Suicide is Preventable: Zero Suicide in Vermont 2/14/2019

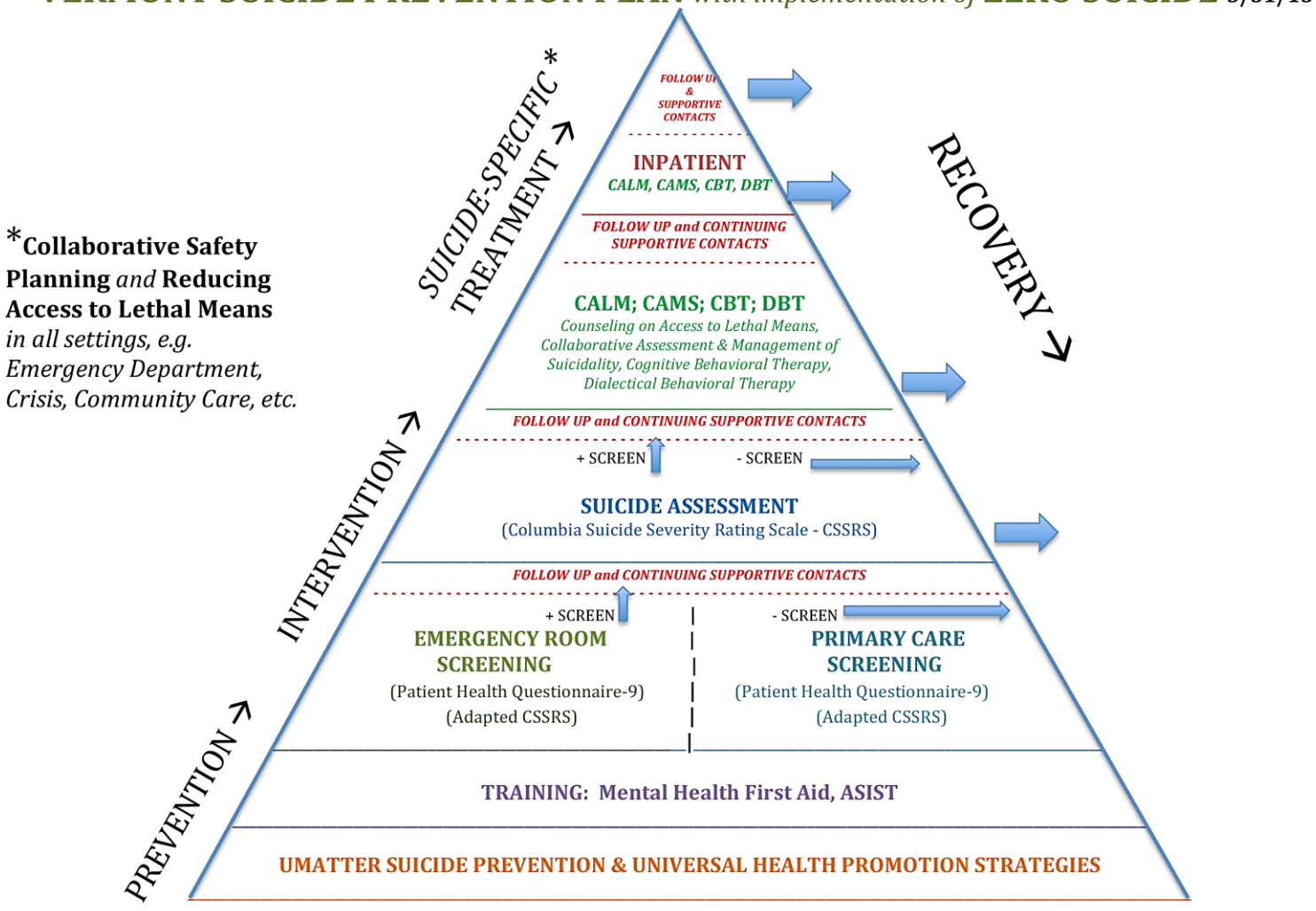
I am JoEllen Tarallo, Executive Director of the Center for Health and Learning, a 501c3, and Director of the VT Suicide Prevention Center, a public-private partnership with the Agency of Human Services. The VTSPC was created as a means of sustainability for suicide prevention following two federal grants in Vermont. We receive a small state allocation through DMH and raise the rest of the funds through foundation grants, contracts, and donors. The VTSPC is advised by a statewide Suicide Prevention Coalition, composed of more than 80 organizations and individuals concerned about suicide. We do a lot on a shoestring and we deal with this issue every day- not easy work. Under this funding the Coalition developed the VT Suicide Prevention Platform 2015 Suicide Prevention Across the Lifespan which serves as the guidance document for VT based on national best practice. It has a broad public health approach with 11 goals. One of the goals in to develop a pathway to care in health care that ensures people with suicidality are screened, identified, assessed, treated and receive followup, ongoing caring contact and care coordination. It turns out that low cost interventions like screening at every visit with an easy to use tool called the Columbia Suicide Severity Rating Scale, assessing and treating with the Collaborative Assessment of Suicide, and following up – none of which are costly, but all of which require a culture that destigmatizes mental health and leadership that ensures workforce development work to reduce suicide, along with other low cost interventions that include many forms of caring contact in follow up to a crisis.

