The Zero Suicide Initiative: Implementation Tailored for Individuals with Chronic Suicidality in Community Mental Health Centers

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in Community Mental Health Centers

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Abstract

In 2018, Suicide was the 10th leading cause of death in the United States (Center for Disease Control and Prevention, 2019), and the American suicide rate continues to rise (Hedegaard, Curtin, & Warner, 2018). The lack of impact in reducing the suicide rate highlights the need to further understand how to help suicidal individuals. Nearly one third of suicides are preceded in the previous year by a visit to a mental health physician (Luoma, Martin, and Person, 2002). This paper proposes a tractable and research-validated strategy for Community Mental Health Centers (CMHCs) to appreciably reduce the suicide rate among their clients. The strategy is based upon the Zero Suicide (ZS) Model, and gives actionable steps for leadership in CMHCs to make actionable change. The core elements in this strategy include: create a holistic and rigorously implemented strategy that engages all CMHC staff and clients; move from a clinician-responsibility to a team-responsibility model for suicide prevention; regularly evaluate clients for their suicide risk, and in particular tailor interventions differently for chronic and acute suicide risks; create and maintain suitable training for all staff; explicitly engage clients in the suicide prevention effort; when needed, use pharmaceuticals that have been demonstrated to reduce risk, and encourage clients to comply with their drug regimens; and given the regrettably large gaps in research-validated knowledge on how to prevent suicide, maintain a working document, and continue to upgrade the strategy as new research comes to hand.

*Keywords*: zero suicide model, chronic suicide, community mental health center
Introduction

There has been no significant reduction in American suicide rates over the past 50 years (Osteen, Frey & Ko, 2014). Suicide is the 10th leading cause of death in America, and the second leading cause for ages 10 to 34. Suicide killed over 47,000 Americans in 2017 (Center for Disease Control and Prevention, 2019). Suicide rates increased on average about 1% per year from 1999 to 2006, and 2% per year from 2006 through 2017 (Hedegaard, Curtin, & Warner, 2018). The number of people who die by suicide in America, and around the world, continues to rise every year despite all efforts to the contrary. Arguably, suicide prevention is one of the greatest challenges facing the healthcare system (Erlich, 2016).

Current suicide treatment is a one size fits all approach, meaning all suicidal individuals receive hospitalization (Jobes, 2019). There are clear risks involved when hospitalizing, however, and those risks increase with frequent involuntary hospitalizations (Foster, 2013). Walsh et al. (2001) found that hospitalizations do not reduce suicidal behavior among those with chronic suicidal intensity. Involuntary hospitalization is demoralizing and stigmatizing for people with chronic suicidality as it takes away from their current treatment team and can reinforce negative coping strategies (Xu et al., 2018). Half of the suicide attempt survivors who received hospital treatment report unmet treatment needs (Han et al., 2014). Community Mental Health Center (CMHC) treatment teams must be equipped to help prevent unnecessary hospitalization.

The Zero Suicide (ZS) model was created, among other reasons, to help mental health professionals prevent unnecessary hospitalization by using evidenced-based interventions. The ZS core curriculum recognizes that suicidal people differ (Jobes, Gregorian, & Colborn, 2018) and stresses that interventions must be targeted to help avoid clients falling through the cracks in
a system. Jobes (2019) proposes CHMCs follow ZS, and implement a “many size mindset,” allowing interventions to be tailored to different suicidal states.

Chronically suicidal people display clinically concerning, persistent, or repetitive passive or active suicidal thoughts, planning, and/or attempts (Meyer et al, 2010). Chronically suicidal clients need regular mental health follow-up, a well-articulated safety plan, routine suicide risk screening, coping skills-building, and management of co-occurring psychiatric symptoms (Rocky Mountain MIRECC, 2019). Chronically suicidal individuals see suicide as a normal response to pain and injustice. Suicidal intensity is often a protective, survival mechanism and the risk is to continue living (Hexe, 2019). Conversely, acutely suicidal people display warning signs of increasing intensity leading to a single episode of suicidal thoughts, planning and/or attempts (Meyer et al, 2010). Individuals with severe mental illness (SMI) often, but not always, have chronic suicidal intensity.

Sansone (2004) found that the differences between acute and chronic suicidal ideation are clinically relevant, requiring different assessment and treatment approaches. These different approaches are highlighted in Table 1.

**Purpose of Paper**

Despite research and development of evidence-based interventions targeting suicidal behavior, suicide rates have continued to increase. The ZS initiative acknowledges the need to continuously develop more successful approaches to suicide prevention using evidence-based research (Erlich, 2016). Current CMHC policies lag behind the research on suicide reduction (Smith, Silva, Covington, & Joiner, 2014).

