OMB No. xxxx-xxxx
Expiration Date:

Garrett Lee Smith (GLS) National Outcomes Evaluation
State/Tribal Suicide Prevention Programs
Behavioral Health Provider Survey (BHPS)

Description of Participation: The survey asks about your organization's process for screening, assessing, and serving youths identified as at risk for suicide and the extent to which your organization contributes to improved access to and community linkages with behavioral health services. Participation is completely voluntary and you can exit from the survey at any time or refuse to answer any question.

Rights Regarding Participation: Your input is important; however, your participation in this survey is completely voluntary. There are no penalties or consequences to you or your organization for not participating. You can choose to stop the survey at any time, or not answer a question for whatever reason. If you stop the survey, at your request, we will destroy the survey. You may ask any questions that you have before, during, or after you complete the survey.

The survey will take approximately 40 minutes.

Privacy: All responses will be kept completely confidential. Contact information will be entered into a password-protected database which can only be accessed by a limited number of individuals (selected ICF staff) who require access. These individuals have signed confidentiality, data access, and use agreements. Your name will not be used in any reports, but it is possible that your agency and/or organization and the information you provide about your agency or organization may be identifiable when reporting results.

Benefits: Your participation will not result in any direct benefits to you. However, your input will help to provide a better understanding of the systems and networks in place to help youths identified as at risk for suicide in your community. The findings will assist in informing the Substance Abuse and Mental Health Services Administration (SAMHSA) about suicide prevention activities and network processes.

Risks: This survey poses few, if any, risks to you and/or your organization. However, it is possible that your agency and/or organization and the information you provide about your agency or organization may be identifiable when reporting results.

Incentives: After completing the survey, you will receive a $10 gift card for your participation.

Contact Information: If you have any concerns about completing this survey or have any questions about the study, please contact Christine Walrath, principal investigator, at (646)695-8154 or christine.walrath@icfi.com.

Please click the "I CONSENT" box below to proceed to the survey.

☐ I CONSENT
☐ I DO NOT CONSENT

As you complete the survey questions, please think about your organization as the one providing services in [location to be specified (e.g., county, city, region)].

[Programming Note: Questions 1–14 will only be asked of one respondent per community (the primary administrator)]

AGENCY/ORGANIZATION TYPE[1]

1. What is the name of your organization? _____

2. Which of the following best describes your organization? *Choose only one from the list below.*

   ☐ Behavioral health association representing multiple service provider organizations across a broad geographic area (e.g., State or region)
   ☐ Behavioral health service provider organization with a single location
   ☐ Behavioral health service provider organization with multiple locations within a small geographic area (e.g., city or county)
   ☐ Behavioral health service provider organization with multiple locations within a broad geographic area (e.g., state or region)
   ☐ Behavioral health service provider operating within a nonbehavioral health organization (e.g., school district, child welfare, or other affiliated organization)
   ☐ Primary care physician or practice or integrated delivery system
   ☐ Emergency department
   ☐ Other, please specify:_____

3. Does your organization have a National Provider Identifier (NPI) number?

   ☐ Yes ☐ No [SKIP TO QUESTION 5]

4. What is the NPI number for your organization? Please report all relevant NPIs for the selected region.

(NPI Registry Search available here: https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do)

- If your organization provides services at a single location, please report the NPI number for that location.
- If your organization provides services at multiple locations within a small geographic area (city or county), please report a NPI number for each location. Click here to access an upload feature for submitting multiple NPI numbers using a Microsoft (MS) Excel spreadsheet.
- If your organization provides services at multiple locations across a broad area (State or region), please report a NPI number for each location in (**STATE OR LOCATION OF GRANTEE**). Click here to access an upload

[1] *Adapted from the 2014 National Mental Health Services Survey, available here: http://info.nmhss.org/*

feature for submitting multiple NPI numbers using a MS Excel spreadsheet.

(NPI is a 10-digit numeric ID)

5. Does your organization offer the following services in any of its locations? *Select "yes" or "no" for each service.*

a.	Behavioral health intake services	Yes	No
b.	Behavioral health diagnostic evaluation	Yes	No
c.	Behavioral health information and/or referral services (also includes crisis response or emergency programs that provide services in person or by telephone)	Yes	No
d.	Behavioral health treatment services (interventions such as therapy or psychotropic medication that treat a person's mental health problem or condition, reduce symptoms, and improve behavioral functioning and outcomes, could be either)	Yes	No

6. Does your organization offer behavioral health treatment services in any of the following service settings? *Select "yes" or "no" for each setting.*

a.	24-hour hospital inpatient services (psychiatric hospitals or general hospitals with separate psychiatric units)	Yes	No
b.	24-hour residential services (24-hour, overnight, psychiatric care in a residential non-inpatient setting [e.g., residential treatment centers for adults or children, or multiservice community mental health centers])	Yes	No
c.	Partial hospitalization/day treatment (e.g., less than 24-hour)	Yes	No
d.	Outpatient (less than 24-hour)	Yes	No

