

Zero Suicide for Abundant Health:

A Faithful Response to Community Prevention, Care Coordination, and Outcome Measurement

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Partners: Henry Ford Health / Zero Suicide International | ZSI Asia Alliance / Group for Technical Assistance | Corner Health Center



Background & The Evidence Gap

Suicide is among the most preventable causes of death — yet religious and spiritual identity is systematically absent from clinical suicide prevention frameworks.

What the evidence shows:

- 63-study meta-analysis (N > 8 million): religious engagement associated with significantly lower odds of completed suicide (OR = 0.31; Ghoreishi et al., 2022)
- Spiritual struggle bidirectionally associated with suicidal ideation over time in psychiatric outpatients (Lemke et al., 2023)
- The Zero Suicide International (ZSI) framework — proven to reduce attempt rates by 25% (Ahmedani et al., JAMA Network Open, 2025) — contains NO items addressing religious or spiritual identity across any validated instrument

Clinical providers worldwide lack tools to engage one of the most potent dimensions of a patient's inner life.

The Michigan Context

- Michigan UMC congregations represent one of the state's most trusted community health infrastructure assets:
- 800+ congregations across 4 districts — urban, suburban, and rural
 - Older adults ~60% of UMC membership — at nearly 2× the general population suicide rate; least likely to seek formal mental health care
 - Rural congregations often serve as the primary mental health support system with no local clinical providers
 - ~7,200 older adult UMC members in Michigan experience suicidal ideation annually
 - 11 UMC congregations have already committed to pilot a faith-based Zero Suicide framework

Proposed Program Structure

- A 24-month pilot in 4 phases, each congregation led by a trained Zero Suicide Coordinator:
- Phase 1A (Mo. 1–5): Listening sessions and focus groups with 15–20 UMC congregations; each identifies a Zero Suicide Coordinator
 - Phase 1B (Mo. 6–9): Global learning delegation to Indonesia; Church Community Edition of ZSI adapted with ZSI Adaptation Team
 - Phase 1C (Mo. 10–24): 12-month pilot; monthly virtual convenings; mixed-methods evaluation
 - Phase 1D (Mo. 23–24): Church Community Edition disseminated free to all Michigan UMCs; community of practice sustained through Abundant Health MI

Partners

- Michigan Annual Conference UMC / Abundant Health MI — Lead; 800+ congregation statewide reach
- Henry Ford Health / ZSI (Dr. Brian Ahmedani) — Research co-lead; ZSI framework expertise
- ZSI Asia Alliance / Group for Technical Assistance — Global learning; Indonesia faith model
- Corner Health Center — Michigan's first SBHC (1981); youth clinical site; Community Therapist model
- MI Mind Network — ZSI-trained care navigators in 72 of 83 Michigan counties with clinical relationships for referrals

Acknowledgements & Contact

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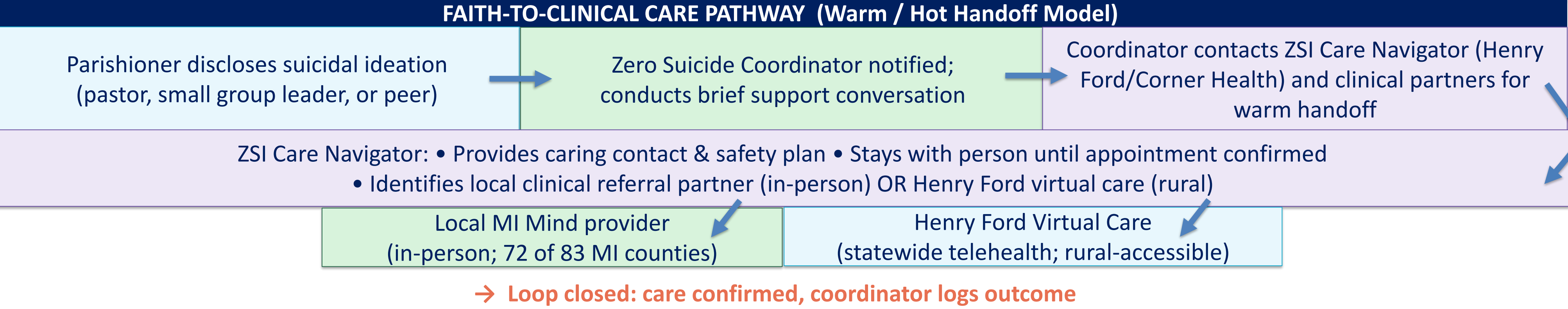
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Program Logic Model

