ZERO SUICIDE

in Your Community:
An implementation guide for community organizations

Plan 2.0

PLAN 2.0

In the Plan 1.0 section of the Zero Suicide Community Implementation Toolkit you reviewed principles of project management, conducting a current state analysis with use of the Organizational Self Study and Workforce Survey, and began designing your Project Charter and Project Plan. Throughout this phase of project planning we will continue to develop and refine your Project Plan.

In this section of the Toolkit we will cover:

- Incorporating Best Practices, Guiding Philosophy of Care, and Staff Mental Wellness
- Introduction to the Suicide Care Management Plan:
    - Suicide Risk Assessment
        - Suicide Screening
        - Full Suicide Risk Assessment
    - Interventions:
        - Suicide Prevention Algorithm or Triage Tool
        - Crisis Management and De-escalation
        - Coping Plan and Safety Plan
        - Referral to Support/Evidence-Based Treatment
        - Engaging Natural and Peer Supports, and those with Lived Experience with Suicide
        - Supporting Transitions in Care
        - Implementing Caring Contacts
        - General Guidelines for Documentation
        - Reviewing Suicide Related Incidents
        - Postvention Support
- Staff Education Planning
    - Sample Education Plan for Community Partner Zero Suicide Implementation
- Planning your Project Evaluation

Resources to have on hand (or screen):

- A copy of the Toolkit: Plan 1.0 section
- A copy of your Project Plan
- Your completed Organizational Self Study
- Your completed Workforce Survey
- Zero Suicide Toolkit website: zerosuicide.edc.org/toolkit
- Canadian Patient Safety Institute - Suicide Risk Assessment- Toolkit and Guide > Table 1: Suicide Risk Assessment Tools and Their Characteristics- Clinician/Mental Health Professional Not Required for Administration

Incorporating Best Practices and Guiding Philosophy of Care

Zero Suicide is a framework that incorporates best practices in suicide prevention with evidence of reductions in suicide deaths in health care systems. Several guiding philosophies and principles of care are incorporated in the Zero Suicide framework however we encourage you to consider how the following could be incorporated into your project planning and implementation:

- Recovery oriented
- Trauma informed care
- Cultural sensitivity and safety
- Stigma free and inclusive (e.g. LGBTQ2S+, race, gender identity, age)
- Health equity
- Anti-oppression
- Person centered
- Your organization's specific guiding principles and mission, vision, and values

At this point, we recommend you re-engage your Project Plan to review whether or not these principles have been reflected. If you are uncertain of what each of these entail, we encourage you to engage in some learning with your team. One leading principle of the Zero Suicide framework is to ensure that the organizational culture is one that is blame free – known as a just culture.

Creating a Restorative Just Culture

A very important component of the "Lead" element of the Zero Suicide framework, is to create a just culture in which staff feel as though they work within a safe and blame free environment.[1] A just culture recognizes that there is shared accountability when something goes wrong within an organization. This shifts from solely focusing on individual accountability or blame to consider how organizational structures and processes may have had a role in what happened. From a suicide prevention perspective, this is important so that staff feel that they can safely share about suicide related incidents, and the organization can take a comprehensive approach to identifying opportunities for improved suicide prevention. This can shift the conversation from being punitive and seeking blame (actual or perceived) to reviewing system-level improvements and addressing the need for a blame-free environment.

Two interventions you can implement to work towards a just culture within the Zero Suicide framework are: 1) reviewing suicide related incidents, and 2) providing opportunities for postvention support for staff. Each of these interventions are discussed further below and in the upcoming "Do" section of this Toolkit.

Take a moment to reflect. Do you feel that you have a "just culture" within your organization?

If no, what would it take to create this?

What will you do prior to and within the Zero Suicide implementation to further promote "just culture"?

Promoting Staff Mental Wellness and Self-Care

Another important guiding philosophy and principle of suicide prevention is promoting and maintaining the mental health and wellbeing of staff. Successful implementation of Zero Suicide depends on staff who feel supported in the challenging work of helping those at risk for suicide. Encouraging staff to ask for help, providing resources, and opportunities for building their own capacity are proactive and essential elements of implementation and ongoing success of Zero Suicide. In your Project Plan, consider how you will promote psychological health and safety and self-care in the workplace.

What is a psychologically healthy and safe workplace?

"A workplace that promotes workers' psychological well-being and actively works to prevent harm to worker psychological health, including in negligent, reckless or intentional ways").[2]

What is psychological resilience?

The process of adapting in the face of adversity, trauma, tragedy, threats, or significant sources of stress.[3]

What is self-care?

Activities we do deliberately to take care of our mental, emotional, and physical health.

"*Something that refuels us, rather than takes from us*." [4]

What does your organization currently do to promote mental wellness and self-care for staff?

Practical Self-Care Examples for Staff:

- A nutritious and healthy diet
- Good sleep hygiene
- Exercise
- Accessing health care
- Relaxation exercises or meditation
- Spending time with friends, families, loved ones, and supports
- Pleasurable activities - going out for dinner with a friend, seeing a movie, or cooking your favourite meal
- Promote a "no list" or boundaries
  For example, no checking e-mails after work or no answering the phone during dinner
- Using humour
- Mindfulness activities and exercise

What is mindfulness?
Derived from Buddhist traditions, mindfulness is bringing awareness to the present moment and what you sense and feel without any interpretation or judgement. Activities can include deep breathing, meditation, guided imagery, stress reduction, and creative exercises.[3]

Many organizations have internal resources to support staff, or utilize others within the community. Identify some key internal and/or community resources for staff:

Employee and Family Assistance or Wellness Program

Occupational Health and Safety Resources

Local Mental Health Crisis Service

Self Help Groups (e.g. Canadian Mental Health Association)

Spiritual Care Resources

How will you ensure that psychological health and safety is embedded throughout your project planning?

Ensuring that these resources are available and known to staff is important.
You may wish to also consider other staff training or resources such as:

- **Training:** Workplace Strategies for Mental Health
- **Training**: Compassion Training- Dr. Kristen Kneff ($) self-compassion.org
- **Resource:** Mental Health Commission National Standard of Canada for Psychological Health and Safety in the Workplace
- **Resource:** Government of Canada - Psychological Health in the Workplace Guide

Where will you make resource information available to staff?

How will you promote additional staff training within your organization?

Cared for staff are better prepared to do the challenging work of suicide prevention. Further, when staff are attentive to (and organizations support) their psychological health and wellness, staff are also less likely to become the individuals that need your support. Remember, no one is immune to suicidal thoughts and/or behaviours.

Introduction to the Suicide Care Management Plan

A Suicide Care Management Plan is a pathway to suicide safer care. This falls under the "**Engage**" element of the Zero Suicide framework.

In a Zero Suicide approach[1]:

- All clients identified to be at risk of suicide are engaged in a Suicide Care Management Plan.
- The client's status on a Suicide Care Management Plan is monitored and documented in an electronic health record (EHR). Please note that if you do not have an electronic documentation system, we encourage you to use your established methods, or think about how you might be able to improve documentation processes.

A Suicide Care Management Plan is a continuous client engagement plan, or pathway to care, which outlines the support that staff will provide clients until no longer considered at risk. This means that clients should be closely followed, and engaged or reengaged at every visit/service encounter[1]. Throughout the rest of the Plan 2.0 section, we will review the different elements of a Suicide Care Management Plan. Organizations should consider what will work within their own unique setting and be willing to test the limits to what more could be possible.

The Suicide Care Management Plan will be outlined in the policy and/or procedure you will design in the "Do" (i.e. implementation) section of this Toolkit and will include information pertaining to[1]:

- Screening tool (up next!) 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 full 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
- 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 a decrease in suicide risk level)
- Consider how management will review charts to determine that policies and protocols are being followed

All of these elements will require your organization's careful consideration. Your current state analysis, Organizational Self Study, and knowledge about community services and system navigation will all be important as you outline for staff what a Suicide Care Management Plan will entail within your organization.

To start off, begin by thinking about how you will care for and track clients at risk for suicide?

Next, we will review how to identify suicide risk with the use of screening and assessment tools.

Suicide Risk Assessment and Screening

Suicide Screening Tools

An important element of the Zero Suicide framework is to "**Identify**" those at risk of suicide with screening and risk assessment. Screening for suicide risk broadly means that we ask a client particular questions to determine whether or not they are at risk of suicide.

Once a screening tool demonstrates risk for suicide, further information is gathered (e.g. risk factors, warning signs, protective factors, and access to lethal means) with the aim of producing a "full risk assessment". Anyone can be trained to consider these elements in determining the risk level of a client. This however, is not the same as completing a formal medical suicide risk assessment/risk formulation which would require a regulated/trained health professional. If your organization has a regulated/trained health professional that can complete a formal medical suicide risk assessment (including a Mental Status Exam) and risk formulation, you may wish to align this work with their role, rather than having the client be referred to external mental health services.

> "The purpose of screening is not to ***predict*** suicide, but rather to plan effective suicide care."[1]

As you can imagine, talking to others about sensitive subject matter such as thoughts or behaviours related to suicide can be challenging. Building supportive and caring relationships (also known as a therapeutic alliance) can help create interpersonal ease before we ask these questions. Discussing how you can approach questions and having opportunities to practice this can be an important element of staff training.

