

Show Me ZERO Suicide



MISSOURI  
**COALITION**  
FOR COMMUNITY BEHAVIORAL HEALTHCARE



## **MISSOURI'S SUICIDE SAFE CARE INITIATIVE**

**REPORT TO STAKEHOLDERS**

**MARCH 13, 2017**

## **Show Me ZERO Suicide Report to Stakeholders**

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## **Show Me ZERO Suicide Planning & Implementation Team**

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See appendix 1 for the organizational chart.

## What is Zero Suicide?

Zero Suicide is a leadership-driven “just” culture of safety that considers suicide a never event in health and behavioral healthcare systems. A just culture of safety focuses on system response, an immediate and thorough investigation, and analysis of the decisions made by employees when providing care so that organizations can make system improvements while dealing with their employees in a fair and just manner. Never events are medical errors that should never occur, are considered serious adverse events, and are usually preventable. In the case of suicide in health and behavioral healthcare systems, Zero Suicide creates a culture in which all suicides are preventable.

Zero Suicide is promoted by the Suicide Prevention Resource Center as both a concept and a practice. A website dedicated to providing training and technical assistance for Zero Suicide implementation is available at the website. [click here](#)

Zero Suicide advances goals 8 & 9 of the National Strategy for Suicide Prevention: Goals and Objectives (2012):

- Goal 8 promotes suicide prevention as a core component of healthcare services, and
- Goal 9 promotes implementation of effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

Identifying individuals at risk for suicide is also included in the national patient safety goals of the Joint Commission, and Zero Suicide concepts are currently embedded in a 2016 sentinel event alert.

Zero Suicide is a commitment to provide suicide safe care in health and behavioral healthcare systems. Suicide safe care includes the following components, identified as “essential elements,” in the success of a Zero Suicide culture:

1. Lead – Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles.
2. Train – Develop a competent, confident, and caring workforce.
3. Identify – Systematically identify and assess suicide risk among people receiving care.
4. Engage – Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.
5. Treat – Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.

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6. Transition – Provide continuous contact and support, especially after acute care.

7. Improve – Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk. (Zero Suicide website).

The implementation of Zero Suicide principles has demonstrated success in reducing suicide in targeted populations and early implementers include:

- Air Force Suicide Prevention Program (report 2001)
- Henry Ford Health System “Perfect Depression Care” (2001-present)
- National Suicide Prevention Lifeline “Suicide Risk Assessment Standards” (2007-present)
- Central Arizona Programmatic Suicide Deterrent System Project (2009-present)  
(National Action Alliance: Clinical Care & Intervention Task Force. (2011). Suicide Care in Systems Framework)

The National Zero Suicide initiative includes public and private partners working to advance the Zero Suicide approach. National collaborative partners include:

- Suicide Prevention Resource Center
- National Action Alliance for Suicide Prevention
- Education Development Center
- Substance Abuse Mental Health Services Administration
- National Council for Behavioral Health

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### Introduction

Since 2014, the Missouri Department of Mental Health has participated in the National Zero Suicide initiative. In June 2014, a team representing the Missouri Department of Mental Health was admitted to the Zero Suicide Academy through an invitation to submit an application. Missouri was 1 of 16 states chosen to attend the first Zero Suicide Academy that was held in Washington D.C. The academy focused on the introduction of Zero Suicide concepts, including leadership commitment, evidence based practices, continuous quality improvement, and workforce development. It also established an ongoing learning collaborative, including coaching, webinars, tools, and resources to assist states in implementing Zero Suicide.

#### **THE NATIONAL INITIATIVE**

The National Action Alliance for Suicide Prevention is a public/private partnership dedicated to advancing the National Strategy for Suicide Prevention. In a 2011 publication, the National Action Alliance, Clinical Care & Intervention Task Force, found these prevention programs had the best outcomes based on three critical factors:

- Core values, beliefs, and attitudes for eliminating suicide deaths and attempts;
- Systems Management including implementation and action for excellence in health and behavioral healthcare; and
- Evidence-based clinical care practices.

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**Diagram 1. The Zero Suicide model.**



### **The Joint Commission**

The Joint Commission includes identifying individuals at risk for suicide in their National Patient Safety Goals. National Patient Safety Goal 15.01.01 addresses patient safety as follows:

1. *Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide.*
2. *Address the immediate safety needs and most appropriate setting for treatment of the individual served.*
3. *When an individual at risk for suicide leaves the care of the organization, provide suicide prevention information (such as a crisis hotline) to the individual and his or her family.*

In 2005, the Joint Commission published a sentinel event alert that added individuals who died by suicide within seventy-two (72) hours of discharge as a reportable sentinel event in addition to suicide deaths in inpatient settings.