Zero Suicide for Abundant Health			
INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES
UMC Michigan 800+ congregations 4 districts Abundant Health MI	Phase 1A: Needs assessment (listening sessions, FGDs, 4 districts)	Needs assessment report; barriers & readiness documented	SHORT-TERM: Pastoral confidence in recognizing suicide risk
ZSI framework & Asia Alliance faith models (Indonesia)	Phase 1B: Global learning delegation; CCE adapted	Church Community Edition toolkit & training curriculum	SHORT-TERM: Care coordinators trained; warm handoff active
Henry Ford / ZSI; Corner Health; Clinical referral partners	Phase 1C,D: Pilot 15–20 UMC congregations; mixed-methods eval	Evaluation report; 180 older adults & 45 youth referred to care	≥9,000 reached statewide; suicides prevented; national model
ULTIMATE GOAL: Faith communities as trusted first-responders — bridging the gap to clinical care			

Faith-to-Clinical Care Pathway



- The warm/hot handoff model goes beyond a referral phone number — the congregation's trained Zero Suicide Coordinator activates a structured response:
- Coordinator conducts a brief supportive conversation, then contacts the ZSI Care Navigator at Henry Ford Health or Corner Health
 - Care Navigator provides safety planning, identifies the nearest clinical referral provider or Henry Ford virtual care (rural), and stays until appointment confirmed
 - Coordinator maintains caring contact and logs the outcome — closing the loop

Proposed Outcome Measures

PROPOSED OUTCOME MEASURES			
Domain	Measure	Method	Timepoint
Short-term Outcomes			
Pastoral Competency	% Zero Suicide Coordinators rating confidence ≥4/5 in recognizing suicidal ideation	Pre/post survey	Mo. 5, 12, 24
Pastoral Competency	% trained lay leaders correctly identifying referral pathway	Knowledge test	Post-training
Care Infrastructure	# congregations with active ZS Coordinator and documented warm handoff protocol	Program records	Mo. 12, 24
Help-Seeking	# parishioner referrals to clinical care provider / HFHS virtual care initiated by coordinators	Referral logs	Monthly
Help-Seeking	% referrals with confirmed care contact (warm handoff completed)	Follow-up log	Monthly
Long-term Outcomes			
Population Reach	# individuals with suicidal ideation identified and referred during 24-month pilot	Program data	Mo. 24
Population Reach	Estimated individuals reached post-statewide dissemination (~9,000 target)	Modeled projection	Post-grant
Equity	% pilot congregations serving rural communities or older adult majority populations	Site profile	Baseline
Framework Adoption	# additional congregations adopting Church Community Edition post-grant	Downloads + survey	6 & 12 mo. post-grant

Equity-stratified analyses planned for rural vs. urban and older adult vs. youth subgroups.

Conclusions

- Faith identity is simultaneously one of the most powerful protective factors against suicide and, for some, a source of amplified risk — yet it is absent from every validated clinical suicide prevention instrument
- Faith communities already function as a de facto mental health system for older adults and underserved populations — they need tools, training, and clinical backstops
- The warm/hot handoff model bridges the gap between congregational identification and clinical care without requiring faith communities to become clinicians
- The Indonesia connection at this Summit reflects a shared global need: faith-informed suicide prevention is globally feasible and urgently needed

Key References

- Ahmedani BK et al. (2025). Zero Suicide framework implementation and suicide attempt rates. *JAMA Network Open*.
- Ghoreishi SA et al. (2022). Religion and Suicide Death: A Meta-Analysis. *J Research Health Sci*, 22(1), e00537.
- Lemke AW et al. (2023). Religious/Spiritual Struggles and Suicide Ideation: A 12-Month Longitudinal Study. *J Affective Disorders Reports*, 14.

Future Directions

- This framework positions faith communities as the first link in a clinical care chain — trusted first-responders equipped to identify, support, and connect. The proposed pilot would produce:
- Validated Church Community Edition of ZSI, free to all Michigan UMCs and adaptable globally
 - 15–20 congregations with trained Zero Suicide Coordinators and functioning clinical referral relationships
 - Tested warm/hot handoff infrastructure connecting faith communities to MI Mind providers and HFHS virtual care statewide

Phase 2 (future): Develop and feasibility-test religion/spirituality screening questions for integration into ZSI's clinical instruments.

Seeking international partners — particularly faith community health networks in Asia, Africa, and Latin America — to adapt and test this framework in their contexts.

