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# Oregon Zero Suicide Implementation Assessment Instrument, v.2.1

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# Oregon Zero Suicide Implementation Assessment Tool (version 2.1)

an adaptation of EDC's Zero Suicide Organizational Self-Study

**Element #1: Lead**

Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.

**Element #2: Train**

Develop a competent, confident and caring workforce.

**Element #3: Identify**

Systematically identify and assess suicide risk among people receiving care.

**Element #4: Engage**

Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet individual needs.

**Element #5: Treat**

Use effective, evidence-based treatments that directly target suicidality.

**Element #6: Transition**

Provide continuous contact and support, especially after acute care.

**Element #7: Improve**

Apply a data-driven quality improvement approach to inform system changes leading to better care and improved outcomes for individuals at risk.

***Suggested Citation:***

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## Background:

**This 2023 update to the 2018 Zero Suicide implementation assessment tool and the accompanying web survey is a collaboration of Portland State University's Human Services Implementation Lab, the Oregon Health Authority, the Zero Suicide Institute and other contributors.** The assessment was adapted from the Education Development Center's Zero Suicide resources available at http://zerosuicide.org/. Content is drawn mainly from:

- **The General and Inpatient Self-Studies:** Questionnaires about the extent to which each component of the Zero Suicide approach is in place at a single organization. Zero Suicide recommends completing this self-study at the start of an organization's Zero Suicide initiative, then every 12 months after that as a measure of fidelity to the model. **The self-study questions serve as the basis for this Oregon Zero Suicide Implementation Assessment and have been reformulated as indicators**. The response options (or anchors) for each question are included in the grid to define the level of implementation for each indicator.
- **The Data Elements Worksheet:** A list of primary and supplemental measures recommended for behavioral health care organizations to strive for to maintain fidelity to a comprehensive suicide care model. The supplemental measures are clinically significant but may be much harder to measure than the primary measures. Zero Suicide recommends reviewing these data elements every three months in order to determine areas for improvement. **Starting with element #3 (Identify) of this implementation assessment, these data points are requested for each relevant indicator as documentation for the rank awarded. Additional data points for indicators added to version 2 of this adaptation were developed by PSU.**

**OHA is using this implementation assessment to track change over time related to suicide prevention efforts among organizations participating in Zero Suicide Academies sponsored by OHA and the subsequent Zero Suicide Community of Practice Conference Calls.**

**For more information on:**

- **Zero Suicide**, visit http://zerosuicide.org/
- **OHA's Zero Suicide Initiative**, contact Megan Crane, OHA Zero Suicide Coordinator at Meghan.Crane@dhsoha.state.or.us
- **The study being conducted using this instrument**, contact Karen Cellarius, Director, Human Services Implementation Lab (https://hsimplementationlab.org/) and Senior Research Associate, Portland State University Regional Research Institute for Human Services at cellark@pdx.edu

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# Zero Suicide (ZS) Implementation Indicators by Element

**Self-Assessment Instructions:** Use the detailed definitions beginning on page 3 to rate the implementation level of Zero Suicide. If every component of a defined rating is not in place, the score has not yet been achieved. Document the reason for the score in the space provided. Include metrics, if available. Transfer the scores to the table below to calculate the overall implementation score for your agency or department. Repeat the process at least annually to track change in implementation level over time.

**Scale:**

**1=Organization has not yet demonstrated awareness for the need for this component of Zero Suicide.**

**2=Organization has demonstrated awareness, but work on this component has not yet begun**

**3=Organization is actively working to implement component**

**4=Component is in place, but it is not yet sustainable or monitored**

**5=Component is sustainably in place, monitoring for continuous quality improvement occurs regularly and includes input from people with lived experience.**

| INDICATOR | SCORE |
|---|---|
| **Element #1: Lead** Mean→ | |
| Commitment to Zero Suicide *(NEW)* | |
| Commitment to DEI *(NEW)* | |
| Staff readiness to implement ZS *(NEW)* | |
| Messaging to staff related to ZS adoption *(NEW)* | |
| Written Protocols | |
| Suicide Care is Documented | |
| Availability of Trainings | |
| Dedicated Staff Time for Zero Suicide | |
| Survivor Involvement in Planning and Processes | |
| Just culture/philosophy of care *(NEW)* | |
| Workforce wellness *(NEW)* | |
| **Element #2: Train** Mean→ | |
| Assessment of Workforce Confidence | |
| Trainings for Non-Clinical Staff | |
| Trainings for Clinical Staff | |
| **Element #3: Identify** Mean→ | |
| Screening for Suicide Risk | |
| Screening Tools Used | |
| Suicide Risk Assessment | |

| INDICATOR | SCORE |
|---|---|
| **Element #4: Engage** Mean→ | |
| Care for Individuals At-Risk for Suicide | |
| Collaborative Safety Planning | |
| Lethal Means Counseling | |
| Postvention for staff and individuals in care *(NEW)* | |
| Postvention for affected community members *(NEW)* | |
| **Element #5: Treat** Mean→ | |
| Access to Suicide-specific Treatment | |
| Safer Environments *(NEW)* | |
| **Element #6: Transition** Mean→ | |
| Engaging Hard to Reach Individuals | |
| Follow-up after Transitions in Care | |
| **Element #7 Improve** Mean→ | |
| Analysis of Suicide Deaths | |
| Tracking Suicide Deaths | |
| Analysis of Suicide Attempts *(NEW)* | |
| Tracking Suicide Attempts *(NEW)* | |
| Appropriateness of Suicide Safer Care *(NEW)* | |
| Continuous Quality Improvement (CQI) | |

