

ZERO SUICIDE

in Your Community:

An implementation
guide for community
organizations



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How to cite:

Van Berkum, A., Graf, S., Sluys, K.,
Cino, K., & Hicks, S. (2021). Zero Suicide
Community Implementation Toolkit.

Acknowledgments:

The development of this Toolkit was made possible through the input, feedback, and guidance of the Education Development Centre and the Suicide Prevention Resource Center and many subject matter experts.

The authors would also like to sincerely thank their employers, affiliated foundations, and public and private parties who have helped to fund suicide prevention work. Further, the leadership teams, fellow staff members, students, volunteers, and patient/client and families have all been instrumental in contributing to the experiences the authors have learned from and described throughout this Toolkit.

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EXECUTIVE SUMMARY

Suicide prevention is a global public health concern and system wide collaboration that involves community organizations is essential to prevent death by suicide. The World Health Organization (2021) reports that:

More than **700 000 people** die by suicide every year, which is **one person every 40 seconds.**¹

There are indications that for each adult who died by suicide there may have been more than **20 others** attempting suicide.¹

Suicide accounted for **1.3% of all deaths worldwide**, making it the **17th leading cause of death** in 2019.

This Toolkit has been designed specifically to support organizations that are not a formal part of the health care sector access tools to enhance suicide prevention. The information presented follows an adapted version of the Zero Suicide Toolkit which was originally designed by the Education Development Centre for health care settings. As you flip or scroll through the pages, you will also notice that this Toolkit guides you through principles of project management and shares experiences of two health care organizations that implemented Zero Suicide. It is our hope that this Toolkit will be practical and expand the potential for suicide prevention within your organization and for the clients you serve.

The Toolkit is divided into sections based on the Plan-Do-Study-Act cycle of project management. Below is a summary of each section:

Introduction

This section of the Toolkit includes an introduction to suicide in Canada and the Zero Suicide framework. You will read an overview of the Zero Suicide implementation at St. Joseph’s Health Care London and Niagara Region Mental Health. You will begin to explore what Zero Suicide implementation could look like at your organization.

Plan 1.0

In the Plan 1.0 section of the Toolkit, we address and review project management principles including a current state analysis. Readers will learn about project planning tools, such as creating a project charter and plan. You will also be introduced to community-adapted Zero Suicide tools: Organizational Self Study and Workforce Survey.

Plan 2.0

The Plan 2.0 section will focus on incorporating best practices, guiding philosophy of care, and staff mental wellness. It will also introduce the Suicide Care Management Plan, including suicide risk assessment and interventions. Finally, planning regarding staff education and project evaluation is explored.

Do

This section of the Toolkit focuses on implementing your chosen suicide prevention strategies. This includes reviewing policy and/or procedure(s), as well as suicide screening tools, risk assessment, and interventions (including safety planning). The focus then shifts to providing staff education, key implementation considerations, and your contribution to building suicide safer communities.

Study

The Study section will focus on project evaluation and data reporting. Regarding project evaluation, common approaches will be introduced which include client outcomes, staff competency, and fidelity to the Zero Suicide framework. Several graphs and charts are presented that outline Zero Suicide data results and trends from the author organizations.

Act

The Act section of the Toolkit will review some key strategies for quality improvement, implementation spread, and sustainability. Zero Suicide promotes creating a culture of continuous quality improvement. This includes refining your project plan (including a sustainability plan), addressing organizational spread, and knowledge translation. Finally, this section will review project close out and a conclusion to the Toolkit.

Important Note About Language:

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

When talking about suicide, it is important to use clear, direct, factual, and safe language. This includes using “people-first” language (such as, “person thinking about suicide” or “people who have experienced a suicide attempt”) and avoiding terms with a negative or accusatory language (such as “committed”).

Using helpful and respectful language can reduce stigma and encourages us to talk openly about suicide. This also encourages others to reach out for help.

Key Terminology:

Suicide: A fatal self-injurious act with some evidence of intent to die

Suicidal behaviour: Ranges from thoughts of suicide to suicide attempts to death by suicide

Suicide attempt: A potentially self-injurious behaviour associated with some intent to die

Active thoughts of suicide: Thoughts about taking action to end one’s life, which may include: identifying a method, having a plan, and/or having intent to act

Passive thoughts of suicide: Thoughts about death, or wanting to be dead without any plan or intent

[Language Matters: Safe Communication for Suicide Prevention](#)

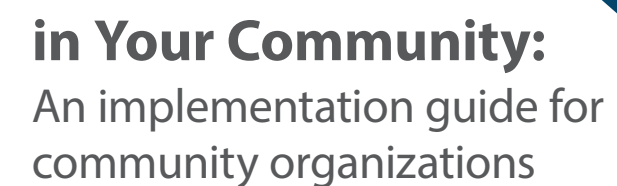
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Introduction

INTRODUCTION

Welcome to the **Zero Suicide in Your Community: An implementation guide for community organizations**. You are about to embark on some incredible and lifesaving work.

This Toolkit has been designed specifically to support organizations that are not a formal part of the health care sector access tools to enhance suicide prevention. The information presented follows an adapted version of the Zero Suicide Toolkit which was originally designed for health care settings. As you flip or scroll through the pages, you will also notice that this Toolkit guides you through principles of project management and shares experiences of two health care organizations that have implemented Zero Suicide. It is our hope that this Toolkit will be practical and expand the potential for suicide prevention within your organization and for the clients you serve.

A few notes about using the Toolkit:

- Each section of the Toolkit will follow a similar format, beginning with an overview of what the section will cover and a list of resources we encourage you to have on hand (or screen!).
- Despite our best efforts to adapt the Zero Suicide framework and associated resources for non-health care settings you may still occasionally notice “health care related language.” As we continue to embark on tool adaptations the Suicide Prevention Resource Centre, new iterations and changes to these resources will be made.
- The Zero Suicide framework and many of its suggested evidence-based practices were evaluated in health care settings. We encourage you to think about the unique context of your organization, adapting content in meaningful and safe ways when deemed necessary (e.g., culture, age, gender identity, ethnicity, etc.). We also encourage you to embark on your own research evaluation (covered in this Toolkit), so that you can contribute to this emerging body of knowledge. Community organizations have a very important role to play in suicide prevention, and recognizing how your organization can contribute to this comprehensive work helps contribute to the broader public health goals to reduce and eliminate suicide. [A Comprehensive Approach to Suicide Prevention | Suicide Prevention Resource Center \(sprc.org\)](#)
- Please note, some of the training and resources listed throughout the Toolkit have a cost attached/for profit. We hope you find the best resources that fit your organization.
- This Toolkit will undergo updates at regular intervals based on community organizations’ feedback and as changes in data and evidence-based practice are updated. Please check the [Niagara Region Public Health](#) frequently to ensure you have the most up to date version.

With that, let’s get started.

In this section of the Toolkit we will review:

- An Introduction to Suicide in Canada and the Zero Suicide Framework
- Zero Suicide at St. Joseph’s Health Care London
- Zero Suicide at Niagara Region Mental Health
- Zero Suicide at Your Organization

Resources to have on hand (or screen!):

Zero Suicide Toolkit website: <https://zerosuicide.edc.org/toolkit> (Note: spend some time exploring this website and bookmark or save as a “Favorite” on your browser- you will be here often!)

Zero Suicide Toolkit website > Lead > [Quick Guide to Getting Started with Zero Suicide](#)

An Introduction to Suicide in Canada and the Zero Suicide Framework

Suicide has been recognized as a public health priority throughout North America. In Canada, suicide is the ninth leading cause of death overall, and the second leading cause of death among youth and young adults (15-34 years).¹

An average of 10 people die each day by suicide and another 210 will attempt.¹

7-10 people are profoundly affected by each suicide loss.¹

Populations experiencing inequalities are disproportionately impacted by suicide.²

Unfortunately, a lack of standardized suicide prevention and treatment has led to poor outcomes across communities.^{3,4} Numerous studies have found that upwards of 83% of those who die by suicide were involved with the health care system in the year before their death⁵⁻⁸ – signifying that referral to health care provides an opportunistic time for health care providers to intervene with individuals at risk of suicide. However, even despite best efforts, not all deaths by suicide are preventable. Evidence suggests that a large proportion of people having thoughts of suicide do not seek help.^{9,10} What we can do as a community, is be better prepared to recognize those at risk, and support people in seeking and receiving help.

In 2001, the Henry Ford Behavioral Health System in Detroit, Michigan, pioneered a vision of “Zero Suicide”. As a large mental health organization that serves individuals with acute and serious mental illness, the application of evidence-based suicide prevention practice led to a 75% reduction in the rate of death by suicide.¹¹ Another large organization, Centerstone, demonstrated a reduction in suicide deaths from 35 per 100,000 to 13 per 100,000 clients after implementing Zero Suicide for 3 years.¹² These promising results led to the National Action Alliance for Suicide Prevention creating and developing a systems-based framework for suicide care: **Zero Suicide**.

The name “Zero Suicide” sets an aspirational goal for suicide prevention, focused on the premise that **one life lost is one too many**. This does not mean that suicide deaths will not occur, and it does not mean that staff are to blame or are not doing the demanding work of suicide prevention.



Image: Suicide Prevention Resource Centre, (2018)¹²

Fundamental to the Zero Suicide framework is a multi-level system strategy/approach on suicide prevention, comprised of three core elements:¹³

- 1) An organizational commitment to the aspirational goal of zero suicide deaths;
- 2) A direct approach to suicidal behaviors; and
- 3) Continual improvement of the quality and safety of care processes.

Zero Suicide represents a culture shift away from fragmented suicide care, and strives towards a holistic and comprehensive approach to client safety and quality improvement.¹² The framework also aims for safety and support for the staff who do the difficult work of caring for and treating clients who are suicidal.¹²

The Zero Suicide framework was designed for health and behavioral health care settings and includes seven core elements:



Image: © 2020 Zero Suicide Institute at EDC.

The totality of the seven elements of the Zero Suicide framework contribute to its effectiveness by incorporating use of evidence-based tools, systematic practices, training, and embedded workflows to ensure safe, quality care.¹²

Despite the fact that suicide prevention is a core responsibility of mental health and non-mental health care,¹² evidence suggests that the majority of people who experience suicidality do not ask for help in these formalized settings.^{9,10} Suicide impacts people everywhere- in their homes, workplaces, schools, places of worship, and beyond. For this reason, our communities are important settings for suicide prevention.¹⁴ With the exception of the Zero Suicide framework’s fifth element (i.e. “Treat”), community organizations can adopt the six remaining elements of the framework. The authors of this Toolkit, suggest that community partners who are not formally part of the health care sector consider reframing element five, “Treat” to “Referral to Effective Treatment”.

While the Zero Suicide framework originally focused on health care settings, we believe that suicide prevention is everyone’s responsibility. Our hope is that your organization will use this Toolkit to become part of the collective, system-wide effort to prevent suicide.



Image: International Association for Suicide Prevention (IASP) (2020).¹⁵



Zero Suicide at St. Joseph's Health Care London

The first Zero Suicide Initiative in Canada was launched at St. Joseph's Health Care London (St. Joseph's) in July 2016. St. Joseph's is a five-site tertiary care organization located in a mid-size urban city and is a leading client care, teaching, and research centre. Services include day/short stay surgery; complex, chronic disease management; specialized mental health care; rehabilitation; complex continuing care; palliative care; long term care; and veteran's care. Implementation of the Zero Suicide Initiative began with mental health programs and components of the framework have been expanded to other non-mental health care areas.

St. Joseph's values of respect, excellence, and compassion were embedded throughout the Zero Suicide Initiative. The organization embraces each client's unique life journey and values the lives of those who receive care with an evidence-based platform to assess, treat, and prevent suicidality. Suicide prevention is a corporate priority and at St. Joseph's, we believe that, *"Patients experiencing suicidality deserve the best we have to offer"*.¹⁶

"Suicide is a major public health issue in Canada and Southwestern Ontario. In spite of our dedication to provide care to individuals at risk for suicide, our own three-year case series of consecutive deaths by suicide (from 2012-2014) in Southwestern Ontario indicated that the majority of individuals who died by suicide (75%) had, had contact with mental services, over half of the decedents (51%) had a previous admission to a mental health unit and two-thirds (67%) of individuals who died by suicide had consulted their primary care physicians prior to their deaths. Although our health and mental health professionals were providing care to these individuals, they were still dying by suicide. In Detroit, during my tenure as Chief of Psychiatry at St. Joseph's, the Zero Suicide approach had been developed with the aim of improving care for individuals at risk of suicide in health and mental health care systems.

The approach relies on a system-wide tactic to improve outcomes and close gaps rather than on the heroic efforts of individual health professionals. This quality improvement initiative has crucial core components at three levels: a direct practice level that focuses on identifying the risk of suicidal behavior and necessitates treating the risk of suicide behavior as a distinct syndrome using best practice interventions; a process level related to quality and safety improvement to provide accessible, reliable, and continuous care to patients; and an organizational level that promotes a safety culture and a system-wide commitment to the aspirational goal of zero suicides.

We felt Zero Suicide held great promise to improve the care of patients treated at St. Joseph's. Our organization boldly became a Canadian leader in asserting that suicide deaths for individuals under care within health and mental health systems are preventable and seeking for zero deaths by suicide."

- Dr. Paul Links, St. Joseph's Zero Suicide visionary and advocate

To date, some key outcomes from the Zero Suicide Initiative at St. Joseph's include:

- Improved confidence and competence of clinicians.
- Improved confidence and competence of clinicians caring for those at risk of suicide.
- Effective policies and procedures on suicide prevention, assessment, and interventions.
- Clients and families have provided positive feedback on the Zero Suicide Initiative.



Zero Suicide at Niagara Region Mental Health

In early 2019, the Niagara region was unfortunately in the midst of responding to a cluster of suicide deaths at a particular location. On average, the Niagara region experiences one suicide death every nine days, and 11% are youth between the ages of 10-24 years old. Amidst a volume of media attention, Niagara Region Mental Health (NRMH) responded, having suicide prevention recently become a priority in 2018. NRMH serves its residents, businesses, and visitors through leadership, partnership, and community focused services while adhering to the values of respect, service, honesty, choice, and partnerships. Aligning with the organization's mission and values, community need, and collaboration with St. Joseph's London, the Zero Suicide Initiative at NRMH began. The Initiative began with a focus on implementing a standardized suicide screening tool in the Electronic Medical Record (EMR), training the workforce, creating structures to support staff in suicide prevention, and developing a collaborative implementation evaluation plan.

While the comprehensive evaluation is still to come, early outcomes are promising:

- Staff report greater confidence and comfort when assessing suicide risk.
- Suicide risk has been identified by the Columbia Protocol in several cases, and led to appropriate intervention.
- Positive feedback from clients, such as, *"You saved my life"*.

The next phase of NRMH's Zero Suicide Initiative has led to ongoing collaboration with St. Joseph's to develop this Zero Suicide Community Implementation Toolkit with the intent to extend the framework into communities to ensure the safety of individuals at risk of suicide.

Zero Suicide at Your Organization

Why get involved?

- 1) Become part of a universal and system-wide approach to prevent suicide.
- 2) Help eliminate the stigma associated with talking about suicide.
- 3) Establish safety at the core of any organization, workplace, and community.
- 4) Staff gain critical skills in suicide prevention.
- 5) Help people who are struggling find hope and recovery.



Image: Coco Masuda. [Illustration Source](#).¹⁷

If your organization is ready to begin this lifesaving work, then let's get started!

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Plan 1.0

PLAN 1.0

Having been introduced to the importance of suicide prevention and the Zero Suicide framework, we will now begin the Planning phase of your project implementation. The process of planning is important, and helps to create the vision of what you hope to accomplish.

In this section of the Toolkit we will address the six W's: Who, What, Where, When, Why, and What If, and review:

- Project Management 101
- Current State Analysis
- Organizational Self Study
- Workforce Survey
- Project Planning Tools
- Project Charter
- Project Plan

Resources to have on hand (or screen!):

- Zero Suicide Toolkit website: <https://zerosuicide.edc.org/toolkit/zero-suicide-toolkitsm>
- Zero Suicide Toolkit website > Lead > [Zero Suicide Work Plan Template](#)

Project Management 101

Many of you will have varying degrees of project management education or experience. This Toolkit aims to help guide you through some basic project management steps to enhance suicide prevention strategies in your workplace. If you don't have any formal education or experience, don't fret. As you work through the Toolkit, the authors intend to help simplify the project's implementation. Before you go any further – an important first step is to recognize and accept that there will be unknown and unexpected challenges throughout the implementation. As such, the authors will share some of their own experiences as “lessons learned” so that we can learn from one another in our endeavours of quality improvement.

Before we get started, let's look at some **key terms** outlined by the Project Management Institute:¹

- Project: A temporary endeavour undertaken to create a unique product, service, or result.
- Project management: Application of knowledge, skills, tools, and techniques to project activities to meet the project requirements.

