ZERO SUICIDE ORGANIZATIONAL SELF-STUDY FOR COMMUNITY-BASED ORGANIZATIONS WITHOUT CLINICAL PROVIDERS

Name of Organization

City, State, or Province

Date Study Completed:

Team Members Completing the Study

Name	Role
Name	Role
Name	Role
Name	Role
Name	Role
Name	Role

Background

This organizational self-study is for community-based organizations that *do not* employ health and behavioral health care providers (e.g., correctional facilities, homeless-serving organizations, and elder care organizations). It is designed to help you assess what components of the comprehensive Zero Suicide framework 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 tool to determine how closely the components of the Zero Suicide framework 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 creating policies and protocols and in providing services for individuals 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. (For information about putting together a Zero Suicide implementation team, visit the Zero Suicide website: https://zerosuicide.edc.org/toolkit/lead).

While the self-study does not cover all of the issues that can affect an organization's suicide prevention and intervention services, it does reflect the components that define the Zero Suicide approach. Each component of the Zero Suicide model is measured on a rating scale from 1 to 5 and is described below.

General Guide to Rating

In this self-study, each component of the Zero Suicide model is measured on a rating scale from 1 to 5. Following are the general descriptions for each rating.

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 toward focusing on improving suicide prevention and intervention.
3	Several steps toward improvement made for this item. The organization has made several steps toward advancing an improved suicide prevention and intervention approach.
4	Comprehensive practices are nearly 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. It now relies on monitoring and maintenance to ensure sustainability and continuous quality improvement.

Key Definitions

- **Care:** Includes all of the actions, tasks, and responsibilities you carry out as you respond to and serve individuals who are at risk of suicide. The term *care* was originally developed for the health care sector. It is frequently cited in this document.
- **Discharge**: Release of an individual from a health or behavioral health care organization (e.g., emergency department, general medical or psychiatric inpatient facility, or outpatient behavioral health care facility).
- **Documentation:** Refers to written or electronic communication.
- **Evidence-based treatment:** Refers to treatments that specifically address suicidal thoughts and behaviors directly and that are shown to be effective through research and scientific study. (For more information see: https://zerosuicide.edc.org/toolkit/treat.)
- **Health and behavioral health care providers:** Broadly, this role refers to staff within an organization who are expected to provide a range of health care services, such as physicians, psychologists, nurses, social workers, psychiatrists, counselors, and specialty medical care providers.
- **Individual:** Used in this document to refer to the person that an organization provides services to. Other terms are *client, patient, resident, service user,* and *customer*.
- **Risk assessment:** A comprehensive evaluation, usually performed by a health or behavioral health care provider. A risk assessment has three goals: (1) to confirm suspected suicide risk in an individual, (2) to estimate the immediate danger to the individual, and (3) to decide on a course of treatment.
- **Risk formulation:** A type of risk assessment that helps health care providers and behavioral health care providers plan prevention services for individuals at risk for suicide.
- **Safety plan or crisis response plan:** A prioritized written list of coping strategies and sources of support that individuals at risk for suicide can use to manage a crisis such as having thoughts of suicide. These plans should be developed in collaboration between the individual and the health or behavioral health care provider.
- **Screening**: Refers to the use of a standardized instrument or protocol (set of questions) to identify individuals who may be at risk for suicide. Suicide screening can be done independently or as part of a comprehensive health screening. Screening may be done orally (with the screener asking questions), with pencil and paper, or with a computer.
- **Services**: Prevention and intervention actions used to identify suicide risk, to screen for suicide risk, or to address possible suicide ideation and behaviors in individuals. Services include screening, assessment, provision of care, and safety plans.
- **Suicide:** Death caused by injuring oneself with the intent to die.

- **Suicide Ideation:** Thoughts of engaging in suicide-related behavior.

- **Transition**: The time when an individual changes to a different medical provider or setting, such as being referred to a new mental health provider, being admitted to a hospital, or being discharged from an in-patient medical facility. *Transition* may also refer to a change in an individual's life circumstances, such as a divorce, unemployment, or a diagnosed illness.

