Suicide Care, Supports & Services

Vermont Care Partners Network

Testimony to Vermont HHC February 11th, 2026

A statewide network of 16 non-profit community-based agencies providing mental health, substance use, and developmental disability services and supports — serving 38,000+ Vermonters and their families.

The VCP Network: Your Community Partners in Suicide Prevention

- 16 agencies serving all 14 Vermont counties
- 12,000+ Vermonters trained in Mental Health First Aid
- Evidence-based practices: CAMS, C-SSRS, DBT, Safety Planning
- Suicide Safer Care Pathways with hospitals and FQHCs statewide
- Youth programs reaching hundreds of students annually
- Postvention and community healing support after every loss

Suicide is preventable. With continued support, the VCP network will keep Vermonters safer — community by community.

What is a Designated Agency?

We are your community-based experts in MH/SUD and DS Services

Specialized, Long-Term Support

Designated agencies provide ongoing, community-based behavioral health and developmental services — intensive case management, residential programs, psychiatric services, and peer support — that extend far beyond short-term interventions, ensuring critical support of Vermonters and partners like primary care, hospitals, and first responders.

Safety Net for Vulnerable Populations

They serve as Vermont's essential safety net, ensuring access to mental health, substance use, and developmental disability services regardless of insurance status or ability to pay.

Continuity for Complex Needs

Designated agencies maintain sustained care coordination across months or years for individuals with chronic behavioral health conditions, filling the critical gap between acute hospital treatment and routine medical care.

VERMONT

16 Designated Agencies
Serving All 14 Counties

- Addison
- Bennington
- Caledonia
- Chittenden
- Essex
- Franklin
- Grand Isle
- Lamoille
- Orange
- Orleans
- Rutland
- Washington
- Windham
- Windsor

Designated agencies are the backbone of Vermont's community based mental health/SUD and DS health infrastructure.

Suicide in Vermont: A Public Health Crisis

104
Vermonters died by suicide in 2024

~6,000
Suicide-related ED visits in 2024

16.1
Deaths per 100,000 residents (2024)

Key Findings

- Vermont's suicide rate has consistently exceeded the national average for 15+ years
- Suicide death rate peaked at 22.0 per 100,000 in 2021, declining to 16.1 in 2024
- Firearms account for more than half of all suicide deaths in Vermont
- 7% of VT high school students attempted suicide in the past year — a significant increase since 2019

Source: Vermont Department of Health, Annual Suicide Data Report, June 2025

Populations Disproportionately Affected

Males

4x

more likely to die by suicide than females

Young Adults (18-24)

Highest

rate of serious suicidal ideation among adults

Youth (15-44)

Highest

rates of suicide-related ED visits

BIPOC Students

2x

as likely to attempt suicide compared to white peers

LGBTQ+ Youth

Higher

rates of suicide morbidity among adults and youth

Service Members and Veterans (2024)

2x+

more likely to die by suicide; 15% of all suicide deaths

Vermont's suicide rate growth is among the fastest in the nation. Suicide is not only a mental health issue — it is a community issue.

Source: VT Dept. of Health Annual Suicide Data Report 2024; VT YRBS 2023; VT BRFSS 2022

Evidence-Based Community Supports for Suicide Care

The 2024 National Strategy for Suicide Prevention and CDC's Suicide Prevention Resource for Action identify these as the highest-impact community-level strategies.

1 Social Connectedness & Belonging

The single most protective upstream factor. Programs that foster sense of belonging, reduce isolation, and strengthen family/peer/community bonds. School-based programs, community engagement, and cultural connectedness initiatives.

2 Lethal Means Restriction

Strongest evidence for reducing suicide deaths. Counseling on access to firearms and medications during elevated risk. Firearms account for >50% of VT suicide deaths — means restriction is one of the most effective prevention strategies.

3 Gatekeeper Training at Scale

QPR, MHFA, and ASIST expand the number of community members who can recognize warning signs and intervene. Builds a distributed early detection network embedded in schools, workplaces, and neighborhoods.

