



Safety Planning and Means Reduction in Large Health Care Organizations

Barbara Stanley, PhD

Becky Stoll, LCSW

Ursula Whiteside, PhD

Sarah Clingan

December 16, 2014



Moderator



Julie Goldstein Grumet, PhD
Director of Prevention and Practice
Suicide Prevention Resource Center



Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention



The nation's only federally supported resource center devoted to advancing the *National Strategy for Suicide Prevention*.



#zerosuicide



Zero Suicide

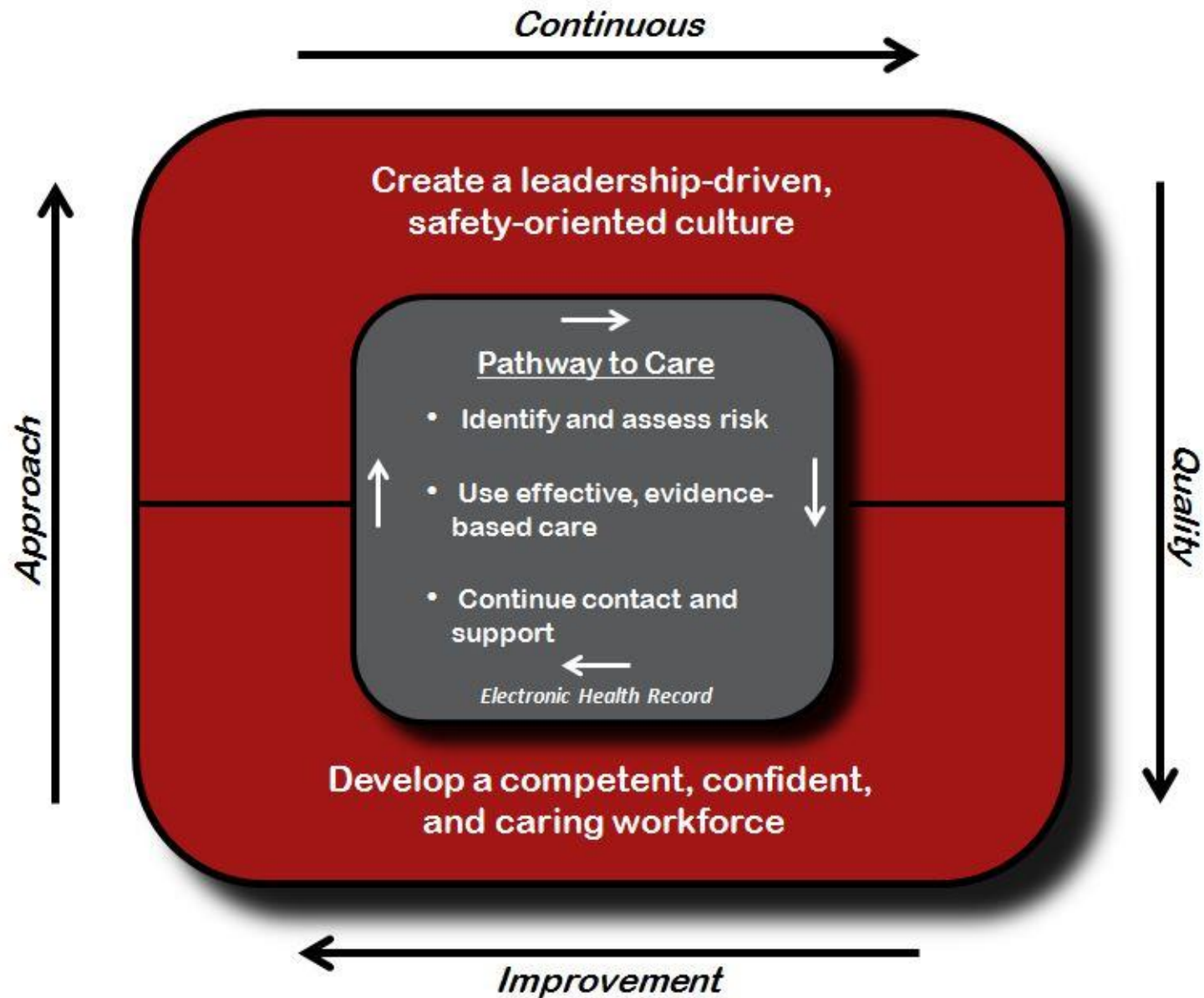
WHAT IS ZERO SUICIDE?



Zero Suicide is...

- **Embedded in the National Strategy for Suicide Prevention.**
- **A priority of the National Action Alliance for Suicide Prevention.**
- **A focus on error reduction and safety in healthcare.**
- **A framework for systematic, clinical suicide prevention in behavioral health and healthcare systems.**
- **A set of best practices and tools including www.zerosuicide.com.**

The Dimensions of Zero Suicide





Resource: Explaining Zero Suicide


NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

what is
ZERO
SUICIDE?