7. What is the primary treatment focus of your organization across all locations? *Choose only one from the list below.*

☐ Mental health treatment
☐ Substance abuse treatment
☐ Mix of mental health and substance abuse treatment (neither is primary)
☐ General health care
☐ Other service focus, please specify:
_____

8. Your organization is operated by: *Choose only one from the list below.*

☐ A private for-profit organization

☐ A private nonprofit organization
☐ A public agency or department

8a. [IF "A PUBLIC AGENCY OR DEPARTMENT" IS SELECTED FOR 8] Which public agency or department? *Choose only one from the list below.*

☐ State mental health agency
☐ State department of corrections or juvenile justice
☐ Other State government (e.g., Department of Health)
☐ Regional or district authority (e.g., hospital district authority)
☐ Local, county, or municipal government
☐ U.S. Department of Veterans Affairs
☐ Other, please specify:
_____

PLEASE NOTE: For questions 9–10, report the number of patients for locations within [**STATE OR LOCATION OF GRANTEE**]. For inpatient settings, please provide a 1-day patient count; for outpatient settings, consider the number of patients seen during the 30-day period from April 1 through April 30.

9. [IF YES TO 6A OR 6B] On April 30, 2015, approximately how many patients received inpatient or residential behavioral health treatment services from your organization (both newly admitted and previously admitted patients)? *Choose only one from the list below.*

☐ <15 clients
☐ 15–29 clients
☐ 30–59 clients
☐ 60–120 clients
☐ >120 clients

10. [IF YES TO 6C OR 6D] During the month of April 2015, approximately how many clients received outpatient behavioral health treatment services from your organization? *Choose only one from the list below.*

☐ <15 clients
☐ 15–29 clients
☐ 30–59 clients
☐ 60–120 clients
☐ >120 clients

TYPE OF CLIENTS SERVED

11. What age groups are accepted for treatment at any of your organization's locations? *Select "yes" or "no" for each age group.*

a.	Youths (aged 17 or younger)	Yes	No
b.	Young adults (aged 18–24)	Yes	No
c.	Adults (aged 25–64)	Yes	No
d.	Seniors (aged 65 or older)	Yes	No

12. Does your organization accept patients who have Medicaid coverage?

☐ Yes ☐ No

a. [IF YES] About what percentage of your organization's practice is composed of patients who have Medicaid coverage?

_____%

13. Does your organization have specialized crisis intake services to handle acute behavioral health issues (e.g., treatment for individuals experiencing problems with psychiatric illnesses and/or emotional disorders that need immediate attention)? *Choose only one from the list below.*

☐ Yes, at all locations
☐ Yes, only at certain locations
☐ Yes, at certain locations and a mobile crisis team
☐ Yes, at all locations and a mobile crisis team
☐ No, we do not have a crisis intervention team

USE OF ELECTRONIC HEALTH RECORDS (EHRs)

14. For each of the following functions, please indicate if your organization uses electronic resources, paper only, or a combination of both to complete the function. Note that if one location uses paper records and another uses electronic records for a particular function, you should select "Both Electronic and Paper" for that function. *Choose only one from the list below.*

	Function	Computer/ Electronic Only	Paper Only	Both Electronic and Paper	N/A
a.	Intake/scheduling				
b.	Assessment/evaluation				
c.	Treatment plan/progress monitoring				
d.	Health records				
e.	Collaboration/referrals with other providers (e.g., primary care providers, other behavioral health providers)				
f.	Suicide specific monitoring (e.g., risk assessment, safety planning, tracking scheduled appointments, tracking suicide attempts or deaths)				

[Programming Note: Questions 15–39 will be asked of all respondents]

RESPONDENT

15. What is your primary professional role in the behavioral health organization? *Choose only one from the list below.*

☐ Administrator
☐ Supervisor of mental health/behavioral health service providers
☐ Other, please specify: _____

SUICIDE PREVENTION AND CARE[2]

[FOR PRIMARY ADMINISTRATOR]

16. Please rate your organization's awareness of/commitment to the Zero Suicide framework, endorsed by the National Action Alliance for Suicide Prevention.

