# Testimony to House Committee on Health Care

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## Background

Like many other health conditions, suicide is generally preventable. Research has shown that suicidality is a diagnosable and treatable mental health condition. The drivers are feeling alone, feeling hopeless and/or a burden, feeling isolated.

Suicide is complex – issues like bullying may be triggering events but would likely not alone cause suicide. We are learning more about how to prevent suicide in many sub-populations, youth, New Americans/refugees, older Americans, LGBTQ, incarcerated people, Veterans, etc. and each of these subpopulations need strategies that increase them to social supports. Middle aged men, for example, are an at risk group that requires unique strategies such as looking at support economically during job transitions, and encouraging work environments that encourage self-care and help seeking. Certainly, helping families cultivate skills for resilience in times of challenge and distress, and our work with Umatter Youth and Young Adults to cultivate skills in youth for self-care, coping, communication and help seeking are important and research based strategies. All these things increase connection; connection underlies every protective factor for suicide.

Suicide shares risk factors with substance abuse, bullying and harassment, traumatic events, including sexual abuse, violence, post-traumatic stress, as well as other mental health and societal conditions. To the degree that community members, providers and consumers of mental health services and institutions can be actively involved in learning about implementing and providing suicide prevention activities, we can all help to prevent suicide.

Suicide prevention requires comprehensive community based approaches supported by state and local systems including education, health care, community services, and which include policies, practices and public messaging based on best practice.

More than 70% of the people who die by suicide feel isolated and have not been in the health care system. Therefore I recommend we focus on getting people into a primary care system that is prepared to identify and respond and is part of n health system that has developed an integrated pathway to care, to and from the institutions which otherwise serve Vermonters.

**Background on the AHS recommendations to the Governor that form the basis of his budget proposal to the legislature:**

Organizations and individuals in Vermont have been working progressively for ten years through the Vermont Suicide Prevention Coalition to address suicide prevention in Vermont; The Coalition consists of over 70 representatives of organizations across sectors, and individuals with lived experience;The work carried out by the VT Suicide Prevention Coalition is aligned to the *National Strategy for Suicide Prevention* and the *Vermont Suicide Prevention Platform* (2015). The Agency of Human Services has established an inter-departmental Suicide Prevention Data and Surveillance Work Group to develop a data-informed suicide safe care system in Vermont.

AHS was charged through H.34 to provide a set of recommendations for suicide prevention in Vermont to the legislature for the 2020 session. The Governor has used the recommendations and included the first dedicated allocation for suicide prevention in his budget proposal to the legislature.

***The recommendations include:***

- ✓ Expand and bring to scale the National Suicide Prevention Lifeline to ensure call response occurs in Vermont.

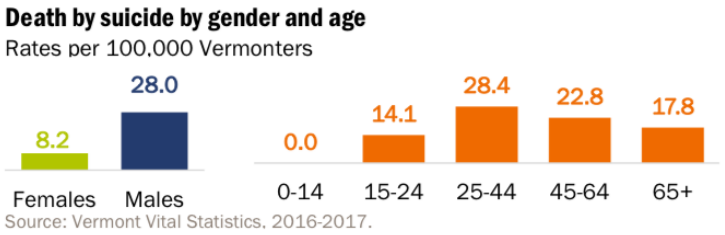
- ✓ Expand and bring to scale Zero Suicide an evidence-based set of principles and practices, including workforce training for suicide prevention.
- ✓ Implement Mobile Response to provide support and intervention into the community improving access to care and averting crisis response at the Emergency Room.
- ✓ Support the Elder Care Clinician Program and address social isolation for older Vermonters.
- ✓ Promote protective factors for youth and families and create prevention-prepared school communities.
- ✓ Address the role of access to lethal means and safe storage practices for firearms.
- ✓ Employ other measures to support the building of sustainable and integrated infrastructure for suicide prevention in Vermont for mental health promotion and suicide prevention, intervention, and postvention;

**Conclusion**

This year the VT Suicide Prevention Coalition calls upon the Legislature to support the recommendations of the Governor and the AHS Suicide Prevention Work Group, based on established needs, and with input from the VT Suicide Prevention Coalition.

**Relevant Data**

Suicide is a national public health problem, with more than 45,000 Americans dying by suicide each year and rates increasing among people ages 10-75. 125 Vermonters died by suicide in 2018.




