New York State Office of Mental Health

2016-2017 CQI Suicide Prevention Project
Clinic Self-Study

This self-study is designed to allow you to assess the components of a comprehensive Suicide Safer Care approach your Clinic currently has in place. This self-study has been adapted from the national Zero Suicide Organizational Self-Study, which was developed to assist Clinics in their efforts to implement suicide safer care.

Clinic leadership and QI project leads should complete one self-study per Clinic. **The survey must be completed electronically- we will not accept a paper version.** Click here to access the electronic survey.

General guide to rating: Anchors, or specific expectations, are included for most components following this guide:

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

1. What type of commitment has leadership made to reduce suicide and provide suicide safer care?

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

- Workforce training
- Suicide screening
- Suicide risk assessment and risk formulation
- Suicide care management plan
- Safety planning
- Lethal means reduction
- Evidence-based treatment
- Contact with clients with known suicide risk who don't show for appointments
- Follow-up with clients with known suicide risk during care transitions or following discharge

Please circle the number where your Clinic currently falls:

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

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

Please circle the number where your Clinic currently falls:

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

3. What is the role of suicide attempt and loss survivors in the Clinic's design, implementation, and improvement of suicide care policies and activities?

Please circle the number where your Clinic currently falls:

1	Suicide attempt or loss survivors are not explicitly involved in the development of suicide prevention activities within the Clinic.
2	Suicide attempt or loss survivors have ad hoc or informal roles within the Clinic, such as serving as volunteers or peer supports.
3	Suicide attempt or loss survivors are specifically and formally included in the Clinic'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 Clinic's suicide care policies.
4	Suicide attempt and loss survivors participate as active members of decision-making teams, such as the suicide prevention implementation team.
5	Suicide attempt and loss survivors participate in a variety of suicide prevention activities within the Clinic, 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.

4. Does the Clinic formally assess staff on their perception of their confidence, skills and perceived support to care for clients at risk for suicide?

Please circle the number where your Clinic currently falls:

1	There is no formal assessment of staff on their perception of confidence and skills in providing suicide care.
2	Clinicians who provide direct client care are routinely asked to provide suggestions for training.
3	Clinical staff complete a formal assessment of skills, needs, and supports regarding suicide care. Training is tied to the results of this assessment.
4	A formal assessment of the perception of confidence and skills in providing suicide care is completed by all staff (clinical and non-clinical). Comprehensive Clinic training plans are tied to the results.
5	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. Clinic training and policies are developed and enhanced in response to perceived staff weaknesses.

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

Please circle the number where your Clinic currently falls:

1	None.
2	Training is available, but it is not required of clinical staff.
3	Training is available and is required of select clinical staff (e.g., psychiatrists).
4	Training on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management is available and is required of all clinical staff.
5	Training on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management is available and is required of all clinical staff. Staff repeat training at regular intervals.

6. Please indicate the training approach or curriculum the Clinic uses to train clinical staff on advanced suicide prevention skills:

- ☐ AMSR (Assessing & Managing Suicide Risk)
- ☐ QPRT Suicide Risk Assessment & Management Training
- ☐ RRSR (Recognizing & Responding to Suicide Risk)
- ☐ RRSR-Primary Care
- ☐ SuicideCare
- ☐ CASE Approach (Chronological Assessment of Suicide Events)
- ☐ Commitment to Living
- ☐ Center for Practice Innovations Suicide Prevention (SP-TIE) modules
- ☐ Other (specify) _____

7. What are the Clinic's policies for screening for suicide risk?

Please circle the number where your Clinic currently falls:

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

8. How does the Clinic screen for suicide risk in the people it serves?

Please circle the number where your Clinic currently falls:

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

9. If a suicidality screening tool is used, indicate the screener used (ex., PHQ-9, Columbia Suicide Severity Rating Scale):

- ☐ PHQ-9
- ☐ National Suicide Prevention Lifeline Risk Assessment Standards
- ☐ PHQ-2
- ☐ Columbia Suicide Severity Rating Scale (C-SSRS)
- ☐ Other tool (please name) _____

10. How does the Clinic assess suicide risk among those who screened positive?

Please circle the number where your Clinic currently falls:

