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ORIGINAL PAPER

Making it Safer: A Health Centre's Strategy for Suicide Prevention

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Abstract Developing and implementing consistent methodology for suicide assessment and intervention is challenging, particularly in a large community hospital which provides both inpatient care and a wide range of ambulatory and community based mental health programs. Patients, families, staff, and ongoing evaluation contributed to the development of an initiative to determine what is best practice and in effecting changes in clinical and organizational practices. The Suicide Assessment project resulted in improved clinical outcomes for patients and clients. Staff report that they feel more supported in probing for suicidal ideation and have the skills required to effectively intervene with the 'suicidal' patient/client. This project advanced our knowledge of suicide assessment and risk management and provided new insights to assist professionals in the aftermath of a client's suicide when, as Valente describes, clinicians report 'feeling overwhelmed with feelings of guilt, self-blame, and responsibility (Valente S: Journal of Psychosocial Nursing 40:7 22-23, 2002).

Keywords Suicide · Mental health patient safety · Patient participation · Clinical protocols · Best practice project

Suicide: a word that means failure to a mental health professional and devastation to a family. Its identification and effective treatment are crucial in providing comprehensive service and the promotion of 'patient safety' for people with serious and persistent mental illness. Mental illness is the most important factor that predisposes people to suicidal behaviour. According to the International Association for Suicide Prevention, in most Western countries, almost 90% of people who die by suicide have a diagnosable mental disorder [2]. Bongar's review of risk assessment and treatment procedures for suicidal patients estimates that 10–15% of untreated or treatment resistant persons with major psychiatric disorders (i.e., affective disorder, substance use disorder and schizophrenia)

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will die by suicide [3]. Asnis states that bipolar patients are at the greatest risk of all, with 20–25% dying by suicide [4]. According to the World Health Organization "suicide is the single greatest cause of violent death around the globe" [5]. In 2001, the yearly global toll from suicide exceeded the number of deaths by homicide (500,000) and war (230,000). Suicide assessment and intervention are essential skills required by all mental health clinicians. Packman notes that "Because of the possible lethality, it is arguable that evaluations of suicidality are the most significant decisions a clinician can make throughout his or her career" [6].

With increased international attention towards suicide prevention, many countries, including Canada with its proposed *Blueprint for a National Suicide Prevention Strategy (2004)*, have set national benchmarks. Health organizations are challenged to meet the Blueprint's national objectives and to promote an integrated, evidence based and systemic approach for suicide prevention. Furthermore, the decrease in length of hospital stays and the shift from hospital to community care has increased client acuity and complexity in the community. Lamberg states that "It used to be that a patient talking about suicide was always hospitalized. Today the patient has to come in with a gun to his head or to your head to get hospitalized. We have to deal with more suicidal patients in the community" [7]. In addition, within community mental health programs, there is increased reliance on non-regulated health professionals to provide ongoing support and monitoring of clients' mental status, including suicide risk assessment.

Patient Safety Project/best Practice Initiative

Trillium Health Centre is a two site facility that serves a population of over one million residents in Mississauga, Ontario. It is comprised of a 660 bed suburban general hospital, an ambulatory care centre and a range of outpatient and community health services. The Mental Health System includes 50 inpatient beds, Crisis Intervention Team (CIT) located in the Emergency Department, two Assertive Community Treatment Teams (ACTT), case management services plus Mental Health Clinics which provide individual counseling and group programs for individuals and families across the lifespan, from children to the elderly.

In 2002, as a best practice patient safety initiative, Trillium Health Centre's mental health programs committed to improve patient care by equipping staff with the tools, education and training to effectively identify and manage suicide risk. Prior to this initiative, there were ongoing efforts to manage the risk associated with treating the 'suicidal' patient. These included staff training and education, clinical supervision and safety audits of the Inpatient unit. However, staff attended different training programs, used a variety of assessment strategies and did not have a common definition of risk.

Recognizing that system-wide change in practice would require understanding of the practices and culture within the different programs and "buy-in" from staff at every level, a strong inter-professional task force was gathered, representing the Health Centre's diverse programs. The Best Practice team included both formal and informal leaders and was supported by a best practice consultant. The project was sponsored by the Director of Mental Health who was committed to the project, attended meetings and brought a broad organizational perceptive to team discussion and decision-making. The Director was instrumental in ensuring that the team had the resources needed to develop and implement this initiative at an organizational level. Formal leaders included the Chief of Psychiatry, the Clinical Nurse Specialist and a manager as chair. Half the group was front line staff,

each from a different service and recognized by their team as highly skilled clinicians. Participation by both management and frontline staff allowed the group to make timely decisions and implement the project with ease.