This paper fills a gap in knowledge on how to help CMHCs reduce suicides for all clients, with an emphasis on tailoring interventions for individuals with chronic suicidal ideation.
Table 1
*Treatment for Acute and Chronic Suicidality, and SMI*

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Helpful for acutely suicidal</th>
<th>Helpful for chronically suicidal</th>
<th>Helpful for SMI</th>
<th>Not helpful at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Checklist” risk assessment</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Interview risk assessment</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thorough history of disorder</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collateral information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of medication compliance</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Content of hallucinations or delusions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No suicide contracts</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Safety Planning</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empathetic Clinician &amp; systemic services</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Walsh et al., 2001  
2 Chan et al., 2016; McAuliffe and Perry, 2007  
3 Foster, 2013  
4 Davis, Williams, & Hays, 2002; Edwards & Sachmann, 2010  
5 King, Horwitz, Czyz, & Lindsay, 2017; Stanley & Brown, 2012  
6 Yager & Feinstein, 2017

This paper will analyze what Zero Suicide is, and the requirements of the ZS initiative; best practices for suicide prevention for the outpatient population; and integrate findings to create a comprehensive understanding of how CMHCs can effectively implement evidenced based training and research findings. The aspirational goal is to reach zero suicides for clients using CMHCs. This paper is a resource for CMHCs to effectively implement the ZS model.

**Layout and Scope of Literature Review**

This paper will first describe the ZS model, and then analyze current suicide prevention interventions and implementation options for ZS. The paper then looks at how to tailor the ZS
Zero Suicide Model Implementation with Chronic Suicidality

initiative for CMHCs and all their clients. Finally, this paper recommends further research to overcome barriers and gaps in the literature.

Relevant studies were identified using PsychINFO and Google Scholar, from the years of their inception through August 2018. A total of 158 potentially relevant studies were identified through electronic searches (Appendix A). With further inspection of abstracts, 108 studies were excluded due to duplications, or irrelevance to zero suicide or suicide prevention. Overall, 50 studies were retrieved for detailed evaluation and contribution to this paper. Reference lists of relevant studies were also searched. Zero Suicide is a relatively new and rapidly developing approach, and as such, this report uses information from the Zero Suicide website (http://zerosuicide.sprc.org/), the relevant postings on the Zero Suicide listserv, and information from the 2019 American Association of Suicidology annual conference.

The Zero Suicide Initiative

Individuals who receive care do not always receive the services needed to prevent a death by suicide. American healthcare providers see around 83-90% of people who die by suicide within the year before their death (Ahmedani et al., 2014; De Leo, Draper, Snowdon, & Kõlves, 2013). Outpatient behavioral health providers, however, see only 32% of those who died by suicide within a year of CMHC attendance (Luoma, Martin, and Person, 2002). This may indicate that behavioral health centers are doing a better job at helping those who are suicidal when compared to other healthcare providers. Conversely, perhaps suicidal people are not accessing behavioral health centers in the same proportion they are accessing other health care channels. Regardless of reason, healthcare providers can agree that these suicide rates after treatment are too high.
The National Action Alliance (2011) for Suicide Prevention published the Zero Suicide initiative to help mental health providers reach zero deaths by suicides in their practices. The ZS model is a framework to coordinate a multilevel approach to implementing evidence-based practices (Brodsky, Spruch-Feiner, and Stanley, 2018). ZS is both a concept and a practice. The ZS model follows the evidence that system-wide approaches are more effective in preventing suicide, and that mental health centers should avoid undue reliance on the efforts of individual practitioners (Education Development Center [EDC], 2015).

ZS was built on prior suicide prevention practices, such as the Henry Ford Health System’s (HFHS’s) Perfect Depression Care model (EDC, 2015). Under HFHS’s model, they saw an annual suicide rate of 5.77 per 100,000, compared to the Michigan suicide rate of 10.82 per 100,000 (Erlich, 2016). HFHS’s methods included suicide assessments for all behavioral health patients, mean restriction, provider education, follow-up via phone calls, and peer support services (Stone & Crosby, 2014). HFHS’s model signaled that sustained and robust health care improvements can affect suicide rates.

Centerstone is one of America’s largest not-for-profit community mental health centers. It maintains facilities in 5 states, and was among the first to implement ZS. Within three years of commencing ZS, Centerstone saw a reduction in suicide deaths from 35 per 100,000 to 13 per 100,000 (EDC, 2018). This reduction indicates the ZS model’s potential to reduce suicide associated with CMHCs.