1 - Not aware of the Zero Suicide framework
2 - Aware of the Zero Suicide framework, but no commitment
3 - Beginning informal steps toward implementation of the Zero Suicide framework
4 - Made several formal steps toward implementing a comprehensive Zero Suicide approach
5 - Commitment to Zero Suicide and working with the Action Alliance on implementation (e.g., as ongoing use of online toolkit, participation in Zero Suicide Learning Collaborative, participation in a Zero Suicide Academy or breakthrough series)

[FOR ALL OTHER RESPONDENTS]

17. Are you aware of any Zero Suicide work in your organization?

☐ Yes ☐ No

18. Please report the policy commitment leadership has made to reduce suicide and provide suicide safer care among people who use the organization's services. (Note: suicide safer care integrates suicide prevention strategies into practice and addresses suicide risk among patients.)

a. Is there a formal written policy specifically addressing suicide prevention and suicide safer care? (e.g., specific requirements for suicide risk assessment, care, or follow-up for people with suicidality)

☐ Yes ☐ No ☐ Don't know

b. [IF YES TO a.] What aspects are addressed by the policy on suicide prevention and suicide safer care? *Please select all that apply.*

☐ Workforce training
☐ Guidelines for screening for suicide risk
☐ Protocols for assessing level of risk among those who screen positive
☐ Interventions tailored based on the level of assessed risk
☐ Safety planning protocols
☐ Lethal means restriction
☐ Evidence-based treatment
☐ Contact with patients who don't show for appointments

[2] Adapted from the Zero Suicide Organizational Self-Study, available here: http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/ZS-Org-SelfStudy_72915.pdf

☐ Follow-up during care transitions or discharge
☐ Prevention of compassion fatigue

c. [IF YES TO a.] Are all staff in the organization aware of the policy on suicide prevention and suicide safer care, and could they describe it if asked?

☐ Yes ☐ No

d. [IF YES TO a.] Are staff trained on these policies periodically and made aware when new ones are introduced?

☐ Yes ☐ No

19. Please report the level of commitment leadership has made through staffing to reduce suicide and provide suicide safer care among people who use the organization's services.

a. Does the organization have at least one staff person with duties related to suicide care practices at the organizational level?

☐ No
☐ Yes, there is one individual
☐ Yes, there is a team of individuals
☐ Don't know

b. [IF YES TO a.] What are their responsibilities? *Select all that apply.*

☐ Discrete tasks related to suicide safe care practices or training on suicide prevention
☐ Examine suicide prevention policies and practices and formulate recommendations
☐ Adopt and enforce change to policies and practices

c. [IF YES TO a.] Is the staff committed to this role for at least a 1-year term?

☐ Yes ☐ No

d. [IF YES, THERE IS A TEAM OF INDIVIDUALS FROM a.] Does the team meet regularly or on an as-needed basis?

☐ Team meets regularly
☐ Team meets as needed

e. [IF YES TO a.] Is there is a budget for suicide prevention and care training and tools?

☐ Yes
☐ No
☐ There isn't a specific suicide prevention budget, but the team can make recommendations for specific suicide prevention items within a broader budget
☐ Don't know

20. Please describe the role of suicide attempt and loss survivors in the development of the organization's suicide care policy.

    a. Are suicide attempt or loss survivors involved in the development of suicide prevention activities within the organization?

        ☐ Yes ☐ No ☐ Don't know

    b. [IF YES TO a.] Suicide attempt or loss survivors are involved in the following activities. *Select all that apply.*

        ☐ Serving in informal roles, such as volunteers
        ☐ Leading a support group or staffing crisis hotline
        ☐ Participating in advisory team providing regular input to organization planning process
        ☐ Participating in decision-making teams or boards, participating in policy decisions
        ☐ Assisting with workforce hiring and/or training
        ☐ Participating in evaluation and quality improvement

    c. [IF YES TO ANY ACTIVITY OTHER THAN INFORMAL ROLE IN b.] Are there two or more suicide attempt or loss survivors participating in these various activities?

        ☐ No, there is only one individual
        ☐ Yes, there are two or more

GATEKEEPER TRAINING OF STAFF

21. Please describe the **basic training** on identifying people at risk for suicide or providing suicide care that has been provided to staff.

    a. Is there a basic training on identifying people at risk for suicide available through the organization (either provided or funded by organization)?

        ☐ Yes ☐ No ☐ Don't know

    b. [IF YES TO a.] Who is required to take this training?

        ☐ No one
        ☐ Selected staff (e.g., crisis staff, clinical staff)
        ☐ All staff

    c. [IF YES TO a.] Is retraining required?

        ☐ No
        ☐ Yes, retraining is required at least every 3 years
        ☐ Yes, retraining is required at least annually

    d. [IF YES TO a.] Please indicate the training approach/curriculum the organization uses. If other, please indicate whether locally developed. *Select all that apply.*

☐ Applied Suicide Intervention Skills Training (ASIST)
☐ Counseling on Access to Lethal Means (CALM)
☐ Kognito At-Risk
☐ QPR (Question, Persuade, and Refer)
☐ safeTALK
☐ Locally developed intervention, please specify: _____
☐ Other intervention, please specify: _____

TRAININGS AND USE OF EVIDENCE-BASED TREATMENT WITH PROVIDERS

22. Please describe the treatment/interventions specific to suicide care used for patients at risk.

a. Does the organization use a formal model for treatment for those at risk of suicide?

