Evaluation of Developing Infrastructure for Suicide Safer Pathways to Care in Vermont 2022

Produced by

JoEllen Tarallo, Ed.D., Director

Thomas Delaney, Ph.D., Evaluation Consultant, UVM

Gabriel Reif, Ph.D., Evaluation Consultant, VT-SPC

Vermont Suicide Prevention Center (VTSPC-

Center for Health and Learning (CHL)

Under funding from VT Department of Mental Health (DMH)

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Background

In Vermont Designated Mental Health Agencies (DA) and health care partners are developing and implementing suicide-safer pathways aimed at increasing access and delivery of quality care in order to reduce suicide deaths. The Zero Suicide 2021-22 Project supported the Agencies in identifying, implementing and measuring changes aimed at quality care that prevents suicide. The Logic Model, Evaluation Design, and Evaluation Tools and Timeline in Appendices 1-3 provide further information on the design of the project.

The Zero Suicide 2021-22 Project was developed and coordinated by the Vermont Suicide Prevention Center (VTSPC), a public-private partnership of the Center for Health and Learning (CHL). CHL is a 501c3 that works with state agencies and partners to address priority issues. VTSPC works with professionals across sectors with education, health care, and community providers to advance evidence and best practices for suicide prevention. VTSPC works concurrently with statewide advisors and stakeholders to support the integration of Zero Suicide into clinical practice and organizational policies and procedures leading to a suicide care pathway within and between organizations.

The Designated Agencies (DA) are organized under the Vermont Care Partners, a collaboration between the Vermont Council and the Vermont Care Network of sixteen non-profit community-based member agencies that offer care to Vermonters affected by developmental disabilities, mental health conditions, and substance use disorders. Seven Designated Mental Health Agencies were committed to activities required by the project:

- Community Care Network / Rutland Mental Health
- Health Care and Rehabilitation Services
- Howard Center
- Lamoille County Mental Health
- Northeast Kingdom Human Services
- Northwestern Counseling Support Services
- Washington County Mental Health

Data Sources and Findings

Three core evaluation data sources were used:

1. **Zero Suicide Designated Agency Surveys**
    a. Planning and Reporting Survey: January 2022
    b. End of Year Reporting Survey: June 2022
2. **Client-level Data Related to Screening and Safety Planning**
3. **Suicide Prevention Training Participation Data**

Zero Suicide Designated Agency Surveys

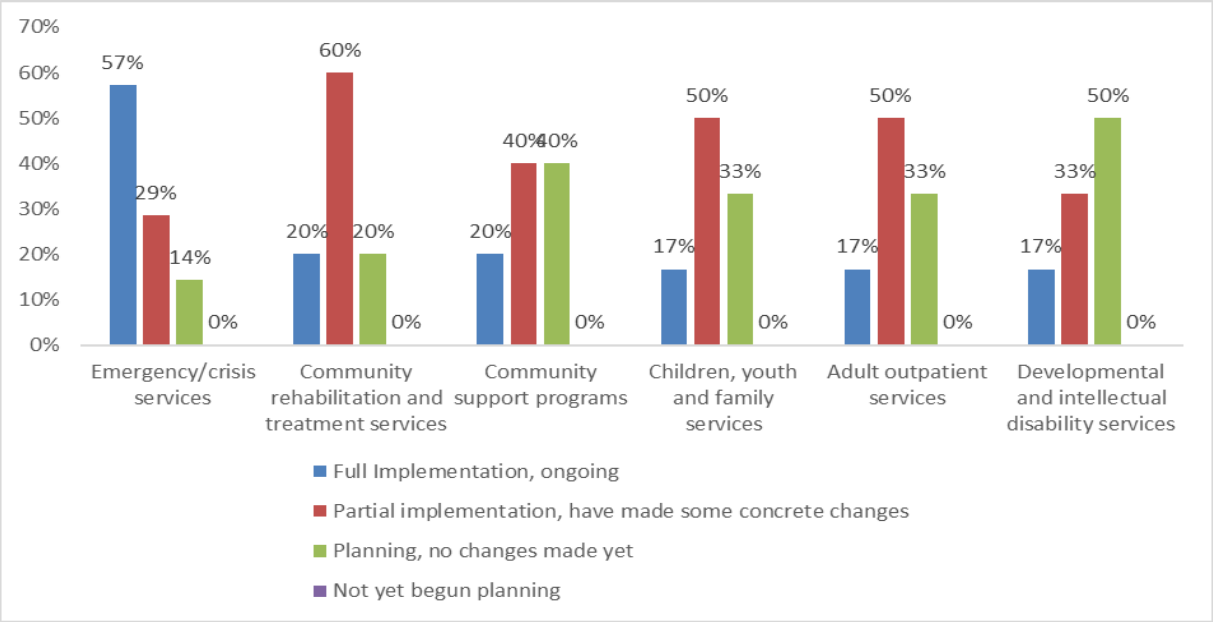
Over the course of the grant period (July 1, 2021 - June 30, 2022), two web-based surveys were administered to all participating DA. In January 2022, the *Planning and Reporting Survey* was distributed to individuals at the DA, and in June 2022, the *End of Year Reporting Surv*ey was distributed to the agencies. Both surveys had response rates of 100% (*n* = 7).