Describing the Zero Suicide Model

As suicide rates continue to rise, a transformational approach to suicide prevention is needed. There are seven elements included in the ZS model (for more detail see http://zerosuicidesprc.org/toolkit).
**Lead.** This step emphasizes the need to engage leadership and administration to create a culture change about suicide prevention (Labouliere et al., 2018). Leadership must promote a culture of safety, commitment to achieving zero patient deaths, and emphasizing and supporting the use of evidence-based practices (Chassin and Loeb, 2013). Leadership must create a transparent, blame-free environment that shifts emphasis away from individual liability or fear, towards a team focus on safety.

**Train.** The workforce must be competent and confident when addressing suicidal clients. Organizations must assess employee beliefs, current training and skills. Every member of the workforce should receive training on the signs of suicide risk and how to interact with suicidal individuals effectively, with different staff roles requiring different competencies (Labouliere et al., 2018).

**Identify.** The ZS model asserts that the organization must implement evidence-based screening and assessment of suicide risk for all patients at intake, and at regular intervals to systematically identify and assess suicide risk among clients (Labouliere et al., 2018).

**Engage.** Every client must be included in regular collaborative safety planning, which needs to address restriction of lethal means. Care for suicidal clients must be timely and tailored to their needs. A pathway that identifies clients at an elevated risk, allowing for frequent re-assessment, specialized treatment and greater intensity of clinical contact is needed (Labouliere et al., 2018).

**Treat.** Only effective and evidence-based treatments that directly target suicidal behaviors should be used. Interventions specifically focused on suicide prevention are more effective than traditional psychotherapies in reducing suicidal thoughts and behaviors (Hogan and Grumet, 2016).
**Transition.** Continuous care and contact should be provided, especially after acute care. Supportive caring contacts should be standard after acute care visits or when services are interrupted (Hogan and Grumet, 2016).

**Improve.** Data-driven improvement measures should be applied to inform system changes that will lead to quality improvement and better care for people at risk of suicide. Both process and outcome of care measures need to be studied and reported (Labouliere et al., 2018).

**Current Strategies for Suicide Prevention**

CMHCs already commit considerable resources to suicide prevention, though in common with other providers, this commitment has not generated any observable reductions in rates of suicide. Common strategies support screening, risk assessment, and intervention.

There are many screening options. The Beck Depression Inventory (BDI) has been an accepted standard for detecting depression and hopelessness among people with major depression and bipolar disorders (Winters et al., 2017), but the Columbia-Suicide Severity Rating Scale (C-SSRS) has become the standard for assessment of suicidal ideation and behavior (Giddens, Sheehan, & Sheehan, 2014). The C-SSRS was developed to measure suicidal ideation and behavior in clinical settings using one screener (Posner et al., 2011). The C-SSRS has predictive validity of suicide deaths (Posner et al., 2011) and correctly identifies 95% of clients at risk of suicide. The C-SSRS has fewer false positives when compared to the Patient Health Questionnaire-9 (PHQ-9), and higher sensitivity and specificity for adult outpatients compared to the Suicide Behaviors Questionnaire-Revised (SBQ-R) (Viguera et al., 2015). There has been increasing criticism that the C-SSRS fails to address the full spectrum of suicidal ideation or behavior, which may cause false negatives (Giddens et al., 2014).
No screening measure should be used in isolation (Mullinax et al., 2018). When conducting a screening, the clinician should adopt a collaborative stance, and express empathy and genuineness. It is important to treat the interview as an exploration rather than a checklist on a clipboard (The Joint Commission, 2016). A positive suicide screen then leads to a suicide risk assessment. A selection of risk assessments are highlighted and presented in Table 2. These tools have all shown some utility in assessing suicide risk.

A “checklist” model of risk assessment is of limited benefit and can be harmful for clients with chronic suicidal intensity (McAuliffe and Perry, 2007). The best suicide risk assessments require presentation through a clinical interview (Foster, 2013). Training and encouragement is required for staff to effectively build an empathetic therapeutic relationship, with genuine engagement, resulting in an effective risk assessment.

Once a suicide screen and risk assessment have been completed, clinicians need the appropriate training to provide evidenced-based care in suicide prevention. There are many training tools and strategies intended to help reduce suicide rates. A selection of training tools is presented in Table 3. These tools have all evidenced positive effects for preventing suicide deaths and/or attempts. Additionally, there are other evidenced-based interventions CMHCs need to consider to reduce suicide rates.