4 Universal Screening in Health Systems

Evidence-based screening (C-SSRS, ASQ) in EDs, primary care, and crisis settings shifts care from reactive to proactive. NKHS data: self-report identifies 11% of SI — standardized screening identifies ~50%.

5 Crisis Continuum & ED Diversion

988 Lifeline, Mobile Crisis, and mental health urgent care (Front Porch) provide a full crisis continuum. Sustained follow-up — not one-time contact — is a protective factor against re-escalation.

6 Peer Support Integration

Peers with lived experience normalize help-seeking, reduce stigma, co-develop safety plans, and bridge clinical care with community life. Effective across crisis, stabilization, and recovery settings.

7 Postvention & Loss Support

Debriefing, counseling, and community outreach after a suicide loss prevents contagion and supports survivors. LOSS Teams and Caring Communities provide systematic response when communities are impacted.

8 Social Determinants of Health

Housing, economic stability, food security, and education create feedback loops that amplify or reduce suicide risk. People with SUDs have 10-14x greater risk. Addressing root social conditions is essential.

Zero Suicide Framework Across the VCP Network

Evidence-Based Clinical Practices

CAMS Care
Collaborative Assessment and Management of Suicidality — therapists across agencies report clients stating this model has saved their lives

C-SSRS
Columbia Suicide Severity Rating Scale — standardized screening implemented network-wide

Stanley & Brown Safety Planning
Evidence-based safety planning intervention for individuals at risk

DBT Programs
Robust Dialectical Behavior Therapy programs for suicide intervention — clients report decreased suicidal ideation and self-harm

CALM
Counseling on Access to Lethal Means — reducing access to firearms and other lethal means

System-Level Initiatives

Active Zero Suicide Committees
Agencies like NKHS (since 2016) and WCMHS maintain active committees with monthly workplans and cross-departmental representation

Suicide Safer Care Pathways
Shared pathways with local hospitals and FQHCs to ensure warm handoffs from EDs — no one slips through the cracks

UMatter Staff Training
All employees across roles trained in suicide prevention and intervention — not just clinical staff

LOSS Teams
Local Outreach for Suicide Survivors — pilot participation with anticipated launch in 2026

Postvention Support
Caring Communities sessions and suicide loss support groups for community healing after loss

VCP agencies are recognized statewide leaders in implementing the Zero Suicide Framework.

Clinical Supports: Intervention & Treatment

CAMS Care

Collaborative Assessment & Management of Suicidality

A therapeutic framework where clinician and client work side-by-side to understand and treat suicidal drivers. Therapists across VCP agencies report clients stating this model has saved their lives.

ASIST

Applied Suicide Intervention Skills Training

A two-day intensive, interactive workshop in suicide first aid. Teaches participants to recognize risk, conduct a suicide intervention, and develop a safety plan. VCP agencies maintain certified instructors for ongoing delivery.

DBT

Dialectical Behavior Therapy

A comprehensive evidence-based treatment for individuals with chronic suicidal ideation and self-harm. Robust DBT programs across agencies — clients report decreased suicidal ideation and self-harm urges. Multiple clients have stated this treatment saved their life.

Stanley & Brown Safety Planning

Evidence-Based Safety Planning Intervention

A brief, collaborative intervention that creates a prioritized, written list of coping strategies and support sources for individuals experiencing suicidal crises. Implemented across VCP agencies as standard practice following risk identification.

Clinical Supports: Screening, Training & Peer Support

C-SSRS

Columbia Suicide Severity Rating Scale

A standardized, evidence-based screening tool that measures suicidal ideation and behavior severity. Implemented network-wide across VCP agencies. Used in EDs, primary care, and crisis settings for consistent, accurate risk assessment.

ASQ

Ask Suicide-Screening Questions

A brief, validated 4-question screening tool developed by NIMH for use in medical settings. Used at ED triage for universal suicide screening — identifies patients who need further suicide risk assessment, including those presenting for non-psychiatric reasons.

CALM

Counseling on Access to Lethal Means

Training and clinical practice focused on reducing access to firearms and other lethal means during periods of elevated suicide risk. A critical component of safety planning — addressing means restriction as one of the most effective suicide prevention strategies.

