

Zero Suicide Initiative Coordinating Center (ZSICC) Evaluation Report

2024–2025



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Executive Summary

Introduction

The Indian Health Service (IHS) has supported multiple rounds of Zero Suicide Initiative (ZSI) grants over the past decade. The purpose of these grants is to address the alarming trends in death by suicide in American Indian/Alaska Native (AI/AN) communities (Leavitt et al., 2018). In 2022, IHS awarded grants to eight organizations, including six Tribally managed health and behavioral health facilities and two Urban Indian Organizations (UIOs). RTI is conducting a cross-site evaluation of the two UIOs: the American Indian Health Service of Chicago (AIHS-C), Inc. and Native American Rehabilitation Association of the Northwest (NARA NW). In this evaluation report, RTI provides data on the UIOs' implementation outcomes. This evaluation report examines the grantees' first three years of implementation (grant years 1 to 3). All findings have been anonymized to emphasize the broader themes across the two organizations and to align with agreements made between the evaluation team and the UIOs.

Overview of Key Findings

ZSI Lead Element

- In the Year 1 Monitoring Report, we found that both organizations had challenges retaining staff members and that this contributed to some staff experiencing burnout.
- The leadership teams at both organizations have bolstered their support for staff to help address and prevent burnout.
 - One key step to addressing and preventing burnout is to ensure that enough staff are available to meet the needs of patients. Understaffed teams require members to wear many hats, which can lead to a cycle of increased turnover and continued burnout. One organization has begun to take steps to increase staffing, while the other has focused on “rightsizing” its program based on the capacity of existing staff.
 - Both organizations have adopted several strategies to support staff wellbeing, including offering mental health days, remote work and flexible schedules, and team bonding activities.
 - Despite these steps, some staff still report that they are frustrated with the speed at which new staff are being hired and continued to feel understaffed.
- Both organizations have developed approaches for ensuring open lines of communication between staff within and across departments.
 - There may be some room for improvement, however, as some staff have reported possible confusion around suicide prevention roles and responsibilities for staff outside of the core ZSI team.
- One organization has begun transitioning to a new electronic health record (EHR) system; leadership has played a crucial role in coordinating this transition. The other organization is considering a new EHR. Some departments at this organization use different EHRs, making information sharing a challenge.
- At both organizations, leadership continues to work with external partners and to develop community engagement, which has been helpful in implementing ZSI.

ZSI Train Element

- Staff at both organizations have been trained to screen, assess, and treat patients for suicide risk.
- Each organization continues to take a different approach to training.
 - One organization trains all staff—including part-time and temporary staff—on culturally informed practices and activities and how to screen and assess suicide risk. This approach aims to raise awareness across the organization about suicide and how to prevent it.
 - The other organization trains staff based on their roles and responsibilities. Thus, only behavioral health staff are trained in suicide risk screening, assessment, and culturally informed practices and

activities.

- Despite significant progress in training the workforce, there are some gaps in knowledge and experience across both organizations.
 - Although most staff at one organization can assess suicide risk, there is some confusion as to how to engage patients into care when they are identified as being at risk.
 - Similarly, although staff are confident in their ability to conduct suicide risk assessments, they are less confident about identifying early warning signs outside of formal screening and assessment.
 - There may be some gaps in training around best practices for safety planning and related suicide prevention approaches.
 - Staff report a need for more training to help them understand the traditions of the specific Tribes the UIOs serve.

ZSI Clinical Pathway to Care (Identify, Engage, Treat, and Transition)

- Both organizations have adapted screening tools, assessment approaches, and treatment to the traditions of the Native American Tribes they serve.
 - This includes making screenings more conversational, adapting evidence-based practices, and using a mix of traditional and Western practices to provide care for patients at risk for suicide.
- Although trained to screen, assess, and treat patients for suicide risk, staff outside of the behavioral health team at one organization described feeling less comfortable screening patients for suicide risk and with the topic of suicide in general.
- Both organizations have implemented approaches for following up with patients who miss appointments. Data show that this practice has been effective.
- At one organization, there have been some challenges transitioning patients out of ZSI programming and back to therapists who were previously treating them.

ZSI Improve Element

- Data continue to show no deaths by suicide among AI/AN patients served at either UIO.
 - One organization has seen an increase in the average number of suicide attempts due to one high-risk patient.
- To support continuous quality improvement, both organizations have established quality improvement teams.
- Both organizations have also developed evaluation plans for ongoing progress monitoring of ZSI implementation.
- One organization has developed additional tools for tracking suicide-related activity.
- One organization is experiencing staff transitions, which have caused remaining staff to temporarily deprioritize quality improvement activities. They plan to restart these activities once the workforce has returned to its original size.

ZSI Sustainability

- The grantees are in the beginning stages of planning for how to sustain their ZSI programs.
- Both organizations reported that they had made significant progress toward planning to sustain most ZSI program components.
 - Grantees have identified the train-the-trainer strategy as a key sustainability approach to ensure that new staff are quickly and efficiently trained and equipped for suicide prevention.
- Both organizations reported that diverse funding streams will be critical to their ongoing work in suicide prevention after grant period of performance ends.

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 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). In 2021, individuals from AI/AN communities were 1.5 times more likely to die by suicide than their non-Hispanic white counterparts (Murphy et al., 2024).

This report provides data on the Zero Suicide Initiative (ZSI) implementation status for the two Urban Indian Organizations (UIOs) that were awarded ZSI grants in 2022. Data cover the first 3 funded years of the UIOs' ZSI projects (April 1, 2022–March 31, 2025). The goal of this report is to provide data to demonstrate how implementing the seven ZSI elements affected key implementation outcomes for each UIO.

This report addresses the following evaluation questions, which are outlined in the ZSI national evaluation plan:

1. How were the ZSI elements adapted over time?
2. What factors influenced implementation processes and progress? What were the implementation challenges? What were the implementation factors or supportive factors? Which factors supported ZSI adoption and sustainability?
3. What were the factors internal and external to the UIOs that influenced how ZSI was implemented by each site?
4. What was the impact of strategies used to implement ZSI on implementation outcomes?

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 these 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. The clinical pathway to care relies on an approach of screening to identify patients' needs, connecting patients to care, and providing evidence-based treatments and transition support. RTI has included sustainability at the center of the ZSI framework—this component entails maintaining programming and its benefits over time. Although not part of the formal ZSI model, sustainability is a critical component for the IHS-funded ZSI grantees to work on and to ensure that suicide prevention efforts are maintained beyond the grant timeframe.

Evaluation Approach

RTI's cross-site evaluation of the UIOs is grounded in Native American history and practices and draws on multiple primary and secondary data sources. RTI's data collection and evaluation approach abides by three key principles of data collection and management:

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

RTI is also 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. Given this, 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 only the most relevant and useful data from UIOs 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 anonymized to emphasize broader themes and align with the evaluation team’s agreements with the UIOs to present their data in a confidential manner. Each UIO will also receive a summary report with its data non-anonymized so staff can use it to inform ZSI implementation.

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

Table 1. Evaluation Report Data Sources

Data Source	Details	Data Timeframe (Grantee Years)
Qualitative staff interviews and provider 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, 2024 to March 2025 (Grantee Year 3)
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 REDCap, a HIPAA-compliant, secure online platform. This report includes data and trends from all three years of Grantee Annual Progress Reports.	March 31, 2022 to April 1, 2025 (Grantee Years 1, 2, 3)
National Vital Statistics System 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.	2020 to 2023 (2 years pre-grant and Grantee Years 1 and 2)
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.	2024 (Grantee Year 3)

CDC= U.S. Centers for Disease Control and Prevention; EDC = Education Development Corporation; REDCap = Research Electronic Data Capture

Primary Data Collection and Analysis

Site Visits

To obtain 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. The UIOs selected relevant staff at each organization—including key ZSI leaders—to participate. The team conducted eight one-on-one semi-structured interviews, each lasting approximately an hour, to understand key barriers, 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. The evaluation team also 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 in November 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) collects quantitative and qualitative information about implementation progress on each of the seven ZSI elements during the previous grant year. Questions are tailored to each grantee and based on their previous year's APR. Also, the Year 3 APR included a new section that examines grantees' progress with sustainability planning. Our team used an adapted version of the Program Assessment Sustainability Tool (PSAT) in which grantees rated their sustainability planning progress on a scale of 1 to 7 with 7 being the highest extent (Schell, et al, 2013). In addition, grantees were asked to explain their rating and what their sustainability planning entailed.

The Year 3 APR was administered in April 2025 through REDCap, a secure online platform. This evaluation includes APR data from Grantee Years 1, 2 and 3.

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 2020 to 2023 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. To best approximate the catchment area or communities served by the two UIOs, RTI mapped counties in the NVSS data to HRRs (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 respective organizations' HRR catchment areas for calendar years 2020 through 2023.

Workforce Survey

The UIOs administered the surveys using the ZSI Workforce Survey developed by Education Development Corporation. Across both organizations, 38 staff responded to the Workforce Survey. In total, nine staff responded to the April 2024 Workforce Survey at one organization and 29 staff responded to the winter 2025 (fielded between January and March 2025) Workforce Surveys fielded by the other UIO.

Workforce Survey responses were analyzed using Excel. 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.

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, we obtained a more comprehensive, accurate, and culturally sensitive perspective on suicide prevention efforts. This multifaceted approach offers invaluable insights for shaping future strategies and initiatives and—potentially—contributing to the enhancement of grantees’ ZSI implementation.

Methodological Limitations

This report does not include Organizational w data, which offer an organizational assessment of ZSI implementation. Neither organization completed an Organizational Self-study in 2024 or 2025 and we did not believe these data that were more than 2 years old would be helpful. Also, because the UIOs administered the Workforce Surveys, RTI did not assist in standardizing the staff sampling or data collection across the two UIOs. Thus, the team has used other data to triangulate the points highlighted through the Workforce Survey data.

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. AIHS-C provides services 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; HIV testing and prevention; and community outreach. AIHS-C has 14 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 Illinois. Because approximately 53% of Illinois’ AI/AN population live outside of AIHS-C’s health hospital region (HRR),¹ AIHS-C uses telehealth services to extend its reach—highlighting the importance of telehealth to expand access to care for AI/AN populations. 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 who live in the Northwest, representing over 300 Tribes. NARA NW has 429 staff, 204 of whom work directly with patients across 11 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 also supported by the 4-in-1 grant program at IHS. NARA NW adopts a collaborative and strengths-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 the more than 1,900 Native people it serves 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. Notably, 86% of Oregon’s AI/AN population resides within NARA NW’s HRR, highlighting its critical role in delivering culturally responsive services.

UIO Service Reach in HRRs

As part of this evaluation, we examined the service reach of the UIOs by calculating the proportion of the AI/AN population residing within each UIO’s HRR that was served during Year 2 of the ZSI grant. The AIHS-C HRR includes Cook County, Illinois, while the NARA-NW HRR includes several counties along the Oregon-Washington border. Data show that AIHS-C served 1% of its HRR’s AI/AN population and NARA NW served approximately 2% of its HRR’s AI/AN population. Although both organizations serve a large community of AI/AN individuals, these data show that only a small percentage of AI/AN individuals who live in their

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).

catchment areas are routinely being seen. This suggests that the UIOs may have limited ability to affect death by suicide trends.

