-1212
Fort Erie	905-382-0689
Grimsby/West Lincoln	905-563-6674

Gillians Place - 24/7 Support Line:
Immediate phone support, emergency shelter or longer term support in creating a new, abuse-free life.
905-684-8331
French services: 1-877-336-2433

Niagara Health Mental Health and Addictions Program: St. Catharines Site Emergency Department (1200 Fourth Ave.) 905-378-4647 ext. 49613
niagarahealth.on.ca/site/mentalhealthservices

Niagara Region Sexual Assault Centre (24-hour):
sexualassaultniagara.org 905-682-4584

Victim Services Niagara - Victim Crisis Assistance Ontario: A service providing on-scene early intervention and crisis intervention to victims of crime and tragic circumstances.

Crisis Phone:	905-682-2626
Office Phone:	905-688-4111 ext. 5084

Health

Bridges Community Health Centre: Primary health care, illness prevention, and community development.
bridgeschc.ca

Port Colborne location	289-479-5017
Fort Erie location	905-871-7621

Centre de Sante Communautaire: Services for French-speaking clients including primary care, prenatal, nutrition, youth programs, settlement services, programs for victims of violence, addiction and mental health counselling.
cschn.ca 905-734-1141

Health Bus Outreach: For populations in Niagara who cannot access traditional health services.
Call or text 905-401-4074

Niagara Falls Community Health Centre: Multi-service health centre that provides free primary health care and community development services.
nfchc.ca 905-356-4222

Niagara Region Public Health
905-688-8248 or 1-888-505-6074

Quest Community Health Centre: Provides primary health care and community capacity building.
questchc.ca 905-688-2558

Telehealth: Free, confidential telephone service. Get health advice from a registered nurse. 1-866-797-0000

Counselling and Support Services

Canadian Mental Health Association:
Walk-in counselling: cmhaniagara.ca/ourservices/immediate-services/walk-in-counselling
Urgent Support Service:
cmhaniagara.ca/urgent-support-services 905-641-5222

Community Support Services of Niagara: Helps seniors and adults with disabilities live independently in their own homes. 1-866-283-1931

Consumer Survivor Initiative: Advocates for people who have used mental health services. 905-732-4498

Design For A New Tomorrow: Support for individuals who have experienced abuse. 905-684-1223

Family Counselling Centre Niagara: Drop-in and immediate support for personal crisis.
fccniagara.on.ca 905-937-7731 ext. 3345

Family Support Network of Niagara: Support and education for families who have a relative with mental health issues. 905-894-6808

Fort Erie Native Friendship Centre: Provides Indigenous people access to appropriate services for their mental, emotional, spiritual and physical well-being.
905-871-8931

Gateway: Provides programs to support people living with mental illness. 905-735-4445 or 1-877-735-4445

Mental Health & Addictions Access Line 24/7 support
1-866-550-5205

Niagara Gatekeepers: Phone referral service for at risk seniors to stay safe and independent at home.
905-684-0968

Niagara Life Centre: Family support centre and counselling.

St. Catharines	905-934-0021
Fort Erie	905-871-0236

Counselling and Support Services Cont'd

Niagara Region Mental Health Early Intervention in Psychosis Program: For individuals 14-35 years old who are experiencing a first episode of psychosis.
niagararegion.ca/health 905-688-2854 ext. 7262

Niagara Region Public Health, Community Programs for Seniors: Programs to help older adults remain safe and independent at home.
905-984-2621 or 1-877-212-3922

Niagara Region Public Health, Healthy Babies Healthy Children: A free home-visiting program that assists expectant mothers and new parents who need support. (Niagara Parents) 905-684-7555

Niagara Region Public Health, Mental Health Referral Line: Confidential treatment and counselling.
(Monday to Friday) 905-688-2854 ext. 7262

Niagara Region Public Health, Niagara Parents: Connect with a public health nurse.
niagararegion.ca/parents
Email: parents@niagararegion.ca
Twitter/Facebook: @NiagaraParents
(Monday to Friday, 8:30 a.m. - 4:15 p.m.) 905-684-7555

Niagara Regional Native Centre
nrnc.ca 905- 688-6484

Oak Centre: Community mental health program.
905-788-3010

St. Joseph's Healthcare, Women's Health Concerns Clinic: Assists in the diagnosis and treatment of women 18 years+ with mental health challenges who are pregnant or up to 9 months postpartum.
1-905-522-1155 ext. 33605 (Hamilton)

Start Me Up Niagara: Addiction, mental illness, poverty, homelessness and unemployment support. 905-984-5310

Alcohol, Drugs, Tobacco and Gambling

Addiction Recovery Services: St. Catharines and Port Colborne. Members of Addictions Ontario.
niagarahealth.on.ca/site/addictionrecoveryservices

Alcoholics Anonymous 1-866-311-9042

Al-Anon Family Groups: Program for anyone affected by someone else's drinking.
al-anon.alateen.on.ca 905-328-1677

ARID Recovery homes: Provides a comfortable room and basic needs in a home-like environment for up to 9 months.
aridhomes.ca 905-227-1113

Community Addiction Services of Niagara: Assessments, treatment planning, counselling, and referrals.
cason.ca 905-684-1183

Men's Detox Centre 905-682-7211

Narcotics Anonymous
niagarana.com 1-888-811-3887

Segue Clinic: A community-based addiction treatment centre specializing in opioid use disorder.
segueclinic.com 905-688-1827

Tobacco Hotline: Quit smoking support and reporting a smoking or vaping complaint.
niagararegion.ca/health (search quit smoking)
905-688-8248 ext. 7393 or 1-888-505-6074 ext. 7393

Women's Addiction Recovery Mediation (WARM): Programs for women experiencing addiction and families affected by addiction.
ywcaniagararegion.ca/womens-addiction-recovery-mediation
905-988-3528 ext. 4022

Women's Detox Centre 905-687-9721

Self-Help Apps and Online Support for Mental Well-being

These self-help apps are not a replacement for assessment/ treatment but may help you while waiting for appointments or while on a wait list.

Beyond the Silence App: Information and support for managing mental health at work. beyondsilence.ca/app

Big White Wall: An online mental health and wellbeing service offering self-help programs, creative outlets and a community that cares. bigwhitewall.ca

Bounce Back: A free online program designed to help adults and youth 15+ manage symptoms of depression and anxiety. bouncebackontario.ca

Mind Your Mood: Track your moods and get a 'mood report.' mindyourmind.ca

MindShift: Strategies based on cognitive behavioural therapy to help you learn to relax and be mindful, develop more effective ways of thinking, and use active steps to take charge of your anxiety.
anxietycanada.com/resources/mindshift-cbt

Mother Matters: Women's College Hospital: 8-week online support group for women with mood/adjustment challenges following the birth of their baby. Registration is limited.
womenscollegehospital.ca (search Mother Matters)

My Anxiety Plans: Free on-line anxiety management program based on cognitive-behavioural therapy.
maps.anxietycanada.com/

Niagara Region Public Health, Mental Well-being: Mental health training, workplace mental health, suicide prevention/life promotion, and online tools.
nigararegion.ca/living/health (search mental wellbeing)

Smiling Mind: Daily meditation and mindfulness exercises from any device. smilingmind.com.au

Still not sure who to call?

Call **INCommunities** at 211. This is a free, confidential, 24-hour line. They can tell you who to call.

niagararegion.ca/health

What is Lavender Alert?

You can use Lavender Alert as a means of accessing support during a critical incident – if you are feeling particular stress, are going through a crisis or loss.

The purpose of Lavender Alert is to provide you with accessible, timely support when you need it.

You create the support that would be most helpful to you – individually, peer supported, or group debriefing.

It is normal to be impacted by stressful events. The Lavender Alert system has been proven to help lower distress during a critical incident.

Situations or Circumstances Prompting a Lavender Alert

- Unexpected or critical death
- Highly engaged family members
- Moral distress
- Crisis event
- Attachment to client
- Ethical dilemma
- Issue related to staff support
- Triggering event
- Other issues

If this support could be helpful to you, please proceed to page 2 for next steps.