QPR

Question, Persuade, Refer

A gatekeeper training that teaches anyone to recognize warning signs, offer hope, and refer to help. VCP network has trained 2,020+ participants across 137 sessions since 2017. Available monthly on Zoom and in-person by request.

MHFA

Mental Health First Aid

Available in teen, youth, and adult formats. Breaks down stigma and builds help-seeking skills. VCP holds three active grants (VDH, DMH, SAMHSA) and has trained 12,000+ Vermonters since 2014, with 97.9% demonstrating knowledge improvement.

Peer Support

Peer-Delivered Suicide Care

Trained peers with lived experience are integrated into crisis care settings including Front Porch, where 100% of guests receive peer involvement. Peers provide non-clinical support, normalize help-seeking, co-develop safety plans, and model recovery — reducing isolation and stigma.

Mental Health First Aid: Statewide Training Impact

12,000+
Vermonters trained since 2014

1,061
Mental Health First Aiders this year

97.9%
Demonstrated knowledge improvement

440
2025 Reported referrals from survey responses

VCP MHFA Grant Portfolio

Three active grants: VDH, DMH, and SAMHSA

SAMHSA grant alone: 50+ in-person, virtual, or hybrid trainings including teen, youth, and adult MHFA

Trainings emphasize safety with gun use and de-escalating a crisis

Growth trajectory: 267 (Year 1) → 728 (Year 2) → 1,061 (Current Year)

Training Formats

tMHFA — Teen Mental Health First Aid for high school students

yMHFA — Youth MHFA for adults who support youth

MHFA — Adult MHFA for adults supporting adults

All formats break down barriers and encourage help-seeking behaviors among participants

89%

Community
Disposition Rate

98%

988

96%

24/7 Mental Health Urgent Care

94%

VSP Embedded MHCS

85%

Mobile Crisis

Community-Based Prevention & Training

QPR — Question, Persuade, Refer (NKHS data)

Certified QPR Instructors since 2017

137 trainings offered • 2,020+ participants trained

~20 trainings per year incl. monthly Zoom and in-person

Since Sept 2025: 144 adults trained across 9 sessions

Pre-training: 30.66% rated understanding as high/very high

Post-training: 81.69% rated understanding as high/very high

Youth Prevention Programs

Gizmo's Pawesome Guide to Mental Health (NKHS Data)

Pre-K through 5th grade — 150+ youth since Sept 2025

It's Real: Teen Mental Health

Middle/high school — 200+ youth since Sept 2025

Proud multi-year partnerships with school districts including Kingdom East

Agencies invited into schools after loss for postvention and prevention

Postvention & Community Healing

Caring Communities

Informational sessions supporting loss survivors and re-entry into their communities — 4 sessions, 150+ participants since Sept 2025

Suicide Loss Support Groups

Staff being trained to facilitate suicide loss support groups in local communities

LOSS Teams

Local Outreach for Suicide Survivors — pilot underway with full launch anticipated in 2026

"This training allows me to reflect on the suicide situations I have witnessed... Thank you for all the hard work." — QPR Participant

Cross-System Partnerships & Suicide Safer Pathways

Suicide Safer Care Pathways

VCP agencies partner with local hospitals and Federally Qualified Health Centers to create Suicide Safer Care Pathways — ensuring warm handoffs for individuals presenting at Emergency Departments with suicidal ideation. These pathways ensure that no one slips through the cracks, connecting people in crisis directly with community-based clinical support.

Hospital & FQHC Partnerships

Agencies partner with local hospitals and Northern Counties Health Care (NCHC) through Zero Suicide Initiative pathways. Shared protocols like the CVMC-WCMHS Suicide Safer Care Pathway model warm handoffs and continuity of care.

State & Community Partners

Extensive collaboration with VPQHC and the Department of Health on system development across all spectrums of suicide prevention in community-serving organizations including NEKCOA, Umbrella, and NEKCA.

National Training Partners

Staff trained by QPR Institute, National Council for Mental Wellbeing, AFSP, and NAMI Vermont to deliver grass-roots suicide awareness and prevention trainings across our communities.

