Welcome to the 2022 Learning Collaborative

What is a Learning Collaborative?

- “Learning collaboratives combine learning and social connectedness to provide both peer-to-peer and expert-to-peer learning. Through learning communities, peer organizations come together to focus on a problem, explore that challenge, and co-create solutions. Because this process happens in community, successes are shared, and each site can adapt insights to their context.”

~ The National Center for Complex Health & Social Needs, An initiative of the Camden Coalition


future-oriented
standardization
improvement
client-centered
collaborative
dissemination
hope
flexibility
quality
continuity
norming
internet
connection
community
collaboration
kindness
diversity
gatherings
connectivity
innovation
progress
continue
teaming
success
parity
fluidity
integration
shift
consistency
valuable
patience
interagency
efficiency
resilience
access
engagement
reduction
re-vitalization
optimization

Dates	Offerings
February 11 **8:30 – 12:30**	Preventing Death by Suicide: Involving the Whole Community in Suicide Prevention.
March 18 **8:30 – 12:30**	Preventing Death by Overdose: Focus on Harm Reduction and Low Barrier Access to Treatment.
April 29 **8:30 – 12:30**	The ‘Care’ in Healthcare: Links Between Clinical and Community Care.
May 20 **8:30 – 12:30**	Building A Trauma Informed Community: From Practice to Policy.

Suicide Prevention in Vermont: A Statewide Perspective

Tom Delaney, PhD

February 11, 2022

Acknowledgements

Vermont Departments of Health and Mental Health

- Caitlin Quinn and the VDH Health Surveillance Team

Center for Health and Learning / VT-SPC

Vermont Suicide Prevention Coalition

NNEPC and the Intentional Self-Poisoning Prevention Work Group

UVM Departments of Pediatrics and Psychiatry

Drs. Rebecca Bell, Loan Hegg, Rachael Comeau and many others…

VCHIP
Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT LARNER COLLEGE OF MEDICINE

VERMONT
DEPARTMENT OF HEALTH

Firearm Injury and Death

January 2022

A firearm injury is a nonfatal injury caused by the discharge of a firearm by accident, assault, intentional self-harm, or through legal intervention. A firearm death is a death caused by the discharge of a firearm unintentionally, in an assault, to complete suicide or through legal intervention. This brief looks at deaths and hospital visits due to firearms among Vermont residents.. Statistically significant differences are noted with an asterisk.

Firearm Injuries and Deaths

Firearms were responsible for 49 hospital visits and 75 deaths in 2020. Tl

VERMONT
DEPARTMENT OF HEALTH

Intentional Self-Harm and Death by Suicide

January 2022

Intentional self-harm is anything a person does to purposefully cause injury to themselves, with or without suicide intent. Death by suicide i intentionally taking one's own life. Research suggests that self-injurio behaviors, which include suicide attempts, are risk factors for suicide

Trends in Intentional-Self Harm & Death by Suicide

In 2020, Vermont had 903 hospital visits for intentional self-harm, wi a rate of 160.3 per 100,000. The rate of visits in 2020 decreased fro 2019, and this may have been influenced by the COVID-19 pandemic and fewer visits to the hospital overall. The rate of intentional-self har 2014* and has been decreasing since 2017. No rate in 2015 is shov codes, and caution should be taken when comparing 2014 to later da

In 2020, there were 117 suicide deaths among Vermont residents, w Suicide is the 8th leading cause of death in the state. Over the past 1(suicide has fluctuated, with the rate lowest in 2012, and highest in 2(increased 18% from 2019 to 2020. Compared to the U.S., Vermont's

Suicide-Related Emergency Department Visits

Most Suicide-Related Emergency Department Visits are for Suicidal Ideation.

Between January 1 – June 30, 2021 Vermont Emergency Departments (EDs) saw 2,376 suicide-related ED visits.* Of these visits, 1,747 mentioned suicidal ideation (SI); 177 self-harm with SI; 145 intentional poisoning and SI; 128 intentional poisonings; 120 other self-harm; 8 SI, intentional poisoning, and self-harm; and 6 oisonings.

KEY POINTS

VERMONT
DEPARTMENT OF HEALTH

Industry and Occupation of Vermonters Who Died by Suicide

January 2022

There are several factors that influence health and life expectancy, including where we work and the types of work we do. Death certificates collect information about the industry and occupation from those who have died. In this context, this brief refers to the work that was performed during most of a person's working life, focusing on Vermonters between the ages of 16 and 64. These data are collected through interviews with family members and people who knew the decedent, and then are classified into industry and occupation major groupings using national standardized methodology.[1,2] Significant differences are noted with an asterisk.

KEY POINTS

- **Vermonters working the in agriculture, forestry, fishing and hunting or construction industries have a suicide rate that is 3 times higher than the general population.**
- **Vermonters working in farming, fishing, and forestry occupations have a suicide death rate 6 times higher than the general**

Overview of Today's Presentation

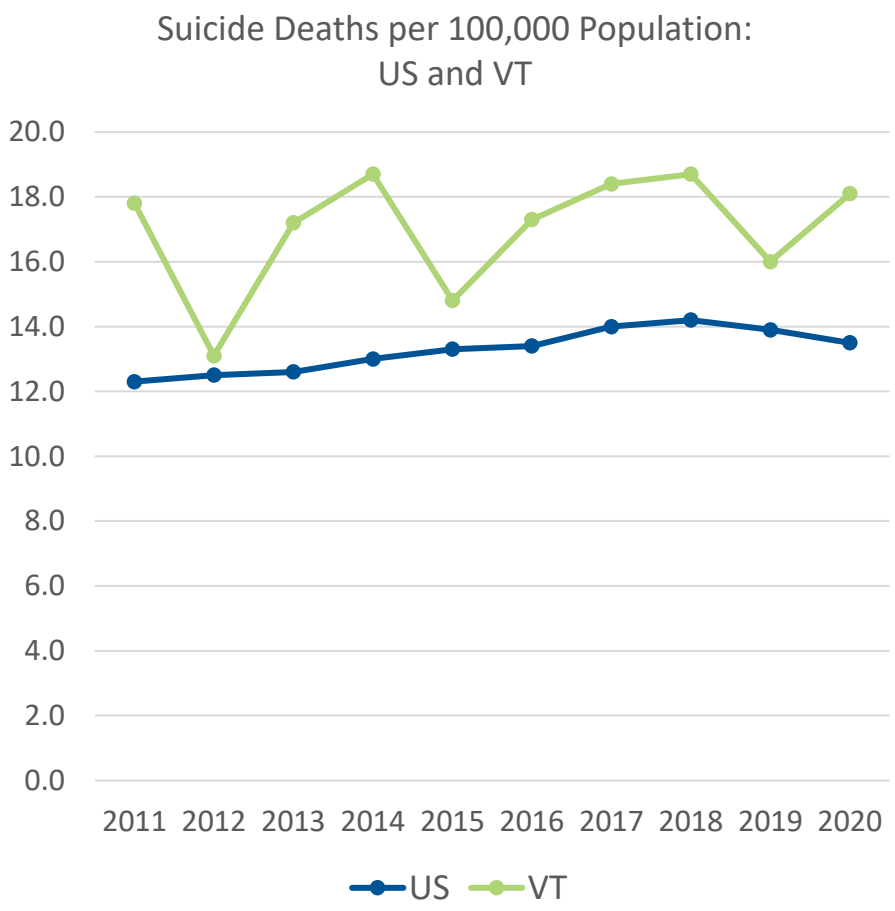
- Background on suicide in Vermont and the US
- Overview of Lethal means and risk factors
- COVID-19 and suicide risk
- Review statewide initiatives
- Questions and discussion

