

Zero Suicide Initiative Coordinating Center (ZSICC) Monitoring Report 2023–2024



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Contents

Executive Summary 1

 Introduction 1

 Overview of Key Findings 1

 ZSI Element 1: Lead 1

 ZSI Element 2: Train 1

 ZSI Element 3: Identify 1

 ZSI Element 4: Engage 2

 ZSI Element 5: Treat 2

 ZSI Element 6: Transition 2

 ZSI Element 7: Improve 2

Purpose 3

 ZSI Is Organized Around Seven Elements 3

Community Context 5

 American Indian Health Service of Chicago, Inc. – Chicago, IL 5

 Native American Rehabilitation Association of the Northwest, Inc. – Portland, OR 5

 Baseline Suicide Rates 6

Evaluation Approach 7

 Primary Data Collection and Analysis 8

 Site Visits 8

 Annual Progress Report 8

 Secondary Data Collection and Analysis 9

 National Vital Statistics System 9

 Workforce Survey 9

 Organizational Self-Study Survey 9

 Data Synthesis 9

 Methodological Limitations 9

Findings 11

 Section 1: ZSI Lead Element 11

 Develop Local-Level Policies and Procedures 14

 Partnership 15

 Community and Patient Engagement 16



Workplan.....	16
Section 2: ZSI Train Element.....	17
Training Received by Staff.....	17
Section 3: ZSI Identify Element.....	20
Approaches to Suicide Risk Screening and Assessment	21
Provider Experiences Screening and Assessing Patients.....	21
Section 4: ZSI Engage Element	22
Commitment to Engagement to Care	23
Strategies and Challenges to Engagement in Care	24
Section 5: ZSI Treat Element	25
Practices and Adaptations Informed by Native American Tradition	27
Section 6: ZSI Transition Element	28
Organizational Procedures for Ongoing and Continuous Follow-Up	29
Provider Experiences Working with Individuals During Their Transitions in Care.....	30
Section 7: ZSI Improve Element.....	30
Using Continuous Quality Improvement.....	31
Conclusion.....	32
UIOs Implemented Some ZSI Elements Similarly.....	32
Some Differences in ZSI Implementation Emerged for Other Elements.....	33
Across ZSI Elements, UIOs Faced Implementation Facilitators and Challenges.....	33
Next Steps	34
Roadmap for the Year 2 Evaluation.....	35
Evaluation Report	35
Annual Data Collection.....	35
Data Dissemination	36
References	38
Appendix A: Urban Indian Organization Engagement Throughout the Data Collection Process	A-1



Figures

[1. Zero Suicide Model 4](#)

[2. Clinical Pathway to Care 5](#)

[3. Leadership-to-Staff Impact Pathways 14](#)

[4. Percentage of Staff Trained in Skill Areas, by Organization.....17](#)

[5. Percentage of Patients Screened and Assessed for Suicide Risk, by Organization.....20](#)

[6. Patient Engagement, by Organization 23](#)

[7. Treatment of High-Risk AI/AN Patients, by Organization 25](#)

[8. Transition of High-Risk AI/AN Patients, by Organization 29](#)

[9. Roadmap for the Year 2 Evaluation.....37](#)

Tables

[1. Monitoring Report Data Sources.....7](#)

[2. Execution of Key Lead Activities 11](#)

[3. One Organization’s Treatment Approaches for Different Patient Categories 27](#)

[4. Suicide-Related Activity by Organization.....31](#)

[5. Year 2 Evaluation Data Sources and Timeline 35](#)

[Appendix Table 1. UIO Engagement Process in the Qualitative Interview Guide Development.....A-2](#)

Executive Summary

Introduction

Death by suicide disproportionately impacts American Indian/Alaska Native (AI/AN) communities (Leavitt et al., 2018). Recent data from the National Violent Death Reporting System (NVDRS) show a nearly 20% rise in the rate of death by suicide among the AI/AN population (Stone et al., 2022). To address these alarming trends, the Indian Health Service (IHS) has supported multiple rounds of Zero Suicide Initiative (ZSI) grants over the past decade.

In 2022, IHS supported a new cohort of eight ZSI grantees that included six Tribally-managed health and behavioral health facilities and two Urban Indian Organizations (UIOs): American Indian Health Service of Chicago (AIHS-C), Inc. and Native American Rehabilitation Association of the Northwest (NARA NW). RTI is conducting a cross-site evaluation of these two UIOs. The purpose of this monitoring report is to provide a summary of the progress that these UIOs have made in implementing ZSI within their respective organizations. Because of the cross-site nature of this report, all findings have been made anonymous to emphasize the bigger picture and align with the agreements that the evaluation team has with the UIOs to present their data in a confidential manner. An overview and summary of key findings follow.

Overview of Key Findings

ZSI Element 1: Lead

- With one exception, both organizations implemented all the required activities associated with the ZSI Lead element. The single exception was that neither organization established a formal community advisory board.
- Interviewees from both organizations described their community partnerships as both important and broadly successful, though one organization had some previous negative interactions with external organizations, which were perceived as an implementation barrier to its ZSI project.
- Both organizations cited the strength of their leadership teams as critical for implementing ZSI.
- Neither organization has implemented formal policies around how to best support staff whose patients have died by suicide—these policies tend to prevent staff turnover and burnout. This absence of support was associated with some staff reporting negative perceptions of leadership support.

ZSI Element 2: Train

- Although some training opportunities were targeted to specific staff roles, one organization universally provided all staff with training in the use of traditional Native American practices or activities and spiritual health or pastoral activities.
 - Staff from this organization also reported fewer knowledge gaps than staff from the other organization that did not universally train its staff.
- Staff at both organizations reported a key training gap was their knowledge of the specific traditions of the different Tribal communities of their patients.
- Staff at both organizations reported that Question, Persuade, Refer (QPR) training was effective for increasing their comfort around discussing suicide risk with patients.

ZSI Element 3: Identify

- One organization transitioned from using depression and anxiety screening to assess suicide risk to using the Ask Suicide-Screening Questions (ASQ) screener at the beginning of the ZSI grant.
- The other organization has held internal discussions about possibly making a similar transition to the ASQ screener.

- Both organizations reported screening nearly all patients for suicide risk; however, this practice has been associated with some provider reports of perceived screening fatigue from patients who are screened repetitively when receiving care from multiple providers on a single day.
- Providers at one organization reported receiving inconsistent guidance from ZSI leadership regarding when and how to administer the screening tool.
- Both organizations completed suicide risk assessments for all patients who screened positive for suicide risk.

ZSI Element 4: Engage

- Most staff at both organizations were familiar with the clinical pathway to care for individuals at risk for suicide.
- Organizations differed in the procedures staff used to develop safety plans, with one organization having a more formal template to help staff identify patient-specific risks and triggers and provide tailored coping strategies and the other providing safety plans for individuals at elevated risk for suicide but without formal guidance or a policy for staff around the content of the safety plan.
- Both organizations incorporated lethal means restriction as a component of patient safety plans.
- Staff at both organizations cited medical mistrust and misdirected referrals as key challenges associated with engaging patients in suicide prevention care.

ZSI Element 5: Treat

- Both organizations reported offering a variety of evidence-based treatments to individuals at risk for suicide.
- Staff from both organizations stressed the importance of tailoring treatment to the individual patient. One organization developed specific protocols to guide care based on different patient presentation characteristics.
- At both organizations, most staff also highlighted the importance of incorporating traditional Native American practices into suicide prevention care and treatment.

ZSI Element 6: Transition

- Organizations took different approaches to engage patients at risk for suicide who missed appointments:
 - One organization highlighted the protocols it has in place intended to ensure timely follow-up after missed appointments, including phone calls to the individual, followed by calls to their family members; the other organization reported no specific guidelines for following up with patients who missed appointments.
- Most staff at both organizations reported they felt confident in their ability to work with patients at risk of suicide during their transitions to different levels of care.

ZSI Element 7: Improve

- Neither organization reported any known deaths by suicide in the past year and relatively small numbers of reported suicide attempts.
- Staff at both organizations recognized the importance of having an electronic health record (EHR) system that could support tracking suicide-related activity and care transitions; however, staff at one organization reported having a less efficient and functional EHR system to use for this purpose.
- Both organizations conducted some form of quality improvement activities.
- Staff from one organization perceived some improvements in patient functioning, stability, and reductions in suicide risk because of ZSI.

Purpose

American Indian/Alaska Native (AI/AN) communities are disproportionately affected by suicide. AI/AN individuals have the fastest-growing rate of suicide in the United States (U.S.) (Leavitt et al., 2018). The National Violent Death Reporting System (NVDRS) reported a nearly 20% rise in the rate of death by suicide among AI/AN populations, from 20 per 100,000 individuals in 2015 to 23.9 per 100,000 in 2020 (Stone et al., 2022). Among AI/AN males, rates of death by suicide increased 71% from 1999 to 2017 compared to 26% among males of other demographic subgroups in the same time period (Curtin & Hedegaard, 2019).

This report provides data on the implementation status of the Zero Suicide Initiative (ZSI) for the two Urban Indian Organizations (UIOs) awarded ZSI grants in 2022. Data cover the first two funded years of the UIOs' ZSI projects (April 1, 2022–March 31, 2024). The goal of this report is to describe the context in which the two UIOs are implementing the seven ZSI elements, and their implementation progress. Future ZSI Coordinating Center (ZSICC) reports will focus on impacts.

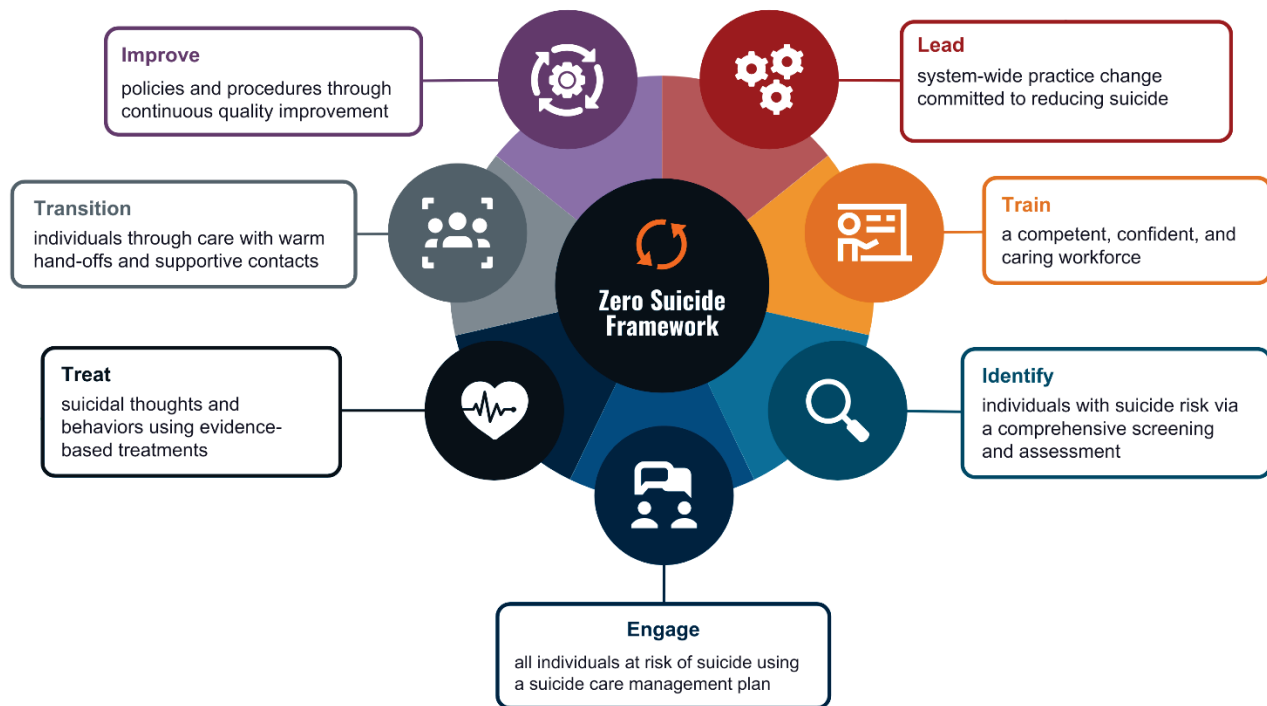
This report addresses the following evaluation questions, which were identified in the national evaluation plan:

1. How were the ZSI elements implemented by each site?
2. What were the factors internal and external to the UIOs that influenced how ZSI was implemented by each site?
3. What factors influenced implementation processes and progress? What were the implementation challenges? What were the implementation factors or supportive factors?

ZSI Is Organized Around Seven Elements

For the past decade, the Indian Health Service (IHS) has been committed to addressing suicide in Indian Country through implementation of ZSI, which has seven key elements: Lead, Train, Identify, Engage, Treat, Transition, and Improve. Together, these elements provide a holistic approach for organizations to build a foundation of suicide care. The Zero Suicide Model presented in [Figure 1](#) illustrates the interconnected nature of the elements.

