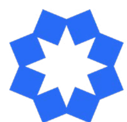
Frequently Asked Questions About Zero Suicide and CCBHCs



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Many Certified Community Behavioral Health Clinics (CCBHCs) ask how the CCBHC criteria fit with the Zero Suicide framework. For a full explanation, see the Zero Suicide and Certified Community Behavioral Health Clinic Crosswalk of Requirements. This document — a continuation of the Zero Suicide FAQ — answers many of the other frequently asked questions about Zero Suicide and CCBHCs.

How Will Zero Suicide Help Us With Our CCBHC Certification?

1. Zero Suicide meets CCBHC requirements for suicide screening, assessment and treatment.

CCBHCs must screen for suicide risk, assess the individual and provide suicide-specific treatment. Zero Suicide's practices directly support these requirements. For additional information, view the Identify element of the Zero Suicide Toolkit.

2. It strengthens required evidence-based practices.

CCBHCs are required to use evidence-based practices (EBPs) in treating individuals with behavioral health disorders. Zero Suicide promotes and integrates EBPs like:

- Safety Planning Intervention
- Cognitive Behavioral Therapy for Suicide Prevention
- Collaborative Assessment and Management of Suicidality

For additional information, view the Treat element of the Zero Suicide Toolkit.

3. It supports care coordination and transitions.

CCBHCs are required to manage transitions of care (e.g., from inpatient to outpatient). Zero Suicide emphasizes warm handoffs, follow-up care, caring contacts and post-discharge engagement, aligning with this requirement. Learn more in Best Practices in Care Transitions for Individuals With Suicide Risk: Inpatient Care to Outpatient Care, a resource from Zero Suicide.

4. It improves quality reporting and outcomes.

CCBHCs must develop a continuous quality improvement (CQI) plan and address how they will review events such as deaths by suicide or suicide attempts of people receiving services. Zero Suicide provides recommended data points for collecting and improving these metrics through CQI. For additional information, view the Improve element of the Zero Suicide Toolkit.

5. It demonstrates commitment to population health.

CCBHCs aim to address broad community mental health needs. Zero Suicide's system-wide approach ensures that everyone who interacts with a person at risk — from front desk staff to clinicians — is trained and involved in suicide care specific to their role in the organization, promoting a safety-oriented organizational culture.

6. It builds staff competence and confidence.

CCBHCs must show staff are trained and competent. Zero Suicide recommends providing initial and ongoing training, monitoring staff using EBPs and providing coaching to improve suicide screening, assessment and response. For additional information, view the Train element of the Zero Suicide Toolkit.

For more about how Zero Suicide supports CCBHC requirements, see the Zero Suicide and CCBHC Crosswalk of Requirements.

Is Zero Suicide an Evidence-based Practice?

Zero Suicide was constructed around EBPs, which inform the seven elements of safer suicide care in the framework. Zero Suicide is best described as an evidence-informed, CQI framework for improving suicide care within health and behavioral health care systems. For more on the efficacy of the framework, visit the Evidence page in the Zero Suicide Toolkit.

How Do We Monitor Fidelity to Zero Suicide?

Monitoring fidelity to Zero Suicide is crucial to ensure that the model is implemented as intended and achieves its full impact. Zero Suicide is a systems approach, rather than a manualized intervention with a strict fidelity tool, but you can assess and track fidelity using established tools, data and processes in the following structured ways:

1. Use the Zero Suicide Organizational Self-study.

The Zero Suicide Organizational Self-study is designed to assess what components of the Zero Suicide approach are currently in place and the degree to which the components are embedded within key organizational and clinical areas. The self-study also helps to assess strengths and opportunities for development in each component, both across the organization and within clinical areas. After the initial self-study, it is meant to be repeated periodically to monitor progress.

2. Use the Zero Suicide Workforce Survey.

The Zero Suicide Workforce Survey is a tool to assess staff perception of their own knowledge, confidence and comfort interacting with patients who may be at risk for suicide, including providing specific elements of care such as screening, treatment and support during care transitions.

It is helpful to:

- Measure at baseline, before major Zero Suicide implementation efforts, and at regular intervals afterward.
- Disaggregate results by role, department or site to identify training or support needs.
- Track progress in staff comfort and skills at a point in time.
- Pair findings with the Zero Suicide Organizational Self-study results for a more complete picture of fidelity.

3. Track outcome and process data.

Monitoring fidelity also means measuring what matters. Recommended components to measure are on the Data Elements Worksheet. Your organization can enter them into the Zero Suicide Data Dashboard for consistency and to monitor organizational progress. Multiple staff can have access and enter data.

Suggested items are:

- Screening
- Assessment
- Safety plan development
- Lethal means counseling
- Missed appointment follow-up
- Contact after discharge
- Caring contacts
- Patients on a suicide care management plan
- Evidence-based, suicide-specific treatment

4. Conduct chart audits and documentation review.

Identify individuals on the suicide care pathway in the electronic health record and regularly audit clinical records to ensure the suicide care pathway is being followed and documentation is present. Zero Suicide emphasizes supporting staff who provide care to individuals at risk of suicide.

5. Maintain staff training logs and conduct competency assessments.

Maintain role-specific training records for all staff who received training related to Zero Suicide and suicide care. Assess staff confidence and competence with materials they have been trained on, and provide coaching to help staff implement suicide care practices with fidelity.

6. Perform continuous quality improvement cycles.

Use Plan-Do-Study-Act cycles or other CQI methods to test improvements in suicide care. By following this process, organizations can test small improvements and allow for adaptations and adjustments as improvements are implemented. The Institute for Healthcare Improvement website offers more information on how to use this improvement process. You can see how some organizations did this in the Journey Stories on the Zero Suicide website.

What Is the Difference Between a Crisis Plan and a Safety Plan?

Crisis Plan	*Suicide-specific Safety Plan*
Generally broad and emergency-focused	Designed specifically for individuals with suicidal thoughts or behaviors
Created prior to a crisis	A stepped approach
Designed for any behavioral, emotional or psychological crisis, not just suicide	Created prior to suicidal thoughts, or created after suicidal thoughts to help with future thoughts
Aims to manage and de-escalate a crisis that is already happening or imminent	Helps the individual identify warning signs, coping strategies and reasons to live
Often includes instructions for caregivers, educators, crisis teams or first responders	Primarily used as a self-management and therapeutic tool
Often developed by providers	Collaboratively created with the individual
May be protocol-based for agencies or schools	Engages supportive family and friends in the plan
Focused on external response	Encourages active participation and self-reflection
	Empowers the person to take ownership of their own safety
	Shared with providers and supports

Both are valuable, and they often complement each other. The safety plan may prevent escalation, while crisis plans outline what to do if prevention fails.

CCBHC Requirements

Crisis plans are required following a psychiatric emergency (Criterion 2.c.6). Suicide-specific safety plans are required as part of person-centered treatment planning (4.e.1) and the comprehensive evaluation (4.d.4). Annual staff training on suicide and overdose prevention is required for all staff (1.c.1).