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. It is both a concept and a practice. Its core propositions are that suicide deaths for people under care are preventable, and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems. It represents a commitment to patient safety—the most fundamental responsibility of health care—and also to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.

The challenge of Zero Suicide is not one to be borne solely by those providing clinical care. Zero Suicide relies on a system-wide approach to improve outcomes and close gaps rather than on the heroic efforts of individual practitioners. This initiative in health care systems also requires the engagement of the broader community, especially suicide attempt survivors, family members, policymakers, and researchers. Thus, Zero Suicide is a call to relentlessly pursue a reduction in suicide for those who come to us for care.

The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through multiple cracks in a fragmented and sometimes distracted health care system, and on the premise that a systematic approach to quality improvement is necessary. The approach builds on work done in several health care organizations, including the Henry Ford Health System (HFHS) in Michigan. Like other leading health care systems, HFHS applied a rigorous quality improvement process to problems such as inpatient falls and medication errors. HFHS realized that mental and behavioral health care could be similarly improved. This insight led to the development of HFHS's Perfect Depression Care model, a comprehensive approach that includes suicide prevention as an explicit goal. The approach incorporates both best and promising practices in quality improvement and evidence-based care and has demonstrated stunning results—an 80 percent reduction in the suicide rate among health plan members.

 Using these successful approaches as the basis for its recommendations, the Clinical Care and Intervention Task Force of the National Action Alliance for Suicide Prevention identified essential dimensions of suicide prevention for health care systems (i.e., health care plans or care organizations serving a defined population of consumers, such as behavioral health

www.zerosuicide.com

Access at: <http://www.zerosuicide.com>



Presenters



Barbara Stanley, PhD



Becky Stoll, LCSW



Ursula Whiteside, PhD



Sarah Clingan



Learning Objectives

By the end of this webinar, participants will be able to:

- 1) identify safety planning and lethal means reduction as part of a comprehensive Zero Suicide approach;
- 2) discuss ways to maximize the effectiveness of a safety plan;
- 3) develop an organizational policy for lethal means reduction; and
- 4) explain the importance of input from people with lived experience during safety planning and means reduction policy development.



Presenter



Barbara Stanley, PhD
Columbia University Department of Psychiatry
New York State Psychiatric Institute

Background

- What are brief interventions?
- Origin of Safety Planning Intervention
- Safety Planning: current uses

Target Population for Safety Planning Intervention

- Individuals at increased risk but not requiring immediate rescue
- Patients who have...
 - Made a suicide attempt
 - Suicide ideation
 - Psychiatric disorders that increase suicide risk
 - Otherwise been determined to be at risk for suicide

“Theoretical” Approaches Underlying SPI

- Suicide risk fluctuates over time (eg, Diathesis-Stress Model of Suicidal Behavior)¹
- Problem solving capacity diminishes during crises—over-practicing and a specific template enhances coping (e.g., Stop-Drop-Roll)
- Cognitive behavioral approaches to reducing impulsive behaviors (e.g., Distraction)

¹Mann JJ, et al. *American Journal of Psychiatry*. 1999;156:181-189.

Safety Planning Evidence Base

Incorporates elements of four evidence-based suicide risk reduction strategies:

- means restriction;
- teaching brief problem solving and coping skills;
- enhancing social support and identifying emergency contacts; and
- motivational enhancement for further treatment.

Contrast the Urgent Care Patient with a Suicide Attempt and the ED Patient with a Fracture



SPI as a “Cast” for Suicidal Patients

- Equivalent of putting cast on a broken limb
- Provides immediate intervention to those who do not need or require inpatient hospitalization
- Fills gap between ED discharge and follow-up
- Alternative for those individuals who refuse outpatient care

Safety Planning Intervention: Overview

Prioritized written list of coping strategies and resources for use during a suicidal crisis

- Helps provide a sense of control
- Uses brief, easy-to-read format in the individual's own words
- Can be used as single-session intervention or incorporated into ongoing treatment
- Usually takes 20-40 minutes

Safety Plan Intervention: What It Is Not

- It does not substitute for treatment
- It does not help if the individual is in imminent danger of death by suicide
- Safety plans are not “no-suicide contracts”
 - No-suicide contracts ask patients to promise to stay alive without telling them how to stay alive

Overview of Safety Planning: 6 Steps

1. Recognizing warning signs
2. Employing internal coping strategies without needing to contact another person
3. Socializing with others who may offer support as well as distraction from the crisis
4. Contacting family members or friends who may help resolve a crisis
5. Contacting mental health professionals or agencies
6. Reducing the potential for use of lethal means



POLL QUESTION

Does your organization use a standard safety planning template?