A project Dashboard was developed with indicators to demonstrate how the project was having an impact. The quantitative indicators included:

(a) The percentage of ER visits and hospital admissions with the diagnosis of suicide or self-harm;
(b) Average length of stay for patients admitted due to suicide or self-harm;
(c) Percentage of clients/patients assessed for suicide risk;
(d) The percent of clients/patients with appropriate documentation of assessment and safety plan;
(e) Staff attendance at educational events related to suicide prevention.

The qualitative indicators included:

(f) Staffs' sense of comfort and competence in assessing and managing suicidal clients/patients;
(g) Staff satisfaction with training;
(h) Family and client perspectives on the gap between the care they wished for and the care they received.

Identifying suitable indicators for measurement was not straightforward. For example, one of the indicators was the number of in-patient admissions due to self-inflicted injury or suicidal thoughts or actions. The dilemma was whether more admissions would indicate a higher awareness of suicide risk and therefore demonstrate that the project was effective, or would fewer admissions indicate that our staff had developed increased skill and comfort in working with people at risk for suicide in the community; or, finally, would these factors balance each other leading to no change in the admission rates?

In reviewing health records data, it was difficult to establish an accurate baseline of the number of hospital admissions due to suicidal behaviors. The hospital coding system combines "suicide and self-inflicted injury", not differentiating between para-suicidal and suicidal behaviours. Over a three month period, all charts of patients coded as "suicide and self-inflicted injury" were audited. This audit revealed that 25% of emergency presentations were the result of para-suicidal behaviours, 21% following a suicide attempt and 35% with suicidal ideation. The remaining 18% were brought to hospital by family members who were concerned about risk of self-injury.

Identifying Best Practices in Suicide Assessment

Norton's Rapid Cycle Change methodology [8] provided a framework to divide the project into a number of smaller initiatives that built on each other and created momentum. The first initiative, a literature review, summarized relevant literature to better understand the phenomenon of suicide, and the factors that bring a person to this point; to determine the key issues in developing a suicide best practice initiative and the pitfalls to avoid. In addition to reviewing the literature, a more comprehensive understanding of suicide was sought though conversations with experts in the field and attendance at a variety of conferences, lectures and training workshops.

The task force divided into four work groups and involved other staff in these groups in order to give voice to other perspectives, and to broaden support for the project at the

frontline. The work groups' objectives were: (1) involving clients/patients and families in the project; (2) developing a comprehensive suicide risk assessment and rating scale; (3) determining the most effective way to provide related staff training and; (4) writing suicide assessment and risk management protocols. The work groups focused on both identifying evidence based practice and developing strategies to integrate these findings into clinical practice.

Listening to Those Impacted by Suicide

There was philosophical agreement amongst the task force about the importance of including the patient voice in best practice initiatives as this would add credibility and new dimensions to the process. Despite initial ethical concerns about reopening painful memories and the perceived sensitive nature of talking about suicide with survivors and their families, a commitment was made to include them in the project.

Listening to Clients

Two focus groups were conducted with 10 clients in each. These clients ranged in age from 25 to 64; were diagnosed with major mental illness: both Axis I and II; had been recent in-patients; and were attending a day hospital program. All of the participants had experienced suicidal ideation and/or made attempts. Clients were informed about the focus groups by their primary therapist and given the opportunity to be voluntary participants. Ethical considerations regarding patient safety led to holding the groups in the morning to ensure that the client had access to staff for debriefing and support throughout the day. Also, as there is increased risk in the first week post-discharge as noted in the National Suicide Prevention strategy for England, clients recently discharged from hospital were excluded [9].

The clients were pleased to be given the opportunity to talk about their experiences and their view of mental health services. They were open in discussing the aspects of their care that they experienced as helpful and unhelpful. Clients reported that strong therapeutic and peer relationships were key to their recovery. Frequent blunt questioning about suicidal ideation was annoying and sometimes resulted in minimizing reporting of symptoms. Clients suggested that the risk assessment should be embedded in a caring conversation. The clients advocated for families to receive more support and education from staff to assist them in coping with the impact on their lives of the suicide ideation and attempts; and to help families provide better support to them when they were feeling 'suicidal'.

