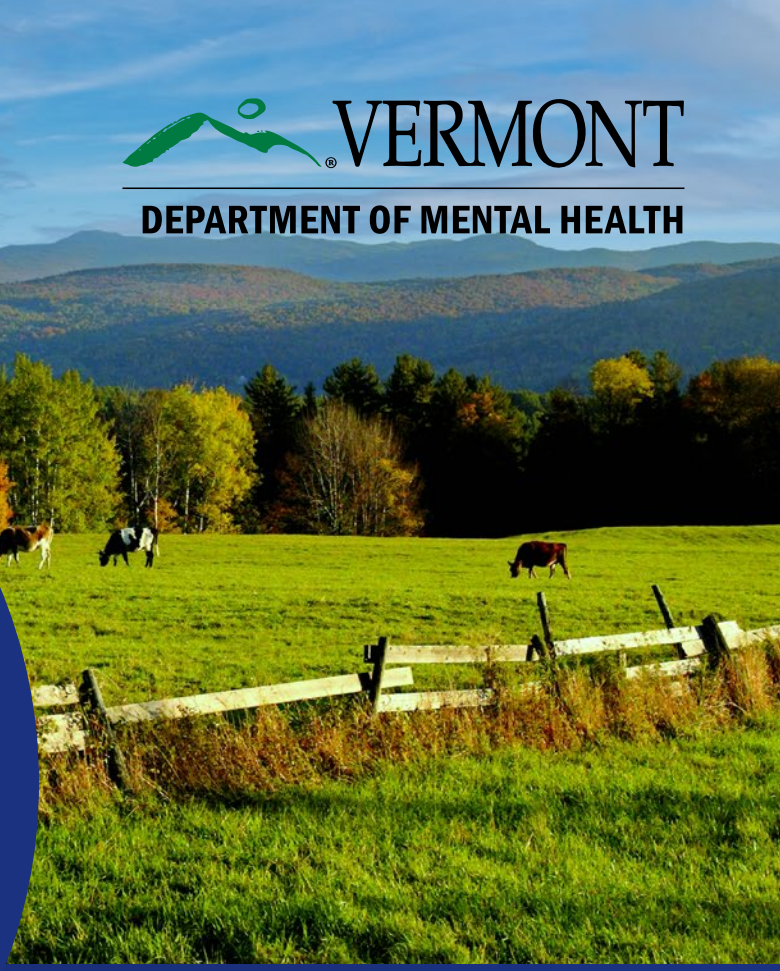
VERMONT
DEPARTMENT OF MENTAL HEALTH



Vermont State Strategic Plan for Suicide Prevention 2024-2029

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Dedication

This plan is dedicated to those who carry the weight of despair and the compassionate souls committed to lifting it. The Steering Committee expresses sincere gratitude to the many loss and attempt survivors, community members, family members, peers, administrators, and providers who contributed to the development of this plan. The plan stands as our collective vow to prevent the heart-wrenching loss of lives to suicide. May it serve as a beacon of hope, illuminating the path towards a world where empathy prevails, resilience flourishes, and every human finds the support needed to live a meaningful life.

Together, we will create a future where understanding and compassion are the cornerstones of suicide prevention, ensuring no one walks alone in the shadows.

Land Acknowledgment

We recognize that we live and work in *Wôbanakik*, Dawnland*, the historical and current homeland of the Abenaki people. We recognize the long history of genocide and land theft used to create what we know as the State of Vermont, as part of the United States of America. It is our mission that we seek to combat systemic racism, in part by ongoing education and modeling vulnerability. We accept that decolonization and antiracism are inseparably connected and that the process of healing will take time, energy and a willingness to change. We commit to seeking the voices and needs of people who identify as Abenaki alongside voices of those who identify as Black and/or people of color as one of the essential foundations of our work.

*Closest pronunciation would be, Woe-bun-ah-kick

Letter of Support

July 1, 2024

Dear Vermonters,

Each suicide death is a tragedy that affects a multitude of families, friends, and community members, and suicide continues to be a pervasive public health issue in Vermont[1]:

- Suicide is the 9th leading cause of death among Vermonters, and the 2nd leading cause of death for Vermonters aged 44 years and younger.
- Suicide-related emergency department visits are increasing in the state in every age group, with the largest increase occurring in males 25-44 years of age.
- According to Youth Risk Behavior Survey data between 2011-2021, suicide-related risk factors in Vermont youth are increasing.

Suicide is a complex issue requiring a comprehensive approach across communities and systems. The National Action Alliance for Suicide Prevention encourages states to develop Suicide Prevention Strategic Plans to enhance suicide prevention, intervention and treatment, postvention, and evaluation efforts to impact suicide death trends over time.

The Department of Mental Health has engaged state agencies, healthcare and community organization representatives, and Vermont adults and youth to develop the first Vermont State Strategic Plan for Suicide Prevention. Built on the foundation of the National Strategy for Suicide Prevention (NSSP), four Strategic Directions guide the plan's work: Community-Based Suicide Prevention; Treatment and Crisis Services; Quality Improvement and Research; and Health Equity.

continued

We invite all Vermonters to join this statewide effort to prevent suicides and better support those who have been affected by suicide loss, and we encourage you to review and identify strategies in the Plan that can be used to enhance suicide awareness and prevention in your work and community.

Sincerely,

Monica Hutt
Chief Prevention Officer, Office of Governor Scott

Todd Daloz
Deputy Secretary, Agency of Human Services

Emily Hawes
Commissioner, Department of Mental Health

Mark Levine
Commissioner, Department of Health

Nicholas J. Deml
Commissioner, Department of Corrections

Jill Bowen, PhD
Commissioner,
Department of Disabilities, Aging and Independent Living

Melanie O. Varady
Vice President, Northeastern Division
American Foundation for Suicide Prevention

Dana Kaplan
Executive Director, Outright Vermont

Simone Rueschemeyer
Executive Director, Vermont Care Partners

Hilary Melton
Executive Director, Pathways Vermont

Kirk Postlewaite
Director, Vermont Suicide Prevention Center

[1] "Suicide Morbidity and Mortality in Vermont." Vermont Department of Health. https://www.healthvermont.gov/sites/default/files/document/HSI-Injury-Suicide-Slide-Deck-2023.pdf.

Executive Summary

Words do not capture the profound ripple effects of a suicide death. Family and friends, loved ones, classmates, colleagues, neighbors, workplaces, community members and many others feel the impact. Globally, more than 700,000 people die by suicide each year.[1] In the United States, about 50,000 people die by suicide each year.[2] In 2023, 123 Vermonters died by suicide, and suicide-related emergency department visits are on the rise across all age groups.[3] A Vermonter dies by suicide every three days. Suicide is the 9th leading cause of death among Vermonters.[4]

Suicide is complex. There is no one solution. It will take a multi-faceted comprehensive approach, including a dedicated workforce, passionate advocates, improved data collection, creative thinking, and innovative programs. Only then can we meet people with the right intervention in a timely and effective manner.

Approaches to suicide prevention must affirm individual needs. This includes honoring cultural diversity, humanity, dignity, and the importance of each person. Some populations are disproportionately affected by societal conditions. These populations have an increased risk for suicide. Since societal conditions are a systemic problem, the solution will need to be systemic. Individuals, communities, organizations, and leaders at all levels must collaborate for success. Together, we can reduce suicide deaths.

Our collective vision and mission for the State Strategic Plan for Suicide Prevention is listed below. We created each strategy and objective in alignment with these statements.

Vision: All Vermonters have access to resources in their community to support their mental health and prevent suicide deaths.

Mission: To lead a coordinated, innovative, and comprehensive system of services for suicide prevention efforts in Vermont.

The Vermont Department of Mental Health (DMH) developed the State Strategic Plan for Suicide Prevention with input from representatives across multiple sectors, communities and age groups. This comprehensive document is designed to help Vermonters systematically reduce deaths by suicide and alleviate the burden of mental health struggles in our communities over the next five years.

The new National Strategy for Suicide Prevention, released in 2024, frame the Vermont Strategies, which represent the key priorities for a comprehensive approach to suicide prevention and community response to suicide (postvention) over the next five years:

Vermont Strategies (n=4) by Strategic Direction	
1. Community-Based Suicide Prevention (4 Strategies, 17 Objectives)	
STRATEGY 1	Promote and develop community member awareness through education, training, and programs.
STRATEGY 2	Enhance communication channels with the public, community partners, and elected officials.
STRATEGY 3	Develop state infrastructure and funding for sustainability.
STRATEGY 4	Support partnerships and upstream prevention programs that impact Social Drivers of Health (SDoH).
2. Treatment and Crisis Services (2 Strategies, 9 Objectives)	
STRATEGY 1	Implement and strengthen Zero Suicide in healthcare.
STRATEGY 2	Enhance community-wide and interagency care pathways.
3. Data, Quality Improvement, and Research (1 Strategy, 7 Objectives)	
STRATEGY 1	Improve data collection and analysis.
4. Health Equity (2 Strategies, 7 Objectives)	
STRATEGY 1	Support and promote culturally responsive resources, education, and spaces.
STRATEGY 2	Identify partners for collaboration to support populations disproportionately affected by suicide in Vermont.

A few suggestions for how to use this document:

- Read the Vermont Strategic Directions, Strategies, and Objectives. (Facing Suicide Vermont Strategies and Objectives).
- Review the Performance Measures (Appendix 2) to identify objectives you can embrace in your work, your community and relationships, and in your own life.
- Sign up for the DMH quarterly newsletter, to be released by 2025, to stay informed about resources, trainings, and Strategic Plan implementation.
- Participate and attend the Vermont Suicide Prevention Coalition meetings.
- Visit the FacingSuicideVT.com site to discover ways to get help, give help, get involved, and access resources.

By coordinating efforts statewide, Vermont will be able to face and mitigate this growing public health concern.

Thank you for your dedication to working together with us to prevent suicide deaths and reduce the impact suicide has on our communities in Vermont.

Sincerely

Christopher Allen

Director of Suicide Prevention
Department of Mental Health

[1] "World Suicide Prevention Day." World Health Organization. https://www.who.int/campaigns/world-suicide-prevention-day/2023.

[2] "Suicide Prevention: Suicide Data and Statistics." Centers for Disease Control and Prevention. https://www.cdc.gov/suicide/facts/data.html?CDC_AAref_Val=https://www.cdc.gov/suicide/suicide-data-statistics.htmt.

[3] "Public Health Snapshot: 2023 Suicide Deaths." Vermont Department of Health. https://www.healthvermont.gov/sites/default/files/document/HSI-Injury-Suicide-Summary2023.pdf.

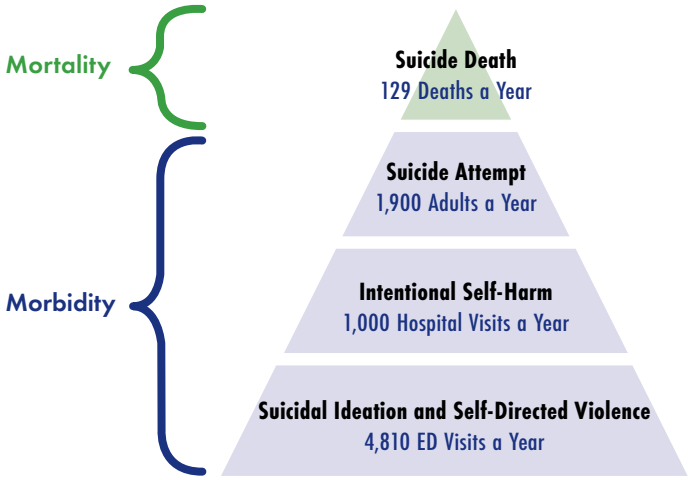
[4] "Suicide Morbidity and Mortality in Vermont." Vermont Department of Health. https://www.healthvermont.gov/sites/default/files/document/HSI-Injury-Suicide-Slide-Deck-2023.pdf.

Data Snapshot

Overview of Suicide in Vermont

Please note: the terms "female" and "male" refer to sex assigned at birth or legal sex, per state and national data categories.

Suicide is a critical public health issue in Vermont. It profoundly affects individuals, families, schools, and communities. In 2023, 123 Vermonters died by suicide, a rate of 19.0 deaths per 100,000 residents. The rate of suicide death has fluctuated over the past 10 years. Over the past 15 years, Vermont's suicide rate has consistently been higher than the U.S. rate. Suicide is the 9th leading cause of death in Vermont, and the 2nd leading cause of death for Vermonters 44 years and younger. The Vermont Department of Health Injury Prevention Data team provided all data for this section.



Suicide: death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death.

Suicide attempt: a non-fatal act where one intentionally tries to take their life.

Intentional self-harm: anything a person does to purposefully cause injury to themselves. This can be with or without suicidal intent.