...and some **key points**:

- A project should be well defined in terms of timelines, scope, and resources
- Develop a diverse and skilled project team (more on [page 20](#))
- Consider use of project management tools (more on [pages 30-31](#)), including the [Zero Suicide Work Plan Template](#)
- Make use of a project management process. You will notice that we've designed this Toolkit with the Deming Cycle (i.e. Plan, Do, Study, Act) framework to guide your project implementation

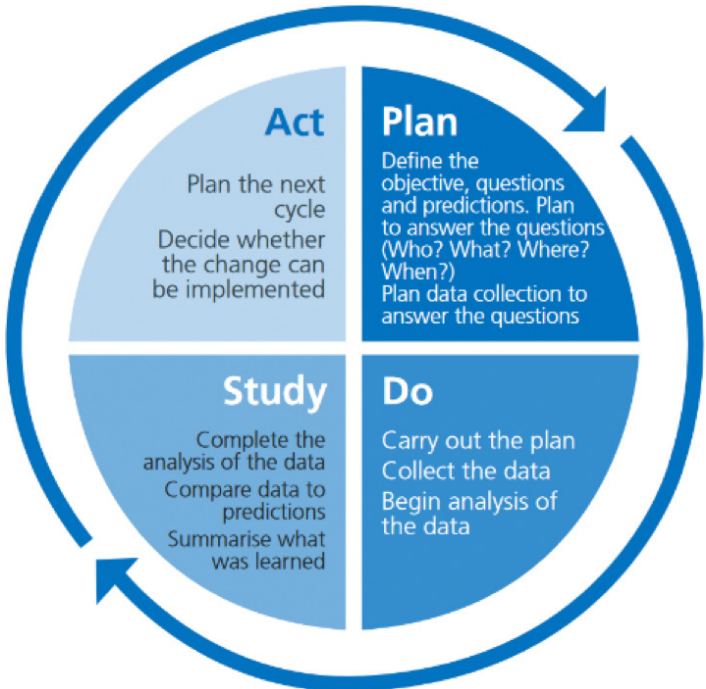


Image: Project Management Guide²

❑ Identify the **WHO (team):**

First up, we recommend that you consider who will make up your suicide prevention project team.

Who will authorize the project? **Who** will be the project’s leader/sponsor?

- 1. _____
- 2. _____

Who will make up the project team?

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____



Consider who is skilled, passionate about, and has capacity to lead this work. At St. Joseph’s the project team is made up of a:

- 1) Project Lead;
- 2) Clinical & Project Support Lead (peer) and;
- 3) Project Support Analyst (Appendix A: Role Descriptions)

If applicable, **who** will make up the Steering Committee (i.e. those who help make formal project decisions)?

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____



The Steering Committee should have diverse membership. At St. Joseph’s this includes the project team, senior leadership, and someone with lived experience, including someone who has been closely impacted by a death by suicide.

At Niagara Region Mental Health this includes a program manager, psychiatrist, and staff from each service team.

Please see [page 54](#) of the Plan 2.0 section to learn more about involving those with lived experience of suicide.

Next, we recommend you schedule weekly 60-90 minute meetings with your project team to work through the remaining elements of this Toolkit.

Meeting	Focus	Your scheduled meeting date and time:
1	Current State Analysis (Pg. 3-5)	
2	Organizational Self Study (Pg. 6)	
3	Define: Why, What, Where, When, and Who Else (Pg. 7-10)	
4	Workforce Survey (Pg. 11)	
5	Determine: What If (Pg. 12-13)	
6	Develop: Project Charter (Pg. 13)	
7	Develop: Project Plan (Pg. 14)	

Current State Analysis

Current state analysis refers to an understanding of an organization’s progress towards a particular benchmark. For example, if the benchmark is “create a more suicide safe environment”, the current state analysis would include identifying where your organization is in terms of meeting this goal. One major benefit of taking meaningful time to understand the organization’s current state, is that you can also complete a parallel “gap analysis”. Recognizing the gaps (i.e. what may hinder/create a barrier to achieving your goal) will help inform your roadmap to achieving your project goals.

With your project team, briefly jot down your organization’s goal(s) as it relates to suicide prevention, management, and/or intervention, as well as some predicted gaps or obstacles in meeting these goals(s).

Goals	Gaps
E.g. Have all staff trained in suicide prevention	E.g. Limited staff education time/budget
1.	
2.	
3.	

TIP:

There are helpful online tools that can help identify gaps, problems, or root cause analysis such as the A3 template and the Fishbone Diagram.

A current state analysis is one of the most important first steps in a project, especially in our fast-paced, evolving, and fluid work environments. Those leading a project may perceive that they know the systems, processes, and environments of an organization well, but this is often not the reality when we consider how many perspectives make up the whole. Most organizations have diverse systems, processes, and cultures that are inherent in different service areas. Completing the current state analysis will initiate organizational participation early on, ensure that the project meets the true needs of the staff and clients, and provides opportunities to prevent potential issues.

Not completing the current state analysis with the justification of not wanting to uncover issues or starting the project faster will actually cost you more time during the implementation (“Do”) phase. Let us share some examples:



With the intention of being innovative and staying current, the Zero Suicide team at St. Joseph’s moved quickly in building the suicide screening tools in the Electronic Health Record (EHR). Without a clear understanding of the EHR’s functionality to build the tool, there have been ongoing challenges with the data collection process, and unanticipated educational requirements for staff.



Analysis of St. Joseph’s current state of suicide screening helped to inform organizational opportunities for improvement, including suicide screening data collection and reporting. Sound data informs project management, progress, and reporting.

Activity:

With your project team, ask someone to record the group members’ responses to the following questions about suicide:

- Are there federal, provincial, and municipal statistics on suicide deaths/hospitalizations (for suicide attempt, suicidal ideation, and self-harm events)? (Tip- public health units often report on municipal suicide deaths).
- Who are “at-risk populations” for death by suicide in your community?
- How does your community talk about suicide? Respond to a suicide death?
- What are unique risk factors that affect at-risk populations in your community (e.g. culture, race, social determinants of health, etc.)?
- Are there unique protective factors in your community?
- Are there other organizations/committees invested in/working towards suicide prevention?
- Where and how do clients currently access support when in crisis?

Risk factors: Modifiable or non-modifiable characteristics of a person or their environment that increase the likelihood that they will die by suicide (e.g. financial difficulties, previous suicide attempt).

Protective factors: Factors that may mitigate the risk of suicide (e.g. supportive relationships, future goals, effective health care).

Next, we will shift to learn more about the current state of suicide prevention within your organization. There are two important Zero Suicide tools developed to further inform your current state analysis:

- 1) Organizational Self-Study for Non-Healthcare Organizations
- 2) Workforce Survey for Non-Healthcare Organizations

Both of these tools have been adapted for non-healthcare settings, so please ensure you have the correct version.

We recommend you send the Organizational Self Study for Non-Healthcare Organizations to the project team members and other staff you wish to participate. Ask them to complete this independently prior to your next meeting.



Zero Suicide Organizational Self Study for Non-Healthcare Organizations
(Appendix B)

The Organizational Self Study is used early in the launch of a Zero Suicide Initiative to assess organizational strengths and weaknesses and to develop goals and a work plan. The Organizational Self Study should be completed by the project team and with the input from other staff.

Having each worked through the Organizational Self Study for Non-Healthcare Organizations independently, you can then review the questions as a project team. We encourage you to discuss differing responses amongst your team, and select a score that the majority of you agree best represents your organization’s current state. Some organizations will only complete the tool collaboratively with the project team (and not independently), allowing for group consensus- this is where the value truly lies with this tool.



St. Joseph’s key learning from the Organizational Self Study:

- The use of assessment tools and safety plans were inconsistent. Current practices relied on clinician and physician discretion, yet provided no formal or standard training on screening, assessment, lethal means restriction, safety planning, or suicide management plans.
- The Patient and Family Councils had not yet been involved in decision making processes related to suicide care.



Checkpoint:
Organizational Self Study for Non-Healthcare Organizations complete ☐

Next Step:

Now that you have completed the Organizational Self Study for Non-Healthcare Organizations, we recommend that you access the Zero Suicide Toolkit website > Lead > [Zero Suicide Work Plan Template](#). You can utilize this in conjunction with this Toolkit throughout your implementation.

❑ Define your organization’s **WHY**:

Now that the Organizational Self Study for Non-Healthcare Organizations is complete, let’s spend some time digesting what you have learnt about your organization, and continue identifying the 6 W’s of your project.

Why does this project (focused on suicide prevention) matter to your organization?

(Note: Consider organizational goals as well as the mission, vision, and values.
What impact will this have on staff?)

Why does this project matter for the clients you work alongside?

(Note: You may wish to engage with some clients to better learn what this would mean from their perspective).

❑ Define your organization’s **WHAT**:

GOAL/OBJECTIVE:

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?

What does your organization hope to achieve with this project?

1.
2.
3.

What do you predict might happen with this project’s implementation?

❑ Identify the **WHERE & WHEN:**

What services (where) will you implement the Zero Suicide project in?

Key considerations:

- 1. **Who** are the at-risk populations that you work alongside?
Who will benefit from enhanced suicide prevention and why?
Where (e.g. which service areas) are these clients located?
- 2. Service area feasibility: priorities, resources, timing, etc.
- 3. Will this be a rolling (phased) implementation?
Or will you seek to implement the project in all target service areas at once?

At St. Joseph’s, our 5-year project was planned in 3 phases:



- 1) Pilot phase (i.e. outpatient mental health programs)
- 2) Intra-organizational implementation
(i.e. all mental health and some non-mental health programs)
- 3) Community extension and partnership

Identify where you plan to implement the project and when you intend for this to happen. Give yourself ample time to respond to delays (they will come) and to reflect between the phases of project implementation and areas you implement the project in.

Where	When

❑ Identify **WHO ELSE:**

Who are other key stakeholders and subject matter experts in suicide prevention that the project team will consult on an as needed basis?

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____



Stakeholder: One who is involved in or affected by a course of action.

Stakeholders and subject matter experts may be those both internal and external to your organization.

How will you engage those with lived expertise as key stakeholders?



At St. Joseph’s, the Patient and Family Councils have been engaged throughout the project, beginning early on in the Planning Phase. The members have contributed meaningfully to the project’s work, including presenting the idea of the Coping Plan (more on this later!) which is used for all clients within our organization today. A recent review identified that 70% of patients agreed that the Coping Plan has helped them work with clinicians to create a wellness plan.



At Niagara Region Mental Health, the Client Advisory Committee had input and involvement in the planning, delivery, and evaluation of services. This included providing advice and recommendations for high quality care provision.

Having a better understanding of “Who” and “When” for your project planning, it is time to further understand the current state of the staff training requirements with use of the Workforce Survey for Non-Healthcare Organizations.

Next step:

Before you proceed, it is time to introduce the Zero Suicide project and Workforce Survey (next!) to those staff in the service areas in which you plan to implement. You can utilize established forms of communication (e.g. e-mail, newsletter, meeting), and adapt the following: Zero Suicide Toolkit > Train > [Sample Letter to Staff about Zero Suicide Workforce Survey](#).

Zero Suicide Workforce Survey for Non-Healthcare Organizations
(Appendix C)

The Workforce Survey is a tool for assessing staff knowledge, practices, and confidence in order to determine training needs. It takes an average of 10-15 minutes for staff to complete and responses are anonymous. The Workforce Survey for Non-Healthcare Organizations should be sent to those staff who will be a part of the early project implementation/service changes. For example, if you are choosing to pilot the project with one service area first, these staff should receive the survey. We encourage you and your team to review the Zero Suicide website resources which provide tips and tricks for administering the Workforce Survey. Determine the plan for administering the Workforce Survey for Non-Healthcare Organizations, and act!

TIPS:

- We recommend completing the survey on hard copy or electronically. You can build the survey electronically into Google Surveys, which helps to populate your results.
- Check out the Zero Suicide Toolkit: Train > [Workforce Survey](#) AND > [Guidelines for Administering the Workforce Survey](#) Remember to use the Workforce Survey for Non-Healthcare Organizations in [Appendix C](#)

Niagara Region Mental Health key learning from the Workforce Survey:

- Offer additional training to increase staff level of confidence in screening, assessment, and treatment protocols when suicide risk is identified.
- Identify a standardized and evidence-based treatment approach to treat suicidal clients and train staff accordingly.
- Implement more defined policies, procedures, and workflows for prevention, assessment, screening, treatment, and transitions in care.
- Implement a standardized tool for suicide screening and risk assessment.

Checkpoint:
Zero Suicide Workforce Survey for Non-Healthcare Organizations complete ☐

☐ **Identify the WHAT IF:**

The Project Management Institute (PMI) cites several articles that reference incomplete risk identification and management as one of the top mistakes in project implementation. “Risk” is defined in project management as “any uncertain event or condition that, if it occurs, has a positive or negative effect on a person’s objectives”.³ In other words, risk is associated with uncertainty - things may not go as planned, and that could have a good or bad impact on the project.³ Therefore, we need to be ready to expect the unexpected. Completing a current state analysis and planning your project will never capture the totality of the complex and fluid systems that we work in. The goal of risk identification and management is to maximize the positive effects of opportunities and minimize or eliminate negative threats to the project’s objectives.³

Time to brainstorm. What potential risks do you predict with project implementation? Remember, risks may yield positive or negative outcomes. For example, staff may feel uncomfortable screening for suicide and be resistant to this change, or discussion around suicide prevention may bring up opportunities to improve environmental safety.

(Note: Always a good idea to ask your key stakeholders, as they can offer diverse perspectives.)

- _____
- _____
- _____
- _____

Now, take a moment to rank these risks, #1 representing the worst impact and so forth.

The next step is to consider how you can plan to respond to these risks should they arise. How will you plan to reduce/respond to each of these risks?

Risk	Risk Response
1.	
2.	
3.	
4.	
5.	

TIP:

Change resistance amongst staff is a common risk factor in project implementation, success, and sustainability. One strategy to reducing its impact is ensuring that staff with a wide range of influence are early adopters of the project implementation. Explaining WHY the project matters and having staff personally connect to this rationale is vital to achieve their “buy in.”

Remember that new risks may present themselves throughout the entire life of the project. If a new risk does arise, spend some time thinking about potential impact and cycling back to your “current state analysis mind-set” to understand the root causes and events that led to this. With this greater understanding of what is going on, you can work to alleviate/resolve the risk.

Some tips from our experience are to: listen, be participatory throughout the project, get creative, remain flexible, and adapt! And don’t forget to document any new risks as unexpected “findings” in your implementation (anecdotal data!).

Project Planning Tools

Developing a Project Charter

Project Charter: A short document that describes your project in its entirety – including its scope, objectives, and the roles of those involved.

There are several different templates of a Project Charter on the Internet. St. Joseph’s has included a template of their Project Charter ([Appendix D](#)). The Project Charter should be developed and agreed upon as a team before developing your Project Plan.



Checkpoint:
Zero Suicide Project Charter complete ☐

Developing a Project Plan

Project Plan: Identifying, prioritizing, and assigning tasks to meet the project’s objectives.

There are several different templates of a Project Plan available on the Internet. Please feel free to explore different options, and complete one that will suit the needs of your organization. St. Joseph’s has included a template of their Project Plan ([Appendix E](#)).

Both the Project Charter and Project Plan documents should be shared with the project team and kept at your fingertips throughout your implementation.

Four key points in developing your Project Plan are:

- Ensure the development of the Project Plan is participatory;
- Develop SMART (i.e. Specific, Measurable, Achievable, Relevant, and Time-bound) goals;
- Refer to your Project Plan often to ensure you are not entering the dangerous “scope creep” project zone and;
- Document your progress along the way.

Scope creep: Refers to how a project’s requirements tend to increase over a project lifecycle. This can feel like continuous, uncontrolled growth in the project after it begins, and the deliverables or features of the project expand from what was originally outlined.⁴

On a final note, it is very important that the Project Plan addresses how you will conduct an **evaluation** of the project and ensure that it is **sustainable**. Early project management literature identified the disregard of evaluation and sustainability planning, with one article identifying this as “...so important, yet so neglected”.⁵

Evaluating a project is conducting an analysis of the goals that were completed and whether the project produced the results, expected benefits, or desired changes that were intended. We begin developing the evaluation and sustainability plans in the next sections of this Toolkit, but including goals related to your evaluation and project sustainability in your Project Plan can start at this stage. We encourage you to update your Project Plan as this becomes more refined later on. Re-visiting the Organizational Self-Study to see if staff rankings have changed over time is also helpful.

Think about the goals you identified for your organization:

How will we know that we have achieved these?

How will the project impact continue, once the implementation is complete?

How will the results be sustained once the project is complete?

TIP:

Begin to think about your evaluation plan and consider the scope and capacity of your organization. Are there other's (including external research collaboration opportunities such as a local College/University) who may be able to support the evaluation of the project's implementation? For example, NRMH was able to receive support from the Niagara Region Public Health Epidemiologist for evaluation support.



Checkpoint:

Zero Suicide Project Plan complete ☐

Great work having successfully started your project planning. In the next section of this Toolkit, you will narrow in on how the Zero Suicide framework will be adapted and implemented in your organization.

References

1. Project Management Institute. (2020). *What is project management?*
<https://www.pmi.org/about/learn-about-pmi/what-is-project-management>

2. Project Management Guide. (2013). *PMBOK 5 knowledge areas and processes.*
<https://www.pmvista.com/pmbok-knowledge-areas-and-processes/>

3. Lukas, J. A. & Clare, R. (2011). Top 10 mistakes made in managing project risks. Paper presented at PMI® Global Congress 2011—North America, Dallas, TX. Newtown Square, PA: Project Management Institute.

