Department of Mental Health

Vermont Suicide Prevention Model Protocol for Health Care Facilities

Published:
7.1.2024

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Executive Summary

The Department of Mental Health, in collaboration with the Vermont Suicide Prevention Emergency Department Quality Improvement Initiative, developed this comprehensive model protocol for health care facilities to improve the identification and treatment of patients at-risk for suicide and ensure appropriate postvention response following a death by suicide. Originally intended to provide guidance for the Vermont Emergency Departments, this protocol has been broadened to be applicable for all health care facilities.

Emergency Departments (ED) are a primary point of access for care and treatment of suicidal ideations. Data from the Suicide Data Linkage Project (2020-2021) highlighted this critical role:

- 65% of people who died by suicide interacted with healthcare services within a year of death.
- 35% visited an ED within a year of death, with 24% having a mental health or suicide related ED visit.
- 11% visited an ED within a month of death
- 47% of older Vermonters, a disproportionately impacted population, sought care at an ED within a year of death.

The quality improvement initiative was led and designed by the Vermont Program for Quality in Health, in consultation with suicide loss survivors, hospitals, Center for Health and Learning/Vermont Suicide Prevention Center, community mental health agencies, the Department of Health, the State Office of Rural Health, Department of Mental Health, independent psychiatrists, and the Vermont Association of Hospitals and Health Systems.

Key components of the model protocol:

1. Evidence-based screening
2. Mitigation
3. Suicide risk assessment

4. Interventions
5. Care transitions
6. Discharge planning
7. Post-discharge follow-up
8. Outpatient care

The initial project year (2022) focused on sharing educational, networking, and financial resources to Vermont hospitals to support initiatives centered on improving the quality of care for suicidal patients presenting to ED's. In the subsequent program year (2023), each ED is tasked with building on the previous year's activities, lessons learned, and training to incorporate into the development of a suicide care pathway in alignment with evidence-based best practice. To accomplish this, EDs consulted the Essential Elements of the Suicide Care Pathway Guidance document, a resource developed under the statewide quality improvement initiative, which provided the foundation of the state model protocol on suicide prevention for health care facilities. The components of the model protocol are evidence-based screening, mitigation, suicide risk assessment, suicide specific interventions, care transitions, discharge planning, post-discharge follow-up, and outpatient care.

Implementing this coordinated, comprehensive model protocol is a critical first step toward ensuring timely and effective access to services that will save Vermonter's lives.

Acknowledgements: This protocol was created in partnership with the Vermont Program for Quality in Health, Inc. through the Vermont Suicide Prevention Emergency Department Quality Improvement Initiative. Its contents are adapted from Essential Elements of the Suicide Care Pathway Guidance created by Dr. Edwin Boudreaux, PhD. University of Massachusetts Chan Medical School.

This project was supported by generous funding from the Vermont Department of Health, the Office of Rural Health, the Four Pines Fund, and the Vermont Community Foundation.

Legislative Language

From ACT 56:

On or before July 1, 2024, the Director of Suicide Prevention, in collaboration with the Agency of Human Services, medical and professional boards, and stakeholders, shall develop and submit a model protocol to the House Committee on Health Care and to the Senate Committee on Health and Welfare for health care facilities regarding suicide prevention and postvention services. This model protocol shall consider the recommendations of the report required pursuant to 2022 Acts and Resolves No. 115, Sec. 13.

Components of the Model Protocol for Health Care Facilities

Care pathway elements.

A suicide-safe care pathway in a health care facility or setting must include the following essential elements, specifying who completes each component, when it is completed, and how it is documented. An initial comprehensive environmental safety assessment will have to be completed prior to enacting these steps. Treatment locations must designate the setting as ligature resistant or not, with care pathways differing based on ligature resistant status and location of care. In such cases, the specifics of the care pathway should be clear. Care pathways should be informed by people with lived experience, flexible to allow patient-centered, compassionate care, and should enhance rather than override clinician judgement. Alterations to the care pathway for an individual patient should be documented as part of the care decision-making process.

1. Evidence-based screening

Initial screening using an evidence-based screening tool should be completed. The care pathway should include:

1. **Client Identification:** Clearly identify which clients are to be screened, including if it is clinically indicated (e.g., people presenting with a mental health issue) or universal (everyone walking through the door).
2. **Trained Screening Personnel:** Specify who will conduct the initial screening.
3. **Timely Access:** Determine when the screening will be performed (e.g., triage vs initial assessment).
4. **Evidence-Based Tools:** Identify the evidence-based screening tool to be used, including whether different tools will be used for different age groups and settings; and
5. **Proper Documentation:** Develop a policy that outlines how and where to document the screening in the patient record.

Ideally, the initial screening will identify the level of current risk, such as negligible, mild, moderate, or high risk. This initial screening is primarily for triage purposes and is conservative. Secondary screening or brief assessment by a trained clinician, such as the emergency physician, social worker, or mental health professional, can also happen to help further define or modify the individual's risk.

Examples of evidence-based screening tools include:

- PHQ-9 (Patient Health Questionnaire)
- Columbia Suicide Severity Rating Scale (C-SSRS) Triage Version
- Patient Safety Screener
- Ask Suicide-Screening Questions (ASQ)

For further information, click here.