- **Warm handoff:** Communication that connects a patient with a new provider before the first appointment and that goes beyond simply providing the name and phone number of the provider. For example, an inpatient staff person facilitates a phone call between a patient and a new outpatient provider before the first appointment or a peer specialist calls to encourage a patient to keep an appointment. The goal of a warm handoff is to increase the likelihood that a patient will follow up on a referral from one provider to another provider.

1. Create a Leadership-Driven, Safety-Oriented Culture

What type of commitment has leadership made to reduce suicide and provide suicide prevention services?

This item refers to the development of formal policies, processes, or guidelines in one or more of the following components of the Zero Suicide framework:

- Workforce training
- Suicide screening
- Suicide risk assessment and risk formulation
- Prevention and intervention plans for individuals with suicidal thoughts or behavior
- Safety planning
- Lethal means safety
- Referral to evidence-based treatment (see detailed list here: https://zerosuicide.edc.org/toolkit/treat#intervention-treatment)
- Contact with individuals with known suicide risk who don't show for scheduled services (e.g., outreach via phone)
- Follow-up with individuals with known suicide risk during significant transitions in their lives or following discharge

Please select the number where your organization falls on a scale of 1–5.	
1	The organization has no policies, processes, or guidelines specific to suicide prevention and intervention
2	The organization has one to two formal policies, processes, or guidelines specific to suicide prevention and intervention, such as what to do when someone mentions suicide during a visit to your organization.
3	The organization has formal policies, processes, or guidelines specific to suicide prevention and intervention. They have been developed for at least three different components of the Zero Suicide framework.
4	The organization has formal policies, processes, or guidelines specific to suicide prevention and intervention. They address at least five components of the Zero Suicide framework. Staff receive training on processes as part of their orientation or when new ones are developed. Processes are reviewed and modified at least annually.
5	Formal policies, processes, or guidelines address all components of the Zero Suicide framework listed above. Staff receive 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.

The Zero Suicide approach relies on formalizing specific policies to establish guidelines and to promote the adoption of suicide prevention services. Please consider whether you have established written policies as well as staff training on the following areas.

	Do you have a written organizational protocol specific to this component of suicide prevention services? (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)	Do you have additional comments? (Please write below)
2. Screening				
3. Assessment				
4. Lethal means safety				
5. Safety planning				
6. Standard set of expectations for prevention and intervention services provided to individuals with suicidal thoughts or behavior				

7. Create a Leadership-Driven, Safety-Oriented Culture

What type of formal commitment has leadership made regarding staffing to reduce suicide and to provide safer suicide prevention and intervention?

		Please select the number where your organization falls on a scale of 1–5.
	1	The organization does not have a dedicated staff person responsible for building and managing suicide prevention and intervention efforts for the organization.
	2	The organization has designated several individuals who are responsible for developing suicide prevention- and intervention-related processes and expectations. Responsibilities are diffused. Suicide prevention is not a priority responsibility for these individuals, and they do not have authority to change policies. The organization lacks systemwide policies and strategies, and discussions about suicide prevention occur on an individual basis (e.g., supervisor to supervisee).
	3	The organization has assembled an implementation team that meets on an as-needed basis to discuss suicide prevention and intervention. The team has authority to identify and recommend changes to policies, processes, and practices and may share them with staff.
	4	The organization has a formal Zero Suicide implementation team that meets regularly. The team is responsible for developing policies, processes, and practices for suicide prevention and intervention and for regularly communicating to staff.
	5	The Zero Suicide implementation team meets regularly. It is composed of members who have a variety of experiences and educational backgrounds. Staff members serve on the team for terms of one to two years. The team periodically reviews and modifies policies, processes, and practices based on data review and staff input and regularly communicates these changes to all staff.

If you wish to describe or elaborate on this item, please do so in the space provided below.

8. Create a Leadership-Driven, Safety-Oriented Culture

What is the role of suicide attempt and suicide loss survivors in the organization's design, implementation, and improvement of suicide prevention and intervention policies and services?