Steps of the Lavender Alert Protocol

1. Options for support include **individual, peer facilitated, and group debriefing**.

    a. **Individual**: You would work through the protocol (or parts of your choice) on your own.
    b. **Peer Facilitated**: With the support of 1 or more peers, work through the protocol, including the Focused Conversation together.
    c. **Group Debriefing**: With support of NRMH Management, a group debriefing can be organised to process a critical event as a team.

2. Complete the **Focused Conversation** individually, with peers, or as a group. **(See Page 3)**

3. Is further support needed? **(See Page 4)**

It may be that the support from the Focused Conversation is sufficient to lower your distress. However, additional support may be needed. If so, please look through Tab 3 for suggestions about additional supports. This may include developing a plan for self-care, follow-up with Homewood Employee Health (EAP), community crisis lines, and other local resources.

Focused Conversation

Opening ***Name the expectations of the conversation***	**Objective** ***What are the facts around the event?***	**Reflective** ***Focus internally to feeling, moods, emotional tones***	**Interpretive** ***Focus on meaning and purpose people ascribe to situation***	**Closing** ***Focus on resolution, implication, and action***
We will spend 5-7 minutes debriefing. Ground rules: • No speaking over one another • No right reaction/ answer • What is said here stays here (unless needs to be brought to management)	What are the details of what happened? What do you remember most about the event and/or client?	What impact has this event had on you? How do you foresee this impacting the rest of the team? What was most stressful for you during this event? What has challenged you with this event?	What questions are coming to mind? How has caring for this client changed you?	How do we support each other through this? What do you need from each other to continue to do your work? What would make these situations less stressful for you?

Is Further Support Needed?

Employees of Niagara Region Mental Health have 24 hour access to Employee and Family Assistance Program services through Morneau Shepell at 1-844-880-9142.

Welcome to the Employee and Family Assistance Program (EFAP) Site

Niagara Region recognizes that Employee and Family Assistance Program (EFAP) services are important to the health and wellness of our employees and a cornerstone of our People First strategy. We are very excited to partner with **Morneau Shepell** who have been a leading provider of EFAP, Workplace Mental Health, and Wellness services in Canada for over 37 years.

The EFAP offers you immediate, **confidential** *and* complimentary access to support. Having an EFAP ensures our employees have a trusted place to turn to for expert help and support work, health or life issues arise.

What's included?

Short-term Professional Counselling provides support for personal and emotional issues.	**Specialized Counselling and Online Programs** to assist with career challenges, managing stress, and more.
Family Support Services provides access to child and eldercare resources.	**Naturopathic Services** provide consultation with Naturopathic Doctors.
Legal Support Services provide consultation with professional lawyers to answer legal questions.	**Nutritional Services** offer consultation with Registered Dieticians on any nutritional matter or concern.
Financial Support Services provide consultation with financial professionals to answer financial questions.	**Health Coaching** by Registered Nurses can provide information and advice.

Seeking access to the EFAP is 24/7/365 - by telephone or online:

- Call the Shepell Care Access Centre toll free at **1-844-880-9142**
- Via www.workhealthlife.com for:
- **'Online Access'** to request services;
- **'First Chat'** to type/text a real-time conversation with a counsellor or;
- **'E-Counselling'** to exchange written messages online with a counsellor

7 ways to access, allows you accessibility and choice.

My EAP mobile application provides on-the-go support with a timely selection of articles, videos and direct access to e-counselling. Download today at www.workhealthlife.com/myeap.

Visit workhealthlife.com **to register and learn more about our EFAP with Shepell** and gain access to 700+ health and wellness expert articles.

Self Care Tools and Additional Resources

- Pleasant Events List (enclosed)
- Normal Stress Response (handout)
- Crisis Resources
  - COAST: 1-866-550-5205
  - Niagara Region Sexual Assault Centre Crisis line: 905-682-4584
  - Niagara Distress Centres:

Beamsville/Grimsby	905-563-6674
Niagara Falls	905-382-0689
St. Catharines	905-688-3711
Welland	905-734-1212

- Mindfulness exercises
- Relaxation exercises

Suicide Care Management Plan Columbia Training Day Evaluation

Your feedback is valuable to help improve future training sessions and assess staff's preparedness for implementing the SAFE-T Protocol with C-SSRS. Please complete this short evaluation form and leave it on the table for collection.

Select the option in the left-hand side of the table that best represents your level of knowledge of each topic **BEFORE** attending this training. Select the option in the right-hand side of the table that best represents your level of knowledge of each topic **AFTER** attending the training. *(It doesn't matter whether your knowledge has stayed the same, or changed.)*

	BEFORE THE WORKSHOP					**AFTER THE WORKSHOP**				
	Poor	Fair	Good	Very Good	Excellent	Poor	Fair	Good	Very Good	Excellent
Zero Suicide Initiative	O	O	O	O	O	O	O	O	O	O
Therapeutic Relationship / Trauma Informed Lens	O	O	O	O	O	O	O	O	O	O
Warning Signs	O	O	O	O	O	O	O	O	O	O
Risk Factors	O	O	O	O	O	O	O	O	O	O
Protective Factors	O	O	O	O	O	O	O	O	O	O
Risk Formulation	O	O	O	O	O	O	O	O	O	O
MSE	O	O	O	O	O	O	O	O	O	O
Documentation	O	O	O	O	O	O	O	O	O	O
C-SSRS Tools	O	O	O	O	O	O	O	O	O	O
Safety Planning	O	O	O	O	O	O	O	O	O	O
Lethal Means	O	O	O	O	O	O	O	O	O	O

C-SSRS Implementation

Begin administering the C-SSRS with:

O Intensity of ideation section

O Suicidal ideation section

O Suicidal behavior section

O Lethality of behavior

If a person denies having any wishes to die or non-specific thoughts of killing him/herself, then:

O the assessment is finished

O administer the suicidal behavior section next

O administer the intensity of ideation section next

O ask about any specific thoughts of killing him/herself involving a method

The intensity of ideation section of the full C-SSRS:

O is not rated unless the severity of suicidal thoughts contains at least a method

O includes questions about frequency and predictability of thoughts

O is rated on a two-point scale

O is rated with respect to the most severe type of ideation

The C-SSRS ideation subscale defines the types of ideation of increasing severity from one to five.

O True

O False

A young man denies suicidal thoughts but his friend tells you that the man had said he wished he was dead and mentioned writing a goodbye Facebook post. The suicide risk assessment record based on the C-SSRS will say:

O Recent suicidal ideation (intent unknown)

O No recent suicidal ideation or behavior

O Recent suicidal ideation and preparatory behavior

O Recent suicidal ideation and non-suicidal behavior

A man you are interviewing tells you that he recently made a suicide attempt after purchasing a gun, writing a suicide note and giving some of his valuables away. This would be categorized as:

O Suicide attempt

O Preparatory behavior and suicide attempt

O Two preparatory behaviors and suicide attempt

O Three preparatory behaviors and suicide attempt

A girl tells you about a time she cut herself intentionally with a razor blade. You have determined that she was doing this only to get attention and had no intent to die when she did this. You would leave the Actual Attempt section blank.

O True

O False

Please rate the following questions using the scale as described:

As a result of attending this training…	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
… I am more familiar with organizational procedures related to suicide screening and risk assessment.	O	O	O	O	O
… I am more confident in my ability to screen clients for suicide risk.	O	O	O	O	O
… I am more confident in my ability to conduct a suicide risk assessment	O	O	O	O	O

Overall, I am satisfied with the overall training session (e.g., size of class, time spent covering content, handouts [if applicable], etc.).

O Strongly disagree

O Disagree

O Neutral

O Agree

O Strongly agree

Please provide any additional comments:

Zero Suicide Initiative
Best Practice Updates & Frequently Asked Questions: Q1 2020

St. Joseph's Health Care London (St. Joseph's) strives to deliver safe and excellent care for our patients, clients, and residents (hereafter referred to as patient). This resource has been developed to remind/inform staff of best practice, and to answer some of the frequently asked questions as they relate to the Zero Suicide Initiative.

"What people living with suicidality need is the best we have to offer" - Dr. Jobes

1. What is the Zero Suicide Initiative and why is it important?

Death by suicide is the ninth leading cause of death in Canada. It occurs across the lifespan, with an average of ten people dying by suicide per day.[1] The ripple effect is significant, as 7-10 people are profoundly impacted by each suicide loss.

