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Bernalillo County Behavioral Health Initiative: Suicide Prevention Process Evaluation

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Table of Contents

Introduction

Suicide is a complex phenomenon that can have devastating personal costs for individuals, families, friends, and communities. Enumerated and aggregated to the county, state and national levels, the losses associated with suicide and suicide attempts are expressed in terms of social costs: lost family income, lost worker productivity, and increased medical and behavioral health service demands. A conservative estimate of the national cost of suicide and suicide attempts in the United States in 2013 was between $58 and 93.5 billion dollars (Shepard et al., 2015). For 2019, the estimated cost of suicide deaths in New Mexico was about $507 million dollars (CDCP, 2021) Because it is seen as preventable, suicide[1] is considered a public health problem where the emphasis for prevention moves beyond helping individuals who are expressing suicidality to include prevention education and early identification of high suicide risk individuals before they attempt suicide. The public health perspective of suicidality promotes assessment, mitigation of risk factors, and increasing the number and strength of protective factors (CDC, undated).

In October 2019 three new suicide prevention efforts began in Bernalillo County. First Nations Community HealthSource (FNCH), Centro Sávila (CS) and Albuquerque Public School were awarded contracts to implement universal screening in a health care setting (FNCH), establish an on-call crisis line and enhance existing screening and treatment resources (CS), and implement a peer-based program to increase suicide awareness, early detection of suicidality in students, and help-seeking opportunities for students (APS) in a school setting. Due to its specific youth focus and school year-based data availability, the APS Peer Helper Suicide Prevention Program has been evaluated separately.

This process evaluation synthesizes information from multiple data sources to better understand how the CS and FNCH programs function, what short-term outcomes they have realized, and their potential for addressing suicidality in their target populations. We evaluate provider performance based on current suicidality literature, national standards and best practices, and the organizational expectations for the program.

Background: New Mexico Suicide and Risk Factors

In 2018, approximately 1.7% of all deaths in the United States of America were by suicide, or 14.2 suicide deaths per 100,000 people. The 2014-2018 average suicide death rates for New Mexico and Bernalillo County were 23.4 and 22.7 per 100,000 population respectively. In 2018, suicide was the ninth leading cause of death for all ages, the second leading cause of death for people 10-34 years old, and the fourth leading cause of death for people 35-44 years old. Whites (29.7) and American Indians (21.1) were more likely to die by suicide than Hispanics (NMDOH, 2019). In 2019 there were 515 suicide deaths in New Mexico, 21 fewer than in 2018 (NMLFC 2020).

Mental health issues and substance use are considered risk factors for suicidality. At the state level, the Treatment Advocacy Center estimated the prevalence of severe mental illness in New Mexico at approximately 3.3% (TAC, 2017). New Mexico's Indicator-Based Information System (NM-IBIS) reported that 23.1% of adults in Bernalillo County experienced mental distress lasting more than 6 days in 2016 (NM-IBIS, 2017a). The *2012 National Survey on Drug Use and Health (NSDUH) Report:*

[1] Suicide is an intentional fatality resulting from self-harm. Suicidality encompasses thoughts of suicide (ideation), suicide plans, and non-fatal attempts.

Metro Brief focused on the Albuquerque SMA found that the annual average number of adults experiencing a major depressive episode from 2005-2010 was 6.6% (SAMHSA, 2012, p.5).

The 2019 Behavioral Risk Factor Surveillance System (BRFSS) Annual Report found: 14.5% of adult New Mexicans reported frequent mental distress; 17.3% had been told they had a depressive disorder; the prevalence of binge drinking was 14.7%; heavy drinking was 6%; and 7% of New Mexico adults thought about committing suicide. (Whiteside, 2019). The 2019 National Survey of Substance Abuse Treatment Services (N-SSATS) report compared two-year averages for 2017-2019 and noted that among people 12 years old and older, New Mexicans experienced increases in heroin use and decreased marijuana use disorder and alcohol use disorder.

Lack of access to behavioral health services is another suicide risk factor relevant to New Mexicans. The 2019 National Survey on Drug Use and Health (NSDUH) reviewed mental health service use among adults in New Mexico and found, "the prevalence of past-year mental health service among those with any mental illness was 44.3%, similar to both the regional average (40.6%) and the national average (43.6%)." (SAMHSA, 2020, p33).

Access to lethal means of intentional self-harm is a risk factor for which there are data to contextualize the issue in New Mexico. From the N-SSATS it is estimated that 39% of adults kept a firearm in or around their home (2019). NM-IBIS reported 11.7 intentional self-harm firearm deaths per 100,000 people in 2017. "Since 1999, the suicide firearm rate has been on average 2.4 times higher than the homicide firearm rate. In the past 5 years … the firearm suicide rate increased by 1.6%." As a percent of firearm deaths in 2017, suicide accounted for 66% and homicide for 30% (IBIS 2021).

The Bernalillo County Behavioral Health Initiative: Suicide Prevention

In February 2015, the Bernalillo County Commission and voters approved a new, non-sun setting gross receipts tax of 1/8 percent to develop a unified and coordinated behavioral health system in the County to improve access to care throughout the region. This tax was expected to generate up to $17 million per year (CPI, 2015) and funds the Bernalillo County Behavioral Health Initiative (BHI). The BHI is a series of programs meant to ultimately improve behavioral health outcomes in the community.

As part of the development of a business plan for a regional, cohesive system of behavioral health care, Community Partners, Inc. (CPI) assessed the behavioral health care delivery system and recommended a governing board structure and planning process. Although they noted the rising numbers of suicides in their 2015 report, they did not make a specific recommendation for suicide prevention. Instead, they indicated the need for a general crisis call center accessible to anyone in the community for non-emergency behavioral health calls, and a strategic prevention planning framework. The framework would "complement traditional, individual-focused programs and foster cohesive prevention/early intervention programming focused on early identification of problems and access to treatment, and education and empowerment of individuals, communities and systems" (CPI, 2015).

In March of 2019 Bernalillo County released a request for proposal (RFP # 32-19-NL) to "…provide Suicide Prevention Services for youth and adults who experience suicidal ideation or who are at risk for suicide in Bernalillo County. Services should also encompass the needs of family or community members supporting individuals who are considering suicide" (Brown 2019, p. 3). BHI indicated they intended to fund several programs with total costs not to exceed $1,000,000. The RFP encouraged

community organizations to offer services to address aspects of suicide prevention for target populations they served. The RFP process resulted in three contracted providers: Centro Sávila (CS), First Nations Community HealthSource (FNCH), and Albuquerque Public Schools (APS). The suicide prevention efforts of Centro Sávila and First Nations are the subject of this evaluation report.

Centro Sávila provides outpatient mental health services in Albuquerque's South Valley and International District. They provide culturally and linguistically informed care in English and Spanish and offer a suite of services for their clients including psychotherapy, a therapeutic garden, drug and alcohol recovery, case management, insurance enrollment, and food security.

First Nations Community HealthSource (FNCH) is both a Federally Qualified Health Center and an Urban Indian Health Center. They provide integrated services to address the physical, social, emotional, and spiritual needs of American Indian/Alaska Native families. FNCH operates three clinics in the International District of Albuquerque and four school-based health centers. Among the services FNCH provide are primary care, pharmacy services, traditional wellness program, alternative therapies, vision and dental services, mental health and substance abuse counseling, and social services.

Centro Sávila and FNCH offered different approaches to suicide prevention. FNCH's program is based on the SBIRT model (Screening, Brief Intervention, and Referral to Treatment). Originally, this model was an evidence-based intervention for individuals dealing with drug and alcohol addiction; FNCH has integrated suicide prevention with their existing SBIRT model (SBIRT-SPP). Centro Sávila expanded their existing services to include an on-call crisis phone line for their patients and increased provider capacity for suicide risk screening, counseling, and suicide prevention education in Spanish and English. FNCH's program was designed as universal suicide risk screening in a primary care setting with intervention and referral to treatment conducted by staff specific to the suicide prevention program. In their behavioral health setting. CS proposed a brief screening and triage during the first call for services. Clients expressing suicidal intent were to be immediately referred to emergency services, an available therapist, or an appointment was made for the time and place most convenient for the client, all dictated by the level of assessed risk.

Both FNCH's SBIRT-SPP and CS's suicide prevention services are solely for their patients. Common among the services offered by CS and FNCH are suicide screening and assessment through administration of the Columbia Suicide Severity Rating Scale (C-SSRS); the development of individual treatment plans; case management; out-patient behavioral health services; provision of information and resources for suicide prevention; and opportunities for long-term services in other programs within their agencies or with other community providers. FNCH and CS also screen for some social determinants of health (SDOH) as potential risk factors for suicidality.

Evaluating the Centro Sávila and First Nation Suicide Prevention processes may illuminate best practices and opportunities for program improvement for the delivery of suicide prevention services to specific target populations. Evaluation of the short-term outcomes and potential community-level impacts of the programs will help inform the County's distribution of tax dollars across the behavioral health continuum and contribute to the understanding of the role these suicide prevention efforts have in addressing risk and protective factor associated with suicidality.

This report includes several sections. Following this introduction is a brief review of the suicidology literature most relevant to CS services and the FNCH SBIRT suicide prevention model. The study period for this evaluation, our methods and data sources are next with descriptions of the County performance measures, administrator and staff interviews, and the client record review. The analytic component of this evaluation follows, organized by provider, and presents the findings in full from each of the data sources before synthesizing the results in the discussion section for each provider. The summary and recommendation portion of the report is both specific and general: each provider is discussed separately with general observations for the BHI-funded suicide prevention efforts as a whole, completing the last report section. Prior to finalizing the report drafts were provided to each provided and the County for comments. A letter from Centro Sávila is included as Appendix E and provides their response to the report.

Literature

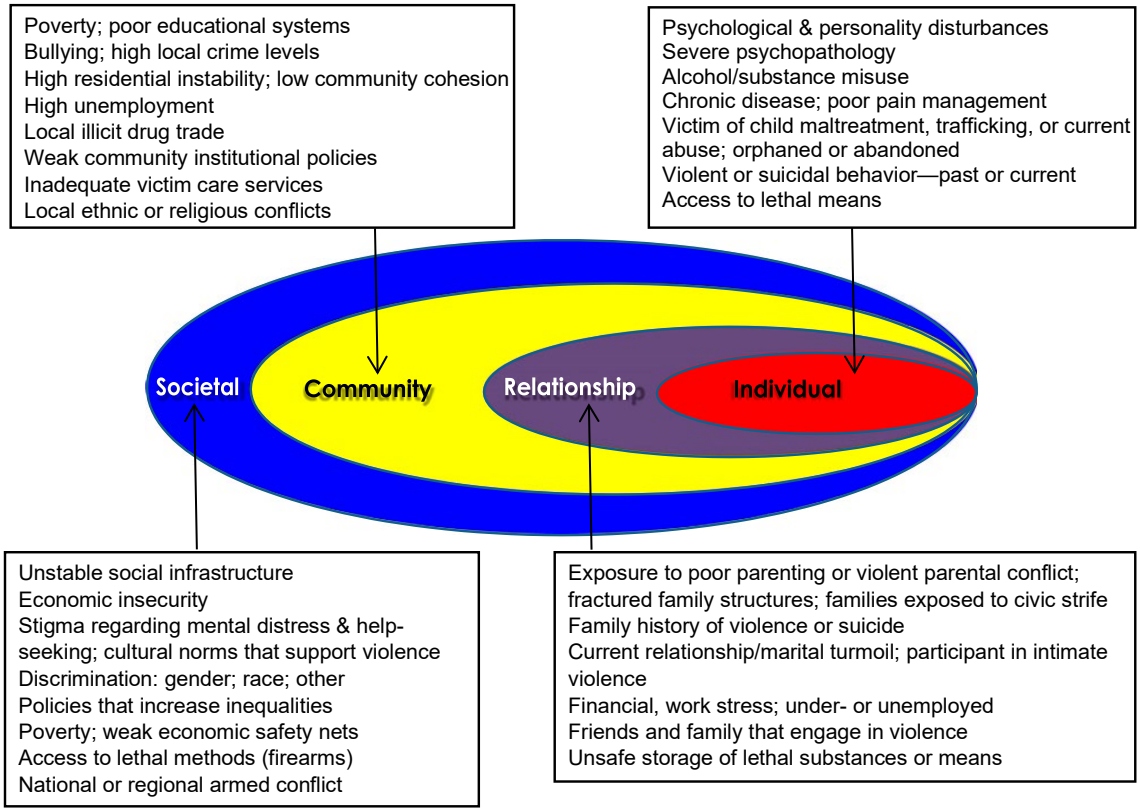
The Centers for Disease Control and Prevention (CDC) defines suicide as death caused by injuring oneself with the intent to die. A suicide attempt is self-injury with the intent to end life that does not result in death. (2021). Because it is seen as preventable, suicide is considered a public health problem where the emphasis for prevention moves beyond helping individuals who are expressing suicidality to include prevention education and early identification of high suicide risk individuals before they attempt suicide. The public health perspective of suicidality promotes assessment, mitigation of risk factors, and increasing the number and strength of protective factors (CDC, undated).

In 2004, Knox et al. offered the criticism that for a public health problem, the prevention efforts had been, "…narrowly focused on identifying proximate, individual-level risk factors, rather than thinking about population mental health in terms or complex social and ecological relations" (p. 37). They explored the lessons learned from the development and implementation of community-based heart disease prevention strategies to suggest a population risk reduction approach for suicide. In 2017, Fitzpatrick made a similar observation, arguing that current suicide prevention strategies based largely on individual-level theorizing makes individuals and communities responsible for suicide prevention and downplays the role of public policy and systemic inequities.

The CDC frames prevention of violence to self (suicide) and others in terms of a social-ecological model (SEM)[2]. Their model has four levels: Individual, Relationship, Community, and Societal. As articulated by Caine (2013), the model includes risk factors at each level, suggests interactions among factors across levels, and illustrates how some issues could be addressed simultaneously at multiple levels to reach a desired outcome. Individual level factors are a person's physical and mental health status and behaviors, they can be outcomes of a person's life experiences at the Relationship level (friends and family), including past and current trauma, which are, in turn, shaped by a person's community, which is influenced by Societal factors. As an example of interconnectedness across levels, Societal factors, such as weak economies or discrimination, could affect employment levels at the Community level, which can put strain on Relationships (e.g., increased interpersonal violence, stress on families), affecting the Individual, perhaps exacerbating existing substance use or behavioral disorders. Based on his review of suicide-related research, Caine adapted the model as presented in Figure 1.

[2] Social-ecological models explore the complex interactions among personal and environmental factors to explain a behavior.

Figure 1: Social-Ecological Model of Violence to Self and Others

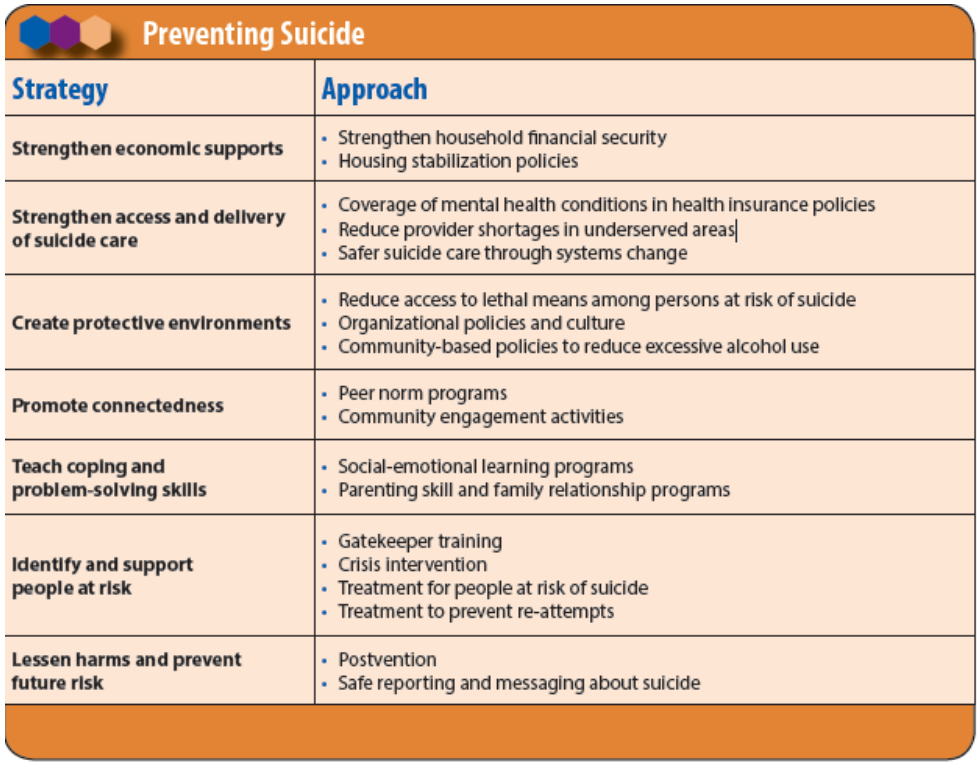


(Caine, 2013, p .826)

In 2017, Stone, et al., authored for the CDC *Preventing Suicide: A Technical Package of Policy, Programs and Practices.* The recommendations reflect an SEM view of suicide. The technical package, "represents a select group of strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to prevent suicide" (p. 7). The inclusion criteria for their strategies were empirical evidence of impact on suicide generated by at least one rigorous study, the likelihood of beneficial effects on multiple forms or violence, no evidence of harm, and feasibility of implementation in a US context.

For each strategy chosen they explain the rationale for its inclusion, present brief descriptions of multiple approaches to the strategy, articulate potential outcomes, discuss the evidence base for the approaches, and describe specific programs or policies. Figure 2 lists the strategies and approaches. The technical package is an excellent resource for the County and providers to reference in evaluating suicide prevention services for Cento Sávila and FNCH's SBIRT-Suicide Prevention Program. Given the County's emphasis on the collection of Social Determinants of Health (SDOH), this package can draw the links between SDOH and suicide, as well as alternatives for the allocation of suicide prevention funding.

Figure 2: CDC Strategies and Approaches for suicide Risk Reduction.



Preventing Suicide

Strategy	Approach
Strengthen economic supports	• Strengthen household financial security • Housing stabilization policies
Strengthen access and delivery of suicide care	• Coverage of mental health conditions in health insurance policies • Reduce provider shortages in underserved areas • Safer suicide care through systems change
Create protective environments	• Reduce access to lethal means among persons at risk of suicide • Organizational policies and culture • Community-based policies to reduce excessive alcohol use
Promote connectedness	• Peer norm programs • Community engagement activities
Teach coping and problem-solving skills	• Social-emotional learning programs • Parenting skill and family relationship programs
Identify and support people at risk	• Gatekeeper training • Crisis intervention • Treatment for people at risk of suicide • Treatment to prevent re-attempts
Lessen harms and prevent future risk	• Postvention • Safe reporting and messaging about suicide

(Stone et al., 2017 p.12)

Another reference resource is the Suicide Prevention Resource Center's (SPRC) *Suicide Prevention Toolkit for Primary Care Practices*. (WICHE MHP, 2017). This provides useful templates and processes that are helpful for providers and for our evaluation of providers' preparedness to undertake a suicide prevention program, whether they are in a primary care or a clinical setting. In their *Quick Start* for implementing a suicide prevention program, providers are encouraged to: communicate with all the organizational staff, assign a lead coordinator, develop office protocols for all aspects of the program, schedule training for staff, develop a referral network for the collaborative care of suicidal patients, review basic information about causes of suicidal ideation, effective prevention strategies, suicide risk assessment, effective interventions, and to create community and patient education tools. The Implementation Checklist for this toolkit is in Appendix A, along with the web link for quick access to the entire toolkit.

Other researchers have intensified the focus on the individual emphasizing quality interventions that empower the client to recognize and respond to their suicidal thoughts. In his discussion of brief interventions to prevent suicide (including crisis response plans and safety plans), Bryan, (2020) summarized six essential ingredients for effective suicide interventions: a simple, empirically-based model; high fidelity implementation by clinician; adherence by the patient; emphasis on skills training; client self-management prioritized; and easy access to crisis services. He describes three innovative programs that meet these criteria. **Brief Cognitive Behavioral Therapy for Suicide Prevention (BCBT)** is a 12-session program in three phases based on emotional regulation, cognitive flexibility, and relapse prevention. **Crisis Response Planning (CRP)**, a narrative assessment of a person's experiences

leading up to the suicidal episode that informs the collaborative CRP by identifying personal warning signs, self-management strategies, reasons for living, social supports, and discrete steps to take in an emergency or crisis. **Firearms Safety Counseling** (see below) is the last example of innovative individual-focused treatments.