☐ No, clinicians rely on experience and best judgment in treatment
☐ Yes, the organization promotes certain treatment model
☐ Don't know

b. [IF YES TO a.] Does the organization offer one or more evidence-based treatments targeting suicidal thoughts and behaviors specifically (e.g., AMSR, CAMS, CASE Approach, CBT for Suicide prevention, Commitment to Living, DBT, QPRT, RRSR, Seeking Safety, and SuicideCare)?

☐ No, the organization promotes evidence-based treatments for psychological disorders, but does not offer specific evidence-based treatments for suicidality
☐ Yes, the organization offers one or more evidence-based treatments targeting suicidal thoughts and behaviors

c. [IF YES TO b.] Does the organization provide training in evidence-based treatment(s) specific to suicide?

☐ Yes ☐ No

d. [IF YES TO c.] Clinicians in the organization receive formal training in a specific, evidence-based, or promising suicide treatment model. *Select all that apply.*

☐ AMSR (Assessing and Managing Suicide Risk)
☐ CAMS (Collaborative Assessment and Management of Suicidality)
☐ CASE Approach
☐ CBT for Suicide Prevention (Cognitive Behavioral Therapy)
☐ Commitment to Living
☐ DBT (Dialectical Behavior Therapy)
☐ QPRT (Suicide Risk Assessment and Management Training)
☐ RRSR (Recognizing and Responding to Suicide Risk)
☐ RRSR–Primary Care
☐ Seeking Safety
☐ SuicideCare

☐ Other, please specify: _____

e. [IF YES TO a.] Does the organization assess fidelity to treatment and outcomes?

☐ Yes ☐ No

ASSESSMENT OF STAFF SELF-EFFICACY AND TRAINING ADHERENCE

23. Please describe how the organization formally assesses staff on their perceived confidence, skills, and support to care for individuals at risk for suicide.

a. Is there a formal assessment of staff on their perceived confidence and skills in providing suicide care?

☐ No
☐ Yes, for staff who provide direct patient care (clinicians)
☐ Yes, for all staff
☐ Don't know

b. [IF YES TO a.] Is staff perception reassessed at least every 3 years?

☐ Yes ☐ No

c. [IF YES TO a.] Are the results of assessments used to enhance training and/or develop policies?

☐ Yes ☐ No

SCREENING AND ASSESSMENT PRACTICES

24. Please describe how your organization ***screens*** for suicide risk in the people you serve.

NOTE: *Screening is defined as systematically identifying individuals at risk for suicide.*

a. Is there a standardized tool(s) routinely used across the organization to screen individuals for suicide risk?

☐ Yes
☐ No, the organization relies on the clinical judgment of its staff regarding suicide risk
☐ Don't know

b. [IF YES TO a.] Is the screening performed for particular groups designated as higher risk (e.g., crisis calls) or for every individual receiving care from the organization?

☐ Higher-risk individuals ☐ Every individual

c. [IF YES TO a.] When are suicide risk screenings conducted? *Select all that apply.*

☐ At intake
☐ When suicide warning signs are observed
☐ Prior to discharge/end of treatment

d. [IF YES TO a.] Please indicate the screening tool used. *Select all that apply.*

☐ Patient Health Questionnaire (PHQ)
☐ Columbia Suicide Severity Rating Scale
☐ National Suicide Prevention Lifeline Risk Assessment Standards
☐ Ask Suicide Screening Questions (asQ)
☐ Beck Depression Inventory (BDI)
☐ Behavioral Health Screen (BHS)
☐ Suicide Behaviors Questionnaire (SBQ-R)
☐ Locally developed tool, please specify:_____
☐ Other tool, please specify: _____

e. [IF YES TO a.] Do staff receive regular training on use of the screening tool?

☐ Yes ☐ No

25. Please describe how your organization ***assesses*** suicide risk in the people served?

NOTE: *Assessment is defined as determining the level of risk for a person who screens positive for suicide risk by formally evaluating suicidal ideation, plans, means availability, presence of acute risk factors, and history of suicide attempts, and any other risk or protective factors.*

a. Does the organization have routine procedures for assessing level of risk following a positive suicide screening?

☐ Yes ☐ No ☐ Don't know

b. [IF YES TO a.] Is there a standardized tool routinely used across the organization to assess suicide risk after an individual has been identified as at risk?