Figure 1. Zero Suicide Model

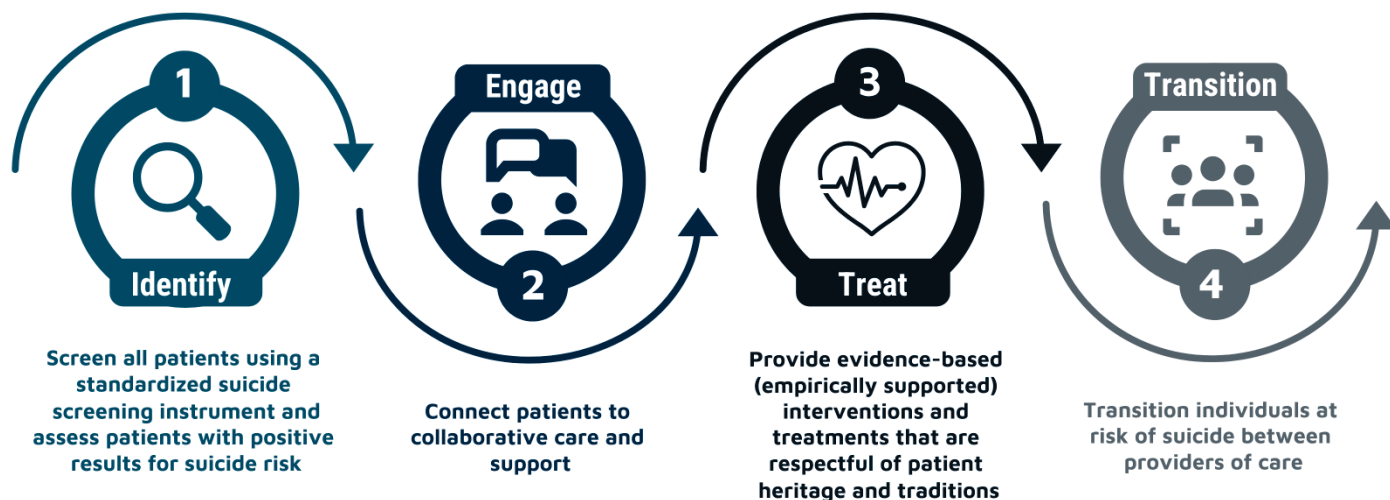


Source: RTI International

ZSI aims to integrate suicide care within the health care system and use an integrated behavioral and physical health model to eliminate deaths by suicide and improve other related health outcomes. The Lead, Train, and Improve elements focus on the organizational infrastructure and capacity that support suicide care while the Identify, Engage, Treat, and Transition elements focus on the clinical pathway to care.

Clinical Pathway to Care. Aligned with other clinically oriented interventions, ZSI relies on an approach of screening to identify patients' needs, connecting patients to care, and providing evidence-based treatments and transition support. [Figure 2](#) illustrates the clinical pathway to suicide care. Under the Identify element, screening and assessment are the first steps to identifying whether patients are at risk. Under the Engage and Treat elements, individuals are engaged through collaborative care and support in evidence-based care that is respectful of patient heritage and traditions. Under the Transition element, individuals may be transitioned out of care or between care settings while maintaining their connection to providers who are working with them to reduce their risks of suicide and strengthen protective factors around them.

Figure 2. Clinical Pathway to Care



Source: RTI International

Community Context

This report provides data on the ZSI projects implemented by two UIOs. This section provides background context for these two organizations.

American Indian Health Service of Chicago, Inc. – Chicago, IL

American Indian Health Service of Chicago, Inc. (AIHS-C) was established in 1974 with a mission to provide high-quality health care that is sensitive to the traditional practices of AI/AN individuals and underserved populations in Chicago, IL. Based on the evaluation team’s qualitative interviews with UIO staff, AIHS-C provides services from a single site to AI/AN individuals representing approximately 156 Tribes. In addition to suicide prevention programming, AIHS-C offers a range of services, including medical and behavioral health clinics; substance abuse counseling; diabetes education; domestic violence prevention programming; human immunodeficiency virus (HIV) testing and prevention; and community outreach. AIHS-C has 35 staff who work directly with patients at a single operational site. Although AIHS-C is one of 80 urban health centers for AI/AN individuals in the United States, it is the only American Indian–operated medical and behavioral health clinic in the state of Illinois. To reach individuals beyond Chicago, AIHS-C uses telehealth services. Because a greater concentration of AI/ANs live throughout Illinois than in Cook County where the UIO is located, telehealth has extended AIHS-C’s reach to the AI/AN population in Illinois. Finally, AIHS-C is a recipient of the 4-in-1 grant program from IHS, which ensures comprehensive public health services that are respectful of traditional practices are available and accessible to Urban Indians.

Native American Rehabilitation Association of the Northwest, Inc. – Portland, OR

Native American Rehabilitation Association of the Northwest, Inc. (NARA NW) was established in 1970 in Portland, OR, with the goal of promoting the overall wellbeing of AI/AN individuals, representing over 255 Tribes in the Northwest. NARA NW has 382 staff, 202 of whom work directly with patients across 10 operational sites. Although originally focused on outpatient substance abuse treatment, NARA NW expanded its services to include a residential family treatment center, outpatient treatment, child and family services, primary health care, mental health services, a wellness center, and transitional housing for Native women and children through multiple sites across Oregon. NARA NW’s work is supported by the 4-in-1 grant program at IHS.

NARA NW adopts a collaborative and strength-based approach to its services by integrating traditional practices and spirituality. Although the organization is committed to supporting the emotional, physical, spiritual, and mental health of over 5,000 Native people served annually, the organization maintains strong connections to the local hospital where it refers clients. NARA NW also provides support as needed to ensure comprehensive care for its clients.

Baseline Suicide Rates

In 2021, across the hospital referral regions (HRRs)¹ for the two UIOs, the average suicide rate was 9.70 per 100,000 AI/AN individuals. This rate was lower than the suicide rate for the non-AI/AN population: across the same HRRs, the average suicide rate for the non-AI/AN population was 13.45 per 100,000.² The suicide rate in NARA NW's HRR was greater than that of the HRR for AIHS-C. This contrast may reflect differences in the AI/AN population sizes in the respective HRRs; there were a larger number of AI/AN individuals in NARA NW's HRR compared to AIHS-C's HRR in 2021. Suicide rates within the HRRs for each UIO were similar to the suicide rates observed statewide. In 2021, the average suicide rate in Illinois and Oregon was 14.00 per 100,000 AI/AN individuals.

¹ Dartmouth statisticians have developed HRRs to approximate the catchment areas for hospitals and health centers located throughout the United States (Bronner et al., 2021).

² To protect individual and family privacy and to maintain confidentiality of these deaths, suicide rates are reported here as an average across the two hospital referral regions. One hospital referral region had extremely low suicide death rates and could not be reported separately for privacy reasons.

Evaluation Approach

RTI is conducting a cross-site evaluation grounded in the history and practices of Native Americans that leverages multiple primary and secondary data sources. RTI’s data collection and evaluation approach abided by three key principles of data collection and management:

1. Uphold Indigenous data sovereignty.
2. Center data collection efforts on the ZSI grantee teams.
3. Ensure meaningful data collection.

RTI is committed to upholding Indigenous data sovereignty and recognizes that Tribes have the authority to self-govern, which includes the ownership, control, and possession of, and access to, their data, consistent with data sovereignty. Recognizing the importance of Indigenous data sovereignty, RTI prioritized engaging the UIOs in the data collection process; conducted ongoing and transparent conversations about data collection efforts; established relationships with the UIOs so that their staff could offer feedback on the feasibility and appropriateness of collecting data elements and the data provision process; and provided details to the UIOs about data storage, analysis methods, and approaches to sharing analyzed data with UIOs (see [Appendix A](#) for details on UIO engagement in data collection and reporting). Last, RTI sought to collect from the UIOs relevant and useful data on UIO and IHS programmatic decisions and aimed to do so using the least burdensome approaches. Because of the cross-site nature of this report, all findings have been made anonymous to emphasize the bigger picture and to align with the agreements that the evaluation team has with the UIOs to present their data in a confidential manner.

Table 1 summarizes the five main data sources described in this monitoring report. Additional detail around each of these data sources and the analyses subsequently conducted follow.

Table 1. Monitoring Report Data Sources

Data Source	Details	Data Timeframe (Grantee Years)
Qualitative stakeholder interview and focus group data	Data collected on implementation contexts and approaches used by the two UIOs during site visits. Eight interviews conducted with key leadership staff, each of which lasted approximately one hour. Two focus groups convened with behavioral health treatment staff ($n = 10$).	April 1, 2022 to March 2024 (Grantee Years 1 and 2)
Annual Progress Report data	Primary quantitative and qualitative data collected from the ZSI grantees on their implementation progress and fidelity to each of the seven ZSI elements. Survey administered and data collected through Research Electronic Data Capture (REDCap), a HIPAA-compliant, secure online platform.	March 31, 2023 to April 1, 2024 (Grantee Year 2)
National Vital Statistics System (NVSS) data	Secondary data source managed by CDC that reports mortality data along suicide deaths among AI/AN individuals that occurred within the UIO’s catchment areas with all county-restricted mortality data.	2019 to 2022 (Prior to Grantee Year 1)
Workforce survey data	Survey of organization workforce developed by EDC that assesses staff’s knowledge, practices, and confidence implementing the seven elements of the ZSI model.	2023 (Grantee Year 2)*

Data Source	Details	Data Timeframe (Grantee Years)
Organizational Self-Study survey data	Survey developed by EDC to assess each organization’s approach to the ZSI model. This survey also identifies organizational strengths and weaknesses and identifies areas for improvement with integrating the ZSI model. Each component of the Zero Suicide Model was measured on a rating scale from 1 to 5.	2023 (Grantee Year 2)

CDC= U.S. Centers for Disease Control and Prevention; EDC = Education Development Corporation
* Workforce survey data were only available for Grantee Year 2 for both UIOs. One UIO was missing workforce survey data for Grantee Year 1; therefore, the evaluation team decided to exclude Grantee Year 1 data.

Primary Data Collection and Analysis

Site Visits

To obtain more in-depth information on the unique implementation context and approaches employed by each organization, the evaluation team conducted in-person interviews with staff at both UIOs. Relevant staff at each organization—including key ZSI leaders—were selected by the UIOs. The team conducted eight one-on-one semi-structured interviews, each lasting approximately one hour, to understand key barriers and facilitators and lessons learned from the UIOs’ ZSI implementation efforts. Interviews focused on four main topics: organizational readiness and leadership, external landscape, initial implementation, early insights, and any additional feedback and insights from staff. Furthermore, the evaluation team conducted a one-hour focus group discussion with frontline behavioral health care providers at each organization (a total of 10 individuals participated across both organizations). Focus group discussions aimed to capture the unique perspectives and experiences of frontline staff working directly with patients and implementing components of ZSI. The site visits took place between February and March 2024. The evaluation team used a mix of deductive and inductive thematic analysis methods to analyze the qualitative data from the site visit interviews and focus groups. All qualitative interview data were coded using the deductive and inductive analysis approach. This deductive approach focused on categorizing the data into predetermined sets of themes grounded in implementation science theory. A codebook was created to guide categorization. The team coded all interview data under one of the deductive codes. Following the deductive analysis, the team conducted inductive coding or categorizing subsections of the deductively coded data using newly identified concepts.

Annual Progress Report

The Annual Progress Report (APR) collected quantitative and qualitative information regarding implementation progress on each of the seven ZSI elements during the previous grant year (April 1, 2023, to March 31, 2024). Questions were tailored to each grantee and based on their previous year’s APR. The survey was administered in April 2024 through REDCap, a secure online platform.

Because the APR only included a few open-ended questions, the APR qualitative data were systematically coded, and code reports were reviewed to identify key themes around progress in implementing the ZSI model. The evaluation team calculated descriptive statistics (e.g., means, percentages, rates) for key quantitative measures.

Secondary Data Collection and Analysis

National Vital Statistics System

To describe the suicide mortality rates of AI/AN people in the communities served by the two UIOs, this evaluation used data from the U.S. Centers for Disease Control and Prevention (CDC) National Vital Statistics System (NVSS). All county-restricted mortality data from 2021 were requested and obtained from the NVSS. A key advantage of this dataset is that it is geocoded, which allowed us to define and identify county-based catchment areas for the two UIOs. RTI mapped counties in the NVSS data to HRRs to best approximate the catchment area or communities served by the two UIOs, (Bronner et al., 2021).

The NVSS data include date, location (county/state of residence), and cause of death for all 50 states, the District of Columbia, and U.S. territories. The evaluation team calculated suicide mortality rates per 100,000 individuals at the state and the HRR catchment areas levels that encompass the respective organizations for calendar year 2021.

