VERMONT

**State of Vermont**
Department of Mental Health
280 State Drive, NOB 2 North
Waterbury, VT 05671-2010
http://mentalhealth.vermont.gov/

*Agency of Human Services*

[phone] 802-241-0090
[fax] 802-241-0100
[tty] 800-253-0191

# MEMORANDUM

**TO:** Representative Lori Houghton, Chair, House Committee of Health Care

**FROM:** Alison Krompf, Deputy Commissioner, Department of Mental Health

**DATE:** March 16, 2023

**RE:** Suicide Prevention Follow Ups from 3.14.23 Testimony

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## Postvention:

1. *Provide more clarity on second to last data point of postvention DA Slide, POSTVENTION FINDINGS FROM ZERO SUICIDE 2022 DESIGNATED AGENCY END OF YEAR REPORTING SURVEY: "FOllow up or long-term outreach, education and supports to organizations (schools, employers) that have experienced a suicide death"*
   *0% of DAs providing*
   *The Committee would like further clarification on what this means.*

   The questions within the Postvention Findings Slide were developed to capture specific responses from our DA partners in terms of what services they are providing related to postvention. The percentages represent the answers given by the DAs and indicate what services the DAs are offering, not what their respective communities are accessing. For the specific questions being addressed, "Follow up or long-term outreach, education and supports to organizations (schools, employers) that have experienced a suicide death", 0% of the DAs are providing long-term supports at this time. However, 86% of our DAs are providing short-term outreach, education, and supports. We address that point to indicate that DAs are working with their communities to immediately address suicide deaths and offer supports, typically through their Emergency Services Divisions. So, the discrepancy here is between short-term and long-term supports, and this can help frame future efforts to improve Postvention supports across communities in the long term, which is also addressed in the answer to question 2 below. The Department would also note that often what could be considered long-term supports, such as DAs offering Grief and Bereavement groups, long term individual therapy and other supports through time may not be captured in this set of survey questions. DAs certainly providing long-term and ongoing supports to communities and individuals in response to suicide loss, but that information can be missed as it is part of day-to-day embedded services and not necessarily as discrete service or outreach that is seen as specifically a Postvention service.

2. *Is CHL facilitating the postvention survey again during this current contract, or providing ongoing analysis of postvention services in another way?*

   *The* Center for Health and Learning (CHL) will again utilize this postvention set of questions in their end of the year survey through the Zero Suicide Project to capture any changes across this set of data, to allow tracking of changes through time

   Additionally, CHL is working with Vermont Department of Health through the Centers for Disease Control grant to address Postvention across the state. CHL's work will include a summary of the "Community Response to Suicide Loss" (Postvention) section of the CDC grant:

   -CHL will work with AFSP and other stakeholders to identify and possibly update resource materials for loss survivors, First Responders and Schools.

   -CHL will work with stakeholders who represent First Responders to plan and support 2 training events on postvention response for First Responders.

   -CHL will work with stakeholders who represent both First Responders and mental health crisis staff to develop and promote best practice guidelines for postvention response and coordination of support between First responders and mental health crisis staff.

3. *How many brief interventions/supports to loved ones immediately following a suicide were provided by the Designated Agencies in our last data cycle? Do we have this information?*

   *In short, we do not have this information readily available, if at all. The process of identifying a family member/friend/etc. of someone who died by suicide is very difficult in and of itself, which then we would need to* cross-check through MSR data to identify whether an identified individual received services of any nature through a Designated Agency. An important point to note is individuals may have sought services outside the system of care that the Department of Mental Health oversees, as the Department does not oversee private providers or have purview over them. Thus, someone could seek grief and loss counseling through a private provider with no affiliation with a Designated Agency.

**988:**

4. *Why is the Department requesting just $497,000 for 988, and not the full grant amount in FY25?*

   The request for $497,196 in FY25 is if $209,258 (current request is $275,200) will be added to the base budget of $440,159. When added together the total of these is $1,146,613 which is the full grant amount given our current level of service. The full grant amount is not a static number as the level of service changes frequently, and the level of service has increased since 988 began in July 2022. In other words, the level of funding determines the level of service Vermont Lifeline Centers can maintain.