*Older Vermonters*

- Middle aged and older Vermonters have higher rates of suicide than the national average, especially those aged 25-55, 70-74 and 80-84. (source CDC WISQARS based 2011-2015 data)
- Highest Vermont death rates due to suicide are seen in middle age and older adult men.
- Although older adults attempt suicide less often than those in other age groups, they have a much higher completion rate because of the means they choose- predominantly firearms.

*Veterans*

- The number of Veteran suicides exceeded 6,000 each year from 2008-2017
- Firearms were the method of suicide in 70.7% of male Veteran suicide deaths and 43.2% of female suicide deaths in 2017
- In 2017, 10 Vermont Veterans died by suicide
- In 2016, 25 Vermont Veterans died by suicide

*Lethal Means- Firearm Safe Storage*

- Three in five intentional self-harm hospital visits are due to poisonings; three in five deaths by suicide are due to firearms. (*Source: Vermont Vital Statistics, 2016-2017. Vermont Uniform Hospital Discharge Data System, 2016-2017*)
- More than 50% of Vermonters who die by suicide used a firearm to end their own life.
- 43% of all Vermont households store firearms in or around the home.
- 17% of households with firearms in the home keep a firearm loaded.
- 65% of households with a loaded firearm in the home keep a firearm unlocked.

*Mobile Response and Zero Suicide*

- More than 70% of the people who die by suicide have not been in the health care system. Of those who seek help in the healthcare system, the majority die by suicide. Access to early intervention is important. Mobile Response reaches people in the community. Zero Suicide is a set of evidence-based principles and practices that improve health outcomes when people seek help in mental health and healthcare systems.

**Infrastructure in Vermont for suicide prevention**

**Health Communication**

UMATTER MESSAGING: SUICIDE IS PREVENTABLE and "You matter because you may need help and you matter because you may be in a position to help"

Like many other health conditions, suicide is generally preventable. Research has shown that suicidality is a diagnosable and treatable mental health condition. Suicide share risk factors with substance abuse, bulling and harassment, traumatic events, including sexual abuse, violence, post-traumatic stress, as well as other mental health and societal conditions. To the degree that community members, providers and consumers of mental health services and institutions can be actively involved in learning about implementing and providing suicide prevention activities, we can all help to prevent suicide. As such, VTSPC creates messaging on these themes. We use a multi-format messaging approach.

- Conducted public information and outreach
- VTSPC website had 19000 page views
- VT Crisis Text Line website had 92% new visitors and a 151% increase from 2017 with 5000 page views
- 700 people actively following VTSPC Facebook

**Health policy**

- Research and report dissemination on best practices including:
- Lethal means restriction and firearms, leading to the development of the Gun Shop Project to work with gun shop owners in Vermont
- We worked with community members, legislators and AOT to successfully mitigate the Quechee Bridge – an effort that occurred over five years.
- Worked with legislators to develop and pass H.184 requiring AHS to collect, analyze data and present reccs to the legislature.

**Workforce Development to create suicide safer pathways to care**

- 1149 people were trained in Suicide Prevention by VSPC in 2018.
- Worked with 135 schools in Vermont to train school teams to create prevention prepared communities which include training, protocols to guide suicide prevention and postvention and implementation of the Lifelines curriculum in grades 7-12. Recently we are responding to requests to tailor this to elementary schools and these adaptations have been made are being tested now.
- Trained 28 Umatter community level trainers
- Trained 200 participants in Umatter for Schools and Communities and other community trainings
- Trained 225 clinicians in CAMS – an EB assessment and treatment and 160 clinicians trained in Counseling on Access to Lethal Means (CALM)
- Engaged three Das as pilot sites for implementation of ZS, and six more about to undertake the work
- Developed the VT Zero Suicide Initiative- evidence-based set of principles and practices for creating suicide safer pathways to care in health care. Provided leadership and clinical training for 24 healthcare organizations including BCBS of VT, OneCare VT, VT Blueprint for Health, UVM Medical Center and VT independent providers
- In 2019 offered a series of six ZS webinars leading to a two day ZS Practice Institute, with more than 100 people and 25 health care organizations participating. In past years offered Institutes and annual Symposium to more than 1000 people.