1	There is no routine procedure for risk assessment following a positive suicide screen or the procedure is to send clients who have screened positive for suicide to the emergency room for clearance.
2	Risk assessment is required after positive screening, but the process or tool used is up to the judgment of individual clinicians.
3	Providers conducting risk assessments use a standardized risk assessment, all clients who screen positive for suicide receive a risk assessment.
4	Providers conducting risk assessments use a standardized risk assessment, all clients who screen positive for suicide receive a risk assessment. Assessment includes both risk and protective factors. Staff receive training on risk assessment and approach.
5	Providers conducting risk assessments use a standardized risk assessment, all clients who screen positive for suicide receive a risk assessment that includes both risk and protective factors. Staff receive training on risk assessment and approach. Risk is reassessed and integrated into treatment sessions for every visit for clients with risk.

11. What best describes the Clinic's approach to managing and tracking people at risk for suicide?

Suicide management should include the following:

- Screening
- Assessment & Risk Formulation
- Safety Planning
- Evidence-Based Treatment
- Supportive contacts with clients who don't show for appointments and during care transitions (e.g. after hospital discharge)

Please circle the number where your Clinic currently falls:

1	Providers use best judgment in the care of clients with suicidal thoughts or behaviors and seek consultation if needed. There is no formal guidance related to care for clients at risk for suicide.
2	When suicide risk is detected, providers are expected to screen and refer to a senior clinician.
3	All providers are expected to provide care to those at risk for suicide. The Clinic has guidance for care for clients at different risk levels, including frequency of contact, care planning, and safety planning.
4	Electronic or paper health records are enhanced to embed all suicide management components listed above. Providers have clear protocols or policies for management for clients with suicidal thoughts or behaviors, and information sharing and collaboration among all relevant providers are documented. Staff receive guidance on and clearly understand the Clinic's suicide management approach.
5	Clients at risk for suicide are placed on a suicide care pathway. The Clinic has a consistent approach to suicide management, which is embedded in the electronic health records and reflects all of the suicide management components listed above. Protocols for putting someone on and taking someone off the suicide care pathway are clear. Staff hold regular case conferences about clients who remain on the suicide care pathway beyond a certain time frame, which is established by the implementation team.

12. What is the Clinic's approach to collaborative safety planning when an client is at risk for suicide?

Please circle the number where your Clinic currently falls:

1	Safety planning is neither systematically used by nor expected of staff.
2	Safety plans are systematically used for all clients with elevated risk, but there is no formal guidance or policy around content. There is no standardized safety plan, plan quality varies across providers.
3	Standardized safety plans are systematically used for all clients at elevated risk. Plan content is governed by formal guidance and policy (e.g. call provider, call helpline) but is not individualized to a client's strengths or natural supports. Plan quality varies across providers.
4	Standardized safety plans are systematically used for all clients at elevated risk. Plan content is governed by formal guidance and policy and requires individualized identification of risks and triggers and provides concrete coping strategies. All staff receive training in how to create a collaborative safety plan.
5	A standardized safety plan is developed on the same day as the client is assessed positive for suicide risk. The safety plan is shared (with consent) with the client's partner, family members, and other health providers (with consent). The safety plan identifies individualized risks and triggers and provides concrete coping strategies, prioritized from most natural to most formal or restrictive.

Please indicate whether or not the Clinic uses the Stanley Brown Safety Plan Intervention? ☐ Yes ☐ No

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

How frequently is the safety plan reviewed with the client? _____

13. What is the Clinic's approach to lethal means reduction?

Please circle the number where your Clinic currently falls:

1	Means restriction discussions and who to ask about lethal means are up to individual clinician's clinical judgment. Means restriction counseling is rarely documented.
2	Means restriction is expected to be included on safety plans for all clients identified as at risk for suicide. Steps to restrict means are up to the individual clinician's judgment. The Clinic does not provide any training on counseling on access to lethal means.
3	Means restriction is expected to be included on all safety plans. The Clinic provides training on counseling on access to lethal means. Steps to restrict means are up to the individual clinician's judgment. Family or significant others may or may not be involved in reducing access to lethal means.
4	Means restriction is expected to be included on all safety plans, and families are included in means restriction planning. The Clinic provides training on counseling on access to lethal means. The Clinic sets policies regarding the minimum actions for restriction of access to means.
5	Means restriction is expected to be included on all safety plans. Contacting family to confirm removal of lethal means is the required, standard practice. The Clinic provides training on counseling on access to lethal means. Policies support these practices. Means restriction recommendations are plans are reviewed regularly while the client is at an elevated risk.