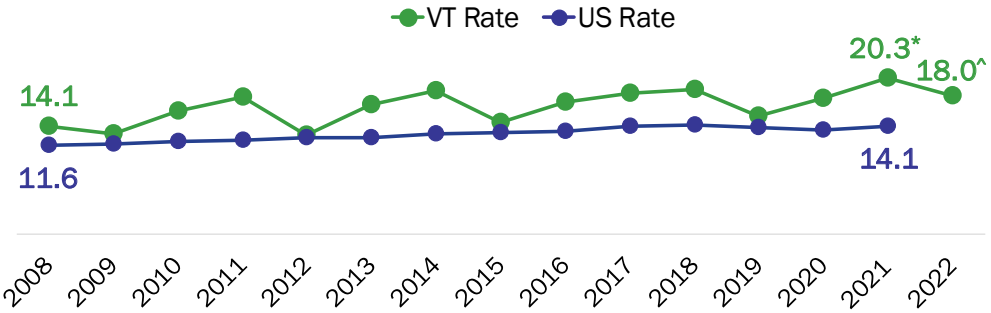
Suicidal Ideation: self-reported thoughts of engaging in suicide-related behavior or thoughts of being better off dead.

Morbidity: a diseased state, disability, or poor health due to any cause. The term may be used to refer to the existence of any form of disease, or to the degree that the health condition affects the person.

Mortality: referring to death. A mortality rate is a measure of the number of deaths in general or due to a specific cause per population per period of time.

Suicide Deaths

Age-adjusted rate per 100,000 residents

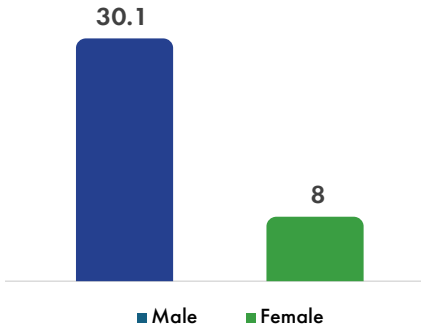


*statistically significant.

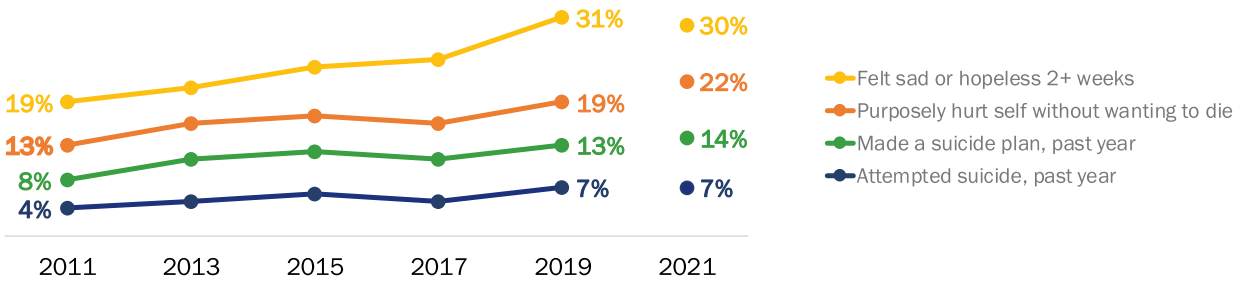
Source: Vermont Vital Statistics, 2008-2022. ^2022 data are preliminary.

Populations at an Increased Risk for Suicide Include:

- **Males**
  - Males are 3.8 times more likely to die by suicide than females.
  - Rate by Sex per 100,000 Vermonters (* = statistically significant):

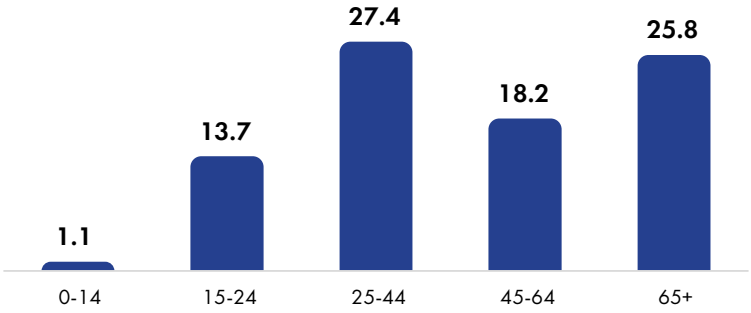


- **Rural**
  - Suicide rates are higher in rural areas than urban areas. Among rural residents those most at risk are males, those 15 years and older, and Veterans.
  - Death by suicide rates per 100,000: Rural Males: 35.3, Urban Males: 18.7; Rural Females: 7.5, Urban Females: 8.2.
- **Youth**
  - Youth and young adults have the lowest suicide death rate of any age group and the highest rate of suicide-related ED visits.

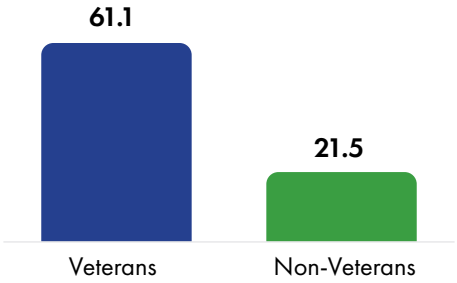


Source: Youth risk behavior survey (YRBS), 2011-2021.

- Death by Suicide Rate per 100,000 by Age:

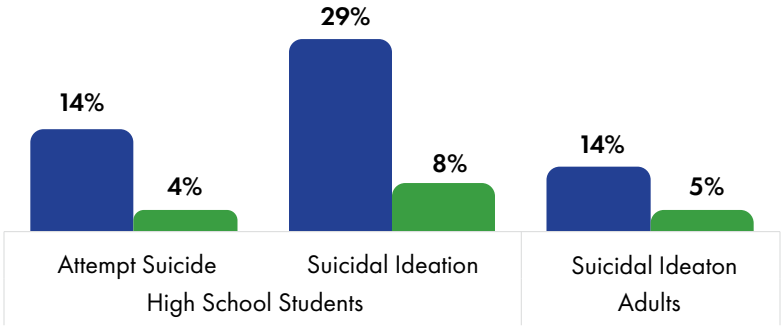


- **Veterans**
  - Veterans have a suicide death rate almost 3 times higher than non-Veterans.



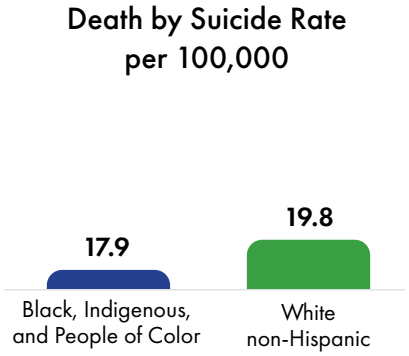
Source: Vermont Vital Statistics, 2022 preliminary; BRFSS, 2021.

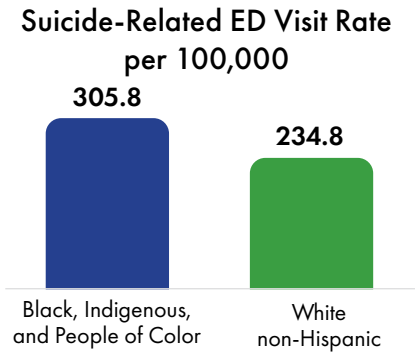
- **LGBTQ+**
  - People who identify as LGBTQ+ are more likely to report suicidal ideation or attempt suicide than heterosexual cisgender people.



- **Work in farming, fishing, forestry, construction or extraction occupations**
  - People working in farming, fishing, and forestry occupations have a suicide rate that is over 6 times higher than the rate of suicide in the general population.
  - People working in construction and extraction occupations have a suicide rate that is over 3.5 times higher than the rate of suicide in the general population.

- **Black, Indigenous, or People or Color (BIPOC)**
  - People who identify as BIPOC have high suicide morbidity; they do not have high suicide mortality.



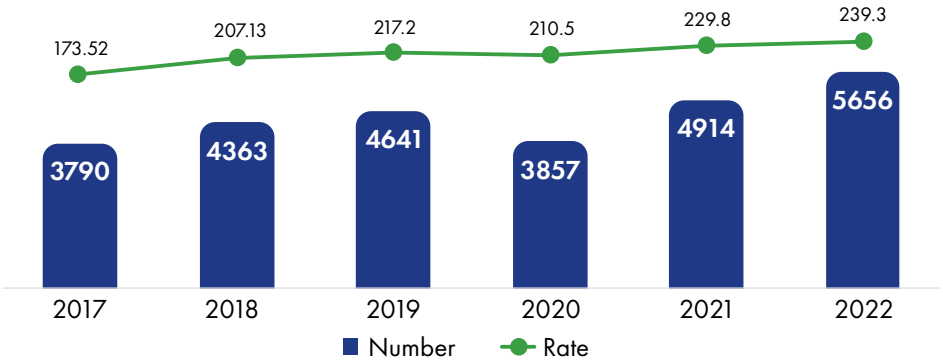


- **High school education or less**

  People with a high school education or less have a higher rate of suicide death and are more likely to have seriously considered suicide in the past 12 months than people with some college or more education.

- **Divorced, single, or never married**
  - People who are divorced, single, or never married have a higher rate of death by suicide and a higher rate of seriously considering suicide in the past 12 months compared to people who are married.
- **Disability**
  - Adults with a disability are 3 times more likely to seriously consider suicide compared to people without a disability (11% vs. 4%).
- **Recently released from incarceration**
  - The suicide rate is six times higher for those released from a correctional facility within a year of death (114.4 vs. 19.1).
- **Recently involved with the court system**
  - People who had a case with a court system within a year of death were more likely to die by suicide compared to the general population.

Suicide-Related Emergency Department (ED) Visits

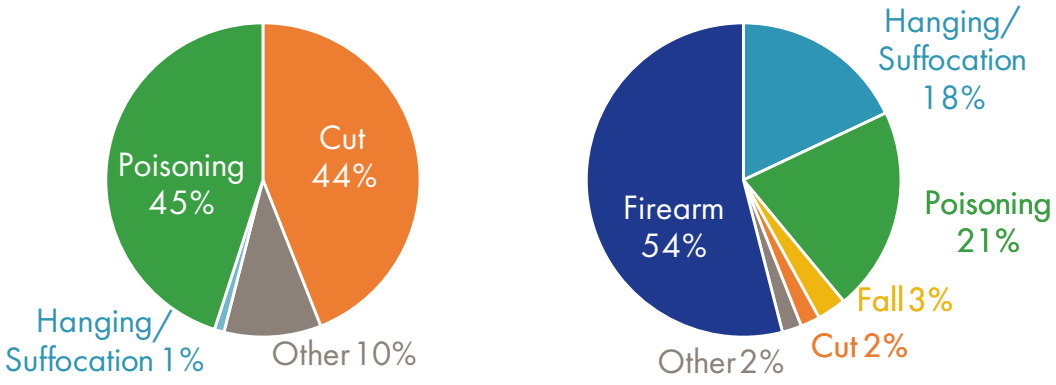


*statistically significant.
Please note the number of suicide-related ED visits is influenced by the number of hospitals reporting in ESSENCE. Hospitals not reporting: Brattleboro Memorial Hospital January 2017 – May 2022; North Country Hospital from January 2017 – June 2020 and May 2022 - January 2023. Source: Electronic Surveillance System for the Early Notification of Community-Based Epidemics ESSENCE, 2017-2022.
Vermont Department of Health

- Suicide-related ED visits are increasing in every age group. The largest increase is in males 25 to 44.
- Suicide-related ED visits are higher for females less than 24 years old. ED visits for ages 25-44 are higher for males.
- Females are 2.5 times more likely to visit a hospital for intentional self-harm.

Vermont Suicide Methods:

- **Over half of suicide deaths are due to firearms.**



Below are links for additional information:

VDH Suicide Slide Deck

Intentional Self-Harm and Death by Suicide Report October 2023

Suicide Mortality in Rural Vermonters

2021 Vermont Behavioral Risk Factor Surveillance System

2021 Vermont Youth Risk Behavior Survey

Suicide Data Dashboard

Epidemiology Glossary (Centers for Disease Control and Prevention-CDC)

An Overview of the Planning Process

After reviewing national best practices for strategic planning, a planning process framework was developed. This included a strategic planning worksheet and an environmental scan and analysis. Using these tools, we identified focus populations, opportunities for growth of prevention efforts, and potential barriers to new programs and activities. We workshopped the framework with multiple community partners to gather input and ensure alignment.

In the summer of 2023, the Steering Committee was created. It includes a small group of representatives from state agencies and community-based health and mental health organizations. Selected Steering Committee members represent suicide prevention efforts across Vermont. Steering Committee members developed the State Plan's Strategies and Objectives. These include feedback from a variety of community partners, using the above framework. Members also created the Plan's Mission and Vision that will guide Vermont's suicide prevention work over the next five years.

Advisory Group and Public Listening Sessions

In the fall of 2023, an Advisory Group was created. This group met multiple times periodically throughout the planning process. Membership was comprised of state agencies, community partners, mental health professionals working in various settings, community mental health agencies (DA), and healthcare systems. The role of this group was to provide consultative feedback and input on the development of Strategic Plan.

