

## “AIM for Zero: Suicide Care is Healthcare”

Suicide Prevention Center of New York

September 28-30, 2021

*Reports by The Sophie Fund*



### DAY I — Zero Suicide in Healthcare



**Tuesday, September 28**  
**8:30 am-12:30 pm**

**Keynote speaker:**

Charles Edward Coffey, MD,  
*DLFAPA, FAAN, FANPA, FISEN -  
Affiliate Professor of Psychiatry  
and Behavioral Sciences at the  
Medical University of South Carolina*

### DAY II — Equity, Cultural Responsiveness & Suicide Prevention in Healthcare



**Wednesday, September 29**  
**8:30 am-12:30 pm**

**Keynote speaker:**

Sadé Heart of the Hawk Ali,  
*MA (Mi'kmaq First Nation) -  
Tribal Lead, Senior Project Associate  
at the Zero Suicide Institute*

### DAY III — Going from Good to Great in Suicide Care



**Thursday, September 30**  
**8:30 am-12:30 pm**

**Keynote speaker:**

David Covington, LPC, MBA  
*CEO and President of Recovery  
Innovations International, Partner at  
Behavioral Health Link & serves on  
Executive Committee of National  
Action Alliance for Suicide Prevention*

## **“Vision Zero: Eliminating Suicide & Transforming Healthcare” [\[WATCH VIDEO\]](#)**

*C. Edward Coffey, a professor of Psychiatry and Behavioral Sciences at the Medical University of South Carolina*

C. Edward Coffey, a professor of Psychiatry and Behavioral Sciences at the [Medical University of South Carolina](#), begins his presentation with a statement that is both a troubling snapshot and a call to action: “We have a real crisis in this country with regard to suicides.”

Coffey’s presentation, [“Vision Zero: Eliminating Suicide & Transforming Healthcare,”](#) the kickoff session of the Suicide Prevention Center of New York’s [“AIM for Zero: Suicide Care is Healthcare”](#) symposium September 28-30, noted that suicide rates in the United States increased 35 percent from 1999 to 2019.

Coffey cited the landmark [“Crossing the Quality Chasm: A New Health System for the 21st Century,”](#) a damning report by the Institute of Medicine two decades ago, for helping lay the foundation for Zero Suicide, a model aimed at preventing suicides among patients in healthcare systems.

“Our thought leaders are saying back in 2001 that our system is broken,” Coffey said. “And, furthermore, it is so badly broken that we're not going to fix it by tweaking at the margins. We need to basically tear it up and start over. Remember, this criticism is not coming from a fringe group, but was authored by the thought leaders in international healthcare.”

Coffey pointed to [2021 research](#) published by the Commonwealth Fund showing how the United States ranked “dead last” among well developed high income nations in overall healthcare, access to care, administrative efficiency, equity, and outcomes. The same research, he noted, found that the U.S. ranks dramatically lower than the other nations in value for money spent on healthcare. “Although the Chasm report was written 20 years ago and it bemoaned our healthcare system then, the unfortunate news is that problems persist,” he said.

The Chasm report described six dimensions of ideal healthcare, Coffey explained; “healthcare should be safe, effective, patient-centered, timely, efficient, and equitable.”

He took up the challenge himself by becoming a leader in developing what has become known as the [Zero Suicide Model](#), designed to prevent suicide deaths through systemic quality improvements within healthcare systems. In the early 2000s, Coffey led the [Perfect Depression Care Initiative](#) at Michigan’s Henry Ford Health System. The initiative achieved an 80 percent reduction in suicide deaths among Henry Ford patients including a decline to zero suicides in some annual reporting periods.

With a grant from the [Robert Wood Johnson Foundation](#), the initiative sought to apply perfection goals for suicide prevention to the Chasm report’s elements of ideal healthcare. It began by applying the audacious goal of eliminating suicides to the element of effective care. Other goals included eliminating medication errors and achieving 100 percent patient satisfaction in the areas of patient-centered care, timely care, efficient care, and equitable care.

Coffey stressed that improving suicide care requires creating a “just culture” in the healthcare workplace, a “culture in which mistakes and errors are viewed as system issues, not personal failings, [and] are viewed as opportunities for learning and for improving the system, not punishing people. It's profoundly important. We can't ask our teammates to go up to plate and try to hit a home run every time, and then turn right around and punish them for striking out.”

Zero Suicide protocols that grew from the Henry Ford experiment include leadership of a system-wide culture change committed to reducing suicides, training a competent workforce, identifying individuals at risk with comprehensive screening and assessment, engaging at-risk individuals with care management plans, treating suicidal thoughts and behaviors with evidence-based treatments, and transitioning patients through care with warm hand-offs and supportive contacts.

Coffey said that early adopters of the Zero Suicide Model are now replicating Henry Ford's advances. Among them: [Centerstone](#), which provides mental health and addiction services in Tennessee and other states; [Gold Coast Mental Health and Specialist Services](#), in Australia; and [110 community mental health clinics](#) in New York State.

Coffey noted how Zero Suicide's standards and goals are embedded in U.S. health policy and accreditation guidelines and requirements, such as the [2012 National Strategy for Suicide Prevention](#) and The Joint Commission's [National Patient Safety Goal for Suicide Prevention \(NPSG\) 15.01.01](#).

Addressing colleagues who bemoan the immense challenges of preventing suicide deaths, Coffey recalled the internal discussions in developing the Perfect Depression Care Initiative at Henry Ford.

“What number of suicides are we going to tolerate? Is 12 suicides a year the right number? Is that numbering your parent or my sister? We realized that the only answer to this question is zero. Our goal has to be zero. And at that moment, our department was transformed. We stopped trying to be the best, we stopped trying to improve incrementally, and we began to strive for perfection in all of our goals. What does it mean to be the best in a mediocre industry? ‘Being the best’ isn't good enough. We've got to pursue perfection.”

Coffey emphasized the importance of leadership in implementing the Zero Suicide Model.

“Leadership involvement is essential to the success of this kind of work,” he said. “This cannot be the flavor of the month. It can't be the quality improvement project of the month. It has to be a system-wide initiative.”

**“If Preventing Suicide Is Our Target, Suicide Safe Care—in All Healthcare Settings—Is the Bullseye” [[WATCH VIDEO](#)]**

*Michael Hogan, former New York State Commissioner of Mental Health and co-developer of the Zero Suicide Model*

Michael Hogan, former New York State Commissioner of Mental Health and co-developer of the [Zero Suicide Model](#), asks healthcare professionals to reconsider a conventional wisdom.