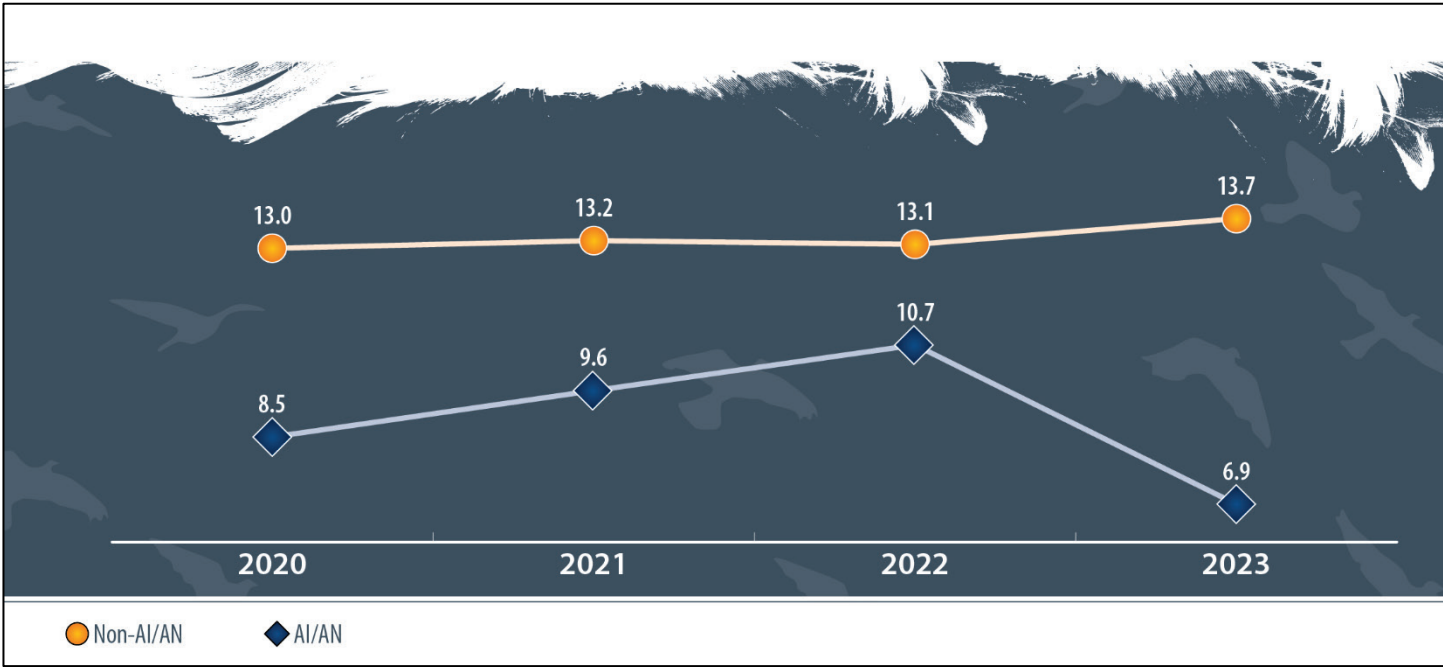
Trends in Suicide Mortality Rates: 2020 to 2023

Between 2020 and 2023, suicide mortality rates among AI/AN individuals within the HRRs served by AIHS-C and NARA NW demonstrated both fluctuation and an overall downward trend, though the trend was not statistically significant. In contrast, suicide rates among the non-AI/AN population remained relatively stable during the same period (Figure 2).

In 2020, the average suicide rate across HRRs was 8.5 per 100,000 AI/AN individuals. This rate increased in subsequent years, reaching 9.6 per 100,000 in 2021 and 10.7 in 2022, demonstrating a 26% increase over the 3-year span. However, by 2023 the average suicide rate among AI/AN individuals declined significantly to 6.9 per 100,000—a 36% decrease from the 2022 peak point.

We observed additional regional differences between 2020 and 2023. NARA NW continued to report more suicide deaths among its HRR’s AI/AN population than AIHS-C. This might reflect differences in the HRRs’ respective AI/AN population sizes, given that NARA NW’s HRR had a bigger AI/AN population from 2020 through 2023. Notably, in 2023, there were no reported deaths in AIHS-C’s HRR.

Figure 2. Average Rates of Death by Suicide of AI/AN and Non-AI/AN Individuals per 100,000 Persons within the Two HRRs, 2020–2023



Note. Data were pooled across the hospital referral regions for the two urban Indian organizations. For privacy reasons, we cannot report these data at a disaggregate level.

Findings

ZSI Lead Element



This section provides data on the UIOs’ progress on Lead activities. In Year 3, the ZSI leadership teams at both organizations continued ZSI implementation via a diverse set of tasks. Both organizations also provided a great deal of support to staff to prevent and address burnout, a major issue raised in Year 2. Leadership also reviewed policies, coordinated adoption of new electronic health record (EHR) systems, sought external guidance on program implementation, and continued to engage external partners.

Table 2 shows that both organizations continued to have relatively high fidelity to the Lead element and implemented most required activities in Year 3. Although only Organization 1 had a community advisory board (CAB) comprising members from outside the organization, both organizations solicited guidance and oversight from their communities and people with lived experience, which is also a key component of the Lead element. The Organizational Self-study, last completed in Year 2, was not required in Year 3. Although both organizations have a workplan, only Organization 1 updated it in Year 3.

Table 2. Execution of Key Lead Activities in Year 3

Key Activity	Organization 1	Organization 2
Establish local ZSI team	✓	✓
Develop local-level policies and procedures	✓	✓
Establish CAB	✓	-
Conduct Organizational Self-study	N/A	N/A
Develop ZSI implementation workplan	✓	✓

N/A = Not Applicable; - = Not Implemented
Source: ZSI Year 3 Annual Progress Report
Timeframe: ZSI Grantee Year 3, April 1, 2024–March 31, 2025

Staff Support and Burnout Prevention

Unlike in Year 2, staff at both organizations indicated that burnout was not a significant challenge during Year 3. Although it is still difficult to determine which strategies have had the strongest impact on changing the Year 2 trend of staff burnout, the paragraphs that follow outline some strategies the UIOs implemented to better support staff and reduce burnout.

“I think it’s also really helpful because I’m able to speak to before [Program Director] came on and after... [Before] it was constant work, constant organization and constantly trying to support [patients]. So, it was a lot of actual work that had to happen. And then when [Program Director] came on, there was a lot more intentionality around structuring who’s doing what and what that looks like, and the timeline and everything else. And so that helped build that framework and took a lot of the stress and burnout away.” – Behavioral Health Provider

In Year 3 of implementation, both organizations shared a commitment to supporting staff and preventing staff burnout. During grantees’ second year of ZSI implementation (and in our Year 1 report), staff burnout was identified as a significant barrier to successful implementation, especially given that burnout and staff

transitions tend to require significant adjustments to workload distributions and program delivery. In Year 3, the behavioral health team at one organization had a 40% reduction in staff but maintained its number of patients. The staff reduction slowed ZSI implementation as more leadership time was spent ensuring patient treatment was covered. It also limited staff time spent on ZSI growth, improvement, or sustainment. As a result, teams have had to adapt their program implementation timelines while working to maintain service quality. All these efforts increased burden on staff and potentially exacerbated the burnout and turnover problem.

Staff at both organizations indicated that suicide prevention work needed to remain a priority across all levels of an organization to help prevent staff burnout. At one organization, tension between leadership staff and the behavioral health team emerged. According to behavioral health staff, this stemmed from the team's perceived lack of leadership investment in the team's work and a perceived unwillingness to plan for future ZSI programming. Among staff who responded to the Workforce Survey at one organization, only 63% agreed that their leadership explicitly saw suicide prevention as a priority and that their organization provided them with access to ongoing support and resources to further their understanding of it. At the other organization, a higher percentage of staff (76%) agreed that their leadership explicitly saw suicide prevention as a priority; however, only 59% of staff agreed that their organization provided them with access to ongoing support and resources to further their understanding of suicide prevention. This trend across both organizations underscores the importance of continued, explicit communication and resource allocation to ensure staff in ZSI programs have the necessary support to carry out their work.

"I think it's incredibly frustrating when you share any concerns or any need for more supports and then it doesn't get actualized." – Behavioral Health Staff

Ensuring and managing staff capacity was an approach that staff at both organizations identified as being critical to prevent staff burnout. At both organizations, changes in staffing had a direct impact on implementation capacity and staff burnout, which creates a cycle where burnout leads to turnover, which in turn increases pressure on remaining staff and therefore contributes to more turnover. Both organizations indicated that when teams are small and employees are required to serve in multiple roles, they tend to have insufficient time for self-care or processing of difficult experiences. During interviews, staff at both organizations emphasized that expanding team size can mitigate staff burnout. One organization has taken steps to increase staffing to better support staff and clients. Although the other organization has not increased its number of staff, leadership did engage a psychiatrist for more time each week and adjusted its program efforts. Both organizations have also demonstrated flexibility and commitment to meeting implementation goals despite staffing challenges.

"Adding the bigger team and more resource support has allowed us to be able to support more clients more effectively and [in a timelier way]. I really appreciate that, and I think the clients appreciate that as well." – Behavioral Health Staff

Staff at both organizations described efforts to prioritize staff wellbeing and self-care to prevent burnout and provide support. Staff described various supportive practices, including mental health days, remote work and flexible scheduling opportunities, workload management, generous PTO and team bonding activities as well as access to staff mental health workshops, traditional healing practices (e.g., smudging, prayer, meditation), massage chairs, and exercise equipment. Leadership at both organizations endorsed the importance of maintaining open communication and being flexible with staff work hours.

"We are obviously making sure the client is getting the support that they need. But even afterwards... we're checking in with [staff who work with clients]. We are making sure that they're feeling supported, making sure that their mental health is okay. giving them resources, and kind of talking about it, too, afterwards, debriefing a little bit.... If, you know, if there was anything we should have done differently." – Behavioral Health Provider

Staff at both organizations described organizational support for the safety and care of patients at high risk of suicide. In the Workforce Survey, 75% of staff at one organization and 86% at the other indicated that they felt their organization would be responsive to issues they bring up related to the safety of individuals at risk for suicide. Importantly, no staff who had interacted with an individual who ended their life by suicide indicated that they felt blamed. These same staff had positive or neutral feelings about their organization's support of their work with patients at risk of suicide and they agreed that there were practices in place to support staff when a patient death by suicide occurred.

Despite organizational support, staff expressed a desire for more support to help patients with high levels of need or basic needs outside of mental health support. Interview data indicated that staff sometimes felt discouraged and as though their work is not making a tangible difference when a patients' needs included social services (e.g., housing) and fell outside of their behavioral health purview. Specifically, behavioral health staff described these needs as difficult to address, *"It's just really easy to burn out with the kids when they're at you and at you [with high level of need] ... And [counselors] just feel like they're not making any difference sometimes."*

Staff Communication

At both organizations, ZSI team members described consistent structures and processes to communicate and share feedback among the team. At one organization, staff communication occurs through supervision meetings, meetings between the physical health and behavioral health teams, and informal channels such as one-on-one meetings or ad hoc gatherings with leadership and other staff. In particular, the monthly meetings between the physical health and behavioral health teams provides a space for providers across UIO departments to discuss integrated patient care and referral process procedures. The other organization also maintains regular team meetings to support program coordination. In Year 3, this organization continued early morning huddles to discuss patient challenges, provide input on ZSI programming, and share information across the team related to ZSI implementation.

Communication with leadership also takes place consistently among ZSI team members at both organizations. At both organizations staff described being able to share feedback directly with UIO leadership. At one organization, staff highlighted that regular meetings between the Chief Behavioral Health Officer, CEO, and program directors (including the ZSI Program Director) were helpful for discussing and strategizing about ZSI program implementation, including challenges and planning.

Leadership also played an active role in fostering cross-organizational engagement and outreach focused on suicide prevention. At one organization, leadership has advocated for more suicide-specific support groups and cross-departmental meetings. At the other organization, leadership supports the ZSI team to visit different departments and is developing a program champion model in which staff in other departments become ZSI champions and serve as liaisons with the ZSI programs and its staff. At both organizations, these efforts to increase program visibility and staff time within the UIO also improve ZSI implementation effectiveness as staff in other departments become more familiar with how to manage referrals to and from the ZSI program.

"We are constantly having conversations...we have those team meetings in the morning. We're talking about what type of clients we have, what information we have about them, and what might get in the way."

– Behavioral Health Staff

Both organizations have internal structures that foster staff communication and support successful ZSI implementation but each still has room to improve staff familiarity with the ZSI framework.

Approximately 62% of staff who completed the Workforce Survey across both organizations indicated that they understood their roles and responsibilities related to suicide prevention. However, there were notable

differences between organizations: 71% of staff at one organization agreed that they were familiar with the Zero Suicide framework, compared to only 31% at the other organization.² This suggests that, although staff generally understand their specific roles, those outside the core ZSI teams may not be fully engaged with or aware of the broader ZSI framework.

Policy and Procedure Development and Review

Organizational policy and procedure development is at the heart of the ZSI Lead element. To prevent deaths by suicide, health systems implementing ZSI must ensure that their policies and procedures reinforce the core components of suicide care, such as screening, assessment, safety planning and treatment. Further, these policies and procedures need to be updated to reflect ongoing changes in ZSI implementation. This subsection describes both organizations' approaches to develop, review, and update their ZSI-related policies and procedures.