Further tips on these concepts can be found on the Zero Suicide Toolkit website >

Engage > Building a Therapeutic Alliance with the Suicidal Patient

Engage > Ethical and Competent Care of Suicidal Patients

Identify > Screening Options

In a Zero Suicide approach[1]:

- All clients receiving service are screened with a standardized measure (tool) for suicidal thoughts and behaviours at intake.
- Whenever a client screens positive for suicide risk, further risk formulation is completed for the client by a regulated/trained health professional.
- Written policies and procedures outline:
  - The frequency of screening,
  - How to document risk screenings,
  - Incorporation of screening into workflows and,
  - How to communicate with staff when a client screens positive for suicide risk.

Important note: Research has demonstrated that periods of transition (e.g. prior to a leave of absence, reduction in service provision, or discharge/transfer from a service) are a very high-risk time for clients. It is strongly recommended that clients are screened during transitions[5].

Choosing the appropriate, standardized suicide risk screening tool(s) for your organization can seem overwhelming. Both St. Joseph's and Niagara Region Mental Health (NRMH) conducted a review of screening and assessment tools prior to launching their Zero Suicide Initiative. The project team at NRMH looked at eight different suicide risk assessment tools through an Evidence-Informed Public Health (EIPH) lens and rated these tools based on 13 criteria (Appendix F - NRMH Suicide Screening Tool Criteria). If your organization wishes to undergo a similar review process, we encourage you to check out the following:

- Zero Suicide Toolkit website > Identify > Screening Options
- Canadian Patient Safety Institute and Mental Health Commission of Canada - Suicide Risk Assessment- Toolkit and Guide > Table 1: Suicide Risk Assessment Tools and Their Characteristics - Clinician/Mental Health Professional Not Required for Administration.

Please note that there is frequently new evidence of psychometrics. It is important to review and examine the literature at the time of your project planning and make an informed choice for your organization.

Psychometrics: Assessing a tool's validity by looking at evidence that indicates the tool measures what we think it should[6].

TIP:

As you plan throughout this document, ensure that you are thinking about sustainability. More specifically, this means considering and planning for how the changes and interventions you are considering will work within the organization over the long term. A good question to ask is, will this still be relevant, or will this process still be effective in 1, 5, or 10 years?

Some questions to consider:

Note: Answering these questions now will help you breeze through the screening tool section of your policy and/or procedure(s) development.

What is the population that we work with (sociodemographic and cultural factors)? Is there a screening tool that has undergone psychometric testing with this population?

Does this screening tool meet the cognitive capacity or language of the population we work with?

How difficult is this screening tool to administer?

Will staff be able to be trained and use this tool appropriately? Why or why not?

Does training have a cost? Is it within our budget?

How long will this tool take to administer to a client? Is this feasible?

Niagara Region Mental Health and St. Joseph's worked through similar questions and determined that the Columbia Suicide-Severity Rating Scale (C-SSRS) was the best screening tool for their respective organizations. Having had a positive experience with these tools, we share some C-SSRS specific information below.

The C-SSRS was chosen based on the following criteria:

- Valid and reliable
- Many versions to meet organizational needs
- Can be used across the lifespan (youth to seniors) including a version for cognitive impairment
- Uses plain and direct language (offers alternative languages)
- Identifies both suicidal ideation and behaviour
- Non-stigmatizing; consistent with safeTALK and ASIST training programs
- Identifies both risk and protective factors
- Training is free (more on this under "Education Planning" below)

The C-SSRS supports suicide risk assessment through a series of simple questions. The answers help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the client needs.

Users of the C-SSRS tool ask clients:

- Whether or not, and when, they have thought about suicide (ideation)
- What actions they have taken, and when to prepare for suicide (preparatory acts or behaviours)
- Whether or not, and when, they attempted suicide or began a suicide attempt that was either interrupted by another person or stopped by their own volition (suicidal behaviour)

The C-SSRS tools that were selected at NRMH and St. Joseph's include:

Lifetime Recent/Full version:
Assessment tool that gathers lifetime history of ideation AND behaviour

Safe-T-Protocol with the C-SSRS: (NRMH only)
Incorporates documentation

Focuses on risk and protective factors (check list)

Formal suicide risk assessment

Used to determine a person's immediate risk of suicide

Short-Screener:

Shortened version of the Lifetime Recent/Full version (3-6 questions) that asks about suicidality in the last 30 days

Since Last Contact: (St. Joseph's only)
Shortened version of the Lifetime recent/full version (3-6 questions) that asks about suicidality since the last contact between the staff and client

Let's start thinking about some important questions related to suicide screening within your organization:

Who will be screened for suicide?

Who can/will be trained to complete suicide screening?

When (frequency) will suicide screening take place with the clients you work with?

Will you screen clients more frequently if they are determined to be at high risk?

Is there a private, confidential space that suicide screening can take place with clients? How can you support access to this?

What do you perceive will be staff members concerns in regards to suicide screening, and what do you need to do/prepare in order to address these?

Full Suicide Risk Assessment

As mentioned above, screening tools are an essential element of a full suicide risk assessment, but other important information is required to support your judgment about the client's suicide risk. These include[1]:

- Risk factors
- Warning signs
- Protective factors
- Access to lethal means
- Past suicidal behaviours
- Recent/present suicidal ideation or behavior
- Long-term risk factors
- Impulsivity/self-control
- Identifiable stressors (especially when coupled with a lack of protective factors)
- Engagement and reliability
- Presentation
- Coping resources
- Potential triggers

Please see Appendix G for a PowerPoint presentation (*Completing a Full Suicide Risk Assessment*) developed for staff teaching that outlines what each of these are. This information will be obtained by client observation (objective) and from conversation with the client (subjective). Essentially, a full suicide risk assessment is to think about all the client information collected (e.g. screening tool results, risk factors, warning signs, presence/absence of protective factors, and access to lethal means) as ingredients which could be used to yield an overall judgment of the client's suicide risk. While risk formulation falls under the Identify pillar of the Zero Suicide framework, this full suicide risk assessment will lead to the Engage and Treat pillars, adding context to the clients for better decision making/prevention planning- you are now tailoring the safety plan, interventions, and treatment to meet the client's unique needs/risk level.

Remember, anyone can be trained to consider these elements in determining the risk level of a client, and this is not the same as completing a formal medical suicide risk assessment/risk formulation which requires a regulated/trained health professional. If your organization has a regulated/trained health professional that can complete a formal medical suicide risk assessment (including a Mental Status Exam) and risk formulation, you may wish to align this work with their role.

For more information related to risk formulation, we encourage you to look here:
Zero Suicide Toolkit website > Identify> Risk Formulation

Next, let's look at an example to better illustrate risk formulation:

You notice that a client, Sam, has not been accessing the drop-in at your youth agency as usual lately. When you see them today, you notice that Sam appears withdrawn, sad, and not their "usual self" (warning signs). You ask Sam if they might be willing to talk in a private area, and in conversation, you learn that Sam recently lost their pet dog (absence of protective factor), and is experiencing some conflict in the home (warning sign). Sam is 17 years old, gender non-binary, and has recently started to engage in frequent use of alcohol and marijuana (risk factors). With Sam's consent, you complete the suicide screening tool which indicates that Sam is at high risk of suicide. During screening, Sam shared with you that they have been experiencing suicidal ideation, and have a plan to drink alcohol and take a bottle of Tylenol that they would obtain from a local pharmacy. Sam does not currently have any Tylenol or alcohol in the house (does not currently have access to lethal means). Sam has a close relationship with their high school teacher and has recently become more connected to their spirituality (presence of protective factors). When you mention creating a Safety Plan together, Sam is willing, expressing gratitude, and crying. Together, you work through the Safety Plan, including identifying coping strategies and what crisis resources Sam can access in the community. Sam agrees to calling their grandmother (protective factor) together to discuss monitoring and restricting access to Tylenol and alcohol in the house to help Sam stay safe (restrict access to lethal means). Sam also agrees to book an appointment with the Nurse Practitioner at a local youth agency (protective factors) this week for follow-up. You make this call together, and Sam's appointment is a few days from now. Sam agrees to attend the youth drop in at your agency every day this week, and you discuss a plan to call their grandmother should they not show up. Sam is grateful for the interaction, and confirms that they feel safe for the time being.

Despite screening "high risk" on the screening tool, your identification of protective factors, ability to reduce access to lethal means, and collaborative development of a safety plan, allows you to conclude that Sam is currently safe, not at imminent risk of suicide, and not currently requiring emergency crisis services.

In the example of Sam, we mentioned developing a Safety Plan and identification of coping strategies. We will discuss these next.

Interventions

Development of a Suicide Prevention Algorithm or Triage Tool

Some organizations may opt to build an algorithm or triage tool into their policy and/or procedure which outlines what interventions staff are responsible for as it relates to suicide prevention. Some organizations may opt to develop different interventions based on the client's risk status/level. You may choose to develop this resource as you complete your policy and/or procedure in the next "Do" section of the Toolkit.

The following questions will help you in planning the development of a suicide prevention algorithm or triage tool:

Does client interaction happen virtually or in person, or a hybrid of both? How will this change client interventions?

When a client is at risk, to whom will staff communicate this?

How/when will this communication take place?

What are some of your ideas of what can be done to keep a client safe at different levels of risk?