## Element #1: Lead

Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.

| **a. Commitment to Zero Suicide *(NEW)*** | **Rating** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|---|
| How does leadership demonstrate their commitment to the Zero Suicide framework within the organization? | | Leadership has not yet demonstrated awareness of the need to implement ZS. | Leadership is aware of the value of implementing ZS, but has not yet developed a plan to address it. | Organization has developed a plan toward implementing ZS. | ZS implementation strategies are established in strategic plan. ZS is an ongoing effort, but funding and leadership support are limited. If key staff leave, the initiative may not continue. | Organization has infrastructure to sustain ZS (e.g., work group, champion, etc.). Organization supports ZS implementation through active planning and ongoing budget allocation. Leadership implements changes as a high priority. |
| Comment or justification for score: | | | | | | |

| **b. Commitment to DEI *(NEW)*** | **Rating** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|---|
| How does leadership demonstrate their commitment to diversity, equity and inclusion (DEI) within the organization? | | Leadership has not yet demonstrated awareness that diversity, equity and inclusion (DEI) are key components of suicide prevention | Leadership is aware that inclusion goes beyond inclusion of people with lived experience of suicide to inclusion of people with lived experience of the communities being served. Diversity and equity are also valued for their positive impact on mental health and reduced suicide risk. However, a plan to address DEI has not yet been developed. | Leadership has developed a plan for building DEI within the organization and the communities being served. The plan is informed by input from members of those communities, including organizational staff, service users, and individuals with lived experience. | DEI building strategies are established in strategic plan. Staff and individuals served approve of DEI strategies. DEI is an ongoing effort, but funding and leadership support are limited. If key staff leave, the initiative may not continue. | Organization has infrastructure to sustain DEI (e.g., work group, champion, etc.). Organization supports DEI building strategies through active planning and ongoing budget allocation. Efforts continue to be assessed with input from staff and individuals from the communities being served. |
| | | Comment or justification for score:<br><br>**Suggested metrics:** Method for assessing implementation of DEI principles: _____. Data that is tracked: ☐ Lived experience. READL: ☐Race, ☐Ethnicity, ☐Language, ☐Disability SOGIE: ☐ Sexual Orientation, ☐ Gender Identity, and ☐ Gender Expression. | | | | |

| c. Staff readiness to implement ZS *(NEW)* | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| Are staff committed to implementing ZS and feel confident the organization can support staff and handle challenges that might arise related to ZS? | | Leadership has not yet demonstrated awareness of the need to assess staff buy-in for ZS. | Leadership is aware of the need to assess and promote staff buy-in for ZS, but work has not yet begun. | Leadership is assessing level of staff readiness by listening and responding to their concerns, but staff buy-in is limited. | Staff are committed to implementing ZS and feel confident the organization can support staff and handle challenges that might arise related to ZS, but commitment may wain if process becomes difficult. | Staff are committed to implementing ZS, feedback loops are in place for staff to express concerns, and the assessment of confidence is ongoing. |
| Comment or justification for score: | | | | | | |

| d. Messaging to staff related to ZS adoption *(NEW)* | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| How are Zero Suicide policies and practice communicated to staff? | | Organization has not yet demonstrated awareness of the need for consistent messaging around organization-wide implementation of Zero Suicide. | Organization is aware of value of consistent messaging, but has not yet developed a plan to do so. | A comprehensive communication and messaging plan has been developed and some messaging is occurring. Messaging is infrequent. Less than 50% of staff are aware of the initiative. | A comprehensive communication and messaging plan is in place that engages communications from multiple levels of leadership to reach all staff on a consistent basis in a multitude of communication platforms. | Organization-wide communication around ZS occurs at least monthly and in multiple formats. Staff awareness and buy-in of ZS is assessed. The communication plan is reviewed at least annually. |
| Comment or justification for score:<br>Suggested metric: Tools used for messaging: ☐ Monthly CEO letter, ☐ Quarterly safety newsletter, ☐ All staff or "town council" meetings on ZS efforts, ☐ Standing agenda items on regularly-meeting committees, ☐ Method to report out ZS data on a consistent basis, ☐ Engage buy-in and follow-through with ZS activities (such as the WFS, etc.) | | | | | | |

| e. Written Protocols | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| Does the organization have written **protocols** for specific components of suicide care, including (1) screening, (2) assessment, (3) lethal means safety, (4) safety planning, and (5) suicide care management plans?<br>How are staff made aware of these protocols? | | The organization has not yet demonstrated awareness for the need for all staff to be aware of the protocols for all five components of suicide care. | The organization has demonstrated awareness of the need for all staff to be aware of suicide specific protocols, but a plan for building awareness for all five components has not yet been developed. | The organization has developed a plan for building awareness for the protocols for all five components of suicide care and awareness building activities have begun for all staff. | All staff have been made aware of the written protocols for all five components of suicide care. | Leadership engages staff annually in suicide care protocols through education and evaluation of their knowledge of the written protocols. Awareness building processes are reviewed and modified annually and as needed. |
| Comment or justification for score: | | | | | | |

