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# racZero Suicide Evaluation

## Behavioral Health Provider Survey

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### Description of Participation

Thank you so much for taking the time to speak with me today. My name is [NAME] and I work for Aptive/ ICF. The Substance Abuse and Mental Health Services Administration (SAMHSA) of the Department of Health and Human Services is evaluating their Zero Suicide in Health Systems program. Aptive Resources along with its partner ICF (together as Team Aptive) are contracted by SAMHSA to conduct this evaluation. We are asking you to participate in the Behavioral Health Provider Survey (BHPS). The primary goal of the (BHPS) is to collect information on suicide prevention care practices and the extent of implementation of the Zero Suicide Model. This survey will take about 45 minutes to complete.

### Rights Regarding Participation

- Your participation in this survey is completely voluntary.
- There are no penalties or consequences to you if you do not participate.
- You may stop the survey or skip a question at any time for any reason.
- You may contact the evaluation principal investigator with any questions you have before, during, or after completion.

### Privacy

We will take every precaution to protect your privacy.

All survey responses will be confidential. Your name will never appear in any report. All findings will be reported in aggregate; that is, they will be combined with responses from other individuals. If you are selected to participate in follow-up surveys your responses across administration will be linked with a unique identifier, but your name and responses will not be linked. Your individual responses will not be shared with anyone, including your employer or other grantee-funded staff.

### Benefits

Your participation will not result in any direct benefits to you. However, your input will contribute to a national effort to prevent suicide.

### Risks

Completing this survey poses few, if any, risks to you. Some questions may make you feel uncomfortable. You can choose not to answer any question for any reason. You may choose to stop the survey at any time, or not answer a question for whatever reason. You will not be penalized for stopping. You can contact the principal investigator of the project at any time.

**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@icf.com](mailto:christine.walrath@icf.com).

For any questions related to your rights as they related to this research, please contact the ICF IRF at [IRB@icf.com](mailto:IRB@icf.com).

1) Do you agree to participate in this survey?

☐ YES

☐ NO

## Section 1. Agency/Organization Type<sup>1</sup>

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

- ☐ Administrator
- ☐ Supervisor of mental health/behavioral health service providers
- ☐ Clinician or practitioner
- ☐ Other, please specify: \_\_\_\_\_

18. Confirm the name of your organization: [Drop down menu or prepopulated]

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

- ☐ A private for-profit organization
- ☐ A publicly held for-profit organizations
- ☐ A private nonprofit organization
- ☐ A public agency or department

3a. [IF "A PUBLIC AGENCY OR DEPARTMENT" IS SELECTED FOR 3] 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
- ☐ Tribal Government
- ☐ Indian Health Services
- ☐ U.S. Department of Veterans Affairs
- ☐ Other, please specify: \_\_\_\_\_

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

- ☐ Behavioral health association or network representing *multiple service providers* organizations across a *large geographic area* (e.g., state or region).
- ☐ Behavioral health service provider organization with multiple locations across a broad geographic area (e.g., state or region).
- ☐ Behavioral health service provider organization with multiple locations within a localized area (e.g., city or county).
- ☐ Behavioral health service provider organization operating at a single location.
- ☐ Behavioral health service provider operating within a nonbehavioral health organization (e.g., school district, child welfare, or other affiliated organization).
- ☐ Health Care Organization (HCO) that may or may not include a focus on behavioral health, such as hospitals, primary care practices, or integrated delivery systems.

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<sup>1</sup> Adapted from the 2014 National Mental Health Services Survey, available here: <http://info.nmhss.org/>

- ☐ Specialized department within a broader health care organization, such as an Emergency Department, focusing on acute care and crisis intervention.
- ☐ Other (please specify): \_\_\_\_\_

21. If your organization operates in multiple locations, write in the name of the location that you are answering for. **For the remainder of this survey, answer questions for the location you are responding for.**

☐ [open text or prepopulated from skip logic]

22. Does your organization offer the following **Behavioral Health** services at [LOCATION]? Select “yes” or “no” for each service.

|                                                                                                                                                                                                                              |     |    |            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|------------|
| a. Intake services                                                                                                                                                                                                           | Yes | No | Don't Know |
| b. Diagnostic evaluation                                                                                                                                                                                                     | Yes | No | Don't Know |
| c. Information and/or referral services for directing clients to external Behavioral Health programs or resources?                                                                                                           | Yes | No | Don't Know |
| d. Crisis response or emergency programs (such as psychiatric emergency departments) operated by our HCO, either in person or by telephone?                                                                                  | Yes | No | Don't Know |
| e. 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 | Don't Know |

23. Does your organization offer behavioral health treatment services in any of these service settings? Select “yes” or “no” for each setting.

|                                                                                                                                                                                                                             |           |    |            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|----|------------|
| a. 24-hour inpatient services (psychiatric hospitals or general hospitals with separate psychiatric units)                                                                                                                  | Yes       | No | Don't Know |
| 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 | Don't Know |
| c. Partial hospitalization/day treatment (e.g., less than 24-hour)                                                                                                                                                          | Yes       | No | Don't Know |
| d. Outpatient (less than 24-hour)                                                                                                                                                                                           | Yes       | No | Don't Know |
| e. If you select yes to “Outpatient” [7d.], specify the types of outpatient behavioral health treatment services your organization offers:                                                                                  | Open text |    |            |

24. What is the primary service delivery focus of your organization at [LOCATION]? Choose only one that is most appropriate/prominent service delivery 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: \_\_\_\_\_

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 [**INSERT DATE RANGE**].