Vermont adults participated in two public listening sessions. In these, individuals communicated their lived experiences and priorities for suicide prevention in the state. Three groups of Vermont youth participated in listening sessions, an instrumental contribution to suicide prevention work impacting youth and young adults. Some advisory participants were compensated for their time as part of organizations' intentional efforts and policies to increase access and diversify perspectives represented.

Your words, stories, thoughts, and perspectives matter. Thank you for sharing.

Community Partner Input to the Strategic Plan

The following groups shared their feedback on emerging themes, the Strategic Directions, or draft documents:

Strategic Plan Advisory Group — over 50 active members

Vermont Suicide Prevention Coalition — over 40 active members

Centers for Disease Control Comprehensive Suicide Prevention Grant Advisory Group — 18 active members

Adult Mental Health State Program Standing Committee AMH SPSC — 9 active members

Children State Program Standing Committee — 4 active members

Zero Suicide Coordinators Meeting — 36 active members

Steering Committee Members

Chris Allen (he/him), LICSW, Director of Suicide Prevention, Vermont Department of Mental Health

David Glidden (he/him), Youth Programs Coordinator, Outright Vermont

Heather White (she/her), Area Director, American Foundation for Suicide Prevention – Vermont Chapter

Kirk Postlewaite (he/him), MS., LCMHC, Director, Vermont Suicide Prevention Center / Senior Program Specialist, Center for Health and Learning

Mark Margolis (he/him), Psychologist MA, Suicide Prevention Coordinator, Howard Center

Michelle Nerish (she/her), Ph.D., Suicide Prevention Coordinator, White River Junction Veteran's Association

Molly Shriver-Blake (she/her), LICSW, Outreach and Community Services Director, Pathways Vermont

Nick Nichols (he/him), MSW, Centers for Disease Control and Prevention (CDC) Comprehensive Suicide Prevention Grant Coordinato, Vermont Department of Health

Rebecca Silbernagel (she/her), JD, Principal Assistant, Vermont Department of Disabilities, Aging, and Independent Living

Terri Lavely (she/her), MS, Qualified Mental Health Provider (QMHP), Board Chair, American Foundation for Suicide Prevention – Vermont Chapter

National Strategy Incorporation to Vermont's Strategy

Suicide has been recognized in Vermont as a significant public health issue since 2000, when the Vermont Department of Health included goals related to suicide deaths, suicide attempts, substance misuse, and mental health as named priorities in Healthy Vermonters 2010 as part of the National Healthy People initiative. The Healthy People initiative provides science-based, ten-year national objectives for improving the health of all Americans, and each state chooses objectives based on areas of highest need.

In acknowledgment of suicide as a priority in Vermont, the 2023 Vermont State Legislature passed Act 56. Legislators assigned the Director of Suicide Prevention to lead the state's suicide prevention efforts, intervention supports, and postvention initiatives. Additionally, the Director will collaborate with communities and providers to reduce the number of suicide deaths and attempts in the state.

Vermont's Suicide Prevention Strategic plan is informed by the National Action Alliance for Suicide Prevention (NAA) National Strategy for Suicide Prevention (NSSP) and the updated Vermont Suicide Prevention Platform. NAA is the national group created to guide and advocate for the NSSP. In coordination with the U.S. Surgeon General, they released the NSSP, which serves as a call to action intended to guide the nation's suicide prevention efforts.

In April 2024, the NSSP was updated with the following strategic directions: Community-Based Suicide Prevention; Treatment and Crisis Services; Surveillance, Quality Improvement, and Research; and Health Equity. In creating this plan, we wanted to ensure the identified strategies, information, and recommendations were relevant for all Vermonters across the lifespan while strongly aligning with existing national strategies.

Zero Suicide, a project developed by the NAA Task Force, is a core element of the 2024 NSSP and an evidence-based, overarching framework for implementing suicide prevention practices in Vermont. The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. It presents both a bold goal and an aspirational challenge, and the Vermont Department of Mental Health has chosen Zero Suicide as the framework for current state efforts in healthcare systems.

Zero Suicide identifies 7 elements of suicide care for health and behavioral healthcare systems to adopt: **Lead, Train, Identify, Engage, Treat, Transition, and Improve**. Throughout these elements, Zero Suicide emphasizes the necessity of involving survivors of suicide attempts and suicide loss in leadership and planning. As part of the state's coordinated efforts, Zero Suicide will play a vital role for individuals under care.

The NSSP includes solutions for both healthcare and upstream prevention efforts as a comprehensive approach to suicide prevention. As Vermont aligns its strategic planning efforts with the NSSP, the results and successes of this growing national initiative in communities around the country present an opportunity to have an immediate impact on the number of deaths by suicide.

Read on to learn more about how Vermont is adopting the National Strategy to our context.

Facing Suicide Vermont Strategies and Objectives

VISION: All Vermonters that have been impacted by suicide will have access to resources in their community to support their mental health.

MISSION: To lead a coordinated, state-of-the-art, and comprehensive system of services for suicide prevention efforts in Vermont.

The following Strategic Directions, Strategies, and Objectives align with the 2024 NSSP Strategic Directions and are adapted to meet Vermont's specific needs and opportunities. Through the State Strategic Plan for Suicide Prevention, the Department of Mental Health leads initiatives throughout Vermont and administers an effective suicide prevention program that is evidence-based. It also distinctly focuses on incorporating the perspectives and leadership of those with lived experience of suicide and suicide loss, populations disproportionately affected by suicide, and regional and community leaders in mental health promotion and suicide prevention. As you review the Strategies and Objectives below, identify impact areas relevant to you or your work, and be on the lookout for opportunities to get involved.

In alignment with the Facing Suicide Vermont public awareness campaign and website, this section is titled, "Facing Suicide Vermont Strategies and Objectives". The intent is to further develop Facing Suicide as the hub of resources for specific populations, available trainings, and ways to get and give help and get involved. Additionally, there are real stories from Vermonters on the impact of suicide in their life.

Objectives listed beneath strategies are organized by priority. Performance measures, targets, and resources needed are enclosed in Appendix 2.

#1 Vermont Strategic Direction: Community-Based Suicide Prevention

We know that risk factors for suicide are dynamic and occur from the individual to societal levels. As the Centers for Disease Control and Prevention (CDC) states, "suicide and suicidal behavior are influenced by negative conditions in which people live, play, work, and learn."[1] Focusing on prevention services and education can help reach individuals early and address broader concerns such as community resources, public awareness, and pervasive stigma around suicide and mental health. This work requires building infrastructure to coordinate and fund efforts that address social and environmental factors in Vermonters' mental health outcomes.

STRATEGY 1 Promote and develop community member awareness through education, training, and programs.

Objective 1: Ensure safe storage methods are readily available statewide through coordinated and centralized distribution. Make secure storage and suicide prevention trainings available to organizations interacting with people utilizing lethal means.

Objective 2: Expand suicide prevention education and training to workforce settings who are more likely to interact with people at risk of suicide. This should include first responders, correctional officers, client-facing state employees, and construction workers. Increase access and build networks of peer support, mental health, and wellness for professions disproportionately impacted by suicide such as the professions listed above.

Objective 3: Disseminate publicly available trainings to youth and adults to increase knowledge about mental health, suicide risk and protective factors, the intersection of being in crisis and at risk of suicide, and how to help.

STRATEGY 2 Enhance communication channels with the public, community partners, and elected officials.

Objective 1: Enrich current communication channels with the legislature and elected officials. This should leverage program evaluation to ensure sustainable funding for statewide suicide prevention activities.

Objective 2: Distribute statewide quarterly newsletters informing the public of current suicide prevention efforts and resources. Disseminate safe messaging information and consistent training to media outlets. Develop a community education campaign on lethal means safety to increase public awareness of safe storage methods and locations.

Objective 3: I Utilize the statewide 988 marketing and communications plan to increase awareness of 988 and suicide prevention.

Objective 4: Further develop campaign(s) focused on why people engage in suicide prevention through storytelling and open conversation.

STRATEGY 3 Develop state infrastructure and funding for sustainability.

Objective 1: Organize an Executive Committee made up of key internal and external partners and community organizations to implement and act on the strategies and objectives outlined in the Strategic Plan.

Objective 2: Formalize a statewide Center for Excellence made up of partners and organizations throughout Vermont who collaborate to advance suicide prevention best practices. They support State Plan implementation by leading evaluation and monitoring of performance measures, offering program support, and incorporating current research.

Objective 3: Explore funding opportunities in alignment with the Strategic Plan priorities. Develop multi-year strategic funding plan to maintain progress and sustainability in funding suicide prevention efforts.

Objective 4: Reestablish a policy workgroup of state agency representatives to discover avenues of improving health and wellness of those we assist and our colleagues.

Objective 5: Develop regional suicide prevention coordinators embedded in communities to assist in making connections with local organizations, implementation of Zero Suicide, and organizing postvention response.

Objective 6: Explore restructuring the Vermont Suicide Prevention Coalition to continue supporting the grassroots and advocacy efforts. Consider community-based coalitions to maximize current resources and increase collective leadership.

Objective 7: Evaluate insurance reimbursement rates and make recommendations on rate changes that can impact access to care and quality of care for individuals at risk of suicide.

STRATEGY 4

Engage with Vermont agencies, institutions, and non-profits to develop relationships and partnerships focused on supporting programs that impact Social Drivers of Health (SDoH).

Social Drivers of Health (also known as Social Determinants of Health): According to the Office of Disease Prevention and Health Promotion, SDoH are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[2] They are often grouped into five categories: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Disparities in suicide associated with SDoH are described in more detail in the Health Equity Strategic Direction.

Objective 1: Understand structural gaps in resources impacting quality of life and how they relate to suicide risk.

Objective 2: Build partnerships across many sectors to address upstream risk factors outside of mental health. This must include people with lived experience and disproportionately affected groups.

Objective 3: Support efforts that increase individual and community empowerment and protective factors. Provide resources for organizations and spaces for connection/third spaces programming to offer culturally responsive services.

#2 Vermont Strategic Direction: Treatment and Crisis Services

Implementing suicide-specific care pathways is a core goal of turning the curve on suicide deaths. Pathways should exist both within and beyond health care agencies. We recommend building on the strong systems of care that already exist. This expansion must integrate best practices specific to the needs of the community served. Therefore, this plan recommends strategies to support workforce development, widely promote standards of care, and enhance partnerships and outreach. Critical to this effort is supporting strong interagency referrals, a multisector workforce including peer involvement and embedded mental health staff and ensuring robust community response after a suicide death.

STRATEGY 1 **Implement and strengthen Zero Suicide in healthcare.**
Objective 1: Increase participation and continue to support ZS framework implementation within and across healthcare settings. Distribute needs assessments for facilities and community resources to identify gaps. Expand support for telemental health.
Objective 2: Provide training and technical assistance in best practices for suicide prevention, screening, intervention, safety planning and postvention (community response). Provide specific training on liability laws and best practices in emergency situations for healthcare providers. Work with coalitions to determine baseline standardized training to ensure consistency of care and a unified framework for intervention across state agencies. Disseminate suicide-specific training to staff of Mental Health Urgent Care (MHUC) facilities and mobile crisis units.
Objective 3: Share guidelines that are available statewide and align with federal requirements supporting evidence-based practices. Work with subject matter experts and paid peer programs to integrate non-clinical interventions.
Objective 4: Review the potential role of Memorandum of Understanding (MOU) to support coordination between private practitioners and community mental health agencies (DA).

STRATEGY 2 Enhance community-wide and interagency care pathways.

Objective 1: Establish sustainable funding for a Family Support Services position within the Office of Chief Medical Examiner (OCME).

Objective 2: Provide consistent postvention education to organizations and resources and support to individuals impacted by suicide loss. Increase support for postvention activities, including the Connect Program and LOSS (Local Outreach for Suicide Survivors) Teams amongst other postvention best practices. Make community needs assessment templates available to regions.

Objective 3: Implement follow-up/caring contact services following release from a correctional facility, emergency department, or an inpatient setting.

Objective 4: Communicate standards and create support for active referrals for mental health or substance misuse and more efficient timeframes to care. Support adherence to standards by healthcare organizations.

Objective 5: Support infrastructure for employing peer support staff within clinical and community settings.

#3 Vermont Strategic Direction: Data, Quality Improvement, and Research

Vermont has made important headway in the statewide collection of suicide-related data. There are opportunities to expand what data is collected, and when, to inform suicide prevention priorities. This includes post-death data, allowing for a better understanding of circumstances surrounding a suicide death. Also central to quality improvement is evaluating prevention and intervention program efficacy, including healthcare, alternative care pathways, and crisis systems. Approaching suicide-related data and quality improvements from a health equity lens will enable Vermont to more deeply understand the needs and trends of specific groups within the state.