Stages of Implementation

In the Planning and Reporting Survey, respondents were asked to indicate the stage of implementation of suicide-safer care practices in each of the six Service Areas. Survey participants indicated that of the Service

Areas listed, Emergency/Crisis Services have the most advanced stage of implementation (Figure 1). Emergency/Crisis Services was the only area where most agencies reported full implementation of suicide-safer care practices, although at least 50% of respondents indicated that their agencies had partially or fully implemented suicide-safer care practices in all Service Areas. The Service Area with the second highest level of implementation was Community Rehabilitation and Treatment (CRT) Services, with 20% of agencies reporting full implementation and 60% reporting partial implementation. No agencies indicated that they had not yet begun planning how to implement suicide-safer care practices in any of the Service Areas listed.

Figure 1. Implementation Stage of Suicide-Safer Care Practices by Service Area



Zero Suicide Steering Committees

The *End of Year Reporting Survey* asked DA about the status of their ZS Steering Committees, which function as the driving element to create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Six of the seven DAs (86%) indicated that they have active Zero Suicide Steering Committees. Of those with committees, agencies reported that their committees met between eight and 18 times over the past year. Most respondents reported that they use their meetings to share updates from core team members and discuss follow-up and care coordination. All six steering committees have specified coordinators and five of the committees have representatives from all relevant service areas (i.e., Children, Youth, and Family Services; Developmental and Intellectual Disability Services; Emergency/Crisis Services; Adult Outpatient Services; Community Support Programs; and Community Rehabilitation and Treatment Services). Additionally, five steering committees have other members from beyond these service areas including community members with lived experience, and representatives from other branches of their agencies like administrative divisions and information technology. The DA without an active steering committee indicated that it had an active committee up until 2022, but it has not met yet this calendar year.