Zero Suicide is a system-wide quality improvement initiative that sets a bold goal of reducing suicide and attempted suicide by wrapping care around the individual and outlining processes for determining and assessing suicide risk, risk protocol formulation, and evidence based follow up and treatment. The Zero Suicide model helps to bridge the gap at transitions of care.

Because St. Joseph's is dedicated to the relentless pursuit of safety for patients, family and staff, Zero Suicide is a corporate priority. Our Zero Suicide Quality Improvement Plan is focused on improving our patient Columbia-Suicide Severity Rating Scale (C-SSRS) Lifetime assessments to ensure that all patients are screened for suicide risk- an essential element of suicide prevention.

2. What is available if I want to learn/ gain more skills related to suicide prevention, assessment and management?

St. Joseph's Corporate Policy: Suicide Risk Assessment and Prevention

- Learning Edge Module: Columbia-Suicide Severity Rating Scale (C-SSRS) eLearning
- Learning Edge Module: Suicide Risk Assessment and Prevention (in development)
- Applied Suicide Intervention Skills Training (ASIST) (register through Learning Edge)
- Collaborative Assessment and Management of Suicidality (register through Learning Edge)
- Elsevier's Clinical Skills: Suicide Assessment and Precautions
- Elsevier's Clinical Skills: Adolescent Suicide Risk and Precautions
- Coaching/ support with Clinical Nurse Specialist, Nurse Educator, or Zero Suicide Clinical Lead
- Best practice resources such as Registered Nurses Association of Ontario: Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour , or the Government of Canada: Suicide Prevention Framework

3. What postvention supports are available for staff?

Postvention: Activities which reduce risk and promote healing after a suicide death.[2]

Seven to ten people are profoundly affected by suicide loss,[1] and health care providers are not immune to requiring support during this challenging time.

Please review the Workplace Violence and Prevention Program: Post-incident Response which includes the supports and resources available to address the psychological impact of workplace violence (including witnessing an event).

Leaders are able to support connecting you with an Employee and Family Assistance Program (EFAP) crisis counselor and will discern the need for a crisis counselor to complete on-site support. Within the St. Joseph's, Spiritual Care, Occupational Health and Safety, and the Clinical Ethicist may also be of support to you. The Quality of Care Information Protection Act (QCIPA) reviews also allow for open discussions of critical incidents involving patient care to support quality improvement.

Related Corporate Policies:

- Health and Safety
- Workplace Occurrence Reporting for Staff/ Affiliates
- Reporting and Review of Safety Events (Harmful, No-Harm and Near Miss) Involving Patients and Visitors

4. What are some online/virtual supports available for patients?

- **Connections:** Online directory resource where individuals who have attempted suicide or who struggle with suicidal thinking can connect one-on-one with other suicide attempt survivors who are living in recovery (peer support). Access: https://save.org/peersupport/about/
- **Stanley-Brown Safety Plan:** Mobile Safety Plan. Access: Available in Apple and Google Play App Store's.

Columbia-Suicide Screening Rating Scale:

5. What are the expectations for completing the C-SSRS Lifetime and Since Last Contact Assessment Tools?

Please see Appendices for a review of how to complete the C-SSRS Lifetime **(Appendix A)** and Since Last Contact **(Appendix B)** assessment tools as well as the frequency for when they need to be completed.

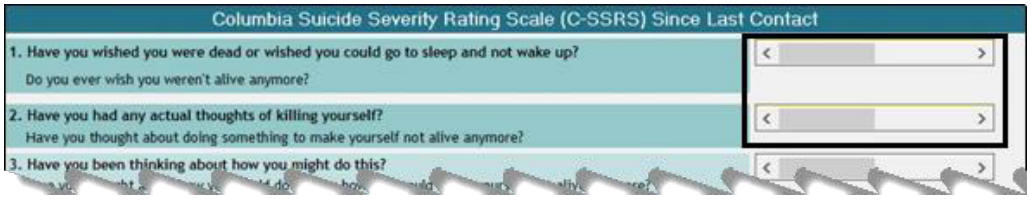
6. How can I improve my documentation when completing the C-SSRS tools?

- Always ensure that you are meeting organizational and Regulatory College standards for all electronic/ hard-copy documentation (e.g. date and signature, completing assessments in full).
- Never document on a C-SSRS tool that a different clinician has initiated. This violates Regulated College documentation standards and causes ambiguity in regards to who completed components of the assessment. A new C-SSRS assessment form should be initiated.
- Make sure that you complete the C-SSRS assessment tool in full. For example, if you select "yes" to past suicidal ideation or suicidal behavior, please describe what these thoughts or actions entailed.
- If an inpatient has had an electronic C-SSRS tool completed within the required timeframe (e.g. Lifetime completed within the last 6 months, or the daily screener already completed within that 24-hour period) please chart: "Task not done," and select "Task duplication" from the drop-down menu. If you work in an outpatient area, please document the rationale "task duplication" in the physical chart's progress notes.
- Acceptable rationales for not completing a C-SSRS assessment tool are:
    - Task duplication (i.e. already completed within the required timeframe)
    - Not appropriate at this time;
    - Patient refused; and
    - Leave of absence.

If you are documenting electronically, please remember to select one of the above four reasons from the drop-down menu, rather than selecting "other" and adding in free text. If you do not feel one of the above rationales appropriately corresponds with the reason for not completing the C-SSRS assessment tool, select "not appropriate at this time" and elaborate further in the clinical chart's progress notes.

7. Why are there slide bars and "ghost buttons" appearing on the electronic C-SSRS assessment tools? How do I fix this?

In order to resolve this issue, staff must change their computer's display resolution to 100%. If you require support or assistance with this, please contact the Help Desk at ext. 44357.



References:

1. Statistics Canada. (2015). Suicide in Canada: Key statistics. Retrieved from https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-canada-key-statistics-infographic.html
2. Suicide Prevention Resource Centre. (2020). Postvention as Prevention. Retrieved from https://www.sprc.org/news/postvention-prevention

Document developed by: Zero Suicide Team
April 2020

Suicidal Ideation

Ask questions 1 and 2.

Only ask questions 3, 4, and 5 if the answer to question 2 is "yes".

Regarding question 2, if the answer for Lifetime is "yes" but the answer for Recent: Past 1 month is "no", then only ask about Lifetime for questions 3, 4, and 5.

Regarding question 2 again, if the answer for Lifetime and Recent: Past 1 month is "yes" for both, then complete all Lifetime and Recent: Past 1-month questions.