STRATEGY 1 **Improve data collection and analysis.**
Objective 1: Continued support for the data linkage project will allow us to better understand the needs or issues of target populations.
Objective 2: Enhance Vermont's Violent Death Reporting System (VTVDRS) suicide data collection of SDoH through the support of the Office of Chief Medical Examiner's Family Services Specialist. Utilize VTVDRS analyses to understand the social drivers of health of Vermonters who died by suicide.
Objective 3: Identify risk factors of those who died using a firearm and how these compare to those who died using other means. Expand data collection and analysis of lethal means to include mental health and other health care and social services interactions prior to death.
Objective 4: Expand data collection to include individuals who died by suicide and have had more than one interaction with AHS services. This helps to deepen our understanding of possibly unmet social, financial, or health needs.
Objective 5: Expand and promote use of statewide data collection systems that capture suicide morbidity and mortality.
Objective 6: Explore opportunities for more timely and robust data reporting within healthcare and crisis systems. Identify trends in client outcomes on the care pathway.
Objective 7: Use group data (e.g., youth, farmers) to highlight needs for increased or improved services.

#4 Vermont Strategic Direction: Health Equity

Certain groups are disproportionately affected by suicide, such as older adults, LGBTQIA+ youth and young adults, those working in construction, mining, or agriculture industries, Veterans, or people living in rural areas (CDC). Suicide rates also vary based on racial and ethnic identity. In Vermont, there is a need to continue identifying and supporting groups who experience excess burden of suicide. Below are strategies focused on health care provider and public education, access to supportive spaces, and building collaborative partnerships. Health equity data is included in the Quality Improvement and Research National Strategic Direction.

We must integrate health equity principles in all suicide prevention strategies. But, understanding that there is a lot of progress to be made, Health Equity is also emphasized with its own set of strategies.

STRATEGY 1 **Support and promote culturally responsive resources, education, and spaces.**
Objective 1: Promote training on culturally responsive approaches to mental health care, including Culturally and Linguistically Appropriate Services (CLAS) standards training and education for mental health professionals.
Objective 2: Expand and ensure access to multilingual suicide prevention and mental health resources.
Objective 3: Provide trauma-informed education and resources for the public, including healthy relationships, communication skills and non-violent problem-solving skills.
Objective 4: Disseminate educational materials and resources to increase the number of healthcare spaces that are trauma-informed and culturally responsive.

STRATEGY 2	**Identify partners for collaboration to support disproportionately affected populations in Vermont.**
	Objective 1: For existing population-specific programs (e.g., Governor's Challenge), identify and implement sustainability measures to improve suicide prevention outcomes. Align Governor's Challenge workplans with this document.
	Objective 2: Create opportunities such as advisory groups, community listening sessions or coalitions to bring diverse voices to the table around suicide prevention efforts and programs, such as Black, Indigenous and People of Color, New Americans, LGBTQIA+ individuals, youth, older Vermonters, people with disabilities, and construction workers.
	Objective 3: Leverage collective leadership to identify and support culturally responsive community interventions for groups disproportionately affected by suicide.

[1] "Disparities in Suicide". Centers for Disease Control and Prevention. https://www.cdc.gov/suicide/disparities/?CDC_AAref_Val=https://www.cdc.gov/suicide/facts/disparities-in-suicide.html

[2] "Social Determinants of Health – Healthy People 2030". Office of Disease Prevention and Health Promotion. https://health.gov/healthypeople/priority-areas/social-determinants-health

Measuring Impact

Vermont commits to evaluating suicide prevention efforts across the state using consistent and reliable frameworks to assess whether these efforts are effective and satisfactory to participants. These participants include individuals who engage in prevention and intervention services, health care and community providers, peer support specialists, people with lived experience and family members, and community members at large. Evaluation will center on assessing ongoing suicide prevention and postvention implementation projects, workforce development and community education, and continuous review of statewide data.

Evaluating suicide prevention activities is part of the ongoing quality improvement process identified by the Suicide Prevention Resource Center, and is used to determine:

— if suicide prevention activities are effective

— if activities are delivered efficiently

— if activities are delivered as intended

— if participants are satisfied with the activities, and

— if activities could be refined or improved

In alignment with the Health Equity National Strategic Direction, Vermont will incorporate culturally responsive evaluation efforts and inclusion of non-traditional program evaluation to learn from and support the full landscape of suicide prevention activities throughout the state.

A central part of evaluation activities is to share the value of and lessons from suicide prevention efforts to community partners, decision-makers, and funders to inform ongoing priorities. As such, this information will be reviewed regularly and shared publicly in the upcoming Suicide Prevention Newsletter and via the Department of Health with partner organizations throughout the next 5 years.

APPENDIX

APPENDIX 1: Plan Quick View

VERMONT SUICIDE PREVENTION

STATE PLAN 2024-2029

FacingSuicideVT

Vision: All Vermonters have access to resources in their community to support their mental health and prevent suicide deaths.

Mission: To lead a coordinated, innovative, and comprehensive system of services for suicide prevention efforts in Vermont.

STRATEGIC DIRECTIONS	STRATEGIES
#1 Vermont Strategic Direction: Community-Based Suicide Prevention	STRATEGY 1 Promote and develop community member awareness through education, training, and programs.
	STRATEGY 2 Enhance communication channels with the public, community partners, and elected officials.
	STRATEGY 3 Develop state infrastructure and funding for sustainability.
	STRATEGY 4 Engage with Vermont agencies, institutions, and non-profits to develop relationships and partnerships focused on supporting programs that impact Social Drivers of Health (SDoH).
#2 Vermont Strategic Direction: Treatment and Crisis Services	STRATEGY 1 Implement and strengthen Zero Suicide in healthcare.
	STRATEGY 2 Enhance community-wide and interagency care pathways.
#3 Vermont Strategic Direction: Data, Quality Improvement, and Research	STRATEGY 1 Improve data collection and analysis.
#4 Vermont Strategic Direction: Health Equity	STRATEGY 1 Support and promote culturally responsive resources, education, and spaces.
	STRATEGY 2 Identify partners for collaboration to support disproportionately affected populations in Vermont.

988 SUICIDE & CRISIS LIFELINE

988 LÍNEA DE PREVENCIÓN DEL SUICIDIO Y CRISIS

Scan the QR code to find more resources and information on https://facingsuicidevt.com/

APPENDIX 2: Performance Measures

#1 Vermont Strategic Direction: Community-Based Suicide Prevention

STRATEGY 1 **Promote and develop community member awareness through education, training, and programs.**

Performance Measures	Target	Target Date	Resources Needed
# of gun lock, medication safe storage bag, and educational material locations, including at least three physical locations in each county.	50	2029	$500,000
# of employees in Vermont workforce trained in suicide prevention. (see Recommended Trainings in Appendix 6)	600	2029	$120,000
# of publicly available training every month of the year. (see Recommended Trainings in Appendix 6)	3	2029	$120,000

STRATEGY 2 **Enhance communication channels with the public, community partners, and elected officials.**

Performance Measures	Target	Target Date	Resources Needed
# of quarterly newsletters from the Department of Mental Health.	12	2029	Time allocated by staff.
# of safe messaging trainings offered to media outlets.	4	2029	$120,000
# of 988 community education trainings held.	15	2029	Time allocated by 988 Program staff.
# of new stories of Vermonters sharing how suicide affected them posted to websites.	6	2027	$40,000

STRATEGY 3 **Develop state infrastructure and funding for sustainability.**

Performance Measures	Target	Target Date	Resources Needed
# of Center of Excellence.	1	2028	$100,000
# of funding opportunities pursued annually.	2	2029	Time allocated by staff.
# of AHS policy workgroups.	1	2025	Time allocated by staff.

STRATEGY 4 **Engage with Vermont agencies, institutions, and non-profits to develop relationships and partnerships focused on supporting programs that impact Social Drivers of Health (SDoH).**

Performance Measures	Target	Target Date	Resources Needed
# of SDoH Community of Practices completed to better identify specific SDoH to Vermonters.	1	2026	Time allocated by staff.
# of spaces for connection with expanded availability and services to connect with people at disproportionate risk for suicide.	3	2029	$200,000

#2 Vermont Strategic Direction: Treatment and Crisis Services

STRATEGY 1 **Implement and strengthen Zero Suicide in healthcare.**

Performance Measures	Target	Target Date	Resources Needed
# of healthcare agencies implementing Zero Suicide.	30	2029	$2,000,000
# of trainings offered to mental health providers. (see Recommended Trainings in Appendix 6)	48	2029	$120,000

STRATEGY 2 : Enhance community-wide and interagency care pathways.			
Performance Measures	Target	Target Date	Resources Needed
# of postvention trainings offered.	8	2029	$120,000
# of correctional facilities, emergency departments, and inpatient settings participating in follow-up/caring contacts.	6	2027	$200,000

#3 Vermont Strategic Direction: Data, Quality Improvement, and Research

STRATEGY 1 : Improve data collection and analysis.			
Performance Measures	Target	Target Date	Resources Needed
# of comprehensive suicide data reports published annually.	1	2028	$140,000
# of annual prevention recommendations made (or actions taken) based on VTVDRS SDoH data analyses.	3	2028	Time allocated by staff.

#4 Vermont Strategic Direction: Health Equity

STRATEGY 1 : Support and promote culturally responsive resources, education, and spaces.			
Performance Measures	Target	Target Date	Resources Needed
# of non-clinical and clinical members of the workforce trained in culturally responsive mental health care. (see Recommended Trainings in Appendix 6)	300	2029	$120,000

STRATEGY 2 : Identify partners for collaboration to support disproportionately affected populations in Vermont.

Performance Measures	Target	Target Date	Resources Needed
# of stakeholder advisory group/coalition specifically for disproportionately affected groups.	1	2028	$80,000

APPENDIX 3: Budget Outlook and Timeline

Vermont state suicide prevention initiatives are currently funded with a mix of state and federal funds. Current funding supports training for mental health providers, community members, and people working with disproportionately impacted populations, Zero Suicide projects in primary care and Emergency Departments, data analysis and monitoring, postvention training and capacity development, the statewide suicide prevention coalition, and the annual suicide prevention symposium. Many of these activities are partially or fully funded by federal grants, which are time limited.

Given the majority of the suicide prevention funding is time limited decisions will need to be made in the coming years on what activities could be continued with support from the DMH suicide prevention allocation. When federal grants are fully expended, DMH has identified in the chart below the priority activities to continue supporting.

Current Funding Source	Amount	Geographic areas targeted	Time Period	Populations Targeted	Activities Supported
Centers for Disease Control and Prevention (CDC) Comprehen-sive Suicide Prevention	$4,465,000 ($893,000 per year)	Statewide	September 2022 – August 2025 (see comment)	Vermonters Age 15–64, Rural VT'ers, Men, LGBTQIA+, VT'ers with disabilities	Data Analysis/Monitoring, Suicide Awareness Training, Lethal Means Safety, Zero Suicide in Healthcare, Postvention Training/ Capacity Development, Media Training/Education, Engagement, Telehealth Expansion, Public Education/Awareness
Garret Lee Smith	$3,765,000 ($735,000 per year)	Rutland, Chittenden, Windham, and Bennington county	August 2022- August 2027	Youth 10–24	Umatter for Schools, Youth and Teen MHFA, Finding Hope, Outright groups, groups for BIPOC youth, marketing campaign, Zero Suicide, suicide loss bereavement groups for youth
DMH SP program	$495,000 per year	Statewide	Not a state line item, included in DMH budget	People across the lifespan	Umatter Skills & Awareness training, Umatter for Schools, Zero Suicide project coordination and trainings (screening, assessment, and safety planning), Mini grant project, Annual Symposium

Current Funding Source	Amount	Geographic areas targeted	Time Period	Populations Targeted	Activities Supported
Project AWARE	$9,000,000 ($1,800,000 per year, $160,000 dedicated to suicide prevention annually)	Southwest Supervisory Union, Caledonia Central Supervisory Union, Barre Unified Union School District	September 30, 2023– September 29, 2028	Local Education Agencies/ Schools	Umatter for Schools, Umatter for Community, Suicide prevention consultation at the SU, Youth and Teen MHFA, Outright groups. Outright training for schools and consultation, transforming trauma in schools consultation and training, student voice groups, Technical Assistance at the SUs to interconnect the local mental health and school systems

APPENDIX 4: Budget Recommendation

Vermont suicide prevention initiatives and activities are currently funded with a mix of state and federal funds. The Department of Mental Health distributes state funds, while the Department of Health has two federal grants, the Comprehensive Suicide Prevention (CSP) from the Centers for Disease Control and Prevention (CDC) and the Garrett Lee Smith (GLS) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). Blending funding between state and federal funds allows us to expand initiatives and activities and therefore have a larger impact, although federal grants do not provide stability. Grants are time-limited, which hampers our ability to have continuity in programs. This continuity is critical to make an impact. Investing in appropriate and evidence-based practices to address suicide in our communities will produce better outcomes for Vermonters experiencing suicidal thoughts and people impacted by suicide. The recommendations below do not indicate support for funding, although they do outline resources needed to begin and sustain the activities. If successful, some activities would need future investment to expand as well.