Priorities for Future Zero Suicide Work

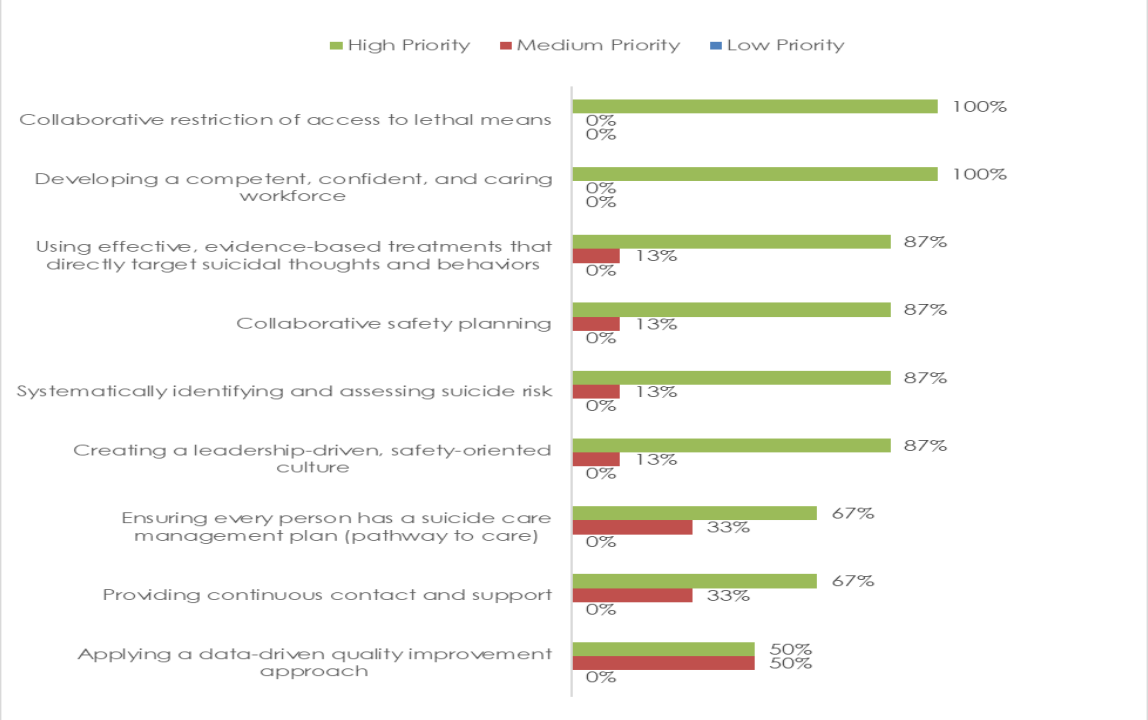
The *End of Year Reporting Survey*, designated mental health agencies listed priorities for future Zero Suicide work (Table 1). **The vast majority of agencies (86%) indicated increasing training, expanding protocols, and building pathways to care with medical providers were still a priority for their organizations.** Slightly

smaller proportions of agencies reported that expanding the implementation of C-SSRS and CAMS (71%) and obtaining client-level measures from their EHR systems (57%) remained priorities.

Table 1. Priorities for Future Zero Suicide Work

Priority	%
Increasing training (e.g., Suicide Prevention Awareness and Support training, CALM, CAMS, Quality Improvement)	86%
Expanding protocols within the agency	86%
Building pathways to care with PCPs and other medical providers	86%
Engaging community partners	86%
Expanding implementation of C-SSRS and CAMS	71%
Obtaining client-level measures from your EHR system	57%

Figure 2. Organizational Self-Study Priorities



Agencies were also asked to indicate the level of priority for the items listed in the Zero Suicide Organizational Self-Study tool (Figure 2). All of the DA (100%) indicated that collaborative restriction of access to lethal means and developing a competent, confident, caring workforce were high priorities. The vast majority of respondents (87%) also said that the following were high priorities: creating a leadership-driven, safety-oriented culture;

systematically identifying and assessing suicide risk; collaborative safety planning, and; using effective, evidence-based treatments that directly target suicidal thoughts and behaviors. Compared to other items, fewer participants (50%) indicated that applying a data-driven quality improvement approach was a high priority.

No participants rated any of the options listed as a "low" priority, underscoring the ongoing nature of the work and the importance and relevance of all elements in a comprehensive approach.

Postvention

In regards to the postvention services that DAs provide, all participating agencies (100%) conduct brief interventions and/or provide support to loved ones immediately following a suicide, while 86% give immediate support and education to organizations that have experienced a suicide death (Table 2). Slightly more than half of the DA (57%) refer clients to postvention support and education and coordinate postvention responses with first responders and other community partners. **Only 14% of agencies indicated that they provide internal postvention for staff and outreach as requested, and no agencies (0%) provide follow-up or long-term outreach to organizations that have experienced a suicide or reach out to media channels after a suicide to provide information on media safe reporting.**

Note: Postvention is a tangential focus through expanding work in Vermont under a comprehensive suicide prevention grant from the Centers for Disease Control. The Vermont Suicide Prevention Center (VTSPC) will be providing additional resources in the coming years.