4. Cracknell, B. (1993) Evaluation feedback: So important, yet so neglected!, *Project Appraisal*, 8(2), 77-82. doi: 10.1080/02688867.1993.9726891

5. Larson, R. & Larson, E. (2009). Top five causes of scope creep ... and what to do about them. Paper presented at PMI® Global Congress 2009—North America, Orlando, FL. Newtown Square, PA: Project Management Institute.

Appendices

- [Appendix A:](#) St. Joseph's Zero Suicide Implementation Team Role Descriptions
- [Appendix B:](#) Zero Suicide Organizational Self Study for Non-Healthcare Organizations
- [Appendix C:](#) Zero Suicide Workforce Survey for Non-Healthcare Organizations
- [Appendix D:](#) St. Joseph's Project Charter Template
- [Appendix E:](#) St. Joseph's Project Plan Template

St. Joseph’s Zero Suicide Team Role Descriptions

Project Lead

The Project Lead will provide leadership in directing and monitoring the sustainability of the Zero Suicide Initiative. The Project Lead actively engages with stakeholders, builds partnerships, and leads and supports the translation of the initiative’s future vision.

One of the primary responsibilities of the Project Lead is Zero Suicide Initiative planning, implementation, evaluation, sustainability monitoring, and continuous quality improvement. This role requires skills in project management to aid in organizational change, improvement initiatives, and strategic planning. Important to this role is innovation, participatory leadership, team building, and communication of the Initiatives status or results. The Project Lead is often tasked with decision making as it relates to the Initiative and must use conflict resolution and critical thinking in resolving issues and overcoming barriers.

Clinical (Staff) Lead

The Clinical Lead role involves three specific areas of focus, including providing clinical support for the elements of the Zero Suicide project, providing project support to develop, implement and evaluate Zero Suicide objectives (including knowledge translation), and also supporting data collection and evaluation. Through a process of continuous quality improvement, the role incorporates identifying and advocating for best practices related to suicide care, such as enhancing safe transitions of care.

The Clinical Lead duties include facilitation of Zero Suicide implementation tools, reviewing, revising and developing relevant policies and procedures as required, and optimizing and sustaining success in areas using the Zero Suicide tools. Responsibilities involve supporting sustainability of the project through ongoing training/education and developing standard tools for communication. Supporting data collection is completed through review of reports and patient safety events to support meeting organizational standards, policies and procedures.

Project Support Analyst

The role of the Project Support Analyst has several responsibilities, all with a focus around data. The individual in this role continuously collects, analyzes, and reports on data throughout the implementation of the Zero Suicide Initiative.

With this data collection/analysis/report development, the Project Support Analyst works in collaboration with the Zero Suicide Team to improve quality, performance, and results of the Initiative. Supporting and educating staff regarding the compliance rates of suicide screening tools is also provided. Monthly, the Project Support Analyst participates in steering committee meetings to present the data findings, and occasionally attends interprofessional meetings focused on quality improvement and safety.

ZERO SUICIDE ORGANIZATIONAL SELF-STUDY

Name of Organization

City, Province

Date Study Completed:

Team members completing study:

Name

Role

Name

Role

Name

Role

Name

Role

Name

Role

Background:

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

Staff involved in the policymaking and who provide service for clients at risk for suicide should complete the self-study as part of an implementation team. The team should complete this tool together during one of their initial meetings (note: information about putting together a Zero Suicide implementation team can be found on the ZEROSuicide website). While the self-study is not exhaustive with regard to all issues that can affect suicide management, it does reflect components that define the Zero Suicide approach.

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

Please note that this document has been adapted from the Suicide Prevention Resource Centre’s Organizational Self Study, version 1.11.17. This version does not constitute endorsement by the EDC. The original copy can be found: <http://zerosuicide.edc.org/resources/zero-suicide-organizational-self-study>

General guide to rating:

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

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

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.
- **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 Care Provider:** A Regulated Health Care Provider (RHCP) 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. RHCP’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 health care provider** refers to any other employee/staff member.
- **Suicide:** The act or an instance of taking one’s own life voluntarily and intentionally.
- **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 Care Provider.

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

What type of commitment has leadership made to prevent/reduce suicide and provide a suicide safer organization?

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

- Workforce training
 - Suicide screening
 - Suicide risk assessment and risk formulation
 - Suicide care management plan
 - Safety planning
- Lethal means restriction
 - Referral to evidence-based treatment
 - Contact with clients with known suicide risk who don't show for appointments or usual/expected visits
 - Follow-up with clients with known suicide risk during significant transitions or following discharge

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How does the organization formally assess staff on their perception of their confidence, skills, and perceived support to work alongside clients at risk for suicide?

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

1	There is no formal assessment of staff on their perception of confidence and skills in providing suicide care.
2	Staff who work directly with clients are routinely asked to provide suggestions for training.
3	Staff complete a formal assessment of skills, needs, and supports regarding suicide prevention and intervention. Training is tied to the results of this assessment.
4	A formal assessment of the perception of confidence and skills in providing suicide support is completed by all staff. Comprehensive organizational training plans are tied to the results.
5	A formal assessment of the perception of confidence and skills in providing suicide support is completed by all staff and reassessed at least every three years. Organizational training and policies are developed and enhanced in response to actual and perceived staff weaknesses.

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

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

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

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

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

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

- ☐ ASSIST (Applied Suicide Intervention Skills Training)
- ☐ QPR (Question, Persuade, and Refer)
- ☐ QPR for Nurses
- ☐ QPR for Physicians, Physician Assistants, Nurse Practitioners and Others
- ☐ safeTALK
- ☐ Mental Health First Aid
- ☐ Centre for Suicide Prevention Workshops
- ☐ Other (please name) _____

____ Please indicate the minimum number of hours of training required annually for staff in suicide prevention and intervention.

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

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

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

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

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

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

- ☐ AMSR (Assessing and Managing Suicide Risk)
- ☐ CASE Approach (Chronological Assessment of Suicide Events)
- ☐ SafeSide Suicide Prevention Training
- ☐ RRSR-MH (Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians)
- ☐ RRSR-PC (Recognizing and Responding to Suicide Risk in Primary Care)
- ☐ suicide to Hope
- ☐ QPRT (Question, Persuade, Refer and Treat)
- ☐ Other (please name):

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

7. Systematically identify and assess suicide risk:

What are the organization’s policies or procedures for screening for suicide risk?

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

1	There is no systematic screening for suicide risk.
2	Clients in designated higher-risk programs or categories (e.g. crisis calls) are screened.
3	Suicide risk is screened at first meaningful contact for all clients.
4	Suicide risk is screened at first meaningful contact for all clients and is reassessed at every visit for those at risk.
5	Suicide risk is screened at first meaningful contact for all clients and is reassessed at every visit for those at risk. Suicide risk is also screened when a client has a change in status: significant transition, change in setting, change to new service, or potential new risk factors (e.g., change in life circumstances, such as divorce, unemployment, or a diagnosed illness).

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

8. Systematically identify and assess suicide risk:

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

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

	1	The organization relies on the discretion of its staff regarding suicide risk.
	2	The organization developed its own suicide screening tool but not all staff are required to use it.
	3	The organization developed its own suicide screening tool that all staff are required to use.
	4	The organization uses a validated screening tool that all staff are required to use.
	5	The organization uses a validated screening tool and staff receive training on its use and are required to use it.

If a suicidality screening tool is used, identify the screener used: ☐ PHQ-9 ☐ PHQ-3 ☐ Columbia Suicide Severity Rating-Scale (C-SSRS) ☐ National Suicide Prevention Lifeline Risk Assessment Standards ☐ Other tool (please name): _____

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

9. Systematically identify and assess suicide risk:

How does the organization **assess** suicide risk among those who screened positive (i.e. at risk)?

Note- Only Regulated Health Care Providers (RHCP's) can complete formal suicide assessment.

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

	1	The policy is to send clients who have screened positive for suicide to the emergency department/other community agency for clearance AND/OR there is no routine procedure for risk assessments that follow the use of a suicide screen.
	2	If your organization has a regulated health care provider (RHCP), a suicide risk assessment is required after a positive screen. The process or tool used for risk assessment is up to the discretion of the RHCP.
	3	If your organization has a RHCP, they conduct risk assessments use a standardized risk assessment tool, which may have been developed in-house. All clients who screen positive for suicide have a risk assessment. Suicide risk assessments are documented/communicated and appropriate team members can access this information.
	4	If your organization has a RHCP, all clients with risk identified, either at screening for the first meaningful visit or at any other point while engaged with your organization, are assessed by the RHCP with validated instruments or established protocols and who have received training. Assessment includes both risk and protective factors.
	5	If your organization has a RHCP, a suicide risk assessment is completed using a validated instrument and/or established protocol that includes assessment of both risk and protective factors and risk formulation. The RHCP received training on the risk assessment tool and approach. Risk is reassessed and integrated into every visit for at risk clients.

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

10. Ensure every client has a suicide care management plan (pathway to care):

Which best describes the organization’s approach to supporting and tracking client’s at risk for suicide?

A suicide care management plan should include the following:

- Screening
 - Process for referral to evidence-based treatment
 - Suicide risk assessment and risk formulation if applicable
 - Safety planning
- Supportive contacts with clients who don’t show for appointments or usual/expected visits, and during significant transitions
 - Lethal means restriction

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

1	Staff use their best discretion to support clients with suicidal thoughts or behaviors and seek consultation if needed. There is no formal guidance related to caring for individuals at risk for suicide.
2	When suicide risk is detected, care is limited to suicide risk assessment and staff refer the situation to a senior staff member.
3	All staff are expected to care for those at risk for suicide. The organization has guidance for supporting clients at different risk levels, including increasing frequency of contact, care planning/case management, and safety planning.
4	Documentation is enhanced to embed all suicide prevention and intervention components listed above. Staff have clear protocols or policies for prevention and intervention for clients with suicidal thoughts or behaviors, and there is information sharing, documentation and collaboration among all relevant staff. Staff receive guidance on and clearly understand the organization’s suicide prevention and intervention approach.
5	Individuals at risk for suicide are placed on a suicide care management plan. The organization has a consistent approach to suicide care management, which is embedded in the documentation records and reflects all of the suicide prevention and intervention components listed above. Protocols for putting someone on and taking someone off a suicide management plan are clear. Staff have regular communication about clients who remain on a suicide care management plan beyond a certain time frame, which is established by the implementation team.

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

11. Collaborative safety planning:

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

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

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

Please indicate whether or not the organization uses the Stanley/Brown safety plan template: ☐ YES ☐ NO

If no, identify the safety planning tool or approach the organization uses:

If applicable, how frequently is the safety plan reviewed with the individual?

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

12. Collaborative restriction of access to lethal means:

What is the organization’s approach to lethal means restriction?

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

1	Means restriction discussions and who to ask about lethal means are up to the staff member’s discretion. Means restriction counseling is rarely documented.
2	Means restriction is expected to be included on safety plans for all clients identified as at risk for suicide. Steps to restrict means are up to the staff member’s discretion. The organization does not provide any training on counseling on access to lethal means.
3	Means restriction is expected to be included on all safety plans. The organization provides training on counseling on access to lethal means. Steps to restrict means are up to the staff member’s discretion. Client’s identified support persons may or may not be involved in reducing access to lethal means.
4	Means restriction is expected to be included on all safety plans, and client’s identified support persons are included in means restriction planning. The organization provides training on counseling on access to lethal means. The organization sets policies regarding the minimum actions for restriction of access to means.
5	Means restriction is expected to be included on all safety plans. Contacting client’s identified supports (with consent) to confirm removal of lethal means is the required, standard expectation. The organization provides training on counseling on access to lethal means. Policies support these practices. Means restriction recommendations and plans are reviewed regularly while the individual is at an elevated risk.

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

13. Use or refer clients to effective, evidence-based treatments that directly target suicidal thoughts and behaviors:

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

Note- Only Regulated Health Care Providers (RHCP’s) can provide formal suicide treatment.

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

1	RHCP’s rely on experience and best discretion in risk management and treatment for all mental health disorders. The organization does not use a formal model of treatment for those at risk for suicide, OR Non-RHCP staff rely on experience and best discretion in risk management and referral to appropriate suicide treatment.
2	If the organization has a RHCP, they may use evidence-based treatments for some psychological disorders, but do not use evidence-based treatments that specifically target suicide, OR Non-RHCP staff may have some understanding of how to refer clients for mental health issues, but are not sure who to refer to, to specifically target suicide.
3	Some RHCP staff have received specific training in treating suicidal thoughts and behaviors and may use this in their usual practices, OR Some non-RHCP staff may have received training in how to refer suicidal clients and may use this in their usual practices.
4	Individuals with suicide risk receive empirically-supported treatment by RHCP’s specifically for suicide (CAMS, CBT-SP or DBT) in addition to evidence-based treatments for other mental health issues. The organization regularly provides all RHCP’s with access to competency-based training in empirically supported treatments targeting suicidal thoughts. Non-RHCP staff have received training in how to refer suicidal clients to evidence-based treatments as well as for other mental health issues. The organization regularly provides all non-RHCP’s with training of community resources and referral processes.
5	The organization has invested in evidence-based treatments for suicide care (CAMS, CBT-SP or DBT), with designated staff receiving training in these models. The organization has a model for sustaining staff training. The organization offers additional treatment modalities for those chronically or continuously screening at high risk for suicide, such as DBT groups or attempt survivor groups.

Please indicate if RHCP’s in the organization receive formal training in a specific suicide treatment model:

- ☐ CAMS (Collaborative Assessment and Management of Suicidality)
- ☐ CBT-SP (Cognitive Behavioral Therapy for Suicide Prevention)
- ☐ DBT (Dialectical Behavior Therapy)

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

14. Provide continuous contact and support:

What is the organization’s approach to engaging hard-to-reach individuals or those who are at risk and don’t show for an appointments or usual/expected visit/shift?

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

	1	There are no guidelines specific to reaching those at elevated suicide risk who don’t show for a scheduled appointment or usual/expected visit/shift.
	2	The organization requires documentation of those individuals who have elevated suicide risk and don’t show for an appointment or usual/expected visit/shift, but the parameters and methods for engaging hard-to-reach individuals are up to the staff member’s discretion.
	3	Follow-up for individuals with suicide risk who don’t show for an appointment or usual/expected visit/shift includes active outreach, such as phone calls to the individual or his or her family members, until contact/all appropriate efforts are made to ascertain the individual’s safety.
	4	Follow-up for individuals with suicide risk who don’t show for an appointment or usual/expected visit/shift includes active outreach, such as phone calls to the individual or his or her family members, until contact/all appropriate efforts are made to ascertain the individual’s safety. Organizational protocols are in place that address follow-up after no-shows. Training for staff includes improving engagement efforts.
	5	The organization may have an established memorandum of understanding with an outside agency to conduct follow-up calls. Follow-up and supportive contact for individuals on suicide care management plans are systematically tracked in documentation. Follow-up for high-risk individuals includes documented contact with the person within eight hours of the missed appointment or usual/expected visit/shift. The organization has approaches, such as peer supports, peer-run crisis respite, home visits, or drop-in appointments, to address the needs of hard-to-reach clients.

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

15. Provide continuous contact and support:

What is the organization’s approach to following up on clients of whom they are aware have recently been discharged from acute care settings (e.g., emergency departments, inpatient psychiatric hospitals)?

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

	1	There are no specific guidelines for contact of those at elevated suicide risk following discharge from acute care settings or not accessing services as usual.
	2	The organization requires follow-up for individuals with suicide risk, but the parameters and methods are up to the individual staff member’s discretion.
	3	Organizational guidelines are directed to the individual’s level of risk and address one or more of the following: follow-up after crisis contact, transition from an emergency department, or transition from psychiatric hospitalization.
	4	Organizational guidelines are directed to the individual’s level of risk and address follow-up after crisis contact, non-engagement in services, transition from an emergency department, or transition from psychiatric hospitalization. Follow-up for high-risk individuals includes distance outreach, such as letters, phone calls, or e-mails.
	5	Organizational guidelines are in place that address follow-up after crisis contact, no-shows, transition from an emergency department, or transition from psychiatric hospitalization. Follow-up for high-risk individuals includes in-person or virtual home or community visits when necessary. Follow-up and supportive contact for individuals on suicide care management plans are tracked in documentation. Policies state that follow-up contact after discharge from acute settings occurs within 24 hours.

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

16. Apply a data-driven quality improvement approach:

What is the organization’s approach to reviewing deaths for those involved in your organization?

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

	1	At best, when a suicide or adverse event happens while the client is involved with your organization, staff meet to discuss the event.
	2	Root cause analysis is conducted on all suicide deaths of people accessing services.
	3	Data from all root cause analyses are routinely examined to look at trends and to make changes to policies.
	4	Root cause analysis is conducted on all suicide deaths of people accessing services as well as for those up to 30 days post mortem/ investigation. Policies and training are updated as a result.
	5	Root cause analysis is conducted on all suicide deaths of people accessing services as well as for those up to 6 months post mortem/investigation, and on all suicide attempts requiring medical attention. Policies and training are updated as a result.