SAFETY PLAN

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Place _____
4. Place _____

Step 4: People whom I can ask for help:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name _____ Phone _____
Clinician Pager or Emergency Contact # _____
2. Clinician Name _____ Phone _____
Clinician Pager or Emergency Contact # _____
3. Suicide Prevention Lifeline: 1-800-273-TALK (8255)
4. Local Emergency Service _____
Emergency Services Address _____
Emergency Services Phone _____

Making the environment safe:

1. _____
2. _____

Reproduced with permission (© 2013 Stanley & Brown). www.suicide-safetyplan.com

Stanley, B. & Brown, G. K. (2013). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*, 258-264.



POLL QUESTION

Does your organization use *this* safety planning template?

Step 1: Recognizing Warning Signs

- Safety plan only useful if individual can recognize warning signs
- Clinician should obtain an accurate account of the events that transpired before, during, and after the most recent suicidal crisis
- Ask: “How will you know when the safety plan should be used?” Be specific!

Step 1: Recognizing Warning Signs

- Ask: “What do you experience when you start to think about suicide or feel extremely distressed?”
- Write down the warning signs using individual’s own words
 - Thoughts, images, thinking processes, mood, and/or behaviors



Safety Plan: Chart Review (n=100)

Step 1: Warning Signs	N (%)
Thoughts	79 (79%)
Emotions	66 (66%)
Behavior	53 (53%)
Physical Sensation	33 (33%)
External Cue	29 (29%)
Not Enough Information	3 (3%)

Brown, Stanley, Pontoski, Mahler, Chaudhury, & Biggs, Unpublished data, 2014

Step 2: Using Internal Coping Strategies

- List activities individual can do without contacting another person
- Activities function as way to help individual take their minds off their problems and promote meaning in their life
- Coping strategies prevent suicide ideation from escalating

Step 2: Using Internal Coping Strategies

- Useful to have individuals try to cope on their own with their suicidal feelings, even if just for a brief time
- Enhances self-efficacy, self-reliance, sense of power over their suicidal urges
- Ask: “What can you do, on your own, if you become suicidal again, to help yourself not act on your thoughts or urges?”

Step 2: Using Internal Coping Strategies

- Ask: “How likely do you think you would be able to take this step during a time of crisis?”
- Ask: “What might stand in the way of you thinking of these activities or doing them if you think of them?”
- Use a collaborative, problem-solving approach to address potential roadblocks



Step 2: Internal Coping Strategies	N (%)
Watching TV or Movie	34 (34%)
Taking a Walk	33 (33%)
Listening to Music	33 (33%)
Exercising	29 (29%)
Playing Video Games or Computer Activities	28 (28%)
Reading or Schoolwork	23 (23%)
Praying, Meditating, Deep Breathing	23 (23%)
House Chores	20 (20%)
Creative Pursuits	19 (19%)
Self-care or Self-soothing Activities	13 (13%)
Looking at Photos of Loved Ones	9 (9%)
Taking a Time Out, Distracting, Walking Away	8 (8%)
Spending Time with a Pet or Animals	7 (7%)
Incorrect location on Safety Plan	21 (21%)
Other	17 (17%)

Brown, Stanley, Pontoski, Mahler, Chaudhury, & Biggs, Unpublished data, 2014

Step 3: Using Socialization as a Means of Distraction and Support

- Coach individuals to use Step 3 if Step 2 does not resolve the crisis or lower risk
- Suicidal thoughts are not revealed in this step. Remember: socialization here is designed to “take your mind off your problems”
- Two options in this step:
 - Go to a “healthy” social setting
 - Family, friends, or acquaintances who may offer support and distraction from the crisis

Step 3: Socializing with Family Members or Others

- Ask: “Who helps you take your mind off your problems—at least for a little while?”
- Ask: “Who do you enjoy socializing with?”
- Ask individuals to list several people, in case they cannot reach the first person on the list

Step 3: Healthy Social Settings

- Ask: “Where do you think you could go that is a healthy environment to have some social interaction?”
- Ask: “Are there places or groups that you can go to that can help take your mind off your problems...even for a little while?”
- Ask individuals to list several social settings



Safety Plan: Chart Review (n=100)

Step 3: Social Settings	N (%)
Library or Bookstore	17 (17%)
Outdoors (park, city streets, etc.)	15 (15%)
Place of Worship or Community Center	12 (12%)
Theater	10 (10%)
Shopping at a Store or Mall	9 (9%)
Restaurant or Coffee Shop	9 (9%)
Someone Else's Home	9 (9%)
Go to the Gym	8 (8%)
NA/AA Meeting or Support Group	8 (8%)
Other	7 (7%)