Workforce Survey

For this report, the team included Zero Suicide workforce survey data from 2023, which included one UIO's respondent data from April 2023 and October 2023 and the other UIO's December 2023 respondent data. The UIOs administered the surveys using the ZSI workforce survey developed by Education Development Corporation. Across both organizations, 41 staff responded to the workforce survey; in total, 12 staff responded to the April and October 2023 workforce surveys at one organization and 29 staff responded to the fall 2023 workforce survey fielded by the other UIO.

Workforce survey responses were entered into an Excel spreadsheet to create a dynamic dashboard for the UIOs that was used to generate descriptive statistics. Most workforce survey questions had responses that were binary (yes/no) or based on a 5-point Likert scale. For the Likert scale questions, the evaluation team grouped responses as “agree/strongly agree,” “neutral,” and “disagree/strongly disagree” so that it could provide proportions based on level of agreement.

Organizational Self-Study Survey

Both UIOs completed the ZSI Organizational Self-Study in fall 2023. One UIO used the ZSI Organizational Self-Study and Self-Study addendum for Tribal or IHS-led health systems that was available in 2023. The other UIO used the 2022 version of the ZSI Organizational Self-Study. The evaluation team analyzed the Organizational Self-Study by identifying the responses in alignment to each element of the ZSI model for each organization.

Data Synthesis

Data synthesis was a pivotal part of the evaluation process, and the evaluation team combined qualitative and quantitative data to create a comprehensive understanding of the UIOs' implementation of ZSI. By integrating qualitative narratives with quantitative statistics, the team obtained a more comprehensive and accurate and perspective on suicide prevention efforts that are also sensitive to traditional practices. This multifaceted approach offers invaluable insights for shaping future strategies and initiatives and—potentially—contributing to the enhancement of grantees' ZSI implementation.

Methodological Limitations

The primary limitation of this report is the early nature of the ZSI grantees' activities, as the included data represent only one year of grantee data and outcomes from the same year. Therefore, although this report

provides insights into early ZSI implementation, it can only describe ongoing trends in outcomes, not the impact of the program on outcomes. The next evaluation report will include insights on the impact of grantees' ZSI activities on outcomes. In addition, there are not multiple years of data for the workforce and Organizational Self-Studies. One organization did not conduct a workforce survey or complete an Organizational Self-Study in 2022; therefore, these analyses lack these 2022 data. Also, because of the monitoring report development timeline, the evaluation team will be including the most recent 2024 workforce survey data in next year's evaluation report. Last, because the UIOs administered the workforce surveys, there are no response rates or data about how staff were sampled or how the survey was fielded. Thus, the team has used other data to triangulate the points highlighted through the workforce survey data.

Findings

Section 1: ZSI Lead Element

The Lead element intends to ensure there is adequate leadership and commitment from the leadership team to support transformation of how suicide risk is screened, assessed, and treated in the Native community and the health and behavioral health care systems.

This section provides data related to the Lead element, starting with a description of the local ZSI leadership teams’ structures, including membership stability, responsibilities, and engagement from key staff. It then discusses the ZSI grantees’ leadership role broadly with respect to policy, communication, and staff support. Following are descriptions of the current landscape of the organizations’ policies and procedures, including recent changes, and partnerships and engagement with other organizations, community members, and patients and how these impacted ZSI implementation. Finally, the section outlines ZSI grantee organizations’ ongoing and upcoming work plan activities.

[Table 2](#) shows that both organizations had relatively high fidelity to the Lead element and implemented all the required activities associated with the Lead element, except for establishing a community advisory board (CAB).

Table 2. Execution of Key Lead Activities

Key Activity	Organization 1	Organization 2
Establish local ZSI team	✓	✓
Develop local-level policies and procedures	✓	✓
Establish community advisory board	-	-
Conduct Organizational Self-Study	✓	✓
Develop ZSI implementation workplan	✓	✓

Source: ZSI Year 2 Annual Progress Report
Timeframe: ZSI Grantee Year 2, April 1, 2023–March 31, 2024

ZSI Leadership Team Structure

Although staff at both organizations reported past challenges with frequent leadership changes, staff now report that they have much more stability in their leadership positions. Prior to this reporting year, both ZSI programs experienced a few years of leadership transitions, which negatively impacted program progress and staff experience. However, according to interviews and the APR, both programs are experiencing relative stability in their leadership teams, which is described as having a positive impact on ZSI programming. This stability allows both organizations to provide consistent perspectives on and communication about implementation. Further, one organization shared in its APR that it was considering expanding its ZSI leadership team to help improve cross-discipline communication and encourage program growth.

Staff from both organizations noted that having leadership roles specifically responsible for managing or promoting the program was helpful to program implementation. One organization benefited from having strong leadership under a previous suicide prevention grant that created a foundation for suicide programming. As part of the previous suicide prevention grant, this organization's leadership designed a staged implementation scale-up that began with mental health providers and systematically expanded to other departments. This organization identified having ZSI champions as important for implementation. This organization is currently in the pre-planning phase of engaging staff from different internal divisions to serve as program champions. At the other organization, a few staff noted that not having a designated individual who focuses specifically on the ZSI grant was a barrier to implementation.

Although the ZSI leadership teams at both organizations include staff with similar roles and positions, there are differences in their implementation approaches and the amount of authority that the leadership teams hold. Each organization's ZSI leadership team has different responsibilities and approaches to implementation. According to the Organizational Self-Studies, one organization's ZSI leadership team meets regularly, while the other organization's team meets on an as-needed basis to discuss suicide care. One ZSI leadership team is responsible for developing policies, processes, and practices for suicide prevention and intervention and for regularly communicating to staff, while the other has the authority to identify and recommend changes to suicide care practices.

Each organization took a different approach to involving staff in the initial grant writing process. At one organization, there was limited staff input in the initial grant writing process. At the other, key organizational leadership staff were involved in shaping the initial grant and implementation plan. During qualitative interviews, a few staff at the latter organization noted that leadership incorporated the perspectives and input of clinicians who were seeing Native American patients with suicidality during the grant writing process. Further, these staff highlighted that this perspective was important for ensuring the feasibility and effectiveness of the proposed grant program.

Both organizations made efforts to involve frontline staff in ongoing ZSI implementation through trainings, meetings, and input gathering. At the same time, staff burnout and turnover posed challenges to consistent staff engagement. Staff at one organization described the challenges leadership faced trying to balance ZSI implementation with other organizational priorities unrelated to suicide prevention. In addition, a few staff at one organization noted an initial learning curve for staff implementing the suicide risk screening, assessments, and safety planning (e.g., what steps to take and when) but noted that staff have adapted over time as the organization solidified its ZSI-related processes and procedures. Both organizations shared their approaches to dealing with staff burnout which included: offering an employee wellness program, holding staff appreciation events, promoting self-care, assessing jobs to ensure that responsibilities and caseloads are appropriately assigned, and hiring more staff when needed.

Both organizations rely on input and guidance from the Native American communities served by the organizations to help adapt interventions and programming. During interviews, staff at one organization mentioned involvement of a council of Native American elders who are tasked with maintaining traditional approaches that provide guidance on staffing and in some cases the ZSI intervention. The other grantee organization relies heavily on Native staff for traditional programming.

“ We have a [traditional practitioner] join our second interviews [for staff hiring]. So that's our team of elders who guide a lot of what we do. So I think that's just a key component right there. ... They're also just kind of seeing if this person will be a good fit within the [our environment], and they might ask some particular [traditionally focused] questions. They can't always make it to interviews nowadays.... But yeah, whenever they're able to be there, it is really, really helpful.

– ZSI grantee staff

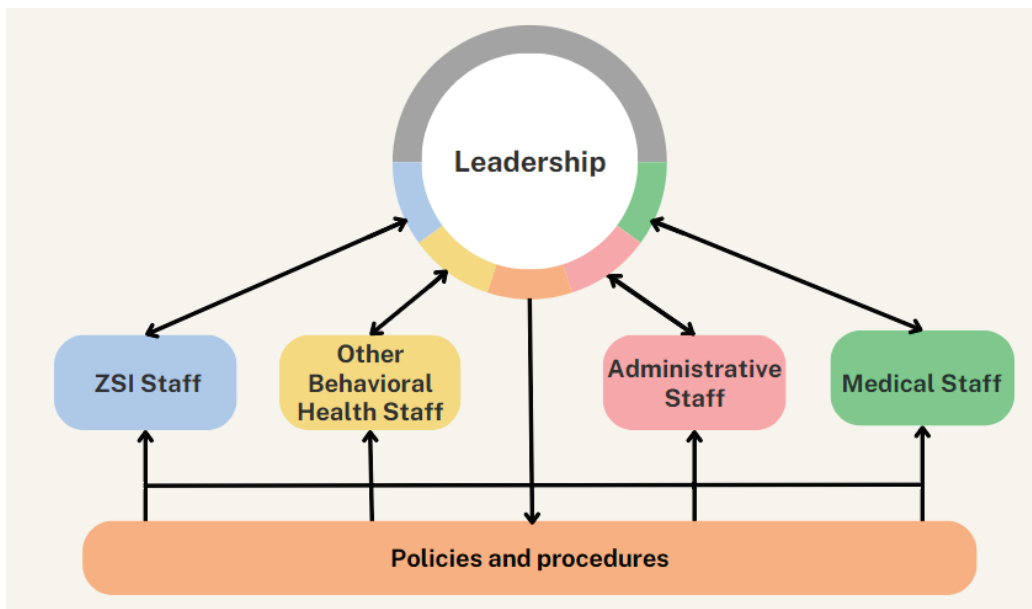
ZSI Leadership Support

Neither organization has specific policies for supporting staff whose patients have died by suicide; this lack of policy guidance is associated with mixed experiences by staff, particularly in their perception of leadership support. In the workforce survey, respondents were asked how their organization responded to them and if they had ever directly or indirectly interacted with an individual who ended their life by suicide. At one organization, five out of five respondents who had interacted with an individual who ended their life by suicide indicated that they felt supported by the organization the last time a suicide occurred. At the other organization, one of the two respondents who had directly or indirectly interacted with an individual who ended their life by suicide indicated that they did not feel supported by the organization the last time a suicide occurred. On a positive note, across both organizations, none of the respondents who interacted with an individual who ended their life by suicide indicated that they felt blamed the last time an individual died by suicide.

Additionally, three of five workforce survey respondents at one organization agreed their organization had practices in place to support staff when a suicide occurs; the other two respondents felt neutral. At the other organization, one of two respondents strongly disagreed that the organization had practices in place to support staff when a suicide occurs; the other staff member did not respond. For context, these survey questions did not specify the timeframe during which staff needed or expected support after a patient death by suicide. Although neither organization endorsed updating the suicide support for staff policies in their recent APR, it is possible these policies have changed since the last death by suicide took place.

Representatives at both organizations named leadership support of cross-division communication as an important implementation driver for success. During interviews, effective communication and visibility of leadership were highlighted as crucial for maintaining morale and clarity within the ZSI implementation process. For example, having the organization's executive director actively engaged in communicating the purpose and expectations of the ZSI grant to staff was described as incredibly helpful for implementation. Repeating key messages and integrating staff into the ZSI leadership or implementation team were additional methods for encouraging cross-division collaboration. Leadership also played a significant role in applying systematic approaches. At one organization, ZSI leadership uses an electronic database to track all referrals and coordinates with other departments to manage patients and aspects of ZSI implementation effectively. At the other organization, leadership uses the EHR system to facilitate coordinated care through review of scanned documents. Understandably, leadership support impacts overall patient care through these processes. For example, in instances where leadership offered backup support in emergency situations (e.g., if no other providers were available), which was noted in one organization's APR, overall patient care and coordination was improved according to staff. [Figure 3](#) illustrates how leadership impacts staff communication both directly and indirectly through policies and procedures.

Figure 3. Leadership-to-Staff Impact Pathways



Source: RTI International

Staff reported that strong working relationships are important and noted they receive support from colleagues. In interviews, staff from both organizations noted they had strong working relationships, defined as either a strong team that works well together or strong communication avenues that foster these relationships through formal meetings and informal connections (e.g., being in close proximity).

“ So we use our village...and it's really just leaning on our coworkers and colleagues in those instances [when you feel overwhelmed], for sure.

– ZSI grantee staff

At one organization, however, a few staff noted that lack of communication hindered the team from functioning well and they hoped that rotating the staff who attended meetings would engage more staff in these collaborations and increase cross-department communication.

Develop Local-Level Policies and Procedures

In addition to playing a key role in securing the grants to support ZSI implementation, leadership at both organizations also help obtain additional funding for case management and other suicide prevention services. According to the interviews, examples of other grants included a 988 Tribal response grant that supported provision of training on AI/AN traditional practices to crisis call center staff and creation of a referral flow.

