



Adapting the Collaborative Care Model - Zero Suicide Integration Model for Low-Resource Communities in Asia:
Addressing Workforce, Infrastructure, Cultural, and Epidemiologic Realities



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Background

Asian countries account for approximately 60% of the world's suicide deaths, yet there is a profound mismatch between the scale of the problem and the resources available to address it. The treatment gap for mental disorders in low- and middle-income countries (LMICs) is 75–95%, with only approximately 4% of individuals with depression accessing minimally adequate treatment. The median number of psychiatrists in low-income countries is 172 times lower than in high-income countries. The Zero Suicide (ZS) model, first implemented at Henry Ford Health in 2001, demonstrated a near 80% reduction in suicide deaths sustained for over a decade. However, the model was developed within a well-resourced US health system, and its core components—**systematic screening, risk assessment, safety planning, evidence-based treatment, and care transitions**—require adaptation for settings with limited specialist workforce, fragmented health infrastructure, and distinct cultural contexts. The Collaborative Care Model (CoCM), which integrates behavioral health into primary care through team-based, measurement-driven care, offers a scalable framework for extending ZS principles into low-resource Asian settings when adapted through task-shifting and cultural grounding strategies.

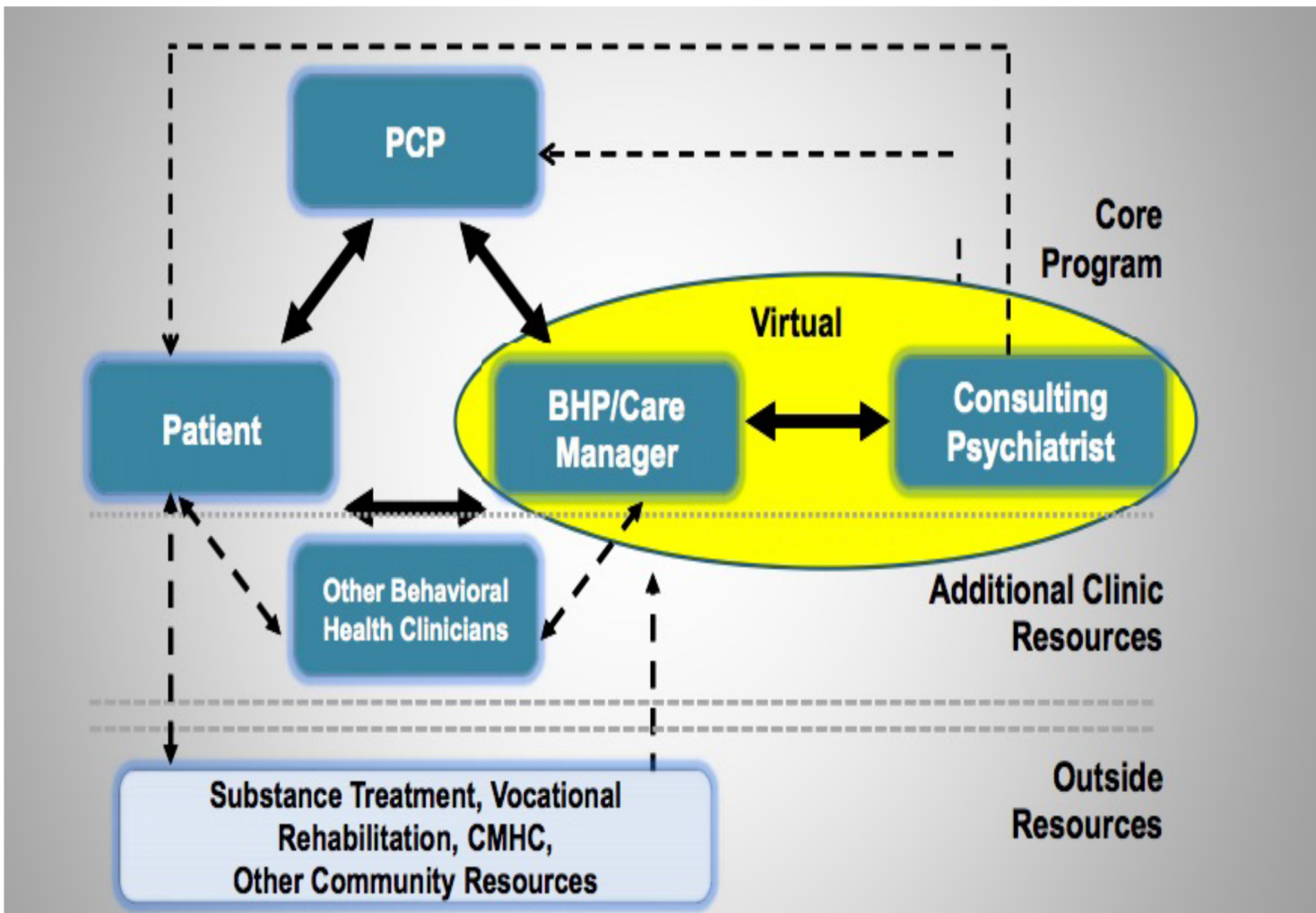
Description/Scope

Proposed Framework for Adapting CoCM as the Delivery Vehicle for Zero Suicide in Low-resource Asian Countries

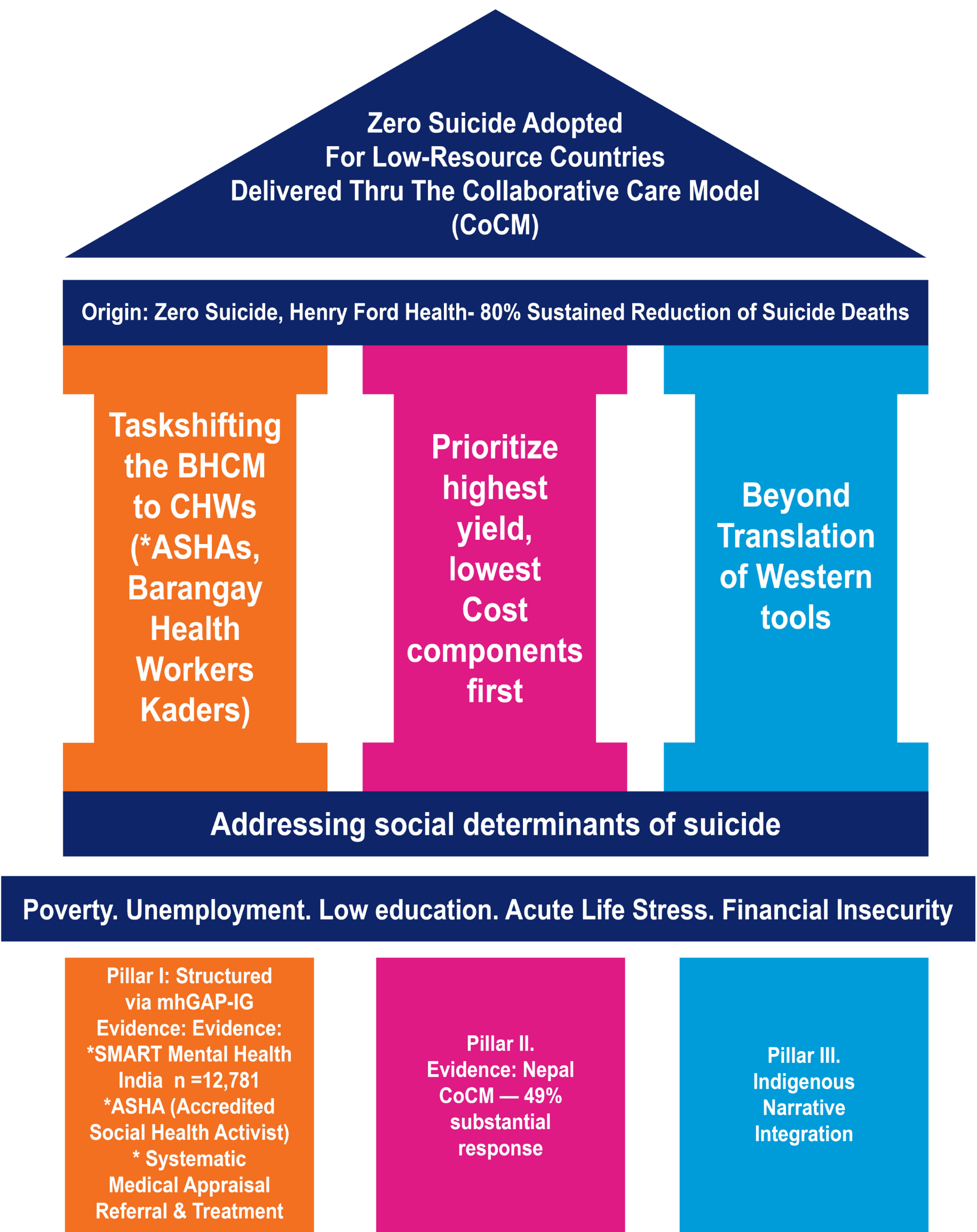
- (1) Task-shifting the Behavioral Care Manager role to community health workers (CHWs).
 - CHWs can be trained to perform core CoCM functions: screening using the PHQ-9, proactive follow-up, treatment adherence monitoring, and supportive counseling. The WHO Mental Health Gap Action Programme Intervention Guide (mhGAP-IG) provides a validated clinical decision-making protocol for non-specialist primary care workers to assess and manage priority conditions including self-harm and suicide
- (2) Adapting ZS care pathway components for low-resource contexts.
 - A phased, cost-benefit approach can prioritize the highest-yield elements first.
 - Priorities:
 - (a) systematic screening
 - (b) a patient registry for tracking
 - (c) structured psychiatric consultation
 - (d) Culturally relevant safety planning and means restriction - particularly community pesticide storage
- (3) Cultural grounding beyond surface-level adaptation.
 - Creation of interventions that integrate indigenous cultural narratives, family-based engagement, and community social structures rather than simply translating Western tools.