Brown, Stanley, Pontoski, Mahler, Chaudhury, & Biggs, Unpublished data, 2014

Step 4: Contacting Family Members or Friends

- Coach individuals to use Step 4 if Step 3 does not resolve the crisis or lower risk
- Rationale: Help individuals to rely on their natural environment
- Ask: “How likely would you be willing to contact these individuals?”
- Identify potential obstacles and problem-solve ways to overcome them
- Ask if the safety plan can be shared with family members

Step 5: Contacting Professionals and Agencies

- Coach individuals to use Step 5 if Step 4 does not resolve the crisis or lower risk
- Ask: “Which clinicians (if any) should be on your safety plan?”
- Identify potential obstacles and develop ways to overcome them

Step 5: Contacting Professionals and Agencies

- List names, numbers and/or locations of:
 - Clinicians
 - Local ED or other emergency services
 - Suicide Prevention Lifeline: **800-273-TALK (8255)**
- May need to contact other providers, especially if listed on the safety plan

Step 6: Reducing the Potential for Use of Lethal Means

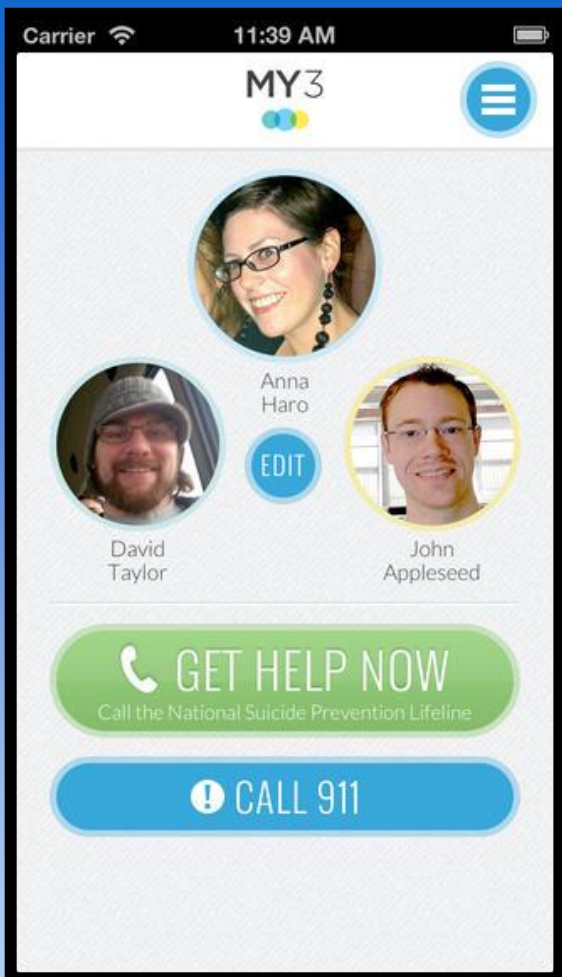
- Ask individuals what means they would consider using during a suicidal crisis
- Regardless, the counselor should always ask whether individuals have access to a firearm
- Rationale for placement at the end of the safety plan: if individuals have a sense of alternatives to suicidal behavior, they are more likely to engage in discussion of means restriction

Step 6: Reducing the Potential for Use of Lethal Means

- For methods with **low lethality**, counselors may ask individuals to remove or restrict their access to these methods themselves
- For methods with **high lethality**, collaboratively identify ways for a responsible person to secure or limit access

Implementation: What is the Likelihood of Use?

- Ask: “Where will you keep your safety plan?”
- Ask: “How will you remember that you have a safety plan when you are in a crisis?”
- Ask: “How likely is it that you will use the safety plan when you notice the warning signs that we have discussed?” “How can you fight the urge, if present, to not try to help yourself?”