Both organizations have patient identification and engagement protocols or activities, demonstrating relative fidelity to ZSI. Staff at one organization indicated they have formal policies, processes, or guidelines

specific to suicide prevention and intervention, such as what to do when someone mentions suicide during a physical or mental health visit. Staff at the other organization indicated they have processes that address all components of ZSI, and that staff receive training on processes annually and when new processes are introduced. Staff also indicated that suicide-related processes are reviewed and modified annually and as needed. Both organizations have written protocols on screening, assessment, safety planning, and suicide care management for suicidal thoughts or behavior. One organization also reported having a written policy on lethal means safety. Finally, one organization offers staff training on screening, assessment, lethal means safety, safety planning, and suicide care management for suicidal thoughts or behavior, while the other organization provides staff training on suicide risk screening and assessment. Also, this organization added a requirement that all staff will take Counseling on Access to Lethal Means (CALM) safety training during its third grant year.

The main procedural foci for both organizations have been on referrals, data tracking, and workflows. At both organizations, having clear, documented workflows and procedures is important for ensuring consistent and effective ZSI implementation, especially in crisis situations when staff need to know exactly what steps to take. In interviews, staff at one organization described making improvements to their workflow by staffing a full behavioral health team that was available to inform and carry out the workflow. In the APR, the other organization described changes to the intake process, tracking data and referrals, and improving the internal organization of systems and processes.

Partnership

Both organizations characterized community partnerships—an important aspect of the Lead element—as successful in some realms and challenging in others. In interviews, grantees described how external partners may be engaged for various reasons, including increasing the referral stream (e.g., partnership with hospitals and crisis lines), connecting patients participating in ZSI with other services (e.g., housing, food, and population-specific care), and securing additional funding (e.g., collaborating with private institutes and foundations). In addition, staff shared several implementation barriers and facilitators associated with external partnerships that arose. For example, staff at one organization identified early and intensive engagement with external partners as a facilitator. These staff described the organization’s strong relationship with a referring hospital due to early ZSI leadership engagement with hospital staff, which included in-person visits and providing patient consultations when requested. Mutually beneficial relationships were another facilitator to partnership building; staff at one organization described a strong relationship with local crisis lines where both entities make referrals to the other to provide their patients with supports.

“

I built relationships...by going out and talking about [Native Americans] and really appropriate treatment for our people. And I think that...helped because then it built a rapport and they were more willing to say, 'I'm out of my zone here. Can I send somebody to you?' Or if I needed someone hospitalized and I was really having a hard time because they knew exactly what to say to keep themselves out of the hospital, but I knew because they needed help. They said, 'I'm going to do this and I'm going to do this after I leave here,' and I would say, 'I'm not leaving you.' And sometimes I could use my relationship with this staff member to sit with me until they heard what I heard and we could keep that person safe, but yeah, it takes a lot of relationship building. It's hard.

– ZSI grantee staff

At the same time, staff at one organization described how a negative perception of the UIO by former community partners still impacted their relationship with other organizations; a referring agency sometimes shared that they were “wary of” the UIO and therefore did not refer all patients to the UIO.

Community and Patient Engagement

Staff recognize the importance of a flexible, adaptive ZSI approach based on community needs and collaboration but faced challenges engaging the community. The development of a CAB is one of the key activities under the Lead element. In the most recent APR, both organizations stated that they had created CABs, but neither included external community partners as expected under the ZS model. According to the APR, one organization’s CAB includes health service system staff, ceremony leaders, UIO program staff, and crisis response teams; and the other organization’s CAB comprises program champions from within the organization. During interviews, staff explained that neither organization currently has an active CAB that includes external organizations or partners. Staff at one organization indicated they planned to establish a CAB with external entities, but the timeframe for this was not specified.

Although neither organization has an active CAB, both are conducting some form of community engagement related to ZSI. During interviews, staff at both organizations described hosting gatherings open to community members. Staff at one organization expressed intentionality around community engagement due to the actions of people previously in leadership roles that negatively impacted the organization’s standing in the community. This organization is conducting numerous community engagement activities, which include social media marketing, tabling with print materials at events, providing merchandise, soliciting community feedback through surveys, ensuring AI/AN individuals are represented on the marketing and outreach team, showing up to community events and listening to community members, and providing responsive care. Barriers to community engagement included staff turnover, which prevented the ability to build trusting relationships with community members. For example, staff turnover, which was high at both organizations, prevented staff from showing up consistently and building trust with AI/AN community members among whom there might be existing medical mistrust. UIO staff highlighted that working with the community to foster collaboration and enhance their own learning was a strategy to overcome these barriers. As one staff member noted, *“Showing up is very, very important, especially if you’re not from this community.”*

Finally, both organizations explained that patients who have experienced a suicide attempt have informal opportunities to engage in ZSI planning and implementation. This engagement is important for ZSI implementation and ZSI leadership development.

Workplan

Both organizations updated their workplans for this year and will continue to maintain their current ZSI implementation while also adding new activities. For one organization, new activities include launching a social media campaign, implementing Caring Contacts, and evaluating the clinical pathways to care to determine needed developments. The other organization plans to transition to a new screening tool, prepare a workplan for children with suicidal ideation, build relationships within the community, offer drop-in services within apartment complexes, create standardized care tracks, and develop a protocol for stabilized clients.

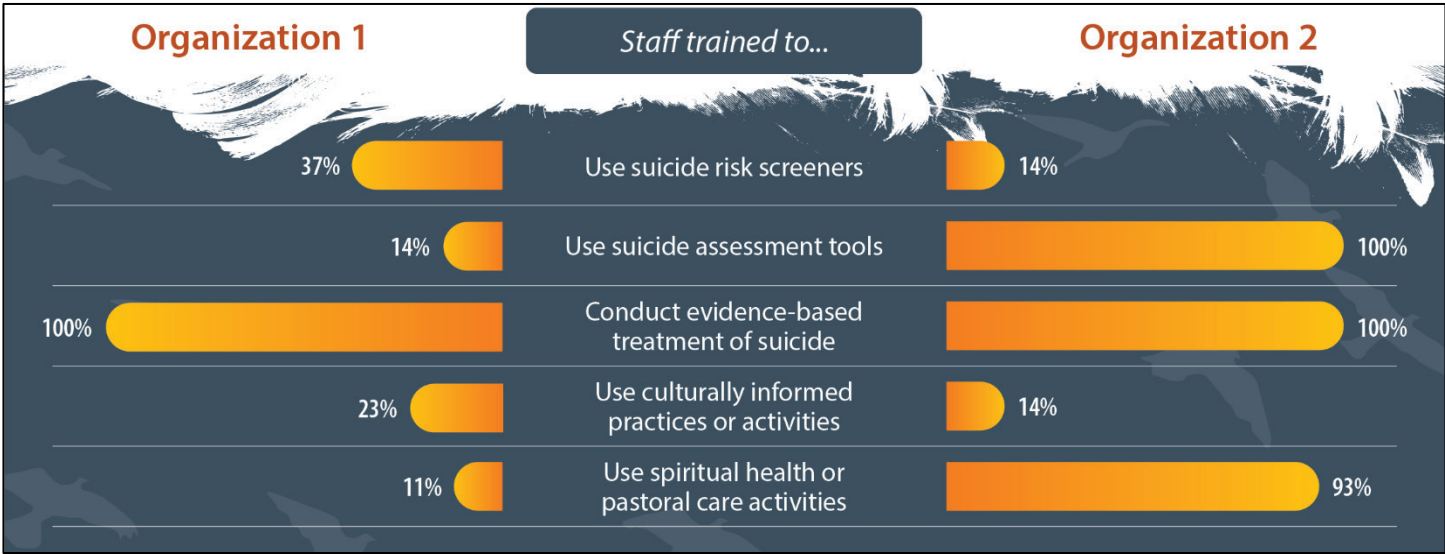
Section 2: ZSI Train Element

The Train element intends to better understand the needs that providers and patient-facing staff have for training around how to screen, assess, and treat individuals at risk for suicide.

This section examines the types of training staff at the two ZSI grantee organizations received and then summarize the approaches these two organizations took to train their staff.

Figure 4 shows that, at Organization 1, 37% of staff were trained to use suicide risk screeners and 14% of staff were trained to use suicide risk assessment tools. All behavioral health staff at this organization were trained to provide evidence-based treatment of suicide. At the same organization, 23% of staff were trained to use traditional Native American practices or activities and 11% were trained to use spiritual health or pastoral activities. At organization 2, 14% of staff were trained to use suicide risk screeners and all staff were trained to use suicide risk assessment tools. All behavioral health staff at this same organization were trained to provide evidence-based treatment of suicide. All staff at organization 2 were trained to use traditional practices or activities and nearly all (93%) were trained to use spiritual health or pastoral activities.

Figure 4. Percentage of Staff Trained in Skill Areas, by Organization



Source: ZSI Year 2 Annual Progress Report
Timeframe: ZSI Grantee Year 2, April 1, 2023–March 31, 2024

Training Received by Staff

Across both organizations, most workforce survey respondents reported receiving some type of suicide prevention training. In 2023, most workforce survey respondents reported receiving suicide prevention–related training. Training was delivered through various channels, including an online learning platform and in person. One organization uses an online learning platform to deliver a consistent set of trainings to new staff and refresher training on select topics annually. One organization uses time during staff meetings to deliver

in-person training to all staff and allows mental health staff to select and participate in ad hoc learning and training sessions. Qualitative feedback from one organization highlighted that experiential learning components like role playing, mock calls, and hands-on sessions are invaluable for skill development in suicide prevention training. Also, staff at one organization emphasized that collaborative events such as the 2024 ZSI Academy are helpful for idea exchange, learning from others, and network building to support implementation.

Among staff responsible for conducting suicide risk screening and assessments, nearly all reported being trained to use screening and assessment instruments, according to the workforce survey. Both organizations also reported in their APR that all staff who provide behavioral health services to patients were trained to use screening and assessment instruments. As mentioned in [ZSI Element 1: Lead](#), the two organizations either use (1) the Ask Suicide-Screening Questions (ASQ) and Patient Health Questionnaire 9 (PHQ-9) for screening and assessment or (2) the PHQ-9 for screening and the ASQ and Columbia Suicide Severity Rating Scale (C-SSRS) for assessment. On average, 26% of all staff who work with patients across both organizations were trained to use suicide risk screens and 57% of all staff who work with patients were trained to use suicide risk assessment tools, according to their APRs. Nearly all staff who responded to the workforce survey who were trained in suicide risk screening and assessment reported receiving their training through their organization; one staff person at each organization indicated they had been trained elsewhere. Further, at both organizations, some staff who were not responsible for conducting suicide risk screening and assessments reported on the workforce survey they had been trained to conduct screenings and assessments. The Organizational Self-Study data reinforce the notion that both organizations train staff to use multiple screening and assessment instruments and tools, including broad suicide risk assessments, C-SSRS, ASQ, and PHQ-9.

A third of workforce survey respondents across both organizations received training in safety planning. Both organizations described safety planning as the responsibility of their behavioral health staff and being the step after a positive suicide risk assessment. Thus, both organizations focused their safety planning training on their behavioral health staff only. During qualitative interviews and as part of the workforce survey, staff from one organization shared experiences participating in CALM training, as well as training using different safety planning tools (e.g., the Stanley-Brown Safety Plan). The other organization indicated that it does not provide staff with training specific to safety planning and lethal means safety. However, in its Year 2 APR, this organization indicated that it will require all staff to take CALM training starting in Year 3.

All behavioral health staff at both organizations were trained in evidence-based treatment of suicide. At one organization, only behavioral health staff (14% of all staff) were trained to use both suicide risk assessment tools and evidence-based treatment of suicide, while all staff at the other organization (including non-behavioral health staff) were trained to use suicide risk assessment tools and only behavioral health staff were trained to use evidence-based treatment of suicide.

Staff at both grantee organizations viewed Question, Persuade, Refer (QPR) training as effective for increasing comfort with discussing suicide risk. According to Organization Self-Study findings, both organizations reported offering staff the opportunity to participate in QPR training. Some staff indicated that QPR training helped them normalize conversations about suicide and assessing patients' suicide risk. Further, most staff at both organizations indicated they had received training at some point to recognize warning signs that an individual may be at elevated risk of suicide. Although most staff who were trained indicated their organization had provided the training, on average about one-fifth of staff across both organizations received this training elsewhere. In addition to QPR training, staff indicated that they received Assessing and Managing Suicide Risk (AMSR), Applied Suicide Intervention Skills Training (ASIST), and Recognizing and Responding to Suicide Risk (RRSR) trainings, all of which helped them recognize suicide risk and, in some cases, screen and assess it.

“ But I think one of the biggest things that all of those trainings have done is making the conversation with clients comfortable. Not being afraid to say, ‘Do you feel like you’re going to kill yourself?’ Or, ‘Why did you feel [suicidal] in that moment?’ And being able to actually use the word suicide or harm yourself or kill yourself or being able to just normalize the conversation.... So that’s been, I think the best part [of the trainings] for me anyway is just being comfortable talking about it.