Although both organizations review their ZSI implementation policies once a year, each organization takes a unique approach in terms of the frequency of policy development and review and the staff involved. At one organization, the Program Director typically reviews and updates ZSI policies before the annual IHS site visit. At the other organization, multiple staff are involved in policy reviews prior to the implementation of the next grant year.

Although each organization adopts diverse strategies to communicate policies to staff and other leaders in the organization, not all staff believe the policies and procedures are clear. Workforce Survey data suggest mixed perspectives on the clarity of organizational policies. Across the organizations, less than half (44%) of the staff surveyed indicated their organization has clear policies and procedures in place that define each employee's role in preventing suicide.

One organization stores finalized policies on a shared drive and reviews them with managers during monthly director meetings. At the other organization, information is distributed through program-wide emails and meetings, in addition to via directors, who are responsible for informing their individual teams. This organization emphasizes standardization of policies across departments while allowing for program-specific adaptations. These communication strategies, though solidified, offer mixed results.

In Year 3, both organizations made changes to their processes and procedures to improve ZSI implementation. One organization tweaked its Care Pathway Policy, updating the referral procedure for those who screen or assess positive for suicide risk. This policy change aimed to better match clients to services based on and appropriate to their level of suicide risk (e.g., therapy, groups, case management). This organization also improved its crisis service offerings by increasing its number of staff and adding roles, including case management and peer support staff. Both organizations made changes to their staff training protocols. One organization now requires its ZSI team to be certified to train others in Question, Persuade, Refer and all staff to be trained in Mental Health First Aid, and Cultural Sensitivity and Experiential Training. Neither organization made major changes to their suicide risk screening or assessment, safety planning, suicide care management planning, lethal means restriction, patient follow-up, or quality improvement protocols.

EHR Transition

In Year 3, one organization navigated an EHR system transition, which negatively impacted ZSI implementation. At this organization, the UIO Executive Director and Medical Director selected the new EHR

² The roles of staff participating in the Workforce Survey may differ across organizations, making comparisons inaccurate (e.g., staff at Organization 1 may consist of individuals more closely aligned with the ZSI program).

system based mainly on medical workflow needs with some consideration for behavioral health requirements. The transition from the old EHR system to the new one presented technical and logistical challenges. For example, staff described being unable to transfer patient records to the new system. As a result, staff are using both EHR systems to ensure they have a full perspective on patients' history and care needs. Workflows that were used with the old EHR system also needed to be adapted. Throughout the phased rollout of the newer system, staff had to maintain both systems temporarily. Some historical data remains in the older system, requiring manual retrieval for patient history, causing frustration among staff.

One organization has continued to use its existing EHR but is considering a transition. This organization has a functioning EHR that it has used for some time; however, it has limitations for medical services, which has reduced capacity to see clients. As a result, the organization is exploring a state-sponsored switch to a new system within the next 2 years to improve functionality and align with state requirements.

Partnership and Engagement

One organization engaged with its CAB in various ways to ensure quality suicide prevention programming in the community. This organization recently re-established its externally comprised CAB that is made up of approximately 20 complementary organization representatives (e.g., AI/AN-serving organizations). Partners are chosen based on internal organization service gaps and client needs. The CAB is engaged through quarterly meetings during which they conduct cross-training (e.g., Mental Health First Aid, domestic violence intersection with suicide and mental health), provide membership updates, and identify ways to support each other's programming. In addition, staff at the organization engage CAB members through less formal, one-on-one calls in between meetings. Maintaining CAB meetings in Year 3 allowed this organization to provide program updates locally and receive training helpful for successful suicide prevention implementation. However, due to staff turnover and role changes both internally and among its partners, this organization is currently re-evaluating the role of the CAB in their ZSI implementation.

“Because our community advisory group only meets quarterly, it's hard to say, ‘Oh, let's wait for the next meeting’... Because we're such a small team wearing so many different hats, we'll have micro meetings between sessions and quickly come up with something and say, ‘Okay, you reach out to this person, I'll reach out to this person, and we'll see how we can collaborate.’” – Leadership

One organization obtained community feedback in other ways, which were aligned with organizational capacity and leadership priorities. This organization does not have an externally comprised CAB due to its leadership's assessment that the program is too small to have an external set of community advisors and prioritization of other activities (e.g., treatment). However, the ZSI program continues to gather external feedback and input to improve ZSI program policies and procedures through engagement with the organization's board, which receives monthly reports about the program and provides oversight to all programs. In addition, the ZSI team receives informal feedback from community Elders.

Both organizations conducted other types of community engagement that have helped ZSI implementation. One organization reported having linkage agreements with external organizations to increase its patients' access to services. Further, Organization 1 gathers community feedback via surveys administered at community engagement events such as Pow Wows, Round Dances, and behavioral health events. Staff also distribute feedback surveys on programming to patients at appointments. In addition, the organization conducts quarterly focus groups to gather patient stories about specific experiences with programming. One recent focus group examined the overlap between suicide and domestic violence. Staff at the other organization reported offering suicide support services to community partners. Specifically, this organization offered support to a partner organization where a staff member died by suicide and further enhanced their working relationship with

this partner organization. Both organizations reported attending events and participating in external partners' programs to increase visibility in the community and encourage integration of suicide prevention throughout the community and its organizations.

Both organizations collected input on ZSI implementation from patients and people with lived experience—that is, individuals who have attempted suicide and families who have a loved one who died by suicide. For one organization, quarterly CAB meetings and behavioral health–related events such as Suicide Awareness Month events offered a chance to engage people with lived experience. The other organization reported in their APR that it administers biannual surveys to all patients to obtain patient feedback.

Both organizations experienced barriers in partnership activities. High turnover rates at partner organizations make it challenging to consistently engage the same person and build a relationship over time. One organization found itself competing with partner organizations to hire and retain talented staff located in the community—particularly Native American staff, who are highly sought after and are sometimes recruited to work at other organizations.

“I think the biggest barrier within the [N]ative [American] community is... overall there's a lot of turn[over] with a lot of organizations. So, when we try to bring in one partner from this organization, and then just when we're getting somewhere or when we're about to solidify that partnership, it's somebody new in that position and having to restart that process over.” – Leadership

ZSI Train Element

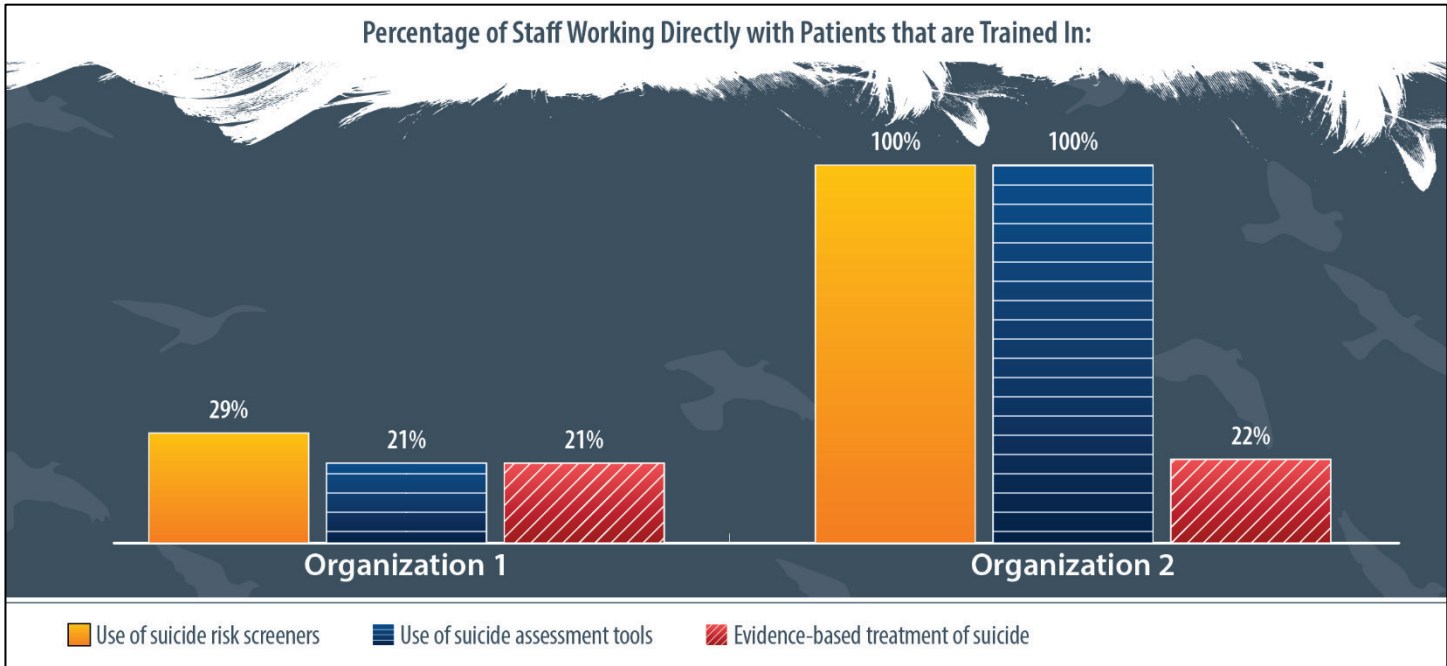


Training is a crucial process designed to prepare the UIO workforce to identify individuals at risk of suicide, assess patients’ risk level, and engage them into care and treatment. This section describes the general approaches that the UIO grantees are taking to train their staff. It also describes the specific trainings staff take to prepare them to conduct suicide risk screening and assessments and treat patients; and staff confidence in using their training knowledge and skills to screen, assess, and treat patients. This section concludes by examining training challenges or gaps that both organizations face. These challenges provide a blueprint for current and future ZSI grantees to consider as they work to enhance their workforce.

Trainings Provided by the UIOs

Each organization continued to maintain a different training approach based on staff roles. In Year 3, Organization 1 trained staff based on their roles and responsibilities and as needed or requested whereas Organization 2 continued to train all staff to conduct suicide risk screenings and assessments. **Figure 3** shows that how the different training approaches each organization took during grant Year 3 resulted in differences in the percentage of staff who were trained between the two organizations.

Figure 3. Staff Training Approaches



Organization 1, 29% of staff who work directly with patients—the entire behavioral health team—are trained to conduct suicide risk screening. At this organization, the physical health team is not trained to conduct suicide risk screening. Moreover, three-quarters of the behavioral health staff, or 21% of staff overall, are trained to use suicide assessment tools and to provide evidence-based treatment of suicide. One staff member conducts the initial suicide risk screening and then patients are triaged to a behavioral health provider who is trained to provide evidence-based treatment of suicide.

In contrast, at Organization 2 continued to train all staff—including those who do not work directly with patients and part-time or temporary staff—in suicide risk screening and assessment. At this organization, leadership indicated that efforts to expand suicide screening and assessment training beyond mental health providers aims to build broader crisis response capacity across the organization. All staff receive a set of electronic trainings each year via an automated workforce training system. Although all Organization 2 staff are trained in screening and assessment tools, only behavioral health providers are trained in evidence-based treatments. Accordingly, data show that 22% of staff were trained in evidence-based treatment of suicide, which includes dialectic behavioral therapy (DBT), cognitive behavioral therapy (CBT), and other treatment modalities. Importantly, these staff include those who provide behavioral health care but who are not directly involved in the ZSI program.

Despite differences across organizations in training approaches, Workforce Survey data show that most staff at both organizations received suicide prevention training. Most staff at both organizations indicated that they had at some point been trained on how to recognize the early warning signs that an individual may be at elevated risk for suicide. Also, staff at both organizations reported receiving Mental Health First Aid training. One organization indicated they plan to continue offering this training even after their ZSI grant ends.

Both organizations also offered training to staff and partners who do not directly interact with patients. One organization provides Mental Health First Aid training to community partners, with the goal of creating a network of informed partners who can better identify and refer at-risk individuals. Also, by providing this training, this organization aims to inform community partners about how best to identify and effectively refer individuals who may be at elevated risk of suicide. The other organization trains all staff, regardless of whether they have direct interactions with patients. This approach aims to equip everyone at the UIO with the skills to screen for suicide and raises awareness about suicide risk screening.