In 2016, the Joint Commission published a sentinel event alert that embeds Zero Suicide concepts as follows:

*Detecting and treating suicide ideation in all settings.*

1. Review each patient's personal and family medical history for suicide risk factors;
2. Screen all patients for suicide ideation using a brief, standardized, evidence-based screening tool;
3. Review screening questionnaires before the patient leaves the appointment or is discharged;
4. Take action using assessment results to inform the level of safety measures needed;

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5. Establish a collaborative, ongoing, and systematic assessment and treatment process with the patient by involving the patient’s other providers, family, and friends as appropriate;
6. To improve outcomes for at-risk patients by developing treatment and discharge plans that directly target suicidality;
7. Educate all staff in patient care settings about how to identify and respond to patients with suicide ideation; and
8. Document decisions regarding the care and referral of patients with suicide risk.

In early 2017, the Joint Commission published that effective immediately surveying, scoring of ligature, suicide, and self-harm in inpatient psychiatric settings will be incorporated for accreditation.

### Zero Suicide Academies

The first Zero Suicide Academy was held in Washington D.C. in June 2014. Admittance to the academy was based on a competitive application process, and Missouri was one (1) of sixteen (16) states that were selected. A team from the Department’s Chief Medical Directors office and a representative from a community provider attended.

#### *90 Day Plan*

Upon completion of the academy, teams developed a ninety (90) day implementation plan. The Missouri plan included making a formal recommendation to Department administration to implement Zero Suicide within the State’s behavioral healthcare system. This system includes two (2) divisions providing services to individuals with intellectual/developmental disabilities, mental illness, and substance use disorders. Services are provided in both community settings and institutional settings, such as hospitals, forensic units, and habilitation centers.

**Table 1. States attending the first Zero Suicide academy.**

Kentucky	Pennsylvania
Rhode Island	Maryland
Ohio	Missouri
Indiana	Oklahoma
Colorado	Tennessee
New York	Maine
Washington	Utah



Dr. Laine Young-Walker, Jacque Christmas, and Debbie Fitzgerald attend the first Zero Suicide Academy in Washington D.C. (2014).



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California	Nevada
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The Department attended a Coalition of Community Behavioral Healthcare Centers meeting in 2015 and encouraged teams to apply for the second Zero Suicide Academy and provided technical assistance during the application process. The second Zero Suicide Academy was held in Baltimore Maryland in June, 2015. Again, admittance to the academy was based on a competitive application process. A team from Behavioral Health Response and Crider Center applied and were one of twenty (20) states that were selected.



David Covington, Ursula Whiteside, Leah Harris, and John Draper, Zero Suicide advisory group and faculty members

### **Zero Suicide Breakthrough Series**

In late 2014, Missouri was invited to participate in the Zero Suicide Breakthrough Series which ran from January through September of 2015. The Department was the designated state lead, and Ozark Center was the community provider.

### ***Findings/recommendations***

In 2014, six states and their provider partners set out with the Suicide Prevention Resource Center and the National Council for Behavioral Health on the *Zero Suicide Breakthrough Series*— a project designed to learn how best to support the successful launch and implementation of the Zero Suicide approach under the direction of a state mental health or public health office. State leaders who had already begun the process of launching Zero Suicide initiatives were asked to invite a provider organization to partner with them in the process. Over the course of the nine-month Breakthrough Series period, they were given additional technical assistance and supports to move towards suicide safer care practices.

--SPRC website



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The Breakthrough Series final report includes the following findings and recommendations.

- State leadership is critical
- System and organizational level data are catalyzing
- Ongoing implementation supports build and maintains momentum
- Workforce needs additional training to adequately implement this approach and supervision to support the changes in practice
- Need for balance between mandate and guidance
- Managed Care Organizations and other financing policies can create barriers to Zero Suicide implementation
- Culture change takes time

To view the Breakthrough Series final report in its entirety, [click here](#).

### Community of Practice

The purpose of the Zero Suicide Community of Practice (CoP) was to build the capacity of states to implement and advance Zero Suicide in state, county, and local health and behavioral healthcare organizations and settings. The CoP ran from January through September of 2016. The Department was the state lead, and Behavioral Health Response was the community provider.