5. *Why are the certain groups (LGBTQ+ Communities, Black, and brown communities, older adults, people living in rural areas, and people with functional disabilities) identified in the 988 partnerships? Provide information regarding the risk factors for these groups*

   *Across the United States and in Vermont, there are various populations at higher risk for suicidality*. Many factors contribute to these disparities including stigma, discrimination, social determinants of health, political determinants of health, barriers to care or culturally empathetic care, exposure to risk factors such as trauma, and those who have less access to protective factors such as community support.

   The below data is a snapshot from a 2021 Vermont Department of Health data brief on intentional self-harm and death by suicide. It provides a brief overview of certain Vermont populations that are at risk for suicidality:

**Populations at risk for intentional self-harm and suicide.**

LGBT students are more likely to feel sad or hopeless, make a suicide plan, or attempt suicide (sad 63% vs. 25%, plan 36% vs. 9, attempt 19% vs. 4%). LGBT adults are significantly more likely to have suicidal thoughts (12% vs. 4%).

Adults with a disability are 5 times as likely to report suicidal thoughts (10% vs. 2%).

Black, Indigenous, and People of Color (BIPOC) students are more likely to feel sad or hopeless, make a suicide plan, or attempt suicide (sad 34% vs. 30%, plan 17% vs. 13%, attempt 10% vs. 6%). BIPOC adults are more likely to have a depressive disorder (30% vs. 21%). BIPOC Vermonters represent 5% of suicide deaths.

Vermonters who served in the U.S. armed forces represent 20% of suicide deaths.

Social isolation is a risk factor for suicide. 9% of adults rarely or never get social and emotional support, with rates highest for those 65 years and older (13%).

6.

   LGBTQ+: The Behavioral Risk Factor Surveillance System (BRFSS) and the Vermont Youth Risk Behavior Survey (YRBS) provide valuable insight via survey data into the health-related risk behaviors, chronic health conditions, and use of preventive services of Vermonters. According to Youth Risk Behavior Survey Data, in 2019, 36% of Vermont adolescents that identity as LGBTQ+ had made a suicide plan in the past year. LGBT students are four times more likely to have made a suicide plan during the past year as compared to heterosexual/cisgender adolescents of the same age.

   People who identify as LGBTQ+ experience high suicide morbidity. We know that LGBTQ+ youth who have made a suicide plan are much more likely to experience other risk factors like

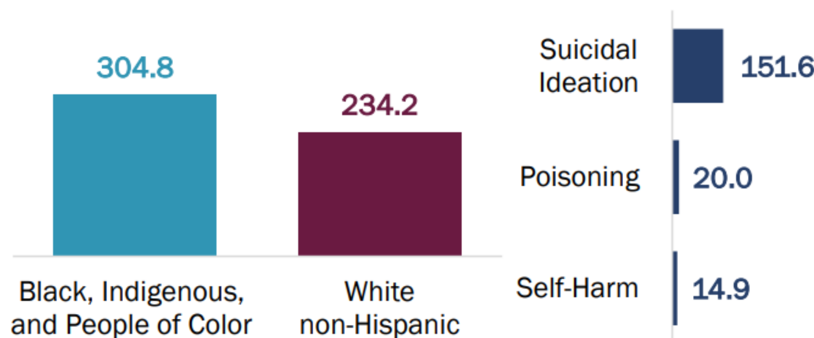
depression, intentionally hurt themselves, be bullied, misuse prescription medications, cannabis, or alcohol, or experience dating violence compared to students who have not made a suicide plan. They have fewer protective factors, especially feeling like they do not matter in their community.

Black and Brown communities: As of 2018, suicide became the second leading cause of death in Black children aged 10-14, and the third leading cause of death in Black adolescents aged 15-19 nationwide. A recent study conducted by the Centers for Disease Control and Prevention found that although the overall rate of suicide in the U.S. decreased by 3% in 2020, the rate of suicide among people of color and young people had increased. Similarly, the Center for Behavioral Health Statistics and Quality revealed that although Black adults reported lower percentages of suicidal ideation in 2021, rates of suicide attempts among Black adults were higher than any other racial or ethnic group.