Table 2. Postvention Services Provided by DA

Type of Postvention Service	%
Brief intervention supports to loved ones immediately following a suicide	100%
Immediate support and education to organizations (e.g., schools, employers) that have experienced a suicide death	86%
Referral to postvention supports and education (e.g., AFSP)	57%
Coordination of postvention response with first responders and other community partners	57%
Long-term follow-up with loss survivors	29%
Bereavement counseling	29%
Support groups for suicide loss survivors	29%
Internal postvention for staff	14%
Outreach as requested	14%
Follow-up or long-term outreach, education and support to organizations (e.g., schools, employers) that have experienced a suicide death	0%
Outreach to local and regional media following a suicide death to provide guidance on media safe reporting of suicide deaths	0%

Staffing Capacity

Despite the accomplishments and progress reported by respondents, items from both the Planning and Reporting Survey and the End of Year Survey indicated that **DA were challenged in numerous important ways by low staffing capacity.** There was consensus across agencies that staffing concerns significantly hindered agencies' ability to provide services to clients, communicate effectively within their organizations, and fully implement the Zero Suicide framework. Addressing this barrier is a key way to help DAs reach their full potential as participants in the Zero Suicide program.

Client-level Data Related to Screening and Safety Planning

The Value of Client-level Reporting

For the purposes of this discussion, the terms clients and patients are reciprocal. The collection of client-level measures is a crucial aspect of understanding the impacts of the Zero Suicide work conducted by the DA teams. It also guides the project and DA teams in future planning of quality improvement activities. In terms of broader program evaluation, the examination of the aggregated data from DAs helps assess the overall effectiveness of the changes they are collectively implementing.

The client-level data consisted of two measures:

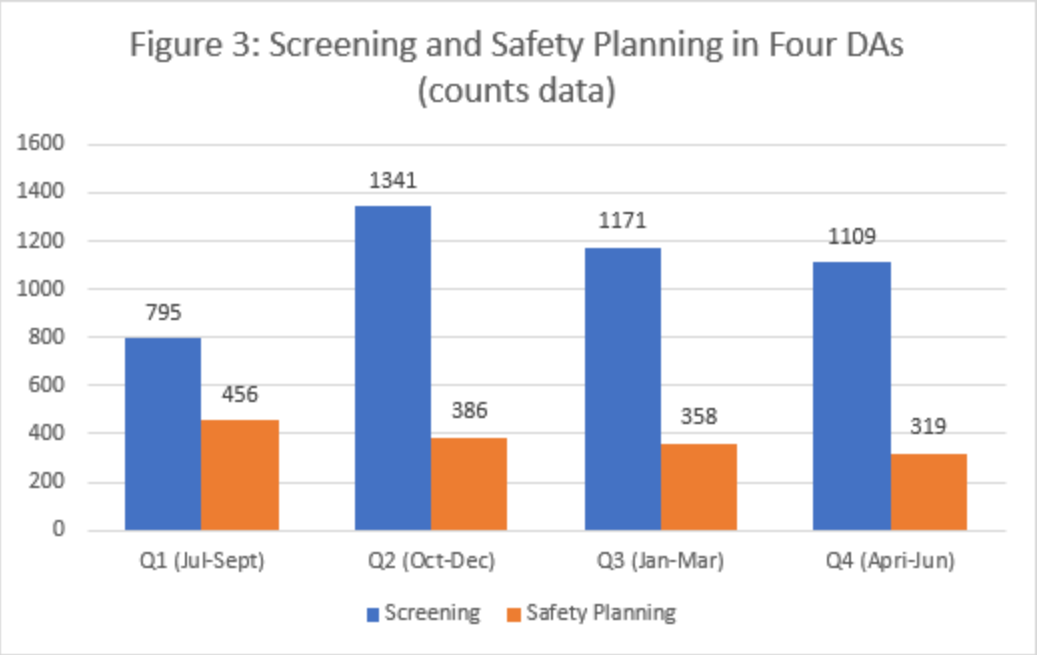
1) # of new clients who had documentation of a suicide screening occurring;
2) # of individuals who had positive screens and also had a safety plan documented within 24 hours of the positive screen.