**Other Evidenced-Based Interventions**

**Assertive Community Treatment (ACT).** ACT services include two to three community or home visits per week that deliver individually tailored assistance, informed by recovery principles aimed at improving both clinical and quality of life outcomes for clients. Services include crisis intervention, psychosocial assistance, supportive counseling, family support, and functional assistance. (Luo et al., 2019). Clients who received ACT were
Table 2

<table>
<thead>
<tr>
<th>Risk Assessment</th>
<th>Time</th>
<th>Effective for clinicians</th>
<th>Effective for non-clinical staff</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessing and Managing Suicide Risk (AMSR-Outpatient)</td>
<td>6.5 hours in person (3.5 hours for staff who provide direct care)</td>
<td>Yes</td>
<td>Yes</td>
<td><a href="http://zerosuicideinstitute.com/amsr">http://zerosuicideinstitute.com/amsr</a></td>
</tr>
<tr>
<td>Chronological Assessment of Suicide Events (CASE) Approach</td>
<td>1 day and 2 day options, 3 hour online training coming</td>
<td>Yes</td>
<td>No</td>
<td><a href="https://suicideassessment.com/the-case-approach/">https://suicideassessment.com/the-case-approach/</a></td>
</tr>
<tr>
<td>Recognizing and Responding to Suicide Risk (RRSR)</td>
<td>2 days in person</td>
<td>Yes</td>
<td>No</td>
<td><a href="https://suicidology.org/training-accreditation/rrsr-clinicians/">https://suicidology.org/training-accreditation/rrsr-clinicians/</a></td>
</tr>
<tr>
<td>Suicide Alertness for Everyone: Tell, Ask, Listen, and Keep Safe (safeTALK)</td>
<td>3.5 hours in person</td>
<td>No</td>
<td>Yes</td>
<td><a href="https://www.livingworks.net/safetalk">https://www.livingworks.net/safetalk</a></td>
</tr>
<tr>
<td>University of Washington Risk Assessment Protocol (UWRAP)</td>
<td>Staff who have had prior suicide risk assessment training, 20-30 minutes; otherwise a 2-day workshop</td>
<td>Yes</td>
<td>Yes</td>
<td><a href="http://depts.washington.edu/uwbrtc/wp-content/uploads/UWRAP.pdf">http://depts.washington.edu/uwbrtc/wp-content/uploads/UWRAP.pdf</a></td>
</tr>
<tr>
<td>Question, Persuade, Refer (QPR)</td>
<td>1 or 2 days, in person online</td>
<td>No</td>
<td>Yes</td>
<td><a href="https://qprinstitute.com/individual-training">https://qprinstitute.com/individual-training</a></td>
</tr>
</tbody>
</table>

\(^1\) Listed on the Zero Suicide Website under “Suicide Care Training Options”

Note: Question, Persuade, Refer, Treat (QPRT) was not included due to lack of evidenced based research.

Significantly less likely to be hospitalized, spend less time in hospital compared to people received standard care or hospital-based interventions (Links, 2005). Despite positive findings, ACT appears to have limited impact on the risk of suicide in persons with SMI. At least 4
Table 3  
*Evidenced Based Suicide Prevention Training*

<table>
<thead>
<tr>
<th>Training</th>
<th>Time</th>
<th>Effective for clinicians</th>
<th>Effective for non-clinical staff</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied Suicide Intervention Skills Training (ASIST) ¹</td>
<td>15 hours, in person</td>
<td>Yes</td>
<td>Yes</td>
<td><a href="https://www.livingworks.net/asist">https://www.livingworks.net/asist</a></td>
</tr>
<tr>
<td>Assess, Intervene, and Monitor for Suicide Prevention (AIM-SP)</td>
<td>1.5 hours, online</td>
<td>Yes</td>
<td>No</td>
<td><a href="https://practiceinnovations.org/I-want-to-learn-about/Suicide-Prevention/Trainings/Full-list-of-SP-TIE-trainings">https://practiceinnovations.org/I-want-to-learn-about/Suicide-Prevention/Trainings/Full-list-of-SP-TIE-trainings</a></td>
</tr>
<tr>
<td>Care  • Collaborate  • Connect</td>
<td>Self-directed 8 hours, online</td>
<td>No</td>
<td>Yes</td>
<td><a href="https://www.carecollaborateconnect.org/">https://www.carecollaborateconnect.org/</a></td>
</tr>
<tr>
<td>Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP) ¹</td>
<td>Varies</td>
<td>Yes</td>
<td>No</td>
<td><a href="https://www.sprc.org/resources-programs/cognitive-therapy-suicide-prevention">https://www.sprc.org/resources-programs/cognitive-therapy-suicide-prevention</a></td>
</tr>
<tr>
<td>Collaborative Assessment and Management of Suicidality (CAMS) ¹</td>
<td>Varies</td>
<td>Yes</td>
<td>No</td>
<td><a href="https://cams-care.com/about-cams/">https://cams-care.com/about-cams/</a></td>
</tr>
<tr>
<td>Dialectical Behavior Therapy (DBT) ¹</td>
<td>1 or 2 days</td>
<td>Yes</td>
<td>No</td>
<td><a href="https://www.sprc.org/resources-programs/dialectical-behavior-therapy">https://www.sprc.org/resources-programs/dialectical-behavior-therapy</a></td>
</tr>
<tr>
<td>Interpersonal and Social Rhythm Therapy (IPRST) ²</td>
<td>8 hours, online</td>
<td>Yes</td>
<td>No</td>
<td><a href="https://www.ipsrt.org/training">https://www.ipsrt.org/training</a></td>
</tr>
</tbody>
</table>