Checking In About Language

Do say	Don't say	Why?
'non-fatal' or 'made an attempt on his/her life'	'unsuccessful suicide'	To avoid presenting suicide as a desired outcome or glamourising a suicide attempt.
'took their own life', 'died by suicide' or 'ended their own life'	'successful suicide'	To avoid presenting suicide as a desired outcome.
'died by suicide' or 'ended his/ her own life	'committed' or 'commit suicide'	To avoid association between suicide and 'crime' or 'sin' that may alienate some people.
'concerning rates of suicide'	'suicide epidemic'	To avoid sensationalism and inaccuracy.

Adapted from everymind.org.au

US and Vermont Suicide Mortality

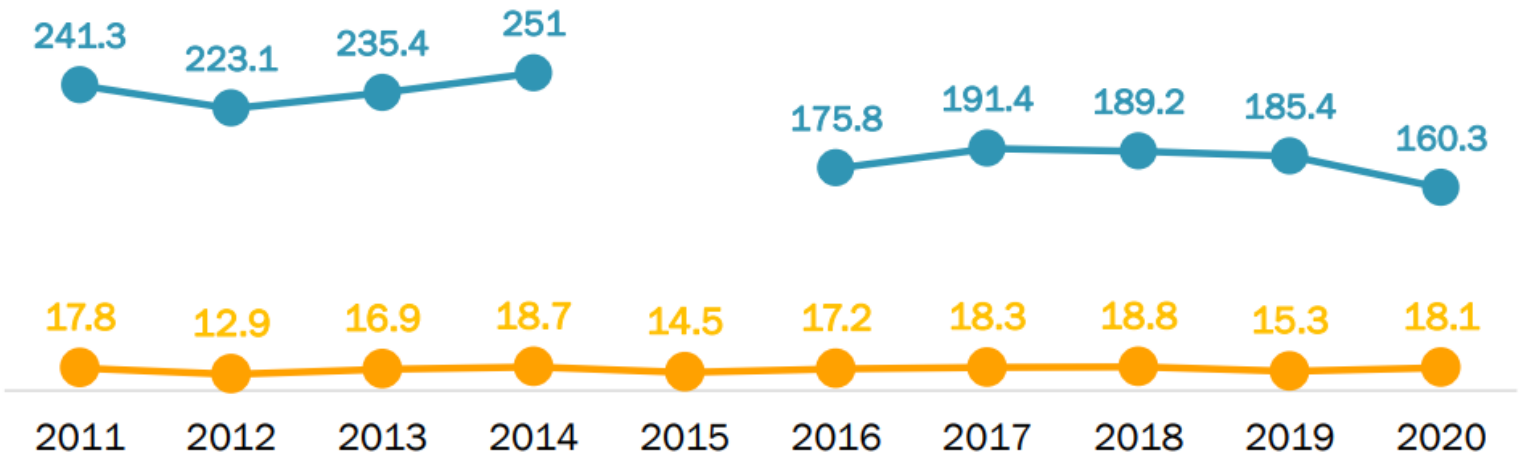


- Using rates to account for population size differences
- VT consistently higher over time
- VT has more variability

VT Trends in Self-harm and Suicide Mortality

Over the past decade, intentional self-harm and death by suicide rates have fluctuated.

Age-adjusted rates per 100,000 Vermonters



Source: Vermont Vital Statistics, 2011-2020, Vermont Uniform Hospital Discharge Data Set, 2011- 2020

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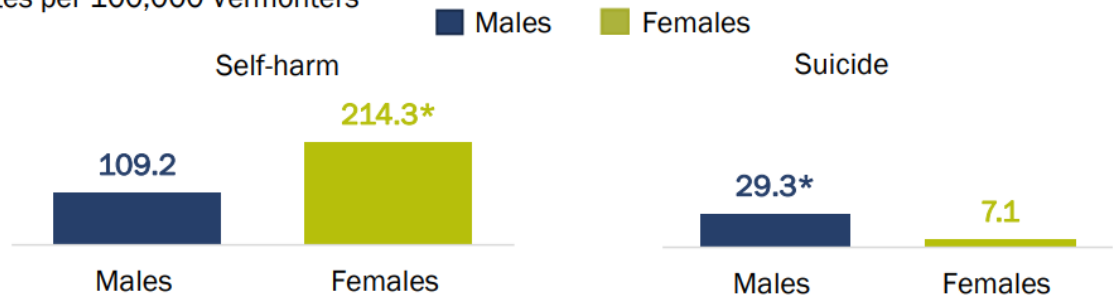
Self Harm and Suicide Rates: Gender and Age

Hospital visit rates for intentional self-harm are significantly higher for females. Suicide deaths are significantly higher for males.

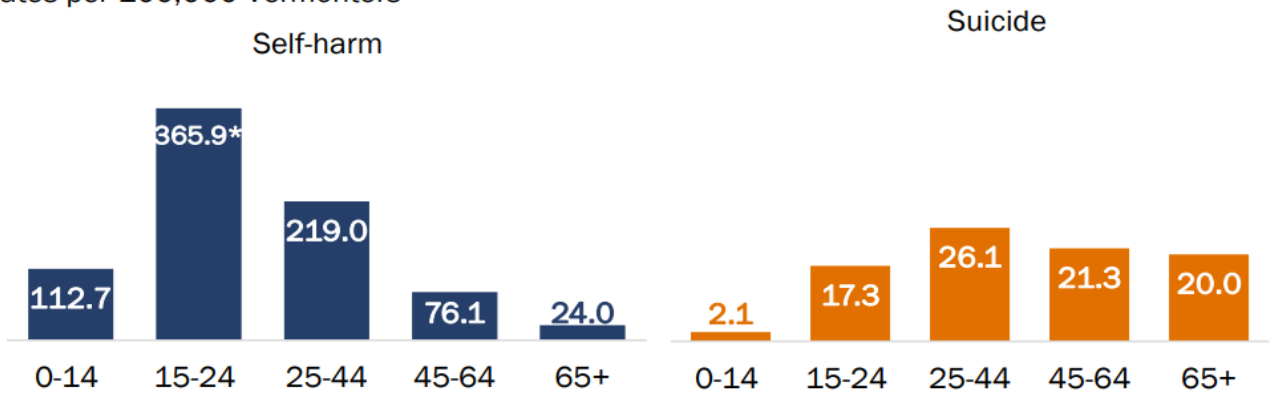
Rates per 100,000 Vermonters



Source: Vermont Vital Statistics 2020, Vermont Uniform Hospital Discharge Data Set 2020

Hospital visit rates for intentional self-harm are significantly higher among 15 to 24-year-olds. Suicide rates are similar by age.