| f. Suicide Care is Documented | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| Are specific components of suicide care embedded in the organization's electronic health record or easily identifiable in written documentation (if no EHR is available), including (1) screening, (2) assessment, (3) lethal means safety, (4) safety planning, and (5) suicide care management plans? | | The organization has not yet demonstrated awareness for the need to embed all five components of suicide care in the organization's EHR or written documentation. | The organization has demonstrated awareness of the need to embed all five components of suicide care in the organization's EHR or written documentation, but they are not currently active data fields. | The organization has developed a plan to embed all five components of in the organization's EHR or written documentation, but not all components are in place yet. The plan includes regular monitoring. | All five components are embedded into the EHR or written documentation, but the monitoring plan has not yet been implemented. | All five components of suicide care are embedded into the EHR or written documentation, they are required or routinely documented by staff, and regular monitoring occurs. The monitoring plan includes continuous quality improvement. |
| Comment or justification for score: | | | | | | |

| g. Availability of Trainings | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| Is training provided on specific components of suicide care, including (1) screening, (2) assessment, (3) lethal means safety, (4) safety planning, and (5) suicide care management plans? | | The organization has not yet demonstrated awareness for the need to provide training on all five components of suicide care. | The organization has demonstrated awareness of the need to provide training on all five components of suicide care but a training plan has not yet been developed. | The organization has developed a plan to provide trainings on all five components of suicide care, but all trainings are not yet available. | The organization provides training on all five components of suicide care and has conducted at least one training on at least 4 of the 5 components. At least 50% of admin and direct service staff have been trained. A training evaluation plan has been developed. | The organization regularly provides training on all five components of suicide care and at least 80% of administrative and direct service staff have been trained. A training evaluation plan is used to monitor trainings for continuous quality improvement. |
| Comment or justification for score:<br>*Metric: Percent of current administrative and direct service staff who have been trained: _____.* | | | | | | |

| h. Dedicated staff time for Zero Suicide | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| What type of formal commitment has leadership made through staffing to reduce suicide and provide safer suicide care? | | The organization has not yet demonstrated awareness for the need for a formal commitment to dedicate staff to build and manage suicide care processes. | The organization has demonstrated awareness of the need for a formal commitment to dedicate staff to build and manage suicide care processes, but has not yet dedicated staff who are responsible for developing suicide-related processes and care expectations. | 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. | The organization has a formal Zero Suicide implementation team that meets regularly and is multidisciplinary. The team is responsible for developing guidelines and sharing with staff. Staff members serve on the team for terms of one to two years. Inclusion of people with lived experience in planning occurs when practicable. | Implementation efforts are built into other initiatives related to quality improvement, risk management and individual safety. ZS processes are modified as needed based on data review and staff input. Lived experience is included in ZS implementation. |
| Comment or justification for score: | | | | | | |

| i. Survivor Involvement in Planning and Processes | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| What is the role of suicide attempt and loss survivors in the organization's design, implementation, and improvement of suicide care policies and activities? | | Suicide attempt or loss survivors are not explicitly involved in the development of suicide prevention activities within the organization. | Suicide attempt or loss survivors have ad hoc or informal roles within the organization, such as serving as volunteers or peer supports. | 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. | Suicide attempt and loss survivors participate as active members of decision-making teams, such as the Zero Suicide implementation team. | 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. |
| Comment or justification for score:<br>*Metric: Percent of workgroup members who are loss or attempt survivors*_____ | | | | | | |

| j. Just Culture/ Philosophy of Care *(NEW)* | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| To what degree does the organization operate in a just culture approach to safety? | | Organization has not yet demonstrated awareness that holding individual staff accountable for errors and mishaps impedes system change and error prevention. | Organization is aware of the benefit of a just culture, but work towards building just culture has not yet begun. Staff continue to be nervous around personal blame for addressing suicide risk. | Culture change is underway through building awareness and embedding just culture principles into the policies, practices and processes of daily work. Staff are increasingly aware that mistakes are generally a product of faulty systems, rather than solely brought about by those directly involved. | After an incident, staff ask "What went wrong?", rather than "Who is to blame?" Staff feel empowered to be a part of change-making and error reduction, and are confident they will receive organizational support in the wake of a suicide attempt or death. | All of the above, plus critical incidents are reviewed as they occur with an eye toward "What went wrong?" and practice and policy change are made as a result. Root cause analysis and cumulative fatality review data are also reviewed at least annually, and system changes are made as a result. |
| Comment or justification for score: | | | | | | |