How much should we rely on upstream suicide prevention efforts like reducing suicide causes and risk factors such as trauma, mental illness, addiction, economic insecurity, pain, loss, and isolation?

Speaking at the Suicide Prevention Center of New York’s [“AIM for Zero: Suicide Care is Healthcare”](#) symposium September 28-30, Hogan agreed that upstream strategies are important and worthy of pursuit.

Yet, he warned in his presentation, [“If Preventing Suicide is Our Target, Suicide Safe Care—in All Healthcare Settings—Is the Bullseye.”](#) upstream strategies are nonetheless “woefully inadequate and unlikely to affect rates of death in the next several decades.”

“It's unreasonable to expect rates of suicide to decrease because of upstream prevention activities unless we really, really dramatically increase them,” Hogan explained. “We have inadequate access to care, as a very significant number of people with mental health problems don't get care. The great majority of people with addiction problems don't have access to care. Reducing suicide by curing depression is a very tough call. Big factors like economic insecurity or human pain and loss and isolation are very tough things to fix in our society.”

Hogan noted that the success in preventing cardiovascular disease by reducing smoking through upstream activities included 30 surgeon general reports, national and state education campaigns, anti-smoking laws, and significant taxes on tobacco products—and still required a 50-year effort that remains unfinished.

Hogan argued that the suicide prevention field can learn from other medical fields that have achieved decreasing rates of death, from heart disease and cancer, for example, due to preventive interventions. He likened the potential of utilizing the Zero Suicide Model for those at risk of suicide to the success of preventive interventions and treatments such as statins, stents, and valve replacements for those at risk with cardiovascular disease.

As heart disease deaths have been reduced through targeted preventive interventions for people at elevated risk, Hogan said, suicide risk can be mitigated by identifying and managing suicidality through targeted preventive interventions such as screening, safety planning, reduction of lethal means, and caring contacts.

“Just as we can identify high blood pressure through a blood pressure screening, or high cholesterol through an examination of blood chemistry, we can identify those who are at risk of

suicide,” Hogan said. “Then, even more importantly, there are things that we can do that are effective. We’ve now got evidence that very brief, small interventions are quite effective in reducing rates of suicide.”

Hogan pointed to research demonstrating the effectiveness of patient screening for identifying suicidality, and of safety planning protocols for reducing suicide behaviors. He cited a [2013 study](#) that looked at more than 75,000 patients who completed the [PHQ-9](#) Patient Health Questionnaire, which found that 80 percent of the respondents who subsequently died by suicide had indicated elevated suicidal thoughts in the survey.

Another study Hogan cited showed a 45 percent reduction of suicide behaviors among patients who received safety planning. Still another study showed a 50 percent reduction in suicide deaths among patients receiving follow-up caring contacts from healthcare providers; caring contacts are phone calls, text messages, letters, or postcards, which are deemed to decrease isolation and increase connectedness.

For treatment of suicidal individuals, Hogan said, just as heart disease can be treated through interventional cardiology, suicidality can be treated with [Cognitive Therapy for Suicidal Patients](#) (CT-SP) and [Dialectical Behavior Therapy](#) (CBT).

Healthcare settings are ideal places for addressing suicide, Hogan said, because more than 80 percent of people dying by suicide and more than 90 percent of people attempting suicide had healthcare visits, and 40 percent had received emergency department care, in the prior 12 months; in the month before death, nearly half of those who died by suicide had a primary care visit, and nearly one-fifth had contact with mental health services.

“If we want to save lives from suicide, broader encouragement and action that focuses on suicide safe care especially in mainstream healthcare settings and most especially in capable or integrated primary care is our best bet,” said Hogan. “I would advocate that that would be the single most feasible effective action we could take to reduce rates of suicide.”

Pressing for suicide care in primary care practices, Hogan added, “It’s almost as if when it comes to suicide we don’t do anything except hope that people see a specialist. I’m going to make the argument that we now have tools for suicide care in primary care that are effective, comparable to things that we now do to care for the heart. So the argument is, let’s care for the brain the way we care for the heart.”

Hogan argued for a culture change in healthcare thinking about behavioral health treatment. “It’s an easily understandable but sad paradox from my point of view that care for the heart is very well established as a primary care responsibility—we know what the internist is supposed to do and what the cardiologist is supposed to do, and the lines of referral between the two are pretty clear—but the care for the brain isn’t that well established.”

Hogan noted emerging evidence that Zero Suicide has reduced suicide rates where it has been adopted compared to usual care. For example, he said the Henry Ford Health System in

Michigan achieved a 75 percent reduction; Centerstone in Tennessee a 65 percent reduction; and the Institute for Family Health in New York a 65 percent reduction.

### **“A National Perspective on Zero Suicide in Healthcare” [[WATCH VIDEO](#)]**

*Richard McKeon, Branch Chief for Suicide Prevention at the Substance Abuse and Mental Health Services Administration (SAMHSA)*

Richard McKeon, Branch Chief for Suicide Prevention at the [Substance Abuse and Mental Health Services Administration](#) (SAMHSA), highlights that Goal 8 of the 2012 [National Strategy for Suicide Prevention](#) encourages healthcare programs to “explicitly adopt the goal of Zero Suicide.”

Goal 8, McKeon noted in [“A National Perspective on Zero Suicide in Healthcare.”](#) a presentation to the Suicide Prevention Center of New York’s [“AIM for Zero: Suicide Care is Healthcare”](#) symposium September 28-30, was reiterated in the U.S. surgeon general’s “Call to Action” issued in January 2021.

“The public and private sector looked at where we were in terms of suicide prevention and came to the conclusion that it wasn’t that we needed a new strategy but rather we needed to be vigilant about implementing the strategy that we have and the things that we know work and bringing them to scale,” McKeon said. “One of those things was Zero Suicide.”

McKeon reviewed the core components of [Zero Suicide](#):

- Makes suicide prevention a core responsibility of healthcare
- Is a systematic approach in health systems, not the “heroic efforts of crisis staff and individual clinicians”
- Applies new knowledge and proven tools for suicide care
- Supports efforts to humanize crisis and acute care
- Is embedded in [The Joint Commission Sentinel Event Alert](#) and the 2012 [National Strategy for Suicide Prevention](#)

McKeon also outlined Zero Suicide’s “pathway to care” model:

- Create a leadership-driven, safety-oriented culture
- Develop a competent, confident, and caring workforce
- Identify and assess risk, by screening and assessing
- Provide evidence-based care, including a safety plan, restricting lethal means, and treating suicidality directly with proven therapies
- Provide continuity of care

“There needs to be agreed upon guidelines for care, such as those that Zero Suicide provides, around identifying and assessing suicide risk, what the approach is for screening, and then for

those who are identified as being at risk for suicide an approach to assessment, and that they have access to evidence-based care,” McKeon explained.