The Collaborative Care Model (CoCM AIMS)

- ❖ Focuses on a defined target population tracked in a registry
- ❖ Measurement-based practice
- ❖ Treatment to target
- ❖ Trained PCPs and embedded Behavioral Health professionals provide evidenced-based medications and psychosocial treatments
- ❖ Supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected



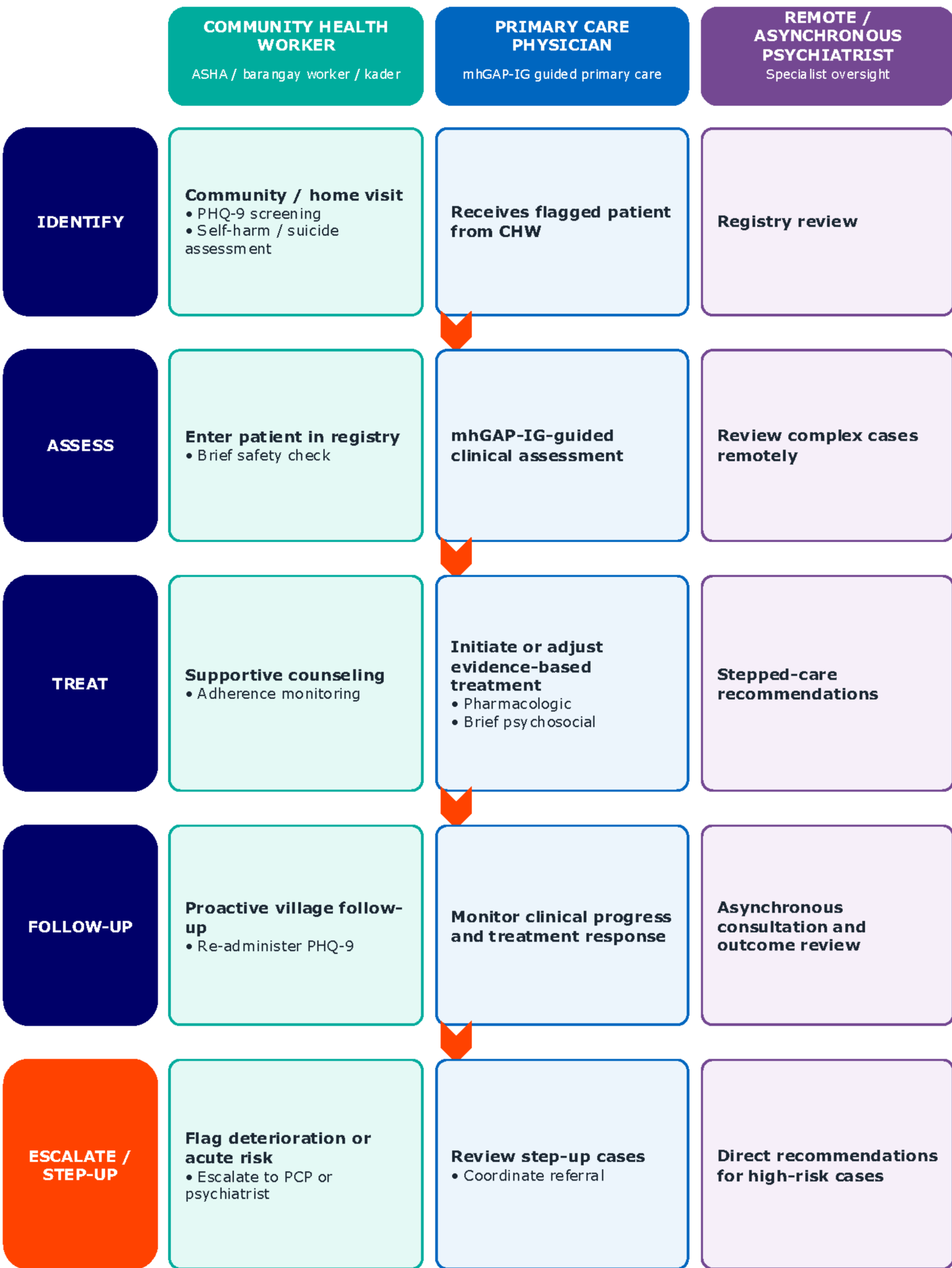
FRAMEWORK FOR CoCM Adaptation (figure 1)



Phased Zero Suicide Pathway in LMICs (figure 2)

Task-shifted CoCM swim-lane care pathway

Community-based identification, stepped care, and remote psychiatric oversight



Why adaptation is important?

Epidemiology of Suicide in Asia
• Narrower Male to Female Ratio
• Higher elderly-to-general population burden
• Greater role of acute life stress
• High lethality driven by access to means (pesticide)

Recommendations

1. Adopt a task-shifted CoCM model using existing CHW infrastructure (e.g., ASHAs in India, barangay health workers in the Philippines, Kaders in Indonesia) as the primary care manager workforce.
2. Train workers using mhGAP-IG protocols for screening, brief intervention, and follow-up of individuals at risk for self-harm and suicide.
3. Implement a phased ZS care pathway, prioritizing the highest-yield, lowest-cost components first:
 - (a) systematic screening integrated into routine primary care or community health visits
 - (b) a simple patient tracking system (paper-based or mobile app registry)
 - (c) means restriction interventions, particularly community pesticide storage in agricultural regions.
4. Leverage mobile health (mHealth) technology for remote psychiatric consultation, clinical decision support, and patient tracking
5. Culturally ground all interventions through community co-design processes that engage local leaders, families, and faith communities, moving beyond translation of Western tools to integration of indigenous narratives and collectivist social structures into safety planning and help-seeking pathways.
6. Integrate social determinants into the CoCM care plan, recognizing that in Asian LMICs, acute life stress, financial insecurity, and family conflict are often more proximal drivers of suicidal behavior than psychiatric illness alone, and that addressing basic needs may be as important as clinical treatment.
7. Build suicide surveillance systems to monitor outcomes that enable real-time tracking of suicide attempts and deaths at the village level.

Conclusion

By adapting the CoCM-Zero Suicide integration model to the workforce, infrastructure, cultural, and epidemiologic realities of low-resource Asian countries, health systems and community organizations can extend evidence-based suicide prevention to the populations that bear the greatest burden of suicide globally.



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