Crisis Workforce: Suicide-Specific Training & Capacity

ASIST — Applied Suicide Intervention Skills Training (NKHS Data)

3 certified ASIST instructors
training up to 24 participants per session
3–4 trainings offered per year

All Emergency Services staff are ASIST-trained
across Mobile Crisis, 988, Front Porch, and Embedded roles — creating consistent language, clinical judgment, and response expectations

Suicide-Specific Clinical Supervision

Provided across all crisis programs:
Mobile Crisis, Embedded Clinicians, Front Porch, 988

Focus areas:
Direct inquiry & assessment of suicidal ideation, risk formulation, lethal means counseling, collaborative safety planning, and transitions of care following crisis episodes

988 Lifeline Workforce Development

Training & Coaching

Continued training and calibration around suicide-specific call handling

De-escalation Focus

Engagement during acute suicidal distress with warm handoffs to Mobile Crisis and in-person care

Beyond the Phone

Suicide-related calls translate into coordinated, real-world support — not just a one-time conversation

Hospital & Health System Integration for Suicide Care Example –

NVRH Emergency Department: Universal Suicide Screening

All patients presenting to the ED are screened for suicide risk at triage using the ASQ.

Patients with suicide-related concerns receive a formal consultation with NKHS Emergency Services, who complete a C-SSRS following the initial ASQ screening — providing dual-measure confirmation and improved accuracy.

EMR integration allows tracking of suicide-related assessment completion rates and embeds screening tools directly into clinical workflows.

This approach identifies individuals who would otherwise be missed by complaint-based screening alone.

Primary Care Alignment

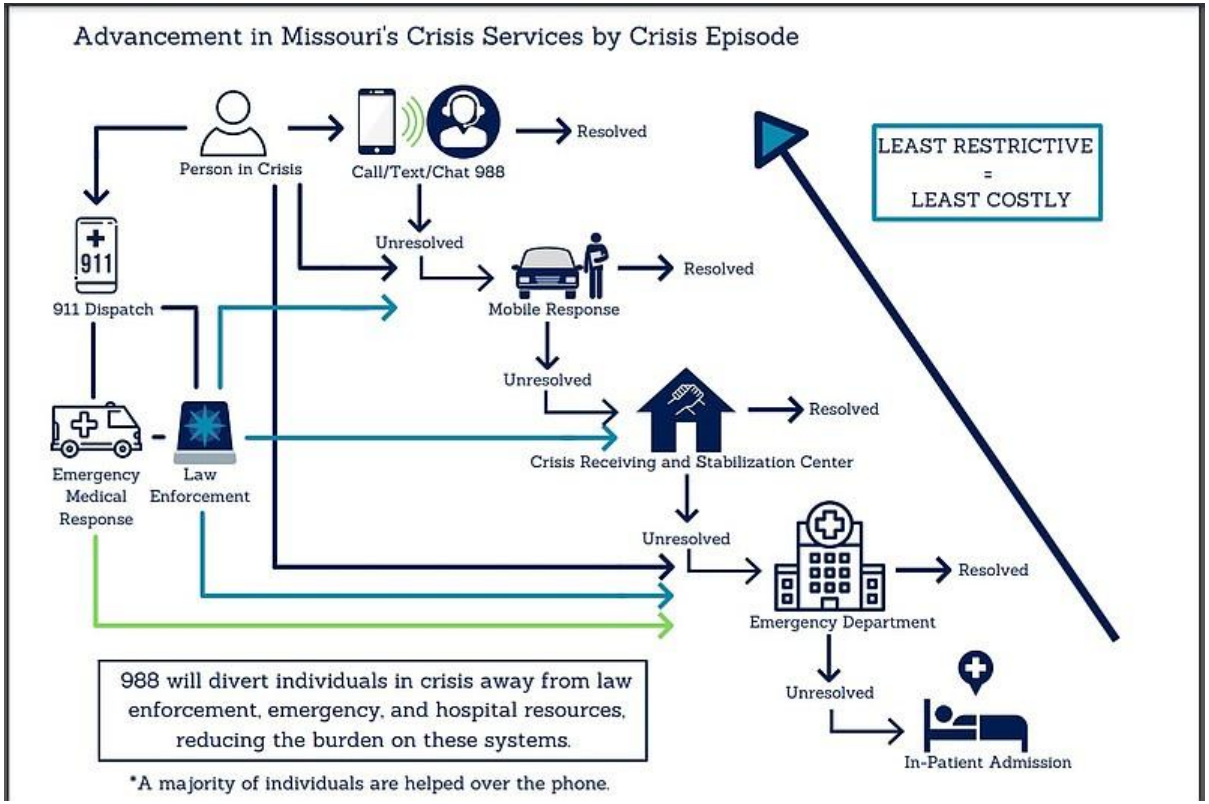
Suicide-safe workflows in primary care: all patients screened for depression, positive screens trigger C-SSRS, elevated risk results in immediate referral to Emergency Services — reducing duplication and shortening response time.