25. [**IF YES TO 7A OR 7B**] On [**INSERT BEGINNING DATE IN DATE RANGE**], about 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

26. [**IF YES TO 7C OR 7D**] During the month of [**INSERT MONTH AND YEAR**], about how many clients received partial/day, or 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

27. Identify the specific roles and responsibilities within your organization that are dedicated to building and managing suicide care processes. *Check all that apply.*

- ☐ Designated leadership or supervisory personnel responsible for developing suicide care processes
- ☐ Implementation team assembled for suicide care process development and management
- ☐ Multidisciplinary suicide prevention team meeting regularly for process development and oversight
- ☐ Staff roles focused on training and support for suicide prevention measures
- ☐ Dedicated roles for coordinating with external organizations and resources for suicide care
- ☐ Team or individuals responsible for policy development and updates in suicide prevention
- ☐ Specific roles for data collection, analysis, and reporting on suicide prevention efforts
- ☐ Dedicated personnel for client follow-ups and engagement in suicide prevention care
- ☐ Staff or team for quality improvement and assurance in suicide care processes
- ☐ Other roles or responsibilities (please specify): \_\_\_\_\_

28. Indicate how suicide attempt and loss survivors are involved in the design, implementation, and improvement of suicide care policies and activities in your organization. *Check all that apply.*

- ☐ Participation in advisory roles or committees for policy-making
- ☐ Involvement in the development and review of suicide care processes
- ☐ Contribution to staff training and education programs
- ☐ Engagement in support groups or peer support roles
- ☐ Providing input in the creation of educational and outreach materials
- ☐ Active roles in suicide prevention advocacy and awareness campaigns
- ☐ Inclusion in quality improvement teams for suicide care services
- ☐ Roles in direct client support services (e.g., crisis hotline staffing)
- ☐ No formal involvement of suicide attempt and loss survivors in the organization
- ☐ Other forms of involvement (please specify): \_\_\_\_\_

## Section 2. Type of Clients Served

13. What age groups are accepted for treatment at any of your organization's locations?

Select "yes" or "no" for each of the following age groups served at your organization.

|                               |     |    |            |
|-------------------------------|-----|----|------------|
| a. Youth (aged 17 or younger) | Yes | No | Don't Know |
| b. Young adults (aged 18–24)  | Yes | No | Don't Know |
| c. Adults (aged 25–64)        | Yes | No | Don't Know |
| d. Seniors (aged 65 or older) | Yes | No | Don't Know |

14. Does your organization accept patients who have **Medicaid** coverage?

- ☐ Yes  
☐ No

14a. [IF YES to 14] About what percentage of your organization's practice is composed of patients with Medicaid coverage? \_\_\_\_\_%

15. Does your organization accept patients who have **Medicare** coverage?

- ☐ Yes  
☐ No

15a. [IF YES to 15] About what percentage of your organization's practice is composed of patients with **Medicare** coverage? \_\_\_\_\_%

16. Does your organization have specialized crisis 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 the option that best describes how these services are available in your organization. If your organization has many locations, think about how these services are offered in all of them. If there is only one location, answer based on that place.

Choose only one from the list below.

- ☐ Specialized crisis services are available at **all** locations, BUT we do not have a mobile crisis team.
- ☐ Specialized crisis services are available only at some locations AND we do not have a mobile crisis team.
- ☐ Specialized crisis services are available at all locations AND we have a mobile crisis team.
- ☐ Specialized crisis services are available at some locations AND we have a mobile crisis team.
- ☐ No, we do not have specialized crisis services, NOR a mobile crisis team.
- ☐

**17. How are suicide attempt or loss survivors involved in developing suicide prevention activities within your organization?**

- ☐ Not involved in the development of suicide prevention activities.
- ☐ Involved informally, such as volunteers or peer supports.
- ☐ Formally included in general approach to suicide care but limited to specific activities.
- ☐ Active members of decision-making teams, such as the suicide prevention implementation team.
- ☐ Participating in various activities including decision-making teams, policy decisions, employee hiring, training, and quality improvement.