McKeon pointed to the use of recent assessment and treatment tools, such as the [PHQ-9 Patient Health Questionnaire](#), [C-SSRS Baseline Screening](#), and the [Brown Stanley Safety Plan](#); and to several therapies for treating suicidality directly: [Dialectical Behavior Therapy \(DBT\)](#), [Cognitive Behavioral Therapy \(CBT\)](#), [Collaborative Assessment and Management of Suicidality \(CAMS\)](#), and the [Attempted Suicide Short Intervention Program \(ASSIP\)](#).

He highlighted restricting access to lethal means as a key evidence-based protocol of care that should be systematically adopted. He also noted that Zero Suicide protocols steer clinicians away from harmful practices.

“For years, clinicians were relying on what were called ‘no suicide’ contracts because we weren't providing them with anything better to utilize in working with people who were at high risk,” he said. “We know that ‘no suicide’ contracts were not only not effective, there was some evidence that they were counterproductive because patients in some sense accurately perceived they were more about the clinician or the system's desire for protection from liability than it was about them and their pain. And of course it wasn't effective to protect against liability, either.”

Another practice that Zero Suicide warns against, McKeon said, is directing healthcare clients to fill out a Patient Health Questionnaire that omits the question about suicidal thoughts and self-harm. “Dropping the suicide question is like putting on the medical chart, ‘If this patient is suicidal, we don't want to know,’” he said.

Research supports the value of providing continuous contact and care for suicidal individuals, McKeon said. For example, he said that a survey of healthcare clients' perceptions of care published by Columbia University researchers showed that 58.9 percent felt that follow-up phone calls helped “a lot” in stopping themselves from taking their own lives, and 21 percent said the calls helped “a little.”

“Ubiquitous and inexpensive technology is changing nearly every other industry,” McKeon said. “At a time when we can track a package halfway around the world, it should be unacceptable in the United States of America for us to lose track of people at high risk for suicide within the lethal gaps in many of our systems.”

McKeon said he understood why the idea of Zero Suicide has been controversial, with skeptics saying “we're never going to be able to get there.” He said he empathized with a feeling among family members as well as clinicians who have lost loved ones or patients that Zero Suicide suggests that they should have been able to prevent the deaths. “That's not at all what we mean, we sometimes talk about the preventability of suicide in too quick a way,” he said.

McKeon argued that Zero Suicide is an important goal representing “an assault on the fatalism around suicide that has held us back for many years, including in mental health components... What we mean is that no suicide is fated, no suicide is predestined, no matter how high the risk,

until the person takes that final fatal step. There is always hope that they can be averted from that trajectory.”

A core belief of Zero Suicide is that the mission cannot be left to the efforts of an individual clinician but rather requires the dedication of the entire healthcare system, he stressed.

“When we say [suicide prevention] is a core responsibility of healthcare, it is really important that that's not misinterpreted as the responsibility of individual clinicians,” McKeon said.

“For too long, but it is now changing with Zero Suicide, suicide prevention depended on the heroic efforts of individual clinicians or crisis staff, and many tried heroically to save lives and did save lives. But they were not backed up by a systematic approach within their system. It's that systematic approach that really works.

“There's a protocol for care for people who have been identified at higher risk, and there is consensus about how to assess the risk and about the treatments that can effective. That's what Zero Suicide is about.”

McKeon outlined various other recent steps the federal government has taken to advance suicide prevention. He cited provisions in the [21st Century Cures Act](#) of 2016 that authorized the [National Suicide Prevention Lifeline](#) into law for the first time and reauthorized the [Garrett Lee Smith Memorial Act](#) that provides grants for youth suicide prevention.

He outlined some of the progress being made in implementing Zero Suicide across the United States. He said SAMHSA has provided 35 Zero Suicide grants, and that implementation is underway in the Indian Health Service and the Air Force.

### **“Implementing Zero Suicide in Health Systems” [[WATCH VIDEO](#)]**

*Brian Ahmedani, director of the Center for Health Policy and Health Services Research at the Henry Ford Health System*

Brian Ahmedani, director of the [Center for Health Policy and Health Services Research at the Henry Ford Health System](#), argues that a two-decade surge in the United States suicide rate underlines the need for greater efforts to prevent deaths by suicide.

“The suicide rate is the only cause of death right now in the U.S. that over the last 20 years has actually been increasing,” said Ahmedani in his presentation, [“Implementing Zero Suicide in Health Systems,”](#) at the Suicide Prevention Center of New York’s [“AIM for Zero: Suicide Care is Healthcare”](#) symposium September 28-30.

“All of the other leading causes of death in the U.S. have annual rates that are either relatively stable or have actually been dropping pretty substantially over this period,” he said.



Ahmedani made the case for preventing suicide in healthcare by pointing to his own [landmark research](#) published in 2014 based on data from nearly 6,000 suicide deaths that more than 80 percent had seen a healthcare provider in the previous 12 months, almost 50 percent within a month, and more than 20 percent within a week.

Moreover, he said, the greatest number of individuals who died by suicide were not receiving mental health services, and more than half did not have a mental health diagnosis, pointing to the importance of using other healthcare settings such as primary care practices to identify suicidal individuals.

“We really need to think about how we can put high intensity services in the settings where the fewest people go but who are at the highest risk, and then make sure that we also have low intensity services in those settings where there’s lots of people going to get care and most people are not at risk but where most people are touching before they die by suicide,” he said.

Ahmedani credited the 2012 [National Suicide Prevention Strategy](#) for the landmark mandate determining that suicide prevention is a core responsibility of healthcare. He said that the [Zero Suicide Model](#), developed at Henry Ford, took that mandate forward and provides the tools for a “golden era” of preventing suicide in healthcare.

At Henry Ford, he said, “We really focused on providing better care overall for our our patients and after doing that we saw a pretty substantial 75 to 80 percent reduction in suicide deaths over time in our in our health system. We were able to sustain that for almost 20 years now. You can think about all the numbers of lives that have been saved just because of that kind of care.”

He credited the development of many tools throughout the last 20 years, such as the [PHQ-9 Patient Health Questionnaire](#), [C-SSRS Baseline Screening](#), [Brown Stanley Safety Plan](#), [Dialectical Behavior Therapy](#) (DBT), and [Collaborative Assessment and Management of Suicidality](#) (CAMS).