☐ Yes, a standardized tool is used
☐ No, assessment of risk is based on clinical judgment

c. [IF YES TO b.] Please indicate the assessment tool used :

☐ Suicide Assessment Five-step Evaluation and Triage (SAFE-T)
☐ Columbia Suicide Severity Rating-Scale (CSSR-S)
☐ National Suicide Prevention Lifeline Risk Assessment Standards
☐ Patient Health Questionnaire (PHQ)
☐ Locally developed tool, please specify:_____
☐ Other tool, please specify: _____

d. [IF YES TO b.] Are the results of the risk assessment documented in the medical record?

☐ Yes ☐ No

e. [IF YES TO b.] Do all medical staff use the same tool? *Select all that apply.*

☐ All physicians use this tool
☐ All nurses use this tool
☐ All mental health professionals use this tool

f. [IF YES TO b.] Is the assessment conducted by a clinician with specialized training to perform the assessment?

☐ Yes ☐ No

g. [IF YES TO b.] Is suicide risk reassessed or reevaluated at every visit for those at risk?

☐ Yes ☐ No

h. [IF YES TO b.] When reflecting on your organization's current protocol for risk assessment, do you think efforts are not enough, just right, or too much?

☐ Not enough ☐ Too much
☐ Just right ☐ Don't know

26. What is your organization's approach or set of procedures for determining whether or not someone poses high or imminent risk of suicide? *Select all that apply.*

☐ Assess suicide thoughts or plans
☐ Assess suicidal intent and whether the youth believes she/he can refrain from attempting suicide
☐ Assess history of suicide attempts
☐ Assessment of nonsuicidal self-injury
☐ Assessment of family history
☐ Assess presence of serious mental illness
☐ Assess availability of means for attempting suicide
☐ Assess presence of depression and/or hopelessness
☐ Assess presence of substance abuse
☐ Ask youth to articulate or list reasons for living
☐ Ascertain whether the youth can agree to a safety contract
☐ Try to develop a safety plan with the youth
☐ Meet with youth's parents or guardians to address concerns and safety issues
☐ Immediately refer the youth to speak to a clinician at a referral agency
☐ Other procedure for determining whether someone is at imminent risk of suicide , please specify:_____
☐ Don't know procedure for determining whether someone poses risk of suicide
☐ Not applicable procedure for determining whether someone poses risk of suicide

27. Once a youth is identified as potentially at risk or as having made a suicide attempt, how long is it usually before someone (either within your organization or within your referral network) can meet with him/her to do a clinical assessment? *Please choose the option that best describes what usually happens.*

☐ Immediately
☐ Less than 2 hours
☐ Less than 4 hours
☐ Within the day
☐ Within 2 days
☐ Within a week
☐ Longer than a week
☐ Don't know

28. What are some of the factors that affect your ability to rapidly conduct clinical assessments for patients at risk for suicide? *Select all that apply.*

☐ Recent suicide attempt
☐ Level of risk
☐ Clinician availability
☐ Insurance or other funding consideration
☐ Other, please specify:_____
☐ Don't know
☐ Not applicable

29. Does your organization have formal policies, protocols, or guidelines (written or communicated otherwise) designating a person who makes decisions in a crisis situation?

☐ Yes ☐ No ☐ Don't Know

FOLLOW-UP CARE AND REFERRAL PRACTICES

30. Please describe the organization's approach to caring for and tracking people at risk for suicide.

a. Are there protocols or guidance for care management for individuals at risk for suicide?

☐ Yes
☐ No, providers use best judgment and seek consultation if needed.
☐ Don't know

b. [IF YES TO a.] Is the protocol or guidance for care management specific for individuals at different risk levels?

☐ Yes ☐ No

c. [IF YES TO a.] What topics are addressed by the protocol or guidance for care management? *Select all that apply.*

☐ Frequency of contacts
☐ Care planning
☐ Safety planning
☐ Personalized means restriction

d. [IF YES TO a.] Are these care management elements embedded in the EHR or other clinical documentation processes?

☐ Yes ☐ No

e. [IF YES TO a.] Are individuals at risk for suicide placed on a special care management plan or care pathway?

☐ Yes ☐ No

f. [IF YES TO e.] Which of the following elements are included in the suicide care management plan/pathway? *Select all that apply.*

☐ Specific protocols for client engagement and frequency of appointments
☐ Psychoeducation groups specific to suicide
☐ Attempt survivor support groups
☐ Drop-in visits without appointments
☐ Outreach/contact/protocol for missed appointments or transitions in care
☐ Coordination of care within the organization for high-risk clients
☐ Chart reviews to monitor risk assessments

31. Please describe the organization's approach to safety planning when an individual is at risk for suicide.

a. Are there any formal protocols regarding safety planning?

☐ Yes ☐ No ☐ Don't know

b. [IF YES TO a.] Are safety plans required for all individuals with elevated risk?

☐ Yes ☐ No

c. [IF YES TO b.] Are there formal guidelines or policies in relation to the content of the safety plan?