| k. Workforce Wellness *(NEW)* | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| To what degree is agency workforce wellness (1) systematically addressed, (2) inclusive, (3) used by staff, (4) addressing the root causes of burnout, and (5) positively received by staff? Key components include: (1) Organization-Wide Wellness Team, (2) Person-Centered Wellness Programs, (3) System-Wide Focus of Leadership, (4) Integration of Health, Wellness with Behavioral Health, (5) Workforce Development, (6) Community Connections and Resources, (7) Self- Management Language and Messaging, (8) Workforce Wellness, (9) Organizational Policies, and (10) Performance Evaluation and Data | | Organization has not yet demonstrated awareness of the need to support workforce wellness. | Organization is aware of value of supporting the wellness of their workforce, but has not yet developed a plan to address it. | Organization is actively reviewing workforce for causes of burnout and toxic stress and a workforce wellness plan has been developed. Staff perspective on the quality of workforce wellness is assessed and acted upon. | All aspects of the workforce wellness plan have the 5 listed characteristics. The plan has been approved by staff. Workforce wellness is an ongoing effort and at least 70% of staff are aware of one or more wellness activities, but funding and leadership support are limited. If key staff leave, the initiative may not continue. | Workforce wellness is supported as its own stand-alone initiative. Funds are not diverted to support other efforts. The process on the quality of workforce wellness is utilized and responded to by leadership. 75-100% of participants report that wellness activities are inclusive, they use them regularly, and are a positive experience. Workforce wellness is codified in policies, procedures, practices, activities, services, and social and physical environments. |
| Comment or justification for score:<br><br>***Suggested metric:*** *Number of paid staff: ___. Number and percent (subset) who report awareness of at least one identified wellness activity ____ (___%). SAMHSA/HRSA Culture of Wellness Implementation Score and Date: _____* | | | | | | |

## Element #2: Train

Develop a competent, confident and caring workforce.

| a. Assessment of Workforce Confidence | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| How does the organization formally assess staff on their perception of their confidence, skills, and level of support to care for individuals at risk for suicide? | | Organization has not yet demonstrated awareness of the need for a formal assessment of staff on their perception of confidence, skills, and perceived support in providing suicide care. | Organization is aware of value of a formal assessment, but has not yet developed the assessment. | A formal assessment has been developed. Clinical staff who provide direct care were involved in the development. | A formal assessment of staff perception of confidence and skills in providing suicide care is completed by all staff (clinical and non-clinical). Comprehensive organizational training plans are tied to the results. | A formal assessment of the perception of confidence and skills in providing suicide care is completed by all staff and reassessed at least every three years. Organizational training and policies are developed and enhanced in response to staff needs. |
| Comment or justification for score: | | | | | | |

| b. Trainings for Non-Clinical Staff | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| What basic training on identifying people at risk for suicide or providing suicide care has been provided to NON-CLINICAL staff? | | Organization has not yet demonstrated awareness of the need for an organization-supported training on suicide care and there is no requirement for non-clinical staff to complete training on suicide risk identification. | Organization is aware of the value of suicide risk identification and care training for non-clinical staff but has not yet developed a training plan. | A plan to train all non-clinical staff in suicide risk identification and care has been developed. | Training on suicide risk identification and care is required of all staff. 50-75% of non-clinical staff are trained. The training used is considered a best practice and was not internally developed. Competency assessments are being developed. | 75-100% of non-clinical staff are trained and trainings are repeated at regular intervals. Staff are assessed for competency at regular intervals. Competency assessment results lower than full competency are incorporated into future trainings and the training plan is modified as a result. |
| Comment or justification for score:<br>*Metrics: Count of current non-clinical staff . Count and percent of current non-clinical staff trained in suicide risk identification: / %* | | | | | | |

| c. Trainings for Clinical Staff | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| What advanced training on identifying people at risk for suicide, suicide assessment, risk formulation, and ongoing management has been provided to CLINICAL staff? | | Organization has not yet demonstrated awareness of the need for organization-supported training on suicide safer care. There is no requirement for clinical staff to complete training on suicide. | Organization is aware of the value of suicide risk identification and care training for clinical staff but has not yet developed a training plan. | A plan to train all clinical staff in suicide risk identification, suicide assessment, risk formulation, and ongoing management has been developed. | Training on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management is required of all clinical staff. The training used is considered a best practice and was not internally developed. 50-75% of clinical staff are trained. Competency assessments are being developed. | 75-100% of clinical staff are trained and trainings are repeated at regular intervals. Staff are assessed for competency at regular intervals. Competency assessment results lower than full competency are incorporated into future trainings and the training plan is modified as a result. |
| Comment or justification for score: | | | | | | |
| *Metric: Trainings required of clinical staff: ☐ Identification of people at risk for suicide, ☐ Suicide assessment, ☐ Risk formulation, ☐ Ongoing suicide risk management* | | | | | | |
| *Count of current clinical staff: _____ Count and percent of current clinical staff who have been trained in all 4 areas: ____/____%* | | | | | | |

## Element #3: Identify

Systematically identify and assess suicide risk among people receiving care.