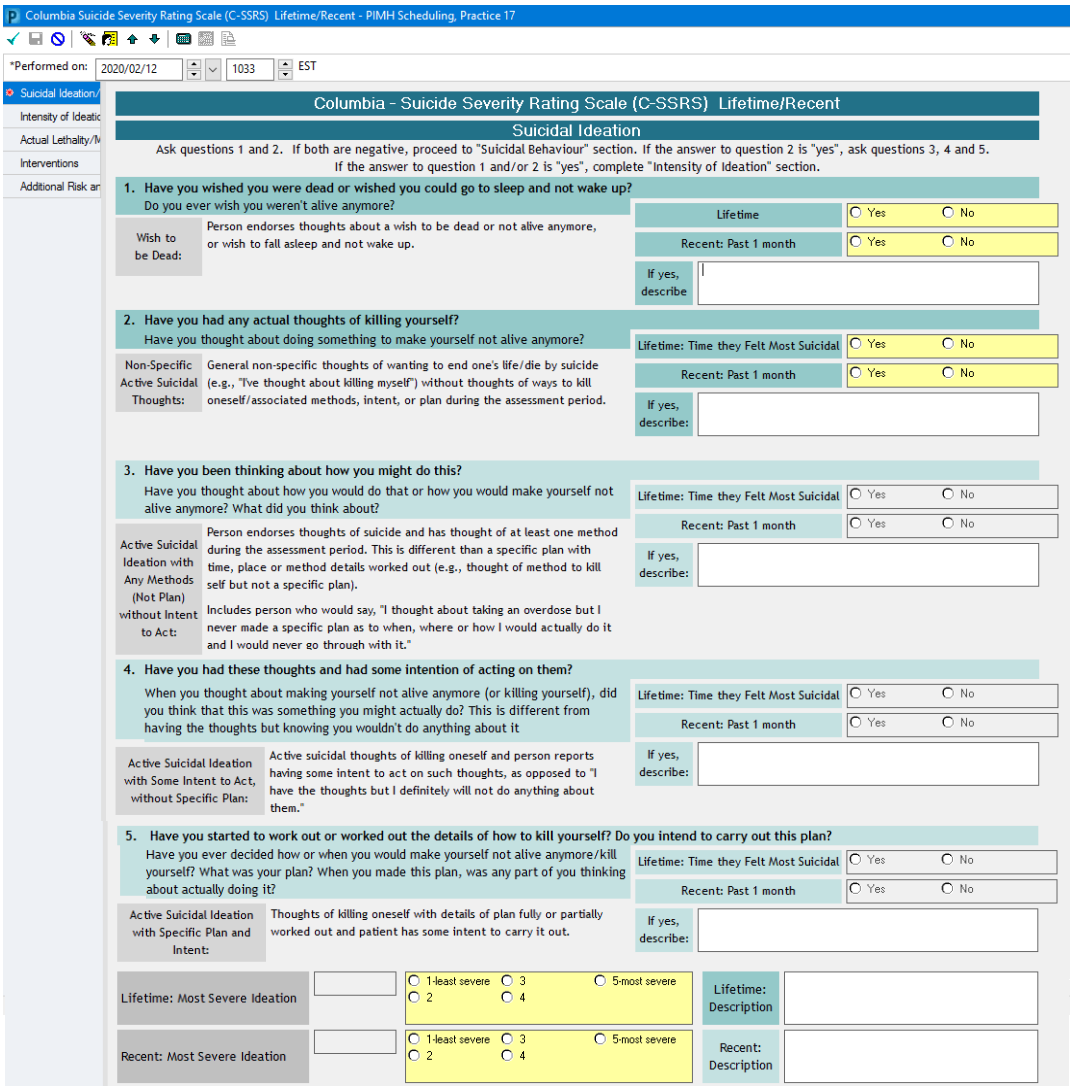
Describe if any answers are "yes".

If the patient answers "yes" to question 2, then complete *Intensity of Ideation* (more information on page 7).

If the patient answers "no" to question 2, then do not complete *Intensity of Ideation.* Proceed to ask *Suicidal Behaviour* questions (more information on page 8).

Appendix A: Methodology and Frequency for Completing the C-SSRS Lifetime Assessment Tool

Overview of C-SSRS Lifetime Assessment Tool



Intensity of Ideation

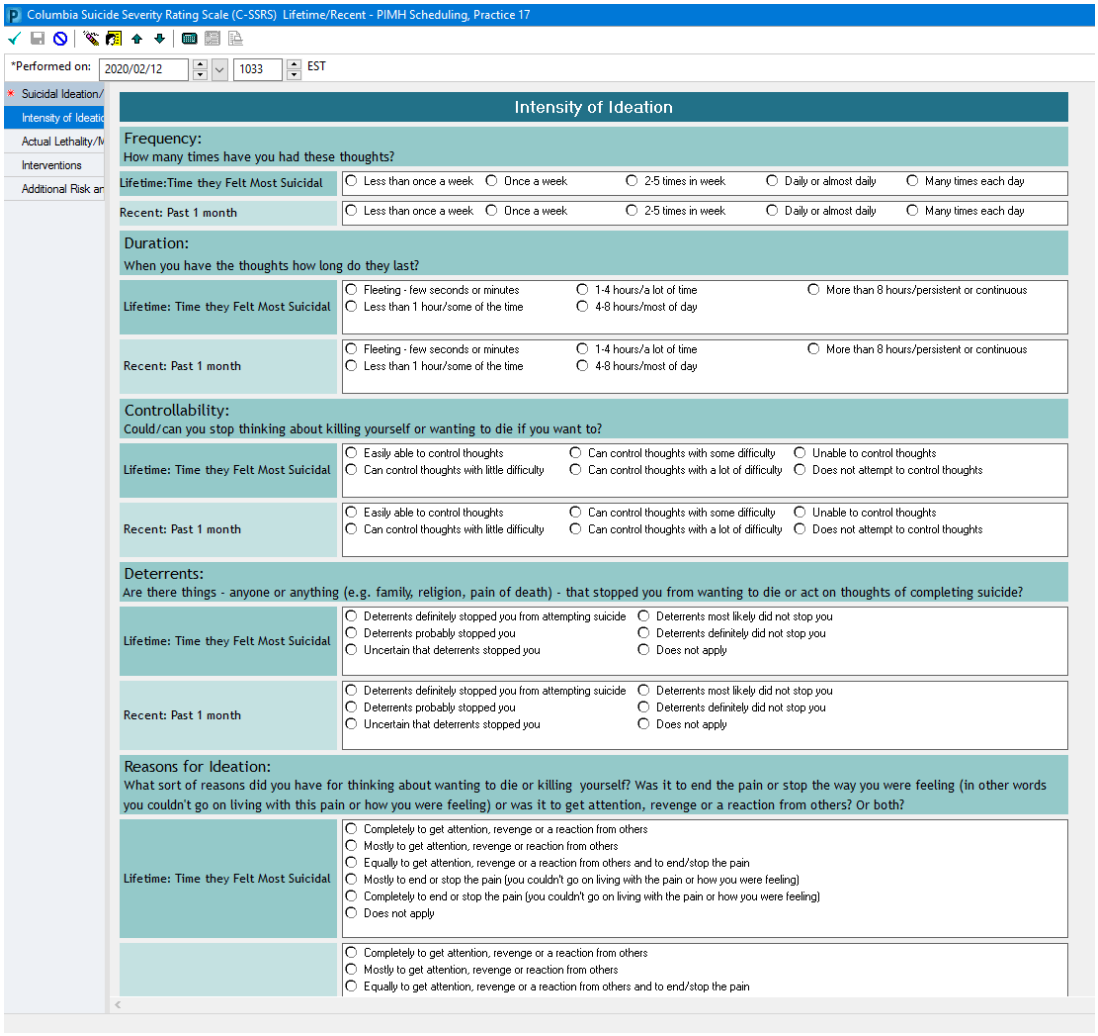
As mentioned above, only complete *Intensity of Ideation* if patient answers "yes" to question 2 of *Suicidal Ideation.*

If this section is required, it has to be selected by clicking the *Intensity of Ideation* tab on the left-hand pane.

In the *Suicidal Ideation* section, if the client only answered "yes" for Lifetime but "no" for Recent: Past 1 month, then only answer Lifetime in this section. If the answer for Lifetime and Recent: Past 1 month is "yes" for both, then complete all Lifetime and Recent: Past 1 month questions.

If this section is required, then ask every question under each sub-section (i.e. frequency, duration, controllability, deterrents, and reasons for ideation).

Overview of C-SSRS Lifetime Assessment Tool Continued



Suicidal Behaviour

Ask all sub-sections (i.e. actual attempt, interrupted attempt, aborted or self-interrupted attempt, and preparatory acts or behaviour).