– ZSI grantee staff

Approaches to Training

A universal staff training approach at one organization appears to be associated with fewer staff reporting training gaps when compared to staff at the other organization. At this organization, staff were offered a targeted training approach, which left them with limited knowledge of suicide interventions and treatments. The two organizations took different approaches to training staff on suicide risk screening and assessment; one organization required training for all staff and the other organization trained staff based on their responsibilities and roles. One organization required that all staff be trained in their suicide risk assessment tool and receive annual refresher trainings. This organization also developed a training video and trained all staff on how to conduct suicide risk assessments in a manner that was aware and respectful of traditional Native American practices. This organization only trained its behavioral health staff who work directly with patients (14% of all staff) in suicide risk screening. At the same time, all staff at this organization—even those who do not work directly with patients—were trained in how to use and implement practices or activities informed by Native American tradition in general, rather than specific to screening and assessment. Further, 93% of staff working directly with patients were trained in how to enable spiritual health or pastoral care activities.

Staff working at the organization that required suicide risk assessment training for all employees reported fewer additional suicide prevention and awareness training needs, according to the workforce survey. Site visit data indicated that strong leadership support and prioritization of suicide prevention training is critical. This support allows staff to have dedicated time and the necessary resources to participate and operationalize the information learned during training.

In contrast, the other organization trained all staff responsible for providing behavioral health care and treatment—14% of all staff working directly with patients—to use the suicide risk assessment tool. This organization trained over a third of its staff (37%) who work directly with patients to use a suicide risk screener. Less than a quarter of staff trained at this organization received additional training on how to ask suicide risk screening or assessment questions of Native American individuals and families coming for services with sensitivity, according to the workforce survey. Also, among staff working directly with patients, less than a quarter (23%) were trained on enabling traditional practices or activities and 11% were trained to enable spiritual health or pastoral care activities. Both percentages for this organization are considerably lower than the same percentages for the other UIO. This discrepancy between the organization raises questions about a potential skills gap or training need at the organization with a lower percentage of staff trained to deliver suicide risk screening and assessment in a manner that is aware and respectful of traditional practices or delivering practices or activities informed by tradition.

Staff from both organizations reported in the workforce survey that they do not perceive that they have received adequate training on the traditional practices of Tribes served by the organization. Although

some staff agreed that training on the traditional practices of Tribes served by their organizations is adequate, most workforce survey respondents at both organizations indicated that they either strongly disagreed or felt neutral about the adequacy of this training. Furthermore, most workforce survey respondents at one organization indicated that they would like more training, resources, and support in working specifically with Tribal people. One staff member indicated that they received trainings and “need[ed] to [tailor] it more relative to our population.” Another staff member said, “I just think that it would be nice to have a tool to utilize that was more....specific [to Native Americans]. Because I think suicide [is] talked about differently, just within the [Native] population. And knowing how to talk about it right? Like having some trainings on that.”

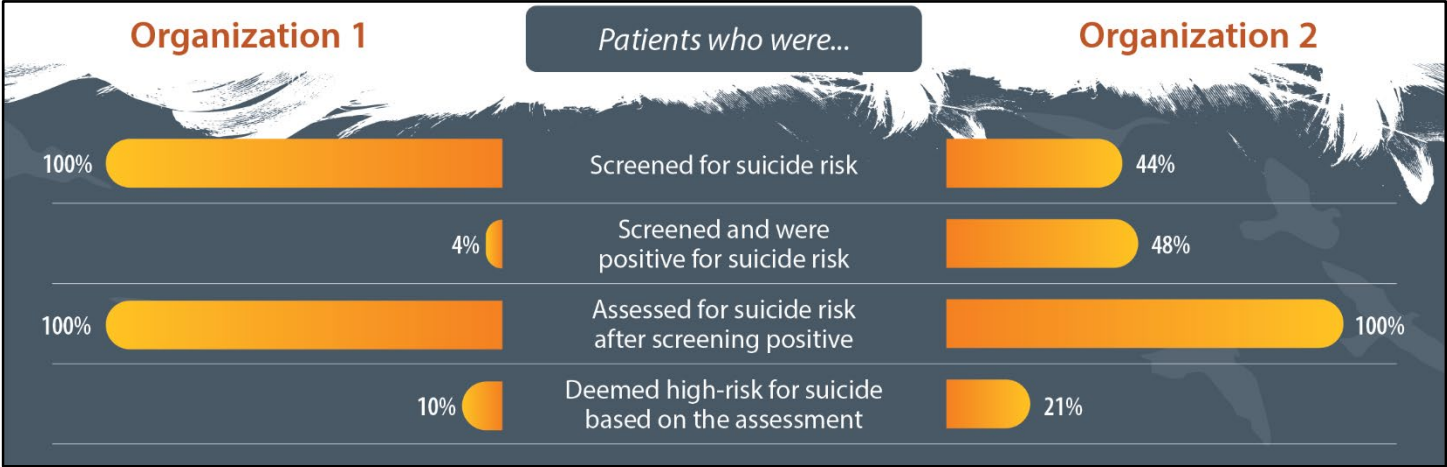
Section 3: ZSI Identify Element

The Identify element focuses on the procedures that are implemented to effectively detect individuals who are at risk for suicide within the health and behavioral health care system.

This section describes the organizational approaches for integrating suicide risk screening and suicide risk assessments into patient care and concludes with a description of provider experiences integrating suicide risk screening and assessments into the care they provide to their patients.

Figure 5 shows that 100% of patients at one organization were screened for suicide risk and 4% of those patients had positive results. It also shows that 44% of patients at the other organization were screened for suicide risk and 48% of those patients had positive results. Across organizations, all patients with positive results for suicide risk completed suicide risk assessments.

Figure 5. Percentage of Patients Screened and Assessed for Suicide Risk, by Organization



Source: ZSI Year 2 Annual Progress Report
Timeframe: ZSI Grantee Year 2, April 1, 2023–March 31, 2024

Approaches to Suicide Risk Screening and Assessment

Aligned with the ZSI model, both organizations have procedures in place to conduct suicide risk screening and assessments among patients. One organization has transitioned from only using screening tools that assess for depression and anxiety (PHQ-9 and General Anxiety Disorder-7) to including a tool that specifically screens for suicide (ASQ). According to data reported in the APR, this organization uses both the PHQ-9 and the ASQ for screening and uses the ASQ for assessments. The other organization uses the PHQ-9 for screening and the C-SSRS for assessment. This organization is considering transitioning to the ASQ for its assessments.

In the workforce survey, 88% of the respondents responsible for conducting screenings for suicide risk and assessments at both organizations reported that they know the organizational procedures for suicide risk screening and 94% of staff reported that they know what organizational procedures exist for suicide risk assessments. Responses to the Organizational Self-Study indicated that providers at both organizations are required to conduct suicide risk assessments among patients at every type of care visit. This process was echoed during the qualitative interviews, as providers noted that it is routine to ask clients about suicide at every session and are instructed by leadership to “assess, assess, assess, and refer, refer, refer.”

Both organizations described receiving referrals for patients who may be at risk for suicide to their ZSI programs from many avenues, including intake, other departments within the organization, self-referral, hospitals, crisis lines, and other organizations. One organization described that some referrals were not related to suicide and instead might have involved, for example, an emotional patient, which increased the referral load.

Provider Experiences Screening and Assessing Patients

Although staff at both organizations reported near-universal screening of patients, staff at one organization also reported that they and their patients have been experiencing fatigue because of over-screening. One organization reported that screening at every visit was a hindrance to care, particularly for patients receiving intensive outpatient services, which involves seeing multiple providers each day and therefore multiple screenings a day. Providers reported that patients shared frustration with over-screening. As one provider said, *“I have some clients who say, Oh, you have to ask me those questions again. No, no, no.”*

Providers at one organization also reported inconsistent guidance from leadership regarding when and how to administer the screening tool. These providers indicated that it would be helpful to know whether they are able to modify the screening questions so they can weave them into conversation or if they should follow the screening questions word for word.

Data from the APR indicate that, across organizations, all AI/AN patients who screened positive for suicide risk received and completed suicide risk assessment. At both organizations, workforce survey data indicates that all respondents responsible for conducting suicide risk assessments discussed patients’ suicide plans and intentions as part of these assessments. Further, most respondents reported that they also obtained information about risk and protective factors for patients as part of the suicide risk assessment process. Across both organizations, 16% of AI/AN patients who are assessed for suicide risk are deemed to be at high risk for suicide.

Only a quarter of workforce survey respondents reported that they have the knowledge and skills needed to conduct a suicide risk assessment. Although most staff responsible for conducting screenings for suicide risk reported having basic knowledge and skills to do so, staff at both organizations may benefit from a refresher course on suicide risk assessments to build their confidence in the assessment processes.

At the same time, experience screening patients for suicide helped establish staff comfort and experience conducting screenings. Staff described that conducting many screenings made them comfortable with following the screening tool. Other staff added that trainings related to the integration of suicide risk screening in their care approaches has also normalized conversations around suicide. These experiences of increased comfort reinforce workforce survey results indicating that most respondents responsible for conducting screenings and assessments for suicide risk are confident and comfortable in their abilities to screen and assess individuals for suicide risk.

During qualitative interviews, staff also shared that adapting how the screening questions are asked to make them more appropriate for AI/AN patients could improve screening delivery. Other staff shared that preparing patients by informing them that the provider will be asking suicide risk screening questions helps ease the conversation.

Section 4: ZSI Engage Element

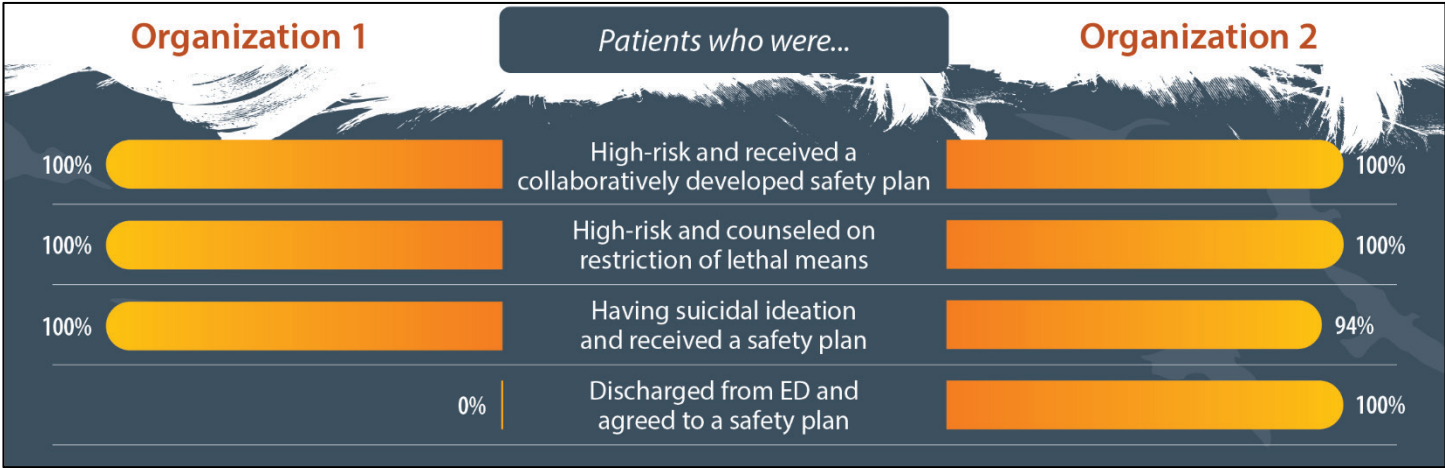
The Engage element is focused on the clinical pathway to care for individuals at risk for suicide, ensuring that all at-risk individuals receive timely and adequate treatment.

This section describes the processes, strategies, and challenges of engaging AI/AN patients at risk for suicide in care.

Figure 6 shows that at both organizations, all AI/AN patients at high risk for suicide received a collaboratively developed safety plan and counseling on restriction of lethal means. At organization 1, all AI/AN patients with suicidal ideation received a safety plan. At organization 2, 94% of AI/AN patients with suicidal ideation received a safety plan. During Grantee Year 2 (April 1, 2023, to March 31, 2024), all patients from organization 2 who were discharged from the emergency department (ED) and were at high risk for suicide agreed to participate in safety planning. At organization 1, none of the patients who were deemed high risk for suicide and discharged from the ED agreed to participate in safety planning with staff during Grantee Year 2.³ However, fewer than five patients fell into this category. Neither organization explicitly described having formal agreements with local EDs to coordinate care transitions when one of their patients is discharged after a suicide attempt.

³ Because of the data reporting timeframe, it is possible that the patients who were deemed to be at high risk for suicide and discharged from the emergency department agreed to participate in safety planning with staff at organization 2 after the grant year ended.

Figure 6. Patient Engagement, by Organization



Source: ZSI Year 2 Annual Progress Report
Time Frame: ZSI Grantee Year 2, April 1, 2023–March 31, 2024

Commitment to Engagement to Care

Most staff at both organizations have knowledge of the clinical pathway to care for individuals at risk for suicide. In the workforce survey, 93% of respondents across both organizations indicated that they were familiar with the clinical workflows related to things such as safety planning, access to lethal means, documentation, and other procedures involved in caring for individuals at elevated risk of suicide. Also, to ensure patients are receiving treatment in a timely and adequate manner, both organizations indicated in their Organizational Self-Study that they have protocols to engage all patients at risk of suicide in care management and safety planning. The Organizational Self-Study data also showed that across both organizations, all moderate- and high-risk AI/AN patients receive a collaboratively developed safety plan. Furthermore, both organizations described processes to provide care quickly and at a high level for patients with urgent mental health needs (e.g., connecting patients to crisis lines for afterhours mental health care).