Crisis Management and De-escalation

The majority of people who are suicidal experience suicidality episodically and for a short period of time (Hawton, 2007). **Your organization will want to have resources in place to manage these situations because helping someone through a suicidal crisis can be life-saving**.

Crisis Management

There are two goals of short-term crisis management when someone is experiencing suicidality. The first is to protect the client engaging in impulsive and harmful behaviours. The second goal is to attempt to reduce/eliminate factors that are contributing to the current crisis[8].

De-Escalation

De-escalation (or "defusing") skills are helpful tools for anyone working alongside clients who are experiencing a suicidal crisis. Communication is at the heart of de-escalation techniques, including both verbal and non-verbal.

Some de-escalation techniques include[9]:

- Ensuring environmental safety
- Establishing rapport and connection
- Remaining calm and non-threatening
- Avoid being dismissive or overbearing
- Asking open questions
- Discussing options

While many basic suicide intervention training programs will include some information on crisis management and de-escalation techniques, your staff may require more in-depth training in this area.

At St. Joseph's, all mental health staff are required to take both online and in-person Prevention and Intervention in Crisis Situations (PICS) training. The training is specific to the hospital setting and additional training is required for those who may need to intervene in community settings.

The Crisis Prevention Institute offers a variety of standardized trainings such as Non-Violent Crisis Intervention ($) as well as free resources on crisis intervention: crisisprevention.com/en-CA/Resources

Do your staff require crisis management or de-escalation training? How will they receive this?

Note: Remember this training when developing the staff education plan.

Coping Plan & Safety Plan

Developing tools that help prevent suicide provide staff with structure and guidance when intervening with suicide risk. See Appendix H for St. Joseph's Safety Plan and Coping Plan. Input from clients and families was important in developing these resources. The idea of the Coping Plan was initiated by St. Joseph's Patient Council.

Coping Plan: Preventative and collaborative, and can help a client to identify their coping strategies. A client may identify adaptive (helpful) or mal-adaptative (unhelpful) coping strategies, and with consent, staff can support clients in identifying helpful coping strategies.

Would a Coping Plan be of use for your clients?

Is this something you would complete with every client as a prevention strategy?
Or, would this be developed and completed with select clients?

Safety Plan: Assets-based, preventative and collaborative document that is used in times of a suicidal crisis (i.e. when someone seriously considers or plans to attempt to take their own life). It is typically written in advance of/or after a suicidal crisis, but not during, as the client can become quite overwhelmed at this time. Rather, the Safety Plan is written (in one or multiple sittings) when the client has hope for the possibility of life[10]. A Safety Plan is not a "no-suicide contract", or "contract for safety" which have mixed reviews in research evidence.

We encourage you to review the Zero Suicide Toolkit > Engage > Resource > Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk.

In general, a Safety Plan includes[10]:

- Personal warning signs
- Coping strategies
- Those who are a source of support of one's life
- How means of suicide can be removed from the environment (lethal means restriction)
- Personal reasons for living/what has helped someone stay alive (protective factors)

Consider whether or not your organization has any other type of safety planning in place (e.g. a crisis plan). Is there an opportunity to incorporate a suicide Safety Plan, or would you need to create a stand-alone suicide Safety Plan?

Note: There are many versions of Safety Plans available on the Internet. Most of these are adaptations of the validated, and well utilized, Stanley Brown Safety Plan.

When will you co-create a Safety Plan with a client? For example, at St. Josephs, a Safety Plan is created with all clients who screen "high risk" on the C-SSRS screening tool and as clinically indicated (e.g. chronic or complex suicidality).

In the next section of the Toolkit ("Do"), you will adopt/adapt/create one or both of these documents (at your discretion).

Referral to/Supporting Evidence Based Treatment

If after completing suicide screening and a full risk assessment, the client is deemed to be high or imminent risk of suicide, it is very important that they receive same day access to a mental/behavioural health professional for a formal mental health risk assessment and risk formulation. If there are Regulated Health Professionals or other trained mental health professionals who are able to complete this within their scope of practice, you may wish to explore how clients can stay within the organization to maintain continuity. If not, common access points include a Primary Care Provider, Emergency Department, Crisis Centre/Mobile Crisis, or another mental health care access point to whom the client is already connected to service. Establishing what the referral process is, is a critical element of the Suicide Care Management Plan. Better yet, is the ability for an organization to create a referral process or memorandum of understanding (MOU) with an access point to evidence-based treatment for suicide prevention.

If a client has received a formal mental health risk assessment and risk formulation and has been identified as someone who would benefit from suicide specific evidence-based treatment, your organization may have a role in supporting a client in accessing and maintaining this treatment regime. The "**Treat**" element of the Zero Suicide framework steps outside of conventional thinking that treating mental health diagnoses (e.g. anxiety, depression) will address underlying suicidality[1]. Instead, research points to treating suicidal thoughts and behaviours specifically and directly – regardless of mental health diagnoses or substance use[1]. This means that both suicidality and the underlying mental health/substance use concerns should be addressed.

A guiding principle for the provision of evidence-based treatment, is to aim for the least restrictive care in the least restrictive setting. In particular, this promotes care in an outpatient treatment setting with an array of supports – avoiding long term hospitalization. If acuity increases however, and it is required, care can be 'stepped-up' to more intensive services when clinically indicated. For more information, visit the Zero Suicide Toolkit > Treat > Providing the Least Restrictive Care.

Engaging Natural and Peer Supports, and Those with Lived Experience of Suicide

Connection with others is pivotal in suicide prevention. We know that isolation and a lack of connectedness can be a risk factor for suicide. Whether someone is experiencing suicidal ideation for the first time or the client has been impacted by a suicide death, your organization will want to have a means of connecting this person to their natural and/or peer support. Your organization may already utilize peer support models in other areas.

Natural supports are resources/people that an individual can access outside of professional support services. These supports can be leveraged as a protective factor from suicide and are typically included in an client's Coping and/or Safety Plan.

Peer support is defined as, "emotional and practical support between two people who share a common experience, such as a mental health challenge or illness"[11]. Peer recovery specialists are those with lived experience who have professional training and may hold certification in peer support.

The Zero Suicide framework promotes the role of peer support services in caring for those at risk for suicide. The Zero Suicide approach recommends organizations embed peer support throughout services as well as promote access to peer support in the community[12].

Evidence has shown that peer support can have a positive impact on mental illness and substance use recovery, and emerging research has demonstrated peer support to also be helpful for those bereaving a suicide death[13].

Benefits of peer support[12]:

- Peer-to-peer support is an evidence-based practice
- Promotes crucial protective factors such as connectedness and hope
- Promotes recovery and resilience
- Promotes choice and voice in treatment
- Challenges negative stereotypes

Online peer support is also available in a variety of ways such as skill-building, moderated forums or communities, and stories of lived experience with suicide. The following are three examples that you may want to include in a community resources list:

Now Matters Now www.nowmattersnow.org

- Online suicide prevention - skills and support for coping with suicidal thoughts. Helpful ways to manage thoughts such as mindfulness, opposite-action, paced breathing, based on principals of Dialectical Behaviour Therapy (DBT)

Lived Experience Academy livedexp.academy

- Online educational site designed to help you recover after getting through a suicidal crisis and supporting your journey of recovery and growth. Offers resources, mini-courses and workbooks

Live Through This livethroughthis.org

- A collection of portraits and stories of suicide attempt survivors across the United States. This website can help others tell their stories to reduce shame and stigma while striving towards hope and change

You can view an example of a brochure from St. Joseph's that is focused on postvention in Appendix I. The brochure is intended for clients and families and contains local, national, and international resources for those with lived-experience with suicide or suicide loss.

At NRMH, peer support is offered for outpatient mental health programs, youth mental health and addiction services, and a program for early psychosis intervention. The peer support worker helps normalize their experience and validate struggles, even during a walk or over a cup of coffee. They share their own story to connect and provide education to meet the individual where they are in their recovery journey.

The SPRC offers a Lived Experience Toolkit to assist organizations and agencies with recruiting and engaging individuals with lived experience, potentially as part of your implementation team. You may find that lived experience can come from within your organization- part of Zero Suicide-related culture change should be creating an environment where staff feel they can contribute their lived experience, and see it as something valuable, as opposed to a detriment to their professional role, if they choose to do so. The National Action Alliance document, "The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experience" may also be helpful for your organization to learn more from the expertise of those with lived experience, and increase awareness of support and resources available. Having representation from both individuals with lived experience alongside peer support specialists in the planning and implementation stages is recommended.

Other resources:

Peer Support Canada

Mental Health America Peer Support

What peer support resources or services are in your community that you could tap into?

Supporting Transitions in Care

A care transition is a very high-risk time for clients, most notably from inpatient care to outpatient services[14]. Many resources and an outline of emerging standards are available on the Zero Suicide Toolkit website: Safe Care Transitions.
A summary of these have been provided below.

The referring staff member should:

- 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[1]:

- 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 loved one's during care transitions if consent is provided
- Provide the client with a copy of their Safety Plan and ensure it is relevant to them given their level of care
- Provide "Caring Contacts" (i.e. communication that entails a brief visit, call, text message, letter) with the client during any transitions of care, or when clients miss an appointment or are discharged. In the caring contact, staff continue to show support for the client by providing encouragement and demonstrating care. More on this below!