Findings/recommendations have not yet been released. An email from Adam Chu, SPRC, shows the following:

“...takeaways across the CoP meeting series:

- Go to where the leadership support exists to find your opportunities for growth  
This includes involving attempt survivors and coalitions
- Define your role as a state in terms of the support and the layout of the support structures you can provide.
- There’s more to improvement than collecting data, setting benchmarks, and looking at implementation processes. It also includes changes to workflows, protocols, training
- Provide technical assistance
- Think about training in tiers
- Look at what’s already being billed for that you may be asking staff to do differently
- Leverage EHRs [electronic health records] where possible
- Examine your progress—evaluate your implementation processes”

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### MISSOURI'S SUICIDE SAFE CARE INITIATIVE

#### Data Analytics

Implementing Zero Suicide is a data driven process. The collection and analysis of suicide data is essential to Zero Suicide. Suicide data from 2008 through 2014 was analyzed early in the Missouri planning and implementation process. There were a total of 208 Department consumers who died by suicide between 2008 and 2014. After identifying the consumers dying by suicide by service and program, an implementation plan was developed and includes collaboration with the Coalition of Community Behavioral Healthcare Centers and the Missouri Association of County Developmental Disabilities Services.

191 deaths by suicide were consumers receiving community services through the Division of Behavioral Health

There were seven (7) deaths in state operated psychiatric facilities with no suicide deaths between the years 2011 through 2014.

Ten (10) suicide deaths were consumers receiving targeted case-management and supported employment services through the Division of Developmental Disabilities, and there were no deaths by suicide in state operated habilitation centers.

**Table 2. Reported suicide events, 2008 through 2014.**

Year	2008	2009	2010	2011	2012	2013	2014
<b>DBH</b>	25	28	24	26	33	37	25
<b>DD</b>	0	1	0	1	2	3	3
<b>Total</b>	25	29	24	27	35	40	28

The data shows that the majority of deaths by suicide is in Division of Behavioral Health populations and occurs in community settings.

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**Division of Behavioral Health Data**

**Table 3. DBH reported suicide events, 2008 through 2014, by service.**

	<b>FY 2008</b>	<b>FY 2009</b>	<b>FY 2010</b>	<b>FY 2011</b>	<b>FY 2012</b>	<b>FY 2013</b>	<b>FY 2014</b>	<b>Total</b>
Adolescent CSTAR Level 1	0	0	0	0	0	0	0	<i>0</i>
Adolescent CSTAR Level 2	0	0	0	0	0	1	0	<i>1</i>
Adult CSTAR Level 1	1	3	2	3	2	3	0	<i>14</i>
Adult CSTAR Level 2	3	0	1	1	2	0	1	<i>8</i>
Adult CSTAR Level 3	1	0	0	0	1	0	0	<i>2</i>
Adult Community Psychiatric Rehabilitation (PR)	8	3	7	11	8	15	12	<i>64</i>
Adult Community Services	7	8	7	8	18	13	11	<i>72</i>
Adult Inpatient - Acute Treatment	0	1	0	0	0	0	0	<i>1</i>
Adult Inpatient - General	1	3	0	0	0	0	0	<i>4</i>
Adult Inpatient - PR	0	1	0	1	0	0	0	<i>2</i>
Adult Residential	0	0	0	0	0	0	1	<i>1</i>
Adult Targeted Case Management	0	1	1	1	0	0	0	<i>3</i>
Non DMH-Funded	0	0	1	0	0	0	0	<i>1</i>
Opioid CSTAR	0	0	0	0	1	0	0	<i>1</i>
Other - Community	0	2	1	0	0	0	0	<i>3</i>
PR+ Level 1	1	2	0	0	0	1	0	<i>4</i>
PR+ Level 1 w./Residential Support	2	2	0	0	0	0	0	<i>4</i>
PR+ Level 2	0	1	0	0	0	0	0	<i>1</i>
PR+ Level 3	0	0	2	0	0	1	0	<i>3</i>
Recovery Support	0	0	1	0	0	0	0	<i>1</i>
SATOP	0	1	0	0	0	0	0	<i>1</i>
Youth Community Psychiatric Rehabilitation	0	0	0	0	0	1	0	<i>1</i>
Youth Community Services	0	0	0	1	1	1	0	<i>3</i>
Youth Inpatient	0	0	1	0	0	0	0	<i>1</i>
Youth Targeted Case Management	1	0	0	0	0	1	0	<i>2</i>
<b>Total</b>	<b>25</b>	<b>28</b>	<b>24</b>	<b>26</b>	<b>33</b>	<b>37</b>	<b>25</b>	<b>198</b>