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

17. Apply a data-driven quality improvement approach:

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

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

	1	The organization has no policy or process to measure suicide deaths for those accessing their services.
	2	The organization measures the number of deaths for those who are accessing their services based primarily on report from family/friends.
	3	The organization has specific internal approaches to measuring and reporting on all suicide deaths for clients accessing their services as well as those up to 30 days post mortem/investigation. Deaths are confirmed through coroner or medical examiner reports.
	4	The organization annually cross checks clients against vital statistics data or other federal data (e.g. collaborating with coroner’s office) to determine the number of deaths for those receiving services up to 30 days post mortem/investigation.
	5	The organization annually cross checks clients against vital statistics (e.g. collaborating with coroner’s office) to determine the number of deaths for those receiving services. The organization tracks suicide deaths among clients for up to 6 months post mortem/investigation.

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

18. Apply a data-driven quality improvement approach:

What is the organization’s approach to suicide prevention and intervention quality improvement activities?

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

1	The organization has no specific policies related to suicide prevention and intervention, and it does not focus on suicide care other than care as usual. Suicide care is left to the discretion of the individual staff member.
2	Suicide prevention and intervention is discussed as part of employee training and by those in supervision.
3	Early discussions about using technology and/or enhanced record keeping to track and chart suicide management are underway. Suicide prevention and intervention is partially embedded in documentation.
4	Suicide prevention and intervention is partially embedded in documentation. Data from documentation and suicide care management plans are examined for fidelity to organizational policies, and discussed by the team responsible for this.
5	Suicide prevention and intervention is entirely embedded in documentation (at least every two months) by a designated team to determine that staff are adhering to suicide prevention and intervention policies and to assess for reductions in suicide. Documentation is updated regularly as the team reviews data and makes changes.

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

ZERO SUICIDE WORKFORCE SURVEY

The Zero Suicide Workforce Survey is a tool to assess staff knowledge, practices, and confidence.

This survey is part of our organizational mission to adopt a system-wide approach to caring for individuals who may be at risk for suicide. Recognizing that variability exists in staff education and experience working with people at risk for suicide, we intend to use the results of this survey to help determine the training needs of our staff.

All responses are anonymous. Please answer honestly so that we can best serve both our staff and clients who may be at risk for suicide. Be thoughtful about your answers even if you do not work directly with clients who may be at risk for suicide. We believe that suicide prevention is a shared responsibility among everyone in our organization. Please pay attention to the directions, as they will navigate you through the questions based on how you respond. Also, unless it is otherwise indicated, please mark only one answer per question. **It is anticipated that it will take you 10-20 minutes to complete this survey.** By answering this survey, you give your consent to participate; however, you may terminate your participation at any time.

Please ensure you read through the Key Definitions found on the next page prior to beginning the survey.

We thank you in advance for your participation and for your dedication to suicide prevention.



Once your implementation team has completed this organizational self-study using this document, the results can be reviewed to assess organizational strengths and opportunities for development across each component.

Please note that this document has been adapted from the Suicide Prevention Resource Centre’s Workforce Survey, version May 2019. This version does not constitute endorsement by the EDC. The original copy can be found: <http://zerosuicide.edc.org/sites/default/files/ZS%20Workforce%20Survey%20July%202020.pdf>

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.
- **Suicide:** The act or an instance of taking one’s own life voluntarily and intentionally.
- **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.

Section 1. Your Work Environment

Thank you for participating in this survey. In the first series of questions we would like to learn more about your work environment and your role within that environment.

1. In which of the following settings do you work? (See Definitions) Required Item – used later for branching
☐ Residential setting ☐ Non-residential setting ☐ Both
2. Please indicate the program you work in:

- 2a. Is this your first time taking part in the Zero Suicide Workforce Survey at your current organization? (choose one)
☐ No ☐ Yes
3. Please choose the one category below that **best** describes your primary professional role. (choose one)
 - ☐ Management (Administrators, Supervisors, Managers, Coordinators)
 - ☐ Business, Administrative, and Clerical (Accounting, Reception, Human Resources, Billing, Records, Information Technology)
 - ☐ Facility Operations (Dietary, Housekeeping, Maintenance, Security, Transportation)
 - ☐ Behavioral Health Clinician (Counselor, Social Worker, Substance Abuse Counselor, Therapist, Psychologist)
 - ☐ Adjunct Therapist (Activity, Occupational, Physical, Rehabilitation)
 - ☐ Case Management
 - ☐ Crisis Services
 - ☐ Physical Health Care/Medication Management (Physician, Nurse Practitioner, Physician’s Assistant)
 - ☐ Nursing (Nurse, Registered Nurse)
 - ☐ Psychiatry (Psychiatrist, Psychiatric Nurse Practitioner)
 - ☐ Technician (Mental Health Technician, Behavioral Technician, Client Care Assistance, Residential Technician)
 - ☐ Client Observer
 - ☐ Support Worker
 - ☐ Outreach Worker
 - ☐ Educator (Teach, Health Educator/Promoter)
 - ☐ Group Facilitator
 - ☐ Housing Support Worker
 - ☐ Volunteer
 - ☐ Other

4. As part of this role, do you *directly interact with individuals who may be at risk for suicide* either in person or from a distance/virtually during your day-to-day duties within the organization? This includes things such as answering phones, scheduling appointments, conducting check-ins, and other interaction with clients.

[Required Item]

☐ No ☐ Yes

Please indicate how much you disagree or agree with each of the following statements. [Note: Only

complete for residential settings]

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
5. I know the organizational protocols for ensuring a safe physical environment for individuals who may be at risk for suicide (including safety precautions around entry, visitors, client belongings, and physical structures in the facility).	☐	☐	☐	☐	☐
6. I know what to do when I have concerns about potential means for suicide in the physical environment in our facility.	☐	☐	☐	☐	☐

Section 2. Suicide Prevention Within Your Work Environment

The next series of questions ask you to reflect on suicide prevention within your work environment.

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
7. I am familiar with the “Zero Suicide” initiative.	☐	☐	☐	☐	☐
8. I understand my role and responsibilities related to suicide prevention within this organization.	☐	☐	☐	☐	☐
9. I believe suicide prevention is an important part of my professional role.	☐	☐	☐	☐	☐
10. The leadership at this organization has explicitly indicated that suicide prevention is a priority.	☐	☐	☐	☐	☐
11. This organization has clear policies and procedures in place that define each employee’s role in preventing suicide.	☐	☐	☐	☐	☐
12. I have received training at this organization related to suicide prevention.	☐	☐	☐	☐	☐
13. This organization provides me access to ongoing support and resources to further my understanding of suicide prevention.	☐	☐	☐	☐	☐
14. I feel that my organization would be responsive to issues that I bring up related to client safety.	☐	☐	☐	☐	☐

15. While working at this organization, I have directly or indirectly interacted with a client who ended their life by suicide. [Required Item]

☐ Yes, it has happened once ☐ Yes, it has happened more than once ☐ No ☐ I Don’t Know

Please indicate how much you disagree or agree with each of the following statements. [Note: Only

complete if “Yes” to #15]

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
16. I felt supported by this organization when a suicide occurred.	☐	☐	☐	☐	☐
17. I felt blamed when a client died by suicide.	☐	☐	☐	☐	☐
18. This organization has practices in place to support staff when a suicide occurs.	☐	☐	☐	☐	☐

Section 3. Recognizing When Clients May Be At Risk for Suicide

We are interested in learning about your knowledge and comfort related to recognizing when a client may be at elevated risk for suicide.

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
19. I have the knowledge and training needed to <i>recognize</i> when a client may be at elevated risk for suicide.	☐	☐	☐	☐	☐
20. I am knowledgeable about warning signs for suicide.	☐	☐	☐	☐	☐
21. I know what organizational procedures to follow when I suspect that a client may be at elevated risk for suicide.	☐	☐	☐	☐	☐
22. I am confident in my ability to respond when I suspect a client may be at elevated risk for suicide.	☐	☐	☐	☐	☐
23. I am comfortable asking individuals who may be at risk for suicide direct and open questions about suicidal thoughts and behaviors.	☐	☐	☐	☐	☐

24. Have you ever received training on how to *recognize* the warning signs that a client may be at elevated risk for suicide?..... ☐ No [go to #26] ☐ Yes [go to #25] [Required Item]

25. Has your current organization provided you with training on how to *recognize* the warning signs that a client may be at elevated risk for suicide?..... ☐ No ☐ Yes

Section 4. Screening and Assessing Clients for Suicide Risk [Note: Only those who interact with

individuals who may be at risk for suicide, i.e. “Yes” to Q4. All other respondents may proceed to #66]

The next questions are about screening clients who may be at elevated risk for suicide.

26. You indicated earlier that you directly interact with individuals who may be at risk for suicide either in person or from a distance/virtually during your day-to-day duties within the organization. Which of the following groups do you *primarily* work with?

☐ Children ☐ Adolescents ☐ Adults ☐ Older Adults

27. Are you responsible for conducting *screenings* for suicide risk? ☐ No [proceed to #32] ☐ Yes [proceed to #28] [Req]

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
28. I have the knowledge and skills needed to screen clients for suicide risk.	☐	☐	☐	☐	☐
29. I know our organizational procedures for screening	☐	☐	☐	☐	☐

clients for suicide risk.					
30. I am confident in my ability to screen a client for suicide risk.	☐	☐	☐	☐	☐
31. I am comfortable screening clients for suicide risk.	☐	☐	☐	☐	☐

Clients who screen positive for suicide risk should be assessed to inform staff decision making. This is sometimes referred to as a suicide risk assessment. Suicide risk assessments are most often completed by a regulated health professional who has the knowledge, skill and judgment required to do so.

32. Are you a regulated health professional who is responsible for conducting *suicide risk assessments* for clients who screen positive for suicide risk? ☐ Yes [\[proceed to #33\]](#) [\[Required Item\]](#) ☐ No [\[proceed to #42\]](#)

Note: If you are a non-regulated health professional and complete suicide risk assessments, please ensure that you follow all organizational policies, procedures and expectations in doing so.

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
33. I have the knowledge and skills needed to conduct a suicide risk assessment.	☐	☐	☐	☐	☐
34. I am knowledgeable about risk factors for suicide.	☐	☐	☐	☐	☐
35. I obtain information about risk and protective factors when conducting suicide risk assessments.	☐	☐	☐	☐	☐
36. I assess the client’s access to lethal means as part of a suicide risk assessment.	☐	☐	☐	☐	☐
37. I assess the client’s suicide plans and intentions as part of a suicide risk assessment.	☐	☐	☐	☐	☐
38. I know what organizational procedures exist regarding suicide risk assessments.	☐	☐	☐	☐	☐
39. I am confident in my ability to conduct a suicide risk assessment.	☐	☐	☐	☐	☐
40. I am comfortable conducting a suicide risk assessment.	☐	☐	☐	☐	☐
41. I know the referral process to follow when a suicide risk assessment indicates the client needs additional clinical care.	☐	☐	☐	☐	☐

Section 5. Training on Suicide Screening and Suicide Risk Assessment

These next questions are about any training you may have received on suicide screening and suicide risk assessment – even if this is not part of your current professional duties.

42. Have you ever received training on conducting suicide screenings or conducting suicide risk assessments?..... ☐ Yes [\[proceed to #43\]](#) [\[Required Item\]](#) ☐ No [\[proceed to #45\]](#)
43. Has your current organization provided you with training on conducting suicide screenings or conducting suicide risk assessments? ☐ Yes ☐ No
44. Which of the following trainings, if any, have you ever taken on *screening or suicide risk assessment*? (select all that apply)

☐ Assessing and Managing Suicide Risk (AMSR)

☐ Chronological Assessment of Suicide Events (CASE) Approach

☐ Commitment to Living

☐ Columbia Suicide Severity Rating Scale (C-SSRS)

☐ Question, Persuade, Refer, Treat (QPR) Suicide Risk Assessment and Management Training (not basic QPR training)

☐ Recognizing and Responding to Suicide Risk (RRSR)

☐ Suicide to Hope

☐ An in-service or webinar training at my organization

☐ An in-service or webinar training at a former organization

☐ A different training on suicide *screening or suicide risk assessment* (please specify):
45. Do you use a standard tool, assessment instrument, or rubric for suicide screening or risk assessment?

☐ Yes [\[proceed to #46\]](#) [\[Required Item\]](#) ☐ No [\[proceed to #47\]](#) ☐ Not applicable
46. Which of the following tools, screening and assessment instruments, or rubrics, if any, do you use? (select all that apply)

☐ Asking Suicide-Screening Questions (ASQ)

☐ Beck’s Suicide Intent Scale (SIS)

☐ Columbia Suicide Severity Rating Scale (C-SSRS)

☐ National Suicide Lifeline Risk Assessment Standards

☐ Personal Health Questionnaire (PHQ)-3

☐ Personal Health Questionnaire (PHQ)-9

☐ Risk Assessment Matrix (RAM)

☐ Risk of Suicide Questionnaire (RSQ)

☐ Risk Formulation with Risk Status and Risk State

☐ SAFE-T

☐ Suicide to Hope

☐ Suicide Ideation Questionnaire (SIQ or SIQ-JR)

☐ A tool, instrument, or rubric developed by my organization (please specify):

☐ A different tool, instrument, or rubric not developed by my organization (please specify):

Section 6. Providing Support to Individuals at Risk

These questions are for staff responsible for providing service to clients determined to be at elevated risk for suicide.

47. Do you provide direct service to clients who have been identified as being at elevated risk for suicide based on their risk assessment?
- ☐ Yes proceed to #48 Required Item ☐ No proceed to #52

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
48. I have the knowledge and skills needed to provide service to clients who have been identified as being at elevated risk for suicide.	☐	☐	☐	☐	☐
49. I am familiar with the referral process at this organization related to things such as safety planning, restricting access to lethal means, documentation, and other procedures for caring for clients at elevated risk of suicide.	☐	☐	☐	☐	☐
50. I am confident in my ability to provide service to clients who have been identified as being at elevated risk for suicide.	☐	☐	☐	☐	☐
51. I am comfortable providing service to clients who have been identified as being at elevated risk for suicide.	☐	☐	☐	☐	☐

52. Have you taken a *Safety Planning Intervention for Suicide Prevention* training?
- ☐ No ☐ Yes
53. Have you taken the *Counseling on Access to Lethal Means* (CALM) course either online or in person?
- ☐ No ☐ Yes

Section 7. Use of Evidence-Based Treatments That Directly Target Suicidality

These questions are for Regulated Health Professionals who deliver suicide-specific evidence-based *clinical treatment* (e.g. Collaborative Assessment and Management of Suicidality (CAMS), Cognitive Behavioural Therapy for Suicide Prevention (CBT-SP), or Dialectical Behavioural Therapy (DBT) to clients who are identified as being at elevated risk for suicide.

54. Do you provide clinical treatment (e.g. CAMS, CBT-SP, DBT) to clients who have been identified as being at elevated risk for suicide?
- ☐ No proceed to #59 ☐ Yes proceed to #55 Required Item

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
55. I have received training on suicide-specific evidence-based treatment approaches (e.g. CAMS, CBT-SP, DBT).	☐	☐	☐	☐	☐
56. I am confident in my ability to provide clinical treatment to clients with suicidal thoughts or behaviors.	☐	☐	☐	☐	☐
57. I am comfortable providing clinical treatment to clients with suicidal thoughts or behaviors.	☐	☐	☐	☐	☐

58. In which of the following suicide-specific evidence-based treatment approaches, if any, have you received training? (select all that apply)
- ☒ CAMS (Collaborative Assessment and Management of Suicide)
- ☐ CBT-SP (Cognitive Behavior Therapy for Suicide Prevention)
- ☐ DBT (Dialectical Behavior Therapy)
- ☐ Another training (please specify): _____
- None

Section 8. Care Transitions

These questions are for staff responsible for ensuring that clients identified as being at elevated risk for suicide are supported during transitions in care.

For the following questions, *transitions in care* include safely discharging and/or transitioning clients who may be at risk for suicide following acute care (hospital) admissions for mental health concerns/suicidality.

59. Are you responsible for ensuring safe care transitions for clients who have been identified as being at elevated risk for suicide?..... ☐ Yes *[proceed to #60] [Required Item]* ☐ No *[proceed to #66]*

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
60. I have the knowledge and skills needed to work with clients who may be at risk for suicide during their transitions in care.	☐	☐	☐	☐	☐
61. I am familiar with organizational procedures for working with clients who may be at risk for suicide during their transitions in care.	☐	☐	☐	☐	☐
62. I am confident in my ability to work with clients who may be at risk for suicide during their transitions in care.	☐	☐	☐	☐	☐
63. I am confident in my ability to work with family members or other support persons who may be involved during a client’s transitions in care.	☐	☐	☐	☐	☐
64. I am familiar with organizational procedures for ensuring that client health information is shared appropriately during a client’s transitions in care.	☐	☐	☐	☐	☐
65. I am comfortable working with= clients who may be at risk for suicide during their transitions in care.	☐	☐	☐	☐	☐

Section 9. Training and Resource Needs

Staff members should have the necessary skills (appropriate to their role), to provide caring and effective assistance to clients who may be at risk for suicide.