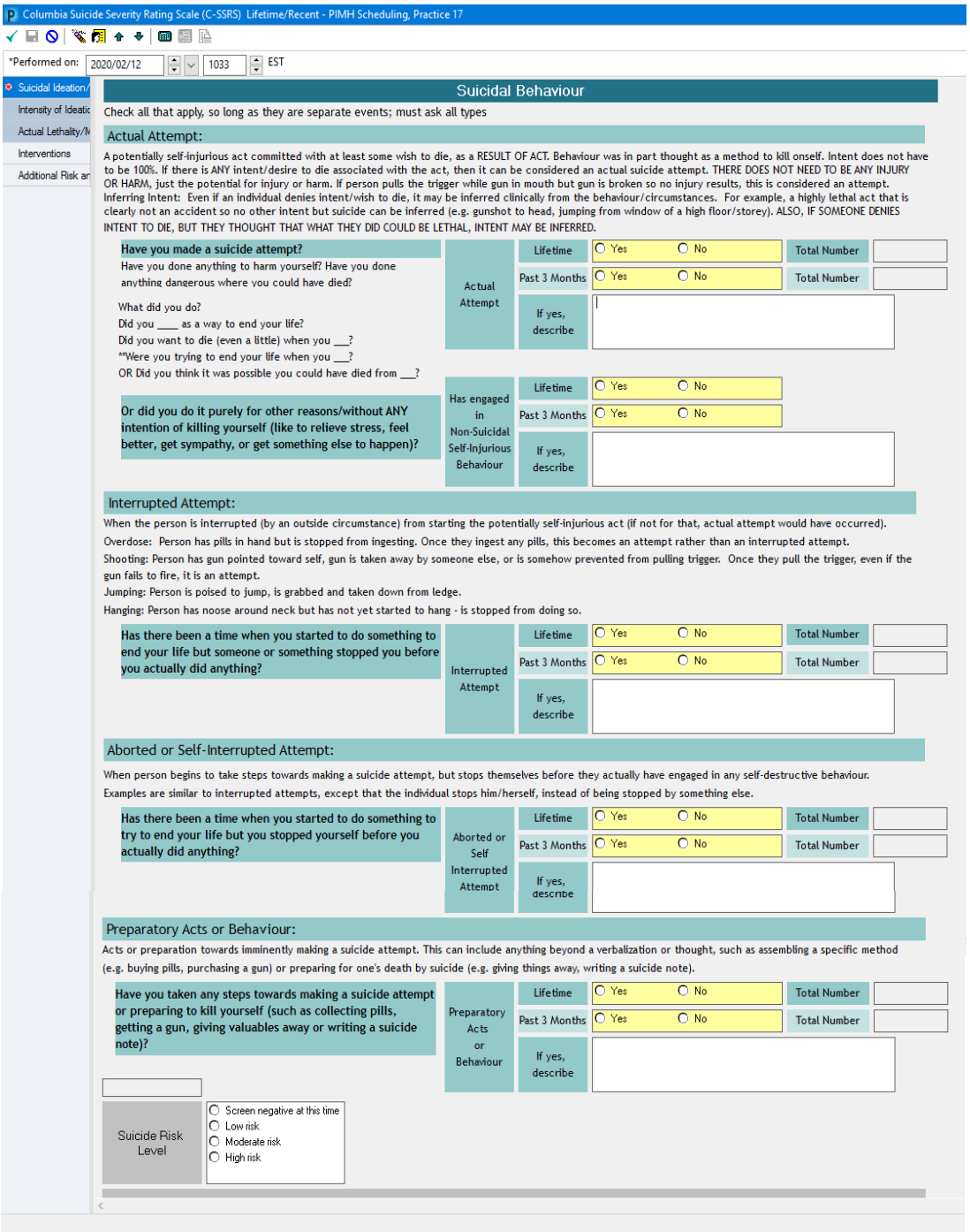
Ask the patient to provide the total number of suicide attempts or acts/ behaviour if the patient answers "yes". If the patient answers "yes" then ask for a description.

If the patient answers "yes" to actual attempt, then complete this section and then proceed to the *Actual Lethality/Medical Damage* section (more information on page 9).

If the patient answers "no" to actual attempt, then complete this section and the assessment is finished.

The suicide risk level will be autopopulated.

Overview of C-SSRS Lifetime Assessment Tool Continued



Overview of C-SSRS Lifetime Assessment Tool Continued

Lethality/ Damage

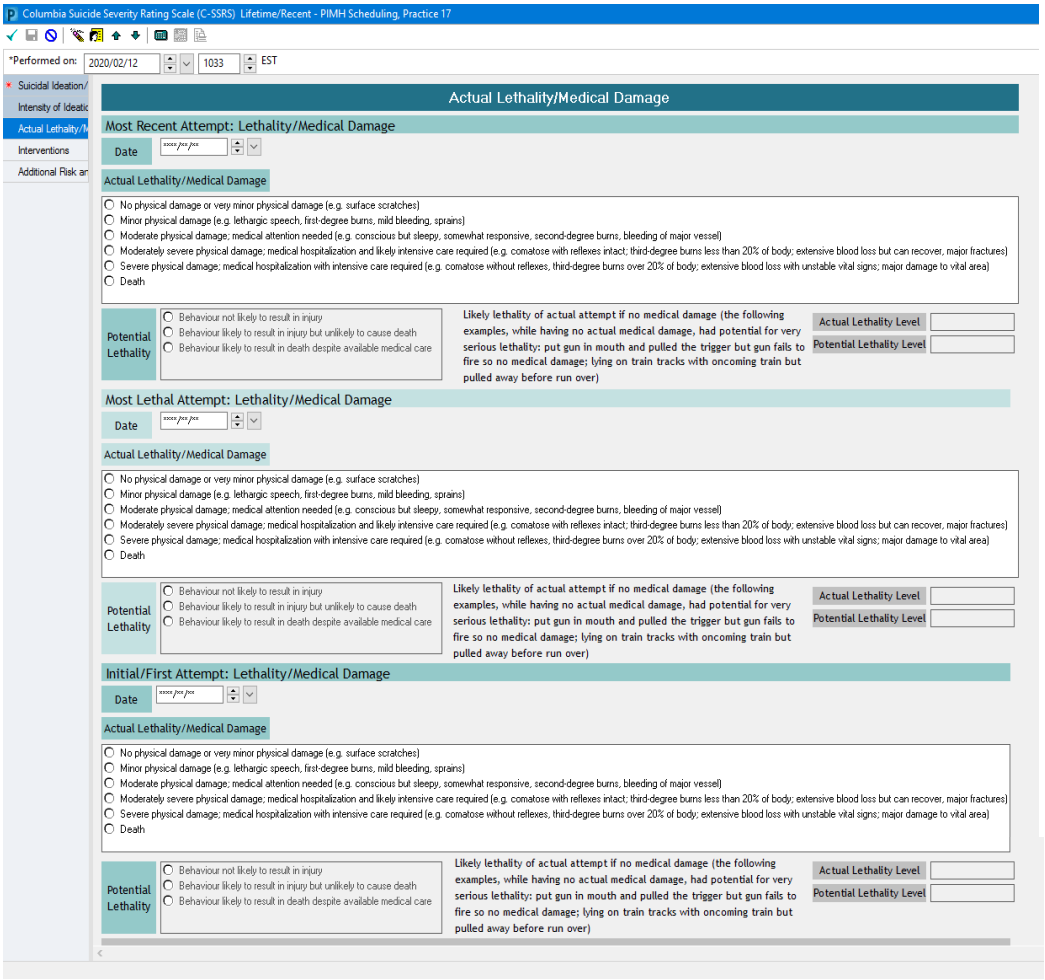
As mentioned above, only complete if patient answers "yes" to actual attempt in *Suicidal Behaviour* section.

If the *Actual Lethality/Medical Damage* section is required, it has to be selected by clicking the *Actual Lethality/Medical Damage* tab on the left-hand pane.

Ask the patient to answer all sub-sections if applicable (i.e. most recent attempt, most lethal attempt, and initial/first attempt).

If the patient answers "no physical damage or very minor physical damage" for actual lethality, then potential lethality needs to be answered. Potential lethality does not need to be answered if actual lethality is a response other than "no physical damage or very minor physical damage" answered.

For this *Actual Lethality/Medical Damage* section to be considered complete, the applicable sub-section(s) has to be



Frequency of C-SSRS Lifetime Assessment Tool:

Mental Health Inpatients

- Completed within 3 days of admission to the unit
- Reviewed and re-completed as needed once every 6 months

Mental Health Outpatients

- Completed within 1 month of admission to an outpatient program
- Reviewed and re-completed as needed once every 6 months

All Other St. Joseph's Program Areas

- Please refer to program specific procedure in the Corporate Policy: Suicide Risk Assessment and Prevention

Since Last Contact

Ask questions 1 and 2.