| a. Screening for Suicide Risk | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| What are the organization's policies for screening for suicide risk? | | Organization has not yet demonstrated awareness of the need to systemically screen for suicide risk. | Organization is aware of the value of a policy for systemically screening all individuals at intake for suicide risk but has not yet developed a plan to create the policy. | A policy to screen all individuals (health, behavioral health, support services, etc.) at intake has been developed. | A policy to screen every individual at intake is in place. The policy includes reassessing individuals in designated higher-risk programs or categories (e.g., crisis calls) at every visit and when an individual has a change in status: (level of care, setting, provider, or risk factors/life circumstances, such as divorce, unemployment, or diagnosed illness). | Screening practice is codified in policy and the policy is followed. Screening is documented in the EHR and quality improvement processes are in place (e.g., monthly provider review of rate of positive screens). |
| Comment or justification for score:<br>*Metric: Percent of individuals enrolled in previous month who were screened for suicide risk:_____.* | | | | | | |

| b. Screening Tools Used | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| How does the organization screen for suicide risk in the people it serves? | | Organization has not yet demonstrated awareness of the need for a validated screening tool. | Organization is aware of the need for a validated screening tool and required staff training, but a plan to train staff has not yet been developed. | Organization has developed a plan to train all staff on the validated screening tool. The plan includes assessing staff for competency at regular intervals. | 50-75% of staff are trained on a validated screening tool. The tool is required to be used by all staff. | 75-100% of staff are trained to use the required screening tool. Staff are assessed for competency at regular intervals, and results lower than full competency are incorporated into future trainings and the training plan is modified as a result. |
| Comment or justification for score:<br>Suicidality screening tool used: _____<br>*Count and percent of current clinical staff who have been trained in using the suicidality screening tool: ____/ ____%* | | | | | | |

| c. Suicide Risk Assessment | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| How does the organization assess suicide risk among those who screened positive? | | Organization has not yet demonstrated awareness of the need for a suicide risk assessment that is (1) validated, (2) includes protective factors, and (3) risk formulation. | Organization is aware of the value of a risk assessment that includes all 3 elements, but has not yet developed a plan to systematically assess individuals who screen positive for suicide risk on the day they screened positive. | A suicide risk assessment plan had been developed that includes (1) assessing suicide risk on the same day as a positive screen, (2) training staff on a validated assessment tool and approach, (3) documenting assessments in medical records, and (4) integrating risk assessments into treatment sessions for individuals at risk. | All individuals with risk identified, at any point during care, are assessed by clinicians who use validated instruments and who have received training on the tool and approach. Assessment includes both risk and protective factors. Suicide risk assessments are documented in the medical records. Competency assessments to ensure clinicians are assessing risk with fidelity to the validated tool are being developed. | Quality improvement processes are in place to review risk assessment protocol. Staff are assessed for competency at regular intervals. Competency assessment results lower than full competency are incorporated into future trainings and the training plan is modified as a result. |
| Comment or justification for score:<br>*Metrics: In the past full month: Percent of individuals in care who screened positive for suicide risk who also had a comprehensive risk assessment on the day they screened positive:_____. Risk Assessment Tool used: _____ Count of current clinical staff: _____ Count and percent of current clinical staff who have been trained in using the assessment tool: ____/____%* | | | | | | |

## Element #4: Engage

Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet individual needs.

| a. Care for Individuals At-Risk for Suicide | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| Which best describes the organization's approach to caring for and tracking people at risk for suicide? | | Organization has not yet demonstrated awareness of the need to create a consistent approach to suicide care management. | Organization is aware of the value of a consistent approach to care for people at risk for suicide, but protocols and polices to do so are not yet developed. | Organization has developed policies or protocols for care management for individuals at different risk levels, frequency of contact, care planning, and safety planning. A plan to train all providers to provide care to those at risk for suicide has been developed. | Protocols or policies for care management for individuals with suicidal thoughts or behaviors are in place and followed. Individuals at risk for suicide are placed on a suicide care management plan. Electronic or paper health records are enhanced to embed all suicide care management components listed above. Information sharing and collaboration among all relevant providers are documented. Staff receive guidance on and clearly understand the organization's suicide care management approach and how engage individuals empathetically. | The organization has a consistent approach to suicide care management. Protocols for putting someone on and taking someone off a care management plan are clear. Staff hold regular case conferences about individuals who remain on suicide care management plans beyond a certain time frame, which is established by the implementation team. |
| Comment or justification for score:<br>*Type of empathetic communication skills training used: ☐ Motivational Interviewing ☐ Reflective Communication ☐ Other: _____* | | | | | | |

| b. Collaborative Safety Planning | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| What is the organization's approach to collaborative safety planning when an individual is at risk for suicide? | | Organization has not yet demonstrated awareness of the need to create a consistent approach to collaborative safety planning. | Organization is aware of the value of a consistent approach to collaborative safety planning, but there is no formal guidance or policy around content. There is no standardized safety plan or documentation template. | Policy for collaboratively creating a safety plan on the same day as the individual is assessed for suicide risk has been developed. | Safety plans are developed according to policy, which includes: (1) risks, (2) triggers, and (3) concrete coping strategies, prioritized from most natural to most formal or restrictive. The safety plan is shared with the individual's support system (with consent). All staff use the same safety plan template and are trained in collaborative safety plan best practices. | Safety plans are reviewed and modified as needed at every visit with a person at risk. Other clinicians involved in care or transitions are aware of the safety plan. Staff are assessed for competency at regular intervals. Competency assessment results lower than full competency are incorporated into future trainings and the training plan is modified as a result. The safety plan policy is reviewed by the ZS implementation team regularly and updated as needed. |
| Comment or justification for score:<br>Safety planning tool used: _____ *Metric: In the past full month: Percent of individuals in care who were screened and assessed positive for suicide risk who also had a comprehensive safety plan developed on the same day.* | | | | | | |