Please select the number where your organization falls on a scale of 1–5.		
	1	Suicide attempt or suicide loss survivors are not explicitly involved in the development of suicide prevention and intervention services within the organization.
	2	Suicide attempt or suicide loss survivors have ad hoc or informal roles within the organization, such as serving as volunteers or peer supports. They are rarely asked to speak about or integrate their lived experience into organizational events.
	3	Suicide attempt or suicide loss survivors are specifically and formally included in the organization's general approach to suicide prevention and intervention. However, their involvement is limited to one specific activity, such as leading a support group. Survivors informally provide input into the organization's suicide prevention and intervention policies.
	4	Suicide attempt and suicide loss survivors participate as active members of decision-making teams, such as the Zero Suicide implementation team.
	5	Suicide attempt and suicide loss survivors participate in a variety of suicide prevention services within the organization. For example, they sit on decision-making teams or boards, participate in policy decisions, assist with employee hiring and training, and participate in evaluation and quality improvement.

If you wish to describe or elaborate on this item, please do so in the space provided below.

9. 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 identify and care for individuals 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 prevention and intervention services.
	2	Staff are formally or informally asked to provide suggestions for training topics related to suicide prevention.
	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	Staff complete a formal assessment of skills, needs, and supports regarding suicide prevention and intervention. Comprehensive organizational training plans are tied to the results.
	5	Staff complete a formal assessment of skills, needs, and supports regarding suicide prevention and intervention. Staff are reassessed at least every three years in these competencies. Organizational training and policies are developed and enhanced in response to actual and perceived staff training needs.

If you wish to describe or elaborate on this item, please do so in the space provided below.

10. Develop a Competent, Confident, and Caring Workforce

What introductory trainings on identifying people at risk for suicide or providing suicide prevention and intervention services have been provided to staff?

Introductory training here refers to trainings that focus solely on risk identification and intervention services.

Please select the number where your organization falls on a scale of 1–5.		
	1	There is no organization-supported training on suicide prevention and intervention services and no requirement for staff to complete training on suicide risk identification.
	2	Training is available on suicide risk identification and prevention and intervention services through the organization but not required of staff.
	3	Training on suicide risk identification and prevention and intervention services is required of select staff and is available throughout the organization.
	4	Training on suicide risk identification and prevention and intervention services 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 prevention and intervention services 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 staff on suicide risk identification and prevention and intervention:

- ❒ ASIST (Applied Suicide Intervention Skills Training)
- ❒ Connect Suicide Prevention/Intervention Training
- ❒ Counseling on Access to Lethal Means (CALM)
- ❒ Kognito At Risk (Government, nonprofit settings)
- ❒ Kognito At Risk (School settings)
- ❒ Kognito At Risk (College, university settings)
- ❒ QPR (Question, Persuade, and Refer) Suicide Triage Training
- ❒ safeTALK
- ❒ None
- ❒ Other (please name): ____________________

Please indicate the minimum number of hours of training on suicide prevention and intervention required annually for health and behavioral health care providers on staff. If this does not apply to you, please write “N/A.”

If you wish to describe or elaborate on any item, please do so in the space provided below.

11. Systematically Screen and Assess Suicide Risk

What are the organization's policies or procedures for screening for suicide risk among individuals you serve?

Please select the number where your organization falls on a scale of 1–5.		
	1	There is no systematic screening for suicide risk.
	2	Individuals in higher-risk categories (e.g., those who are experiencing homelessness or domestic violence) are screened.
	3	Suicide risk is screened at the first meaningful contact for all individuals.
	4	Suicide risk is screened at the first meaningful contact for all individuals. Individuals who screen positive for suicide risk are rescreened during every subsequent meaningful contact.
	5	Suicide risk is screened at the first meaningful contact for all individuals, and individuals at risk are rescreened during every subsequent meaningful contact. Suicide risk is also screened when an individual 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 a divorce, unemployment, or a diagnosed illness).

If you wish to describe or elaborate on this item, please do so in the space provided below.

12. Systematically Screen 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 does not use any suicide screening tools to identify individuals at risk.
	2	The organization has developed its own suicide screening tool to identify individuals at risk, but individuals are not required to be screened.
	3	The organization has developed its own suicide screening tool to identify individuals at risk and requires staff to assess all individuals.
	4	The organization uses an evidence-based screening tool and requires staff to assess all individuals.
	5	The organization uses an evidence-based screening tool and requires all individuals to be screened with it. Staff receive training on how to use the screening tool.