66. In which of the following areas, if any, would you like more training, resources, or support? (select all that apply)
- ☐ Suicide prevention and awareness
 - ☐ Epidemiology and the latest research findings related to suicide
 - ☐ Identifying warning signs for suicide
 - ☐ Communicating with clients who may be at risk for suicide about suicide
 - ☐ Suicide screening practices
 - ☐ Identifying risk factors for suicide
 - ☐ Suicide risk assessment practices
 - ☐ Crisis response procedures
 - ☐ Suicide de-escalation techniques
 - ☐ Managing clients who may be at risk for suicide
 - ☐ Collaborative safety planning for suicide
 - ☐ Awareness of community supports and resources
 - ☐ Understanding and navigating ethical and legal considerations related to suicide
 - ☐ Policies and procedures within your work environment
 - ☐ Staff roles and responsibilities within your work environment
 - ☐ Reducing access to lethal means outside the care environment (e.g. client’s home)
 - ☐ Creating a safe physical environment for clients who may be at risk for suicide
 - ☐ Other (please specify)
 - ☐

[Organization logo]

Project Charter

Project Name:

Current Phase:

Hospital(s):

Executive Sponsor:

Project Sponsors:

Clinical/Physician Leads:

Project Lead:

Prepared by:

Contributors:

Date Issued

Version:

Project Charter Purpose

The project charter defines the scope, objectives, and overall approach for the work to be completed. It is a critical element for initiating, planning, executing, controlling, and assessing the project. It should be the single point of reference on the project for project goals and objectives, scope, organization, estimates, work plan, and budget. In addition, it serves as a contract between the Project Team and the Project Sponsors, stating what will be delivered according to the budget, time constraints, risks, resources, and standards agreed upon for the project.

Document Review/Revision History

Version	Date	Author/Editor	Comments

Date:

Date:

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Section A:

1.0 Project Definition: Initiation Phase (Stage 2- Definition)

1.1 Link to Organization Strategy

1.2 Project Purpose

1.3 Project Objectives

Date:

1.4 Outcome Measurement Metrics / Success Criteria

Project Objective	Success Criterion / Indicator Description	Measurement / Data Collection Strategy	Target	By Whom & How Frequently

Date:

1.5 Project Priority Management

Parameter	Priority			Describe Priority
	1	2	3	
Time				
Cost				
Scope				

1.6 Organizational Change

Type of Change	Level	Description of the Change
Developmental		
Transitional		
Transformational		

Section B: Planning Phase (Stage 3 – Scope/Feasibility)

2.0 Project Parameters

2.1 Scope

2.1.1 Project Scope Includes:

2.1.2 Project Scope Does Not Include:

2.2 Assumptions

2.3 Constraints

2.4 Dependencies

Dependent Project/Work Name and Project/Work Manager	Dependency Type (describe how these are linked)	Potential Risks or Issues

Date:

3.0 Risks

Risk	Probability (High/Med/Low)	Impact (High/Med/Low)	Action to Prevent/Manage Risk

4.0 Stakeholder Analysis

Stakeholder	Interest/Stake	Project Role/Involvement

5.0 Budget (excl. OSI Clinic)

	Dollars	Comment	Class of Estimate (A/B/C/D)
ONE TIME COSTS:			

Date:

6.0 Schedule

7.0 Project Strategy

8.0 Change Strategy

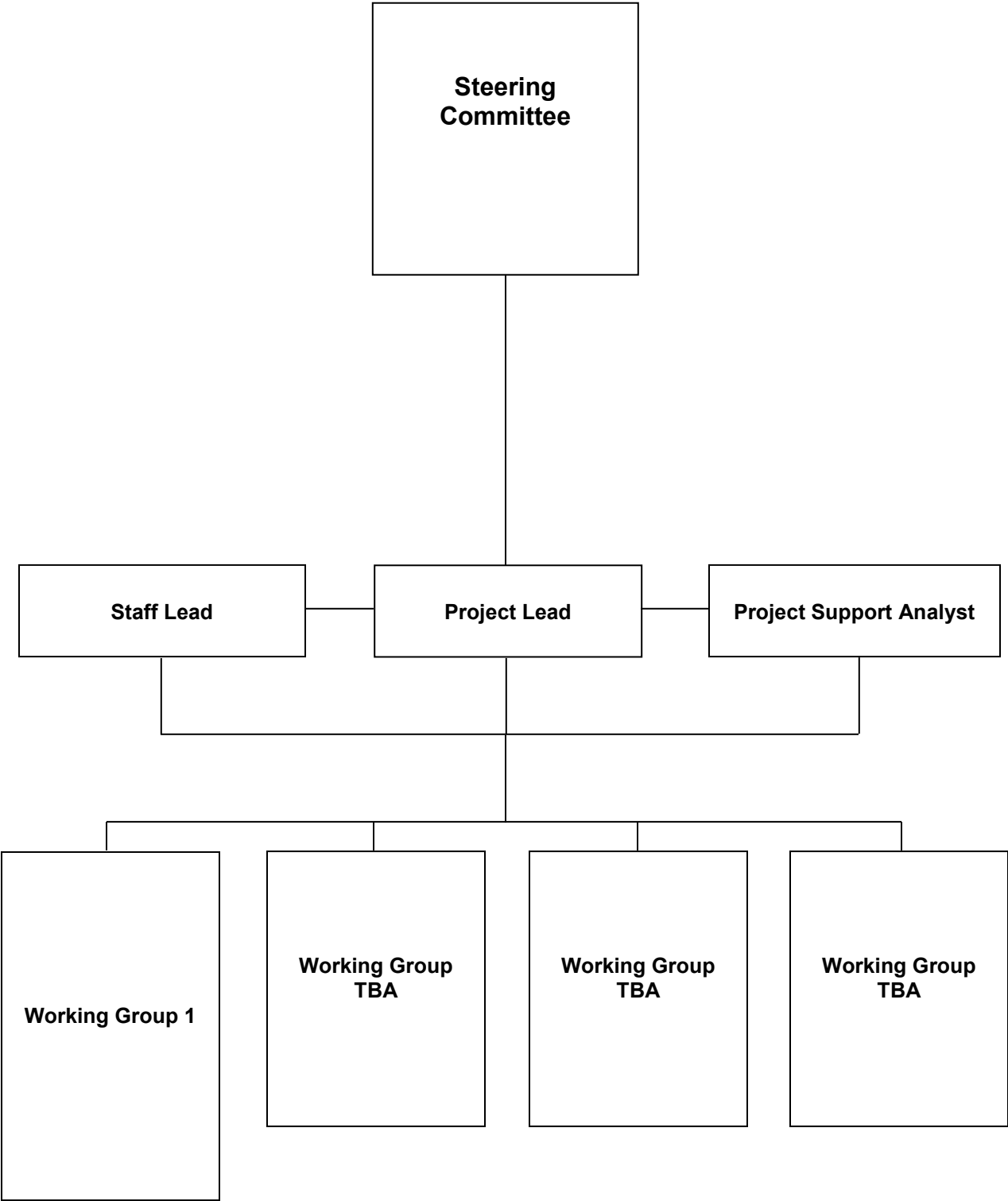
Content

People

Process

Date:

9.0 Project Governance Structure



10.0 Approvals

10.1 Charter

<i>Name, Project Role</i>	<i>Signature</i>	<i>Date</i>

Date:

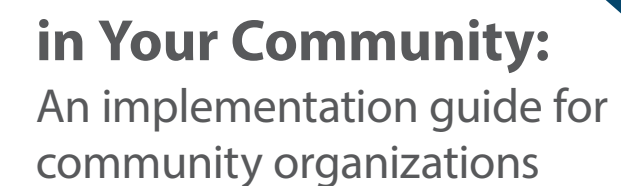
Date:

Organization's Zero Suicide Project Plan

[Dates]

Goal / Objective	Deliverable	Tasks / Actions Required	Responsibility/ Stakeholders	Timeframe	Status / Comments

Goal / Objective	Deliverable	Tasks / Actions Required	Responsibility/ Stakeholders	Timeframe	Status / Comments



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 approach¹:

- 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 encounter¹. 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 to¹:

- 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 approach¹:

- 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 transitions⁵.

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 should⁶.

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 include¹:

- 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 crisis⁸.

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 include⁹:

- 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 life¹⁰. 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 includes¹⁰:

- 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 suicidality¹. Instead, research points to treating suicidal thoughts and behaviours specifically and directly – regardless of mental health diagnoses or substance use¹. 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 community¹².

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 death¹³.

Benefits of peer support¹²:

- 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 services¹⁴. 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 care¹:

- 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 deaths¹⁶.

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 discharge¹⁷.

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

TIP:

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

such as Personal Health Information Protection Act’s, or Required Required Organizational Practices (ROP) monitored by Accreditation Canada¹⁸ 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.

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 include⁵:

- 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 camps-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)

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

	(creator of the Columbia) and St. Joe's Hospital in Hamilton and London		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-retest 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

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	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 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. Develop 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 Specificity 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.

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-Benheit, 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).



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Suicide Risk Formulation

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



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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)



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:

Clinician signature:

Date: _____

Date: _____

Clinician/Physician: 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



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.

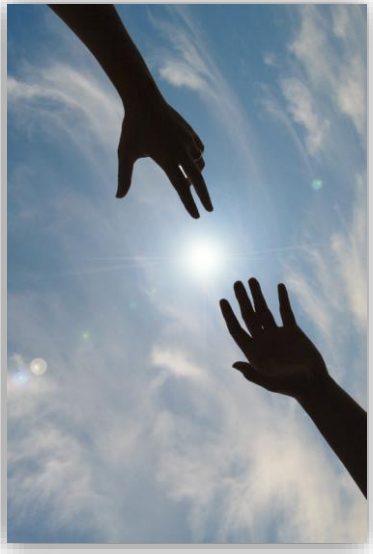
CARING FOR THE BODY,
MIND & SPIRIT
SINCE 1869

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

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 Course)
- 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

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
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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	

[illegible]



in Your Community:

An implementation guide for
community organizations

Do



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

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

Resources to have on hand (or screen):

- A copy of the Toolkit: Plan 1.0 and Plan 2.0 sections
- A copy of your Project Plan
- Your completed Organizational Self Study & Workforce Survey
- Zero Suicide Toolkit website¹: zerosuicide.edc.org/toolkit

Policy and/or Procedure(s) Development

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

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

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

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



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

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

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

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

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

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

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

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

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

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



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



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

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

Policy and/or Procedure(s) Development

Suicide Care Management Plan

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

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

Suicide Risk Assessment

Suicide Screening

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

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

Checkpoint:

Screening tool(s) selection ☐

Full Suicide Risk Assessment

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

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

Checkpoint:

Full suicide risk assessment processes (if applicable) ☐

Interventions

Suicide Prevention Algorithm or Triage Tool(s)

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

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

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

Zero Suicide Website: [Telehealth and Suicide Care During COVID-19 Pandemic](#)

SPRC Website: [Treating Suicidal Patients During COVID-19: Best Practices and Telehealth](#)



Checkpoint:

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

Creating a Community Based Crisis Resource List

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

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

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



Checkpoint:

Local Community Service Resource List complete ☐

Coping Plan and Safety Plan

Coping Plan

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

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

Are all coping strategies helpful?

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

Brainstorm:

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

What coping strategies would be considered maladaptive?

Current research tells us Coping Plans are an effective way to highlight the client's own abilities to cope and reinforce personal strengths. They also encourage connecting with appropriate resources and to escalate to more intensive services as needed².

A Coping Plan should include or identify:

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

What do you do with the Coping Plan once complete?

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

Safety Plan

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

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

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

The Safety Plan should include:

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

TIP:

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



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

Referral to Support/Evidence-Based Treatment

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

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

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

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

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

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

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



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

Engaging Natural and Peer Supports

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

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

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

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

 **Checkpoint:**
Engagement with Natural and Peer Supports ☐

Supporting Transitions in Care

Transitions in care, notably from inpatient to outpatient services, can pose a high-risk time for suicide behaviours⁵.

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

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

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

Other important elements of supporting safe transitions in care include¹:

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

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

 **Checkpoint:**
Supporting Transitions in Care ☐

Implementing Caring Contacts

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

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

A caring contact message should include:

Phone Calls:

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

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

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

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

Examples and templates for non-demanding caring contacts:

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

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

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

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



Checkpoint:
Caring contact process and message developed ☐

Reviewing Suicide Related Incidents

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

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

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

Example:

[The Joint Commission- Root Cause Analysis & Action Plan](#)

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



Checkpoint:
Incident review process/template determined ☐

Postvention Support

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

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

1.

2.

3.

Postvention is a term that is often used when talking about suicide prevention, and refers to activities which reduce risk and promote healing after a death by suicide. Following a death by suicide, staff and other clients will need additional support to work through their grief, and an important part of a policy and/or procedure is to include how those who have been touched by a loss will be supported. Those who have lost someone to suicide are at an increased risk for suicide themselves⁶, and having support and resources available/accessible to staff and other clients is critical. Postvention is prevention!



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

Documentation

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

 **Checkpoint:**
Documentation expectations articulated ☐

Required Education for Staff

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

 **Checkpoint:**
Required education determined and listed ☐

Key Definitions

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

 **Checkpoint:**
Key definitions complete ☐

Appendices

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

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

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

Implementing Suicide Prevention Education for Staff

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

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

General tips for completing staff training include:

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

Tips for organization specific training:

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

Implementation Considerations

Go-Live Date

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

Tips for a successful go live:

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

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

Change Management with Staff

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

Other strategies to support effective change management include:

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

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

Beginning Evaluation: Data Collection

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

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

Building Suicide-Safer Communities

Suicide prevention is everyone’s responsibility. Your organization plays a key role, along with other health care providers, mental health workers, family members, friends, and other community organizations. We are all responsible for helping our communities to become more suicide safe, and we can all make a difference in improving suicide prevention. No action taken to prevent suicide is too small to make a difference⁷.

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

[Canadian Association for Suicide Prevention](#)

[Niagara Suicide Prevention Coalition](#)

[London Middlesex Suicide Prevention Council](#)



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

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Appendices

[Appendix N](#): NRMH Policy and Procedure

[Appendix O](#): St. Joseph’s Triage Tool

[Appendix P](#): St. Joseph’s Triage Tool (Adapted for a virtual care setting)

[Appendix Q](#): NRMH Mental Health and Addictions Community Resource List

[Appendix R](#): NRMH Postvention Support: Lavender Alert

[Appendix S](#): NRMH Zero Suicide Staff Education Evaluation Form

[Appendix T](#): Example of St. Joseph’s & NRMH FAQ documents

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

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

POLICY STATEMENT

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

APPLICATION

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

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

SUPPORTING DETAILS

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

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

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

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

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

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

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

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

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

DEFINITIONS ☐ See the bottom of this document for applicable definitions

ACCOUNTABILITIES

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

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

In conducting Suicide Assessments the clinician must:

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

The following roles will have the associated accountabilities:

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

2. Implementation Team	• Ensure staff are using consistent practices within their respective services • Ensure support is provided to staff who have experienced a suicide death of a client • Ensure staff have appropriate training to talk to clients about suicide risk ie SafeTalk and/or ASIST and C-SSRS training • Ensure staff have opportunity to debrief following a suicide risk assessment or intervention with a client • Ensure suicide care planning is embedded in the electronic health record • An Implementation Team is established, with specific tasks • Each team member acts in Champion role for each service team • Provide regular input and advice on the Suicide Care Management Plan • Participate on evaluation and quality improvement efforts • Support the development of an evaluation plan to assess the impact of the Suicide Care Management Plan Initiative • Support Zero Suicide training to new staff
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CONSEQUENCES AND MONITORING ☒ No additions beyond the section outlined in the Public Health Policy II-070.1 [Developing, Approving Monitoring and Storing of Policies, Procedures and Guidelines](#).

RELATED DOCUMENTS ☐ Not Applicable

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

HELPFUL LINKS ☐ Not Applicable

E-Learning Module for C-SSRS – 1 hour [C-SSRS Online Training Module Link](#)

REFERENCES ☐ Not Applicable

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

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

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

DEFINITIONS ☐ Not Applicable

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

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

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

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

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

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

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

Guidelines for Interventions for Columbia Risk Levels for Inpatient Mental Health

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

Zero Suicide Guidelines to Determine Level of Risk and Develop Interventions to Lower Risk Level

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

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

CARING FOR THE BODY, MIND & SPIRIT SINCE 1869

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.



sjhc.london.on.ca

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

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

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

Mental Health and Addictions

Supports & Services

for adults

Niagara Region

Crisis

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

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

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

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

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

French services: 1-877-336-2433

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

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

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

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

Health

Bridges Community Health Centre: Primary health care, illness prevention, and community development.
bridgeschc.ca
Port Colborne location 289-479-5017
Fort Erie location 905-871-7621

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

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

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

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

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

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

Counselling and Support Services

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

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

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

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

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

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

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

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

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

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

Niagara Life Centre: Family support centre and counselling.
St. Catharines 905-934-0021
Fort Erie 905-871-0236

Counselling and Support Services Cont'd

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

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

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

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

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

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

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

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

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

Alcohol, Drugs, Tobacco and Gambling

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

Alcoholics Anonymous 1-866-311-9042

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

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

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

Men's Detox Centre 905-682-7211

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

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

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

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

Women's Detox Centre 905-687-9721

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

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

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

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

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

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

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

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

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

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

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

Still not sure who to call?