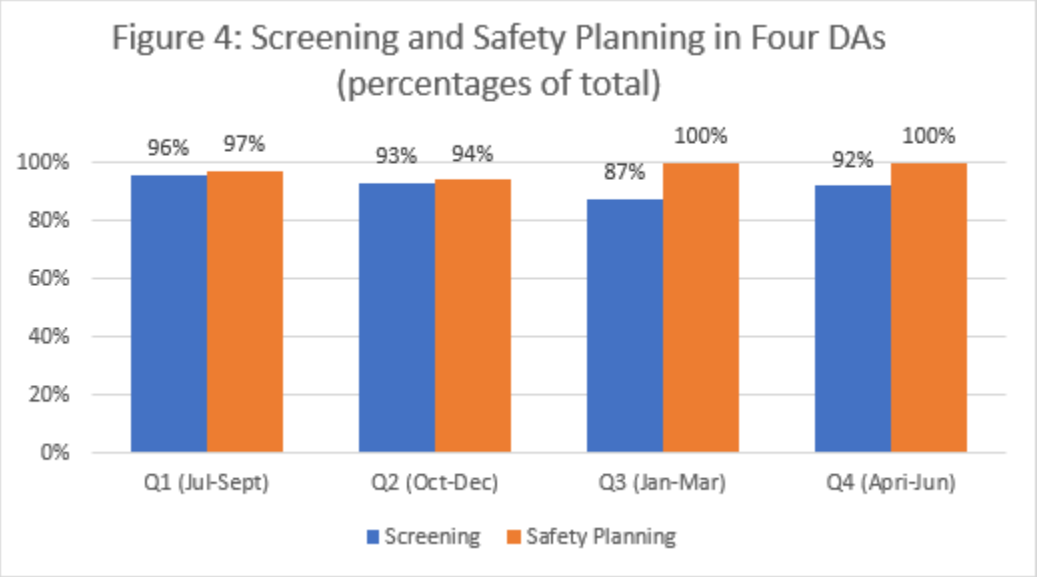
In addition to being reported as counts, these data were also converted into percentages to reflect the proportion of all new clients who were screened and the proportion of all individuals who screened positive and who also had a documented safety plan within 24 hours. These data were collected and reported quarterly by the DAs, starting with July-September 2021 through April-June 2022. The number of DAs providing data for quarters one through four was 3, 4, 3, and 2, respectively. Additional (back-filled) data is expected for Q4.

Trends in Screening and Safety Planning

Figure 3 below shows the counts data for the screening and safety planning documentation measures across the four quarters of the project year. These counts show considerable variability across time, which partly reflects changes in the number of people who entered services as well as the number of DAs that provided data each quarter. These counts do not, however, provide a picture of the proportion of individuals who received needed services—this is presented in Figure 2. In Figure 4 we see that the percentage of new clients who had documentation of a suicide risk screen at the time of starting services, aggregated across the reporting DAs, showed a negative trend from 96% in Q1 to 93% in Q2 and 87% in Q3, before rebounding slightly to 92% in Q4. Across all four quarters, 92% of new clients had documentation of a suicide risk screening being completed.

In contrast, the percentages of individuals who had a positive risk screen and subsequently had documentation of a risk assessment within 24 hours showed a mostly positive trend: 97% in Q1 to 94% in Q2 and then 100% in Q3 and Q4. Across all four quarters, 97% of positive screens had safety plans.





Client-level Data - Conclusions

The data presented in Figures 3 and 4 suggest high variability in the number of screenings that occur, although the true number of screenings is unknown. The proportion of all new clients who had documentation of a suicide risk screening was high relative to data in earlier years of the Zero Suicide initiative, with approximately 11 out of 12 new clients having evidence of a screening. When screenings did occur and were positive for the presence of risk, the reported data show a high proportion (97%) of these individuals having a safety plan documented in their record. These findings support the conclusion that participating DAs have made considerable strides in systematizing the care they provide in the areas of suicide risk detection and safety planning, although there remains room for improvement, particularly in the

area of documentation of screenings. Receiving additional data from DAs will help us understand how robust these improvements are.

