

Recommendations to House Committee on Health Care



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Vermont Suicide Prevention Center

VTSPC is a public-private partnership with the State of Vermont, private foundations, education, health care, community provider organizations, and people with lived experience. The mission of the VTSPC is to create health-promoting communities, in which people have the knowledge, attitudes, skills, and resources to reduce the risk of suicide in Vermont.

VTSPC is guided by the Vermont Suicide Prevention Coalition (<https://vtspc.org/aboutvtspc/coalition/>) consisting of over 100 active representatives from public health, education, State agencies, suicide prevention advocacy groups, youth leadership, health care providers, mental health services and survivors throughout the state. Under the coordination of VTSPC, the statewide Coalition developed the *Vermont Suicide Prevention Platform- Suicide Prevention Across the Lifespan (2015)* to serve as a Guidance Document for a broad community-based public health, cross sector, and ecological approach to suicide (<https://vtspc.org/vt-suicideprevention-platform/>). The Platform is aligned to the *National Strategy for Suicide Prevention*.

Recommendations

The following recommendations are organized under ten categories and can be used in future planning and implementation of Zero Suicide efforts in health care organizations across Vermont.

I. Zero Suicide Coordination

- Provide coordination support and technical assistance to the organizations implementing Zero Suicide. The role and work of VTSPC as a coordinating entity was valued.
- Support local coordination through the DA system. Directors of all program service areas need to be involved.

II. Zero Suicide Organizational Self-Assessments (OSA)

- Support the use and implementation of the OSA in DAs and health care organizations once every three years.

- *“As difficult as it is to go through the OSA process it is key to launching the Zero Suicide work. The OSA provides an overall assessment of strengths and weaknesses in the system, gets everyone using the same language and knowledge of the evidence-based tools, enables a prioritization important for developing work plans, and focuses the team on the same outcomes. It was key to launch the ZS process.”*
- Use the OSA to generate Work Plans by program service areas to help track progress, and update the Work Plans annually.

III. Zero Suicide Workforce Development Surveys (WFDS)

- Support administration of the WFDS by providing a link to the survey, generating reports and recommendations, and providing consultation to participating organizations.

IV. Zero Suicide Training

Based on review of the Zero Suicide WFDS, Zero Suicide Interviews, OSA, the pre- and post-training assessments from the CAMS (Collaborative Assessment for the Management of Suicidality) trainings, the following are suggestions about topics and approaches for Zero Suicide training.

- Support continued focus on use of CAMS and development of effective training to embed the practice in the DA system and beyond.
- Continue supporting new and previously non-CAMS trained clinicians to become CAMS trained (even after three years of CAMS training, each Pilot Site has a different level of “coverage”, e.g., LCMH is very good, NCSS is moderate, and the HC has a serious need for additional clinicians to be trained.
- Adopt universal training on CALM (Counseling On Access to Lethal Means) for all clinicians. This is a free online training.
- Support Gatekeeper training to community members and professionals in Vermont communities and workplaces on how to recognize suicide related behaviors and how to intervene.
 - VTSPC receives numerous requests for suicide prevention Gatekeeper training which are difficult to meet given funding. Additional resources to support the demand through online technologies and training of trainers are needed.
- Expand efforts to train non-agency partners on aspects of CAMS and CALM that are relevant to the work they do with the clients they share with DAs.
 - Examples could include training partner clinicians in schools, Department of Children and Families, and other settings on the principles of CAMS in order to:
 - (a) facilitate the appropriate sharing of helpful information for CAMS treatment in the DAs, and (b) boost referrals from these partners.
 - Another example is that CALM training could be adopted in settings where

suicide risk is being identified by DA and non-DA staff, including schools, primary care, and Emergency Departments.

- Strengthen specific aspects of clinician’s confidence and competence to work with clients at risk for suicide.
 - Develop a focus on applying CAMS, or other approaches, to work with adolescents and young children.
 - Develop a comprehensive menu of safety planning resources available to private clinicians and school-based providers as well as to DA employees, such as smartphone apps.
 - Consider adopting suicide prevention approaches and tools that are complimentary to CAMS, such as the Virtual Hope Box.
 - Support systems’ and individual clinicians’ efforts to provide needed follow-up and post-discharge contact to clients at risk for suicide.
 - Continue and expand efforts for clinicians and their partners to use a universal language around assessment, measuring risk, and safety planning.
 - Strengthen and expand the use of CAMS by reinforcing concepts and practices in clinical supervision, even for non-CAMS trained clinicians. Clinicians can benefit from specific aspects of CAMS practice such as collaborative safety planning.
 - For non-CAMS trained clinicians specific efforts can be made to improve their knowledge, confidence and skills in several areas assessed in the Zero Suicide WFDS (see 5/30/18 report). Examples include engaging clients directly about suicide risk, taking a history that includes a focus on suicidality, and boosting these clinicians’ skills in conducting suicide risk assessments, among others.
 - Support opportunities for professional development that raise the overall knowledge in the field and encourage collegial exchange, such as the Zero Suicide Practice Institute and the Suicide Prevention Symposium.