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

What is Lavender Alert?

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

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

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

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

Situations or Circumstances Prompting a Lavender Alert

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

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

Steps of the Lavender Alert Protocol

1. Options for support include **individual, peer facilitated, and group debriefing**.
 - a. **Individual:** You would work through the protocol (or parts of your choice) on your own.
 - b. **Peer Facilitated:** With the support of 1 or more peers, work through the protocol, including the Focused Conversation together.
 - c. **Group Debriefing:** With support of NRMH Management, a group debriefing can be organised to process a critical event as a team.
2. Complete the **Focused Conversation** individually, with peers, or as a group. **(See Page 3)**
3. Is further support needed? **(See Page 4)**

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

Focused Conversation

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

Is Further Support Needed?

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

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

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

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

What's included?

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

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

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

7 ways to access, allows you accessibility and choice.

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

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

Self Care Tools and Additional Resources

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

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

Suicide Care Management Plan Columbia Training Day Evaluation

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

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

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

C-SSRS Implementation

Begin administering the C-SSRS with:

- ☐ Intensity of ideation section
- ☐ Suicidal ideation section
- ☐ Suicidal behavior section
- ☐ Lethality of behavior

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

- ☐ the assessment is finished
- ☐ administer the suicidal behavior section next
- ☐ administer the intensity of ideation section next
- ☐ ask about any specific thoughts of killing him/herself involving a method

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

- ☐ is not rated unless the severity of suicidal thoughts contains at least a method
- ☐ includes questions about frequency and predictability of thoughts
- ☐ is rated on a two-point scale
- ☐ is rated with respect to the most severe type of ideation

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

- ☐ True
- ☐ False

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

- ☐ Recent suicidal ideation (intent unknown)
- ☐ No recent suicidal ideation or behavior
- ☐ Recent suicidal ideation and preparatory behavior
- ☐ Recent suicidal ideation and non-suicidal behavior

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

- ☐ Suicide attempt
- ☐ Preparatory behavior and suicide attempt
- ☐ Two preparatory behaviors and suicide attempt
- ☐ Three preparatory behaviors and suicide attempt

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

- ☐ True
- ☐ False

Please rate the following questions using the scale as described:

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

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

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly agree

Please provide any additional comments:

Zero Suicide Initiative

Best Practice Updates & Frequently Asked Questions: Q1 2020

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

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

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

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

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

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

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

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

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

3. What postvention supports are available for staff?

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

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

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

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

Related Corporate Policies:

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

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

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

Columbia-Suicide Screening Rating Scale:

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

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

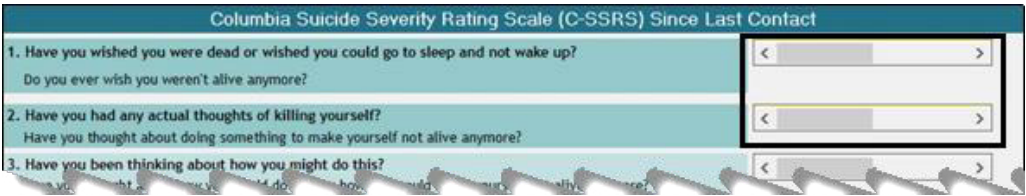
6. How can I improve my documentation when completing the C-SSRS tools?

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

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

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

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



References:

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

Suicidal Ideation

Ask questions 1 and 2.

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

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

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

Describe if any answers are “yes”.

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

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

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

Overview of C-SSRS Lifetime Assessment Tool

Columbia Suicide Severity Rating Scale (C-SSRS) Lifetime/Recent - PIMH Scheduling, Practice 17

*Performed on: 2020/02/12 1033 EST

Columbia - Suicide Severity Rating Scale (C-SSRS) Lifetime/Recent

Suicidal Ideation

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behaviour" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section.

1. Have you wished you were dead or wished you could go to sleep and not wake up?
Do you ever wish you weren't alive anymore?

Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.

Lifetime: ☐ Yes ☐ No
Recent: Past 1 month: ☐ Yes ☐ No
If yes, describe:

2. Have you had any actual thoughts of killing yourself?
Have you thought about doing something to make yourself not alive anymore?

Non-Specific: General non-specific thoughts of wanting to end one's life/die by suicide (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.
Active Suicidal Thoughts:

Lifetime: Time they Felt Most Suicidal: ☐ Yes ☐ No
Recent: Past 1 month: ☐ Yes ☐ No
If yes, describe:

3. Have you been thinking about how you might do this?
Have you thought about how you would do that or how you would make yourself not alive anymore? What did you think about?

Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act: Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan).
Includes person who would say, "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it and I would never go through with it."

Lifetime: Time they Felt Most Suicidal: ☐ Yes ☐ No
Recent: Past 1 month: ☐ Yes ☐ No
If yes, describe:

4. Have you had these thoughts and had some intention of acting on them?
When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do? This is different from having the thoughts but knowing you wouldn't do anything about it

Active Suicidal Ideation with Some Intent to Act, without Specific Plan: Active suicidal thoughts of killing oneself and person reports having some intent to act on such thoughts, as opposed to "I have the thoughts but I definitely will not do anything about them."

Lifetime: Time they Felt Most Suicidal: ☐ Yes ☐ No
Recent: Past 1 month: ☐ Yes ☐ No
If yes, describe:

5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
Have you ever decided how or when you would make yourself not alive anymore/kill yourself? What was your plan? When you made this plan, was any part of you thinking about actually doing it?

Active Suicidal Ideation with Specific Plan and Intent: Thoughts of killing oneself with details of plan fully or partially worked out and patient has some intent to carry it out.

Lifetime: Time they Felt Most Suicidal: ☐ Yes ☐ No
Recent: Past 1 month: ☐ Yes ☐ No
If yes, describe:

Lifetime: Most Severe Ideation: ☐ 1-least severe ☐ 2 ☐ 3 ☐ 4 ☐ 5-most severe
Recent: Most Severe Ideation: ☐ 1-least severe ☐ 2 ☐ 3 ☐ 4 ☐ 5-most severe

Lifetime: Description:
Recent: Description:

Intensity of Ideation

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

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

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

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

Overview of C-SSRS Lifetime Assessment Tool Continued

Columbia Suicide Severity Rating Scale (C-SSRS) Lifetime/Recent - PIMH Scheduling, Practice 17

*Performed on: 2020/02/12 1033 EST

Suicidal Ideation/Intensity of Ideation

Check all that apply, so long as they are separate events; must ask all types

Actual Attempt:

A potentially self-injurious act committed with at least some wish to die, as a RESULT OF ACT. Behaviour was in part thought as a method to kill oneself. Intent does not have to be 100%. If there is ANY intent/desire to die associated with the act, then it can be considered an actual suicide attempt. THERE DOES NOT NEED TO BE ANY INJURY OR HARM, just the potential for injury or harm. If person pulls the trigger while gun in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behaviour/circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g. gunshot to head, jumping from window of a high floor/storey). ALSO, IF SOMEONE DENIES INTENT TO DIE, BUT THEY THOUGHT THAT WHAT THEY DID COULD BE LETHAL, INTENT MAY BE INFERRED.

Have you made a suicide attempt?

Have you done anything to harm yourself? Have you done anything dangerous where you could have died?

What did you do?
Did you ____ as a way to end your life?
Did you want to die (even a little) when you ____?
"Were you trying to end your life when you ____?
OR Did you think it was possible you could have died from ____?

Or did you do it purely for other reasons/without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?

Interrupted Attempt:

When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (if not for that, actual attempt would have occurred). Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so.

Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?

Aborted or Self-Interrupted Attempt:

When person begins to take steps towards making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behaviour. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else.

Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?

Preparatory Acts or Behaviour:

Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g. buying pills, purchasing a gun) or preparing for one's death by suicide (e.g. giving things away, writing a suicide note).

Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?

Suicide Risk Level

Screen negative at this time
Low risk
Moderate risk
High risk

Suicidal Behaviour

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

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

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

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

The suicide risk level will be autopopulated.

Overview of C-SSRS Lifetime Assessment Tool Continued

Columbia Suicide Severity Rating Scale (C-SSRS) Lifetime/Recent - PIMH Scheduling, Practice 17

*Performed on: 2020/02/12 1033 EST

Suicidal Behaviour

Check all that apply, so long as they are separate events; must ask all types

Actual Attempt:

A potentially self-injurious act committed with at least some wish to die, as a RESULT OF ACT. Behaviour was in part thought as a method to kill oneself. Intent does not have to be 100%. If there is ANY intent/desire to die associated with the act, then it can be considered an actual suicide attempt. THERE DOES NOT NEED TO BE ANY INJURY OR HARM, just the potential for injury or harm. If person pulls the trigger while gun in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behaviour/circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g. gunshot to head, jumping from window of a high floor/storey). ALSO, IF SOMEONE DENIES INTENT TO DIE, BUT THEY THOUGHT THAT WHAT THEY DID COULD BE LETHAL, INTENT MAY BE INFERRED.

Have you made a suicide attempt?

Have you done anything to harm yourself? Have you done anything dangerous where you could have died?

What did you do?
Did you ____ as a way to end your life?
Did you want to die (even a little) when you ____?
"Were you trying to end your life when you ____?
OR Did you think it was possible you could have died from ____?

Or did you do it purely for other reasons/without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?

Interrupted Attempt:

When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (if not for that, actual attempt would have occurred). Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so.

Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?

Aborted or Self-Interrupted Attempt:

When person begins to take steps towards making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behaviour. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else.

Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?

Preparatory Acts or Behaviour:

Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g. buying pills, purchasing a gun) or preparing for one's death by suicide (e.g. giving things away, writing a suicide note).

Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?

Suicide Risk Level

Screen negative at this time
Low risk
Moderate risk
High risk

Lethality/ Damage

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

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

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

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

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

Overview of C-SSRS Lifetime Assessment Tool Continued

Columbia Suicide Severity Rating Scale (C-SSRS) Lifetime/Recent - PIMH Scheduling, Practice 17

*Performed on: 2020/02/12 1033 EST

Suicidal Ideation/ Intensity of Ideation

Actual Lethality/Medical Damage

Interventions

Additional Risk as

Actual Lethality/Medical Damage

Most Recent Attempt: Lethality//Medical Damage

Date

Actual Lethality/Medical Damage

☐ No physical damage or very minor physical damage (e.g. surface scratches)

☐ Minor physical damage (e.g. lacerations, speech, first-degree burns, mild bleeding, sprains)

☐ Moderate physical damage: medical attention needed (e.g. conscious but sleepy, somewhat responsive, second-degree burns, bleeding of major vessel)

☐ Moderately severe physical damage: medical hospitalization and likely intensive care required (e.g. comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover, major fractures)

☐ Severe physical damage: medical hospitalization with intensive care required (e.g. comatose without reflexes, third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to vital area)

☐ Death

Potential Lethality

☐ Behaviour not likely to result in injury

☐ Behaviour likely to result in injury but unlikely to cause death

☐ Behaviour likely to result in death despite available medical care

Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; lying on train tracks with oncoming train but pulled away before run over)

Actual Lethality Level

Potential Lethality Level

Most Lethal Attempt: Lethality//Medical Damage

Date

Actual Lethality/Medical Damage

☐ No physical damage or very minor physical damage (e.g. surface scratches)

☐ Minor physical damage (e.g. lacerations, speech, first-degree burns, mild bleeding, sprains)

☐ Moderate physical damage: medical attention needed (e.g. conscious but sleepy, somewhat responsive, second-degree burns, bleeding of major vessel)

☐ Moderately severe physical damage: medical hospitalization and likely intensive care required (e.g. comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover, major fractures)

☐ Severe physical damage: medical hospitalization with intensive care required (e.g. comatose without reflexes, third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to vital area)

☐ Death

Potential Lethality

☐ Behaviour not likely to result in injury

☐ Behaviour likely to result in injury but unlikely to cause death

☐ Behaviour likely to result in death despite available medical care

Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; lying on train tracks with oncoming train but pulled away before run over)

Actual Lethality Level

Potential Lethality Level

Initial/First Attempt: Lethality//Medical Damage

Date

Actual Lethality/Medical Damage

☐ No physical damage or very minor physical damage (e.g. surface scratches)

☐ Minor physical damage (e.g. lacerations, speech, first-degree burns, mild bleeding, sprains)

☐ Moderate physical damage: medical attention needed (e.g. conscious but sleepy, somewhat responsive, second-degree burns, bleeding of major vessel)

☐ Moderately severe physical damage: medical hospitalization and likely intensive care required (e.g. comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover, major fractures)

☐ Severe physical damage: medical hospitalization with intensive care required (e.g. comatose without reflexes, third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to vital area)

☐ Death

Potential Lethality

☐ Behaviour not likely to result in injury

☐ Behaviour likely to result in injury but unlikely to cause death

☐ Behaviour likely to result in death despite available medical care

Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; lying on train tracks with oncoming train but pulled away before run over)

Actual Lethality Level

Potential Lethality Level

Frequency of C-SSRS Lifetime Assessment Tool:

Mental Health Inpatients

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

Mental Health Outpatients

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

All Other St. Joseph’s Program Areas

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

Since Last Contact

Ask questions 1 and 2.

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

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

The suicide risk level will be autopopulated.

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

Overview of C-SSRS Since Last Contact Assessment Tool

Columbia Suicide Severity Rating Scale (C-SSRS) Since Last Contact - PIMH Scheduling, Practice 17

*Performed on: 2020/02/12 1146 EST

Columbia Suicide Interventions

Columbia Suicide Severity Rating Scale (C-SSRS) Since Last Contact

1. Have you wished you were dead or wished you could go to sleep and not wake up?
Do you ever wish you weren't alive anymore? ☐ Yes ☐ No

2. Have you had any actual thoughts of killing yourself?
Have you thought about doing something to make yourself not alive anymore? ☐ Yes ☐ No

3. Have you been thinking about how you might do this?
Have you thought about how you would do that or how you would make yourself not alive anymore?
What did you think about?
e.g. "I thought about taking an overdose but I never made a plan as to when where or how I would actually do it.,and I would never go through with it."
Details:

4. Have you had these thoughts and had some intention of acting on them?
When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?
This is different from having the thoughts but knowing you wouldn't do anything about it. ☐ Yes ☐ No
Details:

5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? ☐ Yes ☐ No
Have you planned out (worked out the details of) how you would do it?
What was your plan?
When you made this plan (or worked out these details), was any part of you thinking about actually doing it?
Details:

6. Have you done anything, started to do anything, or prepared to do anything to end your life? ☐ Yes ☐ No
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to a roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.

Suicide Risk Level: ☐ Screen negative at this time ☐ Low risk ☐ Moderate risk ☐ High risk ☐ Review interventions

Frequency of C-SSRS Since Last Contact Assessment Tool:

Mental Health Inpatients

- Complete once per day

Mental Health Outpatients

- Complete once per visit/appointment

All Other St. Joseph’s Program Areas

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



Suicide Care Management Plan

October 2019



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

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

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

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

FRAMEWORK FOR ROOT CAUSE ANALYSIS AND CORRECTIVE ACTIONS*

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

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

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

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

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

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

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

EVENT DESCRIPTION

When did the event occur?

Date:	Day of the week:	Time:
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Detailed Event Description Including Timeline:

Diagnosis:

Medications:

Autopsy Results:

ROOT CAUSE ANALYSIS - QUESTIONS

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

3	What human factors were relevant to the outcome?	Discuss staff-related human performance factors that contributed to the event. Examples may include, but are not limited to: • Boredom • Failure to follow established policies/procedures			
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#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors/Root Cause Details (Table A-1)
		• Fatigue • Inability to focus on task • Inattentional blindness/confirmation bias • Personal problems • Lack of complex critical thinking skills • Rushing to complete task • Substance abuse • Trust			
4	What controllable environmental	What environmental factors within the organization's control affected the			

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

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

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

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

14	To what degree was all the necessary information available when needed? Accurate? Complete?	Discuss whether client screening and or assessments were completed, shared, and accessed by members of the team, to include referral sources and care providers, according to the organizational processes. Identify the information systems used during client interactions. Discuss to what extent the available client information (e.g., medical record, documents from other organizations)			
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#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors/Root Cause Details (Table A-1)
	Unambiguous?	was clear and sufficient to provide an adequate summary of the client's needs, condition, treatment, and ongoing services/care. Describe staff utilization and adequacy of policy, procedure, protocol, and guidelines specific to the organization.			