“This field is in its infancy stages, but yet we have all of the tools now,” Ahmedani said. “So we are in the opportunity phase of being able to implement those things into practice, and to use not only the knowledge that’s available from, and the structure that we developed at, Henry Ford, but also piggyback on all the research that’s been done across this entire time.”

“We also need the leadership and and the bold vision to push these things forward,” he added.

Ahmedani shared that Henry Ford is participating in three initiatives to further advance the Zero Suicide Model.

He said that Henry Ford and Kaiser Permanente are currently involved in a five-year study in six healthcare systems in Michigan, Washington State, Colorado, Oregon, and California covering 10 million patients a year to evaluate implementation of the Zero Suicide Model. The study is examining the health system metrics for driving implementation, fidelity to those metrics, and whether faithful implementation reduced suicide deaths.

A second initiative is a five-year comprehensive program to “revolutionize” suicide care within the Henry Ford Health System’s emergency departments, he said. It entails universal screening of every ED patient, risk assessments and safety plan counseling for positive screens, bridging referrals to behavioral health care through telehealth appointments with therapists, and post-discharge caring contacts.

Finally, Ahmedani said that through an initiative called MI-MIND, Zero Suicide processes are going to be implemented over the next few years in the five largest healthcare provider organizations across the state of Michigan in coordination with Henry Ford.

“We’re facilitating a suicide learning collaborative with healthcare systems that includes a monthly or a quarterly call to talk through their local implementation challenges, barriers, and opportunities, and work together as systems across the state,” he said.

“This is a model for going from one system, doing core implementation in behavioral health that spread to primary care, the emergency department, the hospitals, and all of our systems internally, to then spreading to new and revolutionized opportunities across multiple systems across the state,” he said.

“We have done this in Michigan, we have done this in different places across the state, and each of you have the opportunity to use this as a model to work across New York. Let’s let Michigan, let’s let New York, be leaders in the nation in suicide prevention.”

Ahmedani said that the Zero Suicide Model has been adopted by the national health systems or local health systems in more than 20 countries. “This this thing is growing like wildfire,” he said.

### **“Best Practices for Primary Care” [[WATCH VIDEO](#)]**

*Virna Little, Chief Operating Officer & Co-Founder of Concert Health, a national organization providing behavioral health services to primary care providers*

Virna Little, Chief Operating Officer & Co-Founder of [Concert Health](#), a national organization providing behavioral health services to primary care providers, trumpets the importance of preventing suicide in primary care.

Research shows that about 84 percent of people who die by suicide, and 92 percent of those who attempt suicide, had a healthcare visit within a year of their acts, Little said in her presentation, [“Best Practices for Primary Care,”](#) at the Suicide Prevention Center of New York’s [“AIM for Zero: Suicide Care is Healthcare”](#) symposium September 28-30.

Little also cited recent research indicating that people who died by suicide had suddenly resurfaced in primary care and became active on their healthcare portals within a month of their deaths.

Little spoke of her experience in conducting [Zero Suicide](#) trainings for 3,000 primary care providers in 27 states. She found that while 95 percent of the providers considered suicide prevention as part of their role, many of them were not trained either in their current positions or in their previous education. She found that many felt they did not have the knowledge or time to assess and intervene with an individual at risk of suicide.

She added that more than half of the behavioral health providers in these primary care settings did not feel comfortable or confident to care for someone at risk for suicide. She found that some people in her trainings were not familiar with the standard Patient Health Questionnaire that includes a key screening question about self-harm ([PHQ-9](#)).

Little reported that many providers who had received traditional suicide prevention training did not feel it was helpful due to the trainers' lack of understanding of how primary care practices operate.

“There are all kinds of places in primary care where people can fall through the cracks,” she said. “What I wanted to do was bring the idea of Zero Suicide and suicide safer care right to the front line, to make sure that we were doing something that would change what was happening in the primary care visit for people that were at risk for suicide.”

In her experience engaging primary care providers, Little said, they could easily identify their population of patients who suffered from diabetes but were usually silent when asked about how many of their patients were at risk for suicide.

Little felt that pediatric providers don't really understand the extent of the problem of youth suicide. She cited data from the [2019 Youth Risk Behavior Survey](#) conducted by the Centers for Disease Control and Prevention indicating that 8.9 percent of high school students in the survey had attempted suicide in the past year, and 18.8 percent had seriously considered taking their own lives.

In her training, Little urges primary care providers to adopt the seven core elements of the Zero Suicide Model, to bring a systemic approach to suicide care into their practices. Little stressed the importance of engaging everyone in a primary care practice, whether physicians and nurses or front desk and billing staff, in the process of suicide care.

“I often give an example of a practice where somebody cancelled three appointments within a very close time frame, and died by suicide,” Little said. “Nobody who answered the phone knew that she was at risk for suicide to do anything different. There was no process in place to catch that.”

Little's training takes providers through the Zero Suicide protocols: effective screening procedures, speaking directly with patients identified as at risk, safety plans for patients, referrals to behavioral health specialists, and follow-up caring contacts.

She advises primary care providers to include suicidality on their patient problem lists, which provide immediately accessible structured data on their patients' most important illnesses,

diseases, injuries, or other health issues. “Imagine telling your primary care provider something really important, and then the next time you came in nobody even remembered,” she said.

Little said she also speaks with primary care providers about creating “pathways” of care for suicidal patients within their practice, and thinking about appropriate levels of care so that suicidal patients are not automatically dispatched to hospital emergency departments.

“For example, everybody that comes in with chest pains, we would probably do an EKG, not everybody would go to the emergency room,” she said. “Not everybody who is asthmatic goes to the emergency room. So, one of our jobs in primary care is to make sure that people get the appropriate level of care.”

Little said that she found suicide care became more relatable when the primary care providers understood how discussing a patient’s suicidal thoughts with them and making referrals was little different than the usual workflows they use for patients with other issues like high blood pressure or asthma.

“Making those comparisons for primary care providers was incredibly helpful because it really helped them say, ‘Wait a minute, you know what? I actually do this.’ I would remind them that, yeah, we shift gears all day long in primary care. It would be a beautiful day in primary care if somebody came in and they just had one thing going on and it was the actual thing that was the most urgent. If you’re going to engage primary care providers in this work, you have to speak primary care.”