This brief review explores the complexity of suicide and suicide prevention, its causes and potential responses at the national, community, and individual level[3]. It also provides context for the two approaches evaluated in this report. CS suicide prevention services are more aligned with the philosophies and intent of the social-ecological model of suicide prevention whereas SBIRT is an example of a more individual-focused intervention. Below we review some of the concepts and practices directly related to the design of Centro Sávila' ces and FNCH's suicide prevention services.

Best practices

Choosing a program.

The Suicide Prevention Resource Center (SPRC) recommends strategic planning for suicide prevention. As part of *Step 4: Select or develop interventions*, they discuss the importance of using evidence-based programs. The Evidence-Based Prevention page outlines what it means to engage in evidence-based practices and use evidence in the selection or development of programs, including program adaptation and cultural considerations. They offer a few things to keep in mind about evidence-based programs:

- ◊ For suicide prevention, relevant outcomes are reductions in suicidal thoughts and behaviors or changes in suicide-related risk and protective factors. Short-term outcomes, such as post-training increases in knowledge, suggest that a program might be effective, but are not conclusive.
- ◊ Make sure you look for programs that have evidence related to the desired outcomes and priority populations in your strategic plan.
- ◊ The program's theory of change should also be clear: why would you expect the program to lead to your desired outcomes? (To learn more, see these resources on logic models, which are diagrams often used to answer this question.)
- ◊ Read the fine print! The criteria used to designate programs as "evidence-based" vary across registries and reviews.
- ◊ No registry or review includes a complete listing of all possible programs, so consult multiple sources.

Retrieved from https://www.sprc.org/keys-success/evidence-based-prevention (Verbatim)

Suicide Screening and Assessment

The Suicide Prevention Resource Center (SPRC) points out, "There is no universal agreement on the definition or utility of either suicide screening or assessment. Yet most experts agree that a process by which people at risk for suicide can be identified and referred to treatment is an essential component of a comprehensive suicide prevention program." (SPRC 2014)

SPRC defines these terms. **Suicide Screening** is a procedure using a standardized instrument or protocol to identify individuals who might be at risk for suicide. In *universal screening programs* everyone in a

[3] HHS's Treatment Improvement Protocol (TIP) 50, Addressing Suicidal Thoughts and Behaviors Literature Review and subsequent updates offer a comprehensive and accessible catalogue of research on suicide-related topics..

population (e.g., every patient who walks into a primary care clinic) is screened using the preferred instrument. *Selective screening programs* target specific groups that have a higher-than-average risk for suicide (e.g. clients with depression or substance use disorder in a behavioral healthcare setting). Screening tools do not predict suicide, they are neither diagnostic nor a treatment, and they should not the sole basis for risk mitigation plans. **Suicide assessment** uses empirically validated tools to confirm a positive finding from a suicide screening, ascertain the immediate danger to self and others, and inform a course of treatment. Suicide assessments do not predict suicidal ideation or behavior.

Columbia-Suicide Severity Rating Scale (C-SSRS)

The C-SSRS is an empirically validated set of questions used to assess suicide risk. No behavioral health training is necessary to administer the six-question instrument. The C-SSRS was designed to quantify the severity of suicidal ideation and behavior; it has been validated in adult and adolescent populations, in clinical, research, and primary care settings (Posner et al, 2011); and has been translated in 114 languages. There are other validated suicide assessments, but the C-SSRS is considered "the gold standard" and used by both CS and FNCH. A sample C-SSRS can be found in Appendix A.

For a thorough discussion of the creation and implementation of the C-SSRS and the research behind its evidence-based practice designation, see https://cssrs.columbia.edu/.

Patient Health Questionnaire (PHQ-2 and PHQ-9)

The PHQ-2 is a two-question screening instrument for detecting depression. The PHQ-9 is a nine-item tool for screening depression, aids in the diagnosis of depressive disorder and its severity, and can be used therapeutically to monitor changes in depression indicators. In their meta -analysis of studies comparing PHQ scores with major depression diagnoses, Levis et al. (2020) found the use of the PHQ-2 followed by the PHQ-9 had an 'acceptable accuracy' for screening depression. In combination, the two instruments were better than the PHQ-9 for correctly identifying people with depression (higher specificity; the ability of test to recognize when someone *does not* have the condition) and similar sensitivity (the ability to correctly identify people who do have the condition).

The PHQ-2/PHQ-9 combination is one of the strategies used by FNCH in its depression screening. However, the relationship between depression and suicide is not causal: being depressed does not lead to suicide. "New data on depression that has followed people over long periods of time suggests that about 2 percent of those people ever treated for depression in an outpatient setting will die by suicide," and yet about 60% of people who die by suicide have been diagnosed with a mood disorder, including major depression." (HHS, 2021).

Addressing the mixed research findings on the predictive ability of suicide screening and assessment instruments SPRC points out, "…there is fairly widespread agreement that both instruments can be useful *if conducted by trained practitioners* within a more comprehensive effort in which individuals identified as being at risk for suicide receive further evaluation and appropriate treatment." (2014, p2)

Social Determinants of Health (SDOH)

Assessing SDOH is not considered a best practice for suicide prevention. It does not aid in either suicide screening or assessment, it is considered an 'upstream' mitigation (e.g., solve a housing or job-related issue before it can affect mental health) that is part of case management or post-crisis service planning. Although a full exploration of the SDOH literature is beyond the scope of this report, this brief review is

included because both Centro Sávila and FNCH screen for SDOH as part of their suicide prevention services and it echoes the intent of the social-ecological model of violence prevention.

Social determinants of health are non-medical factors that affect a person's health. The factors affect almost every aspect of a person's life and can be personal, economic, or environmental. The U.S Department of Health and Human Services, Office of Disease Prevention and Health Promotion group the factors into five domains: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context (DPHP, 2021). As suggested by the social-ecological model of violence to self and others, these factors might shape suicidal behaviors or ideation but, like depression, there is no causal relationship between the factors and suicidal ideation or behaviors.

There is a growing body of literature exploring the links between the policies that affect SDOH and suicide. A search of the scientific literature conducted by the Black Dog Institute identified several policy areas where there is at least one study demonstrating a link between suicide and: unemployment and welfare support policies; improving access to treatment for mental illness; alcohol pricing and availability policy; reducing access to the means of suicide; justice and detention policies; LGBTQI+ marriage equality legislation; and austerity solutions to economic downturn (which puts upwards pressure on suicide rates) (for citations, see their white paper, Black Dog Institute, 2020).

SDOH collection and reporting for CS and FNCH have changed over time. Depending on the provider, SDOH questions might be asked as part of intake, treatment planning or case management.

Safety Planning.

Both CS and FNCH report using safety plans. Safety plans are individualized and incorporate a series of pre-determined steps a client can take to stay safe if they experience suicidal ideation. Ferguson et al, (2021) discovered a common set of safety plan elements: recognizing individual warning signs; identifying and employing internal coping strategies; using social supports as distractions; contacting trusted family or friends to help; contacting specific mental health services; and reducing access to/use of lethal means. A key feature of safety planning is its co-creation by client and clinician. For the design of an effective safety plan, ZERO Suicide offers recommendations (Figure 3).

Figure 3: ZERO Suicide Safety Plan Recommendations

Recommendation: Engage a Safety Plan

Warning Signs	Recognition of the signs that immediately precede a suicidal crisis
Internal Coping Strategies	Things patients can do to distract themselves without contacting anyone
Social Situations That Can Help Distract Me	Places patients can easily access that provide a safe environment (a library, mall, coffee shop, etc.)
People I Can Ask for Help	At least three support persons; persons who are available, able to provide support, aware of resources, and informed that they are a part of the safety plan
Professionals or Agencies I Can Contact During a Crisis	Professionals and crisis support agencies including the hours and contact information for current treatment provider, local and regional crisis support, and national crisis support providing 24/7 crisis services
Making the Environment Safe	Steps to remove access to lethal means, strategies to limit or eliminate substance use, and any other strategies to maintain a safe environment

From the ZERO Suicide Education Development Center, 2017

The SPI is a best-practice *brief intervention* and is part of suicide prevention best practices overall (Labouliere et al., 2018). There are templates and applications for both iOS and Android platforms available at multiple suicide prevention websites. These can aid in the creation of comprehensive, quality safety plans for suicide intervention. In their systematic review of safety planning and suicide related distress, Ferguson et al, (2021) found evidence of improvement in suicidality, suicide-related outcomes, and treatment outcomes; they determined safety planning interventions were a feasible and acceptable intervention. Recently, Pruitt et al (2020) identified safety planning interventions as applicable and adaptable in the challenging COVID-19 pandemic environment.

Lethal Means Counseling

Reducing access to lethal means is an evidence-based strategy for suicide prevention. A slight delay (represented by the time to overcome a barrier to access a firearm or dangerous mediations) from the initial impulse to commit suicide to the act, can make a difference in suicide prevention (Stanley & Brown, 2012). Bryans, Stone, and Rudd (2011) noted lethal means restriction is an important suicide risk management strategy that is infrequently used by clinicians, largely due to lack of training and guidance. Sale et al, (2017) evaluated the Counseling on Access to Lethal Means (CALM) training program for mental health providers and found it improved comfort, knowledge, and frequency of talking about means restriction with clients. They did not correlate this improvement with client satisfaction or safety. In their 2020 quasi-experimental analysis of lethal means assessment risk on suicide, Boggs et al., found that lethal means assessment showed a statistically significant reduction in the risk of a suicide attempt or death within 180 days from 3.3 to 0.83 (2020).

Evidence Based Therapy Targeting Suicide Risk

Behavioral health clinicians are often trained in a variety of therapeutic modalities and weave them together on an as-needed basis for an individual client. The following evidence-based treatments were mentioned by CS or FNCH as part of their suicide prevention efforts. The descriptions and specific evidence-based outcomes are taken verbatim from SPRC. Successful adoption of an evidence-based program requires fidelity to the model: adaptations for cultural reasons or a specific population can be significant enough to render the initial evidence base null and require additional empirical evidence collected for the modified program.

Dialectical Behavior Therapy

Retrieved from: https://www.sprc.org/resources-programs/dialectical-behavior-therapy

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. "Dialectical" refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT has five components: (1) capability enhancement (skills training); (2) motivational enhancement (individual behavioral treatment plans); (3) generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment); (4) structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors); and (5) capability and motivational enhancement of therapists (therapist team consultation group). DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients.

Therapists follow a detailed procedural manual. Generally, mental health professionals will need additional training to implement DBT. Training and training materials are available from Behavioral Tech, LLC for a fee.
Outcome(s) Reviewed (Overall Quality of Research Rating-scale of 0 to 4)
1: Suicide attempts (3.7)
2: Non-suicidal self-injury (parasuicidal history) (3.3)
3: Psychosocial adjustment (3.4)
4: Treatment retention (3.4)
5: Drug use (3.3)
6: Symptoms of eating disorders (3.2)

Cognitive Therapy for Suicide Prevention
Retrieved from: https://www.sprc.org/resources-programs/cognitive-therapy-suicide-prevention

Cognitive Therapy for Suicide Prevention is a cognitive–behavioral psychotherapy program designed for patients who have previously attempted or thought of suicide. The intervention teaches patients skills to use alternative ways of thinking and behaving during episodes of suicidal crises and assists them in building a network of mental health services and social supports to prevent future suicide attempts. It is designed to be provided by individual therapists on a one-to-one basis. Therapists must have a master's degree and must either be a licensed mental health provider or work under the supervision of a licensed mental health provider.
Outcome(s) Reviewed (Evidence Rating)*

- Depression and Depressive Symptoms (Effective)
- **Suicidal Thoughts and Behaviors (Promising)**
- Personal Resilience/Self-Concept (Promising)
- Social Functioning/Competence (Promising)

Screening, Brief Intervention, (Brief Treatment), Referral to Treatment. (SBIRT)

SBIRT is an evidence-based prevention and early intervention model used to address substance abuse. There are three components: evidence-based screening, brief intervention to increase education about the effects of substance use and support motivation to change; and referral to treatment. FNCH has integrated suicide prevention with their existing SBIRT model from their SAMSHA-funded NM-SBIRT project. NM-SBIRT expanded their categorization of screening treatment needs to include: Brief Intervention (BI), Brief Treatment (BT), or Referral to Treatment (RT).

Study Design and Methodology

This process evaluation is a mixed methods design using both qualitative and quantitative data. Report findings are from document reviews, a brief review of monthly performance measures submitted by providers to BHI, interviews with staff and administrators, and analyses of client service data. Due to face-to-face research restrictions resulting from the COVID-19 pandemic we were unable to consider observations of service delivery at any of the provider sites.

In December 2020, the UNM Institutional Review Board approved our request for the use of human subjects in this evaluation, allowing us to conduct interviews with program staff and to receive client-level data from CS and FNCH (identified data for adults and de-identified data for minors). We

negotiated data separately with each provider and received data for different time frames that contained different variables. This was based on several factors including our understanding of what data each provider collected, how data were stored, the provider's ability to deliver the data in an agreed upon time frame, and subsequent negotiations to obtain additional and/or enhanced data.

Period of Study

The time frame for this process evaluation is October 2019 (program inception) through mid-April (client data) or June 2021 (performance measure data). Within four months of beginning their programs, FNCH and Centro Sávila found themselves adapting their services to meet client needs during a global pandemic. The first COVID-19 cases in New Mexico were confirmed on March 11, 2020, and on March 23, 2020, Governor Michelle Lujan Grisham issued a stay-at-home order for non-essential workers[4]. Some behavioral health providers closed their physical offices and moved to telehealth services and put in place public health requirements and protocols including mask wearing, social distancing, and cleaning protocols. While the effects of the public health restrictions and service delivery challenges related to the pandemic are not yet fully understood, we consider some of these extraordinary challenges in our evaluation of these programs.

Performance Measures

BHI service providers are required to submit monthly performance measures to BHI. The providers negotiate which measures will be included and enter the required data into a BHI-designed MS Excel spreadsheet. While some measures vary based on program process and goals, the measures are designed to capture similar information including counts of new and continuing clients, number of screenings for suicide and social determinants of health, etc. They also report standardized client demographic information including: gender, age, race, ethnicity, and type of insurance. The narrative section asks the providers to report successes, learning outcomes, barriers, and quality improvement for the month. For our purposes, the monthly performance measures provide a history of the program and insights into program changes and their potential effect on program implementation. They may also help us understand changes in the client-level data. We do not report the performance measures in detail because they were not intended to be used for program evaluation, rather they are used to help BHI staff monitor contract compliance monthly.

Administrator and Staff Interviews

ISR CARA staff identified the pool of potential administrator and staff interviewees based on staffing positions denoted in the provider contracts. We asked providers for the names and contact information for past and current staff associated with the delivery of suicide prevention services. Staff recruitment was done via email following the approved IRB protocol. Participation in the interviews was voluntary and confidential. Of 17 participants contacted, one declined to participate and another did not respond to recruitment attempts. The staff interviewed were all current program staff; both providers declined to provide contact information for former employees.

Semi-structured interviews were designed to provide detailed insight into the daily implementation of any BHI-funded program (see Appendix A) including client recruitment, treatment services and program discharge. The interviews took between 30 and 90 minutes. Due to COVID-19 restrictions all interviews

[4] From: https://www.krqe.com/health/coronavirus-resources/timeline-coronavirus-in-new-mexico/

were conducted using the University of New Mexico's licensed version of Zoom, which supports audio-only and automatic transcription. Before beginning the interview, all staff were asked for their verbal consent to participate in the interview and to audio-recording for transcription.

In February and March of 2021, 15 interviews were completed with CS and FNCH staff. Program level questions about the suicide prevention programs generated information about outreach, referrals, intake, suicide screening, use of other assessments, service delivery, discharge, and aftercare. Interviews averaged 46.1 minutes to complete. The Table 1 provides the interviewing dates, the total number of eligible interviewees, and number of interviews completed.

Table 1: Suicide Prevention Staff Interview Information

Provider	Data Collection Dates	Eligible Staff	Interviews Conducted
Centro Sávila	February 2021 – March 2021	11	9
First Nations Community Healthsource		6	6

After quality control, the edited transcripts from the interviews were analyzed using Atlas.ti, a qualitative analysis software program. Direct coding was used to understand how program staff described their suicide prevention program's practices and procedures while also looking for similarities and differences between their accounts and our understanding of the program from the process map and other documents. In this report, quotes are lightly edited to enhance readability and protect the identities of the interviewees, their co-workers, and clients. We were cognizant of the need to not alter the meaning of the quote in our editing process.

Client Record Review

The ISR met with CS and FNCH in stages to better understand their program design, their data collection procedures, and to discuss acquiring data for two separate client populations. FNCH provided suicide prevention services to adults, whereas CS provided services to adults and minors (defined as 18 years old or younger). The data for adults included Personal Health Information (PHI). Discussions about client-level data were important because they allowed us to develop a shared understanding about what data were collected by the provider, how data could be extracted from their electronic medical records (EMR), and helped clarify provider and evaluator expectations, goals, and intentions for the use of the client-level data.

Altogether, these sources help us understand how a provider intended the program to operate (program description), the program's self-reported progress (performance measures), and staff perceptions of how the program worked. The client level data will illustrate what services have been delivered and whether they were delivered as expected.

Centro Sávila

We received data for 410 clients who had service appointments between October 2019 and mid-April 2021. In response to state law that does not allow the use of identified minor data without consent but does for adults we agreed to receive de-identified data for all Centro Sávila clients. We received a unique identifier that allowed us to link clients and services. Following the process of linking clients and services a new unique identifier was randomly generated and the original identifier was deleted. In

addition, following federal HIPAA regulations, all dates for minor clients (i.e., first contact date, discharge date, and service dates) were converted to years and because the number of minor clients was small (70, or 17.1% of clients), certain other potential identifiers including gender, age and race/ethnicity were removed from the final dataset.

First Nations Community HealthSource

Data for the client review came from a variety of sources. According to FNCH records, 10,625 PHQ 2 screenings were completed between mid-November 2019 and mid-April 2021. In addition, Columbia Suicide Severity Rating Scale (CCSRS) screenings were administered to 6,223 unique individuals. We were also provided appointment data for 5,749 unique individuals who received at least one service for a total of 28,653 services between October 2019 and April 2021. Finally, we received PHQ 9 data for 329 individuals with 191 of these individuals having at least two assessments (a matched pair).

The next section begins discussion of findings from data analyses. For each provider the evaluation section begins with a program description drawn from their response to the County's RFP, the eventual negotiated contract and the co-created process map depicting the service order a client is expected to experience. Hence the program description reflects how the provider and County envisioned the program or services would be implemented. This is followed by a summary of the performance measures reported to the County. These provide a set of metrics for us to gauge program activities and a history of the challenges and successes from the provider point of view. From the staff interviews we get a sense of the program implementation from some of the people offering services directly to their clients. The analysis of client level further clarifies program implementation, forms the basis for evaluating processes and short-term outcomes, and might highlight gaps in data collection.