14. What is the Clinic's approach to treatment of suicidal thoughts and behaviors?

Please circle the number where your Clinic currently falls:

1	Clinicians rely on experience and best judgment in risk management and treatment for all mental health disorders. The clinic does not use a formal model of treatment for those at risk for suicide.
2	The clinic may use evidence-based treatments for some psychological disorders, but it does not use evidence-based treatments that specifically target suicide.
3	Some clinical staff have received specific training in treating suicidal thoughts and behaviors and may use this in their practices.
4	The clinic regularly provides all staff with access to competency-based training in empirically supported treatments targeting suicidal thoughts. Clients with suicide risk receive empirically-supported treatment specifically for suicide (CAMS, CBT-SP or DBT).
5	The clinic regularly provides all staff with access to competency-based training in empirically supported treatments targeting suicidal behaviors. Clients with suicide risk receive empirically-supported treatment specifically for suicide (CAMS, CBT-SP or DBT).The clinic offers additional treatment modalities for those chronically or continuously screening at high risk for suicide, such as DBT groups or attempt survivor groups.

15. Please indicate if clinicians receive formal training in a specific suicide treatment model:

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

16. What is the Clinic's approach to engaging hard-to-reach clients or those who are at risk and don't show for appointments?

Please circle the number where your Clinic currently falls:

1	There are no guidelines specific to reaching those at elevated suicide risk who don't show for scheduled appointments.
2	The Clinic requires documentation by the clinician of those clients who have elevated suicide risk and don't show for an appointment, but the parameters and methods are up to the client clinician's judgment.
3	Follow-up for clients with suicide risk who don't show for appointments includes active outreach, such as phone calls to the client or his or her family members, until contact is made and the client's safety is ascertained.
4	Follow-up for clients with suicide risk who don't show for appointments includes active outreach, such as phone calls to the client or his or her family members, until contact is made and the client's safety is ascertained. Clinic protocols are in place that address follow-up after no-shows. Training for staff supports improving engagement efforts.
5	The Clinics may have an established memorandum of understanding with an outside agency to conduct follow-up calls. Follow-up and supportive contact for clients on suicide care management plans are systematically tracked in electronic health records. Follow-up for high-risk clients includes documented contact with the person within eight hours of the missed appointment. The Clinic has approaches, such as peer supports, peer-run crisis respite, home visits, or drop-in appointments, to address the needs of hard-to-reach clients.

17. What is the Clinic's approach to following up on clients who have recently been discharged from acute care settings (e.g. emergency departments, inpatient psychiatric hospitals)?

Please circle the number where your Clinic currently falls:

1	There are no specific guidelines for following up on clients discharged from acute care settings.
2	The clinic requires follow-up, but the parameters and methods are up to the individual clinician's judgment.
3	Clinic guidelines regarding follow up are directed to the client's level of risk and address one or more of the following: follow-up after crisis contact, transition from an emergency department, or transition from psychiatric hospitalization.
4	Clinic guidelines regarding follow up are directed to the client's level of risk and address follow-up after crisis contact, transition from an emergency department, or transition from psychiatric hospitalization. Follow-up for high- risk clients includes distance outreach, such as letters, phone calls, and e-mails.
5	Clinic guidelines regarding follow up are directed to the client's level of risk and address follow-up after crisis contact, transition from an emergency department, and/or transition from psychiatric hospitalization. Clinic guidelines require follow-up contact within 72 hours after discharge from acute settings. Follow-up for high-risk clients includes home or community visits when necessary. Follow-up and supportive contacts are tracked in the electronic health record.