**Section 3. Use of Electronic Health Records (EHRs)**

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18. For each service listed below, please specify whether your organization uses electronic methods, paper, or both for carrying out these tasks in behavioral health (BH) services at this location.

| Function                                                                                                                                                   | Computer/<br>Electronic<br>Only | Paper<br>Only | Both<br>Electronic<br>and Paper | N/A |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------|---------------------------------|-----|
| a. Intake/scheduling for BH services                                                                                                                       |                                 |               |                                 |     |
| b. Screening for BH services                                                                                                                               |                                 |               |                                 |     |
| c. Assessment/evaluation for BH services                                                                                                                   |                                 |               |                                 |     |
| d. Treatment plan/progress monitoring for BH services                                                                                                      |                                 |               |                                 |     |
| e. Health Records (Note: Please consider how health records are maintained specifically for BH services, and if integrated with from other health records) |                                 |               |                                 |     |
| f. Collaboration/Referrals with Other Providers (e.g., primary care providers, other BH providers)                                                         |                                 |               |                                 |     |
| g. Suicide specific monitoring (e.g., risk assessment, safety planning, tracking scheduled appointments, tracking suicide attempts or deaths)              |                                 |               |                                 |     |
| h. Lethal means safety                                                                                                                                     |                                 |               |                                 |     |



## Section 4. Suicide Prevention and Care<sup>2</sup>

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19. Please rate your organization's readiness to implement the Zero Suicide framework, endorsed by the National Action Alliance for Suicide Prevention.

- ☐ Not aware of the Zero Suicide framework
- ☐ Aware of the Zero Suicide framework, but no tangible actions toward implementation
- ☐ Beginning informal steps toward implementing the Zero Suicide framework
- ☐ Made several, formal steps toward implementing a comprehensive Zero Suicide approach, including creating an implementation team
- ☐ Actively working on implementing the Zero Suicide framework with internal commitment and initiatives (e.g., developing internal policies and training programs, without direct involvement from the Zero Suicide Institute or SPRC)
- ☐ Extensive commitment to Zero Suicide, including working with the Zero Suicide Institute and/or SPRC on implementation (e.g., ongoing use of an online toolkit, participation in Zero Suicide Learning Collaborative, participation in a Zero Suicide Academy or breakthrough series)

These next questions are about your organization's leadership and commitment to providing 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.*)

20. 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

20a. [IF YES TO 20.] What aspects are addressed by the policy on suicide prevention and suicide safer care? *Please select all that apply.*

- ☐ Workforce training appropriate to different staff roles
- ☐ Guidelines for screening for suicide risk with an evidence-based screening tool
- ☐ Protocols for assessing level of risk among those who screen positive
- ☐ Interventions tailored based on the level of assessed risk
- ☐ Collaborative safety planning protocols
- ☐ Lethal means safety
- ☐ Evidence-based treatment
- ☐ Contact with patients who don't show for appointments
- ☐ Follow-up during care transitions or discharge
- ☐ Prevention of compassion fatigue
- ☐ Suicide care pathway (care management plan)
- ☐ Continuous quality improvement and tracking suicide deaths and/or attempts among patients in care
- ☐ Workplace Culture of safety/no blame

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<sup>2</sup> Adapted from the Zero Suicide Organizational Self-Study, available here:  
[http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/ZS-Org-SelfStudy\\_72915.pdf](http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/ZS-Org-SelfStudy_72915.pdf)

[IF YES TO 20.] Regarding the policies or procedures on suicide prevention and suicide safer care in your organization:

20b. Are all staff aware of these policies or procedures?

- ☐ Fully aware
- ☐ Mostly aware
- ☐ Somewhat aware
- ☐ Not aware
- ☐ Don't know

20c. Could all staff describe these policies or procedures if asked?

- ☐ Yes, all staff could describe them
- ☐ Most staff could describe them
- ☐ Some staff could describe them
- ☐ Few staff could describe them
- ☐ No, staff could not describe them
- ☐ Don't know

[IF YES TO 20.] Regarding the staff training on the policies or procedures for suicide prevention and suicide safer care in your organization:

20d. Are staff periodically trained on existing policies or procedures for suicide prevention and suicide safer care?

- ☐ Yes, staff are periodically trained
- ☐ No, staff are not periodically trained
- ☐ Don't know

20e. Are staff made aware when new policies or procedures are introduced?

- ☐ Yes, staff are made aware of new policies
- ☐ No, staff are not made aware of new policies
- ☐ Don't know

21. Does the organization have at least one staff person whose duties relate to suicide care policies and practices throughout your organization?

- ☐ Yes, there is one individual
- ☐ Yes, there is a team of individuals
- ☐ No [Go to 22]
- ☐ Don't know [Go to 22]

21a. [IF YES TO either category in 21.] What are their responsibilities? *Select all that apply.*

- ☐ Performing discrete tasks related to suicide safe care practices or providing training on suicide prevention.
- ☐ Examining suicide prevention policies and practices, formulating recommendations, and participating in Continuous Quality Improvement (CQI) processes.