Each organization takes a different approach in its safety plan design and implementation. One organization develops safety plans for all individuals at elevated risk of suicide; these plans included patient-identified risks and triggers, along with concrete coping strategies. In comparison, the other organization provides safety plans for individuals at elevated risk for suicide but does not offer formal guidance or a policy around the content required in the safety plan. According to the Organizational Self-Study, both organizations use the Stanley-Brown Safety Plan template as the foundation for their safety plan. However, one organization incorporated elements that acknowledge AI/AN traditions and revised the template to model it after the Medicine Wheel (NLM, n.d.).⁴ The other organization did not report any adaptations or revisions to the Stanley-Brown template.

Both organizations incorporate lethal means restriction into patient safety plans. At both organizations, all high-risk AI/AN patients receive counseling on restriction of lethal means. According to the APR, one organization added lethal means weapons assessment restriction to its behavioral health intake forms so that all behavioral health patients could be engaged in this type of assessment. One organization offers lethal means

⁴ The Medicine Wheel is an Indigenous symbol that numerous North American Tribes have adapted. It commonly represents the dimensions of health and cycles of life.

safety counseling for staff and the other organization added a requirement that all staff take CALM training in its third grant year.

Each organization has a different approach to caring for and tracking individuals at risk for suicide and developing its care management plan. One organization has a systematic approach to develop care management plans and engage individuals at risk for suicide in care. This organization has care management guidance specific to individuals at different levels of suicide risk; the guidance includes detail on the frequency of patient contact, types of care planning, and frequency of safety planning. Further, this organization has embedded all suicide care management components into its EHR. The other organization relies on staff discretion to determine what level of care management individuals at risk for suicide receive. At this organization, care management is documented as part of patient records, but not in a systematic way.

Organizations took different approaches to engage patients who have a high risk of suicide and do not show up for expected services. One organization reported having established protocols that aim to ensure all high-risk patients are actively engaged in care and follow-up. These protocols include outreach to the high-risk patients' emergency contacts until contact is made with them or they can confirm that the patient is safe. Additionally, staff at this organization create "caring cards with good medicine" to remind patients of missed appointments and encourage rescheduling. The other organization reported in its Organization Self-Study that it had no current guidelines specific to reaching high-risk patients who miss appointments, but indicated in its APR that it plans to implement Caring Contacts in the next fiscal year.

Strategies and Challenges to Engagement in Care

Both organizations reported many challenges to engaging individuals in care. Based on site visit interview data, these challenges include medical mistrust and stigma and misdirected referrals. For example, one organization highlighted that engagement in care is challenging because some high-risk patients refuse to have staff create a safety plan or refuse to engage in treatment because they mistrust mental health providers or the mental health and medical systems. Both organizations shared that some patients have been hesitant to be screened because they were uncertain about the care and treatment process that would result from the screening. One organization reported that some patients' needs for housing or other health-related social needs (e.g., transportation) were barriers to care because these needs were more pressing and were outside of staff's current training and expertise. Additionally, some patients did not engage in the ZSI program after screening positive for suicide risk because they preferred to continue receiving mental health care from their current provider.

Both organizations use numerous strategies and systems to support patients' engagement in care. At both organizations, staff noted that clear, documented workflows are important for ensuring consistent and effective implementation and engagement in care. Staff at one organization described having a full behavioral health team as helpful for informing the clinical care workflow. The other organization also described that being fully staffed was necessary for their staff to contact at-risk patients within 24 hours of their initial screening to engage them in a suicide prevention-specific clinical care pathway. This organization also created and displays a crisis flowchart in all departments across the organization; staff reported that they believe the flowchart supports appropriate internal referrals and reduces burden on ZSI program staff. According to the APR, both organizations shared that using practices informed by tradition, ensuring prompt and in-depth care, and having therapists with qualities that align with being non-judgmental, patient, persistent, and non-authoritative are successful strategies to engage patients in care.

As mentioned above, one organization saves and manages patient safety plans in its EHR. This process ensures that assessments can be done in the EHR, which ultimately streamlines referrals to and engagement in care. In contrast, the other organization cannot save safety plans in its EHR and instead relies on separate files scanned

into the EHR. As a result, providers at this organization cannot efficiently share patient safety plans internally or externally when patients transition their care to other providers or organizations.

Section 5: ZSI Treat Element

The Treat element intends to ensure that evidence-based practices are adopted for the treatment of individuals at risk for suicide. As part of the adaptation of ZSI to Native communities, it is important that these practices are informed by Native American tradition.

This section describes treatments that patients received under the ZSI grant. It also describes the types of evidence-based treatment practices that the organizations offer to individuals at risk for suicide and the types of evidence-based treatment practices in which staff at the organizations are trained. Last, this section describes how the organizations have adapted their treatment practices to be informed by tradition.

Figure 7 displays the percentage of high-risk AI/AN patients at each organization who received different types of treatment. At organization 1, 50% of high-risk AI/AN patients received clinical treatment and practices or activities informed by tradition and although they have staff dedicated to providing spiritual health or pastoral care services, the organization reported that no high-risk patients received these services during their second grant year. All high-risk AI/AN patients at organization 2 received clinical treatment, practices or activities informed by tradition, and spiritual health or pastoral care services. No patients at either organization were referred for inpatient psychiatric services.

Figure 7. Treatment of High-Risk AI/AN Patients, by Organization



Source: ZSI Year 2 Annual Progress Report
Timeframe: ZSI Grantee Year 2, April 1, 2023–March 31, 2024

Treatment Modalities Offered

Both organizations reported offering a variety of evidence-based treatment practices to individuals at risk for suicide. According to the APRs, both organizations offered Collaborative Assessment and Management (CAMS), Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP), and Dialectical Behavior Therapy (DBT); all of which are evidence-based treatments for people at risk of suicide.⁵

Organizations offered additional empirically supported treatment modalities to people at risk for suicide. In the Organizational Self-Study data, one organization highlighted offering attempted suicide survivor support groups to people chronically or continuously screening as high risk for suicide. According to the APR, other evidence-based treatment modalities offered by the organizations included person-centered therapy (PCT) and acceptance and commitment therapy (ACT).⁶

Staff from both organizations received training on how to refer patients at risk of suicide to evidence-based treatment. One organization indicated in its Organizational Self-Study that it trained staff on how to refer individuals at risk for suicide to evidence-based treatments. The training also included a review of the available community resources and referral options. Further, nearly all workforce survey respondents from both organizations who deliver clinical treatment to individuals who have been identified as being at elevated risk for suicide indicated that they felt comfortable and confident providing treatment to individuals with suicidal thoughts.

“ I think one of the biggest things is just knowing that as a whole, [ZSI is] not a cut and dry program. It's not a cookie cutter program, that [ZSI] really does have to be individualized for each person and it's going to be the most effective when we take the time to learn who that person is and where they're at. And instead of trying to put our agenda and, 'Okay, you're going to do this skills group and you're going to do'... [Instead, we can say] 'How can we help you? What makes you feel good? Tell me about a time where you were the happiest, what was going on, what people were in your life?' And really being able to just individualize the treatment I think has been my biggest lesson.

– ZSI grantee staff

Staff consistently stressed the importance of individualized treatment plans. Qualitative interviewees stated that a key to implementing ZSI effectively is recognizing that treatment needs to be individualized and tailored to each client's unique needs and circumstances, rather than as a one-size-fits-all approach. In this context, other treatment modalities, such as PCT, allow both organizations to provide individualized treatment for those at risk.

One organization described in its APR its protocol for supporting diverse client needs. At this organization, staff categorize patients into five groupings: recent attempts, current intent and plan, current plan, suicide-adjacent, and passive suicidal thoughts. [Table 3](#) shows the treatment approach associated with each category of patient.

⁵ These are evidence-based care modalities that are only evidence-based for populations with whom they have been tested.

⁶ Although the UIOs indicated that these treatments may be evidence-based, they have not all been evaluated as evidence-based for treatment of suicide among Native American patients and communities.

Table 3. One Organization’s Treatment Approaches for Different Patient Categories

Patient Categorization	Check-in Support	Safety Plans	Case Management	Skills Group	Bridge Therapy	UMHA
Recent suicide attempts	✓	✓	✓	✓	✓	✓
Current suicide intent and plan	✓	✓	-	-	✓	✓
Current suicide plan	✓	✓	✓	-	✓	✓
Assessed suicide risk and no plan	✓	✓	-	-	✓	✓
Passive suicidal thoughts	-	✓	-	✓	-	-

UMHA = Urgent Mental Health Assessment

Both organizations stressed the need to expand services and equip staff to provide treatment. In qualitative interviews, staff at both organizations indicated that they needed more treatment staff. At one organization, staff highlighted the importance of proactively working toward improving the accessibility and availability of psychiatric services in the community. Thus, the organization planned to increase the visiting psychiatrist’s availability from twice a month to four times a month. Additionally, this organization is considering hiring a specialized nurse practitioner to address pediatric psychiatric care and fill a crucial gap in its psychiatric services and care.

One organization indicated that treatment services were limited by physical space. At this organization, staff reported having to compete for physical space. For example, staff had to share offices, limiting the ability to conduct patient care because of the lack of confidentiality and privacy. At the same time, staff at this organization noted that the limited physical space also encouraged growth of alternative work environments such as rotating offices, working virtually, and spreading out across sites. These strategies helped increase the reach of the ZSI program.

Practices and Adaptations Informed by Native American Tradition

At both organizations, most staff highlighted the importance of incorporating traditional Native American practices into treatment for individuals at risk of suicide. In qualitative interviews, staff at both organizations noted that integrating traditional Native American practices into therapy significantly enhanced treatment impact because it demonstrated respect for patients and actively acknowledged their heritage as a core component of healing. This approach not only made the therapeutic experience of suicide prevention more meaningful and impactful but also fostered a sense of identity and empowerment, underscoring the therapeutic role of one’s heritage in mental health treatment.

Both organizations reported in the APRs continuing to use a diverse array of practices informed by Native American traditions as treatment and care for suicide risk. These practices included four sacred medicines, multigenerational healing through trauma, Pow Wows, Wellbriety, healing from historical trauma support circles, hand-drum making, talking circles, traditional drumming, smudging, prayer, wellness bags with traditional medicines, and sweat lodges. According to the APRs, on average 75% of high-risk patients across the two organizations received practices or activities informed by Native American traditions. At one organization, 100% of high-risk patients received spiritual health or pastoral care services. The other organization reported that none of its high-risk patients received spiritual health or pastoral care services.

During an interview, one staff member described how practices informed by traditions were incorporated into patient treatment.

“ And just coming into the building, she was like, ‘I already feel better. This feels good.’ And so then we made dream catchers 'cause she has trouble sleeping. So while making them, we're talking about different ways to kind of calm your body at night and get ready for sleep. And then going over what the dream catcher means in her tribe, what she knows about it.... And then she brought some beading in and then recently now like the last two sessions, she's just talking about all of her trauma.... she feels connected and now she feels safe and she talks about just being in the environment and connected with her [Native American background] is making her feel better. She hates when she has to miss a session 'cause she says it throws her off. So it's just been really cool to see that [these traditions do] heal.

– ZSI grantee staff

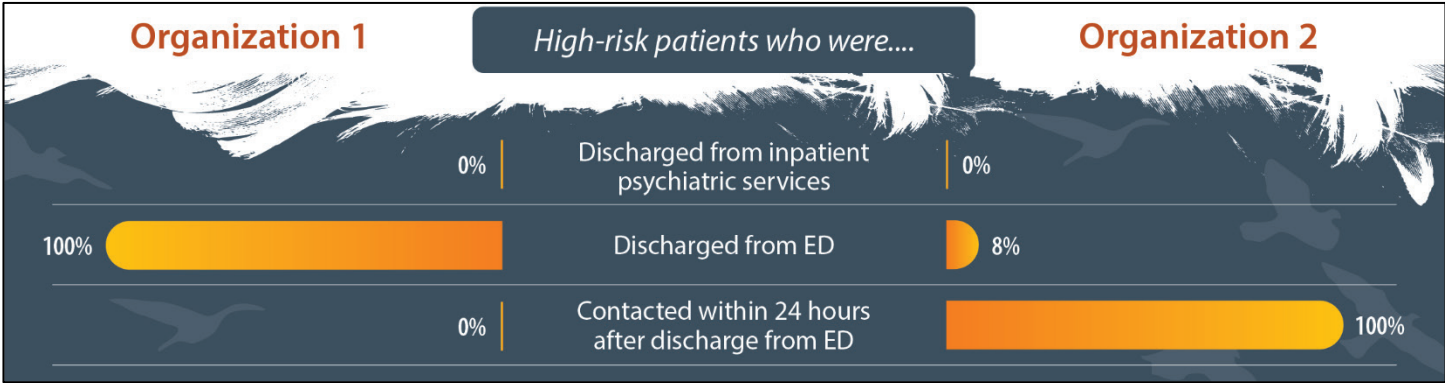
Section 6: ZSI Transition Element

The Transition element intends to ensure that providers conduct ongoing and continuous follow-up care for patients at risk for suicide, particularly those with emergency room visits, inpatient hospital stays, or missed appointments.