2. Mitigation

Safety precautions for clients who screen positive should be deployed, tailored to the individual's risk level, with a primary focus on those who are designated "high" risk. Appropriate measures include:

- **Environmental Safety:** Ensuring the treatment environment is safe, particularly by identifying and mitigating potential hazards.
- **Observation:** Implementing procedures for appropriate levels of observation based on the risk assessment.
- **Restricting Access to Lethal Means:** Removing access to items that could be used for self-harm, such as ligature risks in clothing or other objects.

3. Suicide risk assessment

The suicide safe care pathway will define who gets a comprehensive suicide risk assessment by a trained mental health professional. This assessment includes:

- **Risk Formulation**: Lead to a detailed understanding of the individual's risk factors and protective factors, culminating in a risk formulation.
- **Risk Adjustment:** Allow for the modification of the current risk level and corresponding mitigation procedures based on the assessment.

- **Context Consideration:** Take into account the treatment location and differentiate between acute and chronic risk factors.

Examples of evidence-based risk assessment tools include:

- SAFE-T
- C-SSRS Risk Assessment Version
- C-SSRS Severity Rating Scale Baseline Version
- Beck Scale for Suicide Ideation (BSI; Beck & Steer, 1991)
- Assessment and Management of Suicide Risk (AMSR)

4. Interventions

Brief interventions can help decrease suicide risk, help clients manage suicide-related symptoms after discharge, and promote continued engagement with treatment. These interventions include safety planning, Counseling on Access to Lethal Means (CALM), and other emerging interventions. Pathways should stipulate who will get the intervention, who delivers the intervention, and how interventions are documented.

Notes on safety planning: When feasible, safety planning would include family or other caregivers that might be helping to support the individual, such as group home personnel. Collaborative safety planning should occur prior to discharge from any acute care setting (e.g., ED, medical inpatient unit, mental health inpatient unit).

Examples of evidence-based interventions:

- Stanley-Brown Safety Plan
- Counseling on Access to Lethal Means (CALM)
- JASPR

In addition, a site should consider if additional evidence-based interventions will be provided, such as Collaborative Assessment and Management of Suicidality (CAMS) or Cognitive Behavioral Therapy for Suicidal Ideation. *This is primarily relevant to inpatient mental health units.*

For further information, click here.

5. Care transitions

Communication of the current level of risk across settings and locations of care should be defined in the pathway, including when moving from the ED to medical units, within medical units (Intensive Care Unit to acute care), from medical units to inpatient psychiatric units, and from acute care settings to outpatient settings.

For further information on care transitions, click here.

6. Discharge planning

Discharge planning should include consideration of resources to further mitigate suicide, including outpatient mental health services, crisis resources, and suicide prevention resources, like 988. To the greatest extent possible, the discharge plan should be specific, and delivered in a format that is understandable and health-literacy appropriate. Medical (primary care), mental health, and social service follow-up should be considered. Appointments for follow-up should be scheduled and communicated with the client before discharge when possible.

7. Post-discharge follow-up

Post-discharge follow-up contact should be carefully considered. Caring contact post cards and post-visit telephone follow-up calls are options. The care pathway should identify who is responsible for the cards/calls, content of the cards/calls, frequency, and time window(s).

For further information on follow-up, click here.

8. Outpatient care

Care pathways in outpatient care can be built based on the same basic principles described above. They can either be initiated in outpatient settings or care pathways initiated in acute care can be transitioned to outpatient care. For example, an outpatient care pathway should create a new safety plan for an at-risk individual or state how an already established safety plan created in acute care will be reviewed and

updated as needed in outpatient care. In addition, outpatient care pathways should consider:

- Stipulating criteria for coming “on” and “off” the pathway;
- Identifying the frequency of re-assessment and adjustment of care pathways;
- Identifying frequency of appointments with medical and mental health provider; and/or
- Identifying actions taken if a patient on the pathway cancels or no-shows an appointment. All of these actions should be tailored to the patient’s suicide risk level.

For further information on suicide prevention:

- in primary care, click here.
- in pediatric care, click here.

9. Postvention

The time following a suicide death can have a significant impact for the family, loved ones, and the broader community. Postvention is the organized response after a suicide or other unexpected death that aims to facilitate healing from grief and distress. Having a coordinated, thorough response to offer to people affected can decrease the confusion and offer hope that healing is possible. The response could consist of caring contacts, sharing resources, and/or informing the person of loss survivor groups. Additionally, the response could encompass earlier steps in this protocol, such evidence-based screening and mitigation as someone who has lost someone to suicide is at increased risk for suicide.

For further information on postvention, click here.

Further resources:

- Joint Commission-National Patient Safety Goal on Suicide Prevention in Health Care Settings: https://www.jointcommission.org/resources/patient-safety-topics/suicide-prevention/
- Zero Suicide framework, resources, and toolkits: https://zerosuicide.edc.org/resources/resource-database/applying-zero-suicide-pediatric-care-settings

2022 Acts and Resolves No. 115, Sec. 13

As requested by the House Health Care and Senate Health and Welfare Committees, the Model Protocol for Health Care Facilities considered the recommendations from the Working Group on Services for Individuals with Eating Disorders Report.

The report can be found here: https://mentalhealth.vermont.gov/sites/mentalhealth/files/doc_library/Eating_Disorder_Report_Act_114_Section_13.pdf

When Health Care Facilities develop suicide prevention protocols specific to their setting and practice, recommendations outlined in the above report are strongly encouraged to be incorporated within protocol, guideline, training, and workflow development.