At both organizations, staff who interacted directly with patients indicated in their Workforce Survey responses that they felt confident in their ability to provide treatment. These staff indicated that they had received training on suicide-specific evidence-based treatment approaches such as Collaborative Assessment and Management of Suicidality, Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP), Eye Movement Desensitization and Reprocessing (EMDR), and DBT. Further, across both organizations, nearly all staff surveyed who provide suicide-risk related care (91%) indicated that they felt comfortable providing care to patients identified as being at elevated risk for suicide. Also, all staff who deliver clinical treatments and were surveyed indicated that they felt confident in their ability to provide treatment to individuals with suicidal thoughts or behaviors.

In addition to suicide screening, assessment and treatment trainings, staff also reported completing state-mandated wellness trainings tied to roles such as peer specialists. Although these state-required trainings can add to staff's training burden, they also provide peer specialists with standardized knowledge about responding to suicide risk and allow these staff to bill and be reimbursed for the services that they provide patients, unlike in other states.

Opportunities for Training Improvements

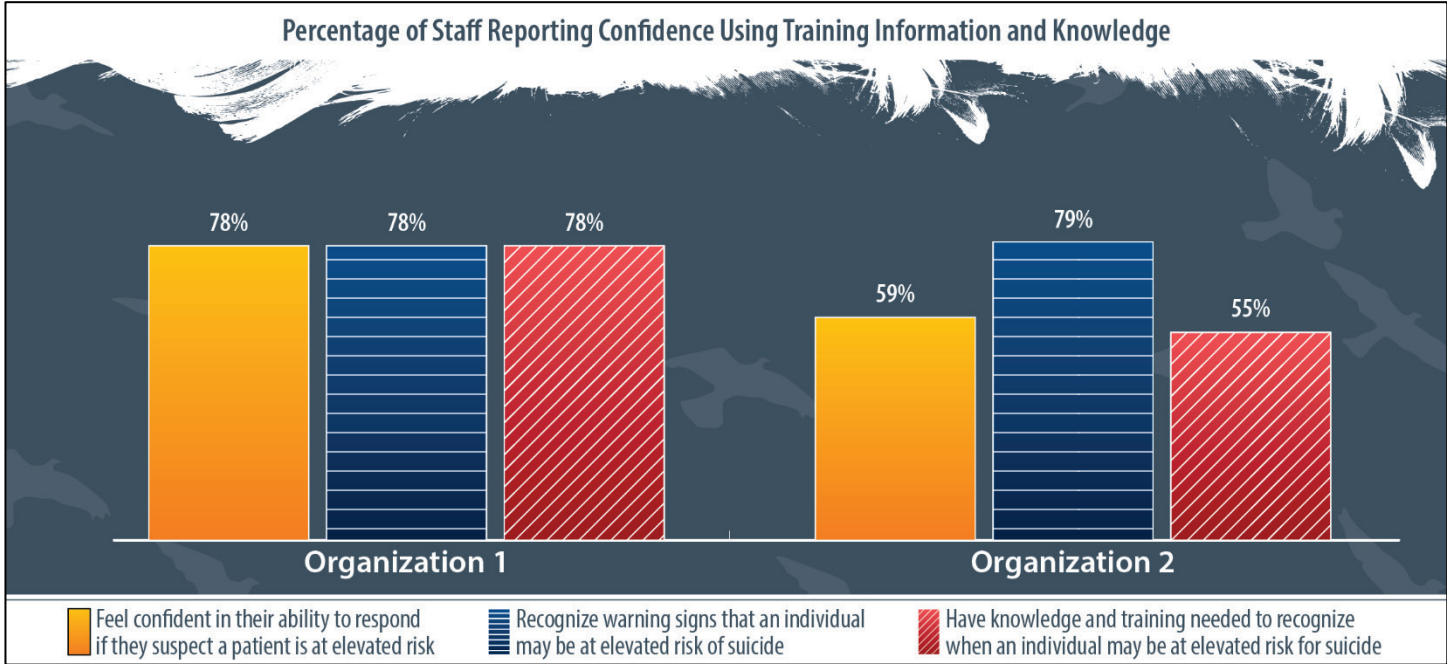
Although leadership at both organizations shared a commitment to ensuring that all staff had access to suicide-related trainings, there were challenges ensuring that staff were trained in suicide risk screening and assessment and felt confident conducting it. Despite the high percentage of behavioral health providers trained to conduct suicide screening at both organizations, not all staff at these organizations indicated that they have ever received suicide screening and assessment training. Only 71% of staff at one organization and 64% of staff at the other organization who interact directly with individuals who may be at risk for suicide indicated

that they had ever been trained to conduct suicide screenings or suicide risk assessments. Even though not all staff had been trained in suicide screening and assessment, all staff at both organizations indicated that they felt confident in their ability to conduct suicide risk screening. Further, all staff responsible for conducting suicide risk assessments at one organization indicated in survey responses that they felt confident in their ability to conduct suicide risk assessments and 86% of staff surveyed at the other organization felt confident.

Staff at both organizations highlighted the need to improve cross-department communication about training needs. One organization highlighted that staff faced challenges ensuring that non-mental health staff consistently used the suicide screener. This organization is introducing ZSI department champions who will help ensure that all patients are screened for suicide and that the screening process is conducted consistently. These ZSI champions can also alert the ZSI program as staff training needs arise. The other organization provides trainings through its time reporting system and reported challenges coordinating trainings on how to use its newly adopted EHR system.

Even among staff who were trained and confident in their ability to screen and assess patients, not all knew what to do when a patient screens as high risk. Across both organizations, most staff surveyed indicated that they felt confident in their ability to respond when they suspected that a patient may be at elevated risk for suicide. **Figure 4** shows the percentage of each organization's staff who were trained to recognize the warning signs that an individual may be at elevated risk for suicide, staff who had knowledge and training to recognize when an individual may be at elevated risk for suicide, and staff who felt confident in their ability to respond if they suspected a patient was at elevated risk for suicide. At Organization 1, 78% of surveyed staff who have direct patient interactions indicated that they felt confident in their ability to respond. At Organization 2, 59% of staff indicated that they were confident. The fact that some staff who interact directly with patients do not feel comfortable or know what to do when a patient screens as high risk indicates a critical gap for both organizations. As one manager shared: *"I feel like sometimes the staff [are] not as trained in the outcome of the [suicide risk screener]. So, when someone screens at high-risk, they say], 'Now, what do I do with this?'"*

Figure 4. Staff Confidence Using Training Information and Knowledge



Outside of using the suicide screening tools, some staff reported that they were not trained and therefore did not feel confident in detecting early warning signs of suicide risk. At Organization 1, the same percentage of staff (78%) indicated that they were trained to recognize the warning signs, had the knowledge and training to recognize when an individual may be at elevated risk, and felt confident to respond if they suspected a patient was at risk. At Organization 2, a similar percentage of staff to Organization 1 reported being trained to recognize the warning signs that an individual may be at elevated risk for suicide. However, nearly a quarter of the staff trained to recognize the warning signs did not feel they had the knowledge and training to recognize someone at elevated risk of suicide (24%; 79% versus 55%) or feel confident in how to respond to a patient’s suspected elevated risk (20%; 59% versus 79%).

Staff across both organizations indicated that they had not been trained in how to do safety planning or Counseling on Access to Lethal Means (CALM). Suicide risk assessments for patients with a high risk of suicide often include safety planning and counseling for lethal means. At one organization, all staff surveyed with direct interaction with patients indicated that they had not taken Safety Planning Intervention for Suicide Prevention (safety planning) training or CALM training. At the other organization, 67% and 75% of staff surveyed with direct interaction with patients indicated that they had not taken safety planning or CALM training, respectively.

Many staff across both organizations indicated that they lacked formal training on how to ask screening or assessment questions in ways that are culturally resonant with AI/AN individuals and families. All staff at one organization indicated that they had not received such training, and over half of staff at the other organization reported the same. In the Year 3 APR, only 29% of staff working directly with patients reported that they were trained in culturally informed practices or activities such as Cultural Sensitivity – Four Sacred Medicines. Conversely, according to the APR, all staff at the other organization have been trained in these practices or activities through automated trainings that are delivered electronically. However, staff indicated that these trainings were not adequate to inform them of the cultures of the Tribes served by the organization.

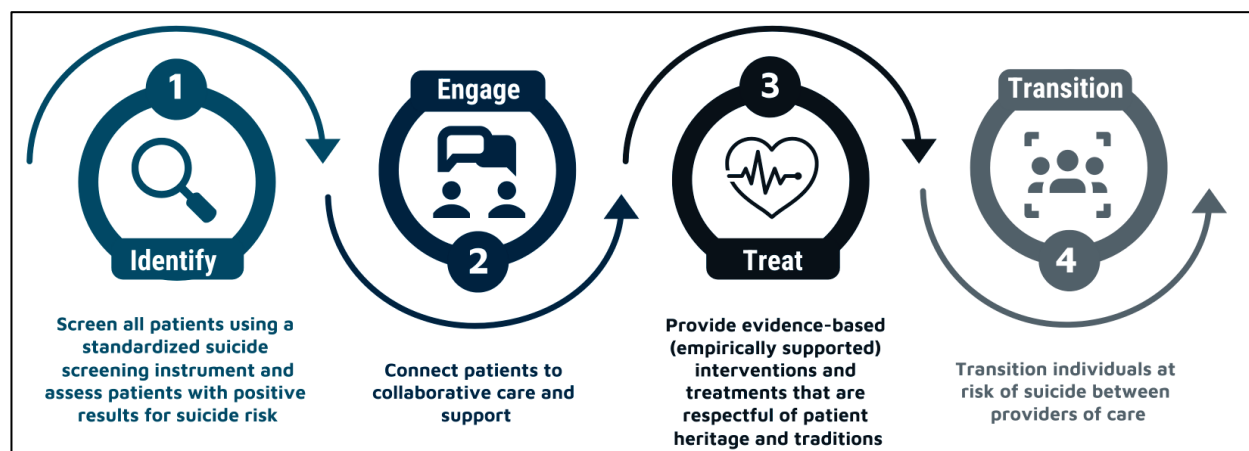
Across both organizations, most staff (an average of 63%) indicated that they did not feel they had received adequate training on the cultures of the Tribes served by the organization. Despite this, 73% of staff across organizations felt comfortable offering traditional healers as a form of clinical care to patients.

Staff at both organizations expressed concerns about training quality, content relevance, and accessibility. Specifically, staff indicated that some training content did not coincide with their roles or that it was difficult to apply. This was particularly true for staff at one organization, where staff were being trained in a new EHR system. At this organization, staff indicated that despite the many different formats of training that staff had participated in, some staff would benefit from being retrained because they lacked understanding of the content and confidence to use the skills they did have. One manager noted that their management team had *“urged [staff] to start training again.”*

ZSI Clinical Pathway to Care – Identify, Engage, Treat, and Transition

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 5** illustrates the clinical pathway to suicide prevention care and includes the definition of four ZSI elements that make up this pathway.

Figure 5. Clinical Pathway to Care



Source: RTI International

The clinical care pathway provides a structure for organizations to continuously engage patients and identify appropriate levels of care for their patients. **Identify** entails routine screening to help normalize mental health conversations, allows for early identification of suicide risk, and is the first step to connect patients to needed care. As part of **Engage**, the second step in the clinical care pathway, providers work to connect patients to care which often begins with a thorough suicide risk assessment and may also include safety planning, and lethal means restriction. **Treat**, the third step in this pathway, involves providers offering evidence-based treatments to address underlying mental health conditions that contribute to an individual's suicidality. In the context of Indigenous behavioral health services, it is important to ensure that treatment is tailored to meet the unique needs of clients; this tailoring helps foster trust, ensure patient safety, and better engages patients in their care. This step of the clinical care pathway also entails providers working with patients to develop a path toward reduced risk, improve treatment adherence, and enhance continuity of care. As part of **Transition**, the last step of the clinical care pathway, patients at risk of suicide receive continuous follow-up care. Transition is an important step for individuals at risk for suicide, particularly those recently seen in emergency departments, discharged from inpatient care, or who have missed scheduled appointments, as it can help transfer critical care information and coordinate ongoing care needs.