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

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

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

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

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

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

CORRECTIVE ACTIONS

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

BIBLIOGRAPHY

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

TABLE

A-1. ROOT CAUSES

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

Team factors	• Speaking up, disruptive behavior, lack of shared mental model • Lack of empowerment • Failure to engage client
Management/supervisory/workforce factors	• Disruptive or intimidating behaviors • Staff training • Appropriate rules/policies/procedure or lack thereof • Failure to provide appropriate staffing or correct a known problem • Failure to provide necessary information
Organizational culture/leadership	• Organizational-level failure to correct a known problem and/or provide resource support including staffing • Workplace climate/institutional culture • Leadership commitment to client safety

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

TABLE

A-2. ACTION STRENGTH

Action Strength	Action Category	Example
Stronger Actions (These tasks require less reliance on humans to remember to perform the task correctly)	Architectural/physical plant changes	Replace revolving doors at the main client entrance into the building with powered sliding or swinging doors to reduce client falls.
	New devices with usability testing	Perform heuristic tests of electronic suicide risk screening tools
	Engineering control (forcing function)	Eliminate free-texting on electronic screening tool to ensure accurate completion.
	Simplify process	Remove unnecessary steps in a process.
	Standardize on equipment or process	Standardize the make and model of telephone devices for conference calling crisis services
	Tangible involvement by leadership	Participate in organization client safety evaluations and interact with staff; support the RCA² process (root cause analysis and action); purchase needed equipment; ensure staffing and workload are balanced.
		Use two registered nurses to independently complete suicide risk screening and risk formulation.
Intermediate Actions	Redundancy	Make float staff available to assist when workloads peak during the day.
	Increase in staffing/decrease in workload	Use computer alerts for clients at high risk for suicidality.
	Software enhancements, modifications	Provide quiet rooms for programming/setting up equipment; remove distractions for staff when programming/setting up equipment.
	Eliminate/reduce distractions	

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

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

Source: National Client Safety Foundation. *RC4² Improving Root Cause Analyses and Actions to Prevent Harm*. Boston, MA: National Client Safety Foundation; 2015. Reproduced with permission.

TABLE

A-3. MEASURE OF SUCCESS

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

TABLE A-4. SAMPLE SIZE*

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



in Your Community:
An implementation guide for
community organizations



Study

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

STUDY

In the Plan 2.0 and Do section of the Zero Suicide Community Implementation Toolkit you worked through your Zero Suicide Initiative implementation. Throughout the Study phase of the project, the focus will shift to evaluating your hard work.

In this section of the Toolkit we will cover:

- Introduction to Project Evaluation
- Common Approaches to Project Evaluation
 - Zero Suicide Outcomes and Impact
 - Client Measure Outcomes
 - Staff Competency
 - Implementation Review
 - Fidelity
 - Data Reporting

Resources to have on hand (or screen):

- A copy of the Toolkit: Plan 1.0 and Plan 2.0 sections
- A copy of your Project Plan
- Zero Suicide Toolkit¹: zerosuicide.edc.org/toolkit

Introduction to Project Evaluation

There has been a lot of time and energy put into planning and implementing the Zero Suicide Initiative, but we can’t stop now! “Study”, or also known as “Evaluation”, is a very important element of project management because it helps to plan, organize, monitor, and control the project’s outcomes, activities, and progress². The data helps us to compare initial predictions about how the initiative would go, and inform quality improvement strategies before reaching sustainability and project close out. In fact, this is such an important element of project management that the Plan-Do-Study-Act (PDSA) cycle has an entire stage dedicated to studying the project’s status, and the Zero Suicide framework included “Improve” as one of the 7 essential elements: “Data-driven quality improvement is essential to ensure improved patient outcomes and better care for those at risk of suicide”¹.

During the Plan and Do phases, you started to do some preliminary thinking about how you would evaluate the Zero Suicide Initiative in your organization. Data collection can be challenging, and feel outside of our comfort zone, but don’t lose sight of why it is done in the first place. When we have the “facts” about how the initiative is going, we can adapt, pivot, and flex as necessary to make quality improvements. Having a sound data plan from the outset can be a great help as you proceed in analyzing how the initiative is going.



At St. Joseph’s, we quickly learned that the process of data collection within hospitals was complex. Some barriers and challenges that we encountered related to training opportunities, methodology, communication, and inter-rater reliability. In saying this, the team overcame these barriers/challenges by creating a methodology report that outlined all data measurements and procedures to ensure accuracy and consistency. We (the immediate project team) also decided to meet with each other once per week to ensure deadlines were met and priorities were well communicated.

TIP:

Now is also a good time to plan out the timelines for when you choose to engage in PDSA cycles to make initiative improvements (e.g., quarterly to align with typical reporting periods). On the outset, your project team may be making more frequent adaptations, but as the initiative nears close out, you may determine to meet every six months, or every year to discuss any required adaptations.

In this section of the Toolkit, we would like to encourage you to think about other elements of data you can consider to enhance your Zero Suicide Initiative evaluation. For example, if you implemented suicide event reviews (recall from the Plan 2.0 section of the Toolkit), you may wish to audit the documentation from your root cause analysis and action plan to identify trends, improvements, and areas of opportunity.

Helpful resource: [Zero Suicide Healthcare Evaluation Framework: Outcomes, Actions & Measures developed by the Zero Suicide Institute of Australia³](#).

There are many methods for data collection, including implementation reviews, surveys, questionnaires, records analysis (documentation), interviews, and focus groups. You will read about how you can integrate many of these different options below. Having a variety of methods in your data collection can add to the depth and breadth of your evaluation.

Common approaches to a project’s evaluation include measuring:

- 1) The outcomes and impact of the Zero Suicide Initiative
- 2) Implementation review (i.e. how did the implementation of the initiative go?)

Below, let’s review some examples of these two types of evaluation.

Common Approaches to Project Evaluation

1. Zero Suicide Outcomes and Impact:

a) Client Outcome Measures

At this point, the project team is now tasked with revisiting your evaluation plan (developed in the plan phase). Having completed project implementation, you may wish to add to the evaluation plan and consider how key client outcome measures that indicate the system and policy changes may be having the desired effect, such as¹:

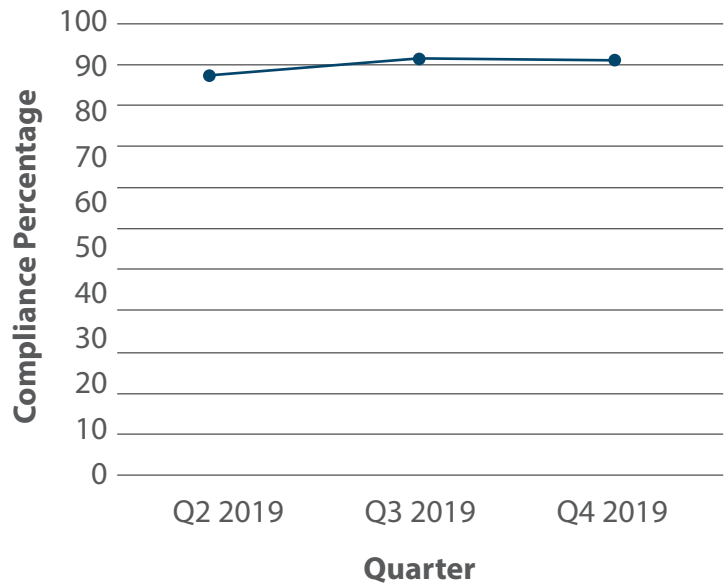
- Preventative processes are adhered to (e.g. suicide screening rates, assessment, Safety Plan, Coping Plan, lethal means counselling and restriction, caring contacts, missed appointment follow up, care planning)
- Required actions for clients who are screened/considered high risk of suicide are adhered to, including number of clients who have been supported in transitions of care (e.g. crisis center, emergency department)
- Rates of suicide attempts and/or deaths with/without identified risk
- The experience and satisfaction of clients who were supported in suicide prevention



St. Joseph’s currently collects data on the following measures: Adherence to caring contact process, suicide attempt and death rates, and quality completion of suicide screening tools, Safety Plans, and Coping Plans. Both manual and electronic data collection take place at St. Joseph’s, and examples of each are provided below.

Manual data collection:

Inpatient Areas’ Compliance Percentages of the C-SSRS Since Last Contact			
Time Frame	Q2 2019 (July 1, 2019 – September 30, 2019)	Q3 2019 (October 1, 2019 – December 31, 2019)	Q4 2020 (January 1, 2020 – March 31, 2020)
Total Number	47	46	74
Total Number Compliant	88.20%	91.84%	91.34%



Electronic reporting system:

During the 2020 year, the St. Joseph’s Zero Suicide team worked with the Quality Measurement and Clinical Decision Support and Business Intelligence teams to develop an automated data reporting system for inpatient screening tool results. The teams also worked together to develop an automated e-mail system that sends notifications to leaders and Clinical Nurse Specialists when there are outstanding or incomplete screening tools. Prior to these automated systems, we solely relied on manual audits which were time and labor intensive. These automated systems have helped increase screening tool compliance rates by sharing results in real-time to drive practice change.

Screenshot of the Automated Electronic Data Reporting System Results (client level):

Electronic Screening Tools - Columbia-Suicide Severity Rating Scale (C-SSRS) Lifetime - Admissions
Parkwood Institute Mental Health and Southwest Centre
May 2020

By Quarter

By Month

Aug 2019

Sep 2019

Oct 2019

Nov 2019

Dec 2019

Jan 2020

Feb 2020

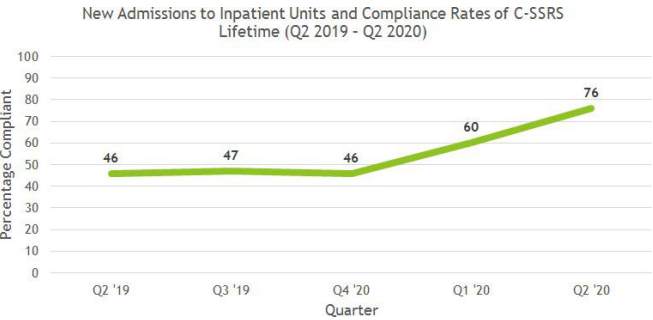
Mar 2020

Apr 2020

May 2020

C-SSRS Lifetime Screening				Parkwood Institute Mental Health and Southwest Centre											
	Total Admissions	Total Complete / Compliant	% Complete / Compliant												
Total (excluding G5 & H2)	8	2	25.0%												
Forensic	1	1	100.0%												
FMH-AU	1	1	100.0%												
Psychiatry	1	1	100.0%												
Confidential Information Removed				Documentation as of 3rd Day of Admission											
	Current or Discharging Unit	Discharge Date/Time	Age	C-SSRS Lifetime Date/Time	Risk Level	Required Sections Answered	Intensity of Ideation Section	Actual Lethality / Medical Damage Section	Reason Not Completed	Reason Not Completed Date/Time	Complete / Compliant				
	FMH-AU		48	2020-05-04 16:56	Screen negative at this time	Yes	Not Required	Not Required			Yes				
Mental Health Specialty Programs	7	1	14.3%												
Adolescent	7	1	14.3%												
PM-ADOL HS	7	1	14.3%												
Psychiatry	7	1	14.3%												
Confidential Information Removed				Documentation as of 3rd Day of Admission											
	MRN	Encounter #	Admit Date/Time	Current or Discharging Unit	Discharge Date/Time	Age	C-SSRS Lifetime Date/Time	Risk Level	Required Sections Answered	Intensity of Ideation Section	Actual Lethality / Medical Damage Section	Reason Not Completed	Reason Not Completed Date/Time	Complete / Compliant	
	PM-ADOL HS					21								No	
	PM-ADOL HS					36	2020-05-07 22:20	Low risk	No	Required, Not Answered	Required, Not Answered			No	
	PM-ADOL HS					29	2020-05-08 15:55	Screen negative at this time	Yes	Not Required	Not Required			Yes	
	PM-ADOL HS					41								No	
	PM-ADOL HS					44	2020-05-05 18:26	High risk	No	Required, Not Answered	Required, Not Answered			No	
	PM-ADOL HS					26	2020-05-05 19:32							No	

Screenshot of a Chart from the Automated Electronic Data Reporting System: Screening Tool Data (organization level):



Screenshot of an Automated E-mail sent from the Electronic Data Reporting System:

Good Morning,

St. Joseph's Health Care London is committed to suicide prevention and quality improvement.

E-mail notifications that identify incomplete Columbia-Suicide Severity Rating Scale (C-SSRS) Lifetime screening

tools create a prompt for your engagement with clinician(s) to ensure completion within 3 days of admission.

If you have questions regarding C-SSRS Lifetime completion, please contact

Thank you for your diligence and ongoing support.

Electronic Screening Tools - Columbia-Suicide Severity Rating Scale (C-SSRS) Lifetime - Admissions

Unit(s):

Error Message: No C-SSRS Lifetime Documentation Can Be Found
Action Required: Complete the C-SSRS Lifetime within 3 days of admission as per SJHC London Corporate Policy: Suicide Risk Assessment & Prevention

Encounter Details	Reason Not Completed Date/Time	C-SSRS Lifetime Date/Time
Encounter Number:	★	
Admit Date/Time: 2021-12-17 10:41		
Due By: 2021-12-20 23:59		

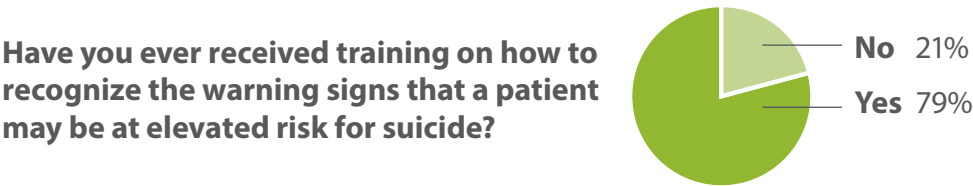
b) Staff Competency

Workforce Survey

Staff competency can be evaluated with re-administering the Workforce Survey (WFS) which you will recall from the Plan 1.0 section of the Toolkit. It is recommended that the WFS is completed with staff every 12-18 months¹. This provides an excellent opportunity to assess the effectiveness of education, and levels of staff competence and confidence. Below we have provided an example of some pre and post Zero Suicide implementation data results from St. Joseph's WFS for an outpatient mental health team.

2018 Zero Suicide Workforce Survey – Key Results (45 respondents)

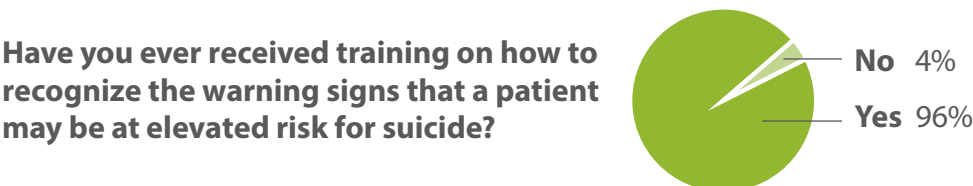
Areas in which staff/physicians would like more training, resources, or support:		
Area	Percentage	Responses
Policies and procedures	60.53%	23
Staff roles and responsibilities	55.26%	21
Understanding and navigating ethical and legal considerations	55.26%	21
Suicide screening practices	50.00%	19
Collaborative safety planning for suicide	50.00%	19
Determining appropriate levels of care for patients at risk for suicide	50.00%	19
Suicide-specific treatment approaches	50.00%	19



2021 Zero Suicide Workforce Survey – Key Results (46 respondents)

Please note that the sample of respondents are not from the same cohort as the 2018 data, which is partially due to staff turnover. However, this still provides a snapshot of reliable comparator data.

Areas in which staff/physicians would like more training, resources, or support:		
Area	Percentage	Responses
Policies and procedures	60.53%	23
Staff roles and responsibilities	55.26%	21
Understanding and navigating ethical and legal considerations	55.26%	21
Suicide screening practices	50.00%	19
Collaborative safety planning for suicide	50.00%	19
Determining appropriate levels of care for patients at risk for suicide	50.00%	19
Suicide-specific treatment approaches	50.00%	19



Focus Groups/ Interviews

Another excellent source of information to assess staff competency and experience is to elicit feedback in conversation with staff. In March 2020, the St. Joseph’s Zero Suicide Initiative team organized focus groups with a group of inpatient and outpatient clinicians to receive feedback on the initiative, have discussions around suicide prevention, and determine any identified areas for further education/training. Below, we have outlined example questions asked, as well as some of the clinicians’ responses.

- Q: What was the most effective education related to suicide assessment/care for you, personally?

A: “ASIST”
- Q: What are some positive elements of the C-SSRS Lifetime tool/its use/purpose?

A: “A segment of the staff think that if we talk about it, it will happen... so this is the opposite and [the tool] forces people to talk about it.”

2. Implementation Review:

Evaluating the implementation of a project, or the methods and strategies that facilitate the uptake of evidence-based practice, is also referred to as ‘implementation science’. As a relatively new field of study, implementation science aims to “...close the gap” between what we know and what we do by identifying and addressing the barriers that slow or halt the uptake of proven health interventions and evidence-based practices”⁴.

Where to start? With your project team, begin to think about how you met your goals, objectives, and activities to determine whether or not the project has produced the planned for/intended results. Review your project plan and create notes beside your goals, reflecting on the status of each. Also consider the field notes you kept throughout the project, and spend some time reflecting on how smoothly the project roll out went, such as:

1) What facilitated the project’s implementation (e.g. leadership support)?

2) What were some of the barriers to its implementation (e.g. timing)?

3) What were some of the most effective mechanisms of change (e.g. stakeholder engagement)?

4) What are some of the strengths I have identified about the organization’s capacity to roll out a project (e.g. innovation)?

Fidelity

Next, let’s take a look at evaluating the implementation of the Zero Suicide Initiative more closely by examining **fidelity** to the framework. Implementation fidelity speaks to the degree to which an intervention or model is delivered as intended. In other words, how closely does your implementation match the Zero Suicide framework and what you planned to do? As for how to measure fidelity, remember that “Organizational Self Study” (OSS) you completed during the planning phase (specifically in the current state analysis) of the Zero Suicide Initiative? You can choose to return to this, completing it based on where your suicide prevention efforts are today.