Below are the suicide prevention initiatives recommended for funding in order of priority:

#1 Secure storage of lethal means–$500,000 needed to coordinate distribution of gun locks, medication bags, have ample supply of lethal means safety devices, and create an education campaign and materials.

Funding addresses the following in the plan: Strategic Direction 1, Strategy 1, Objective 1

Fifty-four percent of Vermont suicide deaths are by firearm, and firearms are by far the most lethal means, resulting in higher numbers of suicide deaths. Twenty-one percent of Vermont suicide deaths are by poisoning. While poisoning does include medication, it is not the only poisoning method. To reduce these rates, a thorough, comprehensive approach to distribute secure storage devices is needed. The devices can be cable locks, firearm lockbox, a gun safe, and medication storage bags. Ample supply of secure storage devices is needed to ensure the devices are readily available by request, at community events, and at designated spaces such as town halls, community centers, libraries, etc.

#2 Follow-up project–$200,000 needed to establish position, conduct outreach, incentives for settings to participate, and provide training on best practice.

Funding addresses the following in the plan: Strategic Direction 2, Strategy 1, Objective 1; Strategic Direction 2, Strategy 2, Objective 2; Strategic Direction 2, Strategy 2, Objective 3

When someone discharges from an Emergency Department (ED), correctional facility, or inpatient psychiatric hospitalization, they are at increased risk for suicide in the immediate aftermath. The Data Snapshot and the Suicide Data Linkage Project highlighted that the suicide rate is six times higher for people recently released from a correctional facility within a year of death (114.4 vs. 19.1 per 100,000). The risk of a suicide attempt or death is highest within 30 days of discharge from an ED or inpatient psychiatric hospitalization.[1] The suicide risk remains high for up to three months and can endure beyond three months.[2] Research has shown that providing follow-up services for people recently discharged has positive results for consumers and mental health providers.[3] These contacts can take the shape of different types of communications, including telephonic and postcards.

#3 Postvention training/Local Outreach to Suicide Survivors (LOSS) teams–$800,000 needed for adequate training in postvention best practices and continue supporting postvention activities statewide.

Funding addresses the following in the plan: Strategic Direction 2, Strategy 1, Objective 2; Strategic Direction 2, Strategy 2, Objective 2

Lack of postvention resources statewide is a gap in the state suicide prevention infrastructure. Postvention can be short- and long-term, as the level of engagement depends on the people affected. Supporting people affected by suicide helps prevent future suicidal despair, attempts, and deaths by suicide. Currently, a limited scope of postvention activities is being supported including support group facilitator training and community needs assessments. These assessments will assist in determining future funding priorities for postvention activities.

#4 Data monitoring/analysis–$140,000 needed for ongoing monitoring of suicide mortality and morbidity data, analysis of respective data, and data products.

Funding addresses the following in the plan: Strategic Direction 3, Strategy 1, Objectives 1-7

Analysis of injuries and deaths due to suicide serves as the foundation for targeted prevention efforts. Vermont's understanding of the contextual circumstances surrounding suicide deaths has significantly improved due to CDC funding, which ends in August 2025. Sustained funding of a Health Department analyst will allow for ongoing identification of the populations most affected by suicide, evaluation of the efficacy of suicide prevention initiatives, and dissemination of suicide-related data crucial to refining prevention strategies. Specifically, continued support of an analyst will allow for monitoring morbidity and mortality indicators and areas of improvement or concern across demographics, geographies, and social drivers of health.

#5 Translated materials–$50,000 needed to create culturally responsive suicide prevention materials and have them available in languages represented statewide.

Funding addresses the following in the plan: Strategic Direction 4, Strategy 1, Objective 2; Strategic Direction 4, Strategy 1, Objective 3

Certain groups are disproportionately affected by suicide, such as older adults, LGBTQIA+ youth and young adults, those working in construction, mining, or agriculture industries, Veterans, or people living in rural areas (CDC). Suicide rates also vary based on racial and ethnic identity. Suicide prevention education materials need to be responsive to the communities disproportionately affected by suicide. Currently, these materials do not exist for many of these communities. Having translated materials available ensures equitable access to information, education, and learning about topics. The materials can provide information on supporting someone with suicidal thoughts, warning signs and risk factors to be aware of, and share local, regional, and national resources, including ways to access them.

#6 Create and establish a Center for Excellence–$200,000 needed to organize partners and organizations to evaluate and monitor the Strategic Plan.

Funding addresses the following in the plan: Strategic Direction 1, Strategy 3, Objective 1; all enclosed strategies and objectives

Currently there is not an established Center for Excellence or Council comprised of partners and organizations throughout Vermont tasked with operationalizing the Strategic Plan. This group would support the plan by deciding on annual priorities, evaluating the implementation and activities, and leading taskforces assigned to carry out objectives in the Strategic Plan.

#7 Office of Chief Medical Examiner (OCME) position–$140,000 needed to ensure sustainability of position.

Funding addresses the following in the plan: Strategic Direction 2, Strategy 2, Objective 1; Strategic Direction 3, Strategy 1, Objective 2; Strategic Direction 3, Strategy 1, Objective 7

The Family Support Services position in the OCME office provides outreach to the families and loved ones of decedents investigated by the OCME. This position serves as the point of contact for the family and loved ones for questions regarding the death investigation progress and status. Building rapport with the family and loved ones and providing resources to ensure support during the grieving process are critical. Information gleaned from these interactions and data collected from the death investigation will inform state suicide prevention initiatives.

#8 Spaces for connection–$150,000 needed to expand availability of services, provide supportive groups, and share community resources.

Funding addresses the following in the plan: Strategic Direction 1, Strategy 4, Objective 2; Strategic Direction 1, Strategy 4, Objective 3; Strategic Direction 4, Strategy 2, Objective 1

A comprehensive suicide prevention approach includes upstream prevention. A core tenant of upstream prevention is having spaces for people to gather, connect with themselves and each other, and that are a safe space to learn, explore, and hear about other available community resources. These spaces can be organized around people who are disproportionately affected by suicide. Typically, they offer groups on particular topics of interest to participants. This strategy enhances protective factors, while simultaneously decreasing risk factors. Spaces for connection exist throughout the state, although existing programming could be strengthened. For example, offering more frequent groups and increasing operating hours.

#9 Evaluation of the Strategic Plan–$60,000 needed annually to monitor and evaluate the implementation of the Strategic Plan.

Funding addresses the following in the plan: impact and effectiveness of the strategies and objectives established in the strategic plan.

Monitoring the implementation of the Strategic Plan is critical to measure the effectiveness of the strategies and build accountability in accordance with the performance measures outlined in Appendix 2. Will guide the strategy moving forward, shifting priorities if not trending to meet performance measures.

#10 Regional and state level suicide prevention teams–$200,000 needed to develop regional suicide prevention coordinators embedded in communities.

Funding addresses the following in the plan: Strategic Direction 1, Strategy 3, Objective 5

Implementation of Zero Suicide within regional systems of care requires both leadership and dedicated staff time to coordinate quality improvement cycles within community-based mental health treatment programs and support the adoption of inter-agency agreements and clinical protocols to ensure suicide safe transitions of care between different mental health and healthcare providers in the region. Dedicated staff time is also required to support regional planning and implementation of public health strategies to reduce risk, enhance community protective factors, and support community awareness. These public health strategies include promotion of lethal means safety (e.g. safe storage of firearms), public awareness and education to increase help-seeking behavior, suicide awareness/community helper training for community partners, identification and engagement with community groups being disproportionately affected by suicide, and development and coordination of appropriate postvention supports and education for individuals, families, and organizations (e.g. schools) following a suicide death. Community coordinators would be able to function at the local or county level to build partnerships, address objectives in the strategic plan, assist with postvention activities, and further implement Zero Suicide.

#11 Training–$120,000 needed to address emergent training needs.

Funding addresses the following in the plan: Strategic Direction 1, Strategy 1, Objective 2; Strategic Direction 1, Strategy 1, Objective 3; Strategic Direction 1, Strategy 2, Objective 2; Strategic Direction 2, Strategy 1, Objective 2; Strategic Direction 4, Strategy 1, Objective 1

A well-trained community is more likely to be able to recognize the warning signs of when someone is struggling, know what to say to support a neighbor, and the resources available to seek additional help as needed. One emergent training need discovered during the planning process is a Collaborative Assessment and Management of Suicidality (CAMS) refresher training. This ensures mental health professionals trained in CAMS are consistently aware of the latest updates to an evidence-based practice, informed of emerging research, and trained on the updated techniques. Having the ability to address training needs as they emerge and are identified is paramount to a responsive suicide prevention program.

Initiative	What this initiative addresses	Projected Cost	Suicide Prevention Strategy this Initiative Addresses
Secure storage of lethal means	needed to coordinate distribution of gun locks, medication bags, have ample supply of lethal means safety devices, and create an education campaign and materials.	$500,000	Strategic Direction 1, Strategy 1, Objective 1

Initiative	What this initiative addresses	Projected Cost	Suicide Prevention Strategy this Initiative Addresses
Follow-up project	Needed to establish position, conduct outreach, incentives for settings to participate, and provide training on best practice.	$200,000	Strategic Direction 2, Strategy 1, Objective 1; Strategic Direction 2, Strategy 2, Objective 2; Strategic Direction 2, Strategy 2, Objective 3
Postvention training/Local Outreach to Suicide Survivors (LOSS) teams	Needed for adequate training in postvention best practices and continue supporting postvention activities statewide.	$800,000	Strategic Direction 2, Strategy 1, Objective 2; Strategic Direction 2, Strategy 2, Objective 2
Data monitoring/ analysis	Needed for ongoing monitoring of suicide mortality and morbidity data, analysis of respective data, and data products.	$140,000	Strategic Direction 3, Strategy 1, Objectives 1-7
Translated materials	Needed to create culturally responsive suicide prevention materials and have them available in languages represented statewide.	$50,000	Strategic Direction 4, Strategy 1, Objective 2; Strategic Direction 4, Strategy 1, Objective 3
Create and establish a Center for Excellence	Needed to organize partners and organizations to evaluate and monitor the Strategic Plan.	$200,000	Strategic Direction 1, Strategy 3, Objective 1; all enclosed strategies and objectives
Office of Chief Medical Examiner (OCME) position	Needed to ensure sustainability of position.	$140,000	Strategic Direction 2, Strategy 2, Objective 1; Strategic Direction 3, Strategy 1, Objective 2; Strategic Direction 3, Strategy 1, Objective 7
Spaces for connection	Needed to expand availability of services, provide supportive groups, and share community resources.	$150,000	Strategic Direction 1, Strategy 4, Objective 2; Strategic Direction 1, Strategy 4, Objective 3; Strategic Direction 4, Strategy 2, Objective 1
Evaluation of the Strategic Plan	Needed annually to monitor and evaluate the implementation of the Strategic Plan.	$60,000	Impact and effectiveness of the strategies and objectives established in the strategic plan.

Initiative	What this initiative addresses	Projected Cost	Suicide Prevention Strategy this Initiative Addresses
Regional and state level suicide prevention teams	Needed to develop regional suicide prevention coordinators embedded in communities.	$200,000	Strategic Direction 1, Strategy 3, Objective 5
Training	Needed to address emergent training needs.	$120,000	Strategic Direction 1, Strategy 1, Objective 2; Strategic Direction 1, Strategy 1, Objective 3; Strategic Direction 1, Strategy 2, Objective 2; Strategic Direction 2, Strategy 1, Objective 2; Strategic Direction 4, Strategy 1, Objective 1

Citations

[1]Knesper, D. J., American Association of Suicidology, & Suicide Prevention Resource Center. (2010). Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit. Newton, MA: Education Development Center, Inc.

[2]National Action Alliance for Suicide Prevention. (2019). Best practices in care transitions for individuals with suicide risk: Inpatient care to outpatient care. Washington, DC: Education Development Center, Inc.

[3]National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group. (2018). Recommended standard care for people with suicide risk: Making health care suicide safe. Washington, DC: Education Development Center, Inc.

APPENDIX 5: 988 Sustainability

988 Sustainability

Vermont 988 Suicide and Crisis Lifeline Centers are currently funded with a mix of state ($715,359 annually) and federal funds ($3,464,288 over 5 years, ending 9/30/2026). Current funding supports 24/7 response to all calls, chats, and texts, 988 service coordinators at each of the two in-state Lifeline Centers and the mobile crisis dispatch center, implementing a technology solution to efficiently dispatch mobile crisis teams, improve workflow, and track and report data.

- **Assumption #1:** Expenditures would increase by 10% annually beginning SFY26. Annual wage increases for 988 staff, increasing staffing levels in alignment with contact volume and national standard of 90% answer rate, anticipated increase in contact volume due to widespread advertising of 988 statewide contribute to the annual budget increase of 10%.
- **Assumption #2:** The state budget will continue to provide $715,359 annually.
- **Assumption #3:** The federal funds include $1.8m for grant years (FFY 25 and FFY 26) that are not yet fully allocated.
- **Assumption #4:** SFY25 expenditures are projected to be $1,731,744 due to additional staff at the Lifeline Centers and Mobile Crisis Dispatch Center. These positions are paid for by federal funds.
- **Assumption #5:** Projections and increases do not account for increases in volume with the implementation of mobile crisis.