Rates per 100,000 Vermonters



Source: Vermont Vital Statistics 2020, Vermont Uniform Hospital Discharge Data Set 2020

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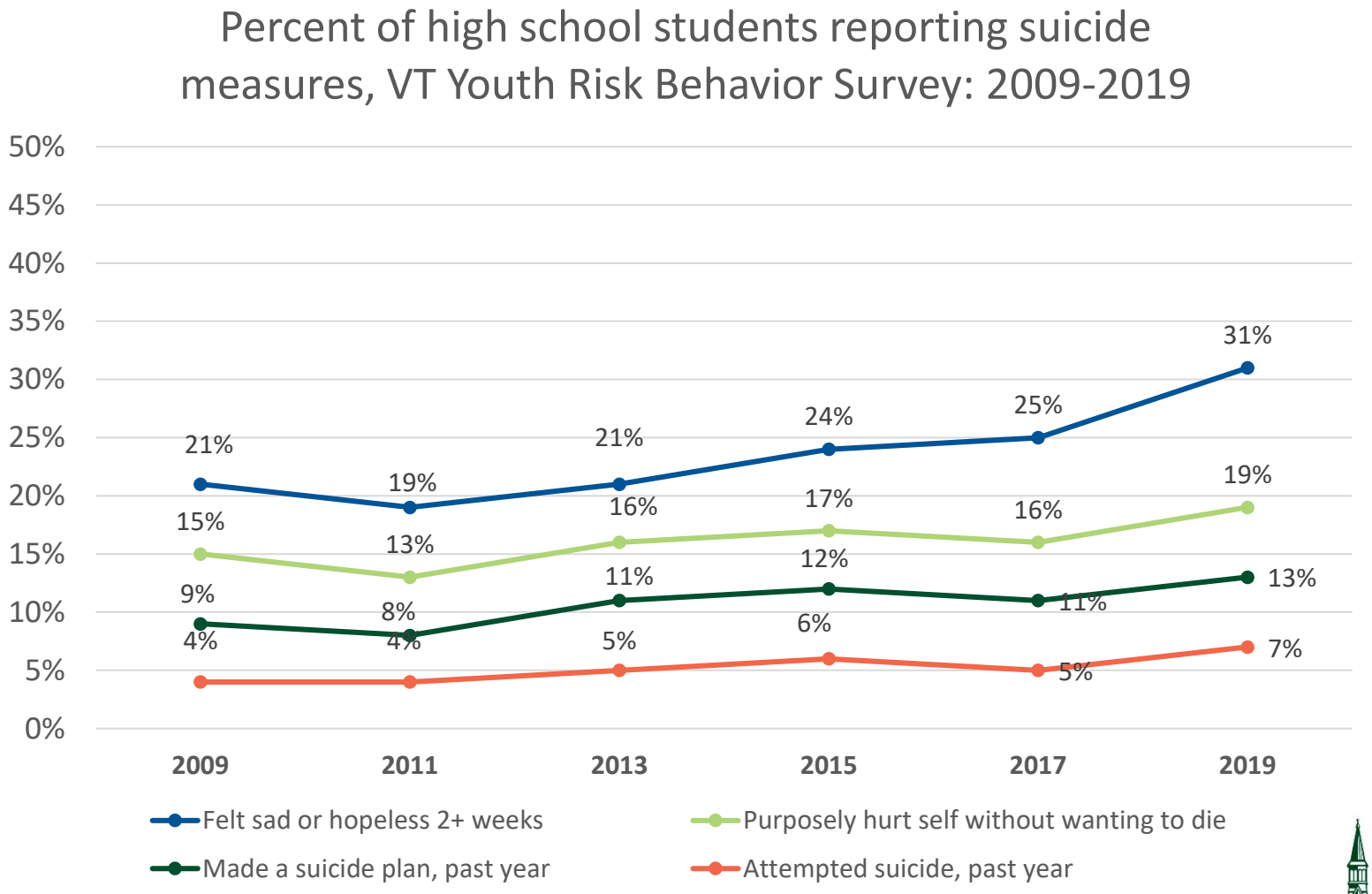
Suicide-related Trends in VT Youth



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Populations at risk for intentional self-harm and suicide.