- ☐ Adopting and enforcing changes to policies and practices, including overseeing the implementation of new strategies and monitoring their effectiveness.
- ☐ Engaging in regular review and analysis of suicide-related incidents and data to inform policy updates and training needs.
- ☐ Collaborating with external agencies or experts for guidance and best practices in suicide prevention.
- ☐ Other, please specify: \_\_\_\_\_

21b. [IF YES, THERE IS ONE INDIVIDUAL FROM 21.] Is this one individual committed to this role for at least a 1-year term?

- ☐ Yes
- ☐ No
- ☐ Don't know

21c. [IF YES, THERE IS A TEAM OF INDIVIDUALS FROM 21.] How often does this team meet?

- |                                 |                                  |
|---------------------------------|----------------------------------|
| <input type="radio"/> Weekly    | <input type="radio"/> Yearly     |
| <input type="radio"/> Biweekly  | <input type="radio"/> As needed  |
| <input type="radio"/> Monthly   | <input type="radio"/> Don't know |
| <input type="radio"/> Quarterly |                                  |

21d. [IF YES TO 21.] 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

22. We want to know how people who have attempted suicide or lost someone to suicide contribute to the way your organization handles suicide care. Are suicide attempt or loss survivors involved in the development of suicide prevention activities within your organization?

- ☐ Yes
- ☐ No [Go to 23]
- ☐ Don't know [Go to 23]

22a. [IF YES TO 22.] 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
- ☐ Acting as patient advocates
- ☐ Participating in evaluation and quality improvement
- ☐ Other: Please specify \_\_\_\_\_

22b. [IF YES TO ANY ACTIVITY OTHER THAN SERVING IN INFORMAL ROLE IN 22a.] 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

## Section 5. Training Staff to Identify Clients/Patients at Risk

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

- ☐ Yes
- ☐ No [Go to 24]
- ☐ Don't know [Go to 24]

23a. [IF YES TO 23.] Who is required to take this training?

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

23b. [IF YES TO 23.] To whom is this training offered (even if not required)?

- ☐ Offered to selected staff only (e.g., crisis staff, clinical staff)
- ☐ Offered to all staff (including non-clinical staff)

23c. [IF Selected staff or All Staff for 18a] Is there a minimum number of hours required annually for staff?

- ☐ Yes
- ☐ No

23d. [IF YES TO 23c], how many hours of training are required annually? \_\_\_\_\_

23e. [IF YES TO 23c] How often retraining required?

- ☐
- ☐ Yearly
- ☐ Every other year
- ☐ Every three years
- ☐ Retraining is not Required.
- ☐ Other: \_\_\_\_\_

23f. [IF YES TO 23.] Please indicate the foundational training approach/curriculum the organization uses. *Select all that apply.*

- ☐ Assessing and Managing Suicide Risk (AMSR)
- ☐ Applied Suicide Intervention Skills Training (ASIST)
- ☐ Connect Suicide Prevention/Intervention Training
- ☐ Connect Postvention Training
- ☐ Question, Persuade, Refer (QPR): Gatekeeper Training for Suicide Prevention
- ☐ Suicide Alertness for Everyone: Tell, Ask, Listen, and Keep Safe (safeTALK)
- ☐ Locally developed intervention, please specify: \_\_\_\_\_

☐ Other intervention, please specify: \_\_\_\_\_

23g. Please indicate the training approach or curriculum used to train clinical staff on advanced suicide prevention skills.

- ☐ Assessing and Managing Suicide Risk (AMSR)
- ☐ Chronological Assessment of Suicide Events (CASE)
- ☐ Collaborative Assessment and Management of Suicidality (CAMS)
- ☐ Recognizing and Responding to Suicide Risk (RRSR)
- ☐ QPR-T (suicide risk assessment and training course)
- ☐ Other, please specify: \_\_\_\_\_
- ☐ None

## Section 6. Trainings and Use of Evidence-Based Treatment with Providers

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

- ☐ Yes, the organization promotes certain treatment model
- ☐ No, clinicians rely on experience and best judgment in treatment[Go to 25]
- ☐ Don't know[Go to 25]

24a. [IF YES TO 24.] Does the organization offer one or more evidence-based treatments targeting suicidal thoughts and behaviors specifically (e.g., Brief Cognitive Behavioral Therapy for Suicide Prevention, CAMS, CBT for Suicide Prevention, DBT)?

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

24b. [IF YES TO 24a.] Does the organization provide training in evidence-based treatment(s) specific to suicide?

- ☐ Yes
- ☐ No

24c. [IF YES TO 24b.] Select which models clinicians in the organization receive formal training on. *Select all that apply.*

- ☐ Acceptance and Commitment Therapy (ACT)
- ☐ Attachment-Based Family Therapy (ABFT)
- ☐ Attempted Suicide Short Intervention Program
- ☐ Brief Cognitive Behavioral Therapy for Suicide Prevention (BCBT)
- ☐ Brief Mindfulness-Based Intervention for Suicidal Ideation
- ☐ Cognitive Therapy – Suicide Prevention (CT-SP)
- ☐ Collaborative Assessment and Management of Suicidality (CAMS)
- ☐ Dialectical Behavior Therapy (DBT)
- ☐ Teachable Moment Brief Intervention
  
- ☐ Other, please specify: \_\_\_\_\_

24d. [IF YES TO 24.] Does the organization assess fidelity to treatment and outcomes?

