House Bill 2012-1140

Suicide Prevention and Follow-Up in Colorado Hospitals

In May 2012, Governor Hickenlooper signed House Bill 1140 into law, which amended Colorado Revised Statute 25-1.5-101(1)(w)(III)(A) concerning the duties of the Colorado Department of Public Health and Environment as coordinator of suicide prevention programs throughout the state. The amendment requires the Office of Suicide Prevention (Office) to provide Colorado hospitals with information and materials about risk factors and warning signs for suicide, treatment and care after a suicide attempt, and available community resources for suicidal individuals. Although not mandated, hospitals are encouraged to provide the information and materials to individuals and families who are in the emergency department or hospital for a suicide attempt or for making a suicidal gesture.

A prior suicide attempt is the number one risk factor for suicide death, and appropriate after-care in the hours and days following hospital discharge is critical. These materials are designed to guide individuals and families through the after-care process, and to better equip emergency department and hospital staff to effectively assess, manage and treat suicidal patients. The Office partners with the Colorado Hospital Association, emergency departments, and community mental health centers statewide to ensure that materials are delivered to the most appropriate personnel serving patients appearing in emergency departments following a suicide attempt.

Once identified within each emergency department (ED), the primary contact provided information on the level of contact staff has with suicidal patients, and whether suicide assessments are done in house, by a contracted mental health agency, or some combination of the two. Thirty-five EDs reported conducting all evaluations in-house, 42 reported contracting services out entirely, and eleven reported some combination of the two procedures.[1] If suicide risk assessments are performed by an outside agency, that agency was also contacted to identify a point person within the organization (18 total). Contact information was obtained for the individual identified by the site to be best situated to disperse materials and information to all appropriate staff.[2]

Because the focus of the project is to get materials into the hands of patients and families following a suicide attempt, the Office targeted its outreach to systems touching this population- EDs who do some level of in-house assessment, community mental health centers providing assessment and discharge services to EDs, and psychiatric acute care hospitals. In the spring of 2015, materials were provided

[1] i.e., in house for privately-insured clients, outside agency for Medicaid clients; or in-house during business hours, outside agency after normal business hours.

[2] 23 of the 42 EDs entirely outsourcing the assessments did not provide contact information for staff, but contact information was obtained for the community agency providing those services.

electronically via email to each contact serving the emergency department, community mental health center, or psychiatric hospital. The email also included instructions and a link for ordering additional print materials at no charge.[3]

A follow-up survey was sent at the end of April 2015. Seventy-nine responses were provided covering eighty-three total entities (56 EDs, 18 mental health centers, and 9 psychiatric acute care hospitals).[4] Of the facilities surveyed, 86 percent responded, providing a good overview of protocols and practices for the systems providing emergency care to suicidal patients including large urban and small rural facilities from every region of the state.

Survey Results:

1. Emergency Departments

Responses were provided by 56 EDs statewide. 47 percent of respondents indicated that the hospital routinely screens all patients regardless of age for depression or suicidality.[5] Of those responding, 33 percent conducted in-house assessment for suicidal patients, 22 percent provided in-house for all but Medicaid patients, and 44 percent contracted with a mental health agency for assessment services. For those utilizing an outside agency, 65 percent also used the agency for all discharge and admission coordination and planning services, the remainder was joint coordination between the ED and the agency. Significant differences were found for services and materials provided to patients depending on whether assessment was performed in house or referred out to a mental health center.

Sixty-four percent of responding EDs conducting in-house assessments and discharge services reported utilizing the Office provided resources (compared to 51% last year). The main reason given by sites not using the materials was that other resources were being utilized and provided to patients.[6]

Additionally, 88 percent of EDs performing in-house evaluations reported that staff always counsel a patient who has been treated for a suicide attempt (or family member of a patient) on temporarily storing any firearms away from the home or locking them in such a way that the patient has no access (68% reported this counseling all the time in regard to lethal medications).

On the other hand, for EDs using an outside mental health agency for assessment, but whose ED staff remains engaged in discharge services, 71 percent of the ED respondents reported providing the Office materials to patients at the time of

[3] In the first year of implementation of HB 1140, the Office mailed bulk print materials to each emergency department, but found in follow-up assessment that the materials were not well utilized. In the second year, the Office provided sample materials along with a cover letter explaining how to order additional print materials for the site. Again, materials were not widely utilized and sites did not take advantage of ordering additional resources.

[4] Please note that as the survey was sent to the community mental health centers which serve the 42 EDs outsourcing evaluations, that the survey was not sent to the 23 EDs for which there was no identified staff contact.

[5] A smaller percentage (29%) reported screening only patients presenting with a behavioral or mental health complaint.

[6] Only 20 percent of these EDs reported not being aware of the materials, an improvement over prior years.

discharge. There also seems to be a difference in perceived services provided as only 29 percent of EDs using an outside mental health agency reported counseling on lethal medication all of the time (43% all of the time for counseling on firearm access), whereas the community mental health centers serving these EDs reported providing the counseling on a more regular basis.[7]

2. *Community Mental Health Centers*

All eighteen mental health agencies surveyed provided responses.[8] The most significant difference was that only 24 percent of these agencies were utilizing the materials provided by the Office, and of the remaining sites, 57 percent responded that they were unaware of the resources. Positively, 81 percent of responding mental health centers reported some standardized follow-up protocol to contact clients post discharge, with most reporting some level of phone outreach.

3. *Psychiatric Acute Care Hospitals*

Nine of the thirteen psychiatric acute care hospitals responded to the survey. Fifty-six percent reported using Office materials. Half not using Office materials reported being unaware of the resources. All nine hospitals reported counseling for both lethal medications and firearms *all of the time* but only 44 percent reported having a standardized protocol for following up with patients post discharge.

Training

Regarding training needs, mental health agencies and psychiatric hospitals were most interested in receiving training geared towards increasing treatment compliance with discharge instructions and other available follow-up supports once a patient is discharged. Preferred training modality was split between online (44%), live webinar (28%) or in-person (28%).

Of responding EDs, 71 percent reported a desire for training on caring for suicidal patients within the ED setting and 59 percent reported a desire for training on treatment compliance or screening and risk assessment. The majority of EDs (83%) reported that online training would be the most feasible.

The HB 1140 process and initial outreach to sites served as the platform to gauge EDs receptiveness to the Commission's ED Pilot Project. Sites were selected after gauging administrative support, volume, location, and a lack of standardized protocol for follow-up with discharged patients. Given the results of the HB 1140 Survey, the Commission's Pilot Project should be expanded to include psychiatric acute care hospitals as well.

[7] 81% reported all of the time counseling on lethal medication restriction, and 90 percent reported counseling all of the time on firearm access.

[8] Aspen Hope, Aspen Pointe, Axis Health, Aurora Mental Health Center, Mental Health Partners (Boulder County Mental Health Center), Centennial Mental Health, Center for Mental Health, Community Reach, Jefferson County Mental Health, Mind Springs, Northeast Behavioral Health, Porter PET Team, San Luis Valley Mental Health Center, Southeast Health Group/Southeast Mental Health, Spanish Peaks Behavioral Health, Solvista Health (West Central Mental Health), West Pines Behavioral Health

There are currently no statewide standards for what information and materials hospitals provide after a suicide attempt. The survey helps identify common practices and needs across the state. Findings from the survey will continue to inform the implementation and priorities of HB 1140, the Office, and the Suicide Prevention Commission. Moving forward, outreach and survey activities will be expanded to inpatient discharge procedures and staff, assuming appropriate contacts can be identified.

For more information on HB 1140 or the results of the survey please contact sarah.brummett@state.co.us