VPQHC Collaboration

Close partnership to strengthen Zero Suicide implementation and suicide-safe pathways within hospital settings, aligning quality metrics, screening practices, and system accountability.

Four Pines Foundation

Ongoing partnership since 2021 focused on expansion and quality improvement of 988 services, increasing system capacity, and sustaining the full crisis continuum including Mobile Crisis and Front Porch.


Advancement in Missouri's Crisis Services by Crisis Episode
Person in Crisis
Call/Text/Chat 988
Resolved
LEAST RESTRICTIVE
=
LEAST COSTLY
911
911 Dispatch
Unresolved
Mobile Response
Resolved
Unresolved
Emergency Medical Response
Law Enforcement
Crisis Receiving and Stabilization Center
Resolved
Unresolved
Emergency Department
Resolved
Unresolved
In-Patient Admission
988 will divert individuals in crisis away from law enforcement, emergency, and hospital resources, reducing the burden on these systems.
*A majority of individuals are helped over the phone.

The Crisis Response System: Core Components

24/7 Mental Health Urgent Care(s)

Provides immediate access to mental health professionals for individuals experiencing a crisis, operating 24 hours a day, 7 days a week.

Mobile Crisis Team

Trained clinicians and peers who respond to mental health crises in the community, working to resolve issues and prevent hospitalization whenever possible.

988 Call Center Collaboration

Partnership with the national 988 Suicide & Crisis Lifeline, allowing seamless connection to local crisis support and resources.

Embedded Mental Health Specialists within Law Enforcement

Mental health professionals integrated into local law enforcement teams, providing crisis intervention and linkage to appropriate services.

Peer Support Integration

Peer supporters are incorporated across all crisis response programs, offering unique perspectives and emotional support grounded in lived experience.

A complete crisis continuum — from phone to field to facility — ensuring no Vermonter falls through the cracks.

Vermont's Mental Health Urgent Care Centers

5 community-based alternatives to emergency departments — giving Vermonters somewhere to go when they need immediate mental health support.

"Someone to call. Someone who can come to you. Somewhere to go." — Vermont's Crisis Continuum

Howard Center — Mental Health Urgent Care

Burlington • Mon–Fri, 9am–5pm

Walk-in care in partnership with UVM Medical Center, Community Health Centers, and Pathways Vermont. Offers mental health assessment, peer support, suicide care, care management, and medical assessment in a trauma-informed setting.

UCS — PUCK

Bennington • Mon–Fri, 8am–5pm

Psychiatric Urgent Care for Kids — dedicated urgent care for children and youth in crisis. Clinician, care coordinator, and support staff available for school-referred youth. Prevents unnecessary ED visits for pediatric behavioral health crises.

NKHS — Front Porch

Newport City • Open 24/7 — Walk-in

Vermont's only around-the-clock walk-in mental health urgent care. Now offers overnight stays up to 10 days. Peer-supported, safety-focused stabilization for adults and families. 74% of guests stabilized without ED transfer.

CSAC — Interlude

Middlebury • Mon–Fri, 10am–6pm

Home-like, trauma-sensitive crisis alternative. Peer-run using Intentional Peer Support (IPS). In FY24, supported 67 individuals with zero referrals to the ED. Addison County's involuntary admission rate is the lowest in the state.