She also said it was useful to provide primary care practices with role modeling for visits by individuals at risk for suicide, and to share storage statements with them that can be used to speak with such patients. She takes primary care providers through a role play of getting an at-risk individual to put the [National Suicide Prevention Lifeline](#) number in their phone contacts, or to access [www.nowmattersnow.org](http://www.nowmattersnow.org), a website that shares stories of how people have coped with and survived painful emotions.

### **“Zero Suicide Work in Emergency Departments: Opening Pandora’s Box” [[WATCH VIDEO](#)]**

*Edwin Boudreaux, professor of Emergency Medicine, Psychiatry, and Quantitative Health Sciences at the University of Massachusetts Medical School*

Edwin Boudreaux, professor of Emergency Medicine, Psychiatry, and Quantitative Health Sciences at the [University of Massachusetts Medical School](#), advocates for universal suicide risk screening for patients entering a hospital emergency department.

The emergency department (ED), he said in [“Zero Suicide Work in Emergency Departments: Opening Pandora’s Box,”](#) his presentation to Suicide Prevention Center of New York’s [“AIM for Zero: Suicide Care is Healthcare”](#) symposium September 28-30, presents an opportunity to identify and provide support for individuals at risk for taking their own lives.

He cited research indicating that some 40 percent of people who died by suicide had made an ED visit within the year, and mostly for reasons other than a personal mental health crisis. “A substantial proportion of them are being seen for a psychiatric crisis, but many of them aren't and then they're dying by suicide in the weeks or months after that visit,” he explained. “Is there something better we could do to try to detect that suicide risk prior to the person dying?”

Boudreaux also cited research showing that when ED patients were systematically screened, a larger than expected percentage indicated an elevated suicide risk due to recent suicidal ideation or a past suicide attempt.

Boudreaux himself led a universal screening study covering eight EDs across the United States. That study found that use of universal screening was feasible to implement, and that it detected suicide risk in 5.7 percent of patients compared to 2.9 percent in “treatment as usual” settings.

“The emergency department is a suicide risk environment, but we're missing most of the patients who have suicide risk by using our existing approaches of just screening patients who are presenting with frank psychiatric symptoms,” Boudreaux said. “We demonstrated that it was feasible to do the [universal] screening and that when we did this improved screening we actually improved detection.”

Boudreaux called universal screening a “Pandora’s Box” because of a common fear among healthcare administrators that such screening could challenge workloads and “break” the ED system. He said they worry about the lack of behavioral health providers, at-risk patient observers, boarding capacity, training for handling suicidal patients, and time required for making assessments. In addition, he said, administrators are concerned about creating patient dissatisfaction among individuals seeking ED services for non-mental health conditions.

“The biggest fear people have is, ‘What if I ask the question about suicide and they say yes. Then what do I do?’” he said. “The objection is it's simply not feasible. There's no way you can implement universal screening because it's going to break the emergency department.”

For making the screening itself more feasible, Boudreaux pointed to [Computerized Adaptive Tests](#), or CATS, a research-tested technological innovation in screening, and a CATS tool for youth known as the [Computerized Adaptive Screen for Adolescents](#), or CASSY. He noted that traditional mono-dimensional quick-screen instruments like the [C-SSRS Baseline Screening](#) focus only on suicidal ideation and behavior. He said that CATS conducts screens quickly and with improved fidelity and efficiency, and also addresses multiple dimensions (such as depression, PTSD, suicidal ideation/behavior, and trauma history) yielding a spectrum analysis with more precise results and allowing a more complex risk formulation.

Boudreaux acknowledged the challenges of implementing universal screening in hectic EDs. He said that his study found that sometimes clinicians go through the motions of screening and mark a patient negative for suicidal thoughts without actually asking them the question.

Boudreaux argued that opening Pandora's Box is do-able if EDs use their Clinical Decision Rules with the support of the CATS tool, and follow the Zero Suicide Model of efficient and appropriate pathways for suicide care.

“You have to establish a very clear protocol,” he said. “People can't be confused or vague about what they do when they ask the screener and if they get a yes, or if they get a mild, moderate, or high risk. There can be no ambiguity. Your institution has to have very clear policies and procedures around the stratification of those patients and what happens. You can't treat all risks the same. It's a huge resource burden.”

He said for example, many patients screening positive for suicidal ideation do not need full psychiatric examinations or intensive safety precautions such as observation or boarding. He said that patients screening for mild risk could be given a referral to a behavioral health provider and educational materials to review.

Boudreaux highlighted the imperative that EDs understand the need for compassionate and evidence-based intervention that takes into account the patient's values and preferences.

“They want respect,” he said. “Their idea of safety is treating is them with compassion. They want to feel like they can trust the clinicians who are working with them and not to overreact if they share that they're suicidal and get the security guard involved and have to strip search them and admit them to an inpatient unit. It's going to make them feel vulnerable. It's going to make them feel traumatized, not safe.”

**“The Promise of 988: Crisis Care for Everyone, Everywhere, Every Time” [\[WATCH VIDEO\]](#)**

*David W. Covington, member of the Executive Committee of National Action Alliance for Suicide Prevention*

David W. Covington, member of the Executive Committee of [National Action Alliance for Suicide Prevention](#), begins a call for upgrading mental health crisis response systems in America with an analogy to a 2010 accident at a gold and copper mine near Copiapó, Chile.

Thirty-three miners became trapped nearly a half mile underground, but were brought safely to the surface after 69 days through an intense international rescue effort, Covington recalled in his presentation, [“The Promise of 988: Crisis Care for Everyone, Everywhere, Every Time,”](#) to the Suicide Prevention Center of New York's [“AIM for Zero: Suicide Care is Healthcare”](#) symposium September 28-30.

“That obvious, caring, engaging, supporting, global collective impact and outreach has not been what we've seen for those whose darkness is not being trapped in a mine but having some kind of a mental health, substance use, or suicidal crisis,” Covington said. “For those individuals, it's been far different.”

Covington’s presentation outlined the new vision for crisis care—“for anyone, anywhere, anytime”—that includes the introduction of the easy-to-remember 9-8-8 national phone number for the [National Suicide Prevention Lifeline](#) to assist people experiencing a mental health or suicidal crisis. Congress passed the [National Suicide Hotline Designation Act](#) in 2020 and the 9-8-8 number officially goes into effect in July 2022.

The new vision for crisis care is reflected in the the [National Guidelines for Behavioral Health Crisis Care](#) issued in 2020 by the Substance Abuse and Mental Health Services Administration, Covington said. The guidelines, he added, stemmed from many efforts including the [Crisis Now](#) project of the National Association of State Mental Health Program Directors, developed with the National Action Alliance for Suicide Prevention.