Listening to Families

Bereaved Families of Peel, a local organization which provides peer support for people who have lost an immediate family member, was supportive of the project and recommended conducting individual interviews rather than focus groups. They referred families willing to be interviewed about their experiences following the death of a family member to suicide. The families expressed their frustration that they were not sufficiently involved in the treatment and that there was a lack of recognition of the support they provided to their relative. They recommended that there be a formal policy to include family members

in collecting initial information as well as in discharge planning and in the development of a realistic safety plan. They felt that patients were often discharged too soon while still voicing suicidal thoughts. Although the patient/client may have refused consent for them to be contacted, families felt that they had information crucial to the health care team regarding treatment decisions and that there should be a way to get around confidentiality as defined in Ontario's Mental Health Act and Personal Health Information Protection Act (2004) [10, 11]. They felt it unreasonable to expect them to be part of a discharge plan when they had not been part of its development.

Other themes that emerged from the interviews included a lack of coordination regarding medical and psychiatric care, poor communication amongst staff, and between staff and family. Families felt unsupported in dealing with the death and subsequent grief. Families recommended a formalized follow up interview with the treating psychiatrist to assist them in dealing with their unanswered questions.

On a positive note, families were appreciative of the nurses who they felt "really knew the patient" and of doctors who built an alliance with the patient. Families were pleased with practical support to increase safety, such as patients being discharged with small amounts of medication or coordination with local pharmacies to dispense medication in non-lethal doses.

These key themes were integrated into the project. This was achieved by the social workers who conducted the client focus groups and family interviews, acting as spokesperson for these stakeholders. As the project proceeded, all decisions were vetted by asking if they were in keeping with what was heard from clients and families. In addition, the integration of the suicide assessment into a caring conversation was one of the criterions used in the selection of the training package. The inclusion of families is clearly articulated in suicide assessment and risk management protocols.

Listening to Staff

All 186 Mental Health staff were surveyed at the beginning of the project to assess their sense of competence and comfort level with conducting suicide assessments and follow up; their need for ongoing education, and interest in a standardized assessment tool. With a 68% response rate, key findings were:

(a) 90% felt confident and comfortable performing suicide assessments and follow up procedures;
(b) 86% felt that a standardized assessment would enhance their clinical practice;
(c) 63% identified the need for adequate ongoing training;
(d) There was significant variation amongst staff, even in the same program, in terms of the timing of the assessments and the frequency for repeating assessments.

Focus groups were also conducted with staff who had experienced a death of a patient/client by suicide to discover their concerns and support needs. Themes that emerged included staff:

- felt responsible for not preventing the death;
- were concerned about other's perception of their clinical practice;
- were unclear about the support and advice they could receive from the organization;
- felt they had no time to process their own feelings of loss.

The Director of Patient Safety was provided with details of these focus groups and utilized the information in the development of organization wide processes to support staff following high risk incidents.

Developing Common Methodology to Suicide Assessment

Improvement Cycle One: A New Assessment Tool and Rating Scale

As feedback was being gathered from the various stakeholders in this project, a sub committee was working simultaneously on finding a clinical assessment tool that could be used by staff with a variety of professional backgrounds, working in different clinical roles. With the potential risk to patient/client safety, finding the ideal suicide risk assessment tool was daunting. The aim was to identify an evidence-based tool that could be used across the age spectrum, from children to seniors, and by all mental health clinicians. As Packman states, for assessment of suicidal risk, the most basic goal is to avoid false negatives i.e. determining a patient is not at risk for suicide, when a potential for suicidal behaviours exists, as this oversight may result in a patient's premature death [12].

A comprehensive review of existing suicide assessments tools was undertaken [13–15]. This review was crucial for the development of a common framework for suicide risk assessment and in the development of clinical protocols. At the time of the search, no suitable assessment tool was found. Our search and efforts confirmed Marris's 1992 conclusion that despite vast amounts of research, there is no "single scale, instrument or tool that alone gives us an accurate suicide assessment and prediction" [16]. Recently, Cutcliffe and Barker published their experience of developing the Nurses' Global Assessment of Suicide Risk (NGASR). They also found that "risk assessment tools are only one part of a more thorough risk assessment" [17].

Since no suitable assessment was found, the working group developed a two page suicide risk assessment tool. This tool included several components previously identified in the literature as being important in assessing risk [18–23]. The assessment tool incorporated (a) the key risk factors, (b) demographics, (c) protective factors and, (d) a scale (high, medium or low) rating the level of risk. The assessment tool was piloted on the Inpatient unit, an ACT Team and the Day Hospital.