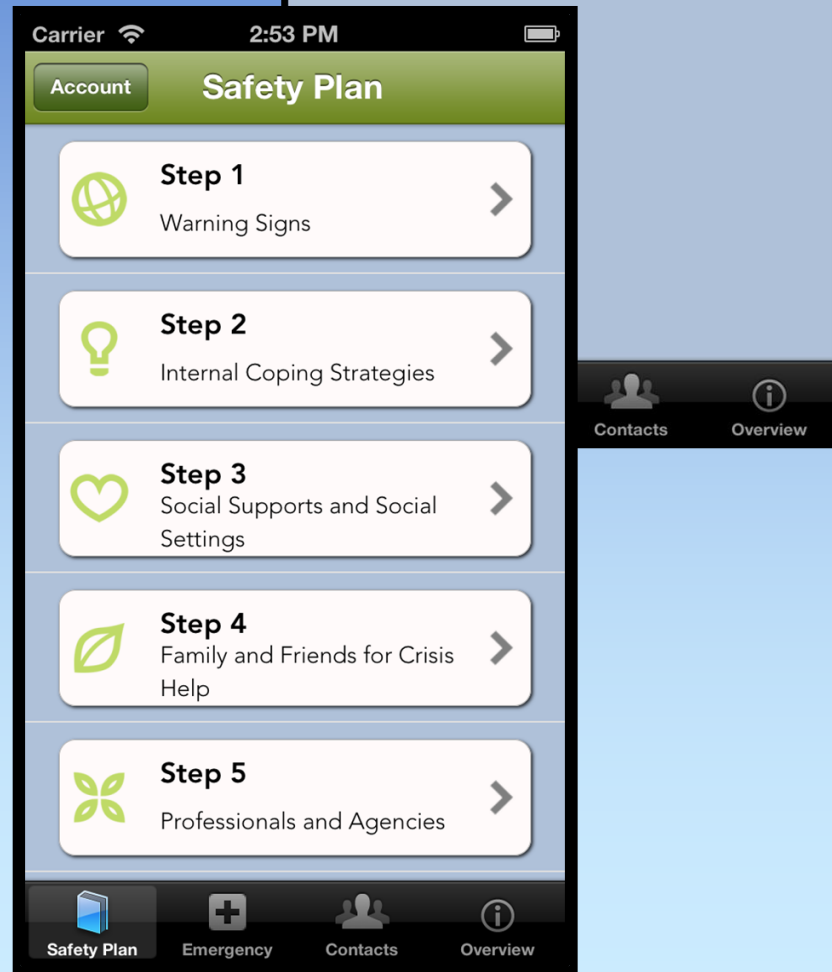
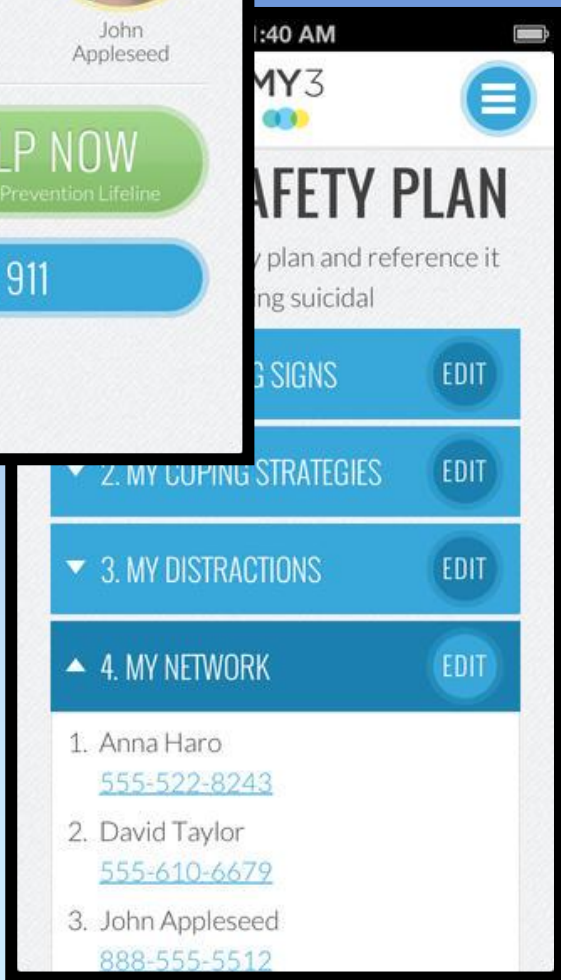


MY3



Safety Plan

Both available in the apple app store and google play



Safety Planning Intervention Resources

- Free, e-learning workshop from Columbia, NY OMH: Safety Planning Intervention for Suicidal Individuals
www.zerosuicide.com

The screenshot shows the interface of an e-learning workshop. At the top, it says "Safety Planning Intervention for Suicide Prevention" with "Menu" on the left and "Exit" on the right. The main heading reads "Welcome to the Safety Planning Intervention for Suicidal Individuals". Below this is a video player showing a man in a light green shirt. To the left of the video is a circular logo with a wind turbine and the text "Suicide Prevention". To the right is the logo for the New York State Office of Mental Health (OMH) and the Center for Practice Innovations at Columbia Psychiatry, New York State Psychiatric Institute, with the tagline "Building best practices with you." Below the video player is a copyright notice: "© 2013 Research Foundation for Mental Hygiene, Inc." At the bottom, there is a navigation bar with icons for "Text Version", "Resources", "Play", "Replay", "Audio", and "Page 1 of 27 Next".