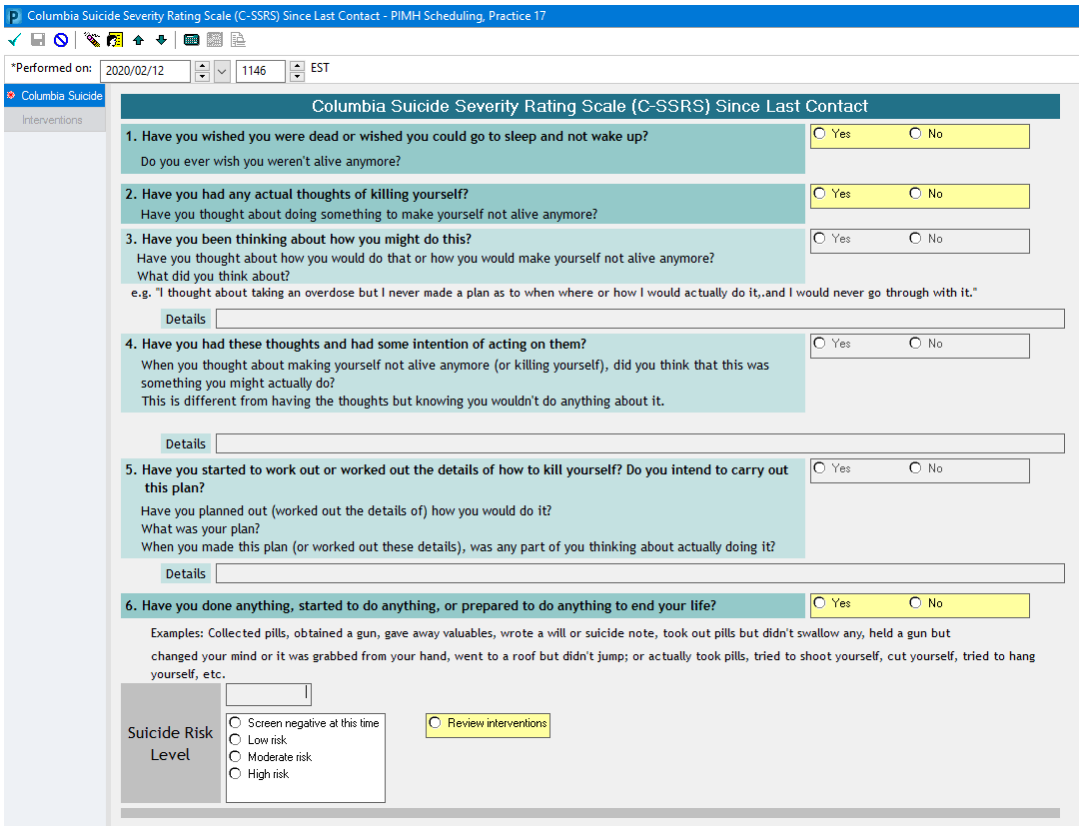
If question 2 is "no", then skip questions 3, 4, and 5 and ask question 6.

If question 2 is "yes", then ask questions 3, 4, 5, and 6.

The suicide risk level will be autopopulated.

Appendix B: Methodology and Frequency for completing the C-SSRS Since Last Contact Assessment Tool

Overview of C-SSRS Since Last Contact Assessment Tool



Frequency of C-SSRS Since Last Contact Assessment Tool:

Mental Health Inpatients

- Complete once per day

Mental Health Outpatients

- Complete once per visit/appointment

All Other St. Joseph's Program Areas

- Please refer to program specific procedure in the Corporate Policy: Suicide Risk Assessment and Prevention

Suicide Care Management Plan

October 2019

Why are we implementing the Zero Suicide initiative within NRMH?	• To increase client safety • To Increase staff comfort, knowledge, skills and confidence when intervening with a client who is suicidal • To adhere to Accreditation Canada and their required organizational practices for suicide prevention. Key areas of focus are - identification, assessment, treatment and documentation for those at risk of suicide • To have a standardized approach to suicide prevention • To have a formal suicide prevention policy
What if my client refuses to complete the assessment or screener questions?	If your client refuses to complete the assessment or screener, discuss this with your manager. • For complex cases or clients you know will be more challenging to assess, discuss this with your teams, colleagues, and leadership, especially when there is high risk for suicide. • You are able to use a variety of ways to gather information to complete the suicide risk assessment including consulting with family, SDM or friends when possible and/or reviewing the clients chart for past history.
Are we going to be implementing the zero suicide tools and processes for all new and existing clients in all services?	YES - the tools are to be used with all new and existing clients. By **December 2019**, 50% of existing clients in all services have one SAFE-T-Protocol (full version assessment) on file By **April 2020**, 100% of existing clients in all services have one SAFE-T-Protocol (full version assessment) on file By **December 2020**, all new clients in all services have one SAFE-T-Protocol (full version assessment) on file Exception: DBT clients conduct their own suicide assessment protocols.
What if the screening creates anxiety or brings up negative emotions for my client?	Zero Suicide screening is not meant to be a standalone entity. It is part of the clinical appointment and provides opportunity for important discussions, such as this. Explain to clients that this is something that all clients are being asked to complete and everyone is receiving the same assessment. Use the brochure to help the clients know what they can expect.

Can I ask the screening questions with a new client while their family member is present?	Whether to include a family member in a discussion such as this is at the discretion of the client and the clinician. There is no hard or fast rule on this.
Will we be screening family members, groups, couples, and/or geriatric clients?	There is no obligation to do screening with family members, groups or couples. You are welcome to use these tools, if your clinical judgment identifies a need. The Columbia tools are validated for all ages, including geriatrics, so we are to screen clients regardless of age.
Can I complete the Columbia screening over the phone?	It is at the discretion of the clinician as to whether to complete the Columbia screener during a phone conversation. Clinically, you may decide to administer the screener over the phone, because the client has identified changes in their level of risk and you may not have a scheduled visit in the near future or they decline to meet with you in person.
Can I take a couple sessions to complete the Columbia lifetime and/or SAFE-T protocol?	YES - Do not expect to have to complete the assessments in one session as it may take a few visits, depending on client needs.
What if the client answers 'yes' to Questions 1 and 2 on the screener, but 'no' to Questions 3-5? Do I still need to ask Question 6?	Yes, as this is a related but separate question specific to suicide behaviours.
Can we start completing the Columbia tools electronically?	YES - all tools are uploaded into CRMS. Text boxes have been added to the electronic version in CRMS that captures narrative information. A request has been made to have the Suicide Management Plan added electronically with an alert to complete when a client has been identified as high risk in the SAFE-T Protocol.
When do I use the "Suicide Management Plan" clients?	The Suicide Management Plan is something you would do with your client when they are having suicidal intent/plan and are high risk. If they are unable to say they can be safe right now then you would get them to hospital, but the idea is to do the Safety Management Plan with them first to decrease acute thoughts of suicide. This Plan helps to problem solve and identify a Safety Plan with a focus on: • Working with the client to identify strategies that would be helpful right now • Who are they willing to call that would help with distraction or isolation

	• Problem solving barriers • Assessing/removing lethal means • Identifying who they are willing to share the plan with (family, friends) • Their reasons for living
When do we use the Suicide Management Plan vs. the Crisis Plan?	The Suicide Management Plan is only used when clients are assessed as High Risk (immediate response to acute suicide risk). Crisis Plans are used for clients assessed as Low Risk. Step 4 on the SAFE-T protocol highlights possible interventions at high, medium, low risk. Suicide Management Plan does not replace the Crisis Plan.
Could the Safety plan be a carbon copy document?	Since the Safety plan is many pages long we are not able to have this carbon copied. The best suggestion is once you enter the information electronically; at the next visit with your client provide them with the paper copy, or you may take a photo of the document to input electronically and leave the client with their copy.
Will the mental status video links (tutorial) be included? Where?	All documents including the training PowerPoint can be found on The Vine Mental Health page site http://collaboration.rmon.pri/Health/csd/cmhp/Pages/scmp.aspx
Do we need to upload the SI screener that is used in every interaction to the client file?	The Screener (and all other tools) are available in CRMS electronically. The expectation is that you complete it directly in the clients file in CRMS. Then you complete another documentation note with the other information for that visit.
Should all screeners be completed regardless of whether the client answers yes or no?	Yes - all screeners must be completed in CRMS, regardless if the client answers yes or no.
What is SAFE-T five step Evaluation and Triage?	The SAFE-T five step Evaluation and Triage stands for: 1. **IDENTIFY RISK FACTORS** Note those that can be modified to reduce risk 2. **IDENTIFY PROTECTIVE FACTORS** Note those that can be enhanced 3. **CONDUCT SUICIDE INQUIRY** Suicidal thoughts, plans, behavior, and intent 4. **DETERMINE RISK LEVEL /INTERVENTION** Determine risk. Choose appropriate intervention to address and reduce risk 5. **DOCUMENT** Assessment of risk, rationale Note: cheat cards with this information will be available.