This section describes the protocols and procedures that each organization implemented to provide ongoing and continuous follow-up to individuals at risk of suicide and ends with an examination of provider experiences of working with individuals during their transitions in care.

Figure 8 shows that there were zero high-risk patients discharged from inpatient psychiatric services at both organizations. At organization 1, all high-risk patients ended up being discharged from the ED and 8% of high-risk patients at organization 2 were discharged from the ED during Grantee Year 2. Staff at organization 1 did not contact these high-risk patients within 24 hours of discharge from the ED whereas staff at organization 2 contacted all high-risk patients within 24 hours of discharge from the ED.

Figure 8. Transition of High-Risk AI/AN Patients, by Organization



Source: ZSI Year 2 Annual Progress Report
Timeframe: ZSI Grantee Year 2, April 1, 2023–March 31, 2024

Organizational Procedures for Ongoing and Continuous Follow-Up

Clinical staff across both organizations were generally familiar with organizational procedures for ensuring safe care transitions for high-risk individuals. Among workforce survey respondents responsible for ensuring safe care transitions for individuals who have been identified as being at elevated risk for suicide, 77% reported that they were familiar with the organizational procedures for working with individuals during care transitions. Additionally, 92% of those same workforce survey respondents shared that they are familiar with the organizational procedures for ensuring that an individual’s health information is shared during their transitions in care.

According to data from the Organizational Self-Study, one organization has a comprehensive policy of continuously following up with patients during their care transitions, while at the other organization, follow-up is based on staff judgment. Data from the APR expand on these processes; one organization reported that its staff contacts all high-risk patients discharged from the ED within 24 hours, while the other organization did not make contact with its high-risk patients who were discharged from the ED within 24 hours during the past year. During qualitative interviews, staff at the organization with follow-up based on staff judgment shared that their behavioral health clinicians follow up with patients within 48 hours to assess the individual’s safety and severity and to determine the appropriate course of action. This could explain why their organization indicated that they did not follow up within 24 hours with high-risk patients discharged from the ED. Additionally, one organization explicitly developed relationships with a local mental health hospital so that they will receive care management and care transition calls when a patient from the UIO is being discharged. However, neither organization explicitly highlighted having agreements with ED staff to coordinate care transition when one of their patients’ is discharged.

Organizations took different approaches for engaging hard-to-reach individuals or at-risk individuals who missed appointments. According to the Organizational Self-Study, one organization indicated that it does not have specific guidelines or processes for reaching out to individuals with an elevated suicide risk who miss scheduled appointments. The other organization highlighted that its organizational protocols aim to address follow-up after no-shows, which includes conducting active outreach through phone calls to the individual followed by calls to family members until contact has been made and the individual’s safety is ascertained. Data (not reported) from the APR showed that more high-risk AI/AN patients who received a follow-up contact within 48 hours of a missed appointment at the organization that had specific protocols on how to conduct follow-ups after no-shows. However, the APR did not capture the number of high-risk patients who missed

appointments. As such, these data are not conclusive to determine whether these policies were associated with a higher or lower percentage of patients with missed appointments with follow-up contact. More information will need to be collected in future APRs to better understand the impact of having more robust policies in place around following up with high-risk patients who miss appointments.

Provider Experiences Working with Individuals During Their Transitions in Care

Most workforce survey respondents responsible for ensuring safe care transitions reported that they have confidence in their ability to work with individuals during their transitions in care. During qualitative interviews, staff shared their experiences with transitioning patients to higher- or lower-intensity care. When transitioning patients to higher-intensity care, staff at one organization shared that if patients had acute or severe risk levels, they had to be involuntarily committed to care due to mandatory reporting requirements. However, it is likely that these incidents were rare, as one staff interviewee described having no recollection of engaging first responders while transitioning patients to higher-intensity care. The other organization shared that it worked with local crisis lines to get afterhours support for patients. This relationship with the crisis lines allowed staff to support at-risk individuals 24 hours a day. When transitioning patients to lower-intensity care, one organization described that some patients disengaged from care as their risk of suicide lowered. One staff member shared, *“And lately, recently there's been multiple clients who are shifting off that radar that don't need to be, you know, they're not high risk anymore. Now they're down to moderate risk. They're living life.”*

Most workforce survey respondents responsible for ensuring safe care transitions reported that they have the knowledge, skills, and humility to work with Native American individuals and families during their transitions in care. Nearly all workforce survey respondents indicated that they have confidence in their ability to work with family members or other support persons who may be involved during a Native American patient’s transitions in care.

Section 7: ZSI Improve Element

The Improve element intends to ensure that projects engage in data-driven, continuous quality improvement activities, covering all the previous six ZSI elements.

This section explores how the organizations use systems and conduct quality improvement activities. It also looks at any perceived patient-level impacts on suicide ideation or suicide attempts.

Table 4 shows that neither organization reported a death by suicide among their AI/AN patients in the past year. At organization 1, patients who attempted suicide did so an average of one time, and at organization 2, patients who attempted suicide did so slightly more than one time (1.36 times), according to the APR. Across the organizations, these suicide attempts occurred in a small fraction of the total number of AI/AN patients seen by the organizations (< 1%). Although this absence of death by suicide among AI/AN patients is encouraging, ongoing monitoring and evaluation are necessary to assess the long-term impact of the ZSI model.

Table 4. Suicide-Related Activity by Organization

Suicide-Related Activities	Organization 1	Organization 2
Death by suicide among all AI/AN patients	0%	0%
Average number of suicide attempts among all AI/AN patients who attempted suicide	1.00	1.36
AI/AN patients who attempted suicide	n=2 (0.40%)	n=25 (1.00%)

Tracking Suicide-Related Activity

Although staff at both organizations named EHRs as important to ZSI implementation, they also highlighted limitations of their EHR systems. Both organizations use an EHR system to track suicide-related activity and have an internal process for reviewing suicide prevention efforts. In interviews, staff at one organization mentioned that data collection continues to be an issue because they have an antiquated EHR system, which is a significant limiting factor for completing quality improvement activities. As a result, leadership at this organization informally review suicide prevention and intervention services; these services are documented at the discretion of individual staff members. Staff at this organization describe the review as a process that is not systematic and makes it difficult to conduct quality reviews of suicide services. This organization has plans to switch to a newer EHR system within the next two years.

“

It's always on paper for now because there are limitations to our EHR, it's from 1963. Very, very old. I think it was, literally, a military EHR....

– ZSI grantee staff

According to the Organizational Self-Study, one organization has suicide care partially embedded in the patients’ EHR. However, some departments use a different EHR system, making it difficult to access and track data needed to reevaluate screening conducted during medical and dental appointments. Despite these challenges, staff at this organization highlighted that they use the EHR to complete Improve-related activities. The organization has a data management specialist who provides monthly reports to help track quality-related data. Data from suicide care management plans are examined for fidelity to organizational policies and discussed by a team. This organization has specific internal approaches to measuring and reporting on all patient deaths by suicide for those who were deemed at risk for suicide as much as 30 days prior to their death. Deaths are confirmed through coroner or medical examiner reports and data are routinely examined to look for trends and to make changes to policies.

Using Continuous Quality Improvement

Both organizations conducted some form of quality improvement activity, such as creating a quality improvement team, developing a quality improvement or intervention fidelity plan, or conducting intervention evaluations. According to the APR, both organizations reported having an active quality improvement team to guide the collection, reporting, and analysis of data and to help develop an evaluation plan for ZSI project activities. Only one organization indicated that it has an established suicide data surveillance

plan to collect, monitor, analyze and use data to inform suicide care activities. The other organization indicated that its quality improvement activities focus on making improvements to its patient satisfaction surveys and programming evaluations that integrate Native American traditions. These efforts aim to gather feedback from patients and community members to ensure that the organization's services are responsive to the traditions and needs of the AI/AN population.

Staff at one organization perceived improvements in client function, stability, and reductions in suicide risk because of ZSI, according to qualitative interviews. ZSI has allowed this organization to fund staff who conduct patient case management, which allows other staff to work with patients to identify and address their social needs. This case management and the ability to address social needs (e.g., through temporary housing) contributes to patients' reduced suicide risk. This theme did not emerge during staff interviews at the other organization so a comparison is not feasible with the current data.

“

It seemed like every month it was like somebody came in, they were really hopeless.... We were able to help them in a very practical way as well as providing the services...it could be helping them find a place to store their items while they move...or [helping them afford to stay] in a hotel until they can get this new housing, and then they end up getting that part of life stabilized, and then the suicide risk goes down and they stay connected with us.... It seemed like the smallest thing to somebody, but to that person, that was that one leap they needed. So we were like a buoy, I guess, to folks.

– ZSI grantee staff

Conclusion

During their first two years of grant funding, both UIOs made significant progress on all seven ZSI elements. No deaths by suicide were reported among their patient populations, which indicates that ZSI may be having its intended impact.

UIOs Implemented Some ZSI Elements Similarly

Each organization had high fidelity to the **Lead element** and had protocols and activities related to the patient identification and engagement that demonstrate relative fidelity to ZSI. Furthermore, staff at both organizations noted that strong leadership and management was critical to their implementation progress and emphasized the importance of intra-organizational communication. Both organizations received some input and guidance from the Native American communities served to help adapt interventions and programming as part of their implementation. This engagement—coupled with external partnerships—increased the UIOs' referral streams and ability to connect patients to alternative means of assistance (e.g., via local crisis lines). Both organizations also recognized the importance of incorporating traditional Native American practices into treatment for individuals at risk of suicide and shared examples of doing so throughout patient treatment and even as part of follow-up care.

Both organizations reported near-universal screening of patients, which was a critical component of the **Identify element**. At the same time, staff at one organization reported that they and their patients have been experiencing

fatigue because of over-screening. As a result, both organizations experienced staff turnover, which impacted the implementation of all ZSI elements.

Staff at both organizations consistently stressed the importance of individualized treatment plans as part of the **Treat element**. Further, qualitative interviewees stated that a key to implementing ZSI effectively—particularly in Native American communities—is recognizing that treatment needs to be individualized and tailored to each client’s unique needs and circumstances, rather than taking a one-size-fits-all approach. As a result, staff at both organizations shared examples of how they incorporate traditional Native American practices into treatment for patients at risk of suicide and even as part of follow-up care.

Some Differences in ZSI Implementation Emerged for Other Elements

For the **Lead element**, the leadership teams at both organizations included staff with similar roles and positions; however, each organization adopted a different leadership approach and offered a different amount of authority to their leadership teams.

For the **Train element**, nearly all staff reported being trained to use screening and assessment instruments and all behavioral health staff at both organizations were trained in evidence-based treatment of suicide. However, the organizations diverged in who was trained; one organization required training for all staff and the other organization trained staff based on their responsibilities and role. In turn, the universal staff training approach appears to be associated with fewer training gaps and, conversely, targeted training leaves some staff with inadequate knowledge to provide holistic suicide intervention and treatment. Last, provider training gaps also emerged as part of the **Engage element**: some patients with high suicide risk refused to work with staff to create a safety plan or engage in treatment because of mistrust of the health system or uncertainty about the care that they would receive.

As part of the **Engage element**, both organizations used the Stanley-Brown template as the basis for their safety plans. One organization adapted this template to include elements of Native American traditions; this has resulted in a more comprehensive template that is coupled with formal guidance to help staff to complete the plan with at-risk individuals. The other organization uses the Stanley-Brown template but offers staff less guidance around the content of the safety plan. The two UIOs also differed in their approaches for developing care management plans. One organization has a systematic approach to develop care management plans and engage individuals at risk for suicide in care that has been integrated into its EHR. In contrast, the other organization relies on staff discretion for care development and management and cannot not save the safety plan in its EHR, relying instead on scanned versions of the plan saved as a separate file.

For the **Transition element**, one organization has a comprehensive policy of continuously following up with patients during their care transitions, while at the other organization, follow-up is based on staff judgment. Each organization also takes different approaches to engage hard-to-reach individuals or those who are at risk and do not show up for appointments.

Last, for the **Improve element**, both organizations conducted some form of quality improvement; however, EHR functionality impacted each organization’s ability to track suicide-related activities—a key dimension of quality improvement—with only one organization being able to track suicide care management records in its EHR.

Across ZSI Elements, UIOs Faced Implementation Facilitators and Challenges

During the second year of the grant, both UIOs faced challenges implementing the ZSI model. In some instances, these challenges were overcome and in others they delayed grantees’ implementation progress. At the

same time, some challenges, once addressed, turned into facilitators that strengthened ZSI implementation and promoted progress.