- ☐ Yes
- ☐ No
- ☐ Don't Know

## Section 7. Assessment of Staff Self-Efficacy and Training Adherence

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25. How does your organization assess and ensure the capacities of staff in providing suicide care, including their confidence, skills, and support? Select the most applicable option.

- ☐ We do not assess staff capacities in suicide care. [In this answer selected, proceed to question 26]
- ☐ Staff are informally asked to self-report their confidence and skills in providing suicide care.
- ☐ Formal assessments are conducted for clinical staff only, focusing on skills and training needs specific to suicide care.
- ☐ All staff (clinical and non-clinical) undergo formal assessments of their capacities in suicide care, with training tailored based on assessment results.
- ☐ Comprehensive assessments of all staff are conducted regularly, and organizational policies and training are continuously updated in response to these assessments.
- ☐ Not sure

25a. [IF YES (FOR ANY STAFF WHO PROVIDE DIRECT CARE OR FOR ALL STAFF) TO 25.] Is staff perception reassessed at least every 3 years?

- ☐ Yes
- ☐ No
- ☐ Don't Know

25b. [IF YES TO 25.] Are the results of assessments used to enhance training and/or develop policies?

- ☐ Yes
- ☐ No
- ☐ Don't Know

## Section 8. Screening and Assessment Practices

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26. Is there a standardized tool(s) routinely used across the organization to screen individuals for suicide risk? **NOTE:** Screening is defined as systematically identifying individuals at risk for suicide.

- ☐ Yes, we have a standardized tool, but staff aren't required to use it
- ☐ Yes, all staff are required to use the standardized tool
- ☐ No, the organization relies on the clinical judgment of its staff regarding suicide risk
- ☐ Don't know

[If No or Don't Know is selected, proceed to question 28]

26a. [IF YES to option 1 or 2 in 26.] Is the screening for suicide risk performed selectively for groups identified as at risk (e.g., during psychiatric intake, inpatient admissions) or is it conducted for every individual receiving care from the organization?

- ☐ At Risk groups
- ☐ Everyone
- ☒ Don't Know

26b. [IF YES TO option 1 or 2 in 26.] When are suicide risk screenings conducted in your organization? Select all that apply, considering the nature of the treatment (one-time, short-term, or long-term) provided.

- ☐ At intake (applicable to all types of treatment encounters)
- ☐ When suicide warning signs are observed (relevant for both short-term and long-term care settings)
- ☐ When a patient has a change in status, such as a transition in care level, change in setting, change to a new provider, or a potential new risk factor like a change in life circumstance (typically more relevant for long-term care)
- ☐ Prior to discharge/end of treatment (applicable in settings with defined treatment durations, both short-term and long-term)
- ☐ At every visit (suitable for ongoing treatment settings, whether short-term or long-term)
- ☐ Don't Know

26c. [IF YES option 1 or 2 in TO 26.] Please indicate the screening tool used. *Select all that apply.*

- ☐ Ask Suicide Screening Questions (asQ)
- ☐ Beck Depression Inventory (BDI)
- ☐ Behavioral Health Measure- 10 (BHM-10)
- ☐ Behavioral Health Screen (BHS)
- ☐ Brief Symptom Inventory 18 (BSI 18)
- ☐ Columbia Suicide Severity Rating Scale
- ☐ Outcome Questionnaire 45.2 (OQ 45.2)
- ☐ Patient Health Questionnaire 9 (PHQ-9)
- ☐ PHQ-3
- ☐ Suicide Behaviors Questionnaire (SBQ-R)
- ☐ Locally developed tool, please specify: \_\_\_\_\_
- ☐ Other tool, please specify: \_\_\_\_\_



26d. [IF YES option 1 or 2 in TO 26.] Do staff receive regular training on the screening tool?

- ☐ Yes
- ☐ No
- ☐ Don't Know

27. [IF YES TO 26.] Does the organization have routine procedures for assessing risk following a positive suicide screening? 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.*

- ☐ Yes
- ☐ No
- ☐ Don't know

27a. [IF YES to 27] If a person is screened at risk for suicide, are clinicians prompted in the EHR to do an assessment?

- ☐ Yes
- ☐ No
- ☐ We don't have an EHR
- ☐ Don't know

27b [IF YES to 27] Are comprehensive risk assessments completed the same day as the screening?