Although the clinical care pathway outlines the elements of Identify, Engage, Treat, and Transition as steps, they are not strictly linear; rather, they are interconnected and ongoing components of care. Patients move back and forth across the clinical care pathway based on their evolving needs and circumstances. In this section, we will discuss clinical workflows, care delivery approaches, cultural integration, patient engagement, screening practices, and implementation challenges and approaches to overcome them.

Screening and Assessment Processes and Procedures

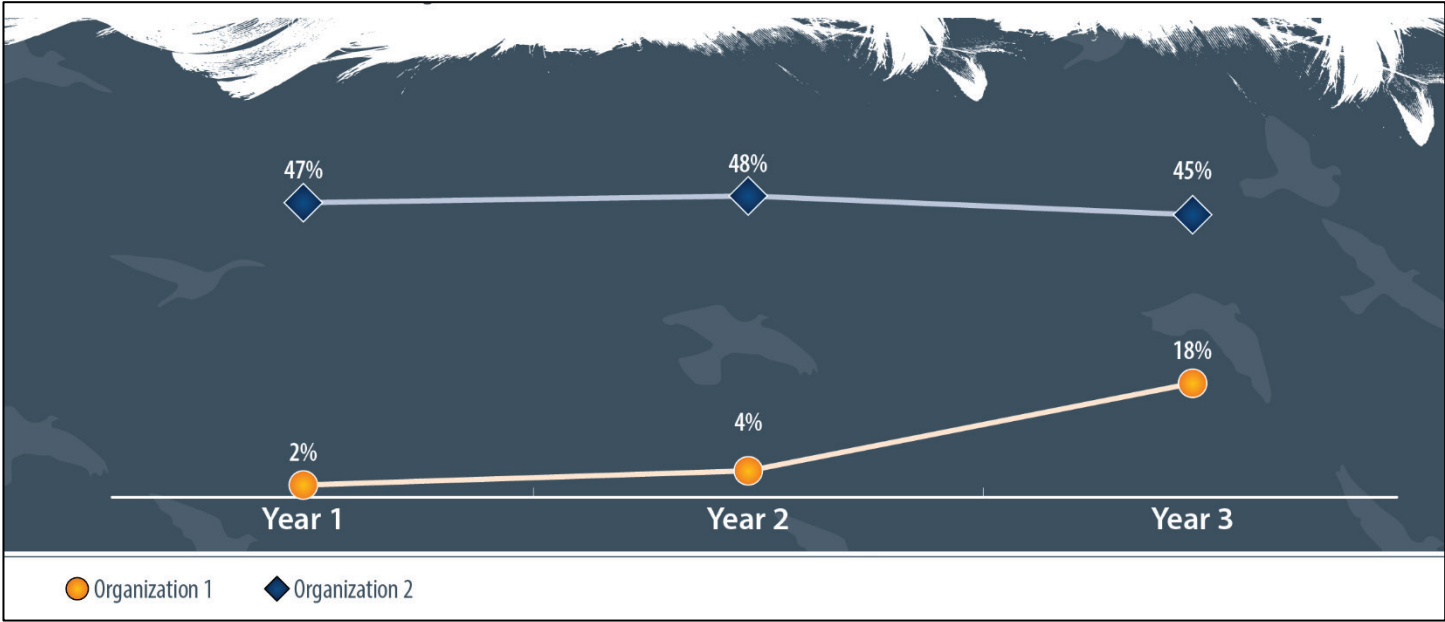
At both organizations, the suicide risk screening and assessment tools and protocols have remained largely consistent over the past 2 years. One organization uses multiple screening tools, including the Ask Suicide Questions (ASQ), the Patient Health Questionnaire 9 (PHQ-9) and the Generalized Anxiety Disorder 7 (GAD-7). The other organization uses the Columbia Suicide Severity Risk Screening (C-SSRS), GAD-7, PHQ-9 and Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) to screen patients. It is worth noting that only the ASQ and C-SSRS screen for suicide risk and suicidal ideation. The remaining screening tools listed screen for other mental health conditions such as depression, anxiety, and post-traumatic stress disorder. For patient assessment, one organization is using the C-SSRS Assessment, while the other uses the Brief Suicide Safety Assessment (BSSA) as its critical suicide assessment tool.

At this organization, screenings are completed at every psychiatry visit, during intake assessments, and on an as needed basis. This ensures that individuals at elevated risk for suicide are identified and connected to appropriate care in a timely manner. This organization also changed its screening process to include a dedicated behavioral health specialist who is responsible for conducting intake screenings. Previously, several staff participated in intake rotations. This new approach—with a dedicated intake screener—streamlines the screening and assessment process and ensures consistency across patients. The other organization’s policy is to have providers conduct suicide risk screenings with patients at every visit, regardless of which department they are visiting.

One organization consistently has a higher positive suicide screening rate than the other organization. As shown in **Figure 6**, the variation in screening tools and protocols across organizations is reflected in the APR data. Organization 2 uses the CSSR-S suicide risk screener, a six-item measure that indicates a positive screen if the individual indicates active suicidal ideation with some intent to act (item 4) or active suicidal ideation with specific plan and intent (item 5). At this organization, the CSSRS is conducted during every patient-provider interaction no matter how many times the patient is seen in a single day (e.g., potentially multiple times in one day). This organization has maintained consistent and relatively high positive screening rates during all three grant years: 47% in Year 1, 48% in Year 2, and 45% in Year 3. In comparison, Organization 1 uses the ASQ, a four-item measure that indicates a positive screen if an individual answers “yes” or refuses to answer any of the questions. At this organization, the ASQ is conducted during intake and then subsequently at the mental health provider’s discretion. This organization reported lower rates during the same period: 2% in Year 1, 4% in Year 2, and 18%³ in Year 3. Tool sensitivity and specificity cannot account for the nearly 30 percentage point difference in positive screening—future site visit interviews will examine this discrepancy.

³ This year of data uses all behavioral health patients as the denominator, whereas Year 1 and 2 uses all physical and behavioral health patients as the denominator. Thus, we observe a higher positive screening rate in Year 3 because the suicide risk may be more concentrated.

Figure 6. Percentage of AI/AN Patients Screened for Suicide Risk with Positive Results



Engagement and Risk Response Protocols

Across both organizations, staff reported that they are familiar with and understand the ZSI clinical workflow. According to the Workforce Survey, 91% of staff across both organizations indicated that they are familiar with how their organization embeds suicide prevention (e.g., safety planning, access to lethal means, documentation) into the clinical workflow.

Both organizations’ clinical care pathways are organized around patients’ risk of suicide and involve frequent check-ins and regular communication. At both UIOs, a critical component of the clinical workflow involves engaging individuals identified as at risk for suicide in structured, responsive, and culturally informed care. This includes the use of safety planning, CALM, and referral to care. As part of the safety planning process, patients often receive referrals for resources or cultural programming based on their needs. Finally, the provider informs the behavioral health specialist to coordinate a timeline of short follow-up appointments to check-in.

At one organization, patients who screen at moderate or high risk are assessed using the BSSA and engaged in collaboratively developing a safety plan using the Stanley-Brown Safety Plan template. Additionally, high-risk patients are prioritized to receive frequent check-ins from a behavioral health specialist. All patients referred to higher levels of care also receive follow-up calls from the behavioral health specialist to help coordinate their care and any transitions.

According to the other organization’s Care Pathway Policy, once the level of suicide risk is identified, patients are connected to specific services that align with their behavioral health needs and risk for suicide (e.g., therapy, group therapy, case management, peer support). Patients screened as low risk are referred to adult mental health services, while those who screen as high risk are eligible for the organization’s specific ZSI suicide prevention programming. Staff immediately follow up with patients who have low or moderate risk and collaboratively create a safety plan. If any patient misses an appointment without prior notification, the organization uses multiple methods to contact them, including follow-up phone calls or sending care cards. At this organization,

staff reported involving family members in lethal means counseling when appropriate as part of a broader, community-centered approach to safety. For patients at high risk of suicide, peer counselors at the organization often try to engage the patient and meet with them in person within the community to prevent harm, as necessary.

Embedding safety plans in EHRs may help with coordinating and ensuring follow-up care is provided.

Only one organization includes safety plans in its EHR, making it easier for providers to refer to and update plans as needed. The other organization is examining the feasibility of integrating safety plans into its new EHR system.

Evidence-Based Treatment Modalities

Both organizations use DBT as their primary treatment modality. Based on interviews, staff at both organizations value DBT because it emphasizes mindfulness, emotional regulation, and distress tolerance. Staff reported that these skills are critical for clients to manage external stressors and therefore help prevent suicide. As a provider from one organization described,

“I use [DBT] more, and it’s evidence-based and it’s really great because I like its root in mindfulness and being present and emotional regulation, emotional identification, interpersonal relationships, and effective communication, distress tolerance.... In every session, it’s building up that distress tolerance.”

Staff at the other organization mentioned finding DBT particularly useful for supporting patients experiencing psychosis. In addition to DBT, staff at both organizations also incorporate other evidence-based treatments such as CBT and EMDR, further strengthening their clinical approaches to behavioral health care and suicide prevention.

Ensuring Continuity and Connection Across Levels of Care

Both organizations implemented processes to increase care continuity and support individuals during care transitions. One organization uses a team-based approach to coordinate care, with warm handoffs from behavioral health to medical staff. Warm handoffs help foster patient trust and engagement, which ultimately increases patient engagement. At this organization, a behavioral health specialist or assigned provider conducts follow-up with patients who are discharged from the emergency department or an inpatient hospital. If the patient is already connected with a provider within this organization, that provider manages follow-up with assistance from the behavioral health specialist as needed. This organization does not have an automatic information-sharing system for patient hospital visits or admissions; therefore, the organization relies on self-disclosure by patients of emergency department or hospital use. At the other organization, multiple teams work in close collaboration to support seamless care transitions. The ZSI program staff collaborate with the adult mental health team and mental health services to ensure clients are safely and effectively transitioned to appropriate care. For individuals with higher levels of behavioral health needs, the ZSI program transitions them to Totem Lodge, the residential care facility associated with the organization. For clients under 18, the ZSI program collaborates with the Child and Family Services department within the UIO, continuing engagement and support throughout the transition to youth-focused care.

When the hospital system informs this organization that a patient is hospitalized, a ZSI team member is responsible for initiating contact within 24 hours. The team member communicates with hospital staff to discuss incident details and, if the hospitalization is suicide-related, the organization works with the patient to develop a plan to prevent future hospitalization. Follow-up procedures after a hospitalization include an attempt to contact within 72 hours if the individual is an existing client and within 5 business days if they are a new client.

Both organizations implemented strategies to ensure a smooth and supportive transition out of care, while also maintaining communication as needed. During interviews, staff at one organization described using linkage agreements with external partners to connect patients with services that are beyond the scope of the UIO. At the other organization, patients are transferred internally if they need additional services because they have a broad array of in-house services.

Integrating Native American Traditions into Clinical Care

A central principle of ZSI is the delivery of evidence-based, person-centered care that is responsive to Native American cultures, beliefs, and traditions. Across both UIOs, intentional efforts have been made to embed AI/AN values and traditions into all aspects of the clinical pathway to care. These efforts recognize that healing extends beyond Western medical models and that culturally informed care is essential for suicide prevention within Indigenous communities.

Although both organizations tailor their care delivery to reflect community and traditional values, additional staff training in this realm would be beneficial. Safety plans are adapted to include clients' cultural identities and staff often make the screening and assessment conversations more relational. At one organization, staff informally adapted their safety plan to include traditional practices such as smudge, Wellbriety, and Talking Circles. Similarly, staff at the other organization incorporate traditional practices into safety planning via the medicine wheel, by talking about client needs and working with them to understand who is part of their support system.

However, as discussed in the Train section, staff across both organizations reported a need for more training on how to conduct screening and assessment questions in a culturally resonant manner with AI/AN individuals and families. According to the Workforce Survey, 43% of staff at one organization reported receiving such training, and no staff at the other organization reported taking this type of training.

Both organizations reported barriers in the provision of support services specific to the traditions of AI/AN people. During interviews, staff across both organizations acknowledged the complex needs of patients transitioning from reservation to urban environments, including identity loss and cultural disconnection. At one organization, staff noted the difficulty of finding culturally appropriate legal support outside Tribal law systems and noted challenges in providing Tribe-specific services in an urban setting. As one provider explained, *"Everybody shares their cultures and their ways, and it's great. I haven't run into anything that's really hindering us, except for the legal. There's not a lot of culturally specific legal help unless it's just tribal law. I have a client that needs some legal help and I'm having trouble finding her any help."*

Across both organizations, 73% of staff who responded to the Workforce Survey reported that combining Western and traditional approaches can be more effective, especially for patients from more traditional Tribes. At one organization, 75% of staff reported familiarity with the use of traditional healers, whereas at the other organization only 57% of staff reported familiarity. In addition, only 54% of staff across both organizations indicated that they had knowledge of cultural nuances to inform care.