Safety Planning Intervention Resources

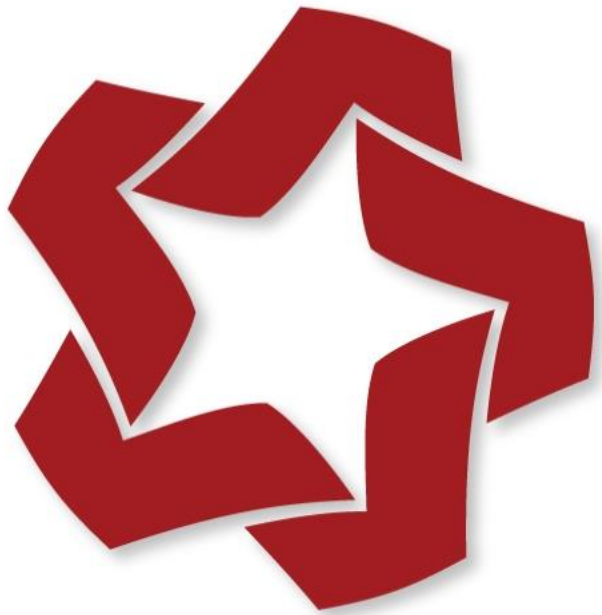
- Stanley B, Brown GK. A Brief Intervention to Mitigate Suicide Risk. *Cognitive and Behavioral Practice*. May 2012;19(2):256-264
- Safety Plan template, manual and other resources:
www.suicidesafetyplan.com
- Safety planning: A quick guide for clinicians
<http://www.sprc.org/sites/sprc.org/files/SafetyPlanningGuide.pdf>
- Safety Plan Treatment Manual to Reduce Suicide Risk:
Veteran Version
http://www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.pdf



Presenter



Becky Stoll, LCSW
Centerstone
@beckycstone



Centerstone's Clinical Pathway for Suicide Prevention

Reducing Access to Lethal Means



Centerstone Footprint

- **Large U.S. outpatient behavioral health provider**
- **Clinical Pathway for Suicide Prevention Implementation**
 - **Centerstone of Indiana and Tennessee: all ages, locations, and service lines**
 - **Centerstone of Illinois: in beginning stages**
 - **Centerstone of Florida (January 2015): will develop plan**



Centerstone's Goals

- **Create culture committed to dramatically reducing suicide deaths**
- **Systematically assess suicide risk levels among people in our care**
- **Ensure every person has a pathway to care**
- **Develop a competent, confident, and caring workforce**



Centerstone's Goals, Cont'd

- Use effective, evidence-based care, including collaborative safety planning, reduction of access to lethal means, and effective treatment of suicidality
- Provide continuing contact and support, especially after acute care
- Apply QI approach to inform system changes



Centerstone Training Requirements


Prior to admitting clients into the Suicide Prevention Pathway, clinical staff **MUST** complete the following trainings:

- **Columbia- Suicide Severity Rating Scale (C-SSRS)** – online course to familiarize staff with administration and interpretation
- **Counseling on Access to Lethal Means (CALM)** – online course to explain 1) purpose of means reduction as critical component of suicide prevention; 2) how to assess for lethal means and provide necessary intervention
- Relias Trainings: **Suicide Prevention** and **Introduction to Centerstone's Zero Suicide Initiative**




Resource: Means Reduction

Counseling on Access to Lethal Means | TOOLS & RESOURCES | COURSE NAVIGATION | EXIT





Menu | Narration Text | Search

- Lifeline Contact Information
- Welcome
- Produced By
- What This Course Covers
- Before You Begin
- Module 1: Introduction to Means Restriction
- Module 2: Counseling on Access to Lethal Means



Counseling on Access to Lethal Means
Online Learning



SLIDE 2 OF 64 | PAUSED | 00:03 / 00:06

Access at: training.sprc.org



Centerstone Service Components while Enrolled in Pathway

1. Validation of client's enrollment in the Pathway, evidenced by signed "Education Sheet"
2. Weekly appointments to assess symptoms and client safety
3. **Reducing access to lethal means**
4. Crisis Planning, identification of supportive friends/family
5. Expectations for follow-up on failed or cancelled appointments



Centerstone Education Sheet



CENTERSTONE

Adding a Pathway to your Treatment Plan

We care about your recovery and want to help you work through this difficult time and find hope. Based on your appointment today, we feel it is important to offer you extra care and attention over the next few weeks.

To do so, we are placing you in a special program we offer to assist people who are having thoughts about suicide. We call it a Pathway. We strongly believe therapy can be a useful tool in understanding your current suicidal thoughts and helping you create changes to where your life seems "livable" again.