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

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

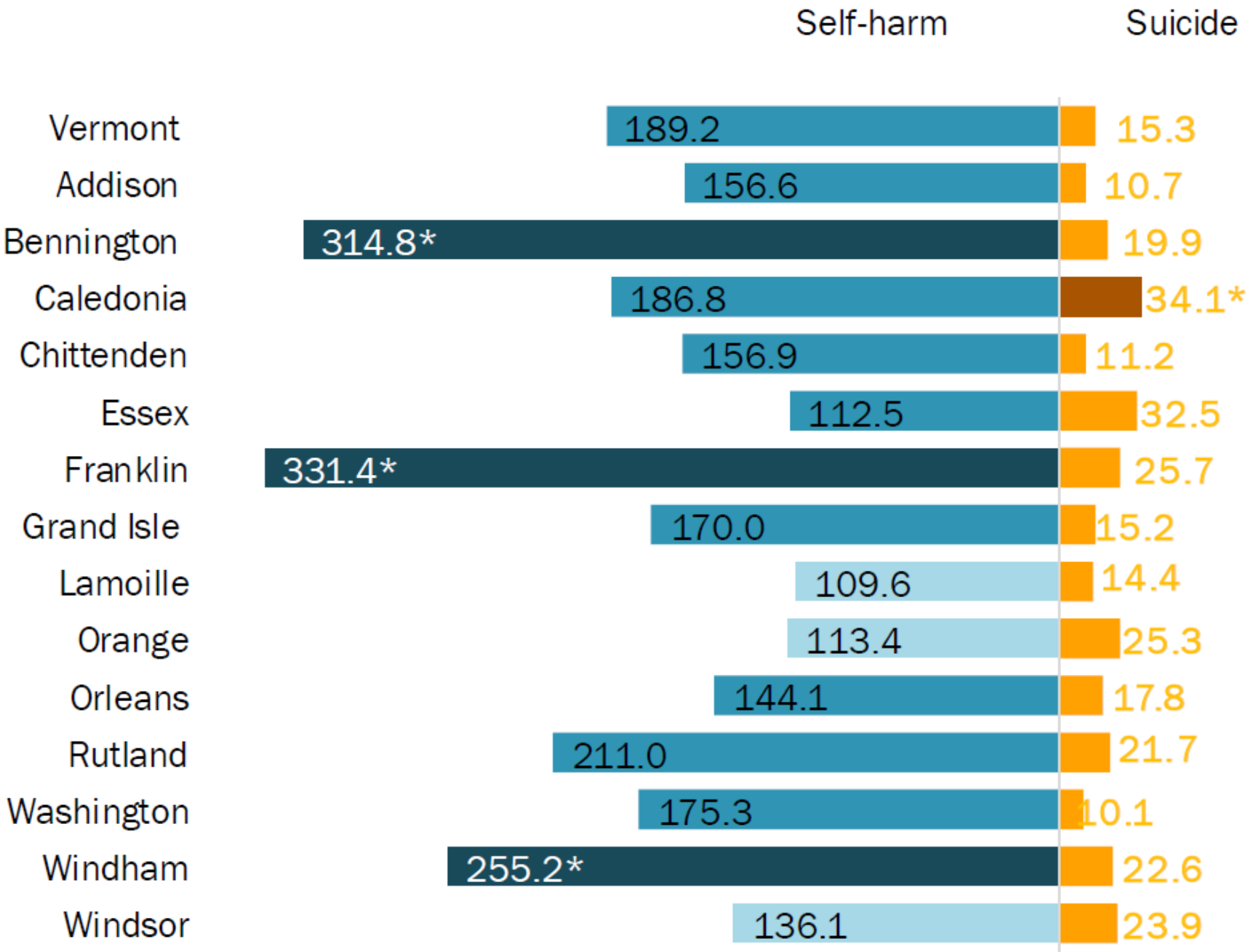
Black, Indigenous, and People of Color (BIPOC) students are more likely to feel sad or hopeless, make a suicide plan, or attempt suicide (sad 34% vs. 30%, plan 17% vs. 13%, attempt 10% vs. 6%). BIPOC adults are more likely to have a depressive disorder (30% vs. 21%). BIPOC Vermonters represent 7% of suicide deaths.

Vermonters who served in the U.S. armed forces represent 13% of suicide deaths.

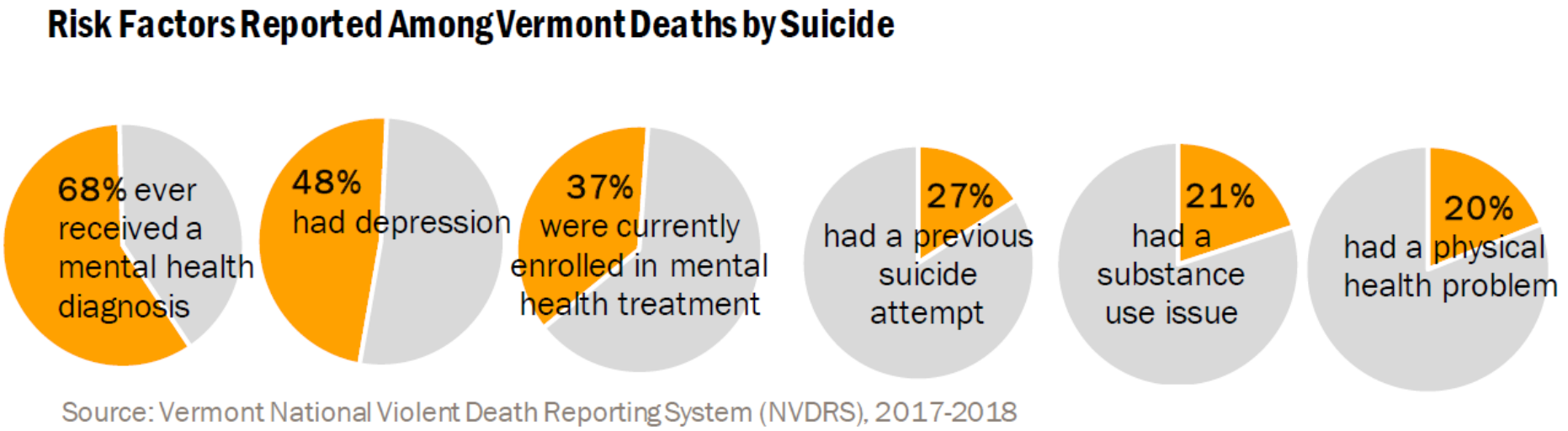
Social isolation is a risk factor for suicide. 9% of adults rarely or never get social and emotional support, with rates highest for those 65 years and older (13%).

Source: Vermont Behavioral Risk Factor Surveillance System 2018, Vermont Youth Risk Behavior Survey 2019, Vermont Vital Statistics, 2020

Rates of intentional self-harm and suicide by county of residence.



Suicide-related Risk Factors in VT



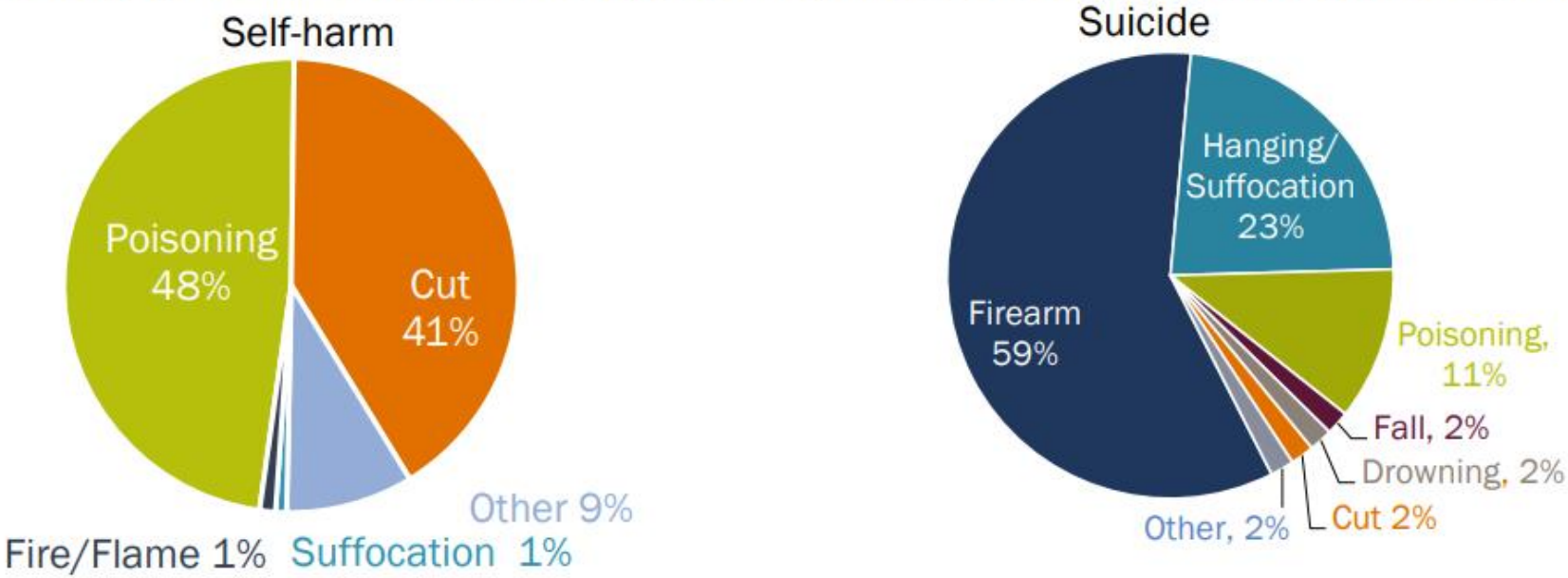
Other Correlates:

- 42% were never married/civil union
- 15% had less than HS education, 44% HS and 12% some college
- 14% had recent release from an institution

Sources: VTVTDRS and www.healthvermont.gov/sites/default/files/documents/pdf/HSVR_injury_suicidemortality_2017.pdf

Suicide, Self-Harm and Lethal Means

Most hospital visits for self-harm are poisonings. Most suicide deaths are due to firearms.



Source: Vermont Vital Statistics 2020, Vermont Uniform Hospital Discharge Data Set 2020

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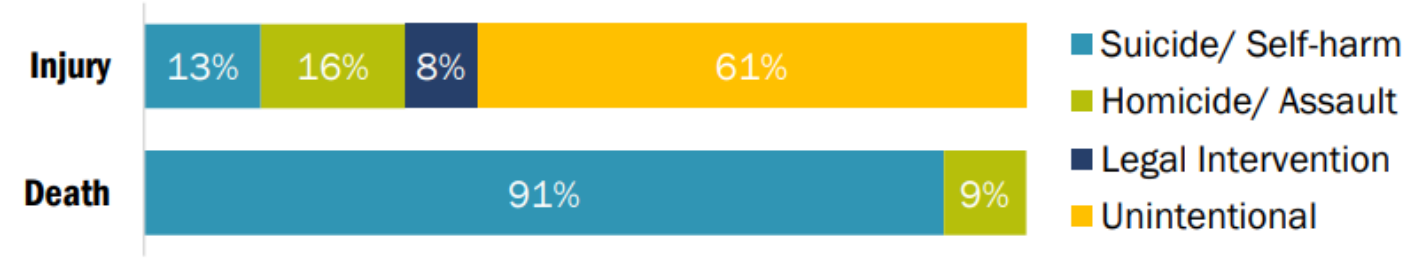
Firearms and Suicide in Vermont

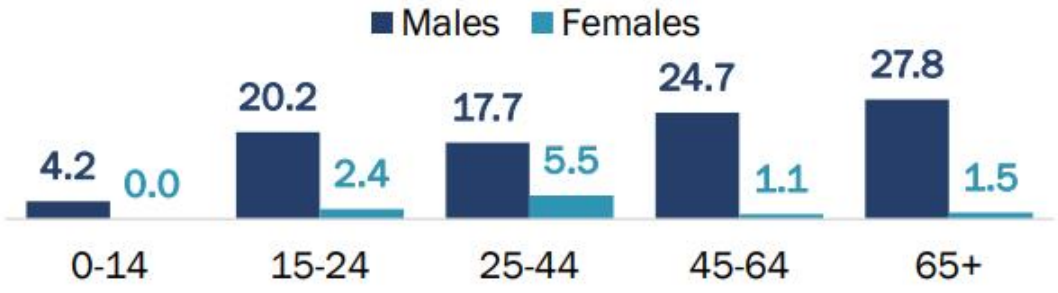
A majority of firearm injuries are unintentional, while the majority of deaths are suicide.



Source: Vermont Vital Statistics 2020, Vermont Uniform Hospital Discharge Data Set 2019-2020

Firearm suicide death rates are highest for 65+ year old males.

Rate per 100,000 Vermonters



Source: Vermont Vital Statistics 2020

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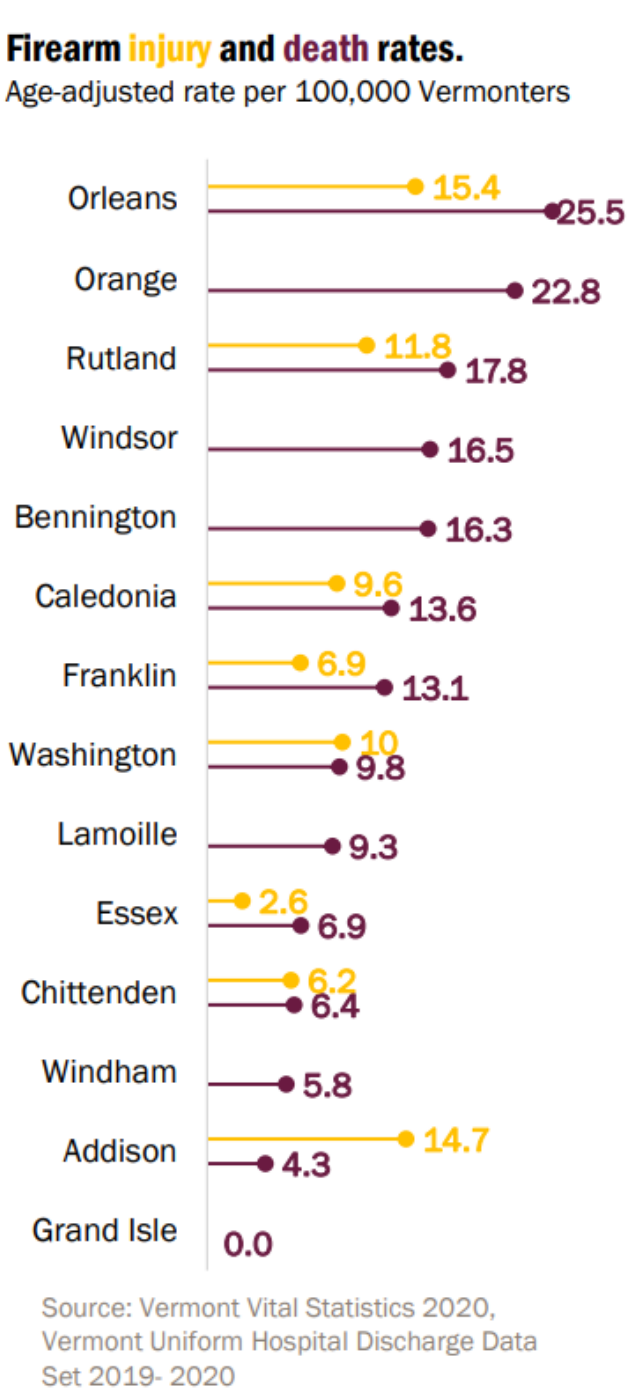


Key Points:

Most firearm deaths are suicides

Having a firearm in the home increases the risk of death by all causes, including by suicide

43% of Vermont households have one or more firearm

All firearms should be stored unloaded and locked, with the ammunition stored and locked separately.