Although nearly half of staff across both organizations reported lacking knowledge of cultural nuances to inform care, staff at both UIOs described a range of culturally informed programs that complement their clinical care. One organization shared that most of its culturally informed practices and activities for care in its ZSI program continue to be implemented. However, a few of its culturally based groups, such as the domestic violence support group, Men's Talking Circle, Wellbriety Circles, and Sweat Lodge have been temporarily paused due to staff transitions. The organization anticipates that these groups will resume once new staff are identified. Meanwhile, in 2024–2025, this organization introduced bimonthly cooking classes that use

traditional foods to educate clients on the link between diet, physical health, and mental wellness, thus reinforcing cultural strengths and holistic healing.

The other organization continued to offer Native American traditional practices, such as prayer, ceremony, and wellness bags, as part of routine care this year, providing clients access to cultural healing practices in addition to Western therapeutic interventions.

At both organizations, providers reported informally adapting their evidence-based therapies, such as DBT and CBT, to align with Native American traditional values and practices. For example, providers at each organization describe conducting an informal spirituality assessment during intake and then incorporating practices such as smudging into sessions. One organization emphasizes spiritually based approaches by intentionally integrating cultural and traditional approaches, such as distributing wellness bags that include Indigenous-medicines—sweet grass, sage, tobacco and cedar to patients, into therapeutic care. Providers ask about these preferences early in treatment and work to incorporate them in a way that complements evidence-based modalities. For example, staff shared that spiritual and cultural elements are interwoven into session using frameworks like DBT, which they find to be a flexible and supportive model for honoring both clinical and cultural dimensions of care.

Staff responsible for coordinating transitions in care across both UIOs reported a high degree of cultural readiness and confidence. Specifically, in their Workforce Surveys, 83% of staff across both organizations indicated that they possess the cultural knowledge, skills, and humility necessary to effectively support AI/AN individuals and families during care transitions. Additionally, they reported feeling confident in engaging family members or support persons, acknowledging the central role of extended kinship networks that exist in many AI/AN communities. Importantly, 100% of staff involved in care transitions across both organizations reported in their Workforce Surveys that they feel comfortable working with AI/AN patients during their transitions to care.

Experiences with Screening and Assessment

Providers at one organization emphasized that a key component of their screening approach involved delivering suicide risk screening questions in a conversational manner (e.g., safety planning, access to lethal means, documentation). Providers emphasized that their approach is to talk to the patients on a personal level first, then ask them about suicide risk. One provider shared that their conversation with a patient typically goes as follows,

“I’m calling from [the UIO]. ... I’m just calling to check on you and see how you’re doing. I got a referral. I heard you were being a little depressed. I just wanted to check on you. I want to be sure that you’re safe.’ And then I’ll talk to them for a little while, and then I’ll say, ‘Are you having any thoughts of hurting yourself? Are you having any thoughts of suicide?’”

Another provider at that same organization shared that if a patient is with them in person, they will not enter responses into the screening form while they are together. Instead, they will wait until the patient leaves so that the patient does not experience the provider multitasking or completing the screening paperwork. These strategies highlight a person-centered approach built on promoting presence and reducing barriers to disclosure. Further, providers at both organizations emphasized the perspective that patients may be more willing to share their experiences when the conversation feels more organic rather than driven by a checklist.

Despite the proficiency with which behavioral health providers are conducting screenings, non-behavioral health staff reported less comfort with screening for suicide risk in one organization. At this organization, one provider explained that screening frequently improves comfort in conducting it. For example,

staff in the behavioral health department find conducting screenings to be “second nature.” However, staff in the medical department are more hesitant because they are uncomfortable with the topic of suicide. In this organization, medical providers typically engage the behavioral team immediately if they suspect a patient is at risk of suicide. This discomfort and sense of being ill-equipped may be exacerbated by the fact that training on the use of screening tools at this organization is voluntary. Thus, staff attending the trainings are either already interested in suicide prevention or find it relevant to their work.

Patients also have mixed comfortability with the screening process. According to providers, some patients—particularly youth—did not feel comfortable with the screening process. A provider at one organization shared that adolescent patients sometimes describe the screening process as providers “being too nosy into their business.” To address this hesitancy, providers emphasize that they are simply asking because they care about their safety and want to be sure that they are safe.

Challenges in Engagement in Care, Treatment, and Transitions

One organization faced patient-level challenges, including stigma, lack of patient clarity about care pathways and outcomes from screening, and fear of repercussions from disclosure, which hinder care and treatment efforts. In their interviews, staff at this organization reported that patient stigma associated with receiving mental health care impedes their ability to provide treatment. Staff also shared that some patients decline to engage in safety planning altogether, choosing not to disclose their location or their access to lethal means because they are unsure or fearful of repercussions. This challenge is reflected in APR data, as only 67% of high-risk AI/AN patients received a collaboratively developed safety plan, underscoring a need for continued efforts to build trust and readiness for engagement. This organization also noted that safety plans are stored in multiple locations, so the low reporting rate may partly reflect documentation inconsistencies rather than a lack of safety planning.

Both organizations described transitioning to a new provider as a challenge impacting patients’ clinical care pathway, which led some patients to drop out of services. At both organizations, providers described patients’ desire to remain with the same provider despite changes in their suicide risk. Providers also describe instances when patients refuse to engage in care transitions, specifically if it involves working with a new provider. At one program, therapists noted that when some patients are no longer at imminent risk of suicide and are expected to transition out of ZSI program, they disengage entirely—missing appointments or stopping services without formally withdrawing. However, staff did not elaborate on how these situations are typically managed within the organizations.

Staff reported barriers to transitioning patients between providers stemming from organization-level factors. According to data from the Workforce Survey, across both organizations, all staff responsible for assisting patients with their transitions in care agreed that they were familiar with the organizational procedures for ensuring that an individual’s health information is shared. A therapist at one organization shared that non-ZSI staff must manage patient engagement with ZSI through the EHR; however, they desired more communication from the ZSI team regarding their patients. For example, providers recommended that a closing summary from ZSI staff when patients transition out of care would help transition patients from ZSI to non-ZSI staff. Staff at this organization also expressed a desire to get to know more staff on the ZSI team, as opposed to having the director serve as the main point of contact.

Providers at one organization shared that although most transitions are internal transfers within the organization, the initial provider does not always remain involved after the transfer. Instead, the initial provider often loses touch with the patient. Staff described a pattern in which, once a patient is referred to the ZSI program, other providers may step back from ongoing involvement because they perceive the suicide

prevention team as primarily responsible for care. When the patient is ready to be transitioned from the ZSI program back to their initial behavioral health provider, this initial provider may be hesitant to take the patient back on because they lack the full treatment and patient history. This organization also shared that their behavioral health department is understaffed, making it difficult to refer patients internally once they are no longer at high risk for suicide. As a result, patients often remain in the suicide prevention program longer than intended—not because they continue to meet the criteria for high-risk care, but because it is not easy to transition patients to a new therapist. One staff member explained that, despite their ZSI program being designed for acute treatment and stabilization, their team continues to work with patients beyond the crisis period due to limited referral options. Further, providers at this organization feel a strong responsibility to maintain care and avoid discontinuing it prematurely, especially in the absence of a clear next step.

Strategies to Improve Engagement in Care, Treatment, and Transitions

At one organization, staff emphasized the value of tailoring engagement approaches to meet the diverse needs of their patients. This approach included implementing youth-specific strategies and adjusting the frequency of communication based on patient preferences. By adopting a flexible, patient-centered approach, providers indicated that they were able to reduce the risk of patient disengagement and foster stronger connections with patients. One provider described patients' experiences thusly: *"If they're like, 'Oh, yeah. Is housing going to call me?' 'Yeah, housing's going to call you.' 'Is the therapist going to?' 'Yeah.' They want the help."*

Both organizations indicated that communicating patient care procedures for engagement helped promote patient comfortability and willingness to engage in care. Providers at one organization shared that being transparent about their protocols, such as describing the suicide risk assessment process, was particularly helpful. The other organization shared that some patients expressed hesitancy to engage in care because they were worried about being sent to the hospital. To address these concerns, providers explained the process for engagement in care, indicating that sending someone to a hospital is a last resort. One provider shared, *"People say, 'Well, if I come in, you're just going to send me to the hospital.' 'No, not if we can absolutely help it. We're not going to send you. Not unless you've got the means in your hand and you're doing it right now, we are not going to send you. We're going to do everything we can to help you, and that doesn't include the hospital.'"* These strategies helped providers set expectations, promote transparency, and build trust with their patients, while also relieving concerns and misconceptions that patients had about engaging in care.

Across both organizations, APR data indicate that all high-risk AI/AN patients who missed an appointment received follow-up contact within 48 hours, demonstrating effective outreach efforts. In their interviews, staff at one organization reported that when patients miss appointments, the front desk staff calls them to check in. At the other organization, staff indicated that therapists call patients who miss appointments at least three times, but usually contact them nine or 10 times via text messages or phone calls. In cases where staff cannot reach a high-risk patient who missed an appointment, staff create and send handmade Native American care cards.

ZSI Improve Element



This section discusses the improvement processes and activities conducted by each of the UIOs, and perceived impacts on patient-level outcomes. It also presents data on each organization’s data monitoring processes and what data they monitor.

Table 3 shows that neither organization reported a death by suicide among their AI/AN patients over the past 2 years. At Organization 1, patients who attempted suicide did so an average of 10.67 times, and at Organization 2, patients who attempted suicide did so an average of once, according to the APR. These attempts occurred among less than 4% of the total number of AI/AN patients seen by Organization 1 (3.8%) and less than 1% at Organization 2 (0.7%). Organization 1 saw an increase from Year 2 to grant Year 3 in the average number of suicide attempts and the percentage of AI/AN patients who attempted suicide. This increase reflects one patient who had as many as 30 suicide attempts. Further, this pattern of suicide attempts reflects a trend among American adults over 18 years of age that, on average, individuals make 25 suicide attempts for every completion (Crosby et al., 2011). Organization 2 saw a decrease over time in both average number of suicide attempts and the percentage of AI/AN patients who attempted suicide. However, it is important to note that both organizations had changes in their data collection approaches and systems, which likely contribute to the year-to-year changes.

Table 3. Suicide-Related Activity by Organization

Suicide-Related Outcome Measures	Organization 1		Organization 2	
	Y2	Y3	Y2	Y3
Death by suicide among all AI/AN patients	0%	0%	0%	0%
Average number of suicide attempts among all AI/AN patients who attempted suicide	1.00	10.67	1.36	1.00
AI/AN patients who attempted suicide	n=2 (0.40%)	n=3 (3.8%)	n=25 (1.00%)	n=14 (0.7%)

Improvement Processes

Because tracking information on suicide-related activities and engagement in care is so critical to improving their ZSI programs, both organizations are confronting challenges with their EHR systems’ ability to perform these functions. In Year 2, both organizations brought up challenges they faced using their EHRs. These challenges were a driving factor in one organization’s decision to transition to a new system. Staff at this organization previously stated that their old system was antiquated and that leadership had to manually review suicide prevention and intervention services provided to each patient in different places within the EHR because it lacked a consistent place to document these items. The transition to a new EHR system, however, presented new challenges. For example, staff had to temporarily maintain both the new and old systems, because not all historical data were transitioned to the new system. This required staff to use time-intensive processes to retrieve patient histories. This organization also faced a challenge connecting its new EHR system with other ZSI processes; for example, they struggled to determine how to integrate screenings and assessments seamlessly into the new system.

Both organizations also experienced challenges exchanging information using their EHR systems and had concerns about other providers at the organization and patients themselves accessing behavioral health

information via the EHR system notes and reports. At the organization that did not transition to a new EHR system, some departments use different EHRs, which causes staff to spend time tracking down information to make referrals or to fully understand patient histories.