¹ Listed on the Zero Suicide Website under “Suicide Care Training Options”  
² Free

Randomized control trials have demonstrated that ACT does not lessen the risk of suicide when compared to conventional treatment (Luo et al., 2019).
**Caring Contacts.** A lack in continuity of care indirectly causes suicides (Olsen, 2018). Caring contacts can help bridge that gap. Caring contacts include postcards, letters, phone calls, and in-person visits. With high risk clients, caring contacts have been shown to be effective in demonstrating that someone is taking time, and cares for the client (Luxton, June, & Comtois, 2013).

**Family Involvement.** It is important for clinicians to consider family members and friends of the client in their treatment planning and suicide interventions. Clinicians should consider the client and family treatment preferences, values and capacity to participate in decisions about their care (Alexander, Haughland, Ashenden, Knight, & Brown, 2009). Families need education to assist with the impact of helping a person with suicidal ideation, so that families are better able to support the client, increase adherence to treatment, and help develop a realistic safety plan (McAuliffe and Perry, 2007).

**Groups for Suicide Attempt Survivors.** Groups co-led by a clinician and peer survivor give clients with the shared experience of surviving a suicide attempt, a space to process past events and collaboratively develop future coping strategies (Hom, Davis & Joiner, 2018). Didi Hirsch Mental Health Services Suicide Prevention Center, in California, has established an evidenced based manual for implementing this group (Sinzelski, Morris, & Stohr, 2014). Groups focused on suicide attempts have an advantage over other suicide prevention groups, such as DBT, as they specifically focus on overcoming stigma.

**Hospitalization.** For people with chronic suicidal intensity, there is a need to determine what realistic goals can be accomplished in 3 days. Without achievable objectives, the client tends to do worse after their hospitalization (Sansone, 2004). An unwanted and unnecessary
hospitalization may disrupt various psychosocial roles and relationships and could threaten protective factors that mitigate suicide risk on a long-term basis (Wortzel et al., 2014).

**Lethal Means Restriction.** Programs and policies leading to restricting access to lethal means have shown to be effective in reducing suicides. More than half of American suicides involve firearm use (CDC, 2017). Professionals generally do not talk to their clients about access to lethal methods to kill themselves (Price, Kinnison, Dake, Thompson, & Price, 2007). Counseling on Access to Lethal Means (CALM) is an evidenced-based approach specifically for mental health and crisis intervention professionals to talk to clients about means restriction (Sale et al., 2018).

**Lived Experience.** Lived experience in the Zero Suicide world is defined as having experienced suicidal thoughts, survived a suicide attempt, cared for someone who has attempted suicide, been bereaved by suicide, or been touched by suicide in another way (Suicide Prevention Australia, n.d.). When training gives an individual with lived experience an equal voice alongside an ‘expert,’ it can validate that clients are experts in their own narrative (Jones et al., 2018) and reinforce the need to work collaboratively with clients for successful results.

**Medication Management.** Medication management can be an effective tool for those with bipolar diagnoses (lithium) (Foster, 2013) or who are on the schizophrenia spectrum disorder (clozapine) (Meltzer, 2005). Other medications have not had the same effect in helping reduce suicidal ideation. Monitoring medication changes is also important. Rates of suicidal ideation and attempts are doubled for people with depression following antidepressant starts or dose changes (Valenstein et al., 2009).

**Peer Support Programs.** Having social support was described by people with chronic suicidal ideation as needed (Montross Thomas et al., 2014). An evidenced-based 12 week
PREVAIL peer support intervention was shown to have positive responses from clients towards the peer specialist’s ability to relate, listen and advice when providing support specifically around discussions of suicide (Pfeifer et al., 2019). Pfeifer concluded that peer support specialist use in suicide prevention is feasible and acceptable for clients at high risk for suicide.

**Recovery Model.** A recovery culture helps clinicians move from caretaking and advice giving to collaboration and helping people find means to grow. The model has three key aspects: personal resilience and robustness; receipt of evidence-based treatment; and recovery of hope and ambition for living a full, purposeful life (Foster, 2013). Suicidal thoughts are related to the recovery process. This means just focusing on suicidal ideation is not enough. The clinician needs to work on goals relating to the recovery process as part of providing optimal care. These include promoting hopefulness, supporting patients taking responsibility for their health, and helping them to live their lives not dominated by their illness. Recovery processes improve quality of life, which could enable the client to experience an increased life worth living (Gale et al., 2012). Training conducted around recovery, resilience, and wellness can transform a system.