What is the timeframe for screening for new and existing clients?	All existing clients to have a completed SAFE-T Protocol within 6 months, by December 2019. All new clients within 30 days of onboarding to the program. Screeners – To be completed at each subsequent visit with the client unless you deem the visit to be an inappropriate time and document rationale in CRMS.
How are we going to continue to revise the Zero Suicide processes?	Ongoing feedback is welcomed. We encourage teams to include Zero Suicide as a standing agenda item for ongoing discussion. Evaluation of the project will be ongoing with regular check points for feedback from staff, clients, as well as review of documentation.
How is the SAFE-T protocol scored and what do the numbers mean? **Note: this is for clients with ideation only.**	For the scoring - it is based on the client's responses and not on clinical judgment. The score itself indicates a higher intensity of ideation if it's a higher number. It's more of an FYI or comparison to previous screening for the clinician to consider as part of their overall assessment of risk level. The SAFE-T Risk Stratification algorithm is a tool and is not meant to replace clinical judgment.
Do we have to do a crisis plan in addition to the suicide management plan for the high-risk clients?	Yes, the Crisis Plan is something you do with all clients regardless of suicide and is used for all potential crises (i.e. what helps and what doesn't, what are the triggers). These are developed collaboratively with every new client upon admission to the program, within 30 days and are reviewed regularly and updated as the client's situation changes.

FRAMEWORK FOR ROOT CAUSE ANALYSIS AND CORRECTIVE ACTIONS*

The Joint Commission's Framework for Root Cause Analysis and Action Plan provides an example of a comprehensive systematic analysis. The framework and its 24 analysis questions are intended to provide a template for analyzing an event and an aid in organizing the steps and information in a root cause analysis.

An organization can use this template to conduct a root cause analysis or even as a worksheet in preparation of submitting an analysis through the online form on its *Joint Commission Connect*™ extranet site. Fully consider all possibilities and questions in seeking "root cause(s)" and opportunities for corrective actions. Be sure to enter a response in the "Analysis Findings" column for each item. Unexpected findings may emerge during the course of the analysis, or there may be some questions that do not apply in every situation. For each finding continue to ask "Why?" and drill down further to uncover why parts of the process occurred or didn't occur when they should have. Significant findings that are not identified as root causes themselves have "roots." "Corrective Actions" should be developed for every identified root cause.

While the online form provides drop-down menus for many of the form's cells, the options for these columns are provided here in the following tables:

The following are in the Root Cause Analysis section:
Root Cause Types: Table A-1 (column 1)
Causal Factors/Root Cause Details: Table A-1 (column 2)

In the Corrective Actions section, the following are added: Action
Strength: Table A-2
Measure of Success: Table A-3 Sample
Size: Table A-4

*Disclaimer: The framework found on *Joint Commission Connect*™ will show the most current iteration of this form.

Please note that this document has been adapted from the Framework For Root Cause Analysis And Corrective Actions. This version does not constitute endorsement by the EDC. The original copy can be found: https://zerosuicide.edc.org/resources/resource-database/framework-conducting-root-cause-analysis-and-action-plan

EVENT DESCRIPTION

When did the event occur?

Date:	Day of the week:	Time:

Detailed Event Description Including Timeline:

Diagnosis:

Medications:

Autopsy Results:

Past Medical/Psychiatric History:

ROOT CAUSE ANALYSIS - QUESTIONS

#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors/Root Cause Details (Table A-1)
1	What was the intended process flow?	List the relevant process steps as defined by the policy, procedure, protocol, or guidelines in effect at the time of the event. You may need to include multiple processes. Examples of defined process steps may include, but are not limited to: • Site verification protocol • Individual/client identification protocol • Suicide risk assessment and intervention procedures • Other prevention and safety guidelines Note: The process steps *as they occurred in the event* will be entered in the next question.			
2	Were there any steps in the process that did not occur as intended?	Explain in detail any deviation from the intended processes listed in Analysis Question #1 above.			

3	What human factors were relevant to the outcome?	Discuss staff-related human performance factors that contributed to the event. Examples may include, but are not limited to: • Boredom • Failure to follow established policies/procedures			

#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors/Root Cause Details (Table A-1)
		• Fatigue • Inability to focus on task • Inattentional blindness/confirmation bias • Personal problems • Lack of complex critical thinking skills • Rushing to complete task • Substance abuse • Trust			
4	What controllable environmental	What environmental factors within the organization's control affected the			

#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors/Root Cause Details (Table A-1)

	factors affected the outcome?	outcome? Examples may include, but are not limited to: • Overhead paging that cannot be heard in offices • Safety or security risks • Risks involving activities of visitors • Lighting or space issues • Staff knowledge of or education on equipment The response to this question may be addressed more globally in Question #17. This response should be specific to this event.			
6	What uncontrollable external factors influenced the outcome?	Identify any factors the organization cannot change that contributed to a breakdown in the internal process, for example natural disasters.			
7	Were there any other factors that directly influenced this outcome?	List any other factors not yet discussed.			
8	What are the other areas in the organization where this could happen?	List all other areas in which the potential exists for similar circumstances. For example: • Residential or day programs? • Identification of other areas within the organization that have the potential to impact client safety in a similar manner. This information will help drive the scope of your action			

#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors/Root Cause Details (Table A-1)
		plan.			
9	Was staff properly qualified and currently competent for their responsibilities?	Include information on the following for all staff and providers involved in the event. Comment on the processes in place to ensure staff is competent and qualified. Examples may include but are not limited to: • Orientation/training • Competency assessment (What competencies do the staff have and how do you evaluate them?) • Provider and/or staff scope of practice concerns • Whether the provider was a regulated health care professional for the care and services he or she rendered • The credentialing and privileging policy and procedures • Leader and/or staff performance issues			
10	How did actual staffing compare with ideal level?	Include ideal staffing ratios and actual staffing ratios along with usual census at the time of the event. Note any unusual circumstance that occurred at this time. What process is used to determine the care area's staffing ratio, experience level, and skill mix?			

11	What is the plan for dealing with staffing contingencies?	Include information on what the organization does during a staffing crisis, such as call-ins, bad weather, or increased client acuity. Describe the			

#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors/Root Cause Details (Table A-1)
		organization's use of alternative staffing. Examples may include, but are not limited to: • Cross training • Float pool • Mandatory overtime			
12	Were such contingencies a factor in this event?	If alternative staff were used, describe their orientation to the area, verification of competency, and environmental familiarity.			
13	Did staff performance during the event meet expectations?	Describe whether staff performed as expected within or outside of the processes. To what extent was leadership aware of any performance deviations at the time? What proactive surveillance processes are in place for leadership to identify deviations from expected processes? Include omissions in critical thinking and/or performance variance(s) from defined policy, procedure, protocol, and guidelines in effect at the time.			

14	To what degree was all the necessary information available when needed? Accurate? Complete?	Discuss whether client screening and or assessments were completed, shared, and accessed by members of the team, to include referral sources and care providers, according to the organizational processes. Identify the information systems used during client interactions. Discuss to what extent the available client information (e.g., medical record, documents from other organizations)			

#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors/Root Cause Details (Table A-1)
	Unambiguous?	was clear and sufficient to provide an adequate summary of the client's needs, condition, treatment, and ongoing services/care. Describe staff utilization and adequacy of policy, procedure, protocol, and guidelines specific to the organization.			