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### Community Behavioral Healthcare Centers

The Zero Suicide model was introduced to the Missouri Coalition of Community Behavioral Healthcare Providers Board at their annual 2015 conference, and they committed to adapting Zero Suicide as one of their initiatives. After partnering with the Coalition of Community Behavioral Healthcare Providers, funding was made available to bring the Zero Suicide Academy to Missouri. In April 2016 over half of the contracted community treatment providers sent teams to the Missouri Zero Suicide Academy held in Jefferson City at the Coalition of Community Behavioral Healthcare Providers office. The Coalition also implemented a Zero Suicide learning collaborative for their members who attended the Missouri Zero Suicide Academy. The learning collaborative meets every other month.



Rick Strait, Heather Williams, Audrey Burger and Wendy Ice from Community Counseling Center at the MO Zero Suicide Academy (2016).

Subsequent to the MO Zero Suicide Academy, funding and materials were provided to each provider for Question, Persuade, and Refer Suicide Prevention Gatekeeper Training, and train—the-trainer self-study kits. Additionally, three (3) regional Assessing and Managing Suicide Risk trainings were provided, with more training scheduled for 2017.

### State Operated Psychiatric Facilities

Seven (7) state operated psychiatric facilities participated in the implementation of Zero Suicide concepts and principles. Each facility completed a workforce survey, an organizational self-assessment, and selected a champion to lead their Show Me Zero Suicide implementation team.

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### ***Workforce survey***

Technical support was provided by the National Action Alliance for Suicide Prevention through the Education Development Center, Inc., to conduct the workforce survey at the state operated psychiatric facilities. All seven (7) state operated psychiatric facilities participated in the workforce survey. On September 6, 2015, a report was submitted to the Department with findings (see appendix 2). Survey participants were asked to identify what aspects of assessing, managing, and treating patients/clients at risk for suicide they would like to learn more about. A total of 366 of the 1,221 respondents (30%) identified one or more areas of need.

The top three areas of need were:

1. Suicide-specific treatment approaches (38% of respondents),
2. Formal screening and assessment practices (36%), and
3. Managing suicidal patients/clients (31%).

### ***Organizational Self-Assessment***

The organizational self-assessments were individualized to each facility; however, the following themes were present:

1. Individuals with lived experience are not in leadership planning roles, and
2. Staff are not formally assessed on their perception of confidences, skills, and perceived support to care for consumers at risk of suicide.

### ***Leadership response***

1. Adapt mandatory suicide prevention training through the MO Employee Learning System beginning in 2017 and repeating annually thereafter.

Develop and implement a training plan for suicide-specific training, such as:

- Assessing and Managing Suicide Risk
- Treatment modalities
  - Cognitive Behavior Therapy
  - Dialectical Behavior Therapy
  - Collaborative Assessment and Management of Suicidality
  - Safety planning
  - Counseling on Access to Lethal Means

2. Adapt a standardized procedure to screen, assess, and formulate risk:

- Suicidal
- Non-suicidal self-injurious behavior

### ***Champions***

Each state operated psychiatric facility designated a person to serve as the facility champion and is the Show Me Zero Suicide lead for their facility. This includes, but is not limited to:

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- Serving as the primary liaison between facility leadership and Central Office staff serving as members of the Zero Suicide Stakeholders Planning and Implementation Team;
- Assisting facility leadership with the development and implementation of Zero Suicide;
- Becoming familiar with the Zero Suicide National Collaborative by reviewing the website;  
[Suicide Prevention Resource Center](#)
- Communicate the Departments Zero Suicide initiative activities, findings, and recommendations to facility leadership;
- Encourage staff to participate in the Departments Zero Suicide activities (be a cheerleader); and
- Encourage supervisors to support staff that has had a suicide loss at work, such as critical incident stress debriefing or employee assistance.

Champions participate in a monthly Zero Suicide learning collaborative specific to inpatient forensic units. A root cause analysis completed on a consumer suicide was shared with the learning collaborative for lessons learned.

### *Suicide Risk Summits*

It is important to note that between 2008 and 2011, the state operated psychiatric facilities held two (2) summits to analyze the root cause of each suicide death (to date). Continuous quality improvement processes were implemented (see table 4), and there was not another suicide death in a state operated psychiatric facility from 2011 to 2016. Processes such as root cause analysis on all suicide attempts and the implementation of an environmental risk assessment appear to have made an impact on suicide deaths in the facilities; however, DMH stopped providing acute care during that time period (2008 – 2011). One might speculate that with the level of patient acuity minimized, suicidality across patient populations may have decreased.