Although staff at one organization reported challenges with transitioning to a new EHR system, they also reported advantages of the new system. The new EHR system offers enhanced patient engagement features such as electronic notifications, patient portal access, and automated follow-up systems. The newer interface is also more user-friendly. Staff report fewer system crashes and a more intuitive design. This organization is also working to customize templates in its new EHR system, using input from Native American staff to adapt templates to better reflect the traditional practices and health perspectives of AI/AN patients.

Continuous Quality Improvement Activities

Both organizations are engaged in a range of quality improvement activities. At both organizations, data are used to guide decisions at the organizational and patient levels. **Table 4** shows that both organizations established a quality improvement team to guide the collection, reporting, and analysis of data and developed an evaluation plan related to ZSI project activities. Organization 2 also established a suicide data surveillance plan to collect, monitor, analyze, and use data to inform suicide care activities. Organization 1 conducted focus group discussions with community members to understand their suicide prevention programming needs and awareness of 988 and similar resources. They also conducted similar community discussions to help guide their domestic violence and overall prevention programming.

Table 4. Types of Continuous Quality Improvement Activities

Quality Improvement Activities	Organization 1	Organization 2
Established a quality improvement team to guide the collection, reporting, and analysis of data.	✓	✓
Developed an evaluation plan related to ZSI project activities.	✓	✓
Established a suicide data surveillance plan to collect, monitor, analyze, and utilize data to inform suicide care activities.	N/A	✓

N/A = Not Applicable

Staff found that routinely meeting with their quality assurance or evaluation teams was helpful for improving their ZSI program. Staff from one organization stated that meetings with their quality assurance team gave them a chance to review policies and procedures, ensuring they are complying with grant requirements. During these meetings, they also review the completeness of clinician notes. Patient satisfaction surveys are used to identify areas for improvement in patients’ therapy and behavioral health experiences. Organization 2 stated that they work with their evaluation team to measure and improve ZSI implementation. This includes tracking training activities, using standardized tools, and tracking outcomes for patients who are referred for inpatient treatment for suicidal risk. Biweekly meetings with the ZSI Program Director, feedback from the board, and daily team meetings offer additional spaces for program improvement identification.

Change Stories, data, and reports are helpful to the UIOs as they track their progress toward achieving zero suicide. Tracking methods include Change Stories, reports, and surveys. Change Stories are a low-barrier participatory story collection method developed by Urban Indian Health Institute as part of its Indigenous Evaluation Framework. It is a participatory evaluation method that builds community ownership of the

evaluation process (Locklear, et al. 2023). Essentially, a Change Story offers a patient-narrated perspective on the impact ZSI is having on their life and mental health outcomes or perspectives. This organization also collects data via patient, community, and employee experience surveys. Although this organization previously had to conduct surveys using paper, staff can now send patient surveys via the new EHR. The other organization develops reports that include metrics such as how many patients were served and how many patients have insurance. The organization also tracks progress on its goals at a quarterly level. At this organization, staff transitions and a smaller workforce have forced quality improvement activities to come after caring for patient's immediate needs. This organization has plans to reprioritize quality improvement activities once its open positions are filled.

Perceived Impact

Staff from both organizations reported that they think ZSI has positively impacted patients. One staff member stated:

“Participants have a safe space to share their needs and feel heard by our facilitators. Patients have reported feeling welcomed and a sense of belonging from attending programs under ZSI. Patients have also indicated learning new coping skills to share with family members or practice with their families at home.”

Staff from the other organization said:

“Being able to see patients faster and provide a more wrap-around style of care than what our traditional adult mental health department can provide has created an environment where clients feel supported and cared for. One client recently lost her partner to death by suicide and reports that because of the support our ZSI team was able to offer her she now feels stable and like she can go on with her life and cope with her grief effectively.”

ZSI Sustainability

Both organizations are beginning to plan for sustainability of their ZSI programs. In this section, we present data about the grantees’ sustainability planning progress. **Table 5** illustrates the ZSI programmatic components and staff ratings on their sustainability and their organization’s progress toward sustainability for each one. This section ends by examining specific activities and challenges the grantees have faced trying to plan their ZSI program sustainability efforts.

In the APR, both organizations rated their sustainability planning progress on a scale from 1 to 7, where 1 represents little or no planning and 7 represents a very great deal of planning. **Overall, Organization 2 rated its sustainability planning as further along compared to Organization 1 (6.3 and 5, respectively).** Both organizations indicated that they had done the most sustainability planning related to the Train and Treat elements, followed by the Lead element and the partnership component. Organization 2 also rated its sustainability planning for the Identify element as having highly progressed (7). Organization 1 indicated that it had conducted the least amount of sustainability planning for the Identify element, while Organization 2 indicated that it had conducted the least amount of sustainability planning related to funding stability.

Table 5. Organizations Progress in Planning for Sustainability Programmatic Components

ZSI Programmatic Component	Definition	Organization 1	Organization 2
Train element	Has plans to continue training approaches after ZSI grant funding ends	6	7
Treat element	Has plans to continue the treatment processes and policies after ZSI grant funding ends	6	7
Lead element	Has plans to continue the leadership and communication structure after ZSI grant funding ends	5	6
Partnerships	Has plans to continue to foster connections between suicide prevention programming and the community after ZSI grant funding ends	5	6
Funding stability	Has a long-term funding plan in place for after ZSI grant funding ends	5	5
Identify element	Has plans to continue the screening and identification processes and policies after ZSI grant funding ends	3	7

Scale is 1 to 7, where 1 = little or no planning and 7 = a very great deal of planning.

Train Element – Sustainability Planning

Both organizations indicated that they had made a considerable amount of progress planning to sustain the Train Element. One organization specified that their planning entailed encouraging staff to participate in train-the-trainer trainings:

“Now that we have our case manager/intake coordinator on board, they’ll also be taking on the role of attending the Mental Health First Aid and Question, Persuade, Refer training as pretty much a train-the-trainer approach. So that way they can bring it back here and train either new employees who are coming on board and then training other departments who have not received those trainings yet.”

This train-the-trainer approach creates an in-house resource of expert staff who can train new or less experienced staff. Further, the train-the-trainer approach helps sustain the ZSI program because it also creates institutional memory and ongoing capacity within the organization.

Treat and Lead Elements – Sustainability Planning

Both organizations indicated that they had made considerable progress planning to sustain the Treat and Lead elements. However, neither organization offered details in their APR about what this planning entailed. During interviews, staff at one organization mentioned the need for additional confidential space to provide treatment and is looking for ways to grow. RTI will continue to collect data on progress for sustainability planning in future years and compare those data to where grantees were at baseline.

Partnerships

Both organizations indicated that their partnership planning was fairly well developed. Specifically, both organizations described collaborating with other organizations as an approach to sustaining their partnerships. For example, one organization indicated that it was working to identify expenses, such as food, that could be funded by other organizations to sustain their ZSI efforts. This organization is also working to develop a partnership strategy to sustain both its ZSI work and continue its collaboration with community partners. Staff at the other organization described working more broadly with partners to save lives.

Identify Element

The two organizations rated their sustainability planning progress very differently for the Identify element. Organization 2 indicated that it had made the most sustainability planning progress for this component, while Organization 1 indicated that it had conducted the least amount of sustainability planning progress for this component. At Organization 2, staff indicated that the organization has plans to continue screening patients throughout nearly all UIO departments after grant funding ends. Conversely, Organization 1 just transitioned to a new EHR system and stopped screening patients on the physical health side of its clinic while the UIO acclimates to its new EHR. The new system has made it hard for mental health staff to track screening across other departments and to plan for sustaining this screening across the UIO.

Funding Stability

Both organizations described diversifying their funding sources as a method of ZSI sustainment and rated their progress in planning this aspect of sustainability the same. One organization stated a need for different grants to cover different aspects of the program. Staff at this organization indicated that they felt confident in the UIO's ability to sustain ZSI because services such as evidence-based cultural practices are billable and therefore "embedded" in the work that is currently being done. In the APR, staff at this organization reported, *"The ZSI team is designed to be self-sustaining, with a majority of the services we offer being billable through Medicare/Medicaid."* Although most of their organization's core services are billable, some of the supportive or ancillary services are not. Thus, these supportive and ancillary services will likely be difficult to sustain without further planning or an alternative source of funding.

Although both grantees have identified the need for different funding sources to sustain ZSI, they still rely on grant funding to sustain their programs. Staff at one organization emphasized that continued funding through the ZSI grant will be important for sustaining the ZSI program.

Conclusions

During their first three 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. As the UIO ZSI grantees move into year four of their five-year grants, they are transitioning from implementation to begin planning to sustain their ZSI model after IHS grant funding ends. Also, they are working to address key implementation challenges and work towards full and sustained ZSI implementation. As grantees continue their ZSI implementation, five overarching lessons learned emerge from their efforts thus far.

Continue to Address Staff Burnout to Prevent Turnover.

Staff Turnover was one of the biggest challenges faced by the UIOs in year 2 and described in our Year 1 report. During grantees' year 3, both organizations made strides to address and prevent staff burnout, and resulting turnover. Thus, in year 3, staff burnout and turnover were no longer significant challenges. Specifically, in grant year 3, both organizations shared a commitment to supporting staff and preventing staff burnout. Also, staff at both organizations described efforts to prioritize their well-being and self-care to prevent burnout and provide support including mental health days, remote work and flexible scheduling opportunities. At the same time, staff remain aware that burnout can perpetuate turnover which can further exacerbate staff burnout. Therefore, this cycle is important to prevent. Staff also highlighted the need for ongoing leadership support and for suicide prevention work to remain a priority across all levels of their organizations to continue to prevent staff burnout and to stop the churn of staff. Although both organizations have made significant progress in this area, continuing to support staff and prevent staff turnover remains a focus of both organizations. Also, greater insight into which staff support strategies are most effective may be beneficial to efficiently use resources and maintain efforts to prevent burnout and turnover.

Continue to Focus on Culture in Suicide Prevention Efforts in Indian Country.

In our Year 1 report, culture featured prominently as both a critical component of ZSI implementation among the UIOs and an area for improvement. For example, staff at both organizations indicated that they lacked formal training on how to ask screening or assessment questions in ways that are culturally resonant with AI/AN individuals and their families. Although the ZSI model has Indigenous specific adaptations to its tools and resources, additional trainings to provide culturally informed perspectives of suicide may be helpful. Moreover, as the UIOs adapt their ZSI implementation to better reflect the culture and Tribes of the patients they serve, staff need to increase their documentation of what these adaptations entail for future replication. Lastly, offering staff practical experiences to conduct culturally informed screening and assessments and assess elevated suicide risk could increase their comfortability and ability to use these important skills.

Continue to Train UIO Staff to Confidently Recognize and Respond to Suicide Risk.

Across both organizations all behavioral health staff were trained to screen and assess patients for suicide risk. Further, nearly all behavioral health staff were trained to provide evidence-based treatment of suicide. However, the two organizations continued to take different approaches to training. One organization trained all staff—including part-time and contract staff—in suicide risk screening and assessment. This organization aimed to raise awareness about the importance of screening and reduce the stigma around suicide risk and prevention. The other organization trained staff based on their responsibilities and roles. This organization trained a smaller cadre of staff, mainly the behavioral health staff, in suicide risk screening and assessment. Although both organizations did train most staff, at least 20% of staff across both organizations reported a lack of confidence to respond if they suspect a patient is at elevated risk, that they felt unable to recognize warning signs that an

individual may be at elevated risk of suicide, and that they do not have the knowledge or training to recognize when an individual may be at elevated risk for suicide. These training gaps exist across all staff not just the behavioral health staff and regardless of whether the organization took a universal or focused training approach. Further, this training gap highlights a critical area of improvement that could help the UIOs maintain their zero suicide deaths beyond grant year 3.

Continue to Provide Strong and Thoughtful Organizational and ZSI Leadership.

In Year 3, staff continued to emphasize the essential role that organization and ZSI leadership play in facilitating ZSI model implementation and sustainability planning. Leadership obtained staff feedback throughout ZSI implementation and advocated for cross-departmental communication. Leadership also served a key role in both organizations by ensuring that they continued to implement the ZSI lead element with high fidelity. At the same time, leadership at each organization has taken a different approach to overseeing ZSI implementation, shaped by their organizational capacity and community dynamics. For example, leadership at one organization selected a new EHR. Despite some noted benefits, staff raised concerns about the manual and burdensome process involved in this EHR transition and the long-term impact of it on ZSI implementation.