WCMHS — The Access Hub

Montpelier • 24/7 Crisis Response

Adults 18+ receive peer counseling, assessment, brief treatment, and referrals. Built around the Living Room model — a safe, welcoming environment staffed by peers and clinicians for immediate stabilization.

Looking for Immediate Mental Health Support?

NKHS is here for you, delivering care across the Crisis Continuum

Someone to **Contact**

Someone to **Respond**

Somewhere **Safe to Go**

Someone to **Follow Up**

NKHS
Northeast Kingdom Human Services

Derby 802-334-6744 | NKHS.org | St. Johnsbury 802-748-3181

Contact - Call/Text/Chat **988**, Mobile Crisis **800-649-0118**

Respond—However you connect to us, we will respond and can come directly to you wherever you are.

Safe to Go - Visit the **Front Porch, Urgent Mental Health Care** Center at 235 Lakemont Rd, Newport, VT. Open 7 days a week.

Follow Up - We are here to support your care.

CORE STAFFING SUMMARY BY PROGRAM

Mobile Crisis Team

8 Clinicians, 4 Peers - Cross-trained for hospital and community response, supports inpatient coordination

Front Porch Urgent Care & Stabilization

14 total Peers and Therapist, 24/7 walk-in and short-term stay (2-10 days) for acute and sub-acute needs

VSP Embedded MHCS

4 Clinicians embedded in local police barracks, strong law enforcement collaboration

988 Call Center

14 Responders, 24/7 call/text/chat, integrated with dispatch and warm handoffs to field teams

Staffed like a 'firehouse' - cross-trained, ready, and locally embedded to enhance speed and effectiveness. Innovating new models like 988-initiated mobile dispatch.

Crisis Data: What Screening Reveals & Front Porch Impact (NKHS)

70%

of Mobile Crisis clients endorse suicidal ideation

11%

SI identified by self-report alone

~50%

SI identified with C-SSRS screening

How we ask determines who we find. Among ~14,000 callers, standardized screening revealed suicide risk that would otherwise remain hidden.

Front Porch: Mental Health Urgent Care as ED Diversion

74%

of guests stabilized without ED transfer

100%

had peer involvement & completed safety plan

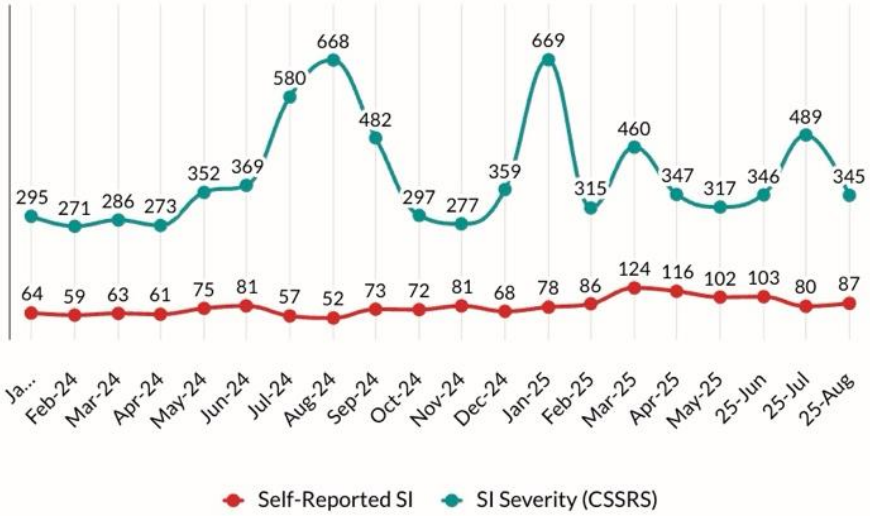
SI presentations increased in 2025 as access expanded, reaching individuals with higher acuity who might otherwise present to EDs.