**Table 4. Categories identified in DMH RCA**

Assessment & Information Management
Communication & Information Management
Care Planning
Physical Environment
Human Factors
Leadership
Continuity of Care

For the 15 years between January 1997 and December 2011, there were a total of 14 suicide deaths in state operated psychiatric facilities.

Between January 2012 and December 2015, there were no suicide deaths in state operated psychiatric facilities.

In 2016, there was one (1) suicide death in a state operated psychiatric facility.

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### Division of Developmental Disabilities Data

Analysis of the Division of Developmental Disabilities reported suicide death events, 2008 through 2014, shows consumers who died by suicide were receiving targeted case management or supported employment services. There are no reported suicides of consumers in state operated habilitation centers or in community placement settings.

**Table 5. DDD reported suicide events, 2008 through 2014, by service.**

Year	2008	2009	2010	2011	2012	2013	2014
Case Management		1		1	2	3	2
Supported Employment					1		

### SHOW ME ZERO SUICIDE IMPLEMENTATION

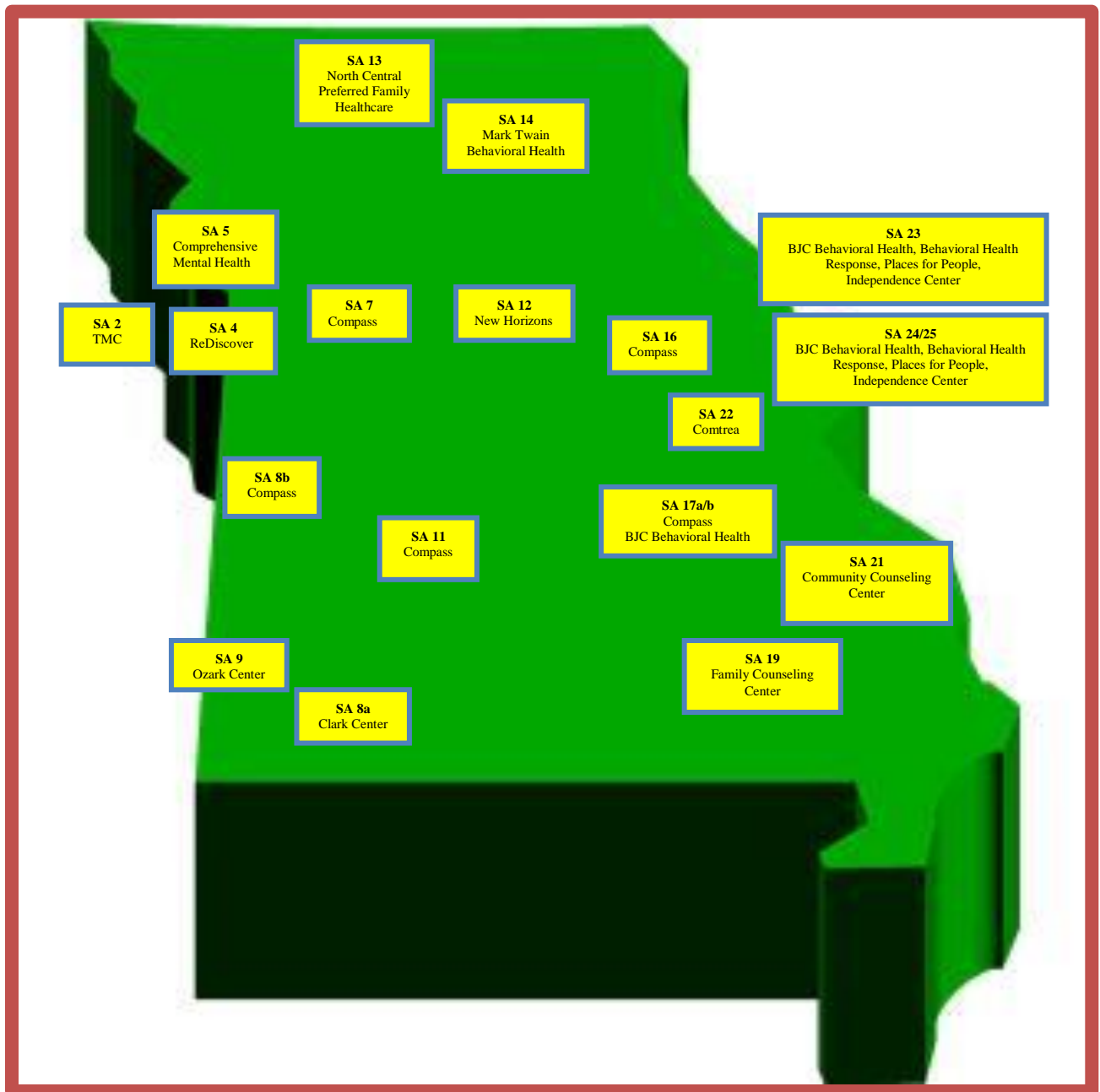
**Table 6. Show Me Zero Suicide cohorts**