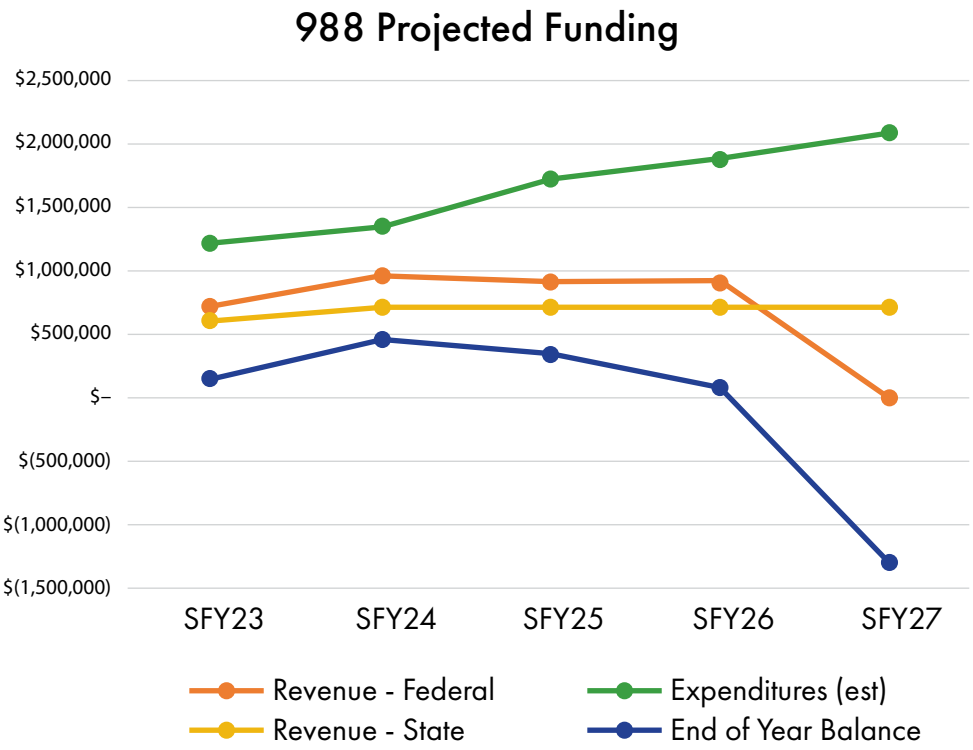
If these assumptions come to fruition, the 988 program is sustainable through state fiscal year (SFY) 2026.

In 2021 DMH applied for and received funding from Vibrant Emotional Health, the national administrator of the Lifeline, to develop a 988 Implementation Plan. DMH worked with planning partners to release this plan in 2022 and within it, described the goal to "Secure Adequate, Diversified, and Sustained Funding Streams for Lifeline Member Centers". The plan includes a survey of the current situation, gaps, progress, and a proposed approach as well as projected costs and funding opportunities, as well as assessment of recommended funding strategies to consider including (1) raising 988 related fees for telecommunication users, (2) Medicaid reimbursements, (3) Mental Health Block Grant funds, (4) direct engagement with State legislative budget committees for 988-specific funding, (5) partnerships with stakeholder groups who may have the ability to contribute to 988 resources (e.g. United Way/211, private insurers, hospitals, philanthropic organizations), and (6) other sources. To date, funding has been secured or is in the process of being secured through (3) Mental Health Block Grant funds, (4) direct engagement with State legislative budget committees for 988-specific funding, and (5) philanthropic organizations.

Below is a table outlining the two revenue sources, state and federal, and estimates of expenditures for future quarters. These expenditures may adjust based on maintaining an answer rate of 90%, the national standard. Given contact volume is dynamic and will likely increase as public awareness of 988 increases, maintaining a minimum answer rate of 90% will increase expenditures. From SFY23 to SFY24, expenditures increased due to state staffing to administer and maintain a high-quality 988 program. In the subsequent year (SFY24-SFY25), expenditures increase further due to utilizing federal funds to employ service coordinators at the Lifeline Center and the Mobile Crisis Dispatch Center and

contracting with an information systems vendor to assist with mobile crisis implementation. A 10% increase of expenditures has been applied beginning in SFY26 and in subsequent state fiscal years. If demand increases beyond our projections, the program will require additional funds to keep the answer rates at or above 90%.

	SFY23	SFY24	SFY25	SFY26	SFY27
Revenue-Federal	$708,333	$955,955	$900,000	$900,000	$ –
Revenue-State	$640,000	$715,359	$715,359	$715,359	$715,359
Expenditures (est.)	$1,209,327	$1,353,870	$1,731,744	$1,888,686	$2,077,555
End of Year Balance	$139,006	$ 456,450	$ 340,065	$ 66,738	$(1,295,458)



APPENDIX 6: Postvention Strategic Plan

The term "postvention" refers to the organized response after a suicide or other unexpected death that aims to facilitate healing from grief and distress, mitigate the effects of exposure to suicide, and prevent suicide among those at high risk.

A Vermont Postvention Needs Assessment and Strategic Plan was developed and completed in October 2022 with support from the five-year Comprehensive Suicide Prevention (CSP) grant from the Centers for Disease Control and Prevention (CDC). Vermont received this grant in September 2020 to support the implementation and evaluation of the state's comprehensive public health approach to suicide prevention in Vermont. The Department of Health, in coordination with the Department of Mental Health, is using the federal grant to build on existing partnerships and programs to implement and evaluate a data-driven public health approach to suicide prevention in Vermont. The grant bolsters collective efforts to integrate healthcare and mental health and works to ensure all Vermonters have access to the support they need.

One strategy of this project is examining and expanding postvention efforts within the state, with an overarching goal of developing a coordinated and consistent statewide postvention effort with state partners and communities. To this end, the following steps have been taken:

- Track existing suicide postvention activities and programs across the state by utilizing survey data, key informant interview data, and working group input on existing programs.
- Determine gaps and needs within the current system as identified by community partners.
- Create a statewide plan for improving postvention support based on the statewide assessment to be implemented over three years.

To view the Postvention Needs Assessment and Strategic Plan, click the link here.

APPENDIX 7: Suicide Data Linkage Project

In September 2023, the Vermont Department of Health, with partial funding from the Centers for Disease Control and Prevention Comprehensive Suicide Prevention Grant, released the Suicide Data Linkage Project Report. With contributions from agencies, organizations, and departments across Vermont, the project serves to improve understanding of the circumstances around and interactions of Vermonters who died by suicide. This information is intended to inform prevention efforts, promote protective factors, and support individuals who may be at risk for suicide throughout the state.

The 2023 project report includes suicide deaths among Vermont residents during 2020 and 2021. This report works to increase the identification of:

- Risk factors for suicide
- Populations at disproportionate risk for suicide
- Patterns in how Vermonters who died by suicide interacted with State and community systems and services prior to their death.

The Suicide Data Linkage Project fosters a deeper understanding of factors surrounding suicide deaths in Vermont. The findings show that:

- People who died by suicide often experienced stressors or crises shortly before their death.
- Within a year of death, 65% of people interacted with healthcare services.
- People also interacted with non-healthcare entities within a year of death, with the most common being law enforcement.
- Some people had multiple interactions with services and agencies within a year of death.

Noted in the report is the fact that the report only reflects populations disproportionately affected by suicide death. Vermonters with high suicide morbidity that do not have high suicide mortality were not represented, e.g. youth and Black, Indigenous, and People of Color (BIPOC).

The report made numerous recommendations, among them:

1. Establish and enhance linkages to care.
2. Integrate state and local prevention and response efforts.
3. Expand data collection and analysis to inform future interventions.
4. Disseminate report findings.

The data analysis and recommendations, which can be reviewed in full here, were reviewed by the Strategic Plan Steering Committee and played a role in identifying Vermont's Strategies and Objectives for suicide prevention for the next 5 years.

The Suicide Data Linkage Project provides insight into three areas: risk factors for suicide; populations at disproportionate risk for suicide and patterns in how Vermonters interacted with state, community systems and services prior to death. Deepening understanding of these factors and having updated data and recommendations released regularly will help providers, agencies, and organizations implement prevention practices relevant to Vermonters.

APPENDIX 8: 2023 Vermont Suicide Prevention Platform

First published in 2005 after the initial release of the National Strategy for Suicide Prevention (NSSP), the Vermont Suicide Prevention Platform is a comprehensive informational document presenting the scope of historical and current suicide prevention efforts in Vermont. The Platform presents eleven goals with objectives and recommended actions that were collaboratively developed in alignment with the strategic directions of the NSSP. The 2023 edition also details current statewide initiatives, available training opportunities, and local, state, and national resources for suicide prevention. Finally, the Platform seeks to educate Vermonters about how you can seek help, and how you can support someone experiencing suicidal thoughts.

The eleven goals identified in the Platform are focused on state agencies, organizations, schools, families, and individuals. The goals and their recommended actions were updated for the 2023 edition which focuses on utilizing four strategic directions and six priority actions from the NSSP.

The Platform has served as a strong foundation for building the Strategic Plan. Its goals, data and related content have helped to build an actionable plan that takes suicide prevention a step further in Vermont: to comprehensively implement strategic initiatives in coordination with partners and communities across the state.

The Vermont Suicide Prevention Strategic Plan is Vermont's official document outlining our comprehensive approach and essential Strategies and Objectives for suicide prevention with performance measures. The plan will be updated every 5 years and reviewed annually to ensure measurable progress is being made. The Vermont Suicide Prevention Platform is aligned with the Strategic Plan and can be used primarily to learn about Vermont's suicide prevention efforts, goals that informed the strategic planning process, and to access state and national resources.

View the document in its entirety here. Please note that information is current as of early 2023.

APPENDIX 9: Recommended Trainings

This is a list of suicide prevention trainings. There is funding available for some of these trainings at low or no cost for participants. For more information, please reach out to Chris Allen, Director of Suicide Prevention, Vermont Department of Mental Health, at Christopher.M.Allen@vermont.gov.

Attachment-Based Family Therapy: https://abfttinternational.com/

Attachment-Based Family Therapy (ABFT) is a 16-week treatment for youths ages 12–24 who have experienced depression, suicidal thoughts, suicide attempts, or trauma. Online and self-paced courses are available.

Adult Mental Health First Aid: https://mentalhealthfirstaid.org (6-8 hours)

A full-day in-person or virtual training designed to gain knowledge and comfort in the steps of ALGEE: Assess for risk of suicide harm/ Listen nonjudgmentally/Give reassurance and information/ Encourage appropriate professional help/ Encourage self-help and other support strategies.

> **Teen Mental Health First Aid (tMHFA):** Teaches teens in grades 10–12, or ages 15–18, how to identify, understand and respond to signs of mental health and substance use challenges among their friends and peers.
>
> **Youth Mental Health First Aid (YMHFA):** Designed to teach anyone who works with or cares about youth how to help an adolescent (age 12–18) who is experiencing a mental health or addictions challenge or is in crisis.

Conversations About Suicide: visit https://www.eventbrite.com/o/vermonts-peer-workforce-development-initiative-34190790833 (8 hours or two 4-hour sessions)
Pathways Vermont Training Institute - explore ways to practice empathy and prioritize autonomy when engaging in conversations about suicide, unpack suicide as a language of pain, and consider ways to support folks who are thinking about dying. Intended for all audiences.

Collaborative Assessment for the Management of Suicidality (CAMS): https://cams-care.com/about-cams/

Community mental health agency (DA) clinicians can access through the Center for Health and Learning and private clinicians via the Vermont Program for Quality in Health Care, CAMS is an evidence-based model designed to support clinicians as they assess, intervene, and treat patients experiencing suicidal thoughts.

Columbia Suicide Severity Rating Scale (C-SSRS): https://vtspc.org/zero-suicide/zero-suicide-project-resources/ (90 minutes)
Virtual live training offered through the Vermont Suicide Prevention Center by The Columbia Lighthouse Project. C-SSRS is an evidence-based screening tool for use in a multitude of community and healthcare settings.

Connect Suicide Prevention: NAMI NH https://www.naminh.org/trainings/ (1 hour to full day, includes other training options)
A Nationally Designated Best Practice Program, how to recognize the warning signs of suicide and connect with the person to get them appropriate help including strategies on how to understand and

access key community services for an effective and comprehensive response.

Connect Suicide Postvention: (1 hour to full day)
A Nationally Designated Best Practice Program on how to coordinate a comprehensive and safe response to a suicide that includes strategies for reducing the risk of contagion, reviewing the complexity of suicide-related grief, and others.

Counseling on Access to Lethal Means (CALM): https://zerosuicide.edc.org/resources/trainings-courses/CALM-course (2 hours)
Free self-paced online course for healthcare and social services providers focused on how to reduce access to the methods people use to kill themselves. It covers who needs lethal means counseling and how to work with people at risk for suicide and their families to reduce access.