The statistics on suicide as an escalating public health problem nationally, but especially in VT, are grim, as Dr. Delaney will describe. The VTSPC provides postvention support to many schools, campuses and communities following a suicide, have trained school teams from 130 public schools grades 7-12 in the Umatter Suicide Prevention program, developed here in VT, was approved as a national best practice program. We are also aiming to move upstream with youth on the problem through the Umatter Youth and Young Adults Mental Health Promotion program which receives small grants of support from DMH and VDH and is largely funded through foundations.

About five years ago it became clear in the national discourse that a large number of people seek help from the healthcare system and go on to die of suicide. This led to the emergence of an evidence based set of practices called Zero Suicide aimed at creating suicide safe practices in health care. Through the deliverables with the DMH we have begun to engage health care over the last two years. As reducing suicide deaths is one of the outcome measures of the All-Payer model this has reinforced the engagement of health care. The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. Zero Suicide requires a system-wide approach to improve outcomes and close gaps[10]. This morning we gathered health care leadership in a press conference to make **an explicit commitment to reduce deaths to suicide through the healthcare system.**

Mental health providers cannot curb the tide on suicide alone. They can adopt evidence based practices, and share the responsibility between Primary Care, Mental Health Services, Emergency Department/Crisis Response, In-patient units, and Recovery Supports is critical to prevent suicides. . My work is in systems change and development of high quality programming. I have had to learn about advocacy and how to leverage policy. So we come asking you to entertain this issue of preventing suicide and how you can bring whatever leverage you have as a Committee to bring more focus to the core values of Zero Suicide, systems management and evidence based practices in health care. Currently there is a $220,000 allocation for all the work that we do in the field. We are making good strides in building infrastructure in state government but the field has tremendous needs for WFD and technical assistance, data and surveillance that must be supported. We stand by to support and help with capacity building, planning, implementation and evaluation of such practices and ask you to consider what levers of influence you have to bring to bear on a rising crisis for which we do not want to be known in Vermont.

VERMONT SUICIDE PREVENTION PLAN *with implementation of* ZERO SUICIDE 5/31/15



Peer Support, Support of Survivors, Involvement of People with Lived Experience

VT SPC Suicide Prevention Center

VERMONT Department of Mental Health

Vermont Suicide Prevention Programs

Vermont Gun Shop Project (VT GSP)
http://vtspc.org/gun-shop-project/
H.184 (Act 34) Evaluation of Suicide Profiles

Quechee Bridge Mitigation
http://vtrans.vermont.gov/planning/projects-programs

Zero Suicide Pilot Projects

VT Suicide Prevention Partnerships

VT Suicide Prevention Center
www.vtspc.org

Vermont Suicide Prevention Coalition
http://vtspc.org/about-vtspc/coalition/

Vermont Child Health Improvement Program (VCHIP)
https://www.med.uvm.edu/vchip

Resources for Survivors of Suicide Loss

A packet for survivors of suicide loss was produced for Vermonters. You may request the packet at *info@healthandlearning.org.*

References:

1. National Action Alliance for Suicide Prevention (www.zerosuicide.org)
2. American Foundation for Suicide Prevention, 2015
3. AFSP, 2015
4. Vermont Department of Health, 2017
5. AFSP, 2015
6. Centers for Disease Control, Web-Based Injury Statistics Query and Reporting System (WISQARS), 2016
7. Dr. Alex Crosby, CDC, 2015 American Association of Suicidology presentation
8. VDH, 2017
9. National Violent Death Reporting System (NVDRS), 2015
10. Suicide Prevention Resource Center (SPRC)

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