**Safety Planning.** A safety plan reduces the suicidal individual’s risk by encouraging use of alternative coping strategies during a future crisis (King, Horwitz, Czyz, & Lindsay, 2017). It is important that the safety plan not be presented as a no-suicide contract. No suicide contracts have been found to be ineffective and potentially harmful (Edwards and Sachmann, 2010). People with chronic suicidal ideation additionally find no suicide contracts to be less helpful as it communicates that they are not able to talk about their suicidal ideation with their therapist (Davis, Williams, & Hays, 2002). Conducting a safety plan in a collaborative method, and following up on the likelihood of use is essential to implementing an effective safety plan (Stanley & Brown, 2012). Safety planning can be difficult. Education and training vary across
settings and little training or follow-up is given once a clinician has been introduced to the safety plan template (Kaymen et al., 2015). Clients may hesitate to use safety plans due to lack of privacy, reluctance to abandon established coping strategies, depression related lethargy, and the feeling that the burden of using a safety plan is too great to carry on their own (Stanley & Brown, 2012). These barriers can be reduced by providing evidenced-based safety plan training (Accessed via: http://zerosuicide.sprc.org/sites/zerosuicide.sprc.org/files/sp/course.htm), a collaborative stance, booster trainings, and practical tool such as wallet-sized safety plans.

Application of the Zero Suicide Initiative

The Zero Suicide Initiative was designed to help fill the gap between current services and the care suicidal individuals receive. To successfully implement ZS, multiple interventions need to be implemented at the same time and tailored to the population served to effectively reduce the rates of suicide (Baker et al., 2017). First, it is important to distinguish low and high lethality patients. The best management approach will differ accordingly (Yager and Feinstein, 2017). Chronic suicidality should not be treated as acute, and acute suicidality is not to be treated as a low-urgency chronic problem. When working with people who are chronically suicidal the clinician must constantly be alert to the tipping points at which risk for suicide escalates to acute status (Yager and Feinstein, 2017).

This paper makes the following recommendations for implementation of ZS for CMHCs:

Lead

Successful suicide reduction requires an organizational culture that no longer finds suicide acceptable, and employees possessing the core value that suicide can be eliminated in a population that receives their care (National Action Alliance, 2011). Leadership is responsible for creating a culture change at CMHCs. Establishing suicide as a priority will require significant
changes to organizational policies, culture and training. Embracing the Recovery Model can help a system transform its mindset from caretaking and advice giving to collaboration and helping clients create an environment in which they want to live. The Recovery Model and accompanying mindset and culture allow staff members to talk about their experiences and fear around suicide. This in turn reduces staff burnout, as there is less stigma around help seeking for clients and staff (Christie-Smith & Gartner, 2006). The Recovery Model follows the foundational tenets of ZS, and can be beneficial for all clients and the culture of a CMHC.

Train

Employee training at CMHCs needs to achieve two outcomes: increased suicide prevention skills, and increased employee confidence in talking about suicide. A clinician’s self-perception as competent and productive is protective when working with suicidal clients (Hughes et al., 2017). Mandatory evidence-based training can relieve some of the stress associated with the challenge of working with clients with chronic suicidal intensity (Foster, 2013) and may help increase empathy for these clients.

In addition, it is important to incorporate lived experience into CMHC’s training. Training that includes lived experience helps clinicians connect to the training, validates the proposition that clients who experience suicidal ideation or behavior should be worked with collaboratively. When a recovery culture is implemented it is easier for staff and clients with lived experience to speak up and be effective in these roles.

Identify

The Columbia-Suicide Severity Rating Scale (C-SSRS) is the best available evidence-based option for suicide behavior and ideation screeners. To comply with the ZS initiative, a suicide
screener should be used at every contact. Further training should be considered for clinicians who have extended contact with suicidal clients.

The Chronological Assessment of Suicide Events (CASE) Approach allows for the flexibility needed when working with chronically suicidal clients. CASE training highlights interview techniques that can sensitively explore a client’s suicidal ideation, planning, actions, and intent over time (Shea, 2019). For the entire organization to play a role in suicide prevention, it is recommended that non-clinical employees complete Question, Persuade, Refer (QPR).