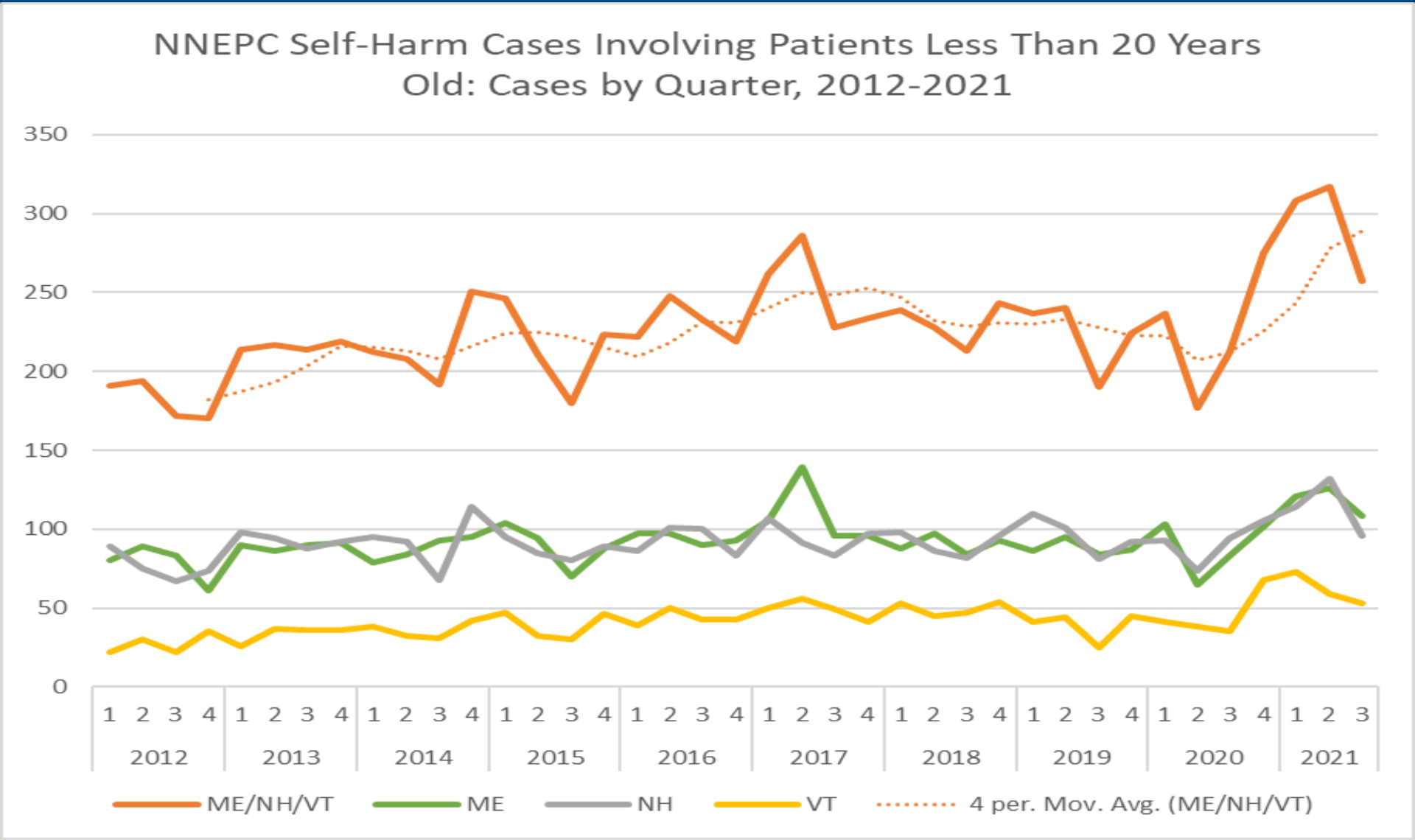
Suicide and Self-harm During COVID-19: What Do We Know?

We're waiting on definitive answers…

Anecdotally, there were increases in mental health symptoms and suicide risk factors starting in spring/summer 2020.

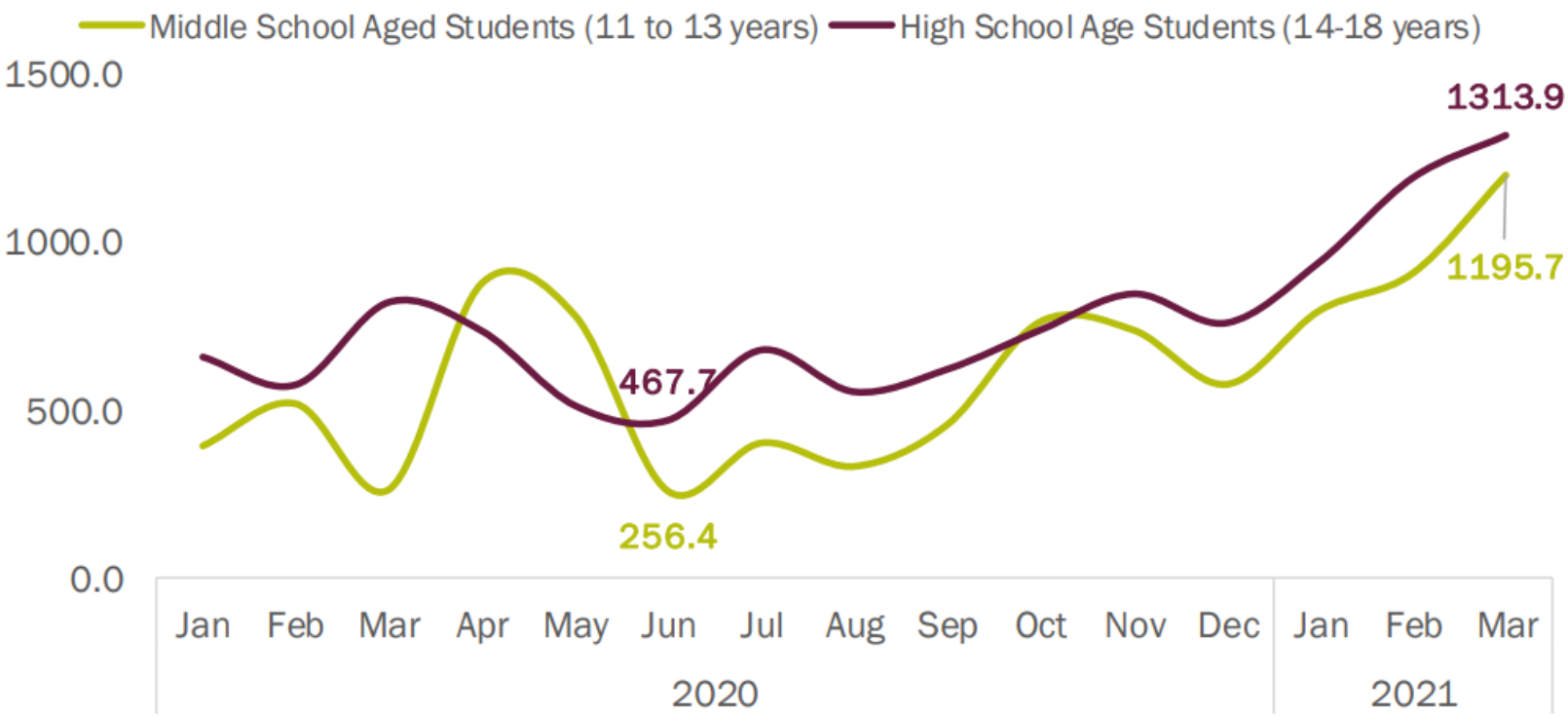
- Emergency Department visits for suicide attempts, suicidal ideation and self-harm appeared to decrease in early/middle 2020, then rebounded
- Suicide deaths rates decreased for the US as a whole, but increased in specific states
- Mental health symptoms broadly increased in specific locations
  - Norwegian study: symptoms increased in young adults from 2018 to 2021 (to 62% of females and 41% of males)
- Poison center calls and ED visits provide some information