Covington said the new model involves handling mental health crises with a minimum or total absence of police and hospital involvement—which the National Alliance on Mental Illness calls the “revolving door of ER visits, arrests, incarceration, and homelessness.” Rather, services are provided by mobile crisis response teams and non-hospital crisis care facilities.

Funding remains a major challenge for scaling up the new model of crisis care, Covington noted, with Congress looking to states to fund upgraded crisis services.

Covington said the new model for crisis care is in line with, and related to, the “extremely bold aspiration” of the Zero Suicide Model for healthcare, and is backed by a growing national momentum. “Let’s talk about how we might dare a much mightier system of care, and think about the way that we responded to those Chilean miners, without judgment, without shame. Instead, with an all-on full effort, an integrated and collective effort, to save their lives and support them, get them back to their lives,” he said.

The new model addresses what Covington called the “two sins” traditionally committed in crisis response.

The first, he said, is the message that reaching out for help leads to “punishment” in the form of a response by armed police officers. “Imagine that the darkness that you’re experiencing isn’t in a Chilean mine but in your living room in your apartment, and the response is law enforcement cars in the driveway, lights flashing,” he said. “About 70 percent of the time they’re handcuffed and placed in the back of the patrol car and transported to to a facility. While they may not in fact be arrested, it certainly feels like an arrest to the individual who’s in pain.”

The second sin, according to Covington, is “warehousing” individuals in a hospital emergency department as a way of handling individuals in crisis. He cited a 2013 [Seattle Times report](#) that found that in Washington State people in crisis arriving at hospital emergency departments were put into psychiatric boarding for an average of three days before getting access to mental health treatment. Some, the newspaper reported, waited for months.

“This is really hard for us to get our heads around, that this is the way we respond to people in a psychiatric emergency, in deep emotional pain, feeling suicidal,” he said. “We land up detaining

them without real active care treatment for days, while they face the gauntlet of trying to get into a service. Many land up just falling through the bottom, falling through the cracks.”

Covington said the 9-8-8 hotline is an important step forward, likening it to the narrow opening that was drilled to make contact with the Chilean miners, to check if they were alive, and send them basic food and water supplies.

But, he said, “if 9-8-8 is all we do, then it's going to be equivalent to those Chilean miners where we dig the four-inch diameter hole but we don't actually get them out of that crisis, we don't get them out of that hole. Many, many individuals will be supported through 9-8-8 and they won't need more intensive services. But for those who need something more, making the connection is not enough.”

Covington said the new crisis care model envisions intermediate levels of support instead of the “red-light, green-light” approach that either directed patients toward the highest level of acute care or outpatient behavioral health care or follow-up care. He pointed to a flagship crisis response system in Arizona equipped with mobile crisis response teams and crisis care facilities.

“What a difference it makes when you have that approach,” he said. “Thousands of individuals are going directly into crisis care, and we're reducing law enforcement engagement. You'll see a much stronger fit of the level of service matching the clinical care they need. We haven't eliminated psychiatric boarding in the Phoenix area, but we've reduced it by a staggering amount.”

Moreover, Covington added, “there's a very significant reduction in overall healthcare spend as well as reductions in the exposure for hospitals. It's an approach where care is much more like care than punishment.” The 9-8-8 number, providing an alternative in mental health crises to the 9-1-1 national emergency number in use since 1968, is an opportunity to reduce the involvement of police in the front end of a mental health crisis where there isn't an explicit threat to public safety, he said.

Covington said the Community Mental Health Act of 1963, which provided federal funding for community mental health centers, never realized its promise.

“The challenges we face today as a result of the lack of that crisis system, the lack of that concerted engagement and outreach for those who are in pain or in darkness, are the extremely long waits in the emergency department, the extremely costly way that we go about this, concerns about the public safety of not having these systems in place, and far too many deaths that have occurred not only from suicide but from opioid overdoses, from alcohol related deaths, and other deaths that could have been avoided,” he said.

Covington said that innovations in crisis care began more than 60 years ago, with the first suicide crisis call center established in Los Angeles in 1958 leading eventually to the National Suicide Prevention Lifeline 1-800-273-8255 in 2005. He pointed to efforts in various states such as Georgia, Arizona, and Colorado to create unified systems of crisis response and care prior to the 2020 SAMHSA guidelines.



## **“From Equality to Equity in LGBTQ Youth Suicide Prevention” [\[WATCH VIDEO\]](#)**

*Keygan Miller, Senior Advocacy Associate for The Trevor Project*

Keygan Miller, Senior Advocacy Associate for [The Trevor Project](#), spotlights the wide disparity in suicide risk for LGBTQ youth compared to straight cisgender youth.

In a presentation, [“From Equality to Equity in LGBTQ Youth Suicide Prevention,”](#) to the Suicide Prevention Center of New York’s [“AIM for Zero: Suicide Care is Healthcare”](#) symposium September 28-30, Miller cited [Trevor Project research](#) indicating that 42 percent of LGBTQ youth—as many as 1.8 million young people—seriously considered taking their own lives in the past year.

That’s four times greater than their peers, they said.

“Most of us know that youth suicide in general is a problem,” Miller explained. “It’s the second leading cause of death amongst young people ages 10 to 24. But for LGBTQ youth in particular, this is dire.”

Miller explained that various aspects of the lives of LGBTQ youth such as discrimination and bullying help explain the disparity. They said that 75 percent reported that they had experienced discrimination based on sexual orientation or gender identity. “Discrimination comes from adults in their lives, peers in their lives, and outside authorities,” they said.

For example, Miller said, 48 percent of LGBTQ youth reported wanting counseling from a mental health professional but were unable to receive it in the past year. Discrimination is felt even when it comes to using basic services. Miller said that 58 percent of transgender non-binary youth reported being discouraged from using restrooms that correspond with their gender identity.

Miller cited social pressures experienced by LGBTQ youth. They said two in three reported that someone had tried to convince them to change their sexual orientation or gender identity. “Or it could be something as terrible as ‘conversion therapy,’ which is the idea that we can change someone’s sexual orientation or gender identity through a variety of means, which is a discredited and dangerous practice,” they said.

LGBTQ youth are also affected by the nation’s politics, Miller said. They said that three-quarters felt that the recent political climate has impacted their mental health or sense of self—“everything from something in your day-to-day life such as using the bathroom all the way up to the narratives that are being woven by people in the highest of power in this country.”