In Vermont, Behavioral Risk Factor Surveillance System (BRFSS) and Vermont Youth Risk Behavior Survey (YRBS) reports have shown the following:

i. In 2019, the percentage of Vermont adolescents of color in grade 9-12 who had made a suicide plan in the past year (YRBS) was 17%.
ii. BIPOC adults are more than twice as likely to report rarely or never getting the emotional and social support they need, compared to white, non-Hispanic adults, a statistical difference.
iii. BIPOC adults are statistically more likely to have depression than white, non-Hispanic adults.

Further information on suicidality in People of Color have been shown through data offered by the Department of Health. This data covers a time period through September 30th, 2022, and represents Emergency Department visit rates for suicidal ideation and self-directed violence by sex and age group, through September 2022:



Older adults: Pre-2017 older Vermonters had the highest rates of suicide deaths of any age group. This rate decreased from 2017-2019, but increased in 2020. Currently the suicide rate is similar to the rate seen for Vermonters 25-64. Risk factors older Vermonters are rurality (rates for those 65+ are much higher in rural parts of the state) and firearms (75% male suicide deaths are firearms). They have fewer protective factors due to social isolation and experience tremendous loss and grief with deaths of loved ones and contemporaries.

People living in rural areas: There are multiple risk factors elevated in rural suicide deaths such as, use of firearms as means, possible mental health stigma, as evidenced by lower rates of mental health diagnoses and treatment compared to urban suicide deaths. Rural Vermonters represent 80% of all Vermont suicides and are less likely to have a mental health treatment at the time of their death.

People with functional disabilities: Another population that we recently learned about who experience high suicide morbidity are adults living with a disability. Those with a disability represent 61% of adults who seriously considered suicide in the past year. The type of disability can influence risk factors related to suicidality. Among disability categories, individuals with a cognitive limitation or complex activity limitation have the highest rates of suicidal behaviors.

Data also shows that the more disabilities a person has, the more likely they also considered suicide. Adults with three or more disabilities are more than twice as likely as those with one disability to seriously consider suicide (19% vs. 8%).

According to data from the Vermont Department of Health, Adults with a disability between 25 and 44 are most likely to seriously consider suicide in the past 12 months (17%).

**988 Lifeline Centers:**

7. *Who do we recommend the committee invite to hear testimony on the 988 call process?*

   Josh Burke at NKHS and Tony Stevens at NCSS. They are the experts in 988 at the respective agencies with Lifeline Centers.

8. *What are the types of calls (topics, what resources are being given, etc ) that 988 is getting?*

   The topics range from suicidal ideation to venting about a situation that the caller is asking someone to listen to. We get callers who are having a panic attack and want help, unable to sleep and needing some tools (recently recommended the sleep help line 03303 530 541), interpersonal distress and wanting some insight and reflective listening, etc. Others will look for grief groups in their area and the 211 database was used to gather that information and send it off to the caller.

9. *What is the process for 988 follow ups?*

The follow up process is to offer a follow up call to those with recent or current suicidal ideation. The utilization to date is relatively low. If a caller would like a follow up call, we get their permission, schedule the date and time for the call and mark it down for the program coordinator. We offer up to two check in calls in order to assist with connecting to the resource requested, if further assistance is needed and to debrief if the resource met their need.

10. *Is there any way to break call data down geographically? The Committee requested that the Department bring this data request to the Vibrant team to explore if other states have done this*

    Yes, each Lifeline Center receives a monthly report on the geolocation of the incoming call to 988.

11. *Is the 988 pilot for Suicide & Crisis Lifeline LGBTQ+, being answered by Vermonters or a national center?*

The 988 LGBTQ+ pilot is being answered by a national center.

12. *Do the 988 Pilot lifeline call staff identify as being of the same community (LGBTQ+ Communities, Black, and brown communities, older adults, people living in rural areas, and people with functional disabilities as the populations they intend to serve?*

    Call responders do not identify their sex, gender, geolocation, etc.