- ☐ Always
- ☐ Sometimes
- ☐ Never
- ☐ Don't know

27c. [IF YES TO 27.] 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
- ☐ Don't know

27d. [IF YES TO 27c.] Please indicate the assessment tool used: *Select all that apply.*

- ☐ Assessing and Managing Suicide Risk (AMSR)
- ☐ CASE Approach
- ☐ Collaborative Assessment and Management of Suicidality (CAMS)
- ☐ Columbia Suicide Severity Rating-Scale (CSSR-S)
- ☐ QPR Suicide Assessment and Management Training (QPRT)
- ☐ Recognizing and Responding to Suicide Risk (RRSR)
- ☐ RRSR- Primary Care
- ☐ Suicide Assessment Five-step Evaluation and Triage (SAFE-T)
- ☐ Locally developed tool, please specify: \_\_\_\_\_
- ☐ Other tool, please specify: \_\_\_\_\_

27e. [IF YES TO 27c.] Are the results of the risk assessment documented in the EHR?

- ☐ Yes

- ☐ No
- ☐ Don't Know

27f. [IF YES TO 27c.] 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

27g. [IF YES TO 27c.] Is the assessment conducted by a clinician with specialized training to perform the assessment?

- ☐ Yes
- ☐ No
- ☐ Don't Know

27h. [IF YES TO 27c.] Is suicide risk reassessed or reevaluated at every visit for those at risk?

- ☐ Yes
- ☐ No
- ☐ Don't Know

27i. [IF YES TO 27c.] When reflecting on your organization's current risk assessment protocol, do you think efforts are not enough, just right, or too much?

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

28. Does your organization have a specific approach or set of procedures for determining if someone poses a high or imminent suicide risk? If yes, please select all the procedures that apply from the list below. If no, please select 'Not applicable'

- ☐ Assess suicide thoughts or plans
- ☐ Assess suicidal intent and whether the patient believes she/he can refrain from attempting suicide
- ☐ Assess history of suicide attempts
- ☐ Assessment of non-suicidal 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 patient to articulate or list reasons for living
- ☐ Immediately refer the patient to speak with a clinician at a crisis center
- ☐ Try to develop a safety plan with the patient
- ☐ Meet with patient's family to address concerns and safety issues
- ☐ Immediately refer the patient to speak to a clinician from our internal behavioral health team or at an outpatient behavioral health clinic

- ☐ 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

29. Once a patient 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/them to do a clinical assessment? *Please choose the option that best describes what usually happens.*

- |                                         |                                          |
|-----------------------------------------|------------------------------------------|
| <input type="radio"/> Immediately       | <input type="radio"/> Within 2 days      |
| <input type="radio"/> Less than 2 hours | <input type="radio"/> Within a week      |
| <input type="radio"/> Less than 4 hours | <input type="radio"/> Longer than a week |
| <input type="radio"/> Within the day    | <input type="radio"/> Don't know         |

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

- ☐ Yes
- ☐ No
- ☐ Don't Know

31. Please describe how your organization handles situations where a suicide risk is identified during a general healthcare visit. Check all that apply

- ☐ We have a standard protocol for immediate referral to mental health services.
- ☐ We assess the risk and decide on a case-by-case basis.
- ☐ There are dedicated staff or resources for handling mental health concerns, including suicide risk.
- ☐ General healthcare providers are trained to manage initial interventions and then refer as needed.
- ☐ Other (please specify): \_\_\_\_\_
- ☐ Not applicable/We do not have a specific approach for this scenario.

## Section 9. Follow-Up Care and Referral Practices

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32. This question aims to clarify the extent and focus of care management responsibilities. Select the option(s) that best describe the scope of care management at your organization:

- ☐ Care management is focused exclusively on the period during which a patient is under the direct care of our Healthcare Organization (HCO).
- ☐ Care management includes post-care follow-up requirements and strategies after a patient leaves our HCO.
- ☐ Both in-care management and post-care follow-up are integral parts of our care management approach.
- ☐ Don't Know

33. Are there protocols or guidance for follow up care management for individuals at risk for suicide?

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

[If answer to 33 is No or Don't Know, proceed to question 34]

33a. [IF YES TO 33.] Is the protocol or guidance for care management provided by your HCO specific for individuals at different risk levels?

- ☐ Yes
- ☐ No
- ☐ Don't know

33b. [IF YES TO 33.] 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 safety
- ☐ Don't Know

33c. [IF YES TO 33.] Are these care management elements embedded in the EHR or other clinical documentation processes?

- ☐ Yes
- ☐ No
- ☐ Don't Know

33d. [IF YES TO 33.] Are individuals at risk for suicide placed on a special care management plan or care pathway?

- ☐ Yes
- ☐ No
- ☐ Don't Know

33e. [IF YES TO 33d.] 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

33f. [IF YES TO 33d.] Are multiple staff involved in a determination to take an individual off the at-risk care management plan or care pathway?