18. What is the Clinic's approach to reviewing deaths for those enrolled in care?

Please circle the number where your Clinic currently falls:

1	At best, when a suicide or adverse event happens while the client is in treatment, a team meets to discuss the case.
2	Root cause analysis (or other comprehensive investigation method) is conducted on all suicide deaths of people in care.
3	Data from all root cause analyses (or other comprehensive investigation methods) are routinely examined to look at trends and to make changes to policies.
4	Root cause analysis (or other comprehensive investigation method) is conducted on all suicide deaths of people in care as well as for those up to 30 days past case closed. Policies and training are updated as a result.
5	Root cause analysis (or other comprehensive investigation method) is conducted on all suicide deaths of people in care as well as for those up to 6 months past case closed and on all suicide attempts requiring medical attention. Policies and training are updated as a result.

19. What is the Clinic's approach to measuring suicide deaths?

Please circle the number where your Clinic currently falls:

1	The Clinic has no policy or process to measure suicide deaths for those enrolled in their care.
2	The Clinic measures the number of deaths for those who are enrolled in care based primarily on family report.
3	The Clinic has specific internal approaches to measuring and reporting on all suicide deaths for enrolled clients as well as those up to 30 days past case closed. Deaths are confirmed through coroner or medical examiner report.
4	The Clinic annually crosswalks enrolled clients (e.g. from a claims database) against state vital statistics data or other federal data to determine the number of deaths for those enrolled in care up to 30 days past case closed.
5	The Clinic annually crosswalks enrolled clients (e.g. from a claims database) against state vital statistics data or other federal data to determine the number of deaths for those enrolled in care. The Clinic tracks suicide deaths among clients for up to 6 months past case closed.

20. What is the Clinic's approach to quality improvement activities related to suicide prevention?

Please circle the number where your Clinic currently falls:

1	The Clinic has no specific policies related to suicide prevention and care, and it does not focus on suicide are other than care as usual. Care is left to the judgment of the clinical provider.
2	Suicide care is discussed as part of employee training and by those in supervision in clinical settings.
3	Early discussions about using technology and/or enhanced record keeping to track and chart suicide care are underway. Suicide care management is partially embedded in an EHR or paper record.
4	Suicide care is partially embedded in an electronic health record (EHR) or paper record. Data from suicide management plans (using EHRs or chart reviews) are examined for fidelity to Clinic policies, and discussed by a team responsible for this.
5	Suicide care is entirely embedded in EHR. Data from EHR or chart reviews are routinely examined (at least every two months) by a designated team to determine that staff are adhering to suicide care policies and to assess for reductions in suicide. EHR clinical workflows or paper records are updated regularly as the team reviews data and makes changes.

TABLE 1. Results of Principal Component Analysis for Zero Suicide Organizational Self Study Scale (17 items and 110 clinics), Rotated Matrix[a]

Item	Component[b]			
	1	2	3	4
5. Staff training	**0.84**			
10. Suicide risk assessment	**0.73**			
20. Suicide-specific quality improvement activities	**0.72**	0.41		
13. Lethal means reduction	**0.66**		0.42	
12. Safety planning	**0.60**		0.32	
8. Use of validated screening tool	**0.54**			0.40
11. Suicide care pathway for patients at risk	**0.52**	0.47	0.34	
2. Leadership commitment to dedicated staffing	**0.52**	0.45		
1. Leadership commitment to suicide-specific policies	**0.51**	0.37	0.37	
14. Suicide-specific treatment	**0.50**		0.38	0.32
18. Reviewing suicide deaths		**0.73**		
16. Outreach after missed appointments		**0.72**	0.35	
17. Acute care transition support		**0.57**	0.55	
7. Suicide screening protocol			**0.81**	
3. Survivors have input into clinic policy				**0.83**
4. Staff assessment	0.46			**0.51**
19. Measuring suicide deaths	0.48	0.38		**0.49**

[a] The principal component analysis was conducted using varimax rotation. The Kaiser-Meyer-Olkin (KMO) measure was 0.85 with individual item measures ranging from 0.60 - 0.93, and Bartlett's test of sphericity was statistically significant ($p <$ .001). The item with the lowest KMO also had the lowest mean score and assessed the inclusion of suicide attempt survivors in clinic policy (item 3). Excluding this item did not change the overall findings. Principal component analysis identified four principal components (eigenvalues >1) accounting for 61.39% of the total variance (26.04%, 14.03%, 11.27%, 10.06%) respectively.

[b] Major loadings are bolded. Loadings below .3 are not reported