This Pathway is meant to help keep you safe while you are working on these life changes.

The following is a list of supports or activities we want to provide for you:

- A plan to get rid of the means or method you might use to hurt yourself. Your family members or a friend may need to help with this.
- Regular check-ins. We hope to have contact with you weekly to make sure you are feeling safe. To do this, we will need your current phone number(s) and an address. Additionally, we'd like to have your permission to contact a family member or friend in case we can't reach you so we will need their phone and address information as well.
- An appointment with one of our medical staff to discuss your current medications or adding/changing medications that could help during your recovery.
- A follow up appointment within a week of starting the Pathway.
- If you don't keep an appointment, we will try to call you. If we can't reach you immediately, we will continue to call you and your emergency contact. If we still can't reach you, we'll send a letter, letting you know we want to hear from you as soon as possible.
- Information about how to get help 24 hours a day, 7 days a week.
- **Most important, we want to help you see there is hope, you can feel better and suicide is not the answer.** We'll want to involve people close to you- with your permission- so they can understand better what is going on with you and learn how to help.

This information was reviewed with me on _____ (date).

Your Name

Centerstone Representative

If you are in crisis, call 800-681-7444.



Centerstone Means Reduction Protocol

- **All clients asked at intake if they have firearm(s) at home**
- **Have client identify emergency contact (support person) and obtain correct phone number and address – call phone numbers in real time to ensure they are working**
- **Have client sign Release of Information for support person**



POLL QUESTION

Do your clinicians ensure ahead of time that the phone numbers they are given for emergency contacts are working?



Centerstone Means Reduction Protocol, Cont'd

- Obtain client's agreement to identify all lethal means they have considered and to limit their access
- If no support person is identified, staff assess client's ability to implement plan independently
- If support person not present, contact him/her with client in room to establish plan to secure lethal means
- Obtain agreement from support person to call Centerstone staff back the same day to confirm lethal means safely secured. Document agreement in clinical record



TYPE IN THE CHAT

How do clinicians in your organization ensure that lethal means have been removed or secured?



Centerstone Means Reduction Protocol, Cont'd

- Centerstone staff must follow up with support person if call not received within timeframe agreed upon
- Do not direct client or support person to bring weapons to Centerstone locations or attempt to relinquish them to Centerstone staff
- Advise support person that return of weapons (including ammunition) to client after the crisis has been resolved is not recommended



Centerstone Means Reduction Protocol, Cont'd

If client does not agree to means reduction:

- **Explicitly discuss with client why lethal means removal is important to their safety**
- **Consult with Clinical Supervisor**
- **Consider referral to higher level of care (including voluntary/involuntary hospitalization if necessary)**
- **If a client leaves without a plan, Crisis Services and support person should be contacted. If client is considered a danger to him/herself, law enforcement may need to be alerted**



Centerstone Means Reduction Key Points

- Document enrollment and disenrollment decision in real time
- Restricting access to means is critical; enlist families to assist whenever possible
- Engage clients in developing a crisis plan specific to their needs and preferences



Centerstone Means Reduction Key Points

- **See clients frequently when possible; contact them by phone as an alternative to face to face**
- **Follow-up with anyone who does not show up or cancels appointments and show concern for them**
- **Remove clients from the Pathway when they are no longer at high risk or if can't reach them after repeated outreach**



Presenter



Sarah Clingan
NowMattersNow
@clingasa



My Lived Experience

Context: I am ONE person with ONE experience.

- **I am a white female with a strong support network**
- **I have been assessed for suicidal ideation in the ER, in inpatient settings, and in individual therapy**
- **I have done crisis planning in these different settings both before and after suicide attempts**



Awareness

- **This is probably one of the worst moments of this person's life**
- **Invasiveness of the process**
 - **Imagine being asked these questions yourself**
- **Shame and stigma**
- **What are your own assumptions and biases?**



What you say MATTERS

- **“Attention seeking”**
- **“Suicide gesture”**
- **Label speak**
- **Validation**



What you do **MATTERS**

- **Look at the person when you are asking questions**
- **Be aware of your own emotions; your stress and fear add to that of the person you are assessing**



Transparency of the process

- Why are you asking what you're asking?
- What will the results determine?
- Who will have access to this information?

Lethal means removal

- Involve the person in every step
- Know their history

Crisis planning

- Think outside the box
- Ask the person what they are actually willing to do



End With Possibility

- **Motivational Interviewing; strengths-based approaches**
- **This person had the courage to be honest. *This is huge.***
- **Hope**



Presenter



Ursula Whiteside, PhD

Forefront: Innovations in suicide prevention

@ursulawhiteside



Background

- **Trained extensively with Marsha Linehan**
- **This experience shaped by my private and public life – and the direction of my career**
- **Led to the development of Now Matters Now**
www.NowMattersNow.org
www.facebook.com/NowMattersNow
[@NowMattersNow](#)



Zero Suicide Perspective in Safety Planning & Lethal Means Reduction

The importance of the role of the system

- Engaging leadership
- Including those with ‘lived experience’
- Creating check and balances
- Continuous improvement



Who might we miss?