☐ Yes ☐ No

d. [IF YES TO c.] Which of the following components is the safety plan expected to address? *Select all that apply.*

☐ Formal interventions (e.g., call provider, call helpline)
☐ Risks, triggers, and concrete coping strategies
☐ Prioritized strategies from most natural to most formal or restrictive
☐ Individual's strengths and natural supports (significant others in the individual's life).

e. [IF YES TO c.] Please indicate the safety planning tool/approach the organization uses:

☐ Stanley/Brown Safety Plan

☐ Locally developed tool, please specify:_____
☐ Other tool, please specify: _____

f. [IF YES TO b.] How frequently is the safety plan reviewed with the individual?

☐ Once, at the time it is created
☐ It varies, but usually more than once
☐ Every visit for individuals at risk

g. [IF YES TO b.] Is it standard practice to complete the safety plan during the initial appointment/encounter (or before discharge for inpatient)?

☐ Yes ☐ No

h. [IF YES TO g.] How often is the safety plan completed during the initial appointment/encounter (or before discharge for inpatient)? *Choose only one from the list below.*

☐ All of the time
☐ Most of the time
☐ Some of the time
☐ Rarely
☐ Almost never

32. Please describe the organization's approach to lethal means restriction.

a. Are there any formal protocols regarding lethal means restriction counseling?

☐ Yes ☐ No ☐ Don't know

b. [IF YES TO a.] Is individualized lethal means restriction planning included on safety plans?

☐ No, only general recommendations
☐ Yes, it is routinely included on safety plans
☐ Yes, it is a standard component of all safety plans

c. [IF YES TO a.] Does the organization provide training on counseling individuals at risk for suicide and their families on access to lethal means?

☐ Yes ☐ No

d. [IF YES TO a.] Does the organization set policies regarding minimum actions required of providers for restriction of access to lethal means (e.g., speaking with family members or significant others regarding lethal means restriction; including lethal means restriction in safety planning)?

☐ Yes ☐ No

e. [IF YES TO a.] Are family members or significant others included in lethal means restriction planning? *Choose only one from the list below.*

- ☐ No
- ☐ Occasionally
- ☐ When readily available
- ☐ Yes, as a standard component of all safety plans

f. [IF STANDARD COMPONENT IS SELECTED on e.] Is contacting family and confirming removal of lethal means standard practice?

☐ Yes ☐ No

g. [IF YES TO a.] Are lethal means restriction recommendations reviewed regularly by care staff and the patient while the individual is at elevated risk?

☐ Yes ☐ No

33. [IF YES TO 6A OR 6B] Please describe the organization's approach to lethal means restriction in inpatient settings.

a. Does your organization have a protocol for observation of high-risk patients?

☐ Yes ☐ No ☐ Don't know

b. [IF YES TO a.] Is verbal interaction with patients required during checks?

☐ Yes ☐ No

c. [IF YES TO a.] Does the protocol for observation require continuous observation (e.g., of patients' hands, or keeping the patient in constant view)?

☐ Yes ☐ No

d. [IF YES TO a.] Do orders for constant observation include all circumstances (e.g., patient should be observed in bathroom, while sleeping, eating)?

☐ Yes ☐ No

e. [IF YES TO a.] Do all staff receive training on counseling on access to lethal means?

- ☐ No
- ☐ Some staff are trained, but not all
- ☐ Yes, all staff must complete training

f. [IF YES TO a.] Are staff competences in observation periodically assessed?

☐ Yes ☐ No

g. [IF YES TO a.] Are multiple staff involved in a determination to take an individual off of constant observation status?

☐ Yes ☐ No

34. What is your organization's typical procedures for managing youths identified as high risk? Do you typically engage in any of the following practices? *Select all that apply.*

☐ Call or meet with parents or guardians to discuss monitoring
☐ Call or meet with parents or guardians to provide education about the need for follow-up treatment
☐ Discuss safety in the home with parents/guardians (e.g., removing means of suicide, such as firearms)
☐ Discuss alternative ways of coping with distress, or alternatives to suicide with the youth
☐ Discuss reasons for living with the youth
☐ Work with youth to identify individuals the youth can contact if feeling suicidal
☐ Refer youth to the emergency department or crisis service
☐ Refer youth to a community provider if the youth/family is/are not already in treatment (may include an elder or cultural-based program)
☐ Provide an after-hours emergency contact number to youth
☐ Provide an after-hours emergency contact number to parents / guardians
☐ If a new referral is given, follow up with the suicidal youth and family to see if they followed through with treatment recommendation or need assistance doing so
☐ Follow up with the youth at school to assess ongoing status/risk
☐ Provide youth with national suicide hotline or other crisis hotline phone information
☐ Follow up to see if the youth kept any scheduled appointments
☐ Other, please specify:_____
☐ Don't know
☐ Not applicable

35. Please describe the organization's approach to engaging hard-to-reach individuals or those who are transitioning in care.

a. Are there specific guidelines and policies for following up with individuals at elevated suicide risk?