Implementing Caring Contacts

Communication between care/service providers is an important element of suicide prevention. Another evidence-based intervention that has demonstrated a reduction in feelings of isolation and improved connectedness between health care providers and clients are "*caring contacts*"[1]. A caring contact is a suicide prevention intervention that involves "...the routine sending of brief messages that express caring concern to [clients] following discharge from treatment"[15]. Caring contacts are completed by a concerned individual (this may include Peer Support, family, or other people-centered team members) and may be a phone call or a "non-demanding" format such as a postcard or automated e-mail/text message which requires no response from the client. Research demonstrates that providing multiple caring contacts (nine or more) has a measurable impact on reducing suicide deaths[16].

Having followed the recommendations of Zero Suicide, St. Joseph's created a standardized caring contact phone call message that can be used for all clients (Appendix J). Caring contacts are especially effective at times of elevated risk, including transitions in care such as program/service transfer or discharge[17].

When would it make sense for caring contacts to be made with clients?

Who would be responsible for administering the caring contact?

In what format (e.g. card, phone call) would caring contacts with clients at your organization be made?

General Guidelines for Documentation

Your organization likely has its own unique system and policy/procedure for documentation. This may be in a client chart/record/file, communication book, or embedded into an electronic health record (EHR) system.

The intent of documentation is to communicate important information to others. Legislation such as Personal Health Information Protection Act's, or Required Required Organizational Practices (ROP) monitored by Accreditation Canada[18] outline important criteria for documentation (e.g. confidentiality and security). Pay attention to what drives your own organizational requirements as you work throughout this Toolkit, both in documentation and beyond.

TIP:

Remember that if your organization has Regulated Health Professionals, each professional body will have its own professional standards for documentation to adhere to.

Documentation Tips:

A client chart/record/file, whether it's hard copy or electronic, is used to:

- Communicate with other care/service providers
- Provide a chronological record of care/service to monitor a client's progress/activity/status
- Provide accessible information and accountability for care/service provided

Just like documentation for other interactions with a client, documentation for suicide risk screening, assessment, and intervention should include and clearly identify:

- What is the issue, goal, focus?
- What is the current state?
- What strategies/interventions are used to support/intervene with the client?
- What outcomes are observed?
- Is the plan working? Does the plan need to change?

Where will a suicide screening tool, Safety Plan, or Coping Plan be filed in a secure and confidential manor?

Where will additional information related to the Suicide Care Management Plan (e.g. full suicide risk assessment and support/interventions) be documented?

How will documentation of progress and symptom reduction take place (i.e. where will this be in relation to the Suicide Care Management Plan)?

How will staff be trained in documentation?

Reviewing Suicide Related Incidents

Many organizations will implement a process to review a client incident of self-harm, suicide attempt, or death by suicide. This is an important aspect of the "**Improve**" element of the Zero Suicide framework. Reviewing suicide related incidents typically takes place in a root cause analysis and demonstrates dedication to continuous quality improvement in suicide prevention. There are many frameworks available on the Internet to guide a root cause analysis, which will help organizations better understand underlying causes of an incident so that effective opportunities for improvement can be identified and implemented. Two resources we recommend are:

- Zero Suicide Toolkit > Improve > Resources > Framework for Conducting a Root Cause Analysis and Action Plan

Root cause analysis: "…is a process for identifying the basic or causal factor(s) underlying variation in performance. Variation in performance can (and often does) produce unexpected and undesired adverse outcomes..." [19].

Does your organization currently conduct a review of incidents/events that impact a client's safety? If so, how might you be able to embed a review of suicide related incidents into current organizational practices? If not, how might you create a forum for reviewing suicide related incidents?

At St. Joseph's, a review takes place for every suicide related incident. The review is conducted in a timely and standardized fashion, and includes key members of the health care team, leadership, and support services (e.g. a member of the Zero Suicide team) as needed. Committed to patient safety and continuous quality improvement, this process provides an opportunity to identify if there are any recommendations for improvement.

Postvention Support

"Postvention is psychological first aid, crisis intervention, and other support offered after a death by suicide to affected individuals (or the workplace as a whole) to alleviate possible negative effects of the event"[20].

A death by suicide can have significant impacts on loved ones, other clients, and staff. The environment and culture of the organization must support other clients and staff to feel comfortable disclosing their personal feelings as a result of death by suicide.

Postvention is prevention[21].

The Zero Suicide framework includes:

- Immediately supporting the family, other clients and staff,
- Conducting root cause analyses and,
- Embedding postvention in policies and protocols.

Postvention in your organization could include[5]:

- Providing/connecting staff with support and education for healthy grieving.
- Connecting staff with postvention services including gathering and utilizing their expertise and feedback and ongoing integration and extension with available postvention services.
- Providing and linking affected clients to required support services.

TIP:

Creating a resource for both those who have survived an attempt, other clients, and loved one's is recommended. This can include a list of available community resources and credible online support groups (see page 57).

Staff may need different levels of resources, services, or support.
Some examples of what your staff may need are:

- Debriefing opportunities
  (meetings, formal review, standard template to guide group discussion)
- Peer support
- Employee and Family Assistance or Wellness Programs
- If appropriate, ability to connect with the family of the deceased
  (e.g. card, attending an open service)
- Involvement with quality improvement processes or initiatives

What other organizational resources might benefit your staff in postvention?
(Engage one or more staff members in seeking this response!)

What external postvention supports currently exist in your community for staff?

What external postvention supports currently exist in your community for clients/loved ones?

Staff Education Planning

Having completed the Workforce Survey, you should have a greater understanding of the training and education requirements of your staff. Developing a plan for staff education will ensure that staff are equipped with the knowledge, skills, and resources to support suicide prevention in your organization. Do not forget to consider how this education can be made sustainable (long term)!

Broadly, education should address the elements of the Zero Suicide framework that your organization is implementing. Below is a sample outline of education, but please adapt this to meet the needs of your organization.

Sample Education Plan for Community organization Zero Suicide Implementation:

1. Introduction to Zero Suicide:
   - Introduction to the project, including why your organization has adopted it
   - Overview of suicide (including definitions, statistics, safe language and dispelling myths) (see Appendix K - Learning the Basics About Suicide PowerPoint Presentation which can be used for staff education)
   - Overview of the Zero Suicide framework (included in Appendix K - Learning the Basics About Suicide PowerPoint Presentation)
   - Review of your organizations specific suicide prevention processes, policy and/or procedure(s) (more on this soon!)
   - Documentation expectations
   - Staff mental wellness, self-care, and restorative just culture

2. Introduction to the Suicide Care Management Plan

   Screening tool(s):

   - Use of the selected screening tool
   - Importance of the therapeutic client/staff relationship
   - Policy/procedure for when and with who suicide screening is completed
   - Review of screening tool documentation (including where the tool can be accessed and stored)
   - Include time for staff to review the tool and practice its administration with others

Online Training on the Columbia-Suicide Severity Rating Scales:
The Columbia Lighthouse Project offers numerous free training options in more than 20 languages. The shortest training takes about 20 minutes, and almost all of them can be completed within an hour. Trainings are not setting specific. Choose the method that works best for you. cssrs.columbia.edu/training/training-options

3. Full suicide risk assessment:
   - Review of risk level including an overview of risk factors, warning signs, protective factors, and access to lethal means (See Appendix G - Completing a Full Suicide Risk Assessment PowerPoint presentation which can be used for staff education).
   - Regulated/trained health professionals (if applicable):
     - Mental Health Status Exam overview

4. Suicide Prevention & Intervention Based Training:

   Policy/procedure as it relates to interventions. This may include some/all of the following:

   - Crisis management and de-escalation
   - Coping Plan development
   - Safety planning
     - Centre for Practice Innovations > Safety Planning
     - The Joint Commission > Resources > Patient Safety Topics > Suicide Prevention > Safety Planning Resources
   - Lethal means restriction
     - Zero Suicide Toolkit > Engage > Resources > Counselling on Access to Lethal Means (CALM)

- Caring Contacts
  - Zero Suicide Contact after Leaving Care Resources
    https://zerosuicide.edc.org/toolkit-taxonomy/contact-after-leaving-care

    Examples of Caring Contacts:
    - Now Matters Now
      https://zerosuicide.edc.org/sites/default/files/nowmmattersnow.pdf
    - Netcare Caring Contacts Examples and Ideas
      https://zerosuicide.edc.org/sites/default/files/NetCare%20Caring%20Cards%20%26%20Ideas.pdf
- Evidence based treatment
  - Regulated/trained health professionals (if applicable):
    - Collaborative Assessment and Management of Suicidality (CAMS):
      CAMS Care cams-care.com ($)
      - Online training available internationally
    - Cognitive-Behavioural Therapy for Suicide Prevention (CBT-SP):
      The Beck Institute beckinstitute.org ($)
      - In-person or online training available internationally
    - Dialectical Behavioural Training (DBT):
      Behavioral Tech behavioraltech.org ($)
      - In-person or online training available internationally
- Supporting safe transitions in care
- Suicide related incident reviews
- Postvention support

In addition to the interventions that you will soon identify in your policy/procedure, you will want to consider whether additional training related to intervention during a high risk or crisis situation is required. Courses such as SafeTALK ($) and ASIST ($) help prepare and equip individuals with skills for suicide prevention, wherever they may be. A brief overview of these two courses is outlined below, however we encourage you to explore what other evidence-based training might be present in your community. Please see Appendix L for a list of Suicide Care Training Options available in Canada and recommendations on potential training opportunities for community organizations.