- **High profile clients**
- **High functioning clients**
- **People in settings with fewer resources or where time is limited**
- **People when we are afraid or stressed**



Public Health Approach to Lethal Means Reduction

“This is a public health safety issue, like wearing motorcycle helmets and knowing the signs of a stroke... We universally recommend that people who are experiencing depression and/or significant stress, and especially people experiencing suicidal thoughts, DO NOT HAVE EASY ACCESS TO GUNS (or pills, etc.) – just like we would for your mother, brother or sister if they were experiencing these symptoms”

-Ursula Whiteside, 2012



What Clients Want from Providers: From Team Now Matters Now

- Be fully present with me
- Help me hold my pain (feel less alone in my pain)
- I feel helpless, broken, and scared
- Please be aware if you are afraid and acknowledge it
- Be transparent about what you are thinking and feeling (but communicate in nonjudgmental and non-defensive way)



What Clients Want from Providers: From Team Now Matters Now

- I may try to manage your emotions for you
- Discuss with me my diagnosis, as it is in the charts and go through the DSM criteria with me
- When including family and friends in plan, tell me and let me decide who and how
- Help me to empower myself
- *First* I need empathy, a witness (rather than fixing)



What Clients Want from Providers: From Team Now Matters Now

- Treat my sleep problem
- Gently examine my paranoid thoughts with me
- I might feel like I'm bad or wrong for having these thoughts
- I might feel like I'm "in trouble" for reporting ideation
- Balance trusting me and my innate capabilities AND yourself as a clinician when what I reveal is potentially unsafe
- Ask, "Would you tell me if you did have [plans, a gun, pills etc]?" then PAUSE and watch my response and nonverbals



What Clients Want from Providers: From Team Now Matters Now

- Acknowledge that there is hope AND also that this is a problem that researchers are still working on finding better cures for
- Give me feedback about the way I am asking you for help
- Know that I am telling you about my suicide ideation/plans because I want to live, I want help, and I want to work together
- I may be paying very close attention to how you respond to what I say, and telling you more or less based on how open I think you are to hearing it and how much I trust you



In nearly all situations and with nearly all clients, you can assume it will be welcome if you **validate**:

- that the client's problems are important (problem importance),
- that a task is difficult (task difficulty),
- that emotional pain or a sense of being out of control is justifiable, and
- that there is wisdom in the client's ultimate goals, even if not in the particular means he or she is currently using.

– Koerner 2011



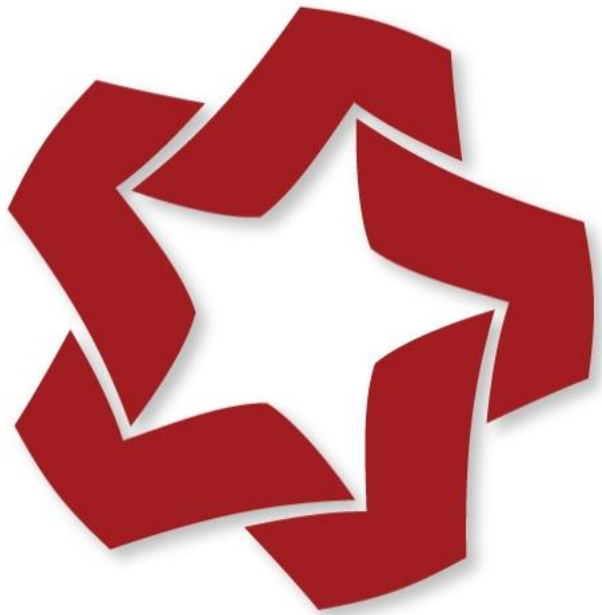
TYPE IN THE CHAT

What questions do you have for any of our presenters?



Getting Started with Zero Suicide

- Create an Implementation Team
- Take *Zero Suicide Organizational Self-Assessment*
- Complete *Organizational Work Plan Template*
- Administer *Zero Suicide Work Force Survey*
- Determine how to educate all staff about adoption of Zero Suicide approach
- Join the Zero Suicide listserv
- Visit www.zerosuicide.com for more information



Contact

Julie Goldstein Grumet, PhD
Director of Prevention and Practice
Suicide Prevention Resource Center
Education Development Center
Phone: 202-572-3721
E-mail: jgoldstein@edc.org