15	To what degree is communication among participants adequate?	Analysis of factors related to communication should include evaluation of verbal, written, electronic communication or the lack thereof. Consider the following in your response, as appropriate: • The timing of communication of key information • Misunderstandings related to language/cultural barriers, abbreviations, terminology, etc. • Proper completion of internal and external hand-off communication • Involvement of client, family, identified supports, and/or significant other			
16	Was this the appropriate physical environment for the processes being carried out?	Consider processes that proactively manage the client environment. This response may correlate to the response in Question #6 on a more global scale. What evaluation tool or method is in place to evaluate process needs and mitigate environmental risks? How are these process needs addressed organization wide? Examples may include,			

#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors/Root Cause Details (Table A-1)
		but are not limited to: • Alarm audibility testing • Evaluation of egress points • Client acuity level and setting			

17	What systems are in place to identify environmental risks?	Identify environmental risk assessments. Does the current environment meet codes, specifications, regulations? Does staff know how to report environmental risks? Was there an environmental risk involved in the event that was not previously identified?			
18	What emergency and failure-mode responses have been planned and tested?	Describe variances in expected process due to an actual emergency or failure mode response in connection to the event. Related to this event, what safety evaluations and drills have been conducted and at what frequency (e.g. mock code blue, rapid response, behavioral emergencies, client abduction or client elopement)? Emergency responses may include, but are not limited to: • Fire • External disaster • Mass casualty • Medical emergency Failure mode responses may include, but are not limited to: • Computer down time • Diversion planning			

#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors/Root Cause Details (Table A-1)
		• Facility construction • Power loss • Utility issues			

19	How does the organization's culture support risk reduction?	How does the overall culture encourage change, suggestions, and warnings from staff regarding risky situations or problematic areas? • How does leadership demonstrate the organization's culture and safety values? • How does the organization measure culture and safety? • How does leadership address disruptive behavior? • How does leadership establish methods to identify areas of risk or access employee suggestions for change? • How are changes implemented?			
20	What are the barriers to communication of potential risk factors?	Describe specific barriers to effective communication among caregivers that have been identified by the organization. For example, residual intimidation or reluctance to report co-worker activity. Identify the measures being taken to break down barriers (e.g. use of Situation, Background, Assessment, Request- SBAR communication). If there are no barriers to communication discuss how this is known.			
21	How does leadership address the continuum of client safety events, including	Does leadership demonstrate accountability for implementing measures to reduce risk for client harm? Has leadership provided for required resources or training? Does leadership			
#	**Analysis Questions**	**Prompts**	**Analysis Findings**	**Root Cause Types (Table A-1)**	**Causal Factors/Root Cause Details (Table A-1)**

	close calls, adverse events, and unsafe, hazardous conditions?	communicate corrective actions stemming from any analysis following reported risks?			
22	How can orientation and in-service training be improved?	Describe how orientation and ongoing education needs of the staff are evaluated and discuss its relevance to event. (e.g., competencies, critical thinking skills, use of simulation/role playing, evidence-based practice, etc.)			
23	Was available technology used as intended?	Describe variances in the expected process due to education, training, competency, impact of human factors, functionality of equipment, and so on: • Was the technology designed to minimize use errors or easy-to-catch mistakes? • Did the technology work well with the workflow and environment? • Was the technology used outside of its specifications?			
24	How might technology be introduced or redesigned to reduce risks in the future?	Describe any future plans for implementation or redesign. Describe the ideal technology system that can help mitigate potential adverse events in the future.			

CORRECTIVE ACTIONS

Root Cause Types (Table A-1)	Causal Factors/Root Cause Details (Table A-1)	Corrective Actions	Action Strength (Table A-2)	Measure of Success (Numerator / Denominator) (Table A-3)	Sample Size (Table A-4)
		Action Item #1:			
		Action Item #2:			
		Action Item #3:			
		Action Item #4:			
		Action Item #5:			
		Action Item #6:			
		Action Item #7:			

TABLE

		Action Item #8:			

BIBLIOGRAPHY

Cite all books and journal articles that were considered in developing this root cause analysis and action plan.

TABLE

A-1. ROOT CAUSES

Root Cause Types	Causal Factors / Root Cause Details
Communication factors	• Communication breakdowns between and among teams, staff, and providers • Communication during handoff, transition of care • Language or literacy • Availability of information • Misinterpretation of information • Presentation of information
Environmental factors	• Noise, lighting, flooring condition, etc. • Space availability, design, locations, storage • Maintenance, housekeeping
Equipment/device/ supply/ IT factors	• Equipment, device, or product supplies problems or availability • Health information technology issues such as display/interface issues (including display of information), system interoperability • Availability of information • Malfunction, incorrect selection, misconnection • Labeling instructions, missing • Alarms silenced, disabled, overridden
Task/process factors	• Lack of process redundancies, interruptions, or lack of decision support • Lack of error recovery • Workflow inefficient or complex
Staff performance factors	• Fatigue, inattention, distraction or workload • Staff knowledge deficit or competency • Criminal or intentionally unsafe act

Team factors	• Speaking up, disruptive behavior, lack of shared mental model • Lack of empowerment • Failure to engage client

Management/ supervisory/ workforce factors	• Disruptive or intimidating behaviors • Staff training Appropriate rules/policies/procedure or lack thereof • Failure to provide appropriate staffing or correct a known problem • Failure to provide necessary information
Organizational culture/leadership	• Organizational-level failure to correct a known problem and/or provide resource support including staffing • Workplace climate/institutional culture • Leadership commitment to client safety

Adapted from: Department of Defense, Patient Safety Program. *PSR Contributing Factors List – Cognitive Aid, Version 2.0.* May 2013.

A-2. ACTION STRENGTH

Action Strength	Action Category	Example
Stronger Actions (These tasks require less reliance on humans to remember to perform the task correctly)	Architectural/physical plant changes	Replace revolving doors at the main client entrance into the building with powered sliding or swinging doors to reduce client falls.
	New devices with usability testing	Perform heuristic tests of electronic suicide risk screening tools
	Engineering control (forcing function)	Eliminate free-texting on electronic screening tool to ensure accurate completion.
	Simplify process	Remove unnecessary steps in a process.
	Standardize on equipment or process	Standardize the make and model of telephone devices for conference calling crisis services
	Tangible involvement by leadership	Participate in organization client safety evaluations and interact with staff; support the RCA[2] process (root cause analysis and action); purchase needed equipment; ensure staffing and workload are balanced.
Intermediate Actions	Redundancy	Use two registered nurses to independently complete suicide risk screening and risk formulation.
	Increase in staffing/decrease in workload	Make float staff available to assist when workloads peak during the day.
	Software enhancements, modifications	Use computer alerts for clients at high risk for suicidality.
	Eliminate/reduce distractions	Provide quiet rooms for programming/setting up equipment; remove distractions for staff when programming/setting up equipment.

	Education using simulation-based training, with periodic refresher sessions and observations	Conduct client handoffs (ensuring the client receives an appropriate referral) in a simulation environment, with after-action critiques and debriefing.
	Checklist/cognitive aids	Use a checklist for a client at high risk for suicidality.
	Eliminate look- and soundalikes	Do not store look-alikes (such as legal forms) next to one another in the organization.
	Standardized communication	Use standard verbal communication and not just electronic communication (email)
	tools	Use a standardized client handoff format.
	Enhanced documentation, communication	Highlight client-specific lethal means restriction measures
Weaker Actions (These tasks rely more on humans to remember to perform the task correctly)	Double checks	One person collaboratively creates the safety plan with the client, another person reviews their safety plan.
	Warnings	Add audible alarms or caution labels.
	New procedure/ memorandum/policy	Remember to check most recent suicide risk screening tool.
	Training	Demonstrate correct usage of a client's safety plan.

Reference: Action Hierarchy levels and categories are based on *Root Cause Analysis Tools*, VA National Center for Client Safety, http://www.clientsafety.va.gov/docs/joe/rca_tools_2_15.pdf. Examples are provided here.

Source: National Client Safety Foundation. *RCA² Improving Root Cause Analyses and Actions to Prevent Harm.* Boston, MA: National Client Safety Foundation; 2015. Reproduced with permission.

TABLE

A-3. MEASURE OF SUCCESS

Fraction Part	Defined	Identified	Example
Numerator	The number of events being measured	Ask a specific question—what are you measuring?	Suicide risk assessments that resulted in transportation to crisis/emergency services
Denominator	All the opportunities in which the event could have occurred	Identify the client population from which to collect the information.	The number of suicide risk assessments completed

TABLE A-4. SAMPLE SIZE*

Population Size	Sample
Fewer than 30 cases	100% of cases
30 to 100 cases	30 cases
101 to 500 cases	50 cases
Greater than 500 cases	70 cases

*The sampling methodology was determined using quality assurance sampling methods which determines the sample size needed to be able to say from a sample of cases that the "defect" rate is less than a specified amount (here we used 10%) with 95% confidence if no "defects" are found in the sample.