SafeTALK – Suicide Alertness for Everybody:
This four-hour training prepares participants to recognize invitations and connect a person with thoughts of suicide to intervention resources.

Target Audience: Anyone (15 years or older) interested in suicide prevention.

Applied Suicide Intervention Skills Training (ASIST):
ASIST is a two-day interactive workshop that prepares caregivers to provide life-assisting suicide first-aid intervention.

Target Audience: Anyone (16 years or older) interested in learning life-saving skills.

A training guideline is used by Niagara Region Public Health for determining which staff at your organization would benefit from available suicide intervention trainings (Appendix L).

Recall, that during your current state analysis and planning you may have identified other areas that staff require additional training (e.g. understanding the roles of other staff members, security processes, use of technology). Sometimes, this doesn't feel exactly within the realm of the project (remember the mention of "Scope Creep"?) but this education/training may be necessary in order for staff to feel well prepared for the "go-live" date.

Before you finish your education planning:

How will you ensure that education is sustainable (e.g. for new staff or those who require a refresh of the content)?

Will training be recorded/electronic?

Will this be offered on frequent intervals to staff?

How will you record/track who completes the education?

Planning your Project Evaluation

In the Plan 1.0 section of the Toolkit, we prompted you to begin thinking about how you wish to study or evaluate your project. We encouraged you to start taking notes about the data you have collected to date, and things you are learning or experiences you are having throughout implementation. You may wish to start a note page entitled "Implementation Notes" to help keep you organized.

At this point, we would like to encourage you to begin planning your evaluation. Doing this early on can prevent missing key time intervals to collect data (e.g. pre-implementation data). You can continue to build on your evaluation plan as you move through implementation, and the entire Study section of the Toolkit is dedicated to ensuring you have a robust and useful evaluation for your organization.

Data is important for a number of reasons but most importantly:

- Drive quality improvement in your initiative
- May align with other required reporting in your organization
- Help you share your excellent work with other community partners, stakeholders, and researchers

Key resources to guide your evaluation plan:

- Skip ahead and review the "Study" section of the Toolkit
- Zero Suicide Data Elements Worksheet (Non-healthcare) (Appendix M)

If you opted to involve a formal program of research (e.g. researcher at a local university), you can share the above resources with them, and support their planning, data collection, analysis, and knowledge translation efforts

Conclusion

In the Plan 2.0 section of the Toolkit, you have done a tremendous amount of work. This may have felt like a lot of time researching, in conversation, and consultation with other stakeholders within (and external) to your organization. You might be wondering, when is it time to take some action and make some change? The answer is at your fingertips, as you move on to the second element of the Plan, Do, Study, Act (PDSA) cycle and partake in the "Do" section of the Toolkit.

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Appendices

Appendix F: Niagara Region Mental Health Suicide Screening Tool Criteria

Appendix G: PowerPoint Presentation: Completing a Full Suicide Risk Assessment

Appendix H: St. Joseph's Safety Plan and Coping Plan

Appendix I: St. Joseph's Suicide Prevention Resources Brochure

Appendix J: St. Joseph's Caring Call Template

Appendix K: PowerPoint Presentation: Learning the Basics About Suicide

Appendix L: Suicide Care Training Options- Canada

Appendix M: Zero Suicide Data Elements Worksheet (Non-healthcare)

	C-SSRS (Columbia Suicide Severity Rating Scale)	**LRAMP** (Linehan Risk Assessment and Management Protocol) Susan	**BSS** (Beck Scale for Suicide Ideation)	**Sad Personas**	**BHS** (Beck Hopelessness Scale)	**SPS** (Suicide Probability Scale) Kim	**SIS** (Scale for Impact of Suicidality-Management Assessment and Planning of Care) Vanessa	**GSIS** (Geriatric Suicidal Intent Scale)A
Targeted Population (e.g., youth, adults,older adults)	ALL	Adults, youth assessment in development	Ages 17-80	Children and Adults	Evidence exists for adolescents to geriatric populations. Pearson website lists Age Range 17-80.			Older adults, 64+
Number of items on tool	21 questions for Lifetime Recent 6 questions for Screener	4 sections: 7 questions with subsections. 31 assessment questions and 12 risk management questions	-21 (19 scored items) -Items look at the past week	10-11	20-item scale True/false response format Responses summed to give severity rating from 0-20			31 questions in 4 categories
Length of time to complete tool	Screener is brief (6 questions) and can be completed at intake in-depth assessment is lengthier 15 to 20 minutes	Not stated. Approximate 20-30 min	5-10 minutes	Brief	5 to 10 minutes			10-15 minutes
Is this tool valid? (Please describe)	Yes Reached out to Kelly Posner	Yes – uses risk factor for suicide from literature	Yes-High interrater	Fair	Original validation studies in 1985			Originally validated with institutionalized

	(creator of the Columbia) and St. Joe's Hospital in Hamilton and London Good convergent and divergent validity (the Columbia – Suicide Severity Rating Scale: Initial Validity and Internal Consistency Findings from Three Multisite Studies with Adolescents and Adults		reliability (0.87 to 0.97);		and 1990; numerous factor analyses and further yvalidation studies since then.			and community-dwelling older adults in 2006. Is a multi-dimensional tool that assesses complex factors of late life suicide. Questions rated in a Likert scale format ranging from Strongly Disagree (1) to Strongly Agree(5). However, Predictive validity has not been established
Is this tool reliable? (Please describe)	Yes	Yes – repeatable findings	yes	No	Internal reliability reasonably high (.82 to .93) but test-restest reliability is modest (.69 after one week, .66 after six weeks)			Test-retest reliability of responses by a sample of 32 nursing home residents was r = .86 (one to two months between points of measurement), and r = .77 for a sample of 13 nursing home residents (1 to 1.5 years between points of

measurement; Heisel & Flett, 2006). Cronbach's alpha for responses to the GSIS (α = .90) and its subscales (.74 ≤ α ≤ .86) suggest acceptable to good internal consistency (Heisel & Flett, 2006). Responses to the GSIS have exhibited strong concurrent validity vis-à-vis the Beck Scale for Suicide Ideation (r = 0.62) and the Geriatric Depression Scale (r = 0.77; Heisel, Flett, Duberstein, & Lyness, 2005). Further positive features include its sensitivity to suicide-related ideation across a range of functioning and subscales that focus on maladaptive and protective factors.							

Cost to buy tool? (yes, no and how much)	No cost	No but a new web based multimedia tool is $239	Pearson clinical website: - $138 for manual and 25 forms -Web version $96 for manual and 5 forms (scored). -$60 for 25 forms	Free	$138.25 for BHS Complete Kit (Includes Manual, 25 Record Forms, and Scoring Key)			No cost, however, tool is not readily accessible online. Have to email Marnin Heisel for permission to use
Training (part of the tool, cost for training?)	No cost St. Joseph's in London to provide train the trainer on the tool at no cost	For those already training in suicide risk and assessment, 30 minutes. All others; 2 days	No	No	Self-administered or verbally by a trained administrator			No
What does the tool measure?	LifeTime Recent version: gathers lifetime history of suicidality as well as recent suicide ideation and behaviour. Since last Visit Version: Monitors suicide related behaviour since last visit or last C-SSR was administered categories include: Suicidal	LRAMP is principle-based rather than protocol-driven. Developed for outpatient DBT clients with chronic suicidality. Mean to reduce fear in therapist and ensure contemporaneous documentation	-assesses the person's current intensity of attitudes, plans, and behaviors to commit suicide. -examines the duration and frequency of ideation, the sense of control over an attempt, the number of deterrents, and the amount of planning involved into a	Risk Factors for Suicide	Hopelessness, defined as generalized negative expectations of the future Higher scores indicate presence of hopelessness Only widely used standardized measure of hopelessness			Suicide Ideation, Perceived Meaning in Life, Loss of Personal and Social Worth, Death Ideation;

	ideation, intensity of ideation, frequency of thoughts, duration of thoughts, controllability of thoughts, deterrents, reasons for ideation, suicidal behaviour, self-harm interrupt Preparatory acts or behaviour Actual lethality Potential lethality ed attempt		contemplated attempt					
Protective Factors (x)	Yes	Yes, checklist	X-asks about deterrents	No	N/A			
Risk Factors (x)	Yes	Yes, checklist	Yes	9	N/A			Yes
Historical Information (x)	yes	Limited – it is expected that the individual already is known by clinician – used for an individual in treatment one on one	No	1	N/A			No
Plan (x)	yes	Yes	yes	1	N/A			No
Screener vs. In-depth Assessment	Both	Screener is first section. In depth	Yes- 5 screening items	Screener	Screener			In-depth

	Lifetime/recent (access of full and recent history of suicide ideation and behaviour) Since last contact – Communities and health care (assessment of full and recent history of suicide ideation and behaviour) Screeners:	is if needed based on first pagers	reduce length for people who are not suicidal					The 10-item Suicide Ideation subscale has been able to discriminate psychiatric patients from nonpatients.
Other notes:	Electronic version available	Completed at: (1) start of treatment (2) suicide attempt (3) self-injury (4) suicide threat or increase in symptoms or surges. Develp for clinical settings/research	development samples include psychiatric adolescent and adult in- and outpatients; used in many other settings and populations	Need to have good clinical interview and context. Quantitative rather than qualitative	Sensitivity 0.80 Specifity 0.42 +LR 1.55 -LR 0.45 People scoring above standard cut-off point on the scale (a score of 9 or more) were 3.39 times more likely to die by suicide than those scoring			No electronic version found.

below that point; this identifies a suicide-potential group (Source: Meta-analysis of four studies that

Completing a Suicide Risk Assessment

To get to a never event, we need always practices.