Please indicate any suicidality screening tool used:

- ❒ ASQ (Ask Suicide-Screening Questions)
- ❒ C-SSRS (Columbia-Suicide Severity Rating Scale)
- ❒ PHQ-9 (Patient Health Questionnaire-9)
- ❒ PHQ-3 (Patient Health Questionnaire-3)
- ❒ SBQ-R (Suicide Behaviors Questionnaire Revised)
- ❒ None
- ❒ Other tool (please name): ____________________

If you wish to describe or elaborate on any item, please do so in the space provided below.

13. Systematically Screen and Assess Suicide Risk

How does the organization ensure assessments for suicide risk are arranged for individuals who screen positive?

Please select the number where your organization falls on a scale of 1–5.		
	1	There is no policy for referring individuals who have screened positive for suicide risk for a risk assessment at another organization or health care provider.
	2	It is up to the judgment of individual staff whether to refer individuals who have screened positive for suicide risk for a risk assessment at another organization or with a health care provider.
	3	Staff refer individuals who have screened positive for suicide risk for a risk assessment at another organization or with a health care provider that the organization has an informal relationship with.
	4	There are organizational policies established that staff must follow for referring individuals who have screened positive for suicide risk for a risk assessment at another organization or with a health care provider.
	5	There are organizational policies established that staff must follow to refer individuals who have screened positive for suicide risk for a risk assessment at another organization or with a health care provider. Staff use a warm handoff method when making referrals. The organization has agreements, such as memorandum of understanding (MOU), memorandum of agreement (MOA), or business associate agreement (BAA), in place with other agencies for timely suicide risk assessments.

If you wish to describe or elaborate on this item, please do so in the space provided below.

14. Ensure the Organization Has a Standard Set of Expectations for Programs and Interventions for Individuals Identified as at Risk for Suicide

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

Your organization's standard set of expectations for programs and interventions for individuals at risk for suicide could include these components:

- Routine screening
- Process for referral to evidence-based treatment
- Suicide risk assessment and risk formulation if applicable
- Safety planning
- Supportive contacts with individuals who don't show for appointments or usual or expected visits and during significant transitions
- Lethal means safety

		Please select the number where your organization falls on a scale of 1–5.
	1	Staff use their best judgment to support individuals with suicidal thoughts and seek consultation if needed. There is no formal guidance related to programs and interventions and/or referrals for individuals at risk for suicide.
	2	When suicide risk is detected, there is limited guidance for staff on additional suicide prevention interventions other than a referral to a health or mental health provider in the community.
	3	Staff are provided guidance on services to offer to individuals at risk of suicide. All staff are expected to educate individuals on available services outside the organization. The organization has few, if any, relationships with outside agencies for making referrals for additional care.
	4	There are clear policies for making referrals for prevention and intervention components outside the organization. All staff are aware of these policies, and there are standard procedures for information sharing between staff within the organization. Suicide risk and referrals made as a result are documented by the organization. As part of the referral process, staff contact outside providers on behalf of the individual at risk for suicide and address barriers to accessing care.
	5	There are clear policies and formal relationships established (e.g., MOUs, MOAs, BAAs) for making referrals for prevention and intervention outside the organization. All staff are trained in these policies, and there are standard procedures for information sharing between staff within and outside the organization. Suicide risk and the services delivered as a result are documented by the organization. When referrals are necessary, staff contact outside providers on behalf of the individual at risk for suicide and address barriers to accessing care.

If you wish to describe or elaborate on this item, please do so in the space provided below.

15. 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	Staff do not ask individuals at elevated risk for suicide whether they have a safety plan.
	2	Staff ask individuals at elevated risk for suicide whether they have a safety plan based on their own judgment. The organization does not encourage or require staff to ask.
	3	Staff are encouraged to ask individuals at elevated risk for suicide whether they have a safety plan and whether it needs to be updated. The organization does not provide guidance or training to staff on how to ask about safety plans.
	4	Staff are required to ask individuals at elevated risk for suicide whether they have a safety plan and whether it needs to be updated. The organization provides guidance and training on how to review safety plans with individuals who receive services. In subsequent points of contact, it is expected that staff check in with individuals to see if there have been any changes to their safety plans. There is no policy in place for how and when staff should connect individuals with health and behavioral health providers outside the organization.
	5	Staff are required to ask individuals at elevated risk for suicide whether they have a safety plan and whether it needs to be updated. The organization provides guidance and training on how to review safety plans with individuals who receive services. In subsequent points of contact, it is expected that staff check in with individuals to see if there have been any changes to their safety plans. Staff document discussions about safety plans, and there is a policy in place for how and when staff should connect individuals with health or behavioral health providers outside the organization.