All this, Miller explained, affects the “crisis threshold” of LGBTQ youth. “We have to look at baseline vulnerability,” they said. “If someone has a lower baseline vulnerability when a stressor is introduced, they are not as likely to meet that crisis threshold as someone who has a higher baseline vulnerability. This is where we end up with a lot of suicidality.”

Miller said that vulnerability is particularly important for people who hold multiple marginalized identities. They noted that while Black LGBTQ youth suffer similar rates of depression as their LGBTQ peers, they are significantly less likely to receive care.

Mental health providers and other adults can take a number of actions to support LGBTQ youth, Miller said. They pointed to research indicating that having just one supportive adult in their life lowers the risk of suicide by 40 percent. “Imagine if they had multiple supporting adults in their lives and how much impact that could have,” they said.

Understanding identity issues, and the value of using preferred pronouns, enables adults to be more supportive, Miller said. “One of the things that our young people face in the mental health space is having to educate their mental health providers about their identity from a very baseline level,” they said. “So, if we have that baseline understanding, then we can really dive into what that identity means for that young person as opposed to having a 101-level conversation.”

Miller called for supportive and inclusive public policies to raise the baseline vulnerability level of LGBTQ youth, tackling challenges such as homelessness, economic instability, and access to physical healthcare and mental health care. In schools, they said, this involves training teachers in mental health and suicide prevention, having crisis services in place, and educating students about mental health.

### **“Singing in a Strange Land: Suicide Prevention for Black Youth” [\[WATCH VIDEO\]](#)**

*Sherry Molock, associate professor in the Department of Psychological & Brain Sciences at George Washington University*

Sherry Molock, associate professor in the Department of Psychological & Brain Sciences at [George Washington University](#), highlights the special suicide risk factors for youth of communities of color, and the need to use culturally salient approaches in suicide prevention, suicide risk assessment, and referral practices.

Suicide rates for Black children aged 5-12 are approximately double the rates for white children of similar ages, according to research data cited by Molock in her presentation, [“Singing in a Strange Land: Suicide Prevention for Black Youth,”](#) at the Suicide Prevention Center of New York’s [“AIM for Zero: Suicide Care is Healthcare”](#) symposium September 28-30.

She pointed to other research that indicated that suicide attempts are greater among LGBTQ college students of color. She said that suicide attempts rose by 73 percent between 1991-2017 for male and female Black adolescents, while injury by attempt rose by 122 percent for adolescent Black males during that time period.

Another important finding, Molock said, comes from the [2019 Youth Risk Behavior Survey](#) conducted by the Centers for Disease Control and Prevention. While the survey showed lower percentages of Black high school students compared to their peers reporting feeling sad or hopeless or considering suicide, the percentage of Black students who actually had made suicide

attempts was significantly higher (11.8 percent) compared to their white (7.9 percent) and Hispanic (8.9 percent) peers. “That trend has been changing for about the last five years,” she said.

Molock called for more studies on youth of communities of color, better funding for Black researchers studying health disparities, and culturally competent providers for communities of color.

Molock cited lack of access to healthcare and economic instability as important risk factors for suicide among African Americans. She cited a [Johns Hopkins University suicide study](#) in Maryland that showed while suicide rates were cut in half for whites during the Covid-19 pandemic, they doubled for Black residents of the state.

“The negative impact of Covid is disproportionate in communities of color,” she explained. “The industries that were most heavily hit by the pandemic were the hospitality service communities, professions where Blacks and Latinos are more likely to work. The rates probably reduced for whites because they're more likely to have a job that allows them to work from home, they have access to better healthcare, and more benefits for economic relief.”

Experiencing racial discrimination is among the particular factors placing African Americans at risk for suicide, Molock said. But she noted that nonetheless Black community norms don't generally support seeking professional mental help treatment.

She explained that Black youth are more likely to discuss problems with family members or are discouraged from sharing information about mental health concerns with “outsiders.” She said that mental health help seeking may be more stigmatizing for Black adolescents, that their peers may not be supportive of seeking treatment, and that particularly Black males seek professional help as a last resort.

Structural barriers and social determinants of health hinder access to treatment, Molock said. She pointed to research that Blacks on average receive poorer quality of care than whites, and that Black youth are less likely to receive care for depressive symptoms and suicide attempts.

Rates of engagement in treatment and treatment completion are lower in Black adolescents compared to white peers, she said. Molock said that Black youth may be misdiagnosed or underdiagnosed because assessment tools are not designed to assess culture-specific expressions of depression.

“We have to ask ourselves,” she said, “are the traditional measures or questionnaires that we use to assess or even screen for depression a one-size-fits-all, or do we need to have more nuance in the way that we ask questions so that we can get at this phenomenon for Black youth?”

She said another key to improving suicide prevention for communities of color is increasing protective factors and decreasing risk factors.

“One of the most important ways that we can prevent suicide is to make sure that people have stable housing, they have food security, and stable employment,” she said. “If we can give people the basics, that their necessities are fulfilled, then a lot of the stress and risk factors that are associated with suicide decrease significantly.

“Every child in the United States should have financial security. They should grow up in stable communities, have stable housing and have job training programs to increase financial stability. We should also strengthen access and delivery of suicide and mental health care.”

Molock called for peer programs that promote help-seeking behavior and services that partner with faith-based and other community organizations where people of color are more comfortable and trusting discussing personal problems.

### **“Making Suicide a Never Event – Zero Suicide in Indian Country” [\[WATCH VIDEO\]](#)**

*Sadé Heart of the Hawk Ali, Tribal Lead and a Senior Project Associate at the Zero Suicide Institute and former Deputy Commissioner of Philadelphia’s Department of Behavioral Health and Intellectual disAbility Services*

Sadé Heart of the Hawk Ali, Tribal Lead and a Senior Project Associate at the [Zero Suicide Institute](#), aims to educate healthcare providers on how to apply the tenets of the [Zero Suicide Model](#) in ways that resonate with the culture of indigenous communities.

In her presentation, [“Making Suicide a Never Event – Zero Suicide in Indian Country,”](#) to the Suicide Prevention Center of New York’s [“AIM for Zero: Suicide Care is Healthcare”](#) symposium September 28-30, Ali emphasized that suicide care must align with indigenous understandings of loss of life and taboos around language.

Ali explained that diversity of beliefs exists among the estimated 574 tribes, villages, bands, and nations recognized by the U.S. government, although universal truths are shared such as reverence for a greater power, honoring ancestors and the land, and belief in traditional medicines and healing ways.