Despite the months of development to establish a best practice suicide and risk management tool, it was not seen as helpful. Staff indicated that the tool didn't prompt them to ask the right questions, or improve communication within the treatment team. More concerning was that the score did not accurately reflect the client's actual suicide risk, and may give a false positive rating for chronic populations who score high on mental status issues, have few protective factors and yet may be clinically, at low risk. There was a concern that the tool, and in particular the rating scale, could overrule clinical judgment and also have medical-legal implications especially where there was a difference of opinion between team members.

Improvement Cycle Two: Staff Training

Feedback provided by patients and families concurred with Jacob's recommendation that it is important to choose an education package that promoted the integration of suicide assessment into all therapeutic interventions [24]. The importance of quickly establishing a

therapeutic alliance with the client while assessing suicide risk was highlighted in Heather Fiske's Reasons for Living Workshop hosted by Hincks-Dellcrest Centre in Toronto. "Given that the modal number of sessions in any form of treatment is one; that most individuals who complete suicide see a health care professional in the weeks before their deaths; … it is strongly recommended that every contact should be therapeutic" [25].

After auditing different training programs and abandoning the search for the perfect suicide assessment tool, the committee sought a comprehensive training program. Applied Suicide Intervention Skills Training (ASIST) [26], was selected as it combines both a consistent model for assessing and responding to suicide risk, with standardized training for staff. ASIST is an established, researched, and internationally respected program of standardized, quality-controlled training. It gives participants not only understanding about suicide but also provides opportunities to practice dialogue which could be used with the suicidal person. The use of role-play, open-ended questioning, and simulation lends itself to customizing content to suit a particular target group or situation. In addition, the ASIST training offers opportunities to practice reflective listening skills which enhance clinical practice in general.

ASIST, developed by Livingworks in Canada, is currently the most widely used suicide intervention program in the world. It is the basis for national and regional suicide intervention training strategies in Australia, Canada, New Zealand, Norway, United Kingdom and United States of America. A study conducted at the University of Tromso, Norway, concluded that psychiatry residents who were trained in ASIST demonstrated greater confidence, skills, and awareness in dealing with persons at risk for suicide [27].

At Trillium Health Centre, staff trainers were recruited internally through an open process which included applicants preparing and presenting a brief teaching demonstration as part of the selection process. Five staff were chosen from different clinical areas and disciplines as a strategy to embed expertise at the front line. A plan was put in place to train all clinical and administrative staff and psychiatrists in our mental health programs over a six month period. With strong endorsement from the Mental Health Director and program managers, staff were required to sign up to attend one of several ASIST training sessions, beginning in the spring of 2004.

In two years, the five ASIST trainers have conducted 20 two-day small group workshops with over four hundred participants. The participants were comprised of 220 mental health staff and 50 staff from the other areas of the hospital—including all hospital switchboard operators and some rehabilitation therapists whose clients are living with chronic, severe pain. In addition, 150 staff and students from local community mental health and social service agencies have participated in these workshops.

The Health Centre is now identified as a leader in suicide prevention training, receiving training requests from other organizations including a three-year contract to train staff of the Toronto Transit Commission. In addition, the local community college has made the program mandatory for their nursing students. The number of ASIST trainers has been increased in order to meet the internal and external demand for training

Improvement Cycle Three: Clinical Protocols

At the outset, the protocol group developed flow charts for each mental health program and identified different actions for different risk levels. Over the life of the project, these protocols were periodically reviewed and revised in order to integrate new learning and to reflect the ASIST training model. Initially, separate protocols were developed for the three

clinical areas: inpatients, office based counseling and community services. Subsequently, the office and community protocols were combined. In response to key messages from families and clients, clinical protocols and assessment templates were developed to encourage mental health clinicians to include families and/or significant others in information gathering and safety planning.

The use of "no harm contracts" was explored in the literature which revealed that such contracts are only useful in the context of a sound therapeutic alliance and as part of a thorough assessment—in and of themselves, they are of *no use* legally or therapeutically [28–31]. In light of these findings, no harm contracts are no longer included in clinical protocols as there was concern that, as Farrow states, they may "… be used, at times, for non-clinical reasons, most notably to protect [clinicians] from the ramifications of a patient completing suicide after a risk assessment" [32]. However, staff work with clients to develop a realistic safety plan.

Project Outcomes

The quantitative and qualitative indicators, listed earlier, were tracked over four years to gauge whether the ASIST training and other initiatives were changing clinical practice and staff perceptions. The Staff Survey, initially conducted in 2002, was repeated in the fall of 2004.