Client-level Data - Limitations

Not all new clients who entered DA services were reported on, but instead, the numbers reflect clients who started services in one of the Service Areas that the DA is reporting on. For example, if Developmental Services was not actively implementing Zero Suicide-related changes, or if those data were otherwise not available, those counts would not be included in the quarterly reporting. Also important to note is that the DAs varied considerably in their ability to collect data each quarter, with some DAs providing data for all four quarters and others less frequently. This variability is attributable to several factors including turnover among DA personnel who were supporting data collection, challenges related to Electronic Health Records data collection and/or reporting capacity, and pandemic-related changes to services and data collection.

Suicide Prevention Training Participation Data

A total of 666 staff across the DAs participated in suicide prevention trainings offered by the Center for Health and Learning over the course of the project period from July 1, 2021 – June 30, 2022. Staff participation in Umatter Suicide Prevention Awareness, Introduction to Zero Suicide in Vermont, Collaborative Assessment for Management of Suicidality (CAMS), CAMS for Supervisors, and Columbia Suicide Severity Rating Scale (CSSRS) Interactive training is summarized below.

Table #3. Zero Suicide Training (CHL) July 1, 2021 – June 30, 2022

Trainings	Total Trained
Umatter Suicide Prevention Awareness Webinars (n=5) 10/7/21, 11/4/21, 12/2/21, 1/6/22 and 2/3/22	108
Introduction to Zero Suicide in Vermont: Suicide Safer Pathways to Care (n=2) 10/15/21 and 2/11/22	61
CAMS (2 Cohorts consisting of 6 calls each - call Series- Fall 21 and Spring 22) (n=2) 11/1/21, 11/15/21, 11/29/21, 12/6/21, 12/20/21, 1/3/22, 5/2/22, 5/16/22, 5/23/22, 6/6/22, 6/20/22, 6/27/22	336
CAMS for Supervisor (2 cohorts consisting of 2 calls each- Spring 2022) (n=2) 5/5/22 and 5/26/22	14
CSSRS Interactive Training (n=4) 11/18/21, 1/13/22, 3/10/22, 5/12/22	116
CSSRS Part II Interactive Training (n=2) 4/14/22, 6/9/22	31
TOTAL	**666**

Conclusion

The project provides a framework and structure to encourage and support the expansion of Zero Suicide principles and practices. All elements of the project demonstrated efficacy, and provide the basis for further supporting this work in these pathways of care. The project results continue to inform a set of lessons learned which can be applied to further expand the approach to workforce development, client services, and the focus on quality improvement.

APPENDIX 1

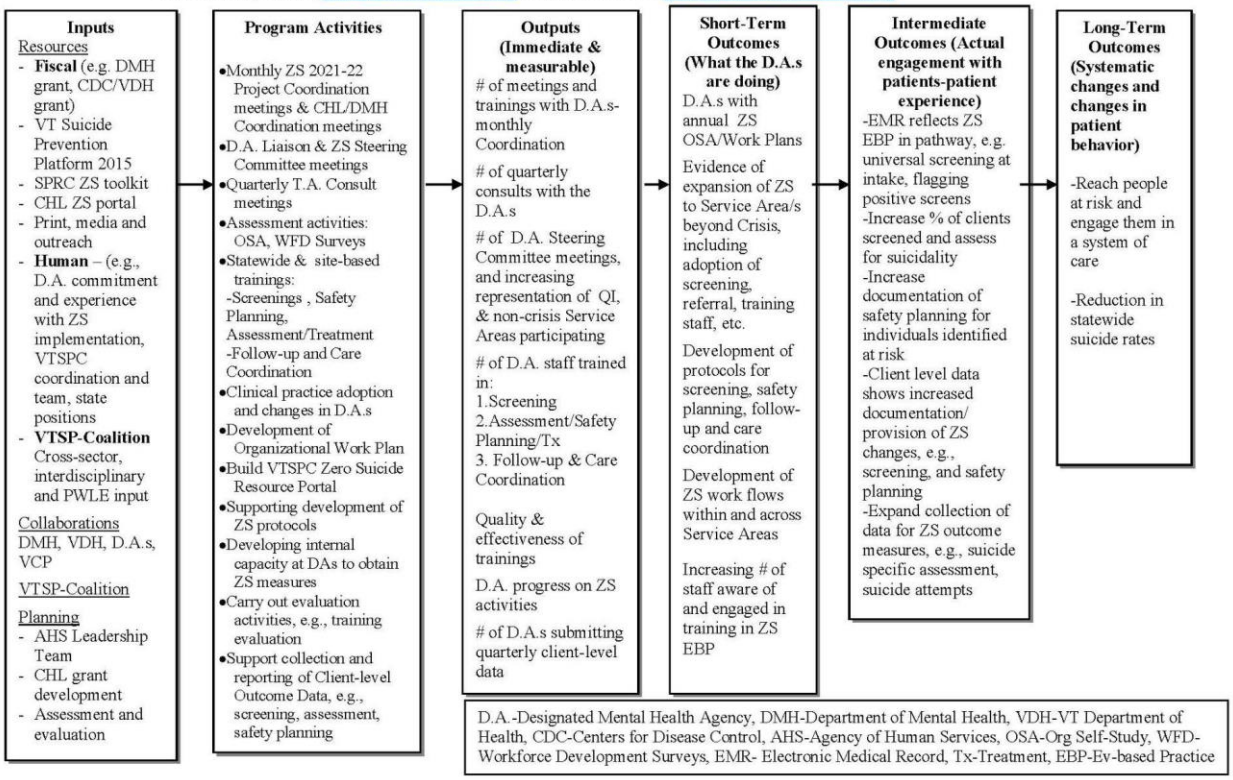
Zero Suicide (ZS) 21-22 Evaluation Logic Model – VT Suicide Prevention Center