Program Descriptions and Study Findings

Centro Sávila Suicide Prevention Services

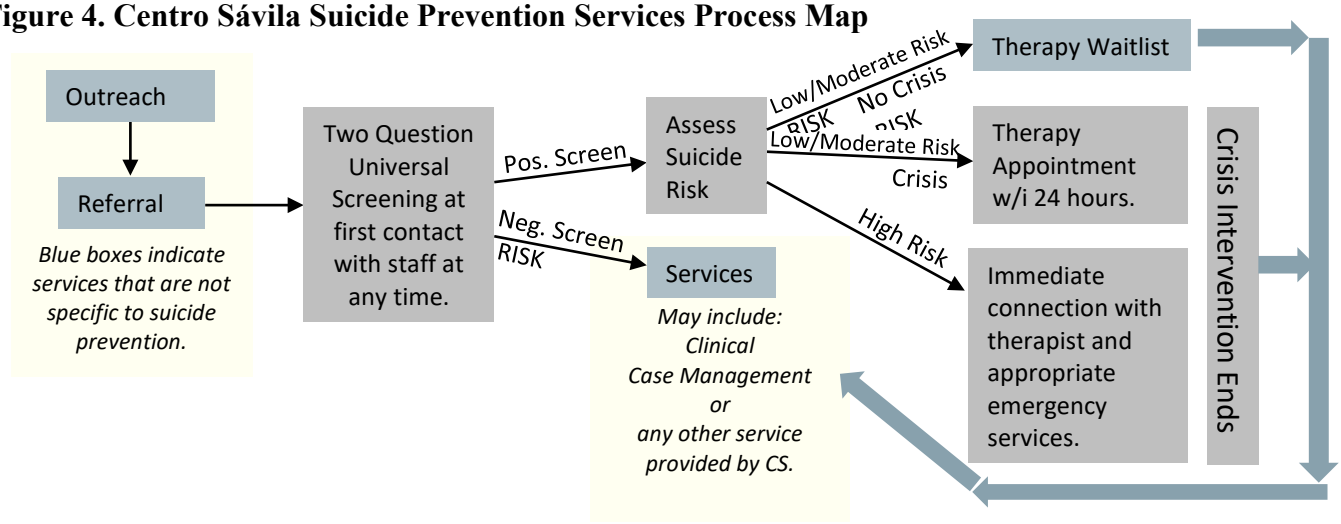
In October 2019, Centro Sávila (CS) contracted with BHI to provide a suite of suicide prevention services for low-income, high-risk youth and adult clients experiencing suicidal ideation or who were at risk for suicide. The target populations were in the South Valley and the International District of Bernalillo County where Centro Sávila said they delivered culturally and linguistically appropriate services (CLAS), including service delivery in Spanish, and an awareness of the nature of homelessness and poverty.

The services proposed were telephonic and in-person screening and triage; individual and family counseling to reduce suicidal ideation; group support; attachment-based preventative education for parents and children; and training for school-based personnel. The BHI funding was intended to help Cento Sávila enhance and expand its existing suicide prevention services, reduce client wait times, and increase the number of clients served. CS noted they would be leveraging funds from other sources to provide client-centered case management to address suicide risk factors associated with social determinants of health. BHI funded: screening, triage, individual and family counseling; four sessions of bi-lingual suicide prevention education at charter schools, and an on-call crisis phone line. All services were to be for uninsurable clients experiencing suicidal ideation or intent as indicate by a positive response to self-danger on the C-SSRS.

Program Description

To understand how potential clients engaged in CS's suicide prevention services (SPS), a process map was created in collaboration with key staff from CS. This process map is an approximation based on the information discussed and represents how a person was meant to experience the suicide prevention services offered by CS.

Figure 4. Centro Sávila Suicide Prevention Services Process Map



The outreach activities described were for CS *as an organization*, not for suicide prevention services specifically. The SPS were to be marketed in-house to existing clients. Potential SPS clients could have referred themselves by walking in, calling the main number, completing an online contact request, or through the crisis intervention phone line. In the model, when a client first talked to a staff member, they were asked "Do you feel safe?" and "Is this an emergency?" If the response was *yes* to the emergency question and *no* to the safety question, the Columbia-Suicide Severity Rating Scale (C-SSRS) was to be administered. Low and moderate risk clients in crisis would be scheduled to see a therapist within 24 hours. Clients who were not in crisis were to be put on a waitlist to see a therapist. A client who scored as high risk for suicide was to be immediately connected to a therapist or, depending on the acuity, certified emergency services were to be contacted. Upon completion of the crisis intervention, clients moved into regular assessment and treatment services offered by Centro Sávila.

During the development of the process map, there was not enough information about their on-call service for established clients; it appeared to be both underutilized by staff and clients. Later, through interviews and conversations with administrative staff, the on-call crisis telephone line was described as a service for clients in crisis after office hours. Also, there was not enough clarity to determine enough about any discharge or aftercare processes to include them. The staff interviews helped us gain more insight into discharge, aftercare, the on-call service, and other suicide prevention services.

Performance Measures

Between October 2019 and June 2021, CS consistently reported to BHI four performance measures (number of clients: *screened for initial intake and case management*; *screened and triaged with case manager*; receiving *individual and family counseling*; and use data for the *on-call crisis phone line*), in addition to client demographics and narrative answers to a standard set of questions. Three other

measures were included only in the year one reports (*partners*, *case management* and *referrals out*). For the second program year (Y2) performance measures, *referrals out* expanded to encompass the full WellRx screening tool for social determinants of health. Additionally, Y2 performance measures included identified *suicide risk severity* (based on the C-SSRS) and *services provided in Spanish*. Data were not presented to the County for each of the three CS sites, they were aggregated as a single report.

According to the monthly performance measures, on average about 27% of clients were minors (age 0-17 years old) and 5% were 65 years of age or older. Clients 25-44 years old were the single largest age category (33%), followed by 45-64 years old (21%) and 19-24 years old (13%). CS reported a monthly average of about 60% female clients. A majority of clients were white (74%) and were more likely to be Hispanic (80%) than non-Hispanic (20%). About 53% of screened clients had no insurance and 45% were Medicaid insured, the remaining clients had commercial insurance. Depending on the service rendered, 56%- 76% of services were conducted in Spanish.

Until August 2020, CS regularly reported their referral source as internal, mostly from their South Valley office. The referrals noted tended to be for food boxes and case management. The South Valley office had a relationship with the Albuquerque Police Department's Crime Outreach and Support Team (COAST) that generated referrals to CS. They also mentioned self-referrals, COVID-19 homeless shelters, and the Westside Emergency Housing Center, as entities who referred potential clients to CS. It is unclear whether these referrals were for suicide prevention services at CS or one of their other services.

Performance reports since program inception indicated 621 clients had been 'screened for initial intake and case management,' 63% of whom were new clients. Approximately 99% of clients screened for intake also appear in the section 'screening and triage,' and 91% of those screened received triage with a case manager. Whereas the demographic measures section reported age by age range, clients in the *Individual and Family Counseling* service reporting block were characterized as new or returning youth or adults. In this measure, CS reported 37.5% of clients receiving counseling services were "youth," which appears to be a broader age range than the aggregation of age ranges that encompass minors under the age of 18. Among youth, 72% were new clients and 65% were adult clients.

CS reported 178 calls to their on-call crisis phone line with a high of 30 calls in March 2020 and zero calls for September, October, and November 2020. About 56% of all calls (99) to the on-call crisis line resulted in contact with a CS staff member. Of those, 22% were referred to further service. During the same nine months in Y1 and Y2, (October to June for 2019/2020 and 2020/2021), reported call volumes dropped from 153 to 22, although the percentage of callers speaking to a CS staff member rose from 52% to 96%.

Beginning in October 2020, CS reported the number of clients with low, medium, and high suicide risk levels based on the C-SSRS. Also included in the *Identified Severity* section were clients transferred to the emergency department and number of clients with improved mental health and decreased suicide ideation. It is unclear how many total clients were assessed with the C-SSRS or whether the assessment occurred during counseling, in an on-call conversation, or during screening and triage. Of the 277 clients thus far in Y2, CS reported 239 clients screened and 107 clients with at least a low C-SSRS risk score. Less than 1% of clients with a risk level indicated were transferred to the ED and 6.5% were considered

high risk. About 8% of clients assessed were rated as medium risk and the vast majority of clients assessed were considered low risk (84%).

CS reported a total of 56 clients screened for SDOH in Y1 and 78 in the first nine months of Y2. In October 2020 CS began reporting the number of clients screened with the WellRx, specifically, and the number of clients with positive scores for each of the social determinates of health. The highest number of clients screened was in February 2021, accounting for 53% of all clients screened in the first 9 months of Y2. On average, clients scored positive for 2.7 of the 12 domains. Among the social determinants most frequently positive for screened clients were income (47%), utilities (41%), housing (37%), food (32%), transportation (31%), and education (27%).

The performance measure narratives portrayed an organization trying to improve basic administrative functions (e.g., client tracking, intake forms, EMR data collection) while incorporating a loosely defined set of suicide prevention services under the pressures of the COVID-19 pandemic. Although clients were reported for the first three months of the suicide prevention program funding, crisis and triage protocols were not reported as implemented until January 2020. The on-call crisis line for clients and its attendant protocols did not appear to work to CS's satisfaction during the 21 months of performance measure reporting. Scheduling and workload issues with staff and difficulties with telephone protocols and messaging functions were most often reported as barriers. In addition to the organizational and programmatic changes mentioned, quality improvement included approximately ~53 training and education opportunities for CS staff. About one-third of the courses and meetings listed appeared to be directly related to screening, assessing, or treating individuals with suicidal ideation.

Staff Interviews

Nine Centro Sávila staff were interviewed in March 2021. Most interviewees held a master's degree and all clinicians interviewed held a New Mexico license in clinical social work. All clinicians were bilingual in Spanish and English. On average, interviewees spent approximately 11 years working in the mental health field and an average of 16 months in CS SPS. All respondents work full-time with an average of 41.5 hours per week. Clinician interviewees noted the time they spent on SPS varied. The majority provided time increments for two services, "crisis intervention" and "on-call." Clinicians reported spending 3-4 hours per week on crisis intervention, and, once every month, spending 15 hours a day for one week on-call, with an average of 105 hours per month. Administrators said they spent 6.5 hours per week on suicide prevention services.

Centro Sávila SPS Staff

Are all bilingual Spanish/English

Avg. work experience: 11 years

Avg. hours worked/week at CS: 41.5 hours

Avg. hours worked on SPS: 16 hours

Clinicians…

Are Licensed Clinical Social Workers

Avg. 3-4 hours/week on crisis intervention

Avg. 105 hours/month on-call for SPS

General Perceptions of the Suicide Prevention Services

Staff generally agreed that one of the goals of the SPS was to provide immediate access to services for individuals who are at risk for suicide. Staff mentioned that the CS SPS does not have its own therapy program. Although a client can initiate SP services, they may also receive different services under other programs at CS. One interviewee said:

We have a suicide program but it's not its own therapy program if that makes sense. We might have somebody coming in, for suicide, but then they would eventually transfer into just being seen by a clinician, but it wouldn't necessarily be under the suicide program anymore.

Staff agreed that Centro Sávila did not have a particular model in place for their suicide prevention efforts, rather their services focused on addressing the social determinants of health that might increase an individual's risk for suicide. One interviewee described their SPS as:

A different model that doesn't exclude a medical model is looking at social determinants of health. 'So, I don't have food to put on the table for my children, I feel like dying.' Okay, well that may not be a serious mental illness, it may just be a crisis of poverty or hunger so do we immediately send you to the emergency room where you go through that rigmarole? …. or do we say, "Can we help secure food for you?" And if we can help secure food for them and that's what fixes it, then we are certainly saving taxpayers a lot of dollars and we've done that person a service.

Outreach

When asked how potential clients or other agencies learned about the SPS, the majority staff said that they were not directly involved with outreach. Some interviewees provided insight into how outreach worked for the agency, and others specified that there was no outreach for SPS specifically.

At our organization, we actually keep it in house, and by that I mean, we don't post posters around the Community to say 'call us if you're having a crisis', but what we intend it to be for mostly, is for our clients. We definitely let our clients know if something's happening after hours or in the evenings overnight, this is a number you can call and it'll be somebody from our organization that will help you and that's how they learn about it.

In this case, CS provided more of an "in-reach" than an outreach because the target population for their suicide prevention services is for already established clients. Some interviewees talked about how potential new clients are screened and receive a crisis intervention. It was unclear in the interviews how these new clients learned about the on-call crisis phone line.

During our discussion with CS about the process map, comments were more about agency-wide outreach than outreach specifically for their SPS. Staff said that individuals learned about CS SPS through word of mouth outside of the organization. For clients who were already established in CS, they learned about the services in-house although the mechanisms for such education were not discusses

Intake/Screening

Intake serves as both an administrative data gathering function and for screening and assessment. Screening is used during or outside of the intake process and is used to identify individuals who may be dealing with a variety of physical, mental, or behavioral health issues, including suicidal ideation.

According to interviewees, to determine potential clients' needs, a screening specialist or case manager would ask two pre-screening questions that assess the nature of the call: "Is this an emergency?" and "Do you feel safe?" If the potential client answered, "Yes, it is an emergency," and "No, I do not feel safe," then the potential client is considered to be in crisis, which one staff member defined as:

> *When we talk about a mental health crisis, we're talking about somebody who is so overwhelmed, they feel they cannot continue in this life and they might think the best way of doing it is just attempting [to end] their lives. Sometimes that's the most serious crisis, when they feel so overwhelmed about everything that is going on and they just need to talk to someone to be able to regulate themselves.*

Another interviewee said the term crisis was not exclusive to suicidal ideation.

> *My understanding about crisis in Centro Sávila…it's if a person calls and says they're very agitated and they want services right away. Some of them have suicidal ideation, others don't have to have suicidal ideation, but they want to see a therapist on an emergency basis and there might be nobody else available or they might not have a therapist.*

According to interviewees, once it was determined that the potential client was in crisis the screening specialist would administer the Columbia-Suicide Severity Rating Scale (C-SSRS) to determine whether the client was at a low, moderate, or high risk for suicide. The level of risk determined how quickly the client would be scheduled to speak with a clinician. If assessed at a high risk of suicide, then the client would be scheduled to talk to a clinician within 24 hours. Low to moderate risk clients would schedule an appointment with a clinician in the next few days, or up to a week from the time the C-SSRS assessment took place. If the client was experiencing severe suicidal ideation, CS would contact emergency services and the client would be referred out for higher level of care. However, referring to emergency services was considered a last resort. One interviewee said:

> *You can cause harm by screening for [suicide] intent and plans. You know whether this is just ideation, and what the appropriate referral [is by the] treatment plan. So you don't want to go to DEFCON 5. You don't want to go to the highest level of care immediately unless it's warranted.*

Service Delivery

Once a person was established as a client at CS and assessed as at least a low suicide risk, they had access to variety of suicide prevention services. The services listed below were primarily offered through a clinician.

Crisis Intervention during regular business hours

Staff described "crisis intervention" as a phone line that was open from 9 a.m. to 5p.m (regular office hours) in response to potential clients who called CS, and who were assessed for any level of risk for suicide ideation on the C-SSRS. These clients were referred to a clinician who continued to assess the client while on the line.

> *So, whenever there's any sort of crisis call, and when I say crisis, I'm talking about suicidality. We first assess for any plans, means, intent… is there a weapon, are you planning on doing this now, do you have a means to do it? Depending on how they answer that, then you know if they have a plan, if they have access to whatever they're planning to use in their home, and they're sounding hopeless or desperate, then that would be severe.*

The goal of a crisis intervention, according to the interviewees, was to get the client back to a "baseline" by creating safety plans, providing suicide prevention resources, and scheduling them to be seen

regularly in therapy sessions. Referrals to other CS services such as case management might have been indicated by the assessment for the social determinants of health.

In regard to the implementation of CS SPS and the utilization of their crisis intervention telephone line, an interviewee said that since the beginning of the program, they have not received many crisis calls.

> *We are kind of new in this prevention program so there's a lot of things that probably are not in place. At least in my opinion, or my personal experience, I haven't heard otherwise, we haven't received as many calls. Which I think is good, but you know, the more calls you get, is the more practice.*

Demand for therapy and clinician availability resulted in fewer services for new, low suicide risk clients.

> *Sometimes we will refer them to other agencies, but if they really wanted to be at Centro Sávila they will need to be on a waitlist. Which right now it's very short…but yeah there was a moment where we did have like maybe 10 or 15 people on the waitlist.*

On-call after hours phone line.

The on-call phone line was described as a service designed for Centro Sávila's established clients who experience crisis outside of regular office hours. A therapist/clinician was available from 5 p.m. to 9 a.m., including weekends and holidays.

> *We implemented our on-call crisis line for existing clients. We saw that a lot of our clients were usually deregulating or running into crises after hours, so we implemented an on-call phone where clinicians would rotate from week to week for established clients who have already initiated services with our clinicians.*

> *To be clear, we're not a hotline.... we're not a 24/7 365 program that we're going to have immediate response. That's not the nature of our program but we want to, within the limits of our contract…be responsive in a very timely manner for the people that that are calling in… we have to be very careful.*

It should be noted that in their discussions of the crisis intervention and on-call services, the clients they served were not limited to those experiencing suicidality.

Assessments

Clinicians mentioned a several assessments they used in their sessions to understand the severity of depression (PHQ-9), anxiety (GAD-7), and suicidal ideation (C-SSRS). These tools may have been used in the first follow up appointment with a client or in more than one session. Clinicians indicated they did not all use the same assessment tools. Only a few mentioned that these assessments were done regularly, otherwise the clinicians used their professional judgement as to when to administer an assessment and what type was appropriate.

Safety plans

Interviewees described safety plans as "things that client can do and who they would call" if a crisis arose or if they were thinking about ending their life. The safety plan could include triggers or risks the client faces daily. One interviewee described it as:

> *It's who are your support systems, how do you know when you're not doing okay, what kind of things can you do to help you feel better, and who can you call? And then, it includes the hotline… like the national hotline the texting …a lot of teens like to do the texting one instead of calling, and then, of course, like 911.*

Suicide prevention resources

According to interviewees, a suicide prevention resource sheet was provided to any individual who scored as at least low risk on the C-SSRS. The resource sheet was described thusly:

> *We have a list of contact information, like the emergency numbers: the National Suicide Prevention Hotline in Spanish and English because a lot of our clients are Spanish-speaking. We also have the numbers for UNM, different departments, like the children's psychiatric center, urgent care, and then for case management and hospitals.*

These resources are provided to the client along with a safety plan. It is unclear how these documents have been provided during the pandemic, given that crisis intervention has been primarily over the phone.

Therapy Sessions

Interviewees referred ongoing therapy sessions or follow-up sessions. These sessions occurred one to two times a week until the clinician and the client decided together on a less frequent schedule. Little was said about the therapy sessions although clinicians reported using a variety of therapeutic modalities during their sessions with clients. The most common practices mentioned were Motivational Interviewing and Cognitive Behavioral Therapy (CBT).

Treatment plans

Interviewees described a treatment plan as a way of tracking a client's progress. Treatment plans were reviewed and potentially revised every three months. Staff generally agreed that these plans consisted of goals the client wanted to accomplish. One interviewee gave an example, "I want to learn how to cope with my depression or with my anxiety, or I want to stop drinking or whatever the problem is." Treatment plans were not specific to suicide prevention and seemed to be a part of CS's general operations. They were also used for determining whether a client was ready to be discharged.

> *I do a treatment plan during the first session and then once they feel that they have completed that treatment plan, or even I feel that they have completed it, I ask them if there's something else [they] want to work on, but if they say no, and if they also feel safe and good about being discharged then that's when we do the discharge.*

> *For my ongoing clients… I go back to the treatment plan, and we look at it together so they can see what goals they have met. Most of the time they see the difference, how they started and how they're ending. And I usually always offer that if they want to come back to therapy they're open to do that from my phone number or they can call the main number again and then they'll provide those services.*

Discharge

Mutual agreement to end service was one way to discharge from the program. In the final therapy session the clinician would discuss the need for referrals for additional services. Another form of

discharge occurred when a client discontinued communication with the CS staff. If CS had contacted them three times with no response, the client was discharged. Interviewees mentioned that informal discharge plans were sometimes created with clients to track how long they were in therapy, how many appointments they had, what kind of goals they set, whether those goals were met, and recommendations about how to reach their unmet goals.

Aftercare

Most of the interviewees said that they did not provide aftercare or follow-up for their clients after the client was discharged. Some staff said that aftercare was provided as part of the program, but that there was no formal process. One interviewee said:

> *We make it clear to clients that we're always available if they want to come back. Even if it's just a check in and not necessarily coming back to regular therapy. So yeah, I don't think it's a formal aftercare plan.*

Program Challenges and Changes

At the time staff interviews were conducted it had been 12 months since the COVID-19 stay-at-home order was first announced. The issues associated with providing behavioral health services during the pandemic were a constant challenge.

> *There have certainly been some challenges with COVID. Less face-to -face interaction with people, which I think does matter, especially when you're in acute phases. But, [being cautious] we are avoiding in-person meetings. I think the changes that we're going through as an organization [are] building up our capacity.*

One of those added capacities mentioned was a new telephone system that incorporates a phone tree so clients do not have to go through multiple staff to speak with a clinician. (A phone tree is a series of automated question/response menus that guide a caller to the appropriate service or person no matter what time they call.)

Client Data

The data for Centro Sávila is reported for 410 clients in the following tables unless otherwise noted. Twelve clients with intake dates prior to October 2019 appear to have been established clients accepted for BHI-funded suicide prevention services as internal referrals. All other clients were internal referrals with initial contact dates within the reporting period.