☐ Yes ☐ No ☐ Don't know

b. [IF YES TO a.] Are the guidelines and policies specific for individuals at different risk levels?

☐ Yes ☐ No

c. [IF YES TO a.] What aspects are addressed by guidelines for follow-up? *Select all that apply.*

☐ Follow-up after crisis contact
☐ Nonengagement in services
☐ Transition from emergency room (ER) or psychiatric hospitalization

36. Please indicate which, if any, follow-up methods the organization employs after nonengagement in services and/or acute care transitions. *Select all that apply.*

a. Nonengagement in services (e.g., failure to appear for scheduled appointments)	b. Acute care transitions (e.g., following presentation in the ER or psychiatric hospitalization)
☐ Text reminders of appointments ☐ Texts of support or encouragement ☐ Postcards or letters ☐ Use of apps ☐ Follow-up call within 24 hours ☐ Follow-up call within 48 hours ☐ Follow-up call within 1 week ☐ Follow-up call within 2 weeks ☐ Follow-up call within 1 month ☐ Mobile crisis team deployed for well checks in case of no answer to calls/texts ☐ None of the above ☐ Other, please specify: _____ ☐ Don't know	☐ Text reminders of appointments ☐ Texts of support or encouragement ☐ Postcards or letters ☐ Use of apps ☐ Follow-up call within 24 hours ☐ Follow-up call within 48 hours ☐ Follow-up call within 1 week ☐ Follow up call within 2 weeks ☐ Follow-up call within 1 month ☐ Mobile crisis team deployed for well checks in case of no answer to calls/texts ☐ Work with other community providers to conduct warm handoffs ☐ None of the above ☐ Other, please specify: _____ ☐ Don't know

37. How long do you typically try to continue following up with youths identified as at risk or as having made a suicide attempt after nonengagement in services, and/or transitions in care? *Select all that apply.*

a. Nonengagement in services (e.g., failure to appear for scheduled appointments)	b. Acute care transitions (e.g., following presentation in the ER or psychiatric hospitalization)
☐ Next day ☐ 1 week or less ☐ Up to 1 month ☐ Up to 3 months ☐ Up to 9 months ☐ 1 year or longer ☐ No typical length ☐ Don't know ☐ Not applicable	☐ Next day ☐ 1 week or less ☐ Up to 1 month ☐ Up to 3 months ☐ Up to 9 months ☐ 1 year or longer ☐ No typical length ☐ Don't know ☐ Not applicable

38. When reflecting on your current protocol for follow-up, do you think efforts are not enough, just right, or too much?

☐ Not enough ☐ Just right

☐ Too much ☐ Don't know

39. Does your organization have formal policies, protocols, or guidelines (written or communicated otherwise) for postvention services for youth or family following a suicide attempt or death?

☐ Yes ☐ No ☐ Don't know

a. [IF YES] When reflecting on your current protocol for postvention services for youths or families following a suicide attempt or death, do you think efforts are not enough, just right, or too much?

☐ Not enough
☐ Just right
☐ Too much
☐ Don't know

[Programming Note: Questions 40–46 will only be asked of one respondent per community (the primary administrator)]

COLLABORATION WITH GLS SUICIDE PREVENTION GRANTEE

40. Have you had any direct contact with **[GRANTEE NAME] in the past 12 months**?

☐ Yes
☐ No
☐ Don't know
☐ My organization is the GLS grantee

a. [IF YES to Q40] Have you received any of the following supports from **[GRANTEE NAME] in the past 12 months**? *Select all that apply.*

☐ Funding for suicide prevention/treatment staff positions
☐ Funding for system improvements (e.g., EHR, surveillance)
☐ Gatekeeper training
☐ Developing partnerships with other organizations (e.g., formalizing a referral network; sharing staff, training, or other resources)
☐ Other support, please specify:_____

b. [IF YES to Q40] Select all of the activities that are primary to your relationship with **[GRANTEE NAME]:** *Select all that apply.*

☐ Providing referrals to the organization
☐ Receiving referrals from the organization
☐ Coordination of gatekeeper trainings
☐ Sharing resources
☐ Sharing information
☐ Creating policies and protocols
☐ Other, please specify:_____
☐ Not applicable

ANNUAL DATA ON SCREENINGS, ASSESSMENTS, CARE PROVISION, AND MONITORING OF AT-RISK PATIENTS

The items below were developed for use by organizations implementing Zero Suicide and participating in the National Alliance Breakthrough Series. Information reported here can be used to support your organization's data tracking on Zero Suicide implementation. It can also be used to track your organization's progress on implementing safer suicide policies and protocols regardless of whether you are participating in the Breakthrough Series.