If you wish to describe or elaborate on this item, please do so in the space provided below.

16. Collaboratively Plan for Lethal Means Safety

What is the organization's approach to lethal means safety?

Please select the number where your organization falls on a scale of 1–5.		
	1	Discussing lethal means safety with individuals identified as at risk for suicide is up to the staff member's judgment.
	2	Lethal means safety is expected to be included when discussing safety with individuals identified as at risk for suicide. Suggesting steps to reduce access to lethal means is up to the staff member's judgment. The organization does not provide any training on counseling on access to lethal means.
	3	Lethal means safety is expected to be included when discussing safety with individuals identified as at risk for suicide. Suggesting steps to reduce access to lethal means is up to the staff member's judgment. The organization provides training on counseling on access to lethal means, but it is not required.
	4	Lethal means safety is expected to be included when discussing safety with individuals identified as at risk for suicide. The organization provides training on counseling on access to lethal means, and the training is required.
	5	Lethal means safety is expected to be included when discussing safety with individuals identified as at risk for suicide. The organization provides training on counseling on access to lethal means, and the training is required. Policies support these practices. For individuals at elevated risk, lethal means safety recommendations and plans are reviewed whenever staff meet with the individual.

If you wish to describe or elaborate on this item, please do so in the space provided below.

17. 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 expected services?

		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 service.
	2	The organization requires documentation of those individuals who have elevated suicide risk and don't show for a scheduled service, but the parameters and methods for engaging hard-to-reach individuals are up to the staff member's judgment.
	3	Follow-up for individuals with suicide risk who don't show for a scheduled service includes active outreach, such as phone calls to the individual or to their family members, until contact is established or all appropriate efforts have been made to ascertain the individual's safety.
	4	Follow-up for individuals with suicide risk who don't show for a service includes active outreach, such as phone calls to the individual or to their family members, until contact is established or all appropriate efforts have been made to ascertain the individual's safety. Organizational protocols are in place that address follow-up after an individual does not show up for services. Staff may receive training on following the protocol.
	5	Follow-up for individuals with suicide risk who don't show for a scheduled service includes active outreach, such as phone calls to the individual or their family members, until contact is established or all appropriate efforts have been made to ascertain the individual's safety. Follow-up and supportive contact for individuals at elevated risk of suicide are systematically tracked and documented. Staff receive training on following the protocol.

If you wish to describe or elaborate on this item, please do so in the space provided below.

18. Apply a Data-Driven Quality Improvement Approach

Quality improvement is important for all organizations that prioritize suicide prevention. Collecting information about whether suicide prevention and intervention services are happening as expected is necessary for understanding whether policies and procedures are being followed.

What is the organization's approach to quality improvement efforts related to suicide prevention services?

Please select the number where your organization falls on a scale of 1–5.		
	1	The organization has no specific system for reviewing the quality of their suicide prevention and intervention services. There is no expectation for monitoring whether suicide prevention and intervention services are being provided.
	2	Suicide prevention and intervention services are informally reviewed by leadership, but not in any systematic manner. Documentation of services provided for suicide prevention and intervention is done at the judgment of individual staff members.
	3	Discussions about establishing systematic reviews of suicide prevention and intervention services by leadership are in progress. Guidance on how to document the services delivered is provided by the organization, but this documentation is not required.
	4	Systematic reviews of suicide prevention and intervention services are completed on a recurring basis. Documentation of services provided for suicide prevention and intervention is required. Reports based on this documentation are examined to assess staff adherence to organizational policies. This information is reviewed by the Zero Suicide implementation team.
	5	Systematic reviews of routinely documented suicide prevention and intervention services are completed at least every two months by a designated team to determine whether staff are adhering to organizational policies and procedures. The designated team reviews data and identifies improvements to service delivery and documentation practices and adjusts organizational policies and procedures accordingly.

If you wish to describe or elaborate on this item, please do so in the space provided below.

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.