Client Population Profile

In this section clients are described by basic demographic information, their scores on the SDOH screening, and their suicide risk as determined (in part) by the C-SSRS. This information provides the context for potentially understanding the services discussed in the next section and subsequent findings.

Demographics

The clients for whom we have data were predominantly adults (82.9%); 17.1% were under the age of 18 (minors). The average age for minor clients was 14 years old and for adult clients, 41.5 years old. Table 2 reports age by age group. The youngest clients were under 10 years old, and the oldest clients were over 79 years old. More than half (54.1%) of CS suicide prevention service clients were between the ages of 20 - 49 years old.

Table 2. Age

	Count	Percent
Under 20	90	22.0%
20-29	72	17.6%
30-39	68	16.6%
40-49	82	20.0%
50-59	43	10.5%
60-69	38	9.3%
70+	17	4.1%

Table 3 reports gender. Most clients were female (56.6%).

Table 3. Gender

	Count	Percent
Female	232	56.6
Male	178	43.4

Race/Ethnicity was not reported for 170 (41.5%) clients. Of those for whom race/ethnicity was noted, Table 4 shows that 85.8% of the clients identified as Hispanic, 8.8% as White, non-Hispanic, 2.1% were American Indian, and less than 1% reported being Asian or African American.

Table 4. Race/Ethnicity

	Count	Percent
American Indian	5	2.1%
Asian	2	0.8%
African American	2	0.8%
Hispanic	206	85.8%
White, non-Hispanic	21	8.8%
Other Race	4	1.7%

Missing 170

Income was reported for 33.7% of clients, the majority of whom (84.1%) indicated income in the range of $0-$20,000. According to client records, almost 85% of clients did not have insurance (Table 5). It is unclear whether this was the initial or current insurance status. Because CS offers health insurance enrollment assistance as one of its services the *no insurance* category might not be representative of this population at the time of intake.

Table 5. Insurance

	Count	Percent
Commercial Insurance	5	1.2%
Medicaid	60	14.6%
No Insurance	345	84.1%

Social Determinants of Health

CS screened 110 clients for SDOH from December 2019 to mid-April 2021. This represents 28.6% of clients for whom we have data. Income (47.7%), utilities (43.5%), safety (31.5%), and food (30.9%) were the four most prevalent determinants identified. The need for childcare (7.7%) and worries about substance abuse by someone in their household (6.4%) were the two domains with the fewest indicators of need. Table 6 shows how many screened clients answered "yes" to each of the 13 questions.

Table 6. Social Determinants of Health Screening Results

	Clients Screened	Yes answers	Percent
Income	109	52	47.7
Utilities	108	47	43.5
Safety	108	34	31.5
Food	110	34	30.9
Employment	108	32	29.6
Education	109	32	29.4
Housing	110	31	28.2
Transportation	107	29	27.1
Abuse	108	21	19.4
Medical	107	18	16.8
Emergency Department Visit	107	17	15.9
Childcare	108	8	7.7
Substance Abuse	109	7	6.4

Services

Centro Sávila service data reported two different aspects of service delivery. The individual client data presented *types of services received by each client* (e.g., a given client received only suicide risk screening, or also received case management and substance abuse services, etc.). The appointment records showed *the number and type of services delivered by Cento Sávila* to its suicide prevention clients (e.g., of 3,801 services delivered, 10 were crisis interventions, 157 involved food distribution, and 901 were individual therapy sessions). Using both data files illustrates service delivery from the perspectives of client care and of overall organizational performance. To establish the need for suicide prevention services among CS clients, we look to the first two services all clients should share: safety screening and suicide risk assessment.

Safety Screening and Suicide Risk Assessment

The *Service Data* field indicated 86.6% of clients received "Suicide Risk Screening." About 62% of clients (257) had recorded answers for the two screening questions asked upon contact with a CS staff person, "Are you safe?" and "Is this an emergency?" Given that the recorded affirmative answers were 3.5% for the safe question (96.7% unsafe) and 1.2% yes to the emergency question (98.8% non-emergency), we suspect a coding or transposition error in importing the data. We tentatively assume 3.5% indicated they were unsafe and 1.2% were experiencing an emergency. However, due to the reliability of these results no link between these activities and a resultant C-SSRS screening can be made.

The CS client data included C-SSRS results for 68 clients, or 16.6% of those who received services in the Y2 of the study time period; they are presented in Table 7. The majority of clients (52.9%) scored in the low-risk category. About 19% of client C-SSRS scores indicated moderate to high suicide risk; more than half of these clients were minors. The remainder were either not scored or scored "no risk at this time." The C-SSRS implementation guidelines for behavioral health settings suggests clinical responses for each risk level although, ultimately, clinicians make that determination based on all the information they have gathered. There were 13 clients without a final risk score. Four of the unscored instruments included a *yes* in only one of their answers (typically signifying low risk); the remainder (69.2%) answered *no* to all questions.

Table 7. C-SSRS Risk Levels among Clients

	Count	Percent
High	5	7.4%
Moderate/High	2	2.9%
Moderate	6	8.8%
Low	36	52.9%
None (currently)	6	8.8%
Not scored	13	19.1%
Total	68	100.0%

Client Service Data: Type of Services Received

The *Service Data* field from the individual client level data file indicated 86.6% of clients received Suicide Risk Screening (Table 8). Within that group, 79.6% received several different types of services and 76 clients (21.4%) had only suicide risk screening (SRS) services noted. Of the 76 clients receiving only SRS services, 46 had data for the two-question screener (65%; all negative for safety risks) and there were no C-SSRS data for any of these 76 clients. When we combine the two service data files, those who were listed as having only suicide risk screening services received from 1-28 instances of that service. The number of services was missing for 35 of the 76 clients so we do not know how often 46% of the SRS only clients received this service.

Of the 410 clients for whom we have data, 36.8% received substance abuse treatment services and 33.9% received case management. Almost 24% of clients (97) received public benefit enrollment services. For 53 of those clients (54.6%), public benefit enrollment was the only other service type received in addition to suicide risk screening. None of them had C-SSRS scores and 62.2% had one service noted. The occurrence of a single public benefit enrollment service (visit) paired with unassessed suicide risk suggests either a severe data recording problem or people receiving services under the auspices of suicide prevention who did not receive any screening or prevention related services. Less than a quarter of clients received out-patient therapy services.

Table 8. Clients Receiving Services by Service Type

Service Data Type	Count	Percent
Suicide risk screening	355	86.6
Substance abuse treatment	151	36.8
Case management	139	33.9
Public Benefit Enrollment	97	23.7
Out-patient therapy	92	22.4
Services for systems involved youth	64	15.6
Victims of crime	29	7.1
Psychoeducation	8	2.0

Service Data: Appointments and Event Types

There were 3,801 appointment entries for 410 clients in the CS service data (Table 9). Appointments were characterized first by their "event type," either *group* or *appointment,* and within *appointment* the type was specified. In order to focus on appointments, we can connect with services clients received it was necessary to remove missed/cancelled appointments from the analysis. As detailed in Table 8, there were a total of 714 (18.8%) appointments made but not kept. For the event *group* over 90% of scheduled appointments were kept; for *appointment* it was 77.5%. The most frequent reason noted for missed *group* events was *no show* (94.7%) and for missed *appointment* events the reasons were *no show* (47.2%) and *cancelled* (31.1%). For the remainder of this section we define *services* as the 2,192 kept *appointments* and 895 kept *group* appointments, for a total of 3,087 services delivered. Once the missing appointments were deleted the number of clients who received services changed to 348 (84.9%); there were no services recorded for 62 clients (15.1%).

Table 9: Appointments Kept and Missed by Event Type

Event Type	Appointment		Group		Total Events	
	Count	Percent	Count	Percent	Count	Percent
Appointments Kept	2192	77.5	895	92.2	3,087	81.2
Appointments Missed	638	22.5	76	7.8	714	18.8
Total Appointments	2,830	100.0	971	100.0	3,801	100.0

For each appointment we received: event status, date, the duration of service, and the appointment type. The next tables report a variety of information about the services provided during the reporting period of approximately 19 months. Services provided under the events labeled *appointment* and *group* were distinct enough in number of clients receiving them, service duration, delivery location, and type, to warrant separate treatment in the following analyses, as appropriate. There were 38 clients (10.9%) who received services in both *appointment* and *group* event types. Because they accounted for 43.3% of all services, we have included a *both* category in the event types. Table 9 shows the number and percent of clients receiving at least one service in each event type and the number of services provided for those clients. A majority of clients (87.1%) received services only in the *appointment* event type and they

accounted for 52.0% of total services reported. Seven individuals (2% of clients) received only *group* services, receiving 4.6% of total services.

Table 10. Clients who Received Services and Number of Services Provided, by Event Type

Event Type	Appointment Only		Group Only		Both		Total	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Clients with at least 1 service	303	87.1	7	2.0	38	10.9	348	100.0
Services Provided	1606	52.	143	4.6	1338	43.3	3087	100.0

Table 11 reports the number of services provided to the 348 clients who received at least one service. Services are presented in ranges along with the number of clients receiving those service in each event type. Overall, a plurality of clients (126, 36.2%) had a single service recorded and 88 clients (25.3%) received between two and five services for a total of 61.5% of clients receiving five or fewer services. Seventeen clients (4.9%) received 40 or more services in the 19-month reporting period.

Within the *appointment only* event type, the most frequent number of services received was one (41.6%); there were no *group only* clients who received one service. Among *group only* clients, the majority (71.4%) received 20-29 services. For clients who received services from *both* event types, the most frequent range of received services was 20-29 (28.9%). The majority of clients (52.6%) in this category received more than 30 services and 3 of those clients received over 60 services each.

The average services per client are also presented by event type. For *appointment only* the overall average number of services per client was 5.3. Looking only at clients who received more than one service, the average was 8.5. For *group only* clients, the average number of services received was 20.4 and for those who received *both* services, the average was 35.2 services.

Table 11. Range of Services Received by Event Type

Event Type	Appointment Only		Group Only		Both		Total Clients in Service Range, All Event Types	
Number of Service Ranges	Count	Percent	Count	Percent	Count	Percent	Count	Percent
1 Service	126	41.6%	0	0.0%	NA	NA	126	36.2%
2 to 5 Services	88	29.0%	0	0.0%	0	0.0%	88	25.3%
6 to 9	35	11.6%	2	28.6%	2	5.3%	39	11.2%
10 to 19	39	12.9%	0	0.0%	5	13.2%	44	12.6%
20-29	9	3.0%	5	71.4%	11	28.9%	25	7.2%
30-39	4	1.3%	0	0.0%	5	13.2%	9	2.6%
40-49	1	0.3%	0	0.0%	6	15.8%	7	2.0%
50-59	1	0.3%	0	0.0%	6	15.8%	7	2.0%
Over 60 Services	0	0.0%	0	0.0%	3	7.9%	3	0.9%
Total clients served	303	100.0%	7	100.0%	38	100.0%	348	100%
Average services per client	5.3		20.4		NA			
Average service per client with 2 or more services	8.4		20.4		35.2			

Group Service Descriptions

Seven clients received services solely in this category and 38 clients received these along with *appointment* services for a total of 47 clients receiving *group* services. The Hopkins Center for Children and Families (HCCF) was the location for 77.7% of the *group* services, followed by the Main Office (17.1%) and telehealth (5.3%). There was no service type noted for 63.5% of services in *group*, the majority (82.6%) of which were associated with the HCCF. Among those with a service identified, 48% were for tasks associated with CS's food program, including form completion, pick up and distribution of food, predominantly at the HCCF location (78.3%). Cooking classes (35.2% of services) were held at the HCCF (41.7%), main office (21.7%) and via telehealth (36.5%).

Table 12. Services Provided under *Group* Event Type

	Count	Percent
Cooking Class	115	35.2%
Food Program/Distribution	157	48.0%
Other Administrative	55	16.8%
Total	327	100.0

Appointment Service Descriptions

Table 13 lists *appointment* services provided by type of service. There were 303 clients (87.1%) who received services only in this category; an additional 38 clients who received services in addition to *group* services. These services were delivered primarily via telehealth (63.1%) with in-person services at the Midtown Public Health Office (23.0%), HCCF (10.5%), Westside Shelter (1.0%), and La Casita (0.5%) locations. Individual therapy (41.3%) and case management services (11.9%) account for over half of the services in this category. Crisis intervention services were less than 1% of all services offered; it is not clear whether those crises were suicide related.

Table 13. Services Provided under *Appointment* Event Type

	Count	Percent
Individual Therapy	905	41.3
Case Management All Services (including 47 in-kind)	261	11.9
Contact Note	201	9.2
Universal Intake & Assessment	155	7.1
Pathways, All services	117	5.3
Peer Case Management, All Services	113	5.2
Benefits Applications, Education, and Follow-up	111	5.1
Assessment	94	4.3
Critical Time Intervention, All Services	56	2.6
Victims of Crime Act, All Services	53	2.4
Individual Session	47	2.1
Intake	22	1.0
Treatment Planning	17	0.8
Collateral w/ and w/o Client Present	14	0.6
Follow Up Individual	12	0.5
Crisis Intervention	10	0.5
Other	4	0.2%
Total	2192	100.0%

Table 14 reports the length of services in minutes for the services listed in Tables 11 and 12. On average *appointment* services lasted 1.1 hours and *group* services averaged 3.7 hours. In the *appointments* category 91.3% of services were 90 minutes or shorter. The majority of services (78.6%) were from 31-60 minutes in duration. The shortest service noted was 5 minutes; the longest was 300 minutes (5 hours).

In the *group* event category there were 22 entries with a duration of 1439 minutes (about 24 hours). They were all noted as "Program w/ Sysco Food Program" within the larger category of Food Program/Distribution from Table 11. They are not included in the calculation of length of *group* services. For *group* services, 47.9 % were 31-60 minutes long with 241 services (27.6%) lasting 480 minutes, or 8 hours. The range in the length of service was 60 minutes to 480 minutes.

Table 14. Length of Service in Minutes by Event Type

	Appointment		Group		Total	
Minutes	Count	Percent	Count	Percent	Count	Percent
30 or fewer	160	7.3%	0	0.0%	160	5.2%
31 to 60	1723	78.6%	418	47.9%	2141	69.9%
61 to 90	119	5.4%	47	5.4%	166	5.4%
91 to 120	168	7.7%	30	3.4%	198	6.5%
121 to 450	22	1.0%	137	15.7%	159	5.2%
451 to 480	0	0.0%	241	27.6%	241	7.9%
Total	2192	100.0%	873	100.0%	3065	100.0%
Average length of service in minutes	64.6		221.9			

Table 15 reports the total hours of service per client. On average, *appointment* clients received 7.1 hours of service with one client receiving 422 hours and 50% of clients receiving 2 hours of service or less. For clients who received only *group* services, the majority (71.4%) received over 100 hours of services each. Clients who received services in both event types most frequently averaged over 100 hours of service (42.1%). Average time per client in each group were: *appointment* 7.1 hours, *group* 91.2 hours, and *both* 80.9 hours.

Table 15. Total Hours of Service per Client by Event Type

	Appointments		Group		Both	
Hours	Count	Percent	Count	Percent	Count	Percent
1 hour or less	85	28.1				
2hours	69	22.8				
3 hours	24	7.9				
4 hours	22	7.3				
5-9 hours	48	15.8	1	14.3	1	2.6
10-24 hours	42	13.9	1	14.3	6	15.8
25-49 hours	11	3.6	0		9	23.7
50- 99 hours	1	0.3	0		6	15.8
Over 100 hours	1	0.3	5	71.4	16	42.1
Total	303	100.0	7	100.0	38	100.0
Average Hours of Service per Client	7.1		91.2		80.9	

The number of days in the program is calculated for 67 of 348 clients who received services (19.3%). There were several initial dates that preceded the start date of the CS funding, their start dates have been adjusted to 10/15/2019. There were also missing and incorrect intake dates (i.e. the intake date occurred after the discharge date). Based on intake dates, the last date clients received a service, and the number of services received, it appears that discharge dates were missing so we cannot determine which clients have been discharged and which are still in the program.

Of the 72 clients with calculated days in program, five did not have any services noted (they averaged 37.8 days in the program). For the 67 remaining discharged clients, the number average of days in the program was 94 with a median of 76 days. The minimum number of days in the program was 6 and the maximum was 447 days or 1.3 years.

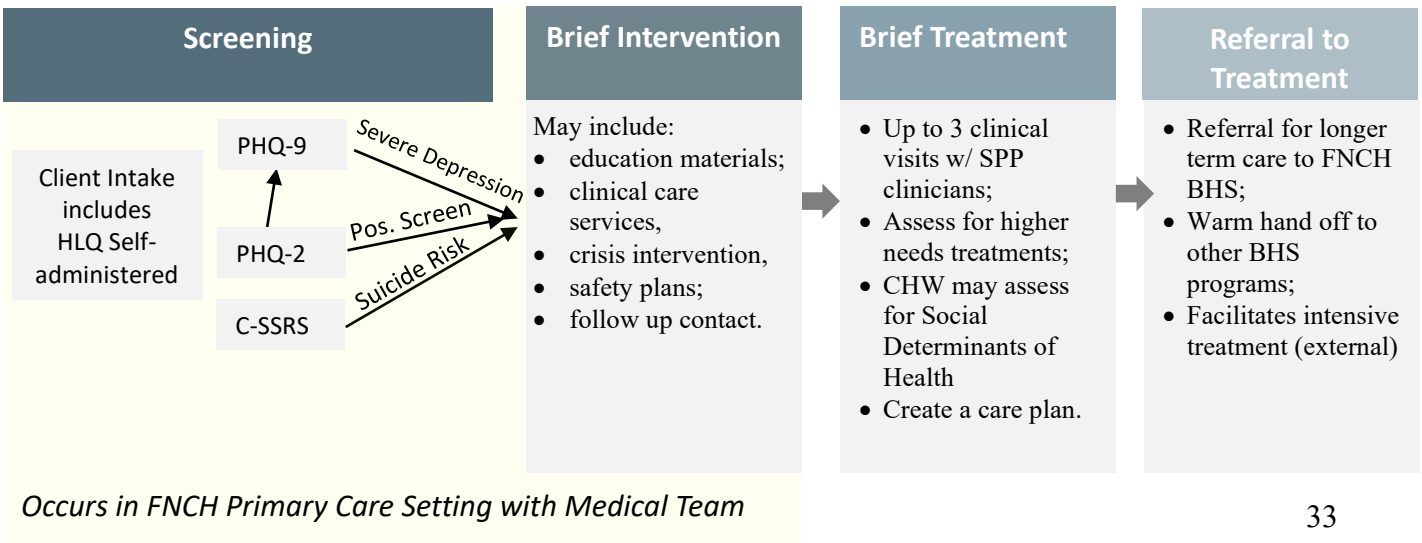
First Nations Community HealthSource

Program Description

The suicide prevention program funded through BHI added evidence-based suicide assessment and treatment to FNCH's existing SBIRT model. Starting in 2017, FNCH participated in a New Mexico Behavioral Health Service-funded initiative to implement the NM-SBIRT program (which included universal **S**creening, **B**rief **I**ntervention, and **R**eferral to **T**reatment) at their Truman Clinic, a primary care setting. Although SBIRT is an evidence-based practice for addressing substance and alcohol misuse, the coalition of NM-SBIRT sites expanded their protocols over time to include validated screening tools for depression, anxiety, trauma, domestic violence, and sex trafficking in their Healthy Lifestyle Questionnaire (HLQ). In response to Bernalillo County's suicide prevention RFP, FNCH proposed adding the C-SSRS to the NM-SBIRT screening and assessment tools, further expanding the mental health issues identified and treated through their SBIRT model. In October of 2019, FNCH signed a contract to provide SBIRT services in support of the BHI's Suicide Prevention Program.

SBIRT-Suicide Prevention Program (SBIRT-SPP) is a universal screening and assessment protocol for implementation in a primary care setting with brief intervention and treatment, and referral to treatment provided by FNCH's Behavioral Health Services division. The process map in Figure 5 represents a simplified version of how individuals engage with and move through the SBIRT-SPP. ISR-CARA staff facilitated the co-creation of a process map to help us better understand the program and identify key data elements for later collection. Descriptions of each stage follow Figure 5.

Figure 5. FNCH Suicide Prevention Program Process Map



According to FNCH, *Community outreach* is conducted by the organization through health and behavioral health job fairs and community events. Because SBIRT-SPP is a service solely for FNCH patients there is no specific external marketing or outreach, or referral stream. We begin the map with a patient visit to the health center.