It is recommended that the OSS is completed approximately one year after implementation, however, based on the size of the organization and when you are completing a PDSA cycle, you may feel that it is appropriate to complete this sooner. Try not to review your previous findings until you have completed the OSS at present time. Then, take some time to compare your previous and current OSS. Don’t forget to stop, take a breath, and recognize all the work you have done, and the progress made – recognizing your efforts. Completing the OSS every year post implementation will reveal to your organization how well you are adhering to the Zero Suicide framework and point out the areas where you can engage in a PDSA cycle and strive for continued improvement.

TIP:

Share your findings from the OSS with staff! This could be in a recap/progress meeting, report, presentation, etc. Rewarding progress and highlighting opportunities for continued improvement will help keep the initiative’s momentum going.



Example: Several years after “go-live” at St. Joseph’s, clinicians identified how they could enhance their care planning procedures and provision of evidence-based treatment. With a commitment to learning and achieving fidelity to the Zero Suicide framework, key stakeholders began working together to study the research about how they could continue improving care for chronic and complex suicidality.

One resource we highly recommend is the Zero Suicide Institute of Australia,³ [“Zero Suicide Healthcare Evaluation Framework: Outcomes, Actions & Measures.”](#) Although this document was created with a healthcare lens, it provides exceptional guidance to organizations seeking to better understand the theory related to project evaluation as well as key outcomes organizations can measure their progress in. Most importantly, organizations can measure their fidelity to the Zero Suicide framework, and also consider their involvement with high level outcome measures (e.g. community suicide death rates, proportion of those presenting to the ED for a suicide attempt). These are important considerations where communities tend to lack coordinated data collection and reporting.

Data Reporting

How you share your data will really depend on the scale of your initiative and the size of your organization. For example, you may have embedded this initiative into a quality improvement organizational program that involves senior leaders and that has specific reporting requirements. Or you may include data results in each Steering Committee or project team meeting. Whatever you decide, the important part is that the data is accurate, transparent, and used positively to promote quality improvement.

Further, it is an important principle to always share data results with those from whom you collected it. The ability to have tangible results demonstrating progress is important for staff - ensuring they can see the fruits of their labor. You may wish to include an area on an organizational webpage, or as a standing agenda item for team meetings where you can report such findings.

Again, depending on the size and scale of the initiative, you may also have requests from the media to share the good news of your work. As an underserved area, such an initiative has the potential to catch the eye of the public. Developing a one-page overview of your work can be a useful reference to use, so that you can share information quickly and effectively.

Other opportunities for data sharing (knowledge translation – more on [page 112](#)) may include (but are not limited to):

- Consortium or community of practice
- Conferences
- Scholarly publications
- Organizational reports
- Public website
- Social media (e.g. infographics or videos)
- Community forums/meetings
- Newsletters

Conclusion

The information provided above is not an exhaustive list of all that you can study or the ways you can share your good work. It is prudent to also consider measures that might be specific to/required by your organization, such as funding or legislated/adopted quality markers/indicators (e.g. Accreditation).

Each organization can benefit greatly from completing a comprehensive and structured evaluation. Recall that you can use the “Zero Suicide Data Elements Worksheet” (Plan 2.0 section of the Toolkit) as a useful guide. By completing ongoing evaluation of the project, your organization stays committed to a culture of learning and growth (quality improvement). Remember, another added bonus is that by completing formal evaluation you will increase your leadership potential in translating your new-found knowledge to others and contribute to the greater ongoing efforts of universal suicide prevention.

In this section of the Toolkit we’ve offered some guidance in developing your project evaluation. Next, we will consider how you act on this data to drive quality improvement.

References

1. Education Development Center. (2015). *Zero Suicide toolkit*. Zero Suicide. zerosuicide.edc.org/toolkit
2. Cleland, D. I. (1985). A strategy for ongoing project evaluation. *Project Management Journal*, 16(3), 11–17.
3. Zero Suicide Institute of Australia (2020). *Zero Suicide healthcare evaluation framework outcomes: Actions and measures*. zerosuicide.org/zero-suicide-healthcare-evaluation-framework/
4. University of Washington. (2021). *What is implementation science?* impsciuw.org/implementation-science/learn/implementation-science-overview/

Appendices

[Appendix N](#) - Root Cause Analysis and Corrective Actions (Non-healthcare)



in Your Community:

An implementation guide for
community organizations

Act

ACT

Having made a significant investment of time and energy into enhancing suicide prevention practices at your organization, sustaining your hard work is crucial.

In the Study section of the Toolkit, we reviewed how quality improvement is iterative and in a continuous cycle. The Act section of the Plan-Do-Study-Act (PDSA) cycle encourages: standardization of improvement; implementing any required changes or modifications; and implementing a new PDSA cycle. In other words, Act stands for “the hard work of experimentation, adaptation”, and “holding the gains”¹. The Act section of the PDSA cycle asks the question: *How can you continue to build on your momentum and success?*

In this section of the Toolkit, you will review some key strategies for quality improvement, implementation spread, and sustainability:

- Refining the plan
- Organizational spread
- Creating a culture of continuous improvement
- Sustainability plan
- Knowledge translation
- Project close-out
- Conclusion

Sustainability: Locking in the progress already made and continually building upon it.

Spread: Actively disseminating knowledge and implementing effective practices in every available program.¹

Resources to have on hand (or screen):

- A copy of the Toolkit: Plan 1.0, Plan 2.0, and Study sections
- A copy of your Project Plan
- Zero Suicide Toolkit website: zerosuicide.edc.org/toolkit

Refining the Plan

As mentioned above, Act is the phase of the PDSA cycle when plan adjustments and adaptations need to be made based on the project’s formal evaluation, anecdotal experience, observation, and informal feedback. This action oriented, experiential learning is invaluable because it is unique to your organization. Review your original Project Plan meaningfully and consider what needs to be refined. Track changes on your original Project Plan, or create a new one that is time stamped, so that you are able to review the implementation’s evolution (recall from the Study section of the Toolkit that this will serve as data in an Implementation Review). There is no wrong amount of adaptation or refinement - the point is that it is being done, and that the organization is committed to the changing nature of project work.



At St. Joseph’s, the implementation team was projected to focus their energy in 2020 on Phase 3 of the project, which entailed spreading the initiative to community partners. With the onset of the COVID-19 pandemic, the team realigned goals to include a PDSA cycle of Phase 1 and 2 of the initiative, alongside our Phase 3 work of developing this Toolkit. A lot had changed in the health care environment and the Zero Suicide team was committed to looking at innovative ways to improve patient care, such as virtual suicide care, team debriefing, and improving evidence-based treatment.



Niagara Region Public Health had been scheduled to roll out Zero Suicide with additional internal programs, but with Public Health at the front lines of the COVID-19 pandemic, many staff were redeployed to support the pandemic response. Focus shifted to creating this Toolkit to support teams as they return from redeployment, as well as community organizations following the pandemic.

Our Mental Health program continued with their services to clients, with slight shifts to align with pandemic restrictions – while this was happening, the working group conducted chart audits to understand how staff are using the C-SSRS tools and look for areas for improvement to support staff with this work.

Once adaptations have been implemented, consider how these “lessons learned” can be applied to other service areas when it is time to “spread” the initiative (if applicable). Take a moment to write down 3 important lessons your organization has learned to date:

- 1. _____
- 2. _____
- 3. _____

Organizational Spread

If you are piloting the Zero Suicide Initiative in a select number of service areas, you may now wish to incorporate what you have learned, and begin implementation and spread to other areas. Recall from your Project Plan, what your broader organizational goals are.

Now is the time to fully develop and implement your spread plan which means re-entering the PDSA cycle (and use of this Toolkit) for the upcoming areas.

Resource: Check out the Institute for Healthcare Management (2008) *Getting Started Kit: Sustainability and Spread (How-to Guide)*, part of the 5 Million Lives Campaign, for some excellent information.

The next areas we plan to spread this initiative to include:

Service Area	Timeframe

The foundation for spread now rests on the success and lessons learned from the project’s pilot service area(s). Reengaging stakeholders (including leadership) to help with planning and oversight of upcoming implementation(s) is important for continued success. Sending a clear message about spreading the initiative, supporting participation from staff, and sharing results from the pilot area(s) with practical examples (and staff quotes) will help with staff engagement and more expedited future implementation. Take advantage of the experience and expertise of the pilot implementation team, as well as the rich learning from the successes and challenges you have experienced to date.

KEY TIPS:

Celebrate and share what has worked well. Connect results to purpose and help staff to realize how they are making a difference.

Leverage the experiences and subject matter expertise of the pilot areas.

Complete a current state analysis for new area(s) of implementation. Leverage what you can from the pilot area(s) (e.g. tools, processes, procedures) and determine what will require adaptation. For example, who are the experts for this location? Are there new risks to mitigate? What adaptations will be required for this area’s success?

Creating a Culture of Continuous Quality Improvement

As suicide prevention practices continue to spread throughout service area(s) in your organization, it is important to consider how to influence a culture of continuous quality improvement. Some well-known, credible sources on sustainability in health care systems outline the following properties that sustain continuous quality improvement^{1,2}:

1. Supportive management structure: Leadership treats quality of service as a high priority, devoting regular attention, creating accountability systems for improvement, and recognizing success.
Example: Review intervention-level performance (metrics) monthly in a structured reporting format.
2. Structures to foolproof change: Organization builds structures that make it difficult (if not impossible) for staff to revert to old ways of doing things.
Example: Leverage tools and technology (e.g. checklist, or electronic documentation system). Ensure required processes are documented in policy/procedure/guidelines and training materials.
3. Robust, transparent feedback systems: Measurement systems that provide data to those at every level of the organization, comparing it to the standards set out by management.
Example: Organization has a data measurement system/personnel that regularly generate data and measure this against the articulated project goals.
4. A shared sense of the systems to be improved: All stakeholders involved in improvements share an understanding of their roles in the processes and systems they are working to improve.
Example: Leaders use tools to map the process that’s been improved (e.g. flow chart), and allow for shared analysis of these systems during ongoing sustainability work.
5. A culture of improvement and deeply engaged staff: Organization shares a sense of pride around performance and improvements and many enjoy the work. Staff are aware of the initiative and feel invested in the outcomes.
Example: Staff job descriptions and performance reviews include attention to the initiative and skills required (e.g. skills in suicide prevention). Staff are able to explain their role in quality improvement. Leaders of the initiative create opportunities for regular feedback sharing.
6. Formal capacity-building programs: Organization makes training and skill building a high priority, and there is a culture where improvement work is integrated into day-to-day activity.
Example: Leaders of the initiative work with staff to enhance competence and confidence, ensuring that every stakeholder in the organization has training for ongoing quality improvement changes.

Which of these properties are evident in your organization?

- _____
- _____
- _____
- _____

In which ways could your organization improve methods to sustain continuous quality improvement?

- _____
- _____
- _____
- _____

Sustainability Plan

Now that you have had your focus on how to sustain lasting project results, it is helpful to develop some specific goals and plans. There are many resources available on the internet, but one we recommend is the [Institute for Healthcare Improvement Sustainability Planning Worksheet](#).

Knowledge Translation

Knowledge translation (using what we have learned from implementation and data collection and moving towards applying that knowledge in a practical way)³ can occur at many stages throughout project implementation - you do not need to have completed your entire implementation before you start sharing your work with others. In the Study section of the Toolkit, we discussed different forms of data collection and evaluation, including 1) the outcomes and impact of the Zero Suicide Initiative, and 2) Implementation review. Depending on how you’ve structured your evaluation, you can now use this information to share your work with others. Sharing your experience and progress made towards suicide prevention is “knowledge translation - *what makes research matter*”⁴.

TIP:

Remember that you do not only have to share what worked well, or as you anticipated, with others. Some of the most valuable information comes from learning what did not work well.

Questions to consider when thinking about your plan for knowledge translation include⁴:

- What is the **concept** (i.e. what am I seeking to share)?
- Who is the **audience** that I am seeking to share this with (i.e. who will use this)?
- What is the **message** that I am trying to deliver (i.e. how will I effectively articulate information for this audience)?
- What is the **medium/method** that is most appropriate to do this (i.e. where/how will this information be shared)?
- What are the **tools** that I will require to do this (i.e. skills, personnel, resources)?

Common mediums/methods for knowledge translation include:

- Community partners
- Local communities of practice/ working groups/tables/educational speaking engagements
- With other branches of your organization (if applicable)
- Online forums, newsletters, or Internet pages (print media)
- Conferences (oral, poster, or other methods)
- Publication to a scholarly journal
- Policy brief to different levels of government
- Develop resources (hint: this Toolkit is one of ours!)

Community of Practice (COP): A group of people who share a common concern, set of problems, or interest in a topic and who come together to fulfill both individual and group goals. A COP typically meets regularly and shares best practice and works to create new knowledge⁵.

TIP:

If you do not currently belong to a community of practice related to suicide prevention, we encourage you to seek out joining, or develop one in your local community.

Jot down a couple of ideas for how you may participate in knowledge translation in the future:

- _____
- _____
- _____
- _____

It may feel like some extra work to engage in knowledge translation, but doing so can create networking opportunities, support professional development, and contribute to the greater body of evidence-based practice that helps make communities more suicide safe.

Ongoing Project Maintenance

The time has arrived, and your project may now be referred to as an ongoing pursuit of patient safety and/or aspiration for a multitude of reasons. Sometimes it is due to a time or resource limitation, but it can also be because you’ve successfully executed your suicide prevention workplan. Whatever the reason – well done.

Feeling as though you can set the sustainability process into motion requires confidence that the project goals have been completed and performance is sustained (also known as “hardwired” or “baked in”). When there is a sense of ownership built into the organization the “special project” you’ve been working on becomes an operational responsibility and staff are motivated to continue the good work... for the long term.

As you work towards ongoing project maintenance (remember Zero Suicide is a continuous pursuit), consider developing a list of potential risks, as well as the implementation team’s perspective of ongoing opportunities for continuous quality improvement.



At St. Joseph’s, the Zero Suicide Initiative team developed a project risk document, which outlined the risk of project close out, risk mitigation strategies, risk level, and the corresponding element of the Zero Suicide framework. See [Appendix V](#) for the template.

Knowing that the implementation’s resources and capacity may be reduced in their intensity, you may consider creating a sustainable working group or select individuals (“Champions”) to continue championing the initiative. This working group may continue to meet regularly at prescribed intervals to monitor and sustain the project. Some common goals of a working group at this time may include:

- Continuing to monitor data and measure progress
- Review or update policy/procedures when required or during prescribed intervals
- Review or update education/educational requirements (respond to changing needs/best practice updates)
- Subject matter experts available for consultation/support for complex client situations
- Connecting with/supporting other organizations as they implement suicide prevention practices

Instead of simply dissolving the regular project team, processes, and structures that have led the initiative, consider how you can communicate with all staff that will be impacted by this change. You may wish to consider sharing the following:

- Initiative successes and key milestones
- Strategy for ongoing support and continued quality improvement

Conclusion

Now that you are focused on, ongoing project maintenance, this Toolkit also comes to an end. Remember that this is a resource you can frequent regularly, and in any order, to meet the non-linear and ongoing needs of project management. Some of you may have started this journey several months, or even years ago. Take a few moments to reflect on this initiative, and recognize all of your hard work to date. What will you take away from your work on this initiative? Consider how this initiative has made an impact in your organization, for those you serve, and in your community.

Thank you, and remember that your work has been of great service to others:

For the 10 people who die by suicide each day, and the other 210 that attempt⁶.

For the 7-10 people profoundly affected by each loss⁶.

Together, let’s remain a part of the collective effort towards suicide prevention.

Simply put, one life lost is one too many.

References

1. Institute for Healthcare Improvement. (2020). How to Guide: Sustainability and Spread. <http://www.ihl.org/resources/Pages/Tools/HowtoGuideSustainabilitySpread.aspx>
2. Studer, Q. (2003). *Hardwiring excellence*. Fire Starter Publishing.
3. Canadian Institutes for Health Research (2016). Knowledge Translation. <https://cihr-irsc.gc.ca/e/29418.html>
4. Bennett, G. & Jessani, N. (2011). The knowledge translation toolkit. Sage Publications. <https://www.idrc.ca/en/book/knowledge-translation-toolkit-bridging-know-do-gap-resource-researchers?PublicationID=851>
5. Edmonton Regional Learning Consortium. (2016). Creating Communities of Practice. <http://www.communityofpractice.ca/background/what-is-a-community-of-practice>
6. Public Health Agency of Canada. (2016). Suicide in Canada: Infographic. <https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-canada-infographic.html#:~:text=Public%20Health%20Agency%20of%20Canada%20analysis%20of%20Statistics,to%20avoid%20labeling%20or%20reporting%20deaths%20as%20suicides>.

Appendices

[Appendix U](#): St. Joseph’s Zero Suicide Project Closeout: Potential Risk Identification Template

Project Closeout: Potential Risk Identification

Risk level	Zero Suicide Element	Risk	Risk Mitigation Strategy
Phase 2:			
Phase 3:			

Risk level description:

High-

Moderate-

Low-