(a) Prior to the project, 56% of suicidal patients presenting in the Emergency Department were admitted. Over the four years of the project, this ratio decreased each year to a current rate of 42%. There has also been an annual increase ranging from 14 to 21% in the identification of suicidal risk among mental health patients in the Emergency Department. Staff of the Crisis Intervention Team reported that with a clearer process of exploring reasons for dying, reasons for living and with an increased focus on strengthening the client's protective factors in the community, some admissions had been averted.

(b) In the first year following implementation, one unexpected finding was that there was a 14.5% reduction in the average length of stay for patients admitted with suicidal ideation or following an attempt. Although this reduced length of stay was not sustained in the following year, a decreased utilization rate of 300 bed days/year has been sustained over the past two years due to the reduction in the admission rates of clients presenting with suicidal ideation.

(c) More staff assess a higher proportion of their clients for suicide risk, with a 13% increase in the number of clinicians who report assessing virtually all of their clients. The survey also showed that the percentage of staff who 'know what steps to take after assessing for suicide risk' increased from 87 to 97% and, post-training, no staff disagreed with this statement. However, only 48% 'strongly agree' that they know what to do after assessment. This reflects the complex nature of suicide risk management and suggests a continuing need for training and support.

(d) All office and community program clients now have a safety plan which is developed early in their engagement with the program. The documentation of these safety plans is included in regular chart audits. Audits over the past year have found a 90+% compliance rate with this requirement. In addition, a "cheat sheet" has been developed to remind staff of the risk assessment format and to serve as a template for clinical documentation. A binder and online folder containing the new protocols and other resources related to suicide risk assessment and treatment has been prepared for easy staff access.

(e) In the first six months of this initiative, 98% of mental health clinical and administrative staff, psychiatrists and a volunteer were trained in ASIST. In addition, most attended a professional development day on suicide intervention. ASIST workshops continue to be held monthly and are attended by new mental health staff and others from both the hospital and the community. Monitoring workshop attendance over the past three years indicates 90% of new staff participate within the first three months of being hired.

(f) The proportion of staff who agreed with the statement "I am provided with adequate, ongoing training in how to assess and respond to patients with suicide risk" increased from 30 to 80%. However, with only 24% of staff 'strongly agreeing' that they receive adequate training and from anecdotal comments in the survey, it is clear that suicide assessment and intervention is an area in which staff want a great deal of ongoing educational support.

(g) An interesting result was the movement from 'strongly agree' to merely 'agree' with the statement "I feel comfortable talking to clients about suicide". In the ASIST training, participants were required to role play responding to expressed suicidal thoughts. This practice allowed participants to more accurately self assess their competency and comfort in exploring suicidal thoughts. The authors hypothesize that the decrease in comfort level is consistent with what Zemke states about adult learners and the process of transferring knowledge to practice. "Integration of new knowledge and skill requires transition time and focused effort" [33].

(h) Attempts were made to hold focus groups with clients following implementation of the program to determine whether their perceptions of the care and treatment received would reflect any changes in practice. Due to program changes, patients on discharge are now referred to diagnostic specific services rather than a Day Hospital. Despite staff efforts, it was not possible to assemble focus groups, similar to the original groups, of recently discharged patients who were admitted due to suicide risk and are therefore unable to comment on this indicator.

Process Improvements Based on Project Findings

Support to Staff Following a Sentinel Event

In the first two years of the project, no patient/client died by suicide. However, within the next three months, there were four deaths by suicide in ambulatory and community programs. Team members were upset to lose a client and distressed that they may have missed an indication of the pending suicide. Feedback from staff focus groups had contributed to standardizing the support given to staff, across the organization through a 'reflective learning' process. Dlugacz describes reflective learning or root cause analysis as a quality improvement process for investigating incidents and near misses [34]. The Director of Mental Health System at Trillium Health Centre attends all reflective learning sessions to support the teams, the process, and to ensure that recommendations are implemented The goal of the reflective learning process is to identify opportunities for process improvement and to avoid a culture of blame.

Systematic reviews of incidents with individuals and teams allow failures in process to be identified and to develop an action plan to reduce risk of reoccurrence. Staff reflect on these challenging and tragic situations by sharing their assessment, clinical decisions and

the impact of those decisions. Staff report feeling supported by the process and acknowledged for the work they do. To encourage candid exploration of the issues, application is made for the process to be protected under Ontario's Quality Care Information Protection Act (QCIPA) [35]. Under QCIPA, the facts surrounding the event and the outcome of the investigation are part of the public record but other discussions related to the root cause analysis are protected and remain confidential.