Screening in the Primary Care Setting

People were able to call the main FNCH number or walk into one of their clinics for primary care service intake. Because they are a healthcare center offering primary care, dental and vision services, and behavioral health services (among others), the setting provides an opportunity for universal screening for a suite of behavioral health issues. At appointment intake, patients were asked to complete the Healthy Lifestyles Questionnaire (HLQ), a form that gathers basic demographic information and contains a series of yes/no screening questions to detect depression (PHQ 2), anxiety (GAD-2), trauma (PTSD Checklist), alcohol use disorders (AUDIT), drug abuse (DAST), domestic violence, human trafficking, and suicide risk (C-SSRS). Existing clients were asked to update their HLQ every three months while continuing services at FNCH. The HLQ was reviewed by a primary care provider. The universal screening process implemented through FNCH's HLQ created pathways from primary care to other FNCH Behavioral Health Services (BHS) SBIRT programs in addition to the SBIRT-SPP.

Eligibility criteria for SBIRT-SPP could be established in several ways. According to FNCH staff, FNCH CEO, patients were asked two questions, "(1) Have you attempted suicide? 2) Are you having suicidal/self-harm thoughts? Positive responses to the two specific suicide questions and/or the C-SSRS on the HLQ were used to trigger SBIRT's brief intervention and brief treatment." (Email correspondence, August 2021). The last set of questions on the HLQ ask: "If you answered YES to any of these questions, would you like to see a counselor at First Nations for some help?" Follow-up questions determined whether they wanted to be seen that day or another day at a time indicated by the patient.

Brief Intervention

The basis for primary care provider response to the results of the C-SSRS were spelled out in the document C-SSRS: Scoring Chart + Risk and Protective Factors, which was derived from the screening version of the C-SSRS. This flow chart addresses possible scoring patterns and takes into account the immediacy or time frame for some answers to create a standardized response to any suicide risk level. Sometimes the judgement of a medical provider or clinician could increase the level of risk based on additional information from the clients or others. The instructions included a reminder to err on the side of caution and seek consultation when in doubt.

For **Low Risk** clients, primary care staff were instructed to refer the client to SBIRT, which could take the form of a note in a chart or a call to an SBIRT-SPP clinician. **Moderate Risk** clients were sent to SBIRT to create a safety plan. **High Risk** clients were required to have face-to-face contact with an SBIRT-SPP or other BHS clinician and the client was either transported to the ER or transportation is dispatched based on a call to 911. Based on the information and permissions given in their release of information (ROI), family or friends may be contacted. If a **High Risk** client declined to go to an ER a clinician was required to meet face-to-face with the client.

Brief Treatment

When they saw an SBIRT-SPP clinician, **Low Risk** clients were provided a Suicide Prevention Resource sheet and the phone number for the FNCH crisis line (common for all risk levels). Further SBIRT appointments were planned and scheduled. SBIRT-SPP clinicians review risk and protective factors with **Moderate Risk** clients, devise safety plans and provide the plan to the client along with the resources document. Clinicians were required to offer safety planning although a client may decline; this was considered a voluntary safety plan. Safety plans were scanned into electronic medical records. Future SBIRT appointments were then planned and scheduled.

For **High Risk** clients, the SBIRT-SPP clinician discussed hospitalization with them and offered to arrange transportation. They also reviewed existing safety plans or created them if the client was willing. If a client was unwilling to complete a plan or go to the ER, they may not be detained: clinicians called 242-COPS to request a Safety Check after the client leaves the premises. If possible, follow-up plans were made with the client or the SBIRT-SPP clinician scheduled a time to follow-up and make an appointment or provide referrals. These clients also received copies of their safety plans and suicide prevention resources. Safety plans were scanned into electronic medical records and clinicians are encouraged to log all notes about theses interactions.

Brief intervention/brief treatment can include crisis intervention, clinical services, safety plans, suicide prevention education, and patient follow-up. The original model described in FNCH's proposal indicated brief treatment for SBIRT-SPP clients was to be no more than six visits. For some clients, the end of this phase is marked by discharge from the program.

Referral to Treatment

Some clients may require additional services after completion of the brief treatment portion of SBIRT-SPP. The options for referrals to longer-term services include FNCH's Behavioral Health Services Department (BHS), other FNCH programs, inpatient facilities, or referral to community-based behavioral health partners. Clinicians provided a warm handoff for longer-term services when possible.

Performance Measures

FNCH reported monthly to BHI eight performance measures, client demographics, and narrative answers to a standard set of questions. Information was reported from the Truman, Zuni, and Louisiana clinics; they are discussed here in aggregate. From October 2019 to June 2021, FNCH reported over 14,000 clients screened, 67% of whom received screening as new clients. In an average month, 96% of clients screened were between the ages of 18 – 44 years old (46% 18-24 years old and 48% 25-44 years old) and 54% were female. A majority were white 53% and almost 41% identified as American Indian/Alaska Native; the screened clients were equally as likely to be Hispanic as non-Hispanic. About 49% of screened clients had no insurance and 47% were Medicaid insured, the remaining clients had commercial insurance.

Approximately 15% of those screened had a 'positive C-SSRS'. Of those who screened positive, 81% were provided services, including suicide education. The performance measures reported *Individual and Family Counseling* separately from *Clinical Care for High-Risk Adults*, primarily distinguished by the number of client visits. In an average month, 54% of clients who received *counseling* services visited one time: 30% two times and 16% three times. According to analysis of the performance measures,

these clients participated in 2755 sessions, approximately 131 sessions delivered per month. Per client in this group, the average was 1.6 visits for *counseling* services. FNCH reported client caseloads by clinician for the first 11 months of funding; it is not reported here.

There was a total of 530 client visits for those designated as High-Risk adults. A change in reporting from program year 1 (Y1) to year 2 (Y2) resulted in 21 visits dropped from the following descriptions. In an average month, 55% of clients who received *clinical care* services visited four times; 28% five times and 17% six times. These clients participated in 2,348 visits, approximately 112 sessions delivered per month. Per client in this group, the average was 4.4 visits for *clinical care* services.

There were 122 clients who received a safety plan, or about 6 per month, although it was unclear whether they were in the clinical care or counseling group. Although FNCH performance measures included *referrals-warm hand offs,* the data reporting changed from Y1 to Y2 so beyond the number of clients referred for services related to the social determinants of health (1,107, or 64% of all clients receiving services), it is unclear what type of services (e.g., housing, food, etc.) were offered.

The performance measure narratives portrayed an organization building its capacity for program implementation, including hiring and training SBIRT-SSP staff, collaboration with primary care providers, and adjustments to protocols and record-keeping. By January 2020, FNCH began reporting their successes as, "The SBIRT clinicians and case manager continued to implement the SBIRT model. The program's success has been the number of individuals screened for depression and suicidal risk and the number of individuals who received brief intervention/treatment." This continues with only slight variation through June 2021, the last month covered in this evaluation. Barriers reported were primarily staff shortages and the challenges of primary care facilities and behavioral health departments to adapt services during the COVID-19 pandemic. Collaboration with primary care staff and on-going hiring efforts were undertaken to address these issues.

Staff interviews

Six FNCH staff and administrator interviews were completed. The majority of interviewees held a master's degree as their highest level of education and all clinicians interviewed noted they were Licensed Clinical Social Workers (LCSW) in New Mexico. Other training certifications held by staff included: Motivational Interviewing, Community Resiliency Model, and Seeking Safety. On average, interviewees had been in their field for 15.1 years. At the time of the interviews, the SBIRT-SPP had been in operation for approximately 16 months, hence all staff had been working under the program for less than 2 years, with an average of 14.3 months. The majority of the staff interviewed worked full-time at FNCH, averaging 47.5 hours per week. Interviewees reported working an average of 29.5 hours on SBIRT-SPP specifically.

FNCH SBIRT-SPP Staff

Avg. work experience in field: 15.1 years

Avg. hours worked/week at FNCH: 47.5

Avg. hours worked on SPS: 29.5 hours

Clinicians are all Licensed Clinical Social Workers

General Perceptions of the Suicide Prevention Program

Overall, there was general agreement among staff about the main goal of the program. One staff member offered that the goal of the program was:

… to integrate behavioral health screenings in primary care so that we're capturing a patient population that normally might not be captured and might be at high risk for suicide or depression, and making sure that the fidelity of the SBIRT model is being adhered to in terms of providing brief intervention, brief treatment and or linkages to care and case management.

SBIRT-SPP clinicians described their roles at FNCH as working with the primary care clinic to initiate counseling (brief interventions) with people who scored positive for suicidal ideation and/or other mental or behavioral health symptoms as indicated on their HLQ.

FNCH Outreach

The majority of interviewees said outreach was not part of their job function and there was no outreach for this specific program. Some interviewees pointed out that all programs within FNCH were aware of the SBIRT-SPP and its services. Generally, they reported that patients were made aware of these services through the FNCH primary care providers who review the HLQs.

FNCH Patient Intake and Screening

According to interviewees, FNCH clients completed the self-administered HLQ at intake, whether they were new patients or returning patients scheduled for their three-month HLQ update. Interviewees described how the HLQ determines a patient's eligibility for SBIRT:

You only have to score on one of the fields…you can score low to high, but as long as you score then it's a positive healthy lifestyle questionnaire, if you score under depression, anxiety substance abuse or suicidal ideation.

Specific to patients with suicidal ideation, one interviewee said:

When someone has high suicide risk they are like pan positive --they're scoring positive across almost the majority of those domains.

Although the HLQ was standard for all patients, some staff pointed out what they perceived as limitations in the way it was administered and the thoroughness of the suicide screening tools.

The other thing is that someone could say no to some of these answers but they could be at risk in other ways that the screen doesn't capture. They could have [had] family members who have completed suicide and who have died from suicide, so we're not screening for that.

I'd like to try to do the suicide assessment part because it's not something I feel should be a self-measure but someone giving you that assessment. Sometimes they'll answer yes to the middle part when they needed to answer yes to certain [other]questions to be able to answer these questions. It gets a little confusing and being able to talk to people about it, I think would be helpful. And then some people just avoid it altogether kind of like it's a taboo or something.

Another staff member commented that occasionally the primary care providers would send a referral to an SBIRT-SPP clinician without a positive HLQ score.

Sometimes the provider will send referrals for a patient that they saw. Maybe on the questionnaire they didn't fill out that form or maybe they didn't request SBIRT services, but the provider felt like they needed it. So that's when the provider will send me a referral and then I'll

follow up with that patient and just explain to them, "you know your provider thought this might benefit you, this is what we offer this is how we can help you. Are you interested in scheduling a brief treatment appointment?"

Referral to SBIRT-SPP

Staff indicated their preferences for a warm hand-off from the primary care setting. The physician would do this by introducing the client to the SBIRT-SPP clinician, or they would ask the SBIRT-SPP clinician to call the patient to schedule an appointment.

Ideally, we're able to just go into the exam room where they're seeing the doctor and meet with them and then engage … if there is high suicide risk, we would be prioritizing the suicide risk but often it has to do with addressing psycho-social issues that are exacerbating underlying mental health and drug use issues.

One interviewee explained the advantages of a warm hand-off, especially with patients who might otherwise be reluctant to participate in SPP services:

The reason we see people on the first day when they're here is that [it] decreases no- show rates by 50%. If someone is here with the doctor and we see them and do a warm handoff, they are 50% more likely to go to their first [SBIRT] appointment. So if we're not seeing people the first time that they're here, we're already decreasing the effectiveness of our program because it's possible people are going to continue to not show up or they might just decline services. A lot of times someone will be like, "No, I'm fine"…on the form, [but] if I walk into the exam room and I introduced myself, and I say, "Hey … I noticed that you mentioned you weren't interested right now, I want to let you know about our services and when are walk-in hours are." Then they might say to me, "You know I just don't want to be a burden, I know that you're already busy, and I don't want to make you more busy." So we can see how depression and suicide risk is playing into that and how important it is to have that intervention happen on the day that they're there to see their doctor in a way that doesn't have stigma.

Brief Intervention/Brief Treatment

Brief intervention and brief treatment were terms often used together in the interviews. By way of clarification, a staff member explained brief intervention as the link between primary care and SBIRT:

[The intervention] explains [to the client] the SBIRT program, what services are available and tries to motivate the individual and educate the patient to recognize his or her signs of depression and possibly at-risk symptoms, and the importance of getting early intervention before they become more severely depressed. It's really an intervention that will lead hopefully to brief treatment… It kind of takes it another step into engaging the patient into brief treatment and/or behavioral health services. Also, I think that [in] intervention, the clinician is also assessing the individual to determine whether a higher level of care is needed and what the risks there are. If the individual is really acute then referrals will be made to a higher level of care.

According to staff, during a brief intervention clients received a suicide prevention resource sheet that listed crisis hotlines and the on-call number for FNCH's behavioral health services. In describing the treatment sessions, interviewees reported using the PHQ-9 depression screening tool as follows:

The PHQ9, we do that every session so that's a one way that we're assessing our overall program effectiveness, sometimes the PHQ9 is used. As a wellness tool as a way of measuring wellness so it's often a standardized tool, because we use that at every session, it makes it so that we are desirable for different research grants

Interviewees were asked if they used any other evidence-based practices or curricula as part of their SPP. Generally, they mentioned using the C-SSRS and motivational interviewing.

Motivational interviewing…I feel like it's validating people in their situation enough for them to realize what they need to do or realize, [at] what level they want to get things accomplished. It's lifting people up from the inside so that they see, okay, this is what I want to do, I want to be better in this, but also validating them in their in their situation and feelings, opening up that wall, you know. 'I can get help' because you're showing them that you know they're able to. …like asking a lot of questions and letting them kind of talk themselves into it .They already know what they need and we're going to be a cheerleader…

Interviewees noted safety plans were not done in a standardized way but usually consisted of a list of family contacts the client could use in an emergency, and specified goals the clients set for themselves. They mentioned that sometimes the C-SSRS was administered to help the SBIRT-SPP clinician determine whether a safety plan was necessary.

Interviewees noted that clients screened "positive" on their HLQ and who have agreed to see an SBIRT clinician could receive an average of 6-12 treatment sessions; one interviewee indicating the maximum was 24 sessions. They also said the clinician and the client would decide what the next steps were in terms of discharge from the SBIRT-SPP; for some that included a referral to treatment.

Referral to Treatment

After completing the brief intervention/treatments, a portion of clients could be referred to FNCH's Behavioral Health Services or other community behavioral health partners for further treatment. However, interviewees indicated that the FNCH BHS program had a long waitlist due to a shortage of clinicians during the COVID-19 pandemic. They discussed how they dealt with clients who should have been referred to FNCH BHS but were on a waitlist.

If someone's still struggling and still finding themselves in crisis more, even towards the end of the 12 sessions, we'll do another HLQ and then that can qualify them for another episode of [SBIRT-SPP] care, so they can start from one again and go to 12.

Clients may also have been referred for other services within FNCH.

We [FNCH] provide a lot, so a lot of our referrals are in house. We basically can provide WIC [Women, Infants and Children Services], we can provide legal services, case management services for Medicare, Medicaid, clothing, food bank, dental, other medical referrals within [FNCH].

Discharge

When asked about their discharge procedures, one staff member said:

There is no formal discharge from the SBIRT-SPP specifically. Rather, this program is meant to refer SPP clients for longer term care either under FNCH's BHS or to another community partner that provides behavioral health services. Once referred to long-term services, that client is no longer apart of the SBIRT-SPP.

However, a client could be administratively discharged from the SBIRT-SPP.

If they've had an appointment scheduled and they don't show, and if the SBIRT clinician tried to reach out to them at least three times, left a message and didn't hear anything back… if that happened three consecutive times, then we would assume that the patient is not interested in continuing to receive care.

Aftercare

Our standard staff interview includes questions about aftercare for clients. Given that SBIRT-SPP is designed to be brief and finite, and that FNCH patients are regularly screened as part of their primary care visits, it follows that aftercare, per se, is not part of the SBIRT-SPP model but is part of FNCH's patient care. One interviewee explained it this way:

So we would never call it aftercare because the service never ends. It's a service available over their lifespan so there's when you do see some aftercare would be provided. …but if we're thinking about it like a traditional mental health program, after care is like, "You've completed treatment, and now you can engage in group," is often how outpatient treatment programs provide after care. So aftercare would be like us connecting them into a program that provides after care services.

Client Data

Data for the client review came from a variety of sources. According to FNCH records, 10,625 PHQ 2 screenings were completed between mid-November 2019 and mid-April 2021. These PHQ 2s were administered to 5,937 unique individuals. Of these unique individuals 3,269 were screened one time and the other 2,668 individuals were screened 2 or more times (range 2 -20 times). This is discussed in more detail later. In addition, 19,102 Columbia Suicide Severity Rating Scale (CCSRS) screenings were administered to 6,223 unique individuals with 3,951 individuals receiving two or more CCSRS screenings (range 1-31, mean 3.3, median 2). In addition to the screening data, we were provided appointment data for 5,749 unique individuals who received at least one service for a total of 28,653 services between October 2019 and April 2021. We received PHQ 9 data for 329 individuals with 191 of these individuals having an initial PHQ 9 and at least one follow up PHQ 9. The PHQ 9 was used as a pre-test and post-test and is a validated questionnaire that reviews the 9 key symptoms of depression based on the DSM diagnostic criteria for major depression. The PHQ 2 is the first 2 questions in the PHQ 9 that asks about lack of interest in activities and depressed mood. The results of the PHQ 9 can be used to measure change from the initial assessment to the follow up assessment.

Client Population Profile

The tables below variously report the different data sources. Demographic data (i.e., race/ethnicity, age and gender) are reported using appointment data. These data are used because they more accurately reflect clients while the screening data (PHQ 2 and C-SSRS) measures screenings and not clients. The PHQ 9 data is important and useful because the comparison of the pre-tests and post-tests provide a measure of change among clients.

Demographics

The First Nations Community Healthsource (FNCH) dataset contained demographic and service data for 7,369 clients whose initial service occurred between October 1, 2019, and April 30, 2021. As shown in Table 16, nearly three-fifths (57.6%) of clients were female.

Table 16. Client Gender

	Count	Percent
Female	4,243	57.6
Male	3,124	42.4
Unknown	2	0.0
Total	7,369	100

Of the 7,369 clients, 5,736 (77.8%) provided any response to a question about their racial/ethnic identification. Table 17 indicates the majority identified as Hispanic or Latino (39.9%), American Indian or Alaska Native (25.8%), or White (17.8%), comprising 83.5% of the total. Another 4.2% responded to the question but either declined to specify their race/ethnicity or refused to answer.

Table 17. Client Race/Ethnicity

	Count	Percent
Hispanic or Latino	2,290	39.9
American Indian or Alaska Native	1,480	25.8
White	1,019	17.8
Black or African American	286	5.0
Other Race/Ethnicity	244	4.3
Asian	78	1.4
More Than One Race	76	1.3
Native Hawaiian/Other Pacific Islander	22	0.4
Declined to Specify/Refused to Answer	241	4.2
Total	5,736	100

Table 18 presents the distribution of client ages. About 14% were younger than age 30 and the remainder were evenly divided among the 30-39, 40-49, 50-59, and 60 and over ranges. The average client was around 47 years old.

Table 18. Client Age

	Count	Percent
<18	11	0.1
18-29	1,027	13.9
30-39	1,544	21.0
40-49	1,608	21.8
50-59	1,549	21.0
60+	1,630	22.1
Total	7,369	99.9
Mean	46.7	

FNCH Clinic Visitation Information

The distribution of the number of times individual clients visited a FNCH clinic during the period covered by the data is presented in Table 19. Approximately one-third of clients visited only once

(34.4%), another third visited between 2 and 3 times (32.8%), and over one-fifth (22.7%) visited between 4 and 7 times. More than 95% visited on 10 occasions or fewer. The average client visited 3.5 times, one client visited 42 times, and together the 7,369 clients accounted for 25,640 visits. It is unclear what portion of these visits were for which SBIRT-SPP services.

Table 19. Visits per Client

	Count	Percent
1	2,538	34.4
2-3	2,417	32.8
4-5	1,107	15.0
6-7	568	7.7
8-10	395	5.4
11+	344	4.7
Total	7,369	100
Mean	3.5	
Maximum	42	
Sum	25,640	

Beyond the 2,538 single visits we cannot assume that X number of visits equals X HLQ screening events. Because the HLQ is supposed to be repeated every three months and the number of visits in any given time period can vary, we cannot calculate the number of opportunities for screening in this universal program to estimate what portion of clients eligible for screening were screened.