| c. Lethal Means Counseling | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| What is the organization's approach to lethal means counseling? | | The organization has not yet demonstrated awareness of the need for lethal means counseling. | Organization has demonstrated awareness of the need for lethal means counseling but how and who to ask about lethal means are up to individual clinician's clinical judgment. Means counseling is rarely documented. The organization may not yet provide any training on lethal means counseling. | Means counseling is included on all safety plans. The organization provides training on counseling on access to lethal means. Steps to reduce means are up to the individual clinician's judgment. The at-risk individual's support system may or may not be involved in reducing access to lethal means. Strategies for reducing access are expected to be included on safety plans for all individuals identified as at risk for suicide. | All of the above, plus support person(s) are included in planning means counseling. The organization has policies regarding the minimum actions for limiting access to means. | All of the above, plus contacting a support person(s) to confirm temporary removal or securing is the required, standard practice. At least 75% of clinical staff are trained on counseling on access to lethal means. Means counseling recommendations and plans are reviewed regularly while the individual is at an elevated risk. Policies support these practices and adherence to these policies are reviewed at least annually. |
| Comment or justification for score:<br>*Metric: In the past full month: Percent of individuals in care who were screened and assessed positive for suicide risk who also had a comprehensive safety plan developed on the same day. Date of most recent lethal means chart review: _____* | | | | | | |

| **d. Postvention for staff and individuals in care *(NEW)*** | **Rating** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|---|
| Does your organization include postvention in their continuum of care for staff and individuals in care? Is it codified in policies and practice? | | The organization has not yet demonstrated awareness of the need for postvention policies and procedures. | The organization has demonstrated awareness of the need for a postvention plan/process that identifies and links affected staff and individuals in care to additional support resources. A designated postvention coordinator may have been identified, but planning has not yet begun. | A postvention and communication plan that facilitates healing and addresses potential contagion has been developed. A coordinator is in place with dedicated funds for implementing the plan. The communication plan includes safe messaging, easy access to a continuum of supports (peer support, debriefing opportunities, EAP) and safe memorialization practices, but supervisors/ managers may not yet know how to support staff and connect them with these supports. | Postvention supports, delivered by internal teams, external teams, EAP or other, are available and provided BEFORE the incident review, which is conducted by a separate team. 50-75% of staff are aware of the protocols. Additional care is provided to the trained postvention team. Staff and individuals in care do not fear that what they say during postvention will be used against them. Affected staff do not feel blamed and are offered support in the wake of a suicide attempt/death. Easy access to support continues at least through the one-year anniversary. | 75-100% of staff have been trained and at least 80% of staff feel confident to respond to a suicide death per agency protocol. Protocols are reviewed and updated annually. Training is part of on-boarding new staff. Postvention plan includes root cause analysis/critical incident review. Staff are confident in their organization's ability to follow the postvention plan. Staff have tools and skills for responding to all forms of grief that can occur in the workplace (grief readiness). |
| Comment or justification for score:<br>*Metrics: Number of current staff: _____ Number and Percent who have been trained in postvention policies and practices: _____ ( ___%) Percent who feel Very or Totally Confident in responding per agency protocol: _____ Percent who feel Very or Totally Confident in responding to grief in the workplace: _____* | | | | | | |

| **e. Postvention for affected community members *(NEW)*** | **Rating** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|---|
| How does the organization engage with the broader community affected by a suicide attempt or death? | | The organization has not yet demonstrated awareness of the need for a continuum of care for the broader community. | The organization has demonstrated awareness of the need to engage with the broader community (extended family members, schools, employers, the media) following a suicide attempt or death. A designated postvention coordinator may have been identified, but planning has not yet begun. | A communication plan is in place and includes safe messaging, internal and external resources, and safe public memorialization practices. The postvention plan includes pulling in external supports, such as county postvention coordinators, to support affected community members. The postvention team is coordinating with external postvention response resources. | The communication plan has been shared with staff and community partners and is followed. There are provisions for culturally appropriate and community specific postvention. 50-75% of staff are aware of the communication plan. Memorialization practices follow the plan. Behavioral health supports and other resources are in place and accessible. | The communication plan is reviewed and updated annually with the response team and community partners. 75-100% of staff are aware of the communication plan and are confident that the organization will communicate with affected community members and partners following a suicide attempt or death. Staff have tools and skills for responding to all forms of grief that can occur in the community (grief readiness). |
| Comment or justification for score: | | | | | | |

## Element #5: Treat

Use effective, evidence-based treatments that directly target suicidality.

| a. Access to Suicide-specific Treatment | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| How does the organization ensure access to quality treatment for suicidal thoughts and behaviors? | | The organization has not yet demonstrated awareness of the need for evidence-based treatments for suicide care, sustained staff training on care models, or additional treatment modalities for people with chronic symptoms. | The organization has demonstrated awareness of the need but has neither identified an external provider nor chosen an evidence-based model (CAMS, CBT-SP, or DBT) to use in-house. | The organization has developed a plan to provide or refer individuals with suicide risk to empirically-supported treatment models. If provided in-house, a training plan has been developed, not yet implemented. | Staff and individuals served have access to evidence-based and/or culturally appropriate suicide specific treatment either in-house, via telehealth, or through referrals. There are robust processes to connect people to appropriate resources in the community. Staff and individuals served are aware of how to access suicide specific services. However, staff training may not be regular or recurring, and monitoring for treatment model changes may not take place. | The organization includes input from people with lived experience in the regular monitoring of their treatment approach. 100% of relevant in-house or external staff are trained in evidence-based treatments and a staff training plan is regularly monitored. Fidelity to EB suicide specific interventions is maintained and documented. Modifications to EBPs are documented and logical for the population. 80% of trained staff report feeling confident to work with someone experiencing suicidal ideation. |
| Comment or justification for score:<br>*Metric: Percent of clinical staff trained in a specific suicide treatment model_____% (Specify model: _____)* | | | | | | |