Strong leadership and management were facilitators. Both organizations noted that strong leadership and management was critical to their implementation progress and emphasized the importance of leadership to foster intra-organizational communication. Further, across the two UIOs, ZSI and UIO leadership played different roles. At one organization, ZSI leadership offered formal guidance on how to complete safety plans, developed systematic approaches to create patient care management plans, and instituted a policy for continuous patient follow-up. At the other organization, such guidance, approaches, and policies were either informal or did not exist. This difference in leadership resulted in variation in the care and treatment provided at the UIOs, with one organization having more formal and consistent protocols and the other having an approach that varied by staff member. Notably, leadership at neither organization has yet developed a policy for how to support staff whose patients have died by suicide, which staff have indicated would be beneficial.

Staff turnover was a prominent challenge that impacted UIO progress implementing ZSI elements. Staff at both organizations reported past challenges with frequent leadership changes; currently, leadership positions at both organizations have stabilized, which has created consistent perspectives on and communication about ZSI. Staff screening and assessment fatigue from near-universal screening of patients along with staff challenges related to juggling their ZSI role and other organizational priorities contributed to staff burnout and slowed ZSI implementation in some instances.

External partnerships were both a facilitator and a challenge for the UIOs. Staff at one organization identified early and intensive engagement with external partners as a facilitator. These staff described external partnerships as a helpful referral stream. Further, the ZSI model includes a CAB as a prominent component of the Lead element. Although both UIOs had CABs, neither included external partners and included only internal staff and ZSI program champions.

Some patients' perceptions of care impeded their engagement in it. Staff at both organizations faced challenges with patients who were hesitant to engage in the clinical pathway to care. For example, some high-risk patients at one organization refused to have staff create a safety plan or to engage in treatment because they mistrust mental health providers or the mental health and medical systems. Both organizations shared that some patients have been hesitant to be screened because they were uncertain about the care and treatment process that would result from the screening. Further, it is important to highlight that both organizations are trying to engage AI/AN individuals at risk of suicide in care. Staff recognize the important role they play and shared ways that both organizations integrate patients' heritage into the approaches, care, and treatment that they provide AI/AN individuals. However, staff also indicated in workforce survey responses that they could use more training on the customs of the Tribes served by their organizations.

EHR capacity impeded both organizations' ability to consistently track patient care, with one organization unable to do so because of its antiquated system and the other because the different departments within the organization use different EHR systems, making information sharing and access challenging.

Next Steps

As the ZSICC prepares for its Year 2 evaluation report, RTI is aware that the organizations' ZSI implementation are not analogous or homogeneous processes. Instead, the differences—and even the challenges—may lead to facilitators of successful implementation and may also create differences in patient outcomes and process measures. **The Year 2 evaluation report aims to examine the impact of the ZS model on patient outcomes and use organizational nuances to try to explain differences in outcomes.**

Roadmap for the Year 2 Evaluation

The evaluation team has planned a series of activities in Year 2 that will result in the first ZSICC evaluation report. The first evaluation report will shift focus from implementation processes and progress and begin to examine the impacts ZSI has had on key outcomes. These include proximal outcomes, which reflect the intermediate goals of ZSI (such as whether ZSI has led to changes in suicide risk screening rates), and distal outcomes, which reflect the long-term goals of ZSI, such as whether ZSI has led to reductions in deaths by suicide within the communities served by the UIOs. The sections below describe the focus of the first evaluation report and outline the steps the evaluation team will take to create it.

Evaluation Report

The evaluation report will provide cross-site findings focused on observed impacts and understanding the implementation process and strategies that may have caused those impacts. In addition to answering the evaluation questions posed in this monitoring report (see [Purpose](#) section), the evaluation report will also address the following evaluation questions identified in the national evaluation plan:

- 1. What was the impact of strategies used to implement ZSI on implementation outcomes?
- 2. What impacts did ZSI have on proximal and distal outcomes, such as uptake of screenings for suicide, and community-level suicide rates?

In August 2024, RTI will review the ZSI National Evaluation Plan with IHS to confirm the purpose and direction for the evaluation report. For the remainder of Year 2, RTI will coordinate the cross-site evaluation with the UIOs.

Annual Data Collection

To address the key evaluation questions identified for the evaluation report, the evaluation team will collect primary and secondary data focused on six topic areas:

- 1. Implementation context
- 2. Implementation of ZSI elements and adaptations made
- 3. Strategies used to implement ZSI
- 4. Community engagement and partnerships
- 5. Proximal outcomes
- 6. Distal outcomes

[Table 5](#) details the primary and secondary data sources the evaluation team will collect and analyze, as well as the timeline for acquiring the data.

Table 5. Year 2 Evaluation Data Sources and Timeline

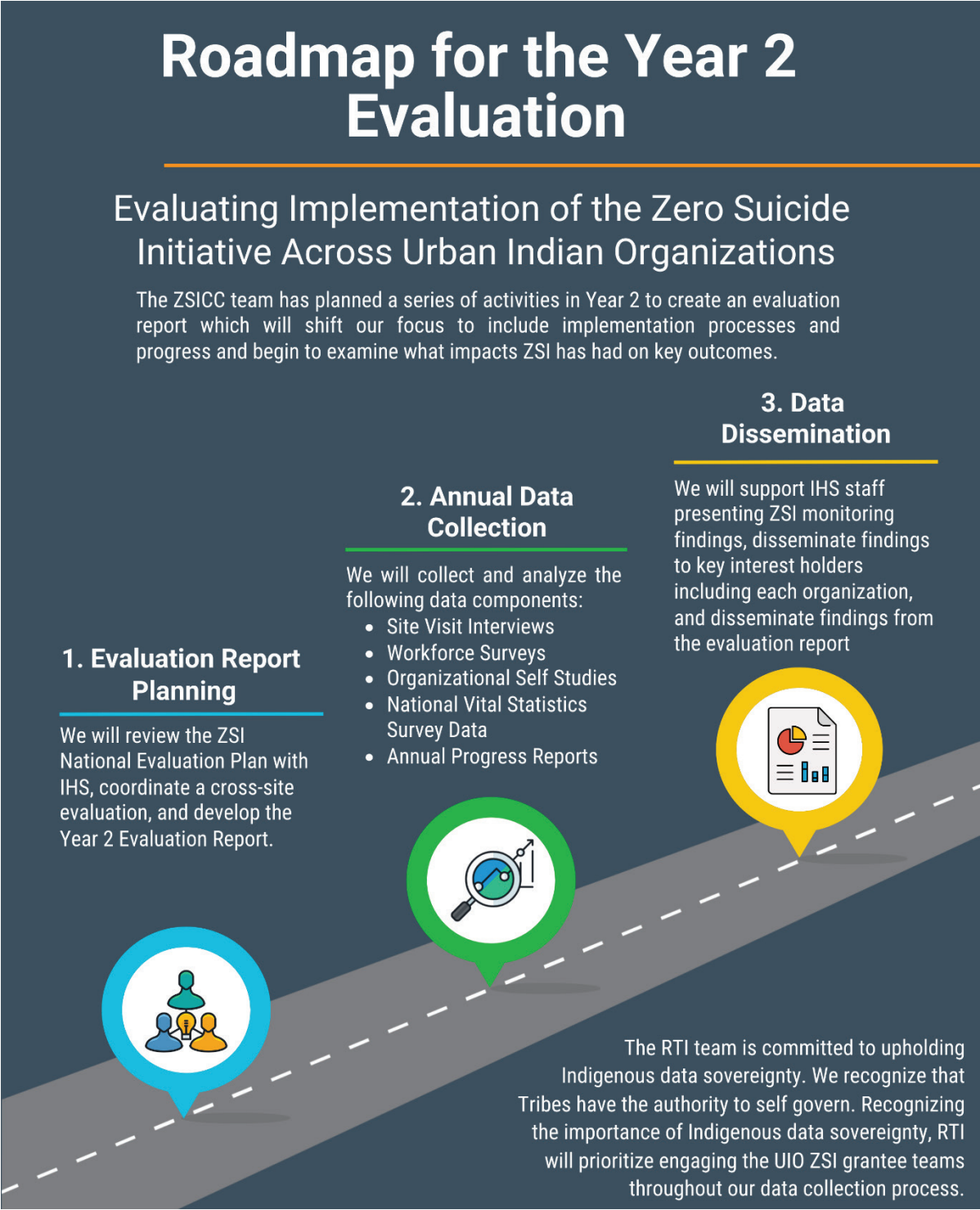
Data Source	Timeline
Site Visit Interviews	By November 2024
Annual Progress Reports	By May 2025
Workforce Surveys	Obtain by January 2025
Organizational Self-Study Surveys	Obtain by January 2025
National Vital Statistics Survey Data	Obtain by beginning of April 2025

Data Dissemination

Starting in August 2024, the evaluation team will support IHS staff in presenting ZSI Year 1 monitoring report findings at relevant meetings or conferences. The goal of this presentation and others like it is to offer a baseline perspective of the ZSI and the grantee's organizations. RTI will also disseminate a one-page overview of UIO findings to each grantee organization that summarizes each organization's ZSI implementation progress and processes and early lessons learned. The evaluation team will also communicate its findings with key stakeholders working on suicide prevention in Tribal communities.

In Year 2 (starting June 2025), RTI will also create slides and talking points to summarize the evaluation report and disseminate findings among similar audiences as the Year 1 monitoring report. [Figure 9](#) provides an overview of RTI's plan to create an Evaluation Report in Year 2.

Figure 9. Roadmap for the Year 2 Evaluation



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Appendix A: Urban Indian Organization Engagement Throughout the Data Collection Process

As the Zero Suicide Initiative Coordinating Center (ZSICC), RTI upholds the following principles throughout its data collection and evaluation approach.

1. Upholding Indigenous data sovereignty.
2. Centering data collection efforts on the ZSI grantee teams.
3. Ensuring meaningful data collection.

This evaluation began with conducting introductory calls with each of the Urban Indian Organization (UIO) grantees. The purpose of these calls was to introduce the team, obtain UIO insights into the data the team hoped to include in the evaluation, and understand the data that the UIOs were currently collecting related to ZSI. The team also shared its commitment to follow the principles for data collection and management grounded in Native American history and traditional practices. The evaluation team discussed its recognition of Tribal authority to self-govern, including oversight of research regulations within their territories and related to Indigenous people. Furthermore, the team shared its plan to be good stewards of the data through secure data storage, which includes keeping all data on HIPAA-secure servers that only the project team can access. Further, secondary data, such as all-county mortality restricted data acquired from the National Vital Statistics System, were safeguarded in a password protected folder to which only a subset of the team has access.

Also, the evaluation team discussed preferred methods and tools for obtaining any UIO data and stressed the importance that the data it collects align with the Ownership, Control, Access, and Possession (OCAP) principles. For example, the team shared its plan to collect annual progress data by using Research Electronic Data Capture (REDCap), a HIPAA-secure web-based data collection instrument. It also inquired about UIO concerns about using REDCap or sharing annual progress data. The UIOs did not express any concerns about using REDCap or sharing this information. Last, the team discussed primary data collection, which includes collecting annual progress report data, conducting one-on-one interviews with leadership and implementation staff at each site, and engaging providers and frontline staff at each site in focus group discussions.

Following the introductory calls, the data manager liaised with the two grantees to create data maps to ensure that the team obtained and collected data from the UIO ZSI grantees in a way that fostered awareness and collaboration. RTI sought to obtain useful data from the sites through the least burdensome approaches, such as obtaining documents from the Indian Health Service (IHS) or working with a designated point of contact for data coordination at each site.

In addition to the introductory calls, the evaluation team sought a collaborative and engaged approach to qualitative data collection. In preparation for the interviews with ZSI staff, the team engaged the UIOs to collect feedback (including suggested wording changes) on the interview guides. One-hour feedback sessions were conducted with key ZSI leaders at each organization. During these sessions, the team reviewed the draft semi-structured interview guide to ensure the protocol questions were clear and assess the staff's level of comfort answering them. UIO staff were encouraged to offer suggestions for improvement and feedback, which were used to revise the interview guides. Last, the evaluation team shared with the ZSI leadership at each organization the types of staff (e.g., medical providers or staff who are in patient-facing roles) it wanted to engage in qualitative interviews. Based on this guidance, ZSI leadership provided a list of staff and their contact information so that the team could schedule interviews in a private and confidential manner. [Appendix Table 1](#) outlines the steps the team took to engage the UIOs in the qualitative interview process.

Appendix Table 1. UIO Engagement Process in the Qualitative Interview Guide Development

Engagement and Feedback Process	Timeframe
Developed a list of interview topics based on the ZSI Model and the ZSICC evaluation plan; incorporated IHS feedback.	January 2024
Drafted interview guides based on identified topics.	Early February 2024
Held 1-hour feedback sessions on the interview guides with ZSI leadership at both UIO organizations.	Late February 2024
Revised the interview guides based on UIO feedback and shared them with IHS for feedback and approval.	Early March 2024

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