The average individual had about five months (159 days) between their first and last visit. Table 20 displays the distribution of the number of days between clients' earliest and latest visit. Approximately one-third of clients had 0 days because they had one visit. Nearly 8% had between 1 day and 30 days between first and last visits and about 10% each had between one and three months (9.0%) or three and six months (10.4%). The remainder were evenly split between six months to one year (19.4%) or more than one year (19.1%), with one client spending 576 days between their first and last visits.

Table 20. Days between First and Last Visit

Number of Days	Count	Percent
0	2,538	34.4
1-7	166	2.3
8-30	405	5.5
31-90	660	9.0
91-180	766	10.4
181-365	1,429	19.4
366+	1,405	19.1
Total	7369	100
Mean	158.6	
Maximum	576	

Screening and Assessment

In the SBIRT model, the results of screenings and assessments should dictate the SBIRT response (intervention, treatment, etc.). Before we can know whether the services rendered were an appropriate follow-up to a 'positive' SBIRT score, we reviewed the provided assessment and screening data. Screening and assessments were conducted initially in the primary care setting with the review of the patient's Healthy Lifestyle Questionnaire (HLC).

Table 21 shows the total count of unique screenings clients received by instrument. Roughly two-thirds (64.3%) of the 29,727 screenings were C-SSRS screenings and the remaining 35.7% were PHQ-2 screenings. The average number of PHQ-2 screenings clients received was 1.6 with a maximum of 20, and the average number of C-SSRS screenings clients received was 2.9 with a maximum of 31. Individual clients could have received only one, both, or neither screening.

Table 21. Number of Screenings per Client

	Count	Percent	Mean	Max
PHQ-2	10,625	35.7	1.6	20
C-SSRS	19,102	64.3	2.9	31

Scores on the PHQ-2 range from 0 to 6 and measure how frequently during the past two weeks respondents were bothered by "Little interest or pleasure in doing things" or "Feeling down, depressed, or hopeless." Respondents were considered for further assessment if they received a PHQ-2 score of 3 or higher, indicating depression and the possibility of a depressive disorder.

Likewise, yes responses to questions 1, 2, and 6 can indicate a need for referral: Question #1, "Have you wished you were dead or wished you could go to sleep and not wake up?"; #2, "Have you had any actual thoughts of killing yourself?"; or #6, "Have you ever done anything, started to do anything, or prepared to do anything to end your life?" (If the timeframe was 12 months ago or longer, it indicates Low Risk but if the timeframe is more recent, the suicide risk level increases.)

Respondents are prompted to answer Questions #3-#5 if they answered "yes" to #2. "Yes" to Question #3, "Have you been thinking about how you might do this?" indicates Moderate Risk. "Yes" to Questions # 4 and #5: "Have you had these thoughts and had some intention of action on them?" and "Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?" indicate a High Risk for suicide, as does Question # 6 if they have exhibited suicidal behaviors or done something to prepare to kill themselves in the last three months.

Table 22 shows the number and percent of all clients who were screened as indicating a need for further referral at least once during any of their FNCH clinic visits. About 17% of the 7,369 clients scored positive for depression on the PHQ-2 at least once and a slightly lower number, 16.5%, scored positive on the C-SSRS at least once.

Table 22. Number of Clients Who Screened Positive for Depression or Risk of Suicide

	Count	Percent (all Clients)
PHQ-2	1,251	17.0
C-SSRS	1,219	16.5

Table 23 presents the number and percent of services clients received other than screenings. Most (77.8%) were treatment-related services, with modest shares receiving either of two case management services: a referral to another healthcare provider (10.8%) or a needs assessment (8.6%). A small proportion received services that were non-treatment related and did not match the case management descriptions (2.8%); these consisted of the provision of either a safety plan or suicide prevention education. As indicated by the low average numbers of such services per person, many clients did not receive any of these services and only received a screening. However, at least one individual each received 90 treatment, 10 non-treatment, 3 needs assessment, and 4 referral services.

Table 23. Number of Non-Screening Services per Client

	Count	Percent	Mean	Max
Treatment	4,679	77.8	0.8	90
Non-Treatment	169	2.8	0	10
Needs Assessment	516	8.6	0.1	3
Referral	651	10.8	0.1	4

Services

Table 24 presents the distribution of the number of services clients received. Listed services included administration of the Patient Health Questionnaire (PHQ)-2 and Columbia-Suicide Severity Rating Scale (C-SSRS), (used to screen for depression and suicide risk, respectively), as well as other services related to treatment and case management. If a client was screened using either or both instruments on a single date this was counted as one service and all other services were counted as unique. The share of clients receiving only one, two or three, or between four and ten services was about 30% each, and the remainder received 11-20 services (5.2%) or more than 20 services (1.2%). One client received 105 services during the timeframe and clients received an average of about four unique services. In all, the 7,369 individuals accrued 28,941 services.

Table 24. Number of Services per Client

Services	Count	Percent
1	2,366	32.1
2-3	2,345	31.8
4-6	1,502	20.4
7-10	688	9.3
11-20	380	5.2
21+	88	1.2
Total	7369	100
Mean	3.9	
Maximum	105	
Sum	28,941	

Table 25 presents the number of services by the SBIRT model component. Almost 80% of services were some type of screening, 5.3% were for brief intervention and 13.7% were for brief treatment. Referrals to treatment outside of the SBIRT services were 2% of total services. Because this was designed as a universal suicide prevention screening program, it follows that the majority of services were for screening. However, based on these data we cannot accurately say how many screens were for admission into SPP services.

Table 25. Services Received by SBIRT Steps

Services Received	Count	Percent
Screening Services	22,638	79.0
Brief Intervention Services	1,529	5.3
Brief Treatment Services	3,918	13.7
Referral to Treatment Services	568	2.0
Total Services	**28,653**	**100**

The screening services in Table 25 were aggregated, in Table 26 we see what services were characterized as "screening" in the data. These represent a sorting mechanism *for all FNCH SBIRT programs*, (DV, Substance use, SPP, etc.). The categories do not appear to be mutually exclusive, making it difficult to understand for which SBIRT program services were declined. Of note are the 1,671 positive C-SSRS screens (5.3% of all services and 7.4% of all screening services), giving us the starting point for the number of patients were eligible for SPP services.

Table 26. Screening Service Detail

Screening Services	Count	Percent of all Services	Percent of Screening Services
Screened Negative	3,224	11.3	14.2
Screened, no additional information	9,179	32.0	40.5
Screened Positive for SBIRT	4,659	16.3	20.6
Screened Positive for C-SSRS	1,671	5.8	7.4
Screened Positive Declined additional services	3,905	13.6	17.2
Total	**22,638**	**79.0**	**100.0**

Assessment Data

The PHQ 9 is a validated questionnaire that reviews the 9 key symptoms of depression based on the DSM diagnostic criteria for major depression. The PHQ 2 is the first 2 questions in the PHQ 9 that asks about lack of interest in activities and depressed mood. PHQ 9 total scores are interpreted as follows:

1-4 No depression
5-9 Mild depression
10-14 Moderate depression
15-19 Moderately severe depression
20-27 Severe depression

The PHQ 9 includes pre-tests and post-tests which allowed us to conduct paired sample t-tests. This test compares two means that are from the same individual, object, or related units. In the case of three instruments, the means from the pre-test and post-test were used to determine whether there was statistical evidence that the means between the paired observations were statistically significantly different (p-value ≤ 0.05), and Cohen's D was used measure the magnitude of the effect. This information is presented in the next section. The information for each assessment is presented in identical table formats.

In Table 27 the first column lists the domain being tested, column two reports the mean of the pre-test and post-test and the average difference between the pre-test and post-test domain, the next column reports the standard deviation (a measure of the spread between numbers), followed by t (the test statistic for the paired t-test), then whether there is a statistically significant difference shown as sig., and finally Cohen's d that measures the effect size. An effect size is a measure of magnitude of the difference between two variables. The larger the effect size the stronger the relationship between two variables. It is important to consider both statistical significance and effect size. Cohen d's effect size suggests that $d = 0.2$ is considered a 'small' effect size, 0.5 represents a 'medium' effect size and 0.8 a 'large' effect size.

There are limitations to this assessment. First, the use of the PHQ 9 was not consistently used by the program. We received 973 PHQ 9s to 329 clients administered between July 2020 and April 2021. For 191 clients we received an initial PHQ 9 and at least one subsequent PHQ 9. On average there were 59.7 days between the initial and last assessment with a median of 38 days (minimum 5 days, maximum 259 days).

This poses challenges for analyzing the data and making comparisons, especially over time, as the PHQ 9 was not administered consistently during the life of the program and re-assessments were not administered at consistent intervals. This limited the statistical power to detect effects and the inconsistent re-administration of such tools may result in a survivorship and selection biases favoring longer-term clients who are doing better in the program versus clients who disengage and withdraw from active program participation.

The PHQ 9 total scores were statistically significantly different between the pre-test and post-test and on average scores were statistically significantly lower at the post-test period compared to the pre-test period, ***with lower scores indicating improvement showing a medium effect size***.

Table 27. PHQ 9 Paired Sample T-Test

	Variable	Mean	Standard Deviation	T	sig. (2 tailed)	Cohen's d
Total	Pre-test	11.6				
	Post-test	8.7				
	Difference	2.9	6.3	6.29	0.000	0.47

Discussion and Summary

Suicide is rare and the prevalence of high suicide risk is relatively low. Challenges exist in having a system or service that is rarely called for, and the ability to deliver the service when immediately needed. This is exacerbated by the fact that, for some suicide-related crises, the availability and

provision of the service can mean the immediate difference between life and death. To varying degrees, neither of these programs engages its resources for suicide prevention all the time. At what point do services move from directly suicide-related (and therefore funded under this County initiative), to services that are similar to traditional clinical or case management services? The preferred resolution of this conflict will vary across funders, providers, clients, and evaluators, providing context for the interpretation of the evaluation findings in this report.

In this section we review findings to answer several process evaluation questions about how suicide prevention services and programs were implemented. Both providers offered screening and referral services, counselling and support services, and early intervention strategies. As part of their County-funding CS also offered a hotline/on-call service for its clients (FNCH had an existing client crisis line that was not discussed as a key element of their program model; it was mentioned only as a resource) and FNCH organized their services based on the SBIRT model.

Centro Sávila Suicide Prevention Services

As was noted in the interviews, Centro Sávila does not have a suicide prevention program *per se*. In part, BHI funding was to expand CS's capacity to address suicidal ideation and suicide risk in their clients through screening and assessment, and by providing crisis counselling for individuals at risk for committing suicide. Was Centro Sávila able to increase its service capacity as proposed? Is there evidence to suggest they are likely to achieve their desired client outcomes for their target population?

Target Audience

According to the BHI contract, CS was to provide behavioral health services in Spanish and English for "low-income, high-risk youth and adult clients experiencing suicidal ideation or who were at risk for suicide" (Chavez 2019). Race/ethnicity was missing for 41.5% of the 410 clients for whom we received data and neither client language preference nor language used for service delivery were noted in the data we received, although they were reported to the County in the monthly performance measures. There were adults (82.9%) and minors (17.1%) among the clients. Approximately 3% of clients receiving services were assessed as moderate to high risk for suicide based on the C-SSRS. There was no empirical evidence in the client data to suggest the 97% of clients who received these services were either experiencing suicidal ideation or "at risk for suicide."

Screening and Assessment for Suicide Risk

Of the 410 clients for whom we received data, 257 (62.7%) had responses to the two non-suicide specific screening questions; fewer than 10 answered they were in danger or not safe at the time, and of those, two-thirds did not have C-SSRS data. Recall that one interviewee noted, "*My understanding about crisis in Centro Sávila…it's if a person calls and says* ***they're very agitated and they want services right away****. Some of them have suicidal ideation, others don't have to have suicidal ideation, but they want to see a therapist on an emergency basis…"* (emphasis added). This more subjective perspective about what constitutes a crisis potentially changes the criteria for who receives services under the auspices of suicide prevention.

Of the 68 people with C-SSRS scores, 22 had no screening information and 44 indicated neither safety nor crisis concerns at the time of screening. The group with C-SSRS scores represented 16.6% of clients receiving services; the remaining clients (83.4%) reported to have received services had not been screened for safety or assessed for suicide risk by the C-SSRS. As for the results of the C-SSRS, there

were no final scores indicated for 13 of the 68 clients assessed (19.1%). Of the 55 clients who were assessed and had final scores, 13 clients (23.6%) scored as moderate to high risk, and 76.4% scored low or no risk.

Centro Sávila performance measure narratives and staff interviews mentioned difficulties with standardizing screening and assessment protocols, especially as they moved to telehealth service delivery in response to the pandemic. They reported using the C-SSRS as early as August 2020 and started reporting scores on their performance measures for program Y2. Staff received C-SSRS training in October 2019, December 2020, and January 2021. There are no records of the C-SSRS assessment in Y1. Sixty-eight assessments were recorded for Y2. We don't know why 97% of the clients who received services for suicide risk had no recorded indication of the need for these services.

The questions, "Do you feel safe?" and "Is this an emergency?" have no empirical basis as effective screeners for suicide risk. Based on inconsistences in screening results and services (or recording scores), screening protocols do not appear to follow best practices. The lack of valid screening data made it difficult to monitor client outcomes including whether there were successful early interventions.

Assessment for Social Determinants of Health

The emphasis by CS and the County on mitigating poor social determinates of health outcomes as a means of decreasing risk of suicide might give some insight into the number of non-suicidal clients who received services under the auspices of prevention. In their initial program description, CS noted they would be leveraging other funding to provide client-centered case management to address suicide risk factors associated with social determinants of health. However, an interviewee described their suicide prevention approach as "*…looking at social determinants of health. 'So, I don't have food to put on the table for my children, I feel like dying.' Okay, well that may not be a serious mental illness,* ***it may just be a crisis of poverty or hunger****…"* (emphasis added). While there may be some face validity to this approach, it is not empirically based, and CS potentially missed opportunities to explore the correlations by only assessing 28.6% of these clients for SDOH. According to their performance measures, CS assessed SDOH in both program years, moving to the empirically validated WellRx in Y2. The client data has ~ 109 records for individuals with and SDOH assessment: 47.7% said they were unemployed or without regular income and 43.5% indicated they were having trouble paying for utilities. Food insecurity was an issue for 30.9% of clients.

Services beyond Safety Screening and Suicide Risk Assessment

If 3% of clients receiving suicide prevention services scored as moderate to high suicide risk on the C-SSRS, what drove the number and types of services given to the other clients? The idea that food insecurity was an issue for 34 clients and there were 157 food distribution services, and 115 cooking class services might make sense, but the connection to reducing suicidal ideation and suicide attempts is less clear. The number of services received by the 13 clients with moderate to high suicide risk (as determined by staff interpretation of the C-SSRS) ranged from 1 to 56. There were no significant differences across the C-SSRS risk levels for hours of service or number of services. The number and variety of the non-suicide prevention services means attributing outcome to suicide prevention activities will be difficult.

Daytime Crisis Intervention Hotline and After-Hours Access to Therapy Services.
Helplines are key activities in suicide prevention. In general, hotlines focus on crisis intervention and warmlines focus on non-crises. These services are not delineated in either the client level service data or in the services rendered data. Based on performance measure narratives and interviews, CS struggled with the implementation of these services, and they were still in flux at the end of the study period. They suffered from a low number of calls (it was unclear how clients learned about the services), a malfunctioning phone system that did not connect clients and staff, and it may have inadvertently been in competition with the practice some therapists had of giving clients their specific contact information for emergencies. There were no opportunities to observe whether the hot- and warm-line calls met best practices and there were insufficient data to understand the accessibility issues. Access to care during acute suicidal ideation is a critical aspect of a suicide prevention program and a major component of CS's proposed services, the flawed program design and implementation of these services are unlikely to improve client suicide outcomes.

Centro Sávila Key Findings

- 410 clients received services.
- 257 clients received safety screening: 3.5% unsafe; 1.2% experiencing an emergency.
- 68 clients assessed for suicide risk (C-SSRS): 13 clients scored moderate or high risk.
- 3,087 services provided.
    - Clients with more than one *individual* service (predominantly therapy) averaged 8.4 per client;
    - Clients with more than one *group* service (predominantly food related) averaged 20.4 per client; and
    - Clients who received both services averaged 35.2 services per client
- Staff averaged: 3-4 hours/week on crisis intervention and 105 hours/month on-call for SPS

Summary

CS SPP services seem to function as general responses to crisis and are not necessarily suicide prevention specific. Instead, suicidal ideation is just one type of crisis CS clinicians might address with their standard care programs. CS's services might have met their target audience demographically but not in identifying and treating clients with suicidal ideation or who were at risk for suicide. Given the problems with access to crisis intervention through their daytime and after-hours phone lines, the apparent inconsistencies in safety screening and suicide risk assessment, and the number and types of services offered that have tenuous connections to suicide prevention, we suggest their services were not implemented as designed. In part, this seems to reflect the lack of specificity and planning for what effective suicide preventions services entail. In discussions with CS staff and form their performance measure narratives, they do seem to be working at identifying problems and creating solutions, sometimes with the help of consultants. At this time, there is little evidence that CS's services are effectively reducing the risk of suicide among its clients.

First Nations Community HealthSource SBIRT-Suicide Prevention Program

Experience with NM-SBIRT likely facilitated the rapid start-up of the SBIRT Suicide Prevention Program (FNCH is a certified SBIRT site for substance abuse treatment). The minor revision of the NM-SBIRT Health Living Questionnaire to include the C-SSRS and the guidance for interpretation and

response to the assessment appear to have provided a strong framework for program implementation. The universal suicide risk screening in this primary care setting appears to be well integrated into the FNCH constellation of SBIRT programs. Observations would help us understand the degree to which SBIRT-SPP is integrated into the primary care setting.

FNCH response to the administrative challenges of revising electronic record-keeping systems and dealing with staff hiring and retention in a global pandemic seems to have been effective. Staff comments from the interviews contextualize the magnitude of the staffing and workload issues during the early months of the pandemic.

> *[During] COVID we've lost seven clinicians. Our waitlist [for BHS] is over six months long, we've lost one SBIRT clinician, and then we lost our homeless outreach clinician. So that's nine clinicians [whose work is] overflowing into our clinic.*
>
> *The SBIRT program is covering for behavioral health. Right now they are not taking any clients at all so it's kind of falling on us to follow up with these individuals that are scoring positive.*
>
> *One of the challenges that we're facing with COVID is our front desk is scheduling all of the COVID testing and COVID vaccinations. So because they're doing a full-time job on top of their full-time job they might forget to give someone the screen that they typically would have given someone every three months, so someone might not have screens done.*

In this section we review data from performance measure narratives, interviews, and client files to answer several process evaluation questions about how the SBIRT-SPP was implemented and who received SBIRT-SPP services. Because there were no program observations, some questions about fidelity to the SBIRT model cannot be answered at this time.

Target Population

The primary target population for this program was Bernalillo County residents experiencing homelessness, substance abuse, or those who have a history of behavioral health challenges or suicidal ideation or suicide attempts. As an urban Indian health center FNCH felt uniquely situated to serve American Indians in Albuquerque; they proposed that at least 25% of their clients would be American Indian.

We received client records for 7,396 people. Race/ethnicity was available for 78% of clients: 39.9% identified as Hispanic, 25.8% Native American, and 17.8% White, non-Hispanic. The service population was predominantly female (57.6%) and 99.9% adults with an average age of 46.7 years old. We did not request or receive information about other behavioral health diagnoses, housing status, previous suicide attempts, or exposure to suicide through family and friend networks.

SBIRT-SPP Components

Although FNCH developed an electronic data reporting template to track the SPP's elements, the data we received included records for what appear to be screenings and services for all SBIRT programs at FNCH. FNCH patients made over 25,000 visits during the study period. Approximately one-third of 7,369 clients visited once (34.4%) and another third visited between 2 and 3 times (32.8%). More than 95% visited on 10 occasions or fewer with an average of 3.5 times per client. It is unclear what proportion of these visits were for which SBIRT-SPP services and their risk scores and related

interventions are unknown. These data seem to suggest that 61%.of clients resolved their issues in 2 to 10 visits.

Screening. Data were available for 19,102 C-SSRS assessments. 1,219 clients (16.4%) scored positive for suicide risk. There was some discussion in the interviews and performance narratives that suggested some clients who were eligible to update their HQLs did not have the opportunity due to staff shortages and resultant heavy workloads. There were no estimates given for how this might have affected the screening numbers.