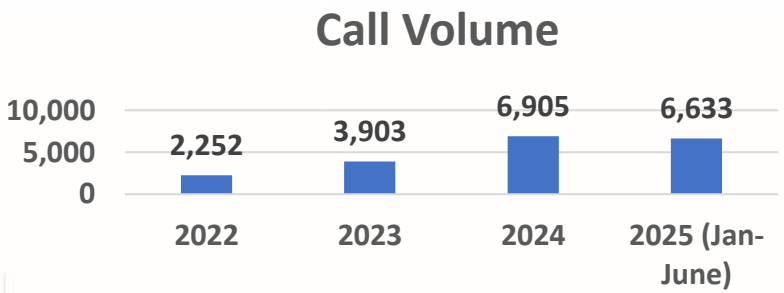
Front Porch is functioning as designed: absorbing suicide-related crises, providing peer-supported and safety-focused care, and allowing stabilization without defaulting to hospitalization.

Data: NKHS Emergency Services, Jan 2024 – Aug 2025

Emergency Services - 988

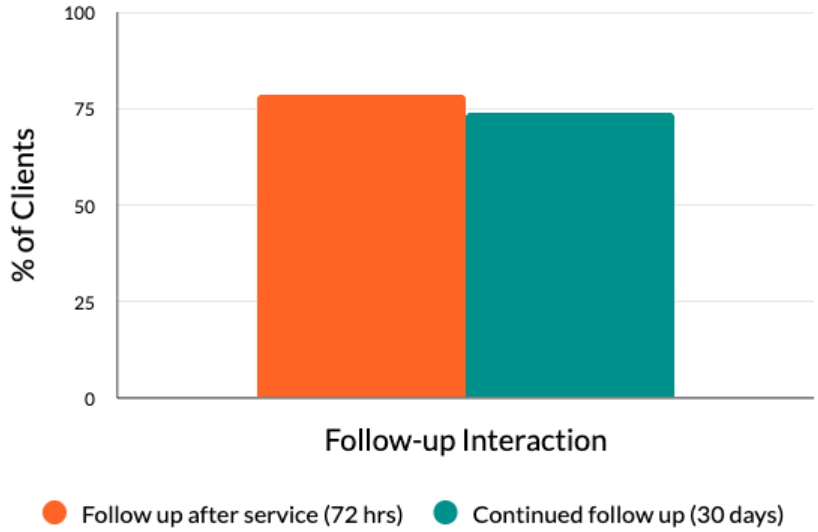
COMPARISON DATA: SELF-REPORTED SI & POST CSSRS

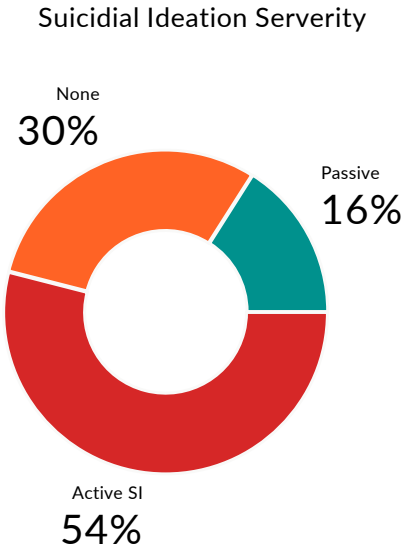




	Totals from Jan. 2024 thru Aug. 2025
Self-Reported SI	1,179
SI Severity (CSSRS)	7,797

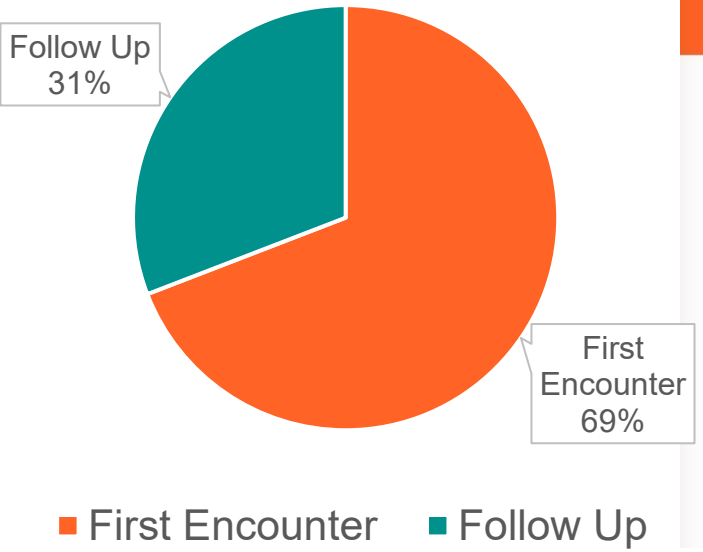
MOBILE CRISIS: FOLLOW UP & SI SEVERITY RATING