She described how indigenous communities that see high suicide rates are affected by historical and current-day trauma that impacts suicidality, ranging from genocide, war, forced relocation, missing and murdered indigenous relatives, the ongoing discovery of mass graves of schoolchildren torn from their families, destruction of food and water supplies, and cultural appropriation in the form of sports team mascots.

“If you're working with us, one of the main things to know is that we have survived layers upon layers upon layers of trauma,” she said. “There have been many assaults on us and this really creates trauma amongst our people. We are not only talking about the trauma that is passed down generationally but there's also modern day trauma that we're experiencing right now.”

Noting that the Zero Suicide Model's framework has not been validated for indigenous people, she argued for the need to "indigenize" the model's seven elements in order to adapt it for safer suicide care in indigenous communities.

She said that this involves understanding the cultural contexts of the communities being served by the Zero Suicide Model, requiring cultural humility among mental health providers, utilizing tribal elders and indigenous community members in implementing elements of Zero Suicide, and respecting the value of traditional concepts of healing and ancestral ways.

"Western ways will be much more readily accepted by the person seeking services if they know that their traditional ways are honored as well," Ali said.

She explained, for example, terms such as "life promotion" should be encouraged in place of suicide prevention. "Many of our languages have no word for suicide," Ali said. "The word 'suicide,' or even talking about someone who took their own life, is taboo in many of our tribes."

### **"A Zero Suicide Story" [\[WATCH VIDEO\]](#)**

*Wykisha McKinney, Zero Suicide Program Manager at The Harris Center for Mental Health & IDD (Intellectual or Developmental Disability)*

Wykisha McKinney lost her brother Johnny to suicide in 2004 and subsequently struggled with suicidal thoughts herself as she coped with a beloved sibling's death.

In "[A Zero Suicide Story](#)," a presentation at the Suicide Prevention Center of New York's "[AIM for Zero: Suicide Care is Healthcare](#)" symposium September 28-30, she shared her personal story to illustrate the importance of the [Zero Suicide Model](#)'s commitment to patient care and a "just culture" for care providers, and the key role that loss survivors like herself play in implementing safer suicide care.

McKinney, Zero Suicide Program Manager at [The Harris Center for Mental Health & IDD](#) (Intellectual or Developmental Disability), said that Johnny was a Texas A&M University grad, an advocate for Black LGBTQ people, and a case manager at a Houston-area clinic for men who were HIV positive.

He was diagnosed with AIDS in 2000 and the illness took a heavy toll on him physically and emotionally, she said. He took his own life shortly after his doctor advised him to be admitted to the hospital to treat his worsening infection.

McKinney said that her brother's death led her to become a suicide prevention advocate who asks many questions:

"What if my brother would have been screened for suicide risk on his routine visit to his doctor who was aware that he was HIV positive, who was aware that he had had an escalation in his health problems, and who was aware that his health issues were getting to the point where he was

thinking about and discussing end of life decisions? What if the hospital system and the clinics prepared their doctors who all worked with HIV positive folks diagnosed with AIDS were all trained in how to screen and assess for suicide, and collaboratively create a safety plan? What if they were able to connect Johnny to a mental health professional? So those [steps] would help to close those gaps.”

The Zero Suicide Model, McKinney said, “answers the ‘what if.’ It tells us what could happen if these things take place. It tells us what could happen if we add or tweak our policies and procedures in a way that could promote life-saving practices.”

McKinney said that the Zero Suicide framework is defined by a system-wide organizational commitment to safer suicide care and behavioral health care. “It represents a culture shift away from fragmented suicide care toward a holistic and comprehensive commitment to patient safety as the most fundamental responsibility of healthcare,” she said.

“For me as a survivor of suicide loss, someone whose brother was actively involved in the health system and visited a health care practitioner the day before he died, I see the value of Zero Suicide. My personal story speaks to the importance of Zero Suicide.”

She explained how Zero Suicide promotes a just culture of practice for healthcare practitioners. “The Zero Suicide framework is not designed to point fingers at people, which is what's wonderful about it,” she said. “Oftentimes when you implement new new procedures or new practices or when you tell your organization we're going to evaluate how we do things, people may think that you mean you want to evaluate what I did or what I'm doing wrong. But the Zero Suicide framework is designed to look at the system as a whole. So it looks at that system and it identifies where those gaps are.”

Survivors of suicide loss regularly ask themselves about the “what-ifs,” McKinney said. “I’m not in any way saying that my brother's medical professionals were responsible for his death, woulda, coulda, shoulda or he would be here today. What I'm saying is that the Zero Suicide framework provides an opportunity where the Johnnys of the future or the Johnnys of today have more opportunity to receive help and care throughout their time with their doctors.”

McKinney said that her position at Texas’s Harris Center reflects how engaging suicide attempt survivors and loss survivors is a key component of the Zero Suicide framework.

“My perspective of the healthcare system and the mental health care system is a little bit different,” she said. “I can see both perspectives, the perspective of the organization and the perspectives of a survivor of suicide loss. It creates an equitable workplace. It helps with quality improvement as it inspires innovation to improve the services. Sometimes our executives have a perspective of what of what may be happening and it may be a little bit different from what actually is happening.

“And so engaging those with lived experience. especially those who've had experience with working through your health system, can help to open your eyes and enlighten you on how these systems that are embedded in our policies and procedures work. It helps to develop employee

and volunteer skills and their knowledge of suicide prevention beyond the theoretical and textbook learning. For the organization, it builds community involvement, it helps us to build relationships of trust with the communities and individuals.”

Adoption of the Zero Suicide framework also provides valuable opportunities to people with lived experience, McKinney said. “It transforms our painful experience into creating positive solutions,” she explained. “For me, as a survivor of suicide loss, helping is healing. Helping was my therapy.”

## **Resources**

[Aim for Zero Suicides: Implementation Guide](#)

[Suicide Prevention Resource Center](#)

[Zero Suicide Model](#)

[2012 National Strategy for Suicide Prevention](#)

[The Surgeon General’s Call to Action to Implement the National Strategy for Suicide Prevention](#)

[1,700 Too Many: New York State’s Suicide Prevention Plan 2016–17](#)

[National Patient Safety Goal for Suicide Prevention \(NPSG\) 15.01.01](#)

[The Zero Suicide Model in Tompkins County](#)

***If you or someone you know feels the need to speak with a mental health professional, you can contact the National Suicide Prevention Lifeline at 1-800-273-8255 or contact the Crisis Text Line by texting HOME to 741-741.***