Under funding from Department of Mental Health **211104**

Problem: **D.A.s and health care partners are developing and implementing suicide safer pathways to care aimed at increasing access to and delivery of quality care in order to reduce suicide deaths in Vermont.**

Program Focus: **Supporting the Designated Mental Health Agencies in identifying, implementing and measuring changes aimed at quality care that prevents suicide.**

For more information:: JoEllen Tarallo, Ed.D. joellen@healthandlearning.org, Tom Delaney, Ph.D. thomas.delaney@uvm.edu, Gabriel Reif, M.Ed., Gabriel.reif@gmail.com, Kirk Postlewaite kirk@healthandlearning.org



D.A.-Designated Mental Health Agency, DMH-Department of Mental Health, VDH-VT Department of Health, CDC-Centers for Disease Control, AHS-Agency of Human Services, OSA-Org Self-Study, WFD-Workforce Development Surveys, EMR- Electronic Medical Record, Tx-Treatment, EBP-Ev-based Practice

APPENDIX 2

Vermont Zero Suicide 21-22 Project Evaluation Design: July 1, 2021-June 30, 2022
Developing Infrastructure for Suicide Safer Pathways to Care
Under funding from Department of Mental Health to VT Suicide Prevention Center **211109**

Developed by VT Suicide Prevention Center (www.vtspc.org):

- JoEllen Tarallo, Ed.D., MCHES, Director
- Tom Delaney, PhD., Assistant Professor of Pediatrics at Larner College of Medicine at UVM
- Gabriel Reif, M.Ed., Consultant
- Kirk Postlewaite, M.S., LCMHS, Sr. Program Specialist

Overview of VTSPC

VTSPC is a public-private partnership of the Center for Health and Learning, a 501c3 that works with state agencies and partners to address priority issues. VTSPC works with professionals across sectors with education, health care and community providers to advance evidence and best practices for suicide prevention.

About the Designated Mental Health Agency System of Care

The Designated Agencies are organized under the Vermont Care Partners, a collaboration between the Vermont Council and the Vermont Care Network of sixteen non-profit community-based member agencies offer care to Vermonters affected by developmental disabilities, mental health conditions, and substance use disorders. There are seven Designated Mental Health Agencies committed to activities required by the project:

- Health Care and Rehabilitation Services
- Howard Center
- Lamoille County Mental Health
- Northeast Kingdom Human Services
- Northwestern Counseling Support Services
- Rutland Mental Health
- Washington County Mental Health

Background on the Project and Evaluation

The Zero Suicide 2021-22 Project was developed and is managed by the VTSPC working concurrently with statewide advisors and stakeholders to support the integration of Zero Suicide into clinical practice and organizational policies and procedures leading to a suicide care pathway within and between organizations. The Evaluation supports the collection of data to inform program processes and outcomes. Please see the corresponding Logic Model.