Suicide Risk Assessment:

- The 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
  - Protective factors

Suicide Risk Assessment

Elements:

- Screening tool(s)
- Risk factors
- Warning signs
- Protective factors
- Access to lethal means

Suicide Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Major physical illnesses
- Previous suicide attempt

Suicide Risk Factors

- Family history of suicide
- Job or financial loss
- Loss of relationship
- Easy access to lethal means
- Local clusters of suicide
- Lack of social support and sense of isolation
- Stigma associated with asking for help
- Lack of health care, especially mental health and substance abuse treatment
- Cultural and religious beliefs, such as the belief that suicide is a noble resolution of a personal dilemma
- Exposure to others who have died by suicide (in real life or via the media and Internet)

Warning Signs of Suicide

- Talking about wanting to die or to kill themselves
- Planning for death (e.g. will)
- Looking for a way to kill themselves, such as searching online or buying a gun
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing their use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or isolating themselves
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

Suicide Protective Factors

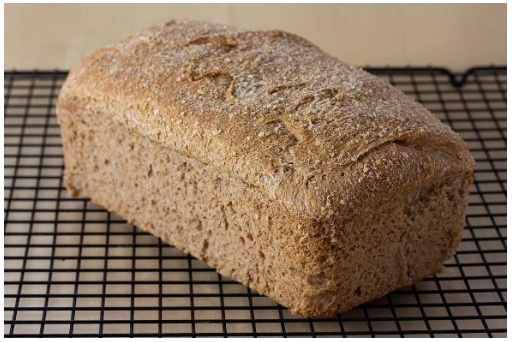
- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution and handling problems in a non-violent way
- Cultural and religious beliefs that discourage suicide and support self-preservation

"The goal of a suicide assessment is not to predict suicide, but rather to appreciate the basis for suicidality, and to allow for a more informed intervention."

Jacobs, D., Brewer, M., & Klein-Benheim, M. (1999). Suicide assessment: An overview and recommended protocol. In D. Jacobs (Ed.), Harvard Medical School guide to suicide assessment and intervention (pp. 3-39). San Francisco: Jossey-Bass.

Risk Formulation

- An understanding of how risk factors interact, exacerbate, and otherwise fuel a heightened or lower risk of suicide



Suicide Risk Assessment

Suicide Risk Assessment

Risk factors make up a Suicide Risk Assessment (presence or absence of predisposing, precipitating and acute risk and protective factors).

Suicide Risk Formulation

An understanding of how risk factors interact, exacerbate, and otherwise fuel a heightened or lower risk of suicide.

Interventions

- Attend to client's immediate safety
- Initiate or review a safety management plan with the patient
- Address psychological/social problems/stressors
- Augment social supports
- Interdisciplinary care planning
- Consider other resources for support (e.g. crisis services)

Safety Planning

Safety planning should address:

- Client-identified coping strategies
- Client-identified supports
- Detailed plans ('*Plan A*') for follow-up, e.g. "Call me at 10:00am tomorrow"
  - '*Plan B*': clinician to contact supports, etc.
- Current reason for staying alive, even if temporary

Access to Lethal Means

- Many suicidal crises are short-lived
- Helping people survive periods of acute risk by restricting/reducing access to lethal means will help them survive in the short and long term
- Lethal means are usually dependent on availability. Discuss with patient what lethal means are available to them (e.g. firearms, medications/other substances)

Restrict/Remove Access to Lethal Means

- Create collaborative plan to remove/restrict access to lethal means (often this involves support person involvement)
  - E.g. Store firearms with law enforcement, or have them locked in a safety deposit box (key to support person)
  - E.g. Ask family member to store medications safely and dispense safe quantities as necessary or collaborate with pharmacy to do so

- Suicide Prevention Resource Centre: Counseling on Access to Lethal Means Course (CALMs)

Next Steps

Name: _____

PIN:_____

Coping Plan

Most stressful thing(s) in my life:

_____

_____

_____

_____

_____

What are the signs that I am getting too stressed or becoming unwell?

BEHAVIOURS:

_____

_____

THOUGHTS:

_____

_____

FEELINGS:

_____

_____

PHYSICAL SIGNS (e.g. headaches):

_____

_____

What are the healthy things I do when I'm feeling stressed or unwell?

_____

_____

_____

_____

_____

_____

_____

_____

Are there any meaningful anniversaries that might interfere with maintaining my wellness?

_____

_____

_____

_____

Name: _____

PIN:_____

ACTION PLAN (e.g. things I will consider doing towards becoming healthier or to prevent becoming unwell):

What do others do that is <u>helpful</u>?	What do others do that is <u>NOT helpful</u>?

Name: _____

PIN:_____

Personal supports:

- Name:_____ Number:_____
- Name:_____ Number:_____
- Name:_____ Number:_____

Professionals/Agencies I can contact:

- Ambulatory Service: _____
- Physician/Psychiatrist: _____
- Clinician: _____
- CMHA Worker: _____
- Other: _____
- Other: _____
- **Community Services:**
  - **CMHA Support Line: 519-601-8055 (toll free: 1-844-360-8055)**
  - **ReachOut Crisis Line: 519-433-2023 (toll free: 1-866-933-2023)**
  - **http://reachout247.ca/**

I understand and agree with this plan:

Patient signature:

_____

Date: _____

Clinician signature:

_____

Date: _____

Name: _____

PIN:_____

<u>Clinician/Physician</u>: The following lists are intended to assist you in providing examples of warning signs as you collaboratively build this Coping Plan with your patient. If they are struggling to provide these signs on their own, they may choose some examples you give from this list or elsewhere.

Thoughts:

- Scattered thoughts
- Disorganized thoughts
- Ruminations
- Can't finish thoughts
- Suicidal thoughts
- Paranoia
- Delusions
- Racing thoughts
- Negative thoughts
- Impulsive thoughts
- Cognitive distortions: overgeneralizations, mind-reading, fortune telling, catastrophizing

Emotions/Feelings:

- Sadness
- Anger
- Irritability
- Indifference
- Self-hate
- Fear
- Shame/disgust
- Nervousness/anxiety
- Despondence
- Numbness
- Tearfulness

Behaviours:

- Impulsivity
- Isolation
- Sleeping too much/too little
- Becoming too busy
- Becoming over involved in others' problems
- Erratic behaviour
- Avoidance
- Obsessions/compulsions
- Socializing too much/too little
- Indecisiveness
- Self-harm
- Substance use
- Self-medicating
- Eating too much/too little
- Lack of self-care
- Agitation/restlessness

Physical Symptoms:

- Upset stomach /bowels /diarrhea /constipation
- Nausea/vomiting
- Heartburn
- Dizziness
- Headache
- Increased pain
- Sweating
- Racing heart
- Shakiness
- Tightness in chest
- Muscle tension
- Heavy head
- Lack of energy/increased energy

Adapted from: Kantor (2015) *Coping Plan*

Name: _____

PIN:_____

REACH OUT Crisis Line: 1-866-933-2023

Canada Suicide Prevention Service (CSPS): 1-833-456-4566 / http://www.crisisservicescanada.ca/

(Under 18) Kids Help Phone counselor 24/7: 1-800-668-6868

Outpatient Suicide Management Plan

Personal Coping Strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

_____

_____

_____

_____

_____

_____

People I can call and/or social settings that provide distraction and reduce isolation:

_____

_____

_____

_____

_____

People I should *not* call for help:

_____

_____

Potential barriers to attending treatment as scheduled, and solutions I will try:

_____

_____

_____

_____

If I do not show up to a scheduled appointment, my physician/clinician will:

☐ Call me at: _____

☐ Leave a voice message at the number above.

☐ Call support person (name): _____ at (number): _____

Name: _____

PIN:_____

REACH OUT Crisis Line: 1-866-933-2023

Canada Suicide Prevention Service (CSPS): 1-833-456-4566 / http://www.crisisservicescanada.ca/

(Under 18) Kids Help Phone counselor 24/7: 1-800-668-6868

The one thing/person that is most important to me and worth living for is:

_____

Making the environment safe/ways to reduce lethal means (identify who will assist and confirm):

_____

_____

_____

_____

I understand and agree with this plan:

Patient signature:

_____

Date: _____

Clinician signature:

_____

Date: _____

I will share this plan with the following support people:

1. Name: _____

2. Name: _____

3. Name: _____

Adapted from: Brown & Stanley (2008) *Patient Safety Plan Template*

International Self-Help Resources

LIVED EXPERIENCE ACADEMY
www.livedexp.academy

An online educational site designed to help with recovery and growth after getting through a suicidal crisis. Offers mini-courses and workbooks.