**Engage**

A systematic suicide care protocol must be followed by clinicians at CMHCs for a continued high standard of care. See Appendix B for an evidenced-based suicide care protocol that incorporates the needs of both acute and chronically suicidal clients. Briefly, a CMHC’s electronic medical records must allow for flagging increased suicide risk to allow for the best follow-up care. Clients given a high-risk flag must receive specialized care and increased contact with clinicians (Labouliere et al., 2018). CMHCs must also train their clinicians on effective safety planning, and provide regular booster training. Effective safety planning must be collaborative. Training should include case studies and roleplays.

Clinicians must talk with their clients about means restriction. Counseling on Access to Lethal Means (CALM) training was specifically designed to help mental health professionals, and has been shown to effectively increase clinician confidence in speaking with clients about access to lethal means (Sale et al., 2018).

Clinicians should not feel alone when treating clients with chronic suicidal intensity. The ZS model emphasizes a systemic approach. Whenever feasible, family members should be involved in the clients’ treatment and recovery. Group therapy can help clinicians feel less alone.
in supporting suicidal clients, and reinforces the systematic approach of ZS. Incorporating group therapy into a client’s treatment plan allows the client to benefit from more points of contact, and focus on suicide prevention. Groups for suicide attempt survivors have been more effective at reducing stigma than other therapeutic groups (Home et al., 2018).

**Treat**

Treatment must be evidenced-based and specifically directed at treating suicidal ideation. Medication management and adherence needs to be monitored. Lithium reduces suicide in patients with bipolar disorders (Baldessarini et al., 2006; Foster, 2013; Rihmer, 2005). Clozapine should be prescribed for clients diagnosed with a schizophrenia spectrum disorder (Foster, 2013; Meltzer, 2005; Meltzer & Okayli, 1995; Ried, 1999). Responses to medication also should be monitored. Increased client clarity from effective medication can sometimes generate the perverse result that clients suffer hopelessness and depression as they better understand their illness (Links et al., 2005).

**Evidence-Based and Reasonably Priced Training.** There is no single best training tool. CMHCs need to develop and deliver the training package most suitable to their needs. Assess, Intervene, and Monitor for Suicide Prevention (AIM-SP) is free and fits the ZS framework. It does not go into depth about when and in what circumstances clinicians should intervene. Care • Collaborate • Connect: Suicide Prevention, and Interpersonal and Social Rhythm Therapy have limited research behind them but offer training online and are relatively cheap or free, respectively. Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP) thus far has only been proven to be evidence-based for adolescents. Dialectical Behavior Therapy (DBT) has been proven to reduce suicide attempts, compared to treatment as usual for clients with borderline personality disorder (Linehan et al., 2006), however a controlled trial found DBT to have no
statistically significant effect for reducing suicidal ideation (DeCou, Comtois, & Landes, 2019). While DBT promotes belief in one’s own ability to succeed, interpersonal effectiveness, and emotional regulation, it may not be the best treatment for targeted suicide prevention.

Collaborative Assessment and Management of Suicidality (CAMS) has been found to be just as effective as DBT for people with borderline personality disorder (Andreasson et al., 2016). CAMS also has a larger impact on how clinicians practice, compared to QPR, AMSR, and DBT (LoParo et al., 2019). Jobes reported its structure may not be the best for clients with chronic suicidality as treatment focuses on two specific issues that make you want to kill yourself, and this may be harder for chronically suicidal individuals to complete (Jobes, personal communication, April 24, 2019). Clients must write a response to the prompt, “The one thing that would help me to no longer feel suicidal would be: ____,” this question may be answered more effectively when the suicidal ideation is acute.

Applied Suicide Intervention Skills Training (ASIST) has a comparatively large amount of research supporting its implementation. ASIST improves clinician confidence and knowledge related to suicide prevention, and increases their ability to make more meaningful connections with clients. ASIST training is flexible enough to be tailored to the varying presentations of SMI and is the recommended evidence-based training to address clients with SMI.

Transition

People who have SMI are more likely to have been hospitalized and exposed to several different mental healthcare systems and treatments. Medicaid and several other organizations have implemented requirements mandating follow-up within 1 week of discharge, and frequent encounters for all patients who have been discharged from inpatient mental health units. Katz, Peltzman, Jedele, and McCarthy (2019) found that rates of suicide are still higher in the first 90
days even with care increasing. For individuals with SMI, risk is increased for 5 years after hospitalization (Zaheer et al., 2018). This indicates that the current efforts during transitions have been insufficient.

**Caring Contacts.** Caring contacts bridge the gap when clients of CMHCs are discharged from hospital, miss an appointment, are considered at acute risk, or are noncompliant with their prescribed treatment. The price and time commitment will vary based on the caring contact method chosen, but all methods have been shown to be effective (Luxton et al., 2013) and a cost-effective intervention to prevent suicides. CMHCs need to create their own caring contact materials and procedures. Some CMHCs, for example, have conducted competitions for clients to create postcards to become caring contacts (Rick Strait, personal communication, September 15, 2019). As with any other care, details count. Letters and postcards, for example, are more meaningful when hand-written, use colorful envelopes, and real stamps (Zero Suicide Listserv, personal communication, February 12, 2019; ZS Listserv, personal communication, October 2, 2019).