41. Please report the number of suicide screenings completed and the number of suicide screenings possible for youths aged 10–24 and for adults aged 25 and older **in the last 12 months**.

In the last 12 months…	Don't Know	Data from EHR System	Data are Estimated	Total	Youth Aged 10–24	Adults Aged 25 and Older
Number of initial suicide screenings completed	☐	☐	☐			
Number of clients served in the last 12 months	☐	☐	☐			

[IF YES ON QUESTION 25A]

42. In Question 25, you indicated that your organization uses a standardized suicide risk assessment. Please report the number of at-risk youths aged 10–24 and adults aged 25 and older for whom a standardized risk assessment was completed and the number who screened positive for suicide thoughts/behavior **in the last 12 months**.

In the last 12 months…	Don't Know	Data from EHR System	Data are Estimated	Total	Youth Aged 10–24	Adults Aged 25 and Older
Number of individuals with a comprehensive suicide risk assessment following a screening	☐	☐	☐			
Number of individuals screening positive for risk of suicide	☐	☐	☐			

[IF SELECTION IS MADE ON QUESTION 30F]

43. You indicated in Question 30f that your organization's care management plan for individuals at risk for suicide includes "Outreach/contact/protocol for missed appointments or transitions in care." Please report the number of at-risk individuals who were contacted within 12 hours of a missed appointment for youths aged 10–24 and for adults aged 25 and older **in the last 12 months**.

Estimates are acceptable if information is not available from your organization's EHR. Please indicate whether data are estimated or from HER.

In the last 12 months…	Don't Know	Data from EHR System	Data are Estimated	Total	Youth Aged 10–24	Adults Aged 25 and Older
Number at risk for suicide who missed appointments contacted within 8 hours of the appointment	☐	☐				
Number of clients at risk for suicide with missed appointments	☐	☐				

[IF YES TO 31G]

44. You indicated in Question 31g that it is standard practice in your organization to complete the safety plan during the initial appointment/encounter (or before discharge for inpatient). Please report the number of at-risk individuals with a documented safety plan prior to discharge for youth aged 10–24 and for adults aged 25 and older **in the last 12 months**. Estimates are acceptable if information is not available from your organization's HER. Please indicate whether data are estimated or from EHR.

In the last 12 months…	Don't Know	Data from EHR System	Data are Estimated	Total	Youth Aged 10–24	Adults Aged 25 and Older
Number who developed safety plan on same date as screening/assessed	☐	☐				
Number of individuals screening positive for risk of suicide	☐	☐				

[IF SELECTION IS MADE ON QUESTION 36B]

45. In Question 36b, you indicated that your organization employs a follow-up method of calling within 24 hours of discharge. Please report your organization's rate of contact by providers during care and care transitions as measured by phone calls or in-person visits where the patient is reached within 24 hours of transition from acute care (e.g., follow-ups after ED or inpatient discharge, contact with crisis services) for youths aged 10–24 and for adults aged 25 and older **in the last 12 months**. Estimates are acceptable if information is not available from your organization's EHR. Please indicate whether data are estimated or from EHR.

In the last 12 months…	Don't	Data	Data are	Total	Youth	Adults

	Know	from EHR System	Estimated		Aged 10–24	Aged 25 and Older
Number of clients contacted (by phone or in person) as reflected in EHR entry on day of transition or next day	☐	☐				
Individuals under your organization's care who are at risk for suicide who experienced an episode of acute care (ED, inpatient, crisis services)	☐	☐				

46. Please describe your organization's approach to measuring and reporting on all suicide deaths and attempts.

    a. Does your organization track suicide deaths and attempts within the patient population?

        ☐ Yes ☐ No ☐ Don't know

    b. [IF YES TO a.] How does your organization identify suicide deaths and attempts within the patient population? *Select all that apply.*

        ☐ Medicaid data
        ☐ Vital statistics
        ☐ National Violent Death Reporting System (NVDRS) data
        ☐ Informal methods (e.g., information shared from other care providers or reported by family)
        ☐ Routine follow-up protocols
        ☐ Other, please specify: _____

    c. [IF YES TO a.] Do you document deaths and attempts in your EHR?

        ☐ Yes ☐ No ☐ Don't know

    d. [IF YES TO c.] Please report the number of known suicide deaths and suicide attempts among patients receiving behavioral health treatment aged 10–24 and aged 25 and older **in the last 12 months**.

In the last 12 months…	Don't Know	Data from EHR System	Data are Estimated	Total	Youth Aged 10–24	Adults Aged 25 and Older
Suicide Deaths: Known deaths among all patients who came for behavioral health services in last 12 months	☐	☐	☐			
Suicide Attempts: Number of individuals who made an attempt among all patients who came for behavioral health	☐	☐	☐			

services in last 12 months						