- ☐ Yes
- ☐ No
- ☐ Don't know

34. Are there any formal protocols regarding safety planning?

- ☐ Yes
- ☐ No
- ☐ Don't know

34a. [IF YES TO 34.] Are safety plans required for all individuals at risk?

- ☐ Yes
- ☐ No
- ☐ Don't know

34b. [IF YES TO 34a.] Are there formal guidelines or policies regarding the safety plan's content?

- ☐ Yes
- ☐ No
- ☐ Don't know

34c. [IF YES TO 34b.] Which of the following components is the safety plan expected to address? *Select all that apply.*

- ☐ Professional/crisis support resources (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).

34d. [IF YES TO 34b.] Please indicate the safety planning tool/approach the organization uses:

- ☐ Stanley/Brown Safety Plan
- ☐ Rudd/Bryan/Joiner Crisis Response Plan
- ☐ Locally developed tool, please specify: \_\_\_\_\_
- ☐ Other tool, please specify: \_\_\_\_\_

34e. [IF YES TO 34a.] 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 BH visit for individuals at risk
- ☐ Every visit to an HCO, regardless of reason

34. [IF YES TO 34a.] Is it standard practice to complete the safety plan during the initial appointment/encounter when risk was identified (or before discharge for inpatient)?

- ☐ Yes
- ☐ No
- ☐ Don't know

34g. [IF YES TO 34f.] How often is the safety plan completed during the initial appointment/encounter when risk was identified (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

35. [IF YES TO 7A OR 7B] Does your organization have a protocol for observation of at-risk patients?

- ☐ Yes
- ☐ No
- ☐ Don't know

35a. [IF YES TO 35.] Is verbal interaction with patients required during checks?

- ☐ Yes
- ☐ No
- ☐ Don't know

35b. [IF YES TO 35.] Does the protocol for observation require continuous observation (e.g., of patients' hands, or keeping the patient in constant view)?

- ☐ Yes
- ☐ No
- ☐ Don't know

35c. [IF YES TO 35.] Do orders for constant observation include all circumstances (e.g., patient should be observed in bathroom, while sleeping, eating)?

- ☐ Yes
- ☐ No
- ☐ Don't know

35d. [IF YES TO 35.] Do all staff receive training in counseling lethal means safety?

- ☐ Yes, all staff must complete training
- ☐ Some staff are trained, but not all
- ☐ No
- ☐ Don't know

35e. [IF YES TO 35.] Are staff competencies in observation periodically assessed?

- ☐ Yes
- ☐ No
- ☐ Don't know

35f. [IF YES TO 35.] Are more than one staff members involved in a determination to take an individual off constant observation status?

- ☐ Yes
- ☐ No
- ☐ Don't know

36. Are there any formal protocols regarding lethal means safety counseling?

- ☐ Yes
- ☐ No
- ☐ Don't know

36a. [IF YES TO 36.] Is individualized lethal means safety planning included on safety plans?

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

36b. [IF YES TO 36.] Does the organization provide training on counseling individuals at risk for suicide and their families on lethal means safety?

- ☐ Yes
- ☐ No
- ☐ Don't know

36c. [IF YES TO 36.] Does the organization set policies regarding minimum actions required of providers for lethal means safety (e.g., speaking with family members or significant others regarding lethal means safety; including lethal means safety planning)?

- ☐ Yes
- ☐ No
- ☐ Don't know

36d. [IF YES TO 36.] Are family members or significant others included in lethal means safety planning? *Choose only one from the list below.*

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

36e. [IF STANDARD COMPONENT IS SELECTED on 36d.] Is contacting family and confirming lethal means safety standard practice?

- ☐ Yes
- ☐ No
- ☐ Don't know

36f. [IF YES TO 36.] Are lethal means safety recommendations reviewed regularly by providers and the patient while the individual is at risk?

- ☐ Yes
- ☐ No
- ☐ Don't know

37. What are your organization's typical procedures and practices for at risk patients? *Select all that apply.*

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

38. Are there specific guidelines and policies for following up with individuals at risk?

- ☐ Yes
- ☐ No
- ☐ Don't know

38a. [IF YES TO 38.] Are the guidelines and policies specific for individuals at different risk levels?

- ☐ Yes
- ☐ No
- ☐ Don't know

38b. [IF YES TO 38.] What aspects are addressed by guidelines for follow-up? *Select all that apply.*

- ☐ Follow-up after crisis contact
- ☐ Nonengagement in services (e.g., failure to appear for scheduled appointments).
- ☐ Transition from emergency room (ER) or psychiatric hospitalization

39. Please indicate which, if any, follow-up methods the organization employs after **nonengagement in services** (e.g., failure to appear for scheduled appointments). *Select all that apply.*

- ☐ Text reminders of appointments
- ☐ Texts of support or encouragement



- ☐ Postcards or letters
- ☐ Use of apps
- ☐ Follow-up call within 4 hours
- ☐ Follow-up call within 8 hours
- ☐ 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
- ☐ Availability of peer supports
- ☐ Availability of peer-run crisis respite
- ☐ Home visits
- ☐ Drop-in appointments
- ☐ None of the above
- ☐ Other, please specify: \_\_\_\_\_
- ☐ Don't know