Suicide and Self-harm During COVID-19: Early Trends



From June 2020 to March 2021, ED visit rates for suicidal ideation and self-directed violence have quadrupled for middle school aged students, and nearly tripled for high school aged students.

Rate per 10,000 Middle/High School Aged Youth ED Visits



Current/Recent Vermont Initiatives Aimed at Reducing Suicide and Self-Harming Behaviors

- CDC grant to DMH and VDH: Comprehensive Suicide Prevention
- Zero Suicide initiative in seven Designated Agencies
- VT-SPC training initiatives (Umatter) as well as MHFA, ASIST and other models
- VCHIP project to increase suicide-specific screening in the ED, led by Dr. Christian Pulcini
- Drs. Bell's & Delaney's project on counseling for firearm safe storage
- Vermont Intentional Self-Poisoning Prevention Toolkit
- Howard Center and their partners promoting safe storage of medications
- Educational work being done in the UVM Dept. of Psychiatry
- UVMMC Community Health Improvement project in primary care
- Suicide Safer Pathways to Care project ("Minigrants")
- Efforts by individual DAs, psychiatrists, community-based providers and others

Conclusions and Discussion

- Rates of suicide and other self-harming behaviors have increased in recent years in Vermont, with some groups having increased risk
- Firearms represent the most common means used for suicide
- Not clear yet on the long-term impacts of COVID-19 on suicide deaths, attempts and self-harm rates
- Wide array of programs and projects aimed at preventing suicide in Vermont

Questions/Comments?

Contact: thomas.delaney@uvm.edu

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Northwestern Counseling & Support Services (NCSS)

Looking In & Out to Increase Suicide Prevention in Franklin and Grand Isle Counties

February 2022

What's Happening in your Community?

What community engagement initiatives or suicide prevention programs would like your VT colleagues to know about? Let us know!

Use the tool bar at the left to add sticky notes to the board.

Lock boxes shared for community and tracking stories

More intentional overlap / embedded clinicians within law enforcement

respond to those in crisis. Similar to what NCSS is doing with VSP and St. A City PD. However, our model is to significantly enhance what Deputies have for capabilities to not only respond to those in crisis, but to

Columbia screening cards in schools to support staff

Suicide prevention training at school inservice

Mental Health
FIRST AID

from NATIONAL COUNCIL FOR
MENTAL WELLBEING

Mental Health First Aid Background

- Public education course designed to increase mental health literacy and intervention skills
- Focus on stigma reduction and creating a positive culture around mental wellbeing
- Uses role play and discussion to facilitate learning
- Focus on recognizing signs and symptoms of distress/crisis and offering support
- Teaches the warning signs of suicide and how to support someone in seeking safety

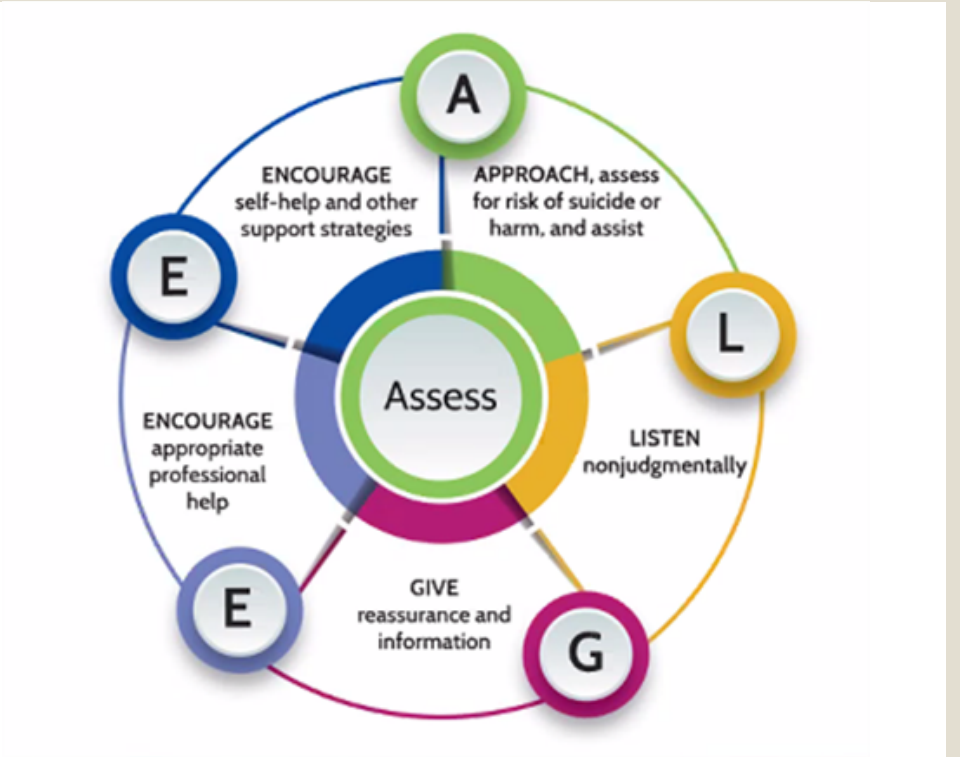
Delivery Options

Adult MHFA

Adult helping peers

Delivery:

- 8 hour in person training
- 2 hours virtual & 6 hours live instruction
- Current funding from AOE for any student or school in Vermont



Suicide Myth or Fact

MYTH OR FACT?