The four deaths by suicide were reviewed and in two cases, the history of suicidal ideation or attempts had been minimized by the patient or family to avoid admission to an inpatient psychiatric unit. However, the family doctors had been aware of the suicide risk and in one case had encouraged admission. The Crisis Intervention Team (CIT) responsible for mental health assessments in the Emergency Department, now routinely attempts to contact the family doctor of all patients presenting with suicide risk factors to include the physicians' assessment and to alert them to the presentation in the Emergency Department.

Staff Communication Skills

The need to integrate assessment within a caring conversation was a primary recommendation from the client focus groups. The importance of the therapeutic alliance was highlighted in the ASIST training and promoted through another in-house training and mentoring program on Establishing a Therapeutic Relationship adapted from the Registered Nurses Association of Ontario (RNAO) Best Practice Guidelines [36]. This training initially was offered to nurses and allied health staff on the Inpatient Unit and was later introduced across the office and community based programs within the Health Centre.

Rapid Access to Mental Health Services

The National Suicide Prevention Strategy for England, A Toolkit for Mental Health Services (2002)[37] includes standards for post discharge prevention of suicide and recommends that patients who have been at high risk of suicide during the period of admission are seen within two days of discharge. A process was developed at the Centre's Mental Health Intake for Adults to 'fast track' patients who are being discharged from the Emergency Department and the Inpatient Psychiatry Unit with a continuing risk of suicide. Currently, all priorized referrals are contacted by a mental health clinic within two working days of discharge.

Summary

The Suicide Best Practice committee, after reviewing the literature and consulting experts in the field, realized that an effective suicide assessment program requires more than a good assessment tool and staff competency in completing the tool. According to Lyons et al, "the major problem with the use of a rating scale was that, as a one-off scoring system, it did not reflect the dynamic and sometimes protracted nature of suicidal behaviour" [38]. At the beginning of this project in 2002, the committee was unable to find literature describing the implementation of a suicide assessment program at an

organizational level or literature describing the effectiveness of such programs. Subsequently, the article by Dlugacz et al described the use of root cause analysis to understand their experience within health care environments. Alcohol withdrawal was identified as a primary risk factor which drove the development of tools and protocols in their project. This was the only article found that addressed the efficacy of instituting a suicide assessment program. They found that "Since the implementation of a detoxification protocol, there have been no suicide attempts in the acute care setting" [39].

The literature, client feedback and our own experience led us to the implementation of a training program for all mental health professionals, focused on enhancing their comfort and competence to engage in a therapeutic dialogue with their patients/clients which is essential to a comprehensive suicide assessment. Oravecz and Moore suggest that "training activities are necessary to improve the ability of professionals to cope with the suicide-related thinking of their patients and resolve their own discomfort in talking about suicide with a patient" [40].

The process of planning and introducing a change in policy and practice in a large organization is complex. Our experience in developing best practices in suicide risk assessment and management proved to be a valuable quality improvement initiative for patient/client, staff, and organizational outcomes.

Some of the key enablers of the project included:

- a committed project leader with excellent facilitation skills;
- organizational support in both time and money to undertake the initiative;
- stakeholder engagement in workgroups;
- strong steering committee with broad representation and strong frontline involvement;
- an area of clinical practice that was relevant to and unified the hospital's entire mental health system.

The first step was to begin a culture shift by ensuring that all staff participated in the same experience based learning program (ASIST) which was strongly endorsed by all levels of the Health Centre's management team. Recognizing that simply introducing a new training program to individual staff would not be enough to shift practice, a number of initiatives were undertaken to support staff in integrating new learning to everyday practice Other efforts included ensuring that the ASIST trainers were embedded as internal consultants in a number of different programs. Using team meetings to review ASIST principles and assigning ASIST trainers as consultants has been successful in some areas. Staff also receive periodic updates on the ongoing work of the best practice committee as a reminder to include suicide assessments in their daily practice. In addition to specific training in suicide assessment, staff and their patients benefited from training in therapeutic relationships and reflective learning from critical incidents. Informal feedback from staff indicates that having the same training and common language regarding risk assessment has resulted in improved inter-professional communication.

Service utilization data demonstrated ongoing reduction in admission rates and hospital days, suggesting that Health Centre resources are being more effectively utilized by improved ability to support suicidal clients in the community. The organization's reputation in the community has been enhanced by developing expertise in this important aspect of mental health. Staff from partner mental health agencies have attended or contracted our ASIST workshops and broadened the impact of this project beyond the walls of our organization.

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