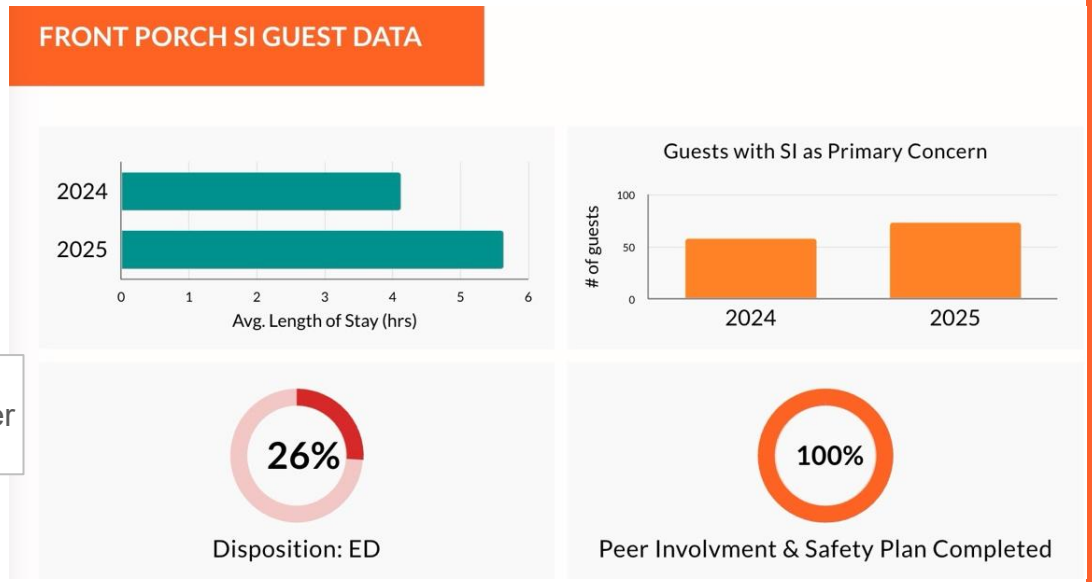




Front Porch Mental Health Urgent Care

The Front Porch had 727 encounters in FY25, with 484 being a first encounter.



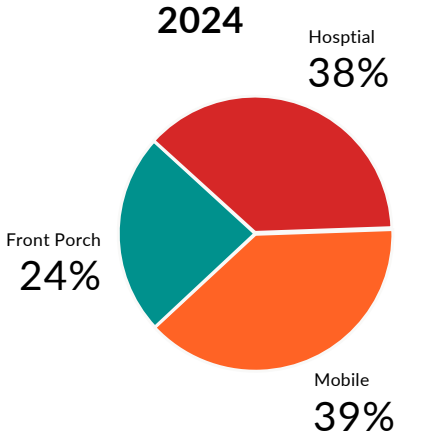


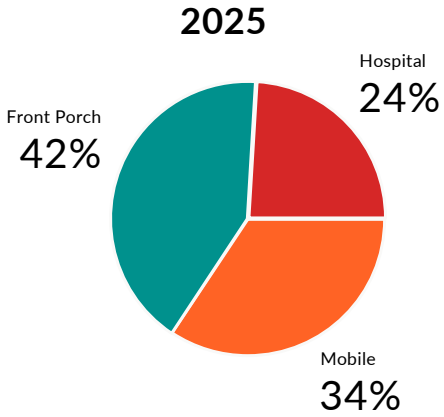
2024 VS 2025 UTILIZATION TRENDS

2024 cumulative community based service location: 63%

2025cumulative community based service location: 76%

This trend suggests greater reliance on timely, community-rooted care—diverting individuals from higher levels of acuity and offering support closer to home.





*thru May 2025