40. During which duration do you typically try to continue to reach patients identified as at risk or as having made a suicide attempt after nonengagement in services? *Select all that apply.*

- ☐ 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

41. Please indicate which, if any, follow-up methods the organization employs after **acute care transitions** (e.g., following presentation in the ER or psychiatric hospitalization). *Select all that apply.*

- ☐ Text reminders of appointments
- ☐ Texts of support or encouragement
- ☐ Postcards or letters
- ☐ Use of apps
- ☐ Follow-up call within 8 hours
- ☐ 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
- ☐ Availability of peer supports
- ☐ Availability of peer-run crisis respite
- ☐ Home visits
- ☐ Drop-in appointments

- ☐ None of the above
- ☐ Other, please specify: \_\_\_\_\_  
Don't know

42. How long do you typically try to continue to reach patients identified as at risk or as having made a **suicide** attempt after transitions in care? *Select only one for each option.*

- ☐ 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

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

- |                                  |                                  |
|----------------------------------|----------------------------------|
| <input type="radio"/> Not enough | <input type="radio"/> Too much   |
| <input type="radio"/> Just right | <input type="radio"/> Don't know |

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

- ☐ Yes
- ☐ No
- ☐ Don't know

44a. [IF YES to 44] When reflecting on your current postvention services protocol for patients or families following a suicide attempt or death, do you think efforts are not enough, just right, or too much?

- |                                     |                                     |
|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Not enough | <input type="checkbox"/> Too much   |
| <input type="checkbox"/> Just right | <input type="checkbox"/> Don't know |

35. **What is your organization's approach to reviewing suicide deaths for those enrolled in care? *Select only one.***

- ☐ Team meets to discuss the case
- ☐ Root cause analysis is conducted only for people currently in care
- ☐ Root cause analysis is conducted for people up to 30 days post last contact
- ☐ Root cause analysis is conducted for people up to 6 months post last contact
- ☐ We do not have an approach

45a. [IF root cause analysis is selected in 45 (options b, c, and d)] Are data from all root cause analyses routinely examined to look at trends?

- ☐ Yes
- ☐ No
- ☐ Don't know

45b. [IF root cause analysis is selected in 45 (*options b, c, and d*)] Are policies and trainings updated because of root cause analysis?

- ☐ Yes
- ☐ No
- ☐ Don't know

36. Does your organization have a policy or process to track suicide deaths for those enrolled in behavioral health care (of any length)?

- ☐ Yes
- ☐ No
- ☐ Don't know

46a. [IF YES to 46] Which data sources does your organization use to confirm suicide deaths? *Select all that apply.*

- ☐ Coroner or medical examiner reports
- ☐ Medicaid data
- ☐ 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 state or federal data systems
- ☐ Other, please specify: \_\_\_\_\_

46b. [IF YES to 46] How long after last contact/case closure do you continue to monitor suicide deaths?

- ☐ We do not monitor suicide deaths past last contact/case closure
- ☐ 30 days
- ☐ Up to 6 months
- ☐ Longer than 6 months

46c. [IF YES TO 46.] Do you document deaths and attempts in your EHR?

- ☐ Yes
- ☐ No
- ☐ Don't know

47. How does your organization approach reviewing **suicide attempts** that require medical care? *Select only one.*

- ☐ Team meets to discuss the case
- ☐ Root cause analysis is conducted only for people currently in care
- ☐ Root cause analysis is conducted for people up to 30 days post last contact
- ☐ Root cause analysis is conducted for people up to 6 months post last contact
- ☐ We do not have an approach

47a. [IF root cause analysis is selected in 47 (*options b, c, and d*)] Are data from all root cause analyses routinely examined to look at trends?

- ☐ Yes
- ☐ No
- ☐ Don't know

47b. [IF root cause analysis is selected in 47 (*options b, c, and d*)] Are policies and trainings updated because of root cause analysis?

- ☐ Yes
- ☐ No
- ☐ Don't know

## Section 9 Collaboration with Zero Suicide Prevention Grantee

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**[ONLY DISPLAY FOR ORGANIZATIONS THAT ARE NOT THE GRANTEE]**

48. 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: \_\_\_\_\_

49. Select all 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

## Section 10. Annual Data on Screenings, Assessments, Care Provision, and Monitoring of At-Risk

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

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

- ☐ Yes
- ☐ No
- ☐ Don't know

51a. [IF YES TO 51.] 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: \_\_\_\_\_

51b. [IF YES TO 51.] Do you document deaths and attempts in your EHR?

- ☐ Yes
- ☐ No
- ☐ Don't know

You've reached the end of the survey! Thanks for your input! Your answer will help us understand the systems that support implementation of Zero Suicide.