**Peer Support.** When clients are asked about what is most helpful in care, the unsurprising response is that strong therapeutic and peer relationships are essential (McAuliffe and Perry, 2007). CMHCs should employ peer support specialists to help clients with SMI feel heard and understood. Peer support models offer hope, empowerment, and increased self-esteem (Alexander et al., 2009). Peer specialists help provide lived experience to the organization.

**Improve**

Measuring implementation outcomes and structured quality improvement are essential to successful implementation of the ZS initiative. Suicide prevention outcomes in mental health services are related to both the nature of the interventions offered and the quality of the
organization from which they are offered (Mokkenstorm et al., 2017). Mental health providers have found that even substantial enhancements to their services might not reduce suicide rates (Katz et al., 2013). CMHCs need to continually assess their interventions and training to incorporate client results and clinician feedback. When a death by suicide does occur at a CMHC, all clinicians should be involved in the mortality conference. Not including all clinicians in the mortality conference is a missed opportunity to improve practices that may have played a role in the suicide, and can reinforce the myth that suicide is extremely rare (Reeves, 2003). Inclusive mortality conferences additionally contribute to a culture of systematic approach to suicide prevention, rather than individual blame.

**Further Research Recommendations**

Additional research needs to evaluate what specific treatments are most efficacious for specific populations to reduce suicide rates (Brodsky et al., 2018). There is a positive relationship between participating in multiple trainings and greater confidence in providing suicide care (Silva et al., 2016), but future research needs to determine whether there is an ideal training package for clinicians working in CMHCs, and at what point additional training no longer justifies its costs. It is known that booster training run by the CMHCs should be completed multiple times during a year, but further research is needed to know how often such training is needed (Katz et al., 2019). No study has conclusively determined the cost-effectiveness and the utility of interventions for suicide prevention. This gap in research makes it difficult for CMHCs to implement evidence-based interventions cost-effectively.

**Conclusion**

Nearly one third of Americans who die by suicide have contact with their mental health provider in the year prior to their death (Luoma, Martin, & Person, 2002). Suicide prevention in
the context of SMI deserves a comprehensive, evidence-based approach to service development and clinical practice (Foster, 2013). CMHCs play an important role in preventing suicide among people with chronic suicidal intensity. Research is ongoing, and currently incomplete. There are, however, strong indicators for effective approaches which all CMHCs should consider adopting. The essential elements in an effective anti-suicide program include: creating a culture of suicide prevention for all levels in an organization, utilizing evidence-based training, including lived experience in training and clinician support; creating an effective caring contact, high risk pathway, and booster training policy; and encouraging feedback from all employees to continuously improve. The recommended course of training for CMHC staff is outlined in Table 4.

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<th>Staff with no client contact</th>
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1 Internally created training
2 Can be internally created or use external.

Further research is needed to better evaluate the effectiveness of training combinations, training material, and how often to provide booster/refresher training. ZS requires permanent
commitment from all levels in an organization. By creating and following a ZS-based suicide
prevention strategy, CMHCs may not reduce their suicide rate to zero. Based on the current body
of research, however, a ZS approach should more than justify the considerable resource
commitment required, through appreciably reduced suicide rates.
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## Table 4
**Search Terms and Studies Generated**

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Appendix B: Suicide Care Protocol

**Low Acuity**
- Ideation:
  - Past month
  - Wishes to be dead
  - More than a month ago
  - Active suicidal thoughts, without plan or intent
    - and
  - Suicidal Behavior:
    - No history of suicidal behavior

**Intermediate Acuity**
- Ideation:
  - Past month
  - Nonspecific active suicidal thoughts or active suicidal thoughts without intent
  - More than a month ago
  - Active suicidal ideation with some intent to act
    - and/or
  - Suicidal Behavior:
    - Seen more than three months ago

**High Acuity**
- Ideation:
  - Active suicidal ideation, some intent, with or without a specific plan and/or
- Suicidal Behavior:
  - Seen within the past 3 months

**Immediate Intervention**
- Psychoeducational tools

**Long Term Treatment**
- Active monitoring in outpatient psychotherapy
- Medication management of co-occurring psychiatric symptoms

**Long Term Treatment**
- Outpatient mental health therapy with suicide specific interventions
- Medication management of co-occurring psychiatric symptoms
- Intensive Outpatient Program (IOP)
- High Risk Flag in EHR

**Adapted from:** Scarff, Lawrence & Lewis, 2019