Cohort 1 (2014)	Cohort 2 (2015)	Cohort 3 (2016)
DMH Ozark Center	Behavioral Health Response Crider Center	BJC HealthCare Clark Community Mental Health Center Community Counseling Center Compass Health Comprehensive Mental Health Services COMTREA Family Counseling Center Independence Center Mark Twain Behavioral Health New Horizons North Central Missouri Mental Health Center Places for People Preferred Family Healthcare ReDiscover Truman Medical Center (TMC) Behavioral Health Response (Team 2) Adapt of Missouri



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Diagram 2. Zero Suicide Community Behavioral Healthcare Centers by Service Area (SA)



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**Table 7. Zero Suicide Initiatives 2015**

<b>2<sup>nd</sup> Zero Suicide Academy</b> (June 2015)	<b>Zero Suicide Breakthrough Series</b> (January 2015 through September 2015)	<b>MO Zero Suicide Stakeholders</b> (January 2015 and ongoing)
<p><b><u>PURPOSE</u></b>                      The purpose of the Zero Suicide Academy is to advance the Zero Suicide approach through providing training and ongoing support to teams in attendance.</p>	<p><b><u>PURPOSE</u></b>                      The purpose of the Zero Suicide Breakthrough Series is to support the successful launch and implementation of the Zero Suicide approach under the direction of a state mental health or public health office.</p>	<p><b><u>PURPOSE</u></b>                      The purpose of the Stakeholder team is to implement the Zero Suicide approach in Community Behavioral Healthcare Centers, DMH state operated psychiatric facilities, Intellectual Disability &amp; Developmental Disability case management entities, Intellectual Disability &amp; Developmental Disability contracted providers, and promote Zero Suicide concepts across the State of Missouri.</p>

**Table 8. Zero Suicide Initiative 2016**

<b>MO Zero Suicide Academy</b> (April 2016)	<b>Zero Suicide Community of Practice (CoP)</b> (December 2015 through September 2016)
<p><b><u>PURPOSE</u></b>                      The purpose of the MO Zero Suicide Academy is to advance the Zero Suicide approach through presenting the National Zero Suicide Academy curricula and faculty to teams from Community Behavioral Healthcare Centers (administrative agents and affiliates) for the Department of Mental Health.</p>	<p><b><u>PURPOSE</u></b>                      The purpose of the Zero Suicide CoP is to build the capacity of states to implement and advance Zero Suicide in state, county, and local health and behavioral healthcare organizations and settings.</p>

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### **CONCLUSION**

The Missouri Department of Mental Health is committed to implementing Zero Suicide within the state behavioral healthcare system. Department staff will continue to provide training and technical assistance to Zero Suicide implementation teams in state operated psychiatric facilities, and Community Behavioral Healthcare Centers. The Department will promote and highlight suicide safe care practices and providers, and will continue to promote Zero Suicide in Intellectual Disabilities/Developmental Disabilities populations, focusing on targeted case management entities and contracted providers.

Collaboration with community partners will continue to advance Zero Suicide across the State of Missouri. Partnerships include, but are not limited to, the following:

- Missouri Primary Care Association
- Missouri Hospital Association
- University of Missouri, Kansas City (Dr. Bill Geis)
- Missouri Department of Health & Senior Services
- Missouri Department of Social Services

Missouri Department of Mental Health was selected as a demonstration site for Excellence in Mental Healthcare and promotes Zero Suicide concepts and principles. The Department will embed Zero Suicide concepts, including, but not limited to the trauma informed care initiative, suicide prevention grants, and rules and regulations to ensure sustainability of suicide safe care practices. Department leadership remains committed to decreasing suicide deaths in behavioral healthcare populations.