| **b. Safer Environment** ***(NEW)*** | **Rating** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|---|
| What is the organization's approach to management of risks in the physical environment that could be used to attempt suicide? | | The organization has not yet demonstrated awareness of the need to manage potential risks in the physical environment nor train staff to ensure comfort to address safety concerns. | The organization has demonstrated awareness of the need to review the physical environment for safety concerns, but the environment has not yet been reviewed. | The organization has conducted a risk assessment to identify potential environmental hazards to individuals who are at high risk for suicide and acted to safeguard them from these risks. Written policies are being developed. | There are written policies for keeping individuals in suicidal crisis safe under appropriate levels of direct supervision. Philosophy of least restrictive care is embedded in policy. Policies exist for one to one monitoring, safe storage of personal belongings, and removal of objects that could be used for self-harm (bell cords, bandages, gowns with strings, plastic bags, cleaning supplies). Anchor points, door hinges and hooks are reviewed for safety. | The organization reviews the physical environment according to industry standard, at least annually, and makes changes as a result. Staff are trained on policies and safety procedures and are comfortable speaking about safety concerns. Safety concerns are reviewed and changes are made as a result. |
| Comment or justification for score:<br>*Metric: Date of most recent environment review*_____ | | | | | | |

## Element #6: Transition

Provide continuous contact and support, especially after acute care.

| a. Engaging Hard to Reach Individuals | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| What is the organization's approach to engaging hard-to-reach individuals or those who are at risk and don't attend appointments? | | The organization has not yet demonstrated awareness of the need to reach those at elevated suicide risk who don't show for scheduled appointments. | The organization has demonstrated awareness of the need to reach those at elevated suicide risk who don't show for scheduled appointments but a plan to do so has not yet been developed. | The organization has developed a plan to follow-up for individuals with suicide risk who don't show for appointments. The plan includes active outreach and includes input from people with lived experience, but the plan is not fully implemented. | The organization is actively implementing their follow-up plan, but the process may not yet be sustainable or monitored. | The follow-up plan is in place, routinely utilized, and practicable. The plan is sustainable and routinely monitored for continuous quality improvement, including input from people with lived experience. |
| Comment or justification for score: | | | | | | |

| b. Follow-up after Transitions in Care | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| What is the organization's approach to following up with individuals who have recently been transitioned from acute care settings (e.g., emergency departments, inpatient psychiatric hospitals) and/or crisis contact, non-engagement in services, or other transitions? | | The organization has not yet demonstrated awareness of the need to follow up with those at elevated suicide risk following discharge from acute care settings. | The organization has demonstrated awareness of the need for follow-up for individuals with suicide risk, but a plan, that includes input from people with lived experience, as not yet been developed. | The organization has developed a plan to follow-up with individuals with suicide risk after discharge from acute care settings (e.g. crisis contact, transition from an emergency department, or transition from psychiatric hospitalization), but the plan may not be fully implemented. | The organization has a follow-up plan in place but it is not sustainable or monitored. If key staff leave, follow-up may not continue. | The follow-up plan is in place, routinely utilized, and practicable. The plan is sustainable and routinely monitored for continuous quality improvement, including input from people with lived experience. |
| Comment or justification for score: | | | | | | |

## Element #7: Improve:

Apply a data-driven quality improvement approach to inform system changes leading to better care and improved outcomes for individuals at risk.

| a. Analysis of Suicide Deaths | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| What is the organization's approach to reviewing deaths for those enrolled in care? | | The organization has not yet demonstrated awareness of the need to conduct a root cause analysis (RCA) or incident review of suicide deaths by individuals in care. | The organization is aware of the need to conduct RCA or incident review on deaths by suicide, but they do not yet regularly conduct them. | The organization has developed a procedure to conduct RCA or incident review on all deaths by suicide for people in the organization (including deaths up to 6 months past case closed) that includes provisions to update policies and training as a result. | A procedure to conduct RCA or incident review on all suicide deaths of people in the organization and on deaths up to 6 months past case closed is in place. The procedure includes updating policies and training as a result, but the procedure may not be monitored or sustainable. | A procedure for RCA or incident review is in in place, monitored and sustainable. Individuals with lived experience provide input on how to improve care for those after a suicide death. Policies and training are updated as a result. |
| Comment or justification for score:<br>*Metrics: (1) Number of days since most recent root cause analysis of a suicide death:_____*<br>*(2) Number of days since most recent suicide death (a) of someone in care: _____ and (b) of someone who had left care less than 6 months before suicide death: _____.* | | | | | | |