Dialectical Behavior Therapy: https://www.vtcpi.org/projects/dbt
Vermont Collaborative for Practice Improvement & Innovation offers a biannual DBT Institute - a series of advanced workshops for teams to implement strategies with adults & adolescents using a cognitive-behavioral treatment approach.

Introduction to Zero Suicides https://vtspc.org/zero-suicide/ (1 hour)
Virtual live training facilitated by the VT Suicide Prevention Center that covers the principles of Zero Suicide, essential elements that make up the framework, evidence-based practices, training, and resources.

LivingWorks safeTALK: https://www.livingworks.net/trainings (4 hours)
At this in-person LivingWorks safeTALK workshop, you'll learn how to prevent suicide by recognizing signs, engaging someone, and connecting them to an intervention resource for further support.

Applied Suicide Intervention Skills (ASIST): (2 days) ASIST is a training program that teaches participants how to assist those at risk for suicide. Anyone 16 years or older can use the approach, regardless of professional background.

QPR - Question, Persuade, Refer: https://qprinstitute.com (1 hour)
Awareness training with virtual, virtual live, or in-person options. QPR trainees learn to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help.

Safety Planning Intervention: https://suicidesafetyplan.com/
The Stanley-Brown Safety Planning Intervention is a brief, collaborative intervention between the clinician and the suicidal individual that aims to mitigate acute risk. Various trainings available, including brief demonstration videos developed by The Joint Commission.

SafeSide: https://safesideprevention.com/
SafeSide provides video-based training for health, community, and educational organizations, and the SafeSide Primary CARE framework acts as a roadmap of best practices helping providers organize their thinking and actions when suicide concerns come up in their practice.

Talk Saves Lives: American Foundation for Suicide Prevention: https: //afsp.org/community-programs (1 hour)
Virtual live or in-person, Talk Saves Lives is a community-based presentation that covers the general scope of suicide, the research on prevention, and what people can do to reduce suicide.

More Than Sad: Parent Education (90 minutes) Teaches parents how to recognize signs of depression and other mental health problems; initiate a conversation about mental health with their teen; and get help.

Finding Hope: Guidance for Supporting Those at Risk (90 minutes) In-person presentation that provides in-depth, practical information for those supporting someone with lived experience.

Umatter® Suicide Prevention Awareness and Skills Training: Center for Health and Learning: https://healthandlearning.org/ourwork/umatter-suicide-prevention/ (90-120 minutes)
Virtual live or in-person training. Participants learn basic knowledge and skills of suicide prevention including best practices for school and/or community settings. The training includes a discussion of best practices for suicide prevention in school and/or community settings.

Umatter® for Schools helps school teams implement and solidify comprehensive suicide prevention by learning more about health education standards, curriculum, protocols for prevention, intervention, and postvention, and gaining overall awareness of suicide prevention within the school setting.
Umatter® Training of Trainers equips individuals, who have previously completed the Umatter® Suicide Prevention Awareness and Skills Training program, to become apprentices and ultimately facilitate the training in their communities or places of work.

VA S.A.V.E. Training: https://www.mentalhealth.va.gov/suicide_prevention/docs/VA_SAVE_Training.pdf (60-90 minutes)
Offered monthly, virtual or in-person training is intended for specialty groups, such as those working in Peer Support, Caregivers, etc. VA S.A.V.E. Training will help you act with care and compassion if you encounter a Veteran who is in crisis or experiencing suicidal thoughts.

Below is a list of resources for trainings from the Zero Suicide Institute:
https://zerosuicide.edc.org/sites/default/files/2020-11/2020.11.18%20Suicide%20Care%20Training%20Options_0.pdf

APPENDIX 10: Key Terms/Glossary

Best Practices: Activities or programs that are in keeping with the best available evidence regarding what is effective.[1]

Confidentiality: The principle in medical ethics that the information a patient or client reveals to a healthcare provider is private and has limits on how and when it can be disclosed to a third party.[1]

Contagion: Suicide contagion is an increase in suicide and suicidal behaviors as a result of the exposure to suicide or suicidal behaviors within one's family, peer group, or through media reports.[2]

Community helper (previously known as gatekeeper): People in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify people at risk of suicide and refer them to treatment or supporting services as appropriate.1 In Vermont, the term "gatekeeper" is replaced with "awareness" - people who have increased awareness and skills to support individuals at risk of suicide.

Evidence-based practices: Suicide prevention activities that have been found effective by rigorous scientific evaluation.[3]

Intentional self-harm: Anything a person does to purposefully cause injury to themselves, with or without suicide intent.

Intervention: A strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as providing lithium for bipolar disorder or strengthening social support in a community).[1]

Lethal Means: Methods of suicide with especially high fatality rates (e.g., firearms, jumping from bridges or tall buildings).[3]

Loneliness: The sense of being alone that includes distress or unpleasant feelings associated with having fewer-than-desired social relationships (subjective concept).[5]

Mental Disorder/Illness: A diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional or social abilities; often used interchangeably with mental illness.[1]

Mental Health: The capacity of people to interact with one another and the environment in ways that promote subjective well-being, optimal development, and use of mental abilities.[1]

Methods: Actions or techniques which result in an individual inflicting self-harm (i.e., asphyxiation, overdose, jumping).[1]

Morbidity: A diseased state, disability, or poor health due to any cause. The term may be used to refer to the existence of any form of disease, or to the degree that the health condition affects the person.[7]

Mortality: Referring to death. A mortality rate is a measure of the number of deaths in general or due to a specific cause per population per period of time.[7]

Person With Lived Experience: Personal knowledge gained through direct, first-hand experiences with suicide. Someone who has experienced suicidal thoughts, survived a suicide attempt, cared for someone who has attempted suicide, been bereaved by suicide, or been touched by suicide in other ways.[4]

Postvention: The organized response after a suicide or other unexpected death that aims to facilitate healing from grief and distress, mitigate the effects of exposure to suicide, and prevent suicide among those at high risk. In Vermont the term "community response to suicide" is also used.

Protective Factors: Factors that make it less likely that individuals will develop a disorder. Protective factors may encompass biological, psychological or social factors in the individual, family and environment.[1]

Public Health: The science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society.[1]

Risk Assessment: A comprehensive evaluation, usually performed by a clinician, to confirm suspected suicide risk in a person, estimate the immediate danger, and decide on a course of treatment.[3]

Risk Factors: Those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment.[1]

Safe Messaging: Media or personal communications about suicide or related issues that do not increase the risk of suicidal behavior in vulnerable people and are intended to increase help-seeking behavior and support for suicide prevention efforts.[2]

Screening: Administration of a brief evidence-based tool to identify persons in need of more in-depth evaluation or treatment.[1]

Social Isolation: Refers to having few social contacts and relationships (objective measure). Note that loneliness and social isolation can occur independently of one another.[5]

Social Support: Assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services.[1]

Stigma: An object, idea, or label associated with disgrace or reproach.[1]

Suicide attempt: A non-fatal act where one intentionally tries to take their life.

Suicidal Behavior: A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide.[1]

Suicidal Ideation/Suicidal Thoughts: Self-reported thoughts of engaging in suicide-related behavior or thoughts of being better off dead.[1]

Suicidality: A term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and died by suicide.[1]

Suicide: Death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death.[1]

Suicide Attempt Survivors: Individuals who have survived a prior suicide attempt.[1]

Suicide Loss Survivors: Those who have experienced the loss of a loved one due to suicide.

Third Spaces: These spaces "host the regular, voluntary, informal, and happily anticipated gatherings of individuals beyond the realms of home and work."[6]

Warning Signs: Indications that an individual is at risk for suicide. [1]

[1] "Mental Health & Suicide Prevention Glossary." 988 Suicide & Crisis Lifeline. https://988lifeline.org/mental-health-suicide-prevention-glossary/. Accessed January 2024.

[2] Walling, Mary Anne. "Suicide Contagion." International Violence, 16 December 2021, https://link.springer.com/article/10.1007/s40719-021-00219-9. Accessed January 2024.

[3] "Topics and Terms." Suicide Prevention Resource Center. https://sprc.org/topics-and-terms/. Accessed January 2024.

[4] "Indiana State Suicide Prevention Plan." IN.gov. https://www.in.gov/children/files/suicide-prevention-plan.pdf. Accessed February 2024.

[5] "Reducing Loneliness and Isolation among Older Adults." Suicide Prevention Resource Center. https://sprc.org/wp-content/uploads/2022/12/Reducing-Loneliness-and-Social-Isolation-Among-Older-Adults-Final.pdf. Accessed April 2024.

[6] Oldenburg, Ray. Celebrating the Third Space. New York, Marlowe & Company, 2001.

[7] "Epidemiology Glossary – Reproductive Health." Centers for Disease Control and Prevention. https://www.cdc.gov/reproductive-health/glossary/index.html.

APPENDIX 11: Risk/Protective Factors

Risk and Protective Factors

The Centers for Disease Control and Prevention state that "suicide is rarely caused by a single circumstance or event. Instead, a range of factors—at the individual, relationship, community, and societal levels—can increase risk. These risk factors are situations or problems that can increase the possibility that a person will attempt suicide."[1]

Please note that risk factors are dynamic and can change over a person's lifetime, although a few are unchanging (e.g. history of prior suicide attempt).[2] Additionally, many can be modified through effective and specific intervention.

Protective factors are personal or environmental characteristics that help protect people from suicide. Similarly, they occur at individual, relational, communal and societal levels. When suicide risk is acute, protective factors are less protective. Risk and protective factors listed here are sourced from the CDC.[3]

Individual Risk Factors

- Previous suicide attempt
- History of depression and other mental illnesses
- Serious illness such as chronic pain
- Criminal/legal problems
- Job/financial problems or loss
- Impulsive or aggressive tendencies
- Substance use
- Current or prior history of adverse childhood experiences
- Sense of hopelessness
- Violence victimization and/or perpetration

Relationship Risk Factors

- Bullying
- Family/loved one's history of suicide
- Loss of relationships
- High conflict or violent relationships
- Social isolation

Community Risk Factors

- Lack of access to healthcare
- Suicide cluster in the community
- Stress of acculturation
- Community violence
- Historical trauma
- Discrimination

Societal Risk Factors

- Stigma associated with help-seeking and mental illness

- Easy access to lethal means of suicide among people at risk
- Unsafe media portrayals of suicide

Protective Factors

Individual Protective Factors

- Effective coping and problem-solving skills
- Reasons for living (for example, family, friends, pets, etc.)
- Strong sense of cultural identity

Relationship Protective Factors

- Support from partners, friends, and family
- Feeling connected to others

Community Protective Factors

- Feeling connected to school, community, and other social institutions
- Availability of consistent and high quality physical and behavioral healthcare

Societal Protective Factors:

- Reduced access to lethal means of suicide among people at risk
- Cultural, religious, or moral objections to suicide

Warning Signs[4]

The Following Behaviors Could Indicate or Signal Suicide Risk

- Communicating a wish to die or plans to attempt suicide
- Expressing the experience of having thoughts of suicide that are intense, pervasive, or difficult to control
- Looking for a way to kill oneself, such as searching online or obtaining a gun
- Giving away possessions
- Drafting notes indicating intent or desire for suicide
- Communicating feeling hopeless or having no reason to live or persistent hopelessness
- Communicating feelings of guilt, shame, or self-blame
- Communicating feelings of being trapped or in unbearable pain
- Communicating being a burden to others
- Increasing the use of alcohol or drugs
- Acleting anxious or agitated; behaving recklessly or engaging in risky activities
- Insomnia, nightmares, and irregular sleeping
- Withdrawing or feeling isolated
- Communicating or exhibiting anxiety, panic or agitation
- Appearing sad or depressed or exhibiting changes in mood
- Showing rage or uncontrolled anger or communicating seeking revenge

Take a screenshot to have this information on hand and easily accessible.

[1]"Risk and Protective Factors." Centers for Disease Control and Prevention. www.cdc.gov/suicide/factors/index.html. Accessed January 2024.

[2]"Executive Summary." Striving for Zero: California's Strategic Plan for Suicide Prevention 2020-2025, p.9. www.sprc.org/wp-content/uploads/2022/11/CA-Suicide-Prevention-Plan_2020_2025.pdf. Accessed January 2024.

[3]"Risk and Protective Factors." Suicide Prevention Resource Center. sprc.org/risk-and-protective-factors/. Accessed January 2024.

[4]"Warning Signs." Striving for Zero: California's Initiative for Suicide Prevention 2020-2025, p.60. https://sprc.org/wp-content/uploads/2022/11/CA-Suicide-Prevention-Plan_2020_2025.pdf. Accessed January 2024.

APPENDIX 12: Language, Stigma, and Common Myths

Stigma and Myths Related to Suicide

A variety of factors, from individual to societal levels, contribute to suicide. Stigma, which is defined by the American Psychological Society as "the negative social attitude attached to a characteristic of an individual that may be regarded as a mental, physical, or social deficiency," still plays a key role in how individuals, communities, and systems respond to people experiencing suicidal thoughts and behaviors. This can include barriers to care or receiving inequitable or inappropriate treatment. Individuals considering suicide, and those who have attempted suicide or lost someone to suicide, may also experience isolation or distrust from others. Myths that have been perpetuated about suicide over time reinforce stigma.