PHQ-2 depression screens were completed 10,625 times and resulted in 973 PHQ-9 assessments; 8.6% of those resulted in scores indicating severe depression with another 16.1% indicating moderately severe depression. We have not been able to ascertain the how severely depressed patients are categorized for purposes of SBIRT-SPP services or the number of clients who are severely depressed and high suicide risk individuals. According to their proposal to the County, the criteria for Brief Intervention was positive scores on the PHQ-2, PHQ-9 and C-SSRS.

Brief intervention. FNCH described brief intervention as suicide prevention education, clinical care services, crisis intervention, crisis plans, and follow-up contacts. While both the proposed model and the C-SSRS Scoring Chart mention suicide prevention education as part of every intervention: there were 67 instances recorded in the data we obtained. Crisis planning is indicated for moderate suicide risk patients and, where possible, for high-risk patients: 102 safety plans were created during the study time period.

Interviewees noted a preference for meeting patients face-to-face to discuss intervention strategies regardless of suicide risk level. For some, this meant opportunities to address cultural biases about accepting help and it was an opportunity to using their Motivational Interviewing skills to increase willingness to participate in services.

Staff commented that improvements to the screening process might include a question about whether the client knew someone who had attempted or committed suicide recently. One staff person preferred to read the assessment questions out loud as a way to clarify answers and foster discussion with patients. Staff also seemed to appreciate the flexibility of having the medical care team (or themselves) increase the risk level and response based on their experience and, perhaps, familiarity with the client.

Brief treatment. FNCH described brief treatment as up to three clinical visits by the SPP clinicians and/or referral for longer-term care to the behavioral health services. Data were received for almost 30,000 services (Table 24). There were over 3,900 ‘treatment services’ in the data. Unfortunately, the way these data were collected or pulled by the organization, or analyzed, does not present a clear picture of services received in the brief treatment phase. Almost 80% of those services are classified as “treatment.”

Referral to treatment. Activities under this portion of SBIRT-SPP includes referrals to FNCH BHS, in- and out-patient resources, Social Determinants of Health assessments and appropriate referrals, and develop care plans with the client. Interviewees appeared knowledgeable about other FNCH programs and willing to help clients access them. Staff also discussed the ease and importance of warm hand-offs for internal referrals. Germaine to this SBIRT-SPP component, data show the delivery of 516 Needs Assessment Services (an expanded version of the WellRx Social Determinants of Health Assessment) and 651 Referral to Treatment Services during the study period. It is important to note that not everyone was offered or consented to a needs assessment or progressed to the referral to treatment portion of the model.

FNCH SBIRT-SPP Key Findings

- American Indians were 25.8% of clients.
- 28,653 services rendered.
- 19,102 suicide risk assessments (C-SSRS) were conducted in a primary care setting; 16.5% of clients (1,219) scored positive for suicide risk.
- Clients received 567 referral services.
- Staff averaged 29.5 hours/week on SBIRT-SPP specifically.

Summary

The universal application of the C-SSRS generated more than 19,000 suicide risk assessments therefore FNCH's SBIRT-SPP target audience (all FNCH clients) seems to have been served. However, without information about the volume of clients *who could have been screened* at the three clinics we do not know exactly how universal the screening was; we would hypothesize 19,000 risk assessments represent a sizeable portion of clients during the study period. Future program observations should shed light on the universality of screening and assessment efforts.

The program appears to have been implemented as designed although the criteria for who should be eligible for suicide prevention services under this program remains unclear. The infrastructure for fidelity to the SBIRT model is in place: staffing and staff training; screening, assessment and response protocols, documentation support through FNCH's electronic medical records system, and a variety of in-house, culturally appropriate services for client's who need them post-SBIRT-SPP. Program observations would shed light on the degree of fidelity to the model.

Given the low prevalence of suicide and suicide attempts, and the difficulties in institutional tracking of these events we cannot definitively say FNCH is preventing suicides in its patient population. However, the literature suggests that best practices such as universal suicide risk screening and the provision of intervention services are critically important, and highly likely to decrease suicide risk. Based on these alone, FNCH could be effectively reducing the risk of suicide among its patients.

Recommendations

These recommendations include general considerations for both providers and provider-specific comments. If you feel like a recommendation does not apply to your organization because you already

have it in place, check your written policies, procedures, and data client level data. If it is not there to be collected by evaluators, they cannot know it is a practice for your organization.

General Program Improvements for Both Providers

A basic process evaluation question is whether the organization served its stated population, in this case, youth and adults who were experiencing suicidal ideation or who were at risk for suicide. It is not clear how suicide risk screening and assessment (when conducted) were related to the number, type, or duration of services. Not everyone who received services had data indicating their suicide risk level, how did they qualify to receive services in this program? If a person is classified with a suicide risk below moderate, how are the services received by those clients different from those who screened as no risk? Providers might consider revisiting what level of suicide risk (as determined by empirically validated assessment instruments) meets the criteria for suicide prevention services.

Both programs would benefit from revisiting the best practices for the implementation of all "suicide prevention" services. The National Action Alliance for Suicide Prevention's *Recommended Standard Care for People with Suicide Risk* (2018) succinctly presented these standards for both primary care and behavioral health settings:

Setting	Emphasis	Identification and Assessment	Safety Planning	Means Reduction	Caring Contacts
Primary Care	Identify suicide risk among patients with MI/SUD* conditions or treatment. Enhance safety for those with risk. Refer to specialized care. Provide caring contacts	Identify suicidality in all patients with MI/SUD conditions or treatment (e.g., psychiatric meds) using a standardized scale. If risk is identified, proceed with active referral for hospital or outpatient care as judged appropriate.	Complete the brief Safety Planning Intervention during the visit where risk is identified. With consent, discuss the safety plan with the family to gain support for safety activities.	As part of the safety plan, discuss any lethal means considered by and available to patient. Arrange and confirm removal or reduction of lethal means as feasible.	Make appointment with mental health professional. Complete one caring contact (phone call or, if preferred by patient, text or e-mail) within 48 hours of visit or the next business day.
Outpatient BH* Care (Mental health and substance use treatment)	Provide treatment and support for individuals who may have elevated suicide risk.	Identify and assess suicide risk at admission and whenever patients are seen by using a standardized scale. Do not assess more than 1x per day. Use judgement if patients are seen daily.	Complete the brief Safety Planning Intervention during the visit where risk is identified Update the safety plan at each visit as long as risk remains high.	As part of the safety plan, discuss any lethal means considered by and available to patient. Arrange and confirm removal or reduction of lethal means as feasible.	Initiate caring contacts during care transitions or if appointments are missed.

While the importance of screening and assessment were emphasized in the County's request for proposal, safety planning, lethal means reduction, and caring contacts are areas Centro Sávila and FNCH might consider to more completely meet best practice standards.

Screening and Assessment of Suicide Risk

- Monitor emerging evidence-based practices for including exposure questions in suicide risk screening and assessment. In their systematic review and meta-analysis of the effects or prior expose to suicide on the likelihood of suicide attempts and suicide, Hill et al, 2020 found that prior exposure increased the odds of subsequent suicide and suicide attempts.

- Monitor emerging evidence-based practices for including lethal means screening and intervention.
- Use instruments appropriate to your setting and population (CSSR-S is available for primary care and behavioral health clinics, and in several languages).
- Standardize implementation of CSSR-S and document completion modes: self-report v. verbal; client fills out self-report versus verbally assisted or derived from interviews.

Data collection and Recording Improvements.

- For all data collection and recording, improve quality and consistency. Develop more robust protocols for processes and data quality controls. Consider working with technical experts to create EMR forms, data collection protocols and data quality control processes.
- Basic demographics and program inclusion criteria are not collected or recorded consistently. Without this information providers and funders cannot be sure the intended populations are being reached.
    - If you do not already collect these, expand collection of client information to show number of clients served who are in the most at-risk populations for suicide (HHS, 2012):
        - Individuals who have attempted suicide
        - Individuals bereaved by suicide
        - Individuals with mental and/or substance use disorders
        - Individuals with chronic medical conditions
        - Individuals who engage in non-suicidal self-injury
        - LGBTQ individuals
        - Men in midlife
        - Older men
        - American Indians/Alaska Natives
        - Members of the armed forces and veterans
        - Individuals in justice and child welfare settings
- Ensure all safety plans and updates are recorded in service data.
- Follow-up contacts with high suicide risk clients (expecially those who leave the facility or office) is a best practice, it is important to incorporated this step in descriptions of your processes and in collected data.

Services

- To increase structure in delivery of therapy consider standardizing provision of evidence-based treatments for suicidality such as Dialectical Behavior Therapy (DBT), Cognitive Therapy for Suicide Prevention (CT-SP), Collaborative Assessment and Management of Suicidality (CAMS), and Brief Cognitive Behavioral Therapy (BCBT).
- The role of organizational hotlines/crisis lines in screening, assessment or service delivery is unexplored at this time. If they are key components to the suicide prevention, the organizations' suicide=specific protocols can be integrated in to the process maps and data collection.
- Incorporate restriction of lethal means counselling into suicide prevention services. The County might consider funding such a training for all BHI providers.
- Standardize the protocols for safety planning, per best practices.

Specific Recommendations for Centro Sávila

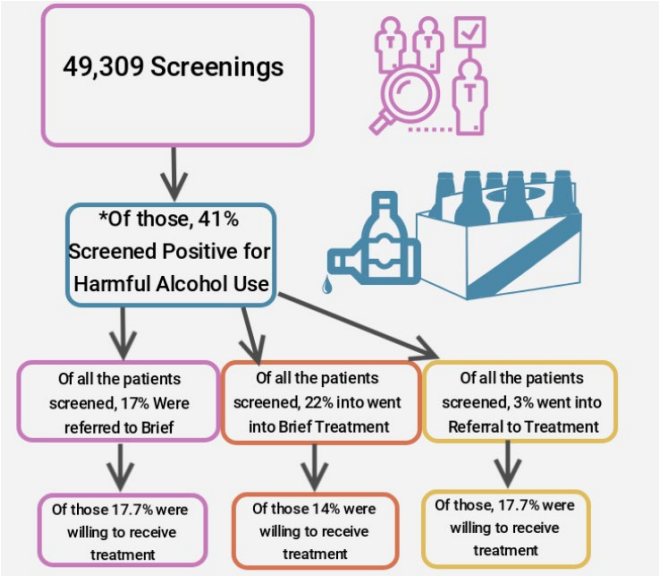
- Developing a Theory of Change that has its basis *specifically* in effective suicide prevention service implementation may be necessary for Cento Sávila to narrow its efforts sufficiently to show short-term and long-term suicide prevention outcomes.
- Revisit whether the cost of staffing the crisis and afterhours lines for under-utilized, non-suicide specific services warrants continuation and funding.

Specific Recommendations for First Nations Community HealthSource.

- If someone declines suicide prevention services when offered, record any SBIRT-SPP follow-up calls. Likewise, when a client has a moderate or high risk score and declines services because they already have a behavioral healthcare provider, the notification of that provider should be documented. This needs to be clear in the data shared with evaluators.
- Report traditional healer/program referrals in shared data, even if they are small.
- Intentionally realign SBIRT for suicide prevention. There is an opportunity to be part of building the evidence base for SBIRT as it is extended beyond use in SUD programs. We suggest working through the differences between suicide prevention and the SUD model (especially in "intervention"); they differ in immediacy, intensity of outcome and, potentially, which structure is most the appropriate intervention.
- Along with any programmatic changes we suggest the development of a new conceptual framework for tracking and presenting information about the process. The NM-SBIRT model is depicted in Figure 6, where it appears that clients are assigned to either BI, BT, or RT. Figure 7 is an example of a template that will allow a data-based depiction of SBIRT process. It uses *screening* as the unit of analysis to study the *process* whereby every screen, every time, elicits a system response that could include all or some SBIRT components. This would help lay out the data as the evaluation transitions from process to outcome, and the unit of analysis becomes client.

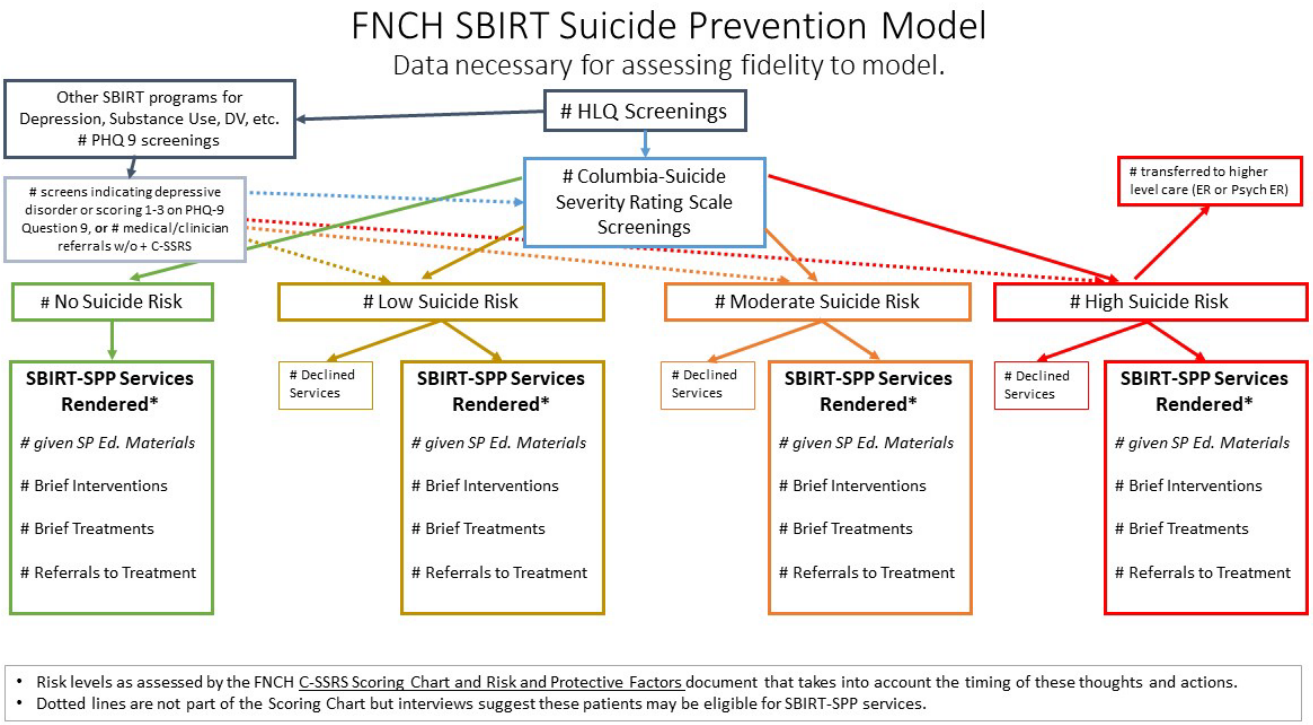
Figures next page.

Figure 6: NM-SBIRT Data Visualization



Waldorf, et al. 2019 UNM School of Medicine

Figure 7: Example for SBIRT-SPP Data Collection and Visualization Template.



In summary, we encourage CS and FNCH to work with suicide prevention experts and evaluators to:

- Further articulate what are considered suicide prevention services in your organization specific to this BHI initiative.
- Develop organization-wide guidance for determining and documenting when a given service is specifically related to suicide prevention program inclusion criteria as determined by a C-SSRS score (or other validated screening or assessment tools).
- Improve client tracking, by indicating when SP services end and clients move to other programs within your organization, e.g., case management for SDOH, regular longer-term therapy, etc. Knowing when clients receive services as part of the suicide prevention program vs as a part of on-going treatment is critical to assessing program outcomes.
- Understand and implement best practices for all aspects of program, and
- Structure data collection and reporting to maximize the ability to track suicide prevention clients and gather the empirical evidence necessary to show both fidelity to best practices and short- and long-term outcomes.

Conclusion

In a 2020 national survey of over 2,000 adults, The Harris Poll found 93% of respondents thought suicide could be prevented *at least sometimes*. Over 85% of respondents indicated moderate support or stronger for asking patients questions about their mental health as part of every primary care visit and supported mental health delivery in primary care settings. If they were having thoughts of suicide, 34% said they would tell a mental health provider, 25% would tell a primary care doctor, and 26% would access a crisis line. (2020). Bernalillo County has allocated $1,000,000 in annually reoccurring BHI funds for suicide prevention programs to meet the needs of residents.

Two of the three funded programs are included in this process evaluation. From approximately November 2019- April 2021, Centro Sávila reported providing 3,087 suicide prevention services to 410 clients, 68 of whom were assessed for suicide risk. Of those assessed, thirteen clients (19.1 %) scored as moderate to high risk on the C-SSRS. First Nations Community HealthSource reported 28,653 services to 6,223 clients. Data show 19,102 clients screened in a primary care setting for suicide risk, with 16.5% of those scoring positive (including low risk). Preliminary outcome data show SBIRT has been an effective intervention for reducing depression, though its effects on suicidal ideation and suicide attempts are not yet known.

Given time to implement any changes, it is likely an outcome evaluation of the FNCH program that uses SBIRT is feasible. An outcome evaluation of the Centro Sávila suicide prevention program may be possible if changes are made to how the program is structured and implemented.

References

Black Dog Institute. What can be done to decrease suicidal behaviour in Australia? A call to action. Director, Black Dog Institute White Paper. October 1, 2020. Sydney, AU: Black Dog Institute.

Boggs, J. M., Beck, A., Ritzwoller, D. P., Battaglia, C., Anderson, H. D., & Lindrooth, R. C. (2020). A Quasi-Experimental Analysis of Lethal Means Assessment and Risk for Subsequent Suicide Attempts and Deaths. Journal of general internal medicine, 35(6), 1709–1714. https://doi.org/10.1007/s11606-020-05641-4

Bryan Craig J. Sharon L. Stone and M. David Rudd A Practical, Evidence-Based Approach for Means-Restriction Counseling With Suicidal PatientsProfessional Psychology: Research and Practice © 2011 American Psychological Association2011, Vol. 42, No. 5, 339–346

Ferguson, M., Kate Rhodes, Mark Loughhead, Heather McIntyre & Nicholas Procter (2021): The Effectiveness of the Safety Planning Intervention for Adults Experiencing Suicide-Related Distress: A Systematic Review, Archives of Suicide Research, doi: 10.1080/13811118.2021.1915217

Hill NTM, Robinson J, Pirkis J,Andriessen K, Krysinska K, Payne A, et al. (2020)Association of suicidal behavior with exposure tosuicide and suicide attempt: A systematic review and multilevel meta-analysis. PLoS Med 17(3):e1003074.https://doi.org/10.1371/journal.pmed.1003074

Kelly Posner, Gregory K Brown, Barbara Stanley, David A Brent, Kseniya V Yershova, Maria A Oquendo, Glenn W Currier, Glenn A Melvin, Laurence Greenhill, Sa Shen, J John Mann The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults Multicenter Study Am J Psychiatry 2011 Dec;168(12):1266-77. doi: 10.1176/appi.ajp.2011.10111704.

Knox, Kerry L., Yeates, C., MD, and E. D. Caine, MD, 2004. If Suicide Is a Public Health Problem, What Are We Doing to Prevent It? American Journal of Public Health. 2004 January; 94(1): 37–45. doi: 10.2105/ajph.94.1.37

Labouliere, C. D., Vasan, P., Kramer, A., Brown, G., Green, K., Rahman, M., … Stanley, B. (2018). Zero Suicide" – A model for reducing suicide in United States behavioral healthcare. Suicidologi, 23(1), 22–30

Levis, Brooke PhD; Ying Sun, MPH; Chen He, MScPH; YinWu,; Ankur Krishnan, MSc; Parash Mani Bhandari, BPH; Dipika Neupane, BPH; Mahrukh Imran, MScPH; Eliana Brehaut; Zelalem Negeri, Felix H. Fischer, PhD; Andrea Benedetti, PhD; Brett D. Thombs, PhDAccuracy of the PHQ-2 Alone and in Combination With the PHQ-9 for Screening to Detect Major Depression Systematic Review and Meta-analysis 2020; for the Depression Screening Data (DEPRESSD) PHQ Collaboration 2300 JAMA June 9, Volume 323, Number 22

National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group. (2018). Recommended standard care for people with suicide risk: Making health care suicide safe. Washington, DC: Education Development Center, Inc.