YOUR LIFE COUNTS
www.yourlifecounts.org

An online global community providing life-affirming resources to reconnect with hope and your reason to live. Resources include articles, a learning centre, and stories of lived experience of working through suicidal crisis.

TOGETHER ALL
www.togetherall.com

Not specific to suicide, but a safe, peer support online community for those experiencing common mental health issues (not for distress/crisis situations). Focused on connectedness and healthy social networking where people can share and support each other anonymously.

Blogs and Websites

LIVE THROUGH THIS
www.livethroughthis.org

A collection of portraits and stories about suicide attempt survivors across the United States. This website helps others tell their stories to reduce shame and stigma, while striving towards hope and change.

SUICIDE AWARENESS VOICES OF EDUCATION (SAVE)
www.save.org

- Click on **"FOR SURVIVORS Resources to help cope"**
  - Hopeful suicide prevention stories, as well as resources and stories on finding hope and coping after a suicide loss.

CARING FOR THE BODY, MIND & SPIRIT SINCE 1869

St. JOSEPH's HEALTH CARE LONDON

sjhc.london.on.ca

Renowned for compassionate care, St. Joseph's is one of the best academic health care organizations in Canada dedicated to helping people live to their fullest by minimizing the effects of injury, disease and disability through excellence in care, teaching and research.

Suicide Prevention Resources

For those with lived-experience or who have been impacted by suicide

CARING FOR THE BODY, MIND & SPIRIT SINCE 1869

St. JOSEPH's HEALTH CARE LONDON

Suicide Prevention Resources

Those who have experienced a suicide attempt, or suicidal thoughts and feelings- either personally or through a loved one- are considered individuals with lived experience of suicide. This also includes those who have been affected by, or suffered a loss, due to a suicide death.

The resources listed in this pamphlet are not treatments or crisis services, but additional supports that are available during your/your loved one's recovery journey.

If you require additional support or have questions about these suggested resources, please connect with your health care team.

If you are experiencing a mental health care crisis in London and Middlesex, you have the following options:

- Contact Reach Out crisis response line: (519) 433-2023 or 1-866-933-2023
- Go to the CMHA Crisis Centre located at 648 Huron St., in London ON, 519-434-9191
- Go to your nearest emergency department

Local Resources (London-Middlesex):

CANADIAN MENTAL HEALTH ASSOCIATION (LONDON-MIDDLESEX)

www.cmhamiddlesex.ca

Bereavement Support Program- including presentations, education, peer supports, 'survivor of suicide' groups and more.

Peer Support Program

LONDON-MIDDLESEX SUICIDE PREVENTION COUNCIL

www.lmspc.ca

A non-profit council comprised of survivors of suicide and volunteers representing organizations that deliver suicide prevention, support and/or treatment programs.

Canadian Resources

MENTAL HEALTH COMMISSION OF CANADA

www.mentalhealthcommission.ca

- Click on **"Toolkit for people who have been impacted by a suicide attempt"**
  - Crisis planning, coping strategies, how to tell your story and hopeful messages.
- Click on "**Toolkit for people who have been impacted by a suicide loss"**
  - How to seek help, coping strategies and hopeful messages.

International Self- Help Resources

NOW MATTERS NOW

www.nowmattersnow.org

Online suicide prevention: skills and support for coping with suicidal thoughts, including helpful ways to manage thoughts such as mindfulness, opposite-action and paced breathing. Based on principals of Dialectical Behaviour Therapy.

24 hour post discharge caring contact call

Call to be made 24-hours post discharge- confirm patients phone number prior to discharge.

If patient does not have access to phone- confirm authorization from patient to call supports, family member, friend, CMHA worker, Outpatient, CDP, TIPP etc. (document authorization in progress notes)

Discharge to be flagged on the white board in nursing station at time of discharge

Chart to remain on unit x 48hrs to facilitate call, documentation and tracking

Calls to be placed on day assignment sheet by night shift unit lead

Post discharge Follow up Phone Call Script (Patient Version)

This form reinforces the information provided to the patient at discharge. The patient's discharge information (ie: coping plan) should be available to the interviewer at the time of this call.

CALLER: Hello Mr./Ms. _____. I am [caller's name], a [type of clinician] from Parkwood Institute Mental Health. You may remember that when you left, your clinician [name of clinician], mentioned you'd receive a call checking in on things.

I am calling to see how you are doing, and see if there is anything I can do to help you.

Do you have all the medications that you were prescribed?

If so, are you having any troubles taking them as prescribed?

Did you receive a copy of your coping plan?

Have you needed to refer to your coping plan?

Are you aware of your follow up appointments?

What are your plans for the day?

Learning the Basics about Suicide

What is Suicide?

- Suicide means that someone ends their life on purpose
- Many people who die by suicide or attempt suicide may not really want to end their life
- Suicide may seem like the only way to deal with difficult feelings or situations

Who Does it Affect?

- Globally – close to 800,000 lives are lost every year to suicide
- In Canada, 4000 people/year die by suicide
- Females are 3-4 times more likely to attempt suicide
- Males are more likely to die by suicide

Myths About Suicide

"If someone is really suicidal, they are probably going to kill themselves at some point no matter what you do."

This is FALSE!

- Multiple studies have found that **>90%** of attempt survivors, including those who make highly lethal attempts, **do not go on to die by suicide**
- Most people are suicidal only for a short amount of time
- So, helping someone through a suicidal crisis **can be life-saving**

Myths About Suicide

"Asking a depressed person about suicide may put the idea in their heads."

This is FALSE!

- Does **not** suggest suicide, or make it more likely
- Open discussion is more likely to be experienced as relief than intrusion
- The risk is in not asking when appropriate

Myths About Suicide

"If you stop someone from killing themselves one way, they'll probably find another."

This is FALSE!

"Means safety" – reducing a suicidal person's access to highly lethal means – has strong evidence as an effective suicide prevention strategy

Communicating About Suicide

- Clear, direct and safe language
- Avoid terms with a negative or accusatory language (such as “committed”)

  “Words matter in a world where silence or insensitivity can make matters worse” (Public Health Agency of Canada, 2018)

- People want to be asked

Zero Suicide

Zero Suicide Model

- A **quality improvement initiative** to lay the groundwork for **system-wide improvement** in suicide prevention and care/management
- Focus is **identifying and preventing suicide** across the community by destigmatizing language and building comfort in asking about suicide
- Began at St. Joseph's Healthcare in London in 2016; currently spreading across Canada

Zero Suicide Initiative

Zero Suicide is a Commitment…

- To make suicide a “never event”
- To ensure client safety
- To train and support staff to do the demanding work of treating clients with thoughts of suicide

Why Zero Suicide?

In the month prior to dying by suicide:

- 45% were seen by their primary clinician
- 10% presented to the ER
- 30% were seen by a mental health care clinician

What's involved with Zero Suicide?

- Suicide Risk Screening/Assessment
  - Screening and assessment tools
- Risk Formulation
  - Warning signs, risk factors, protective factors, mental status exam, access to lethal means
- Suicide intervention
- Safety Planning

Next Steps:

Review of Training Available and Used in Canada

Adapted from: Choosing a Suicide Prevention Gatekeeper Training Program – A Comparison Table (*Suicide Prevention Resource Center, July 2018).*

In-Person only:

- LivingWorks safeTALK
- LivingWorks Applied Suicide Intervention Skills Training (ASIST)
- Mental Health First Aid (Basic Couse)
- Question, Persuade, Refer (QPR)
- Student Support Network (SSN) (For post-secondary education settings)
- Working Minds: Suicide Prevention in the Workplace

Online only:

- LivingWorks Start
- Trauma Informed Care (VIRTUAL)
- Kognito Suicide Prevention Simulations – Educators (Elementary, Middle, High School, and University/College), College and University Students, Friend2Friend
- QPR Online Gatekeeper Training
- Counselling on Access to Lethal Means (CALMS)
- Sources of Strength

Online and/or In-Person:

- Suicide Awareness: An Introduction for Crisis Responders
- Mental Health First Aid (Standard)

Suicide Prevention Training

Potential Community Training Opportunities

Organization	SafeTALK	ASIST
Shelters	All Staff Youth	Staff lead Supervisors
Food Banks/ Community Hubs	All Staff All volunteers	Management Supervisors Staff leads
Youth Programs	All Staff	Supervisors Managers
Employment Services	All staff	Managers Supervisors
Public & School Transit	All drivers Terminal Staff Office staff	Management
Schools & Education Centres	All teaching staff Support staff Administration Maintenance and facilities	Principals CYW & Support staff Academic Advisors
Mental Health & Addiction Services	Case Workers Counsellors Child and Youth Workers Administration Staff Facilities and maintenance staff	All Staff working directly with clients
Service Ontario Centres	All staff	Managers Supervisors
Medical Staff &First Responders	All first responders Telephone responders Maintenance staff Administration staff	All first responders All telephone responders
Senior Facilities & Community Centres	All staff Support staff Administration staff	Managers Supervisors Team leads
Veterinary clinics and Animal Shelters	Veterinary assistants Administration Volunteers	Managers Supervisors

ZERO SUICIDE DATA ELEMENTS WORKSHEET

Description and Instructions

This worksheet is intended to assist organizations in developing a data-driven, quality improvement approach to suicide care. The worksheet:

- Reflects the top areas of measurement that organizations should strive for to maintain fidelity to a comprehensive suicide care model.
- Includes a list of supplemental measures that organizations may want to consider. These measures are significant to suicide care but may be much harder to measure.