Stigmatizing Language[1,2]

The language we use can help mitigate stigma around suicide, or it can exacerbate negative attitudes and assumptions towards individuals who have died by suicide, or individuals with lived experience of suicidal thoughts or attempt.

Recommended language is listed below, on the left, to talk about suicide:

For More Information:

Please Use:	Please Avoid
– Death by suicide – Took their own life – Died of suicide – Killed themself – Suicide death – Person at risk of suicide – Person living with mental health needs	– Committed suicide (this implies that suicide is a sin or a crime) – A successful suicide – A completed suicide – Failed suicide attempt – Suicidal person – Mentally ill person – Suicidal gesture – Contingent suicidality

Canada – Language Matters: Safe Communication for Suicide Prevention

National Action Alliance - Framework for Successful Messaging

Recommendations for Reporting on Suicide

Common Myths

Suicide stigmas, myths and misconceptions can not only cause individuals and communities pain but can prevent people from speaking up and asking for help. Below are common myths and facts about suicide and mental health, adapted from the National Alliance on Mental Illness (NAMI)[3] and Substance Abuse and Mental Health Services Administration (SAMHSA)[4].

Myth: Mental health issues can't affect me.

Fact: Mental health issues can affect anyone. In 2020, about 1 in 5 American adults experienced a mental health condition in a given year; 1 in 6 young people have experienced a major depressive episode, and 1 in 20 Americans have lived with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression. Suicide is a leading cause of death in the United States.

Myth: People with mental health conditions are violent.

Fact: Most people with mental health conditions are no more likely to be violent than anyone else. Only 3%-5% of violent acts can be attributed to individuals living with a serious mental illness. In fact, people with severe mental illnesses are over 10 times more likely to be victims of a violent crime than the general population.

Myth: I can't do anything for a person with a mental health issue.

Fact: Friends and loved ones can make a big difference. In 2020, only 20% of adults received any mental health treatment in the past year, which included 10% who received counseling or therapy from a professional. Friends and family can be important influences to help someone get the treatment and services they need by:

- Reaching out and letting them know you are available to help
- Helping to access mental health services
- Helping to learn self-care and coping techniques
- Listening and sharing facts about mental health, especially if you hear something that isn't true
- Treating them with respect
- Refusing to define anyone by their diagnosis or using harmful labels; instead use person-first language

Myth: It is impossible to prevent a mental health condition

Fact: Prevention of mental, emotional, and behavioral disorders or challenges focuses on addressing known risk factors, such as exposure to trauma or toxic stress, that can affect the chances that children, youth, and young adults will develop mental health conditions. Promoting a person's social-emotional wellbeing leads to:

- Higher overall productivity
- Better educational outcomes
- Lower crime rates
- Stronger economies
- Improved quality of life
- Increased lifespan
- Improved family life

Myth: Suicide only affects individuals with a mental health condition.

Fact: Many individuals who experience a mental health condition are not affected by suicidal thoughts and not all people who attempt or die by suicide have mental health conditions. Risk factors for suicide occur at individual, relationship, community and society levels.

Myth: Once an individual is suicidal, they will always remain suicidal.

Fact: Suicidal crises are often short-term and situation specific. The act of suicide is often an attempt to control deep, painful emotions, thoughts and/or experiences an individual is having. Once these thoughts dissipate, so will active suicidal thoughts. While suicidal thoughts can return, they are not permanent. A person with suicidal thoughts and attempts can live a long, successful life.

Myth: Most suicides happen suddenly without warning.

Fact: Over 70% of people who die by suicide communicated to someone their plans for the attempt prior to death. Planning, including obtaining the means by which to attempt suicide and identifying a location, often happens well before the attempt – sometimes years in advance. Most suicides are preceded by warning signs, such as communicating the desire to die, of having no reason to live, or the feeling of being a burden.

Myth: People who die by suicide are selfish and take the easy way out.

Fact: Typically, people do not die by suicide because they do not want to live – people die by suicide because they want to end their suffering. Those experiencing suicidal thoughts are suffering so deeply that they feel helpless and hopeless, and do not experiencing these thoughts by choice. In this situation, someone is experiencing a significant challenge due to either mental health challenges or a difficult life situation.

Myth: Talking about suicide will lead to and encourage suicide.

Fact: Due to widespread stigma associated with suicide, many people are afraid to speak about it. Talking about suicide not only reduces the stigma, but also allows individuals to seek help, rethink their options and share their story with others. We all need to talk more about suicide.

[1] "Language." Vermont Suicide Prevention Platform, 2023 ed. https://vtspc.org/wp-content/uploads/2023/08/Vermont-Suicide-Prevention-Platform-2023.pdf. Accessed January 2024.

[2] "Stigma and Myths." Striving for Zero: California's Strategic Plan for Suicide Prevention 2020-2025, p.15. https://sprc.org/wp-content/uploads/2022/11/CA-Suicide-Prevention-Plan_2020_2025.pdf. Accessed January 2024.

[3] "5 Common Myths about Suicide Debunked." National Alliance on Mental Illness. https://www.nami.org/Blogs/NAMI-Blog/September-2020/5-Common-Myths-About-Suicide-Debunked. Accessed January 2024.

[4] "Mental Health Myths and Facts." Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/mental-health/myths-and-facts. Accessed January 2024.

APPENDIX 13: Resources

We recognize this is not an exhaustive list, but one that can offer a variety of educational and help resources in VT and nationally.

If you are experiencing suicidal thoughts or crisis, call or text 988. For other crisis and support lines, please see the "Screening Tools, Hotlines and Services" section below.

Support Lines and Services

988 Lifeline — Call, Text or Chat https://988lifeline.org/talk-to-someone-now/

If you're thinking about suicide, are worried about a friend or loved one, or would like emotional support, the Lifeline network is available 24/7 across the United States. The Lifeline is available for everyone, is free, and confidential. The above link includes crisis information for Spanish speakers, Deaf + Hard of Hearing (Deaf/HOH) and American Sign Language Users, and for Veterans.

BlackLine — Call or Text – (800) 604-5841

Visit website for current hotline hours. Provides crisis counseling to BIPOC individuals and collects information on negative police and vigilante contact. Provides services through a Black, LGBTQ and Black Femme lens.

Crisis Text Line — "Steve"

Text "HOME" to 741741 to text with a trained crisis counselor.
Text "Steve" to 741741 to text with a BIPOC-identified crisis counselor.

LGBT National Hotlines

http://www.glnh.org/

LGBT National Hotline includes the main line, youth talkline, senior hotline, and coming out support lines – all found on the website landing page. The site also includes LGBT online peer support chat and a local support finder – LGBTnearMe.org.

Lines for Life Racial Equity Support Line – (503) 575-3764

Visit website for current hotline hours. Offers support to those who are feeling the emotional impacts of racist violence and microaggressions, as well as immigration struggles and other cross-cultural issues.

Pathways Vermont Support Line – (833) 888-2557

https://www.pathwaysvermont.org/what-we-do/our-programs/vermont-support-line/

This line provides confidential, non-judgmental support and connection for all Vermonters over the age of 18 by phone. It's staffed by local peers who've been through tough situations themselves. They listen, talk with you, provide insight, and help you face life's challenges.

Trans Lifeline

https://translifeline.org/

Trans Lifeline connects trans people to the community support and resources we need to survive and thrive.

The Trevor Project

https://www.thetrevorproject.org/

24/7 Counselor support via phone, text or chat. The Trevor Project also engages with advocacy, research, supportive community and public education.

Veterans Crisis Line

https://www.veteranscrisisline.net/

Supports

American Association of Suicidology Attempt Survivor/Lived Experience Division

https://suicidology.org/resources/suicide-attempt-survivors/

To elevate the voices and insights of people with lived experience of suicide attempt in the service of a more fully informed and just understanding of suicide, and better support for those impacted by it.

American Association of Suicidology Loss Survivor Division

https://suicidology.org/resources/suicide-loss-survivors/

To elevate the voices and insights of people who have lost someone to suicide, in the service of a more fully informed and just understanding of suicide, and better support for those impacted by it.

American Foundation for Suicide Prevention — After an Attempt

https://afsp.org/after-an-attempt

A variety of resources for individuals after a suicide attempt, including supportive information, actions one can take following an attempt including developing a safety plan, and connections to the AFSP community.

American Foundation for Suicide Prevention — Resources for Suicide Loss Survivors

Children, Teens and Suicide Loss — https://aws-fetch.s3.amazonaws.com/flipbooks/childrenteenssuicideloss/index.html?page=1

Find a Support Group — https://afsp.org/find-a-support-group

Healing Conversations — https://afsp.org/healing-conversations

International Survivors of Suicide Loss Day — https://afsp.org/international-survivors-of-suicide-loss-day

I've Lost Someone — https://afsp.org/ive-lost-someone

Loving Memories — https://lovingmemories.afsp.org/

Out of the Darkness Walks — https://supporting.afsp.org/index.cfm?fuseaction=cms.page&id=1370

Surviving a Suicide Loss — https://aws-fetch.s3.us-east-1.amazonaws.com/flipbooks/survivingASuicideLoss/index.html?page=1

Resources for children, youth, and adults; support groups, and events for those who have lost someone to suicide. Connecting with other survivors and talking openly about suicide with people who really understand can be a powerful experience and a crucial part of the healing process.

Guide for Sharing Lived Experience

https://www.mamh.org/assets/files/PsychHub-Guide-for-Sharing-Lived-Experience.pdf

Heartbeat: Survivors After Suicide

https://www.heartbeatsurvivorsaftersuicide.org/

Peer support offering empathy, encouragement and direction following the suicide of a loved one.

National Action Alliance Task Force on Survivors of Suicide Loss and Task Force on Suicide Attempt Survivors

https://theactionalliance.org/our-strategy/lived-experience

These two Action Alliance groups have guided work to support engagement of those with lived experience. This page includes information on the task groups and resources they have developed.

National Suicide Prevention Lifeline — for Attempt Survivors

https://suicidepreventionlifeline.org/help-yourself/attempt-survivors

https://lifelineforattemptsurvivors.org/

The National Suicide Prevention Lifeline offers both a lifeline for survivors of suicide attempt and resources.

Special considerations for telling your own story: Best practices for presentations by suicide loss and suicide attempt survivors

https://zerosuicide.edc.org/resources/resource-database/special-considerations-telling-your-own-story-best-practices

United Suicide Survivors International (US)

https://unitesurvivors.org/

An independent global organization serving as a home for people who have experienced suicide loss, suicide attempts and suicidal thoughts and feelings, and their friends and families — collectively known as people with lived experience with suicide — to leverage their expertise for large scale change.

Mental Health Services in Vermont

Clara Martin Center ..... www.claramartin.org

Randolph 802.728.4466
Bradford 802.222.4477
24-Hour Hotline 800.639.6360

Counseling Services of Addison County, Inc. ..... www.csac-vt.org

Middlebury 802.388.6751
24 Hour on-call Emergency Services 802.388.7641

Health Care & Rehabilitation Services ..... www.hcrs.org

Springfield 802.886.4500
Brattleboro 802.254.6028
Bellows Falls 802.463.3947
Windsor 802.674.2539
Hartford 802.295.3031
Crisis/Emergency 24-Hour Hotline 800.622.4235

First Stop for Children's Services:
Springfield 855.220.9429
Hartford 855.220.9430
Brattleboro 855.220.9428

Howard Center — Chittenden County ..... www.howardcenter.org

24-Hour Crisis Hotlines:
First Call for Children & Families 802.488.7777
Adult Mental Health 802.488.6400

Lamoille County Mental Health Services ..... www.lamoille.org

Morrisville 802.888.5026
Weekdays: 8-4:30 ..... 802.888.5026
Nights & Weekends ..... 802.888.5026 Option "1"
(Ask to page Crisis Team or Emergency Services)

Northeast Kingdom Human Services ..... www.nkhs.org

Derby ..... 802.334.6744 or 800.696.4979
St. Johnsbury ..... 802.748.3181 or 800.649.0118

Northwestern Counseling & Support Services ..... www.ncssinc.org

St. Albans 802.524.6554
Crisis Services Toll Free 800.834.7793

Northeastern Family Institute ..... https://www.nfivermont.org/

South Burlington 802.658.0040

Pathways VT.....https://www.pathwaysvermont.org/

Support Line.....833.888.2557
Winooski.....888.492.8218 ext. 300

Rutland Mental Health Services.....www.rmhsccn.org

Rutland.....802.775.2381
24 Hour on-call Emergency.....802.775.1000

United Counseling Service.....www.ucsvt.org

Family Emergency Services (FES).....802.442.1700
Bennington.....802.442.5491
Manchester.....802.362.3950

Washington County Mental Health.....www.wcmhs.org

Montpelier.....802.229.0591