V. Data and Surveillance

- Increase DAs’ capacity for surveillance and the development of responsive interventions that will show success in reducing suicide deaths. For example: Centerstone reduced suicide deaths by 55% in a one year period.
- Possible processes are as follows:
 - Focus on existing clients (active in the past 90 days) or those scheduled to come in for an appointment.
 - All personnel identify clients at high risk for a suicide attempt and report this information to the Quality Improvement (QI) Department.
 - Ensure all such clients receive suicide screening, assessment, and follow up.

VI. Evaluation

- Support a contract with an external Evaluator to works towards (a) identification of common outcome measures across the DAs and (b) tracking of implementation of evidence-based practices, including CSSRS (Columbia Suicide Severity Rating Scale) and CAMS in order to assess fidelity and impact.
 - *“A lot of work was happening but was not being tracked.”*
- Integrate a QI approach that works with internal QI teams to support a measured driven approach.

VII. System of care issues

- Structure an expectation that DAs work with Primary Care Practices (PCPs) and other health care organizations, including hospitals (Emergency Departments and inpatient psychiatric treatment facilities), Home Health, etc., to improve suicide safer care.
- Support PCPs to expand the focus on Depression Care to include screening for suicide as part of their role as an Accountable Care Organization and as part of Patient Center Medical Home requirements.
- Structure and incentivize the expectations to follow up and track medical transitions and discharges within the PCP and inpatient psychiatric hospitalization system.
- Increase coordination with schools and PCPs.

VIII. Suicide Survivor Support

Support the provision of resources for Suicide Survivors.

- Develop communication channels with the Medical Examiner’s Office to identify suicide loss survivors, and provide them with access to support resources.
- Improve and disseminate Vermont Resource Packet materials to Survivors.
 - Support Vermont Survivor Groups to provide peer recovery and support.

IX. Mental Health and Substance Abuse

- Ensure seamless assessment and treatment between mental health and substance abuse providers.
- Continue to invest in the Vermont mental health system to ensure effective and timely services: improve coordination and accessibility of mental health and substance abuse treatment services.

X. Broad Community-Based Public Health Approach

- Invest in the Vermont Suicide Prevention Coalition (VTSP Coalition) to ensure all organizations have the skills and resources they need to carry out a strong public health approach to suicide prevention.

- Support the coordination and maintenance of the VTSP Coalition to ensure input from multiple sectors and people with lived experience.
- Use the Goals and strategies outlined in the *VT Platform for Suicide Prevention Across the Lifespan (2015)* to develop a five-year strategic plan to ensure longterm and sustainable approaches to suicide prevention that incorporate community approaches and cultural considerations related to reaching at-risk sub-populations.

Eleven Goals of the 2015 Vermont Platform

1. Promote awareness that suicide is a public health problem.
2. Build sustainable and integrated infrastructure in Vermont for mental health promotion, suicide prevention, intervention and postvention.
3. Develop and implement strategies to promote positive public attitudes toward being socially and emotionally healthy.
4. Develop, implement, and monitor programs that promote social and emotional wellness.
5. Promote efforts to reduce access to lethal means among people at risk of suicide.
6. Provide training to community members and professionals on how to recognize suicide related behaviors and how to intervene.
7. Promote suicide prevention, screening, intervention, and treatment as core components of health care services with effective clinical and professional practices.
8. Improve coordination and accessibility to mental health and substance abuse services.
9. Promote responsible reporting and accurate portrayals of suicidal behavior, mental conditions and substance abuse in the media
10. Improve and expand surveillance systems in order to: 1) monitor trends and profiles of at-risk population, 2) assess the impact of existing policies and programs, and 3) inform the development of future efforts.
11. Provide care and support to individuals affected by suicide deaths and attempts.

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