| b. Tracking Suicide Deaths | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| What is the organization's approach to measuring suicide deaths? | | The organization has not yet demonstrated awareness of the need to measure suicide deaths for those enrolled in their care. | The organization is aware of the need to measure the number of deaths for those who are enrolled in care for up to 6 months past case closed, but has not yet developed a plan to do so. | The organization has developed a plan to measure all suicide deaths for enrolled individuals in care for up to 6 months past case closed but it may not be fully implemented. The plan may include cross referencing state vital statistics data or other federal data. | The organization measures suicide deaths for those enrolled in care and for 6 months past case closed using verified databases, but this process may not continue if key staff leave. | The organization has a policy or procedure related to measuring suicide deaths, at least annually, that is informed by input from people with lived experience. |
| Comment or justification for score:<br>*Metrics: (1) Date measurement for suicide deaths was established_____. (2) Date of most recent annual crosswalk of enrolled individuals against vital statistics data:_____.* | | | | | | |

| c. Analysis of Suicide Attempts *(NEW)* | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| What is the organization's approach to reviewing attempts for those enrolled in care? | | The organization has not yet demonstrated awareness of the need to conduct a root cause analysis (RCA) or incident review of suicide attempts by individuals in care. | The organization is aware of the need to conduct RCA or incident review on suicide attempts, but they do not yet regularly conduct them. | The organization has developed a procedure to conduct RCA or incident review on all suicide attempts for people in the organization that includes provisions to update policies and training as a result. | A procedure to conduct RCA or incident review on all suicide attempts of people in the organization is in place. The procedure includes updating policies and training as a result, but the procedure may not be monitored or sustainable. | A procedure for RCA or incident review is in in place, monitored and sustainable. Individuals with lived experience provide input on how to improve care for those after an attempt. Policies and training are updated as a result. |
| Comment or justification for score:<br>*Metrics: (1) Number of days since most recent root cause analysis of a suicide attempt:_____*<br>*(2) Number of days since most recent suicide attempt (a) of someone in care: _____ and (b) of someone who had left care less than 6 months before suicide attempt:_____.* | | | | | | |

| d. Tracking Suicide Attempts *(NEW)* | Rating | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| What is the organization's approach to measuring suicide attempts? | | The organization has not yet demonstrated awareness of the need to measure suicide attempts for those enrolled in their care. | The organization is aware of the need to measure the number of attempts for those who are enrolled in care for up to 6 months past case closed, but has not yet developed a plan to do so. | The organization has developed a plan to measure all suicide attempts for enrolled individuals in care for up to 6 months past case closed but it may not be fully implemented. The plan may include cross referencing state vital statistics data or other federal data. | The organization measures suicide attempts for those enrolled in care and for 6 months past case closed using verified databases, but this process may not continue if key staff leave. | The organization has a policy or procedure related to annually measuring suicide attempts that is informed by input from people with lived experience. |
| Comment or justification for score:<br>*Metrics: (1) Date measurement for suicide attempts was established:_____.*<br>*(2) Date of most recent annual crosswalk of enrolled individuals against vital statistics data:_____.* | | | | | | |

| **e. Appropriateness of Suicide Safer Care *(NEW)*** | **Rating** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|---|
| How appropriate are the chosen suicide prevention strategies for those being served, including (1) identification, (2) engagement, (3) suicide-specific treatments, (4) care transitions, (5) postvention and (6) training? | | The organization has not yet demonstrated awareness of the need to match safer suicide care with lived experience and/or chronic symptoms nor of the need for multiple modalities. | The organization has demonstrated awareness of the need for multiple modalities, but specific elements of safer suicide care have yet to be reviewed for appropriateness for the target population. | The organization has developed a plan to reviewed for all 6 modalities for appropriateness for the target population, but not all have yet been systematically reviewed or adapted. | The organization has reviewed at least 4 of the 6 components of suicide prevention and has added multiple options or adaptations as appropriate. A plan is in place to assess the appropriateness of specific modalities for each individual in care through chart review, supervision and/or direct consumer input. | All of the above, plus the organization reviews all components of suicide safer care at least annually to meet their changing population and emerging best practices. |
| Comment or justification for score:<br>*Metric: Percent of clinical staff trained in a specific suicide treatment model:_____ (Specify model: _____)* | | | | | | |

| **f. Continuous Quality Improvement (CQI)** | **Rating** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|---|
| What is the organization's approach to quality improvement activities related to suicide prevention? | | The organization has not yet demonstrated awareness of the need to integrate suicide safer care into quality improvement activities. | The organization is aware of the need to integrate suicide safer care into quality improvement activities but has not yet developed a plan to do so. | The organization has developed a plan to integrate suicide safer care into quality improvement processes. | Quality improvement processes include activities related to suicide safer care. Data from suicide care management plans (using EHRs or chart reviews) are examined for fidelity to organizational policies. However, if key staff leave, chart reviews and QI activities that include suicide safer care may not continue. | Quality improvement processes that include suicide safer care are ongoing and occur regularly. Data from EHR or chart reviews are routinely examined (at least quarterly) by a designated team to determine that staff are adhering to suicide care policies and to assess for reductions in suicide. EHR clinical workflows are updated regularly as the team reviews data and makes changes. |
| Comment or justification for score:<br>*Metric: Most recent date that data from EHR or chart reviews were examined for adherence to suicide care policies:_____.* | | | | | | |