MYTH OR FACT?

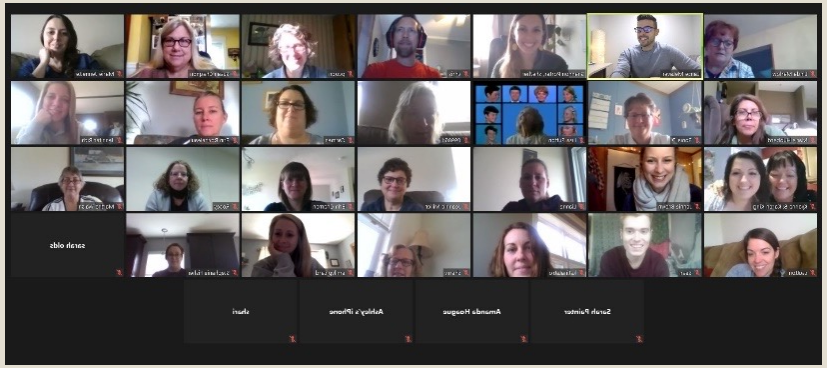
MYTH OR FACT?

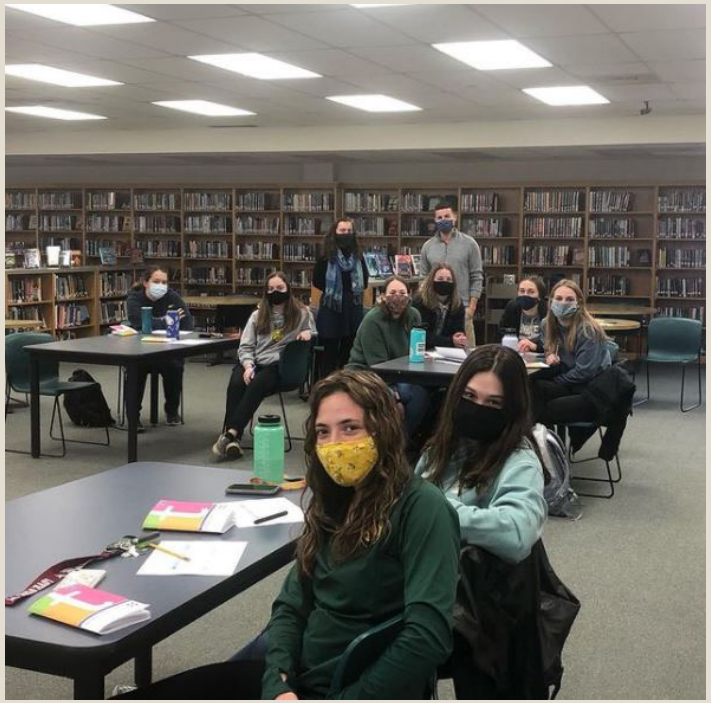
MYTH OR FACT?

MYTH OR FACT?

MYTH OR FACT?

Our Outcomes





How has this helped our mission?

- Offers continual feedback loop with our community
- MHFA training has highlighted additional needs
  - Often for more training needs or specific supports
- Offers high quality suicide prevention/intervention training
  - Creates a positive culture around mental wellbeing
  - Focuses on stigma reduction
  - Increases awareness of supports and increases access to care
- MHFA has saved lives throughout our state

NORTHWESTERN COUNSELING & SUPPORT SERVICES

Questions?

Or

Want to be involved?

Lance Metayer

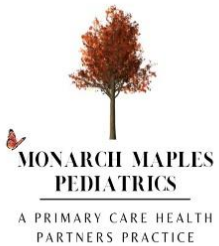
Lance.Metayer@ncssinc.org

Implementing a Suicide Prevention Treatment in Primary Care: CAMS

Deana Chase, LICSW, ACM

Catherine Marrin, LICSW

Northwestern Counseling & Support Services (NCSS)



SENSITIVE USE OF LANGUAGE

Terms that perpetuate stigma or misinformation about suicide are strongly discouraged.

Those who have lost a loved one to suicide are ***suicide survivors***.

Those who have lived through a suicide attempt are ***suicide attempt survivors***.

PLEASE USE:

- Death by suicide
- Took his or her own life
- Died of suicide
- Killed him- or herself
- Suicide death

PLEASE AVOID:

- Committed suicide (because it implies that suicide is a sin or a crime)
- A completed suicide
- A successful suicide
- Failed suicide attempt

NCSS is Embedded in the following Primary Care Practices

- Northwestern Primary Care
- Monarch Maple Pediatrics St. Albans
- Monarch Maple Pediatrics Enosburg
- Northwestern Georgia Health Center
- St. Albans Health Center
- Swanton Health Center
- Alburg Health Center
- Richford Health Center
- Fairfax Health Center
- Enosburg Health Center

Designated Agency & Integrated Health

Behavioral Health in Primary Care

What does this look like?

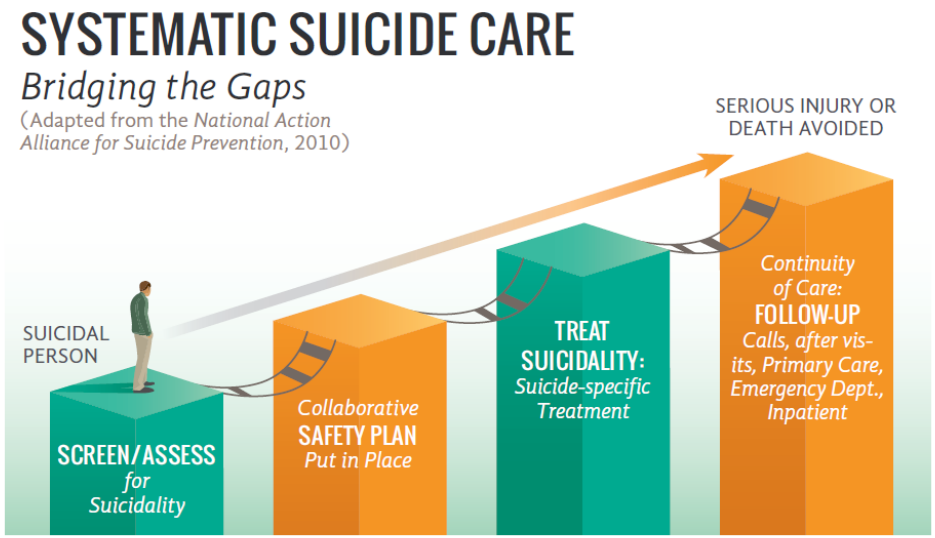
- Social Worker embedded full-time
- A part of clinic workflow & screenings
- Coordination of Care
- Scheduled Patients & Warm Hand-Offs
- Therapy
- Referrals to Services/Navigation of Services
- Consultation with providers

Why Provide Suicide Specific Care in Primary Care