Evaluation Approach and Methods

The overall aim is to assess and collect data on the process and outcomes of program activities designed to advance best practices for promoting high quality suicide prevention care.

1.1 Support the implementation team at each DA in conducting and interpreting the results of the assessments, i.e., Organizational Self-Study and Workforce Development Surveys and identifying priorities for an actionable annual work plan.

1.2 Track DA program activities, including T.A. and training, to support fidelity to the project design and inform progress on ZS activities.

1.3 Work with DA to increase the # of staff aware of and engaged in training in ZS EBP.

1.4 Collect, analyze and report on data related to the quality and effectiveness of training.

1.5 Provide technical assistance aimed at increasing the organization's capacity for collecting and reporting on ZS client-level outcome measures.

1.6 Report to the DA teams, DMH and other stakeholders about the DAs' progress and performance on the client level outcome measures, for screening, safety planning, and assessment, both for individual DAs' performance and across all of the sites.

1.7 Track the development of protocols for screening, safety planning, assessment, follow-up and care coordination.

1.8 Track the development of work flows for each service area. Note: The aim is to have one workflow for each Service Area, or one workflow for Crisis and a minimum of one other Service Area.

Methods

The measures described below will be used during the 2021-2022 project year, and in conjunction with the Logic Model will be the basis for assessing progress towards the Zero Suicide 2021-22 goals. Methods include tracking and documentation of meetings and trainings, evaluating training, reports on assessment activities, and collection of client level data.

1. Zero Suicide Client-level Measures

Currently being collected and reported by five of the seven participating DAs. The measures were adopted form the national Zero Suicide initiative's measures and agree to by the current cohort of DAs in January, 2020. These are defined in the document ZS Outcome Measures Reporting Template, and include: 1) the proportions of clients screened for suicide risk, 2) the proportion of clients with documentation of a safety plan developed within 24 hours of the client's identification of risk for suicide. Individual DAs determine which service areas are included in this reporting, however there is an expectation that as their capacity for reporting increases additional service areas will be included in reporting. DAs are supported in this work by Tom Delaney, and the implementation teams at the DAs are encouraged to involve IT and QI staff, as well as direct service providers and managers/leaders.

2. Organizational Self-Studies (OSS)

All participating Agencies will have completed the Zero Suicide Organizational Self-Study tool at least once. This assessment informs the development of the Zero Suicide work plan for the D.A.

3. Workforce Development Survey (WDS)

All D.A.s have carried out WFD Survey in the past three years. The results of the Workforce Development Survey will be used to identify training needs across the DAs, and will inform the development of statewide and site – specific training plans.

4. Key Process Measures

- Participation in monthly Coordination and quarterly Steering Committee meetings
- Engagement of site-based implementation teams (or Steering Committees)
- Creation/updating of work plans
- Development and adoption of protocols and workflows
- Participation in client-level measures collection and evaluation surveys
- Engaging in continuous quality improvement

5. Training-Related Measures

- Participation in trainings
- Participant evaluation of training design, usefulness, and effectiveness.

Reporting and Timeline

All activities will be carried out between July 1, 2021 and June 30, 2022, and summarized in a final report to the Department of Mental Health by July 31, 2022.

Vermont Zero Suicide Evaluation Tools and Timeline **APPENDIX 3**

- ZS Coordinator meetings agendas and notes (monthly)
- ZS Organizational Self-Studies (reviewed annually)
- ZS Work Force Development Survey (implemented every 2 years)
- ZS Site-based Work Plans and T.A. Tracking (annual and updated quarterly)
- Client-level Outcome Measures Reporting Template (quarterly*)
    - Safety planning, screening, and assessment for individuals at risk
- Training Evaluation Tracking and Summaries
    - Participation, quality, effectiveness
- DA Zero Suicide Planning and Reporting Survey (Closing December 31, 2021)
    - Formative data to inform planning and technical assistance
- DA Zero Suicide Year-End Outcomes Survey (Closing June 30, 2022)
    - Outcomes data relative to progress made