The **Data Elements Worksheet** should be completed every three months, and an evaluation team should use the findings to determine areas for improvement. The data elements included on the worksheet can be captured in an electronic health record to allow data to be tracked and compared over time.

Please note: The Zero Suicide Initiative is an evolving model. While each individual component of the model reflects best practices in care, referral and/or treatment, we understand that variations will occur in delivery and setting. However, it is vital to measure organizational practices and client outcomes and to begin to create a shared understanding of what it takes to reduce suicides for those receiving services in your organization.

Use the **Zero Suicide Data Elements Worksheet** in conjunction with the **Zero Suicide Organizational Self-Study** and your **Zero Suicide Work Plan** to determine where improvements can be made in care, training, and policies. We recommend that you collect data on items 1–8 below and also offer several supplemental measures for your consideration.

Please note that this document has been adapted from the Suicide Prevention Resource Centre's Data Elements Worksheet, version 4.7.15. This version does not constitute endorsement by the EDC. The original copy can be found: https://zerosuicide.edc.org/resources/resource-database/zero-suicide-data-elements-worksheet

Terminology

Case closed: Cases are considered closed when a person has not had a kept appointment in six months and does not have an appointment scheduled in the future. To count suicide deaths for those receiving services, we suggest a rule that uses (1) the case closing date and (2) the time since the last kept appointment. Under such a rule, a suicide would not count if it occurred more than 30 days after a case was closed. But even if a case had been closed fewer than 30 days, or it was still open, the suicide would not be counted if it had been more than 180 days since the last face-to-face contact and there were no pending appointments at the time of the event.

Enrolled in care: A client enrolled in care is anyone with an open case file, who was admitted as a client, or who has been seen at least once face to face.

Open case file: A case is considered open at the point of intake or first contact, regardless of whether the person is formally receiving services. It is assumed that the screening, assessment, safety plan, and lethal means discussions will take place at the time of this intake or soon thereafter. If the client is not immediately referred due to a delay in appointments with a regulated health professional, psychiatrist or another similar barrier, the case is still considered an open case file as of the first contact.

Per 10,000 population: Statistics around the prevalence of conditions or risk are often shown as "per 10,000 people". For rate of suicide death, we recommend using the 'per 10,000 people' measure. For example, if 25 of the 4,500 people who were enrolled in your organization died from suicide in the last three months, the calculation is: 25 / 4,500 = .00555 * 10,000 = 55.5 per 10,000 people.

Risk assessment: A suicide risk assessment is typically performed after an individual scores as 'at risk' on a suicide screen. Suicide risk assessment usually refers to a more comprehensive evaluation done by a regulated health professional to confirm suspected suicide risk, estimate the immediate danger to the patient, and decide on a course of treatment. Although assessments can involve structured questionnaires, they also can include a more open-ended conversation with a client and/or supports (with consent) to gain insight into the client's thoughts and behavior, risk factors (e.g., access to lethal means or a history of suicide attempts), protective factors (e.g., immediate family support), and medical and mental health history.

Safety plan development: Safety plans should be developed at the time of screening and/or assessment when it is determined that a client is at risk for suicide. While a safety plan may be updated and routinely monitored with the client, only the initial safety plan should be counted in this metric.

Screening: Suicide prevention experts usually use the term suicide screening to refer to a procedure in which a standardized instrument or protocol is used to identify individuals who may be at risk for suicide. Screening tools are brief questionnaires that measure the individual's suicide risk. With regard to measuring screening rates, each client is assumed to be screened only once. While this may not be the case in your organization, do not count additional screenings on any client in your total. Screening to determine that a person is at risk for suicide can occur during intake or at any point later during service provision.

Suicide attempt: Suicide attempts should be carefully and consistently defined by your organization and staff. For guidance on how to classify suicide behaviors, please see http://www.cdc.gov/violenceprevention/suicide/definitions.html.

Suicide care management plan: The suicide care management plan is an organization-wide care management plan, or pathway to care, that your organization develops to ensure that all individuals at risk for suicide receive timely, continuous, and effective suicide care services. An individual should be placed on a suicide care management plan as a result of being

screened and assessed positive for suicide risk. Please see the Engage section of our online toolkit for more information about developing a suicide care management plan, available at www.zerosuicide.com.

Other Key Definitions:

Care: Originally developed for the health care sector, the term '*care*' is frequently cited in this document. Because care is provided in many capacities, we encourage you to think about this term more broadly as service provision as it relates to responding to and managing suicidality.

Client: The term *'client'* can be broadly applied to those in which the organization provides service to, including a: individual, patient, resident, service user, customer, colleague, employee, or staff.

Documentation: The term 'documentation' refers to written/electronic communication.

Lethal means restriction: People who attempt suicide do so with a variety of methods, or '*means*' (e.g. overdose, firearm). The term "lethal" is important because some methods are more harmful or destructive than others. Restricting and reducing access to lethal means (e.g. safe dosages of medication at home, removing/locking up a firearm) is one of the most successful strategies in preventing suicide.

Non-residential Setting: Individuals who may be at risk for suicide are provided services with no potential for overnight stay.

Organization: The term *'organization'* is meant to represent the service that works alongside other people and is seeking to improve suicide prevention and may be broadly applied to: agencies, services, institutions, places of work, communities of worship, interest groups, etc.

Regulated Health Professional: A Regulated Health Professional (RHP) is a health care provider that is accountable to a regulatory college which ensures that they deliver health services in a safe, professional and ethical manner. RHP's are accountable for ensuring they have the knowledge, skill and judgment required of their practice. The roles typically involved in mental health care include: Registered Social Worker, Registered Nurse/Practical Nurse, Physician, Nurse Practitioner, Pharmacist, Psychologist, Psychotherapist, and Occupational Therapist. **A non-regulated professional** refers to any other employee/staff member.

Residential Setting: Individuals who may be at risk for suicide have potential to stay overnight or for a period of consecutive nights.

Treatment: For the purpose of this document, *'treatment'* refers to evidence-based management and care for a mental illness or suicidality (including psychotherapy) that can only be provided by a Regulated Health Professional.

Today's date: _____

Three-month reporting period (DD/MM/YY to DD/MM/YY): _____

Name of organization: _____

Name of person completing worksheet: _____

Recommended Measures:

	Measure	Numerator		Denominator		%
1	Screening	Number of clients who received a suicide screening during the reporting period		Number of clients enrolled during the reporting period		
2	Assessment	Number of clients who screened positive for suicide risk and had a comprehensive risk assessment (same day as screening) during the reporting period		Number of clients who screened positive for suicide risk during the reporting period		
3	Safety Plan Development	Number of clients with a safety plan developed (same day as screening) during the reporting period		Number of clients who screened and assessed positive for suicide risk during the reporting period		
4	Lethal Means Counseling	Number of clients who screened and assessed positive for suicide risk and were counseled about lethal means (same day as screening) during the reporting period		Number of clients who screened and assessed positive for suicide risk during the reporting period		

	Measure	Numerator	Denominator	%
5	Missed Appointment Follow-up	Number of clients with a suicide care management plan who missed a face-to-face appointment and who received contact within 8 hours of the appointment during the reporting period	Number of clients with a suicide care management plan who missed a face-to-face appointment during the reporting period	
6	Acute Care Transition	Number of clients who had a hospitalization or emergency department visit who were contacted within 24 hours of discharge during the reporting period	Number of clients who had a hospitalization or emergency department visit during the reporting period	

	Measure	Numerato	Denomina tor		Rate
7	Rate of Deaths by Suicide Among ALL Clients	Number of clients who died by suicide during the reporting period	Number of clients enrolled for services during the reporting period (e.g., open case files) regardless of when they were last seen	**(Numerator/ Denominator) x 10,000**	**Per 10,000 population**

8	Rate of Suicide Deaths Among Those with Identified Suicide Risk	Number of clients with a suicide care management plan who died by suicide during the reporting period		Number of clients with a suicide care management plan during the reporting period		**(Numerator/ Denominator) x 10,000**	**Per 10,000 population**

Supplemental Measures for Consideration:

	Measure	Numerator		Denominator		%
9	Emergency Department Usage	Number of clients who went to the emergency department for making a suicide attempt who had a suicide care management plan during the reporting period		Number of clients who had a suicide care management plan during the reporting period		
10	Inpatient Admissions	Number of clients who were admitted for an inpatient psychiatric stay for making a suicide attempt who had a suicide care management plan during the reporting period		Number of clients who had a suicide care management plan during the reporting period		

	Measure	Numerator		Denominator			Rate
11	Suicide Attempt Rate Among ALL Clients	Number of clients who made a suicide attempt during the reporting period		Number of clients enrolled for services during the reporting period (e.g., open case files) regardless of when they were last seen		**(Numerator/ Denominator) x 10,000**	**Per 10,000 population**
12	Suicide Attempt Rate Among Those with Identified Risk	Number of clients with a suicide care management plan who made a suicide attempt during the reporting period		Number of clients with a suicide care management plan during the reporting period		**(Numerator/ Denominator) x 10,000**	**Per 10,000 population**

NOTES