New Mexico Elative Finance Committee, 2020. Action Plan: Suicide Prevention. December

NM IBIS. Firearm related deaths. Retrieved on June 28, 2021 from New Mexico Department of Health, Indicator-Based Information System for Public Health website: https://ibis.health.state.nm.us/indicator/complete_profile/InjuryFirearmDeath.html

Page-Reeves, J, Kaufman, W, Bleecker, M, Norris, J, McCalmont, K, MD, Ianakieva, V, Ianakieva, D, and Kaufman, A. Addressing Social Determinants of Health in a Clinic Setting: The WellRx Pilot in Albuquerque ,New Mexico. Am Board Fam Med: First published as 10.3122/jabfm.2016.03.150272 on 11 May 2016.

Pruitt, L. D., Mcintosh, L. S., & Reger, G. (2020). Suicide safety planning during a pandemic: The implications of COVID-19 on coping with a crisis. Suicide & Life-Threatening Behavior, 50(3), 741–749. doi:10.1111/sltb.12641

Sale E, Hendricks M, Weil V, Miller C, Perkins S, McCudden S. 2017 Counseling on Access to Lethal Means (CALM): An Evaluation of a Suicide Prevention Means Restriction Training Program for Mental Health Providers. Community Mental Health J. 2018 Apr: 54(3):293-301. doi: 10.1007/s10597-017-0190-z. Epub 2017 Nov 28. PMID: 29185154

Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., and Wilkins, N. (2017). Preventing Suicide: A Technical Package of Policies, Programs, and Practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Substance Abuse and Mental Health Services Administration. 2020. Behavioral Health Barometer: New Mexico, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA–20–Baro–19–NM. Rockville, MD: Substance Abuse and Mental Health Services Administration

Suicide Prevention Resource Center. (2014, September). *Suicide Screening and Assessment*. Waltham, MA: Education Development Center, Inc.

U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012). 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC: HHS. Retrieved from http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf

Waldorf, et al. 2019 NM-SBIRT 2018 Final Report to BHDS. UNM School of Medicine Department of Psychiatry & Behavioral Sciences

Western Interstate Commission for Higher Education Mental Health Program (WICHE MHP) &Suicide Prevention Resource Center (SPRC). (2017). Suicide prevention toolkit for primary care practices. A guide for primary care providers and medical practice managers (Rev. ed.). Boulder, Colorado: WICHE MHP & SPRC

Instructive links

See: https://sbirt.lltraininginstitute.org/.

https://www.hhs.gov/answers/mental-health-and-substance-abuse/does-depression-increase-risk-of-suicide/index.html

https://www.bernco.gov/Department-Behavioral-Health-Services/about-the-initiative.aspx

Appendices

Appendix A: Implementation Checklist

Implementation Checklist for the Suicide Prevention in Primary Care Toolkit

- ☐ Discuss suicide prevention initiative with all Office Staff and determine lead coordinator for the office.
- ☐ Read Chapter 2: Educating Clinicians and Office Staff of the Toolkit (all Office Staff).
- ☐ Identify which depression and suicide screens and assessments will be utilized in your office (e.g., PHQ-9, C-SSRS); determine:
  - When will patients complete this screen/assessment (e.g., with intake paper work)?
  - Who will review it and how is this information flagged? (e.g., flag depression/suicide like any other condition for provider follow-up).
- ☐ Proactively complete Office Protocol Template in Toolkit to establish procedures for working with a suicidal patient. Information here includes:
  - What professionals can be called upon to assist with suicide risk assessment
  - Name and location of nearest Crisis Stabilization Unit or Emergency Department
  - Responsible office staff contacts for documentation and follow-up
- ☐ Have Toolkit resources and individual patient intervention templates regarding suicide assessment and safety planning available to Office Staff and clinicians such as:
  - Pocket Guide: Assessment and Interventions with Potentially Suicidal Patients
  - Safety Planning Guide: A Quick Guide for Clinicians
  - Patient Safety Plan Template
  - Crisis Support Plan
- ☐ Develop a referral network to facilitate the collaborative care of suicidal patients.
- ☐ Conduct a mock drill for safely and sensitively working with and potentially hospitalizing a patient.
- ☐ Follow-up/Outreach. Identify who will follow-up with patients who have expressed suicidal ideation and how follow-up will occur (e.g., office visit, phone call).

In case of the need for hospitalization:

- ☐ Hospitalization is always the last resort, if efforts at illness management, safety planning, and referral fail to mitigate risk.
- ☐ Identify and label where all necessary forms, such as legal Mental Health Hold and Evaluation forms, for hospitalizing suicidal patients will be kept (it is assumed that the patient's physician will fill out all necessary paperwork for hospitalization).
- ☐ Identify who will sit with the patient while waiting for transport to the emergency department if necessary.
- ☐ Identify how soon a patient should be seen back in your clinic after being evaluated by the emergency department and/or being hospitalized. How frequently should they be seen and for what duration should more intensive contact with the PCP occur?

http://www.wiche.edu/pub/suicide-prevention-toolkit-for-primary-care-practices. (WICHE MHP, 2017

Appendix B: BHI Interview Guide

Base BHI Provider Interview Guide

General Interviewer Instructions

Instructions and guidance for interviewers are in italics. You should not skip any questions or sections unless directed to by the instructions. If the interviewee declines to answer any questions please note this. Some questions have a line to record a numeric answer, please use this instead of circling, x'ing or checking the appropriate response.

- *Remember to speaks slowly and remain accessible for questions.*
- *Remind participant that all answers are confidential and they can skip any question they are not comfortable answering.*
- *At the end, review the interview to make sure you did not miss any relevant questions.*
- *If the participant is a former employee of the provider, please note "Former on the "Current Job Title" line and change all relevant language to past tense.*
- *The topics have separate headings. Do not read the headings as part of the interview, they are for your benefit.*
- *Be sure to read through the entire guide before beginning the interview; there are instructions at the end for interviewer observations.*

Text in **Bold** is meant to be read to the interviewee
Text in ***Bolded Italics*** notes skip patterns
Text in *Italics* is instructions for the interviewer

If there is a project specific and/or provider specific addendum, please make sure you have a copy.

Administrative Information *(prefilled by interviewer)*

1. Interview Date: ____/_____/_____

2. ISR Interviewer: _____

3. BHI Program Name: Suicide Prevention_____

4. BHI Program Provider (if more than one provider): _____

Introduction

Before we begin, do you have any questions about the project or the interview?

Thank you for participating in our research. Just to let you know, this interview should take about an hour to an hour and a half depending on the length of your answers. Also, because of recent events we will be focusing on the functioning of your program in two time frames: before and during COVID-19.

First, I need to ask a few administrative questions.

5. Interviewee Name: _____

6. Current Job Title: _____

7. What is the highest level of education you have completed? _____
(*high school/GED = 12, list years of college [BA = 16, MA= 18, PhD = 20]; declined 99*)

8. Please tell me about any certifications and/or licenses you have that are relevant to (*program*):

A. _____

B. _____

C. _____

9. How many total years of work experience in this field do you have? _____
(*Answer should be converted to years and months*)
10. How long have you worked for this Suicide Prevention program? _____
(*Answer should be converted to years and months*)

11. Are you employed: _____
1. Full-time 2. Part-time 3. Or, something else? Please specify: _____
12. About how many hours per week do you work? _____
13. How many hours per week do you work on this Suicide Prevention program: _____
14. Briefly describe what you do in your role as a (*fill in from Job Title above*).

_____

_____

_____

Program Information

Now I'm going to ask you a few questions about your Suicide Prevention Program.

15. In your own words what is the main goal of this program?

_____

_____

_____

16. What do you feel is the most accurate measure of this program's success? _____

_____

_____

17. How successful do you feel this program is based on that measure?

_____

_____

_____

18. Does this program use evidenced-based practices and/or curricula? _____
1. Yes ___2. No ___ 3. Don't know ___
(If No or Don't Know, skip next question.)
19. Would you tell me a little about them and how they are used?

_____

_____

_____

_____

Next, I have a few questions about how potential clients and other providers learn about your Suicide Prevention program.
20. Are you involved in OUTREACH for this program? Yes ____ No ____
If no, skip to next section, if yes,

21. How do potential clients or other agencies learn about your program? (*Probe: Where do you go to let people know about your services?*)

22. On which of those do you focus most?

Incoming Referrals

Next, I have a few questions about incoming referrals to the program.

23. Is handling referrals one of your job functions? Yes_____ No_____

If no, skip to the screening section, if yes,

24. Briefly describe how potential clients are referred to this program? (*Probe: phone calls, word of mouth, from family, criminal justice system [ask for specifics – i.e. courts, police, jail, probation, pre-trial], from within your agency [ask some detail about this], are there formalized procedures or paperwork for this?*)

25. Which of those is the best source of referrals? (*Probe: Is there a top three? What about other providers within the BHI funding initiative?)*

26. Is there a source that you wish you received referrals from? _____

Next, I have a few questions about how individuals are screened for eligibility in your program.

27. Is screening a person for program eligibility one of your job functions? Yes_____ No_____ **Okay, we'll go to the next set of questions…**

If No, then skip to General Intake section. If Yes,

28. What are the inclusion and exclusion criteria for a person's eligibility in this program?

29. Could you briefly describe how the screening works? *(Probe: how are those criteria determined?)*

Next, I have a few questions about what happens to an individual once they are screened and deemed eligible for the program.

30. Is intake one of your job functions? Yes_____ No_____

(If no, skip to the assessment section.)

31. Would you please describe how your intake process works? *Prompt: is there anything else that is part of the process.*

_____

_____

_____

_____

_____

_____

Assessments

Now I'm going to ask you a few questions about the assessment process for the program and any assessment instruments/tools you might use.

32. Is giving or facilitating assessments one of your job functions? Yes_____ No_____

(If No, skip to service delivery section..)

33. When you have a new client, what assessments are administered at or near the time of intake? *List each assessment in the table below. If this interview is audio recorded, make sure to write down the list so you can ask the follow-up questions for each assessment.)*

For each assessment, ask the following questions to complete the table information. Go back through each listed and ask these.

34. At what other times is this administered?

35. How is this information used?

Assessment Name	At Intake	Additional Time points (#)	At Discharge	Use
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	

Service Delivery

Now I am going to ask you some questions about your program's services.

36. Could you please describe the services associated within your Suicide Prevention program?

37. What services do you refer clients to that aren't provided in-house? *(If provider of service is not mentioned, ask who provides the service).* *NTS Repeat Info Back, ask Qs about anything do not know*

Service	In house	Referred out	Notes for prompts: how service is delivered; recipient type, etc.
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Discharge from Program

Next I have a few questions about how clients are discharged from your program.

38. Describe the different ways a person leaves your program.

39. What does it mean for a person to successfully discharge from your program?

40. Under what circumstances can a participant be removed from the program?

41. Do you create some sort of discharge OR transition plans for your clients? Yes_____ No_____ Don't Know_____ ***(If No or Don't Know, skip to Aftercare)***

42. Could you please describe those?

After Care/Follow-up

I have a few questions about aftercare or follow up with clients.

43. Does your program offer after care or any follow-up for your clients? Yes_____ No_____***(If no, skip to conclusion.)***

44. Is aftercare or any follow-up one of your job functions? Yes_____ No_____

45. What does it entail?

_____

_____

46. What kinds of barriers are there to providing aftercare for clients?

_____

_____

47. For how long do you offer this service?

_____

_____

Conclude the Interview.

This concludes the interview questions; thank you for your time. Is there anything I missed or that you would like to add?

Interviewer Notes: Observations made by interviewer

- *How was the interview conducted? (ex: Skype video, audio only, telephone)*
- *Did participant seem comfortable answering questions in this format? Were there any positive or negative comments you could note here?*
- *Did you experience any technical difficulties during this interview? If so, do you think these had any impact on data quality?*
- *Were there any other distractions during the interview? If so, do you think these had any impact on data quality?*
- *Did participant have questions about interview, how the information will be used, or other questions? If so, what were their inquiries?*
- *Did participant have any issues with interview or questions? If so, what were their concerns?*

Appendix C: Example Columbia-Suicide Severity Rating Scale

C-SSRS Self-Report

Please place a check mark in the box for the appropriate answers	In the past Month	
Please answer questions 1 and 2	**YES**	**NO**
1) Have you wished you were dead or wished you could go to sleep and not wake up?	___	___
2) Have you actually had any thoughts of killing yourself? **If <u>YES</u>, answer all questions 3, 4, 5, and 6.** **If <u>NO</u>, skip directly to question 6.**	___	___
3) Have you thought about how you might do this? *(For example, "I thought about taking an overdose but I never worked out the details about when, where, and how I would do that and I would never act on these thoughts.")*	___	___
4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts, but you definitely would not act on them? *(For example, "I had the thought of killing myself by taking an overdose and am not sure whether I would do it or not.")*	___	___
5) Have you started to work out, or actually worked out, the specific details of how to kill yourself and did you actually intend to carry out the details of your plan? *(For example, "I am planning to take 3 bottles of my sleep medication this Saturday when no one is around to stop me.")*	___	___
6) Have you ever done anything, started to do anything, or prepared to do anything to end your life? *(For example: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind about hurting yourself or it was grabbed from your hand, went to the roof to jump but didn't; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.)* **If YES, did this occur in the past 3 months?**	___ ___	___ ___

Appendix D: Lethal Means Counceling Recommendations

Lethal Means Counseling: Recommendations for Providers

What is lethal means counseling?

Lethal means counseling is a vital part of safety planning. It is a process to first assess whether patients are at risk for suicide, and then to work with them to restrict access to lethal means. Lethal means may include firearms, prescription medications, and lethal objects that could be used for suicidal self-directed violence.

When should I use lethal means counseling?

- When patients currently have suicidal thoughts.
- When patients in distress have attempted suicide in the past.
- When patients are struggling with mental health or substance use issues and are exhibiting risk factors, such as hopelessness, withdrawal or lacking reasons for living.
- When patients are struggling with stressful life events that may serve as triggers for suicidal behavior, such as financial, occupational or relationship problems.

Routine Safe Storage Options

Medications: Most common method of suicide attempts

- Safely dispose of medications no longer in use.
- Keep only small quantities on hand. Consult a pharmacist for safe dosing practices and safety packaging as appropriate.
- Lock up abuse-prone medicines, such as opiates, benzodiazepines, sedatives or hypnotics.

Firearms: Most common method of suicide

- Store firearms unloaded in a locked gun safe.
- Store ammunition separately from firearms.
- Ensure locking device on firearms (cable locks or trigger locks).
- Store disassembled firearms.

A collaborative approach for addressing lethal means:

Raise the issue:

- Assess how lethal means such as firearms and medications are currently stored at home.

Develop a plan and recommend safe storage practices:

- Engage the support of family members when possible.
- Safely store firearms until the patient recovers.
- Reduce availability of medications.
- Reduce access to any other method about which a patient has expressed ideation.

Document and follow up:

- Be specific about roles and timeframe.
- Document the plan for safety and next steps.
- Confirm that the plan for safety was implemented.

Am I allowed to ask my patients about firearms?

Yes. Federal law, DoD, and VA policies allow providers who are worried about suicidal behaviors to inquire about the patient's access to firearms and make recommendations to reduce suicide risk[1].

Am I allowed to inform commanders about suicide risk?

Yes, a service member's chain of command has a "need to know" regarding suicide risk status, and such disclosures are authorized by DoD regulations in compliance with the Military Command Exception to the HIPAA Privacy Rule[2]. This also applies to National Guard and Reserve service members while on active duty or actively drilling.

Department of Veterans Affairs and Department of Defense employees who use this information are responsible for considering all applicable regulations and policies throughout the course of care, patient education, and all other related activities.

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Firearms Means Safety Suggestions for Providers[3]

What are some options I can recommend to *temporarily* restrict access to firearms?

These options should be considered temporary. Patients should be reassured that the purpose of restriction is not to remove firearms permanently. Patients should be afforded the opportunity to get firearms back.

- Ask a relative or friend to take possession of firearms.
- Store firearms in a self-storage rental unit if permissible.
- Store firearms at a shooting range with available lockers.
- Store firearms at a gun shop or pawn shop for short period of time.
- Ask law enforcement to take possession of firearms.
- Personally owned firearms may be stored in military unit arms rooms.

✓ Do

- Ask direct questions and let the patient know that other people have similar thoughts and feelings.
- Engage relevant parties, including family members and commanders, in the process of means restriction counseling when recommending firearms restriction.
- Assess access to both military-issued and privately-owned firearms as a core component of risk assessment and safety planning.
- Be aware of state-specific and federal laws regarding the temporary transfer of firearms between individuals.
- Collaborate with all involved parties in the process of firearms restriction and process of removing firearms from the home when patient is at risk of suicide.
- Be aware of the potential impact of firearms restriction on unit readiness, deployability, and sense of self, and take care to use the least-restrictive method to ensure safety.
- Forge relationships with local Veteran Service Organizations as a potential mechanism for voluntary, short-term transfer of firearms to a trusted peer.

✗ Don't

- Take possession of firearms.
- Encourage patient to bring firearms to medical clinics.
- Tell patients to "give away" their firearms.
- Imply that a patient is incapable of carrying a firearm.
- Imply that a patient is "mentally unsound" from a legal perspective.

Resources

U.S. Department of Veterans Affairs Suicide Prevention
Contains resource links for free provider consultation regarding lethal means safety and counseling
mentalhealth.va.gov/suicide_prevention/

Suicide Prevention Resource Center
A national site for suicide prevention resources, including training and tools for lethal means counseling
sprc.org

Center for Deployment Psychology
Online training course titled Lethal Means Safety Counseling to Reduce Suicide Risk
deploymentpsych.org/Lethal_Mean_Safety_Archive

National Shooting Sports Foundation Safety Resources
nssf.org/safety

References:

[1]The Assessment and Management of Patients at Risk for Suicide Work Group. Department of Veterans Affairs & Department of Defense. (2019). VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide. Version 2.0.

[2]HIPAA Privacy Rule, 45 CFR § 164.512(k) (2002).

[3]Hoyt, T. & Duffy, V. (2015). Implementing firearms restriction for preventing U.S. Army suicide. *Military Psychology, 27*, 384–390.

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MEMO

DATE: March 1, 2022

TO: Bernalillo County, Office of Criminal Justice Reform and Behavioral Health Initiatives

FROM: Dr. William Wagner, Executive Director, Centro SávilaDr. Mindy Gutow, Clincial Director, Centro Sávila

RE: Suicide Prevention and Intervention Efforts at Centro Sávila

This document serves as an update to the evaluation conducted by the Institute for Social Research (ISR). The data collected and reviewed by ISR for the evaluation covers the period of October 2019 to April 2021. Since that time, there have been a variety of changes at Centro Sávila (CS) focused on suicide prevention and intervention efforts that should be highlighted to update the Behavioral Health Initiative. Those efforts primarily focused on increasing staff knowledge, clearly articulating CS's internalabilities and related procedures, and increasing access to clients in crisis. Notable activities included:

1. **Increasing staff knowledge** through three interactive trainings (Question, Persuade, Refer; Columbia Suicide Severity Rating Scale; and CS procedures).
2. **Defining CS's role in suicide prevention and intervention** through internal discussions with staff. As a result, CS was able to clarify that organizationally there is not the internal capacity torespond to crisis calls after hours or perform the tasks of an emergency room/first responder. Instead, CS now has adopted the conceptualization of considering our role akin to an urgent care facility. We are most adept at triaging and referring to higher levels of care, when indicated. Additionally, we are skilled at sub-acute stabilization and providing psychoeducationto clients.
3. As a result of the clarity gained in defining CS's strengths and limitations, **a revised protocol** was developed including written **procedures** and a flow chart. Revisions were also made to the electronic medical record to include easier access to screening and documentation materials.
4. The revised procedures were developed with the priority of **increasing access** to clients in a predictable manner. CS now provides urgent call slots twice a day that are staffed by clinicians, as well as the allocation of an on-call supervisor during the work day to support staff when unexpected crises occur. Additionally, all staff members attended the three trainings and are expected to be able to respond to crises utilizing the CS procedures regardless of their role in CS.
5. In 2022, CS **partnered with the New Mexico Department of Health Office of Student and Adolescent Health** to provide evidenced based suicide prevention and youth mental health training to staff and partners. This will allow more staff to become QPR trainers; staff to attend Youth Mental Health First Aid training and provide QPR Gatekeeper and Youth Mental Health First Aid to community partners.