As the grantees move into grant Year 4, leadership may consider increasing their efforts in communicating ZSI policies and procedures especially in situations where changes have occurred. Although ZSI team members described consistent structures and processes to communicate and share feedback among the team, staff's mixed perspectives on the clarity of organizational policies and procedures indicate a potential area for improving communication. Moreover, leadership could have considerable impact in improving the one organization's EHR transition by creating organizational policies, processes, and procedures that promote efficient EHR use and align EHR use for suicide prevention. For example, the new EHR could have suicide screening and assessment forms integrated into the system and have safety plans saved and flagged in the system.

Continue to Prioritize Sustainability Planning.

This evaluation report is the first to examine the grantees' sustainability planning progress using an adapted version of the PSAT. Across all six ZSI program components that were rated by grantees, both organizations rated their sustainability planning progress as above average (5.7 on a 7-point sustainability scale). Further, both organizations indicated that they had done the most sustainability planning related to the Train and Treat elements, followed by the Lead element. The Identify element had the largest difference in sustainability planning, with one organization rating their planning as highly progressed (rating = 7) and the other organization rating it as the least progress (rating = 3). For the organization with the least sustainability planning progress, staff indicated that their EHR transition had delayed the team's ability to plan efforts to sustain screening processes. Further, the EHR transition stopped this UIO from conducting suicide risk screening for patients receiving physical health care because the system lacked the capabilities to efficiently include and store that information. Thus, this organization has not been able to universally screen individuals for suicide risk.

Last, both organizations rated their progress planning to have long-term funding in place after their ZSI grant funding ends, and to continue to foster connections between suicide prevention programming and the community, as above average. Despite this, both indicated that they felt there was additional room for more sustainability planning. RTI will continue to monitor the grantees' sustainability planning progress as they move into their grant years four and five. Further, RTI recommends that grantees continue to make progress in planning for sustainability and increasing their PSAT across all ZSI components examined.



Roadmap for the Year 3 Monitoring Report

The evaluation team has planned a series of activities for Year 3 that will result in the second ZSICC monitoring report. The second monitoring report will focus on implementation processes and progress and will continue to examine the impacts ZSI has had on key outcomes. The sections below describe the focus of the second monitoring report and outline the steps the evaluation team will take to create it.

Monitoring Report

Similar to this evaluation report, the monitoring report will provide cross-site findings focused on observed impacts and understanding the implementation process and strategies that may have caused those impacts. In August 2025, 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 3, RTI will coordinate the cross-site evaluation with the UIOs.

Annual Data Collection

To address the key evaluation questions identified for the monitoring 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, and
- 6. Distal outcomes.

Table 6 details the primary and secondary data sources the evaluation team will collect and analyze, as well as the timeline for acquiring the data.

Table 6. Year 3 Evaluation Data Sources and Timeline

Data Source	Timeline
Site visit interviews	By November 2025
Annual Progress Reports	By May 2026
Workforce Surveys	By January 2026
Organizational Self-study surveys	By January 2026
National Vital Statistics Survey data	By beginning of April 2026

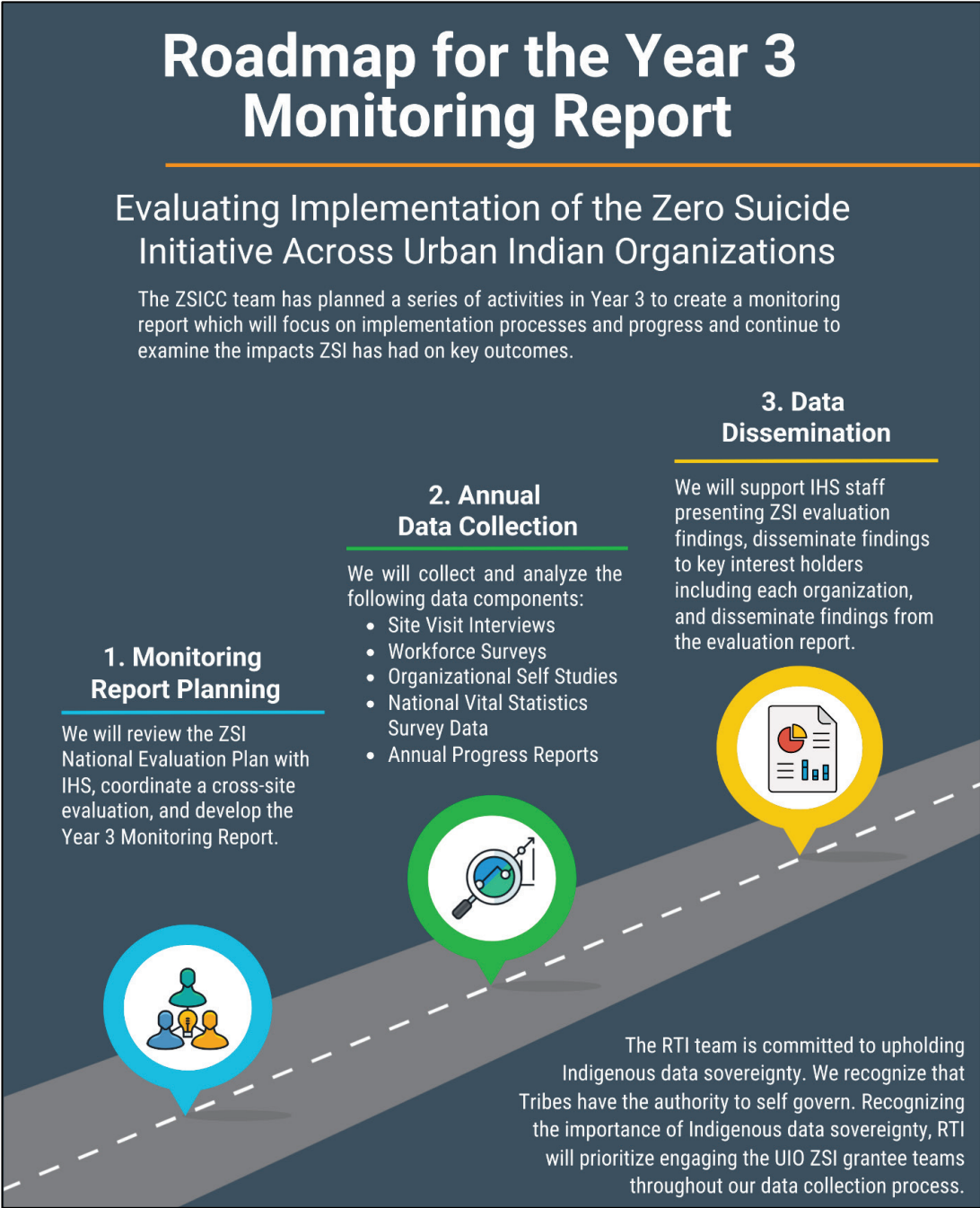
Data Dissemination

Starting in August 2025, the evaluation team will support IHS staff in presenting ZSI Year 2 evaluation 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 processes, impacts, and lessons learned. The evaluation team will also communicate its findings with key interest holders working on suicide prevention in Tribal communities.

At the end of Year 3 (June 2026), RTI will create PowerPoint slides and talking points to summarize the monitoring report and disseminate findings among audiences similar to those of the Year 1 monitoring report and Year 2 evaluation report.

Figure 7 provides an overview of RTI’s plan to create the Year 3 monitoring report.

Figure 7. Year 3 Monitoring Report Roadmap



References

- Bronner, K., Scottie Eliassen, M., & Skinner, J. (2021). *The Dartmouth atlas of health care: 2018 data update*. The Dartmouth Institute for Health Policy and Clinical Practice. https://data.dartmouthatlas.org/downloads/reports/2018_data_report_081821.pdf ↗
- Crosby, A., Gfroerer, J., Han, B., Ortega, L., & Parks, S. E. (2011). Suicidal thoughts and behaviors among adults aged ≥ 18 Years—United States, 2008–2009. *Morbidity and mortality weekly report. Surveillance summaries* (Washington, D.C.: 2002), 60(13), 1–22. <https://doi.org/10.15585/mmwr.ss7101a1> ↗
- Leavitt, R. A., Ertl, A., Sheats, K., Petrosky, E., Ivey-Stephenson, A., & Fowler, K. A. (2018). Suicides among American Indian/Alaska Natives—National Violent Death Reporting System, 18 states, 2003–2014. *Morbidity and Mortality Weekly Report*, 67(8), 237–242. <https://doi.org/10.15585/mmwr.mm6708a1> ↗
- Locklear, S., Hesketh, M., Begay, N., Brixey, J., Echo-Hawk, A., & James, R. (2023). Reclaiming our narratives: An Indigenous evaluation framework for urban American Indian/Alaska Native communities. *Canadian Journal of Program Evaluation*, 38(1), 8–26. <https://doi.org/10.3138/cjpe.75518> ↗
- Murphy, S. L., Kochanek, K. D., Xu, J. Q., & Arias, E. (2024). Deaths: Final data for 2021. *National Vital Statistics Reports*, 73(8). National Center for Health Statistics. <https://dx.doi.org/10.15620/cdc/158787> ↗
- Schell, S. F., Luke, D. A., Schooley, M. W., Elliott, M. B., Herbers, S. H., Mueller, N. B., Bunger, A. C. Public health program capacity for sustainability: a new framework. *Implement Sci*. 2013 Feb 1;8:15. <https://doi.org/10.1186/1748-5908-8-15> ↗
- Stone, D., Trinh, E., Zhou, H., Welder, L., End Of Horn, P., Fowler, K., & Ivey-Stephenson, A. (2022). Suicides among American Indian or Alaska Native Persons - National Violent Death Reporting System, United States, 2015-2020. *Morbidity and Mortality Weekly Report*, 71(37), 1161–1168. <http://dx.doi.org/10.15585/mmwr.mm7137a1> ↗

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

As the Zero Suicide Initiative Coordinating Center (ZSICC), RTI maintains 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.

To uphold these principles in the second year of the evaluation, the evaluation team continued to apply collaborative collection efforts and practice secure data storage. In alignment with introductory calls and data maps created during Year 1 of the evaluation, the evaluation team continued to collect (1) primary qualitative data through one-on-one interviews with leadership and implementation staff at each site, and focus group discussions with providers and frontline staff at each site; (2) Annual Progress Report (APR) data by using Research Electronic Data Capture (REDCap), a HIPAA-secure web-based data collection tool; and (3) secondary data abstracted and synthesized from grantees’ background materials such as applications, patient satisfaction surveys, and staff and organizational surveys.

The evaluation team’s collaborative and engaged approach impacted all aspects of qualitative data collection. In preparation for interviews with ZSI staff, the team reviewed the interview guides with the Urban Indian Organizations (UIOs) to obtain their feedback. Feedback sessions were conducted with key ZSI leaders at each organization. During these sessions, the team reviewed a 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. Finally, the evaluation team shared with the ZSI leadership at each organization the types of staff (e.g., medical providers, staff in patient-facing roles) they wanted to engage in qualitative interviews. Based on this guidance, ZSI leadership provided a list of staff and their contact information so the team could schedule interviews in a private and confidential manner. **Table A-1** outlines the steps the team took to engage the UIOs in the qualitative interview process.

Table A-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.	Early September 2024
Drafted interview guides based on identified topics.	Late September 2024
Held feedback sessions on the interview guides with ZSI leadership at both UIO organizations.	Early October 2024
Revised the interview guides based on UIO feedback and shared them with IHS for feedback and approval.	Late October 2024

In addition to reviewing the qualitative data collection instruments with the UIOs, the evaluation team reviewed the APR data provided by the UIOs to ensure that they were correct. This review process included discussions about apparent anomalies in the data or emerging trends. These discussions took place within a month of

submitting the APR data and will also take place during the upcoming evaluation Year 3 site visits to ensure our team understands and is aware of changes in data trends.

Finally, the evaluation team created two-page summary documents specific to each UIO based on evaluation information from the Year 1 (Grant Year 2) Monitoring Report including data obtained from the site visit, Workforce Survey, Organizational Self-study, and the APR. The evaluation team shared these summaries with UIOs so they could use them for their own purposes (e.g., funding, program improvement). Upon completing each two-pager, the evaluation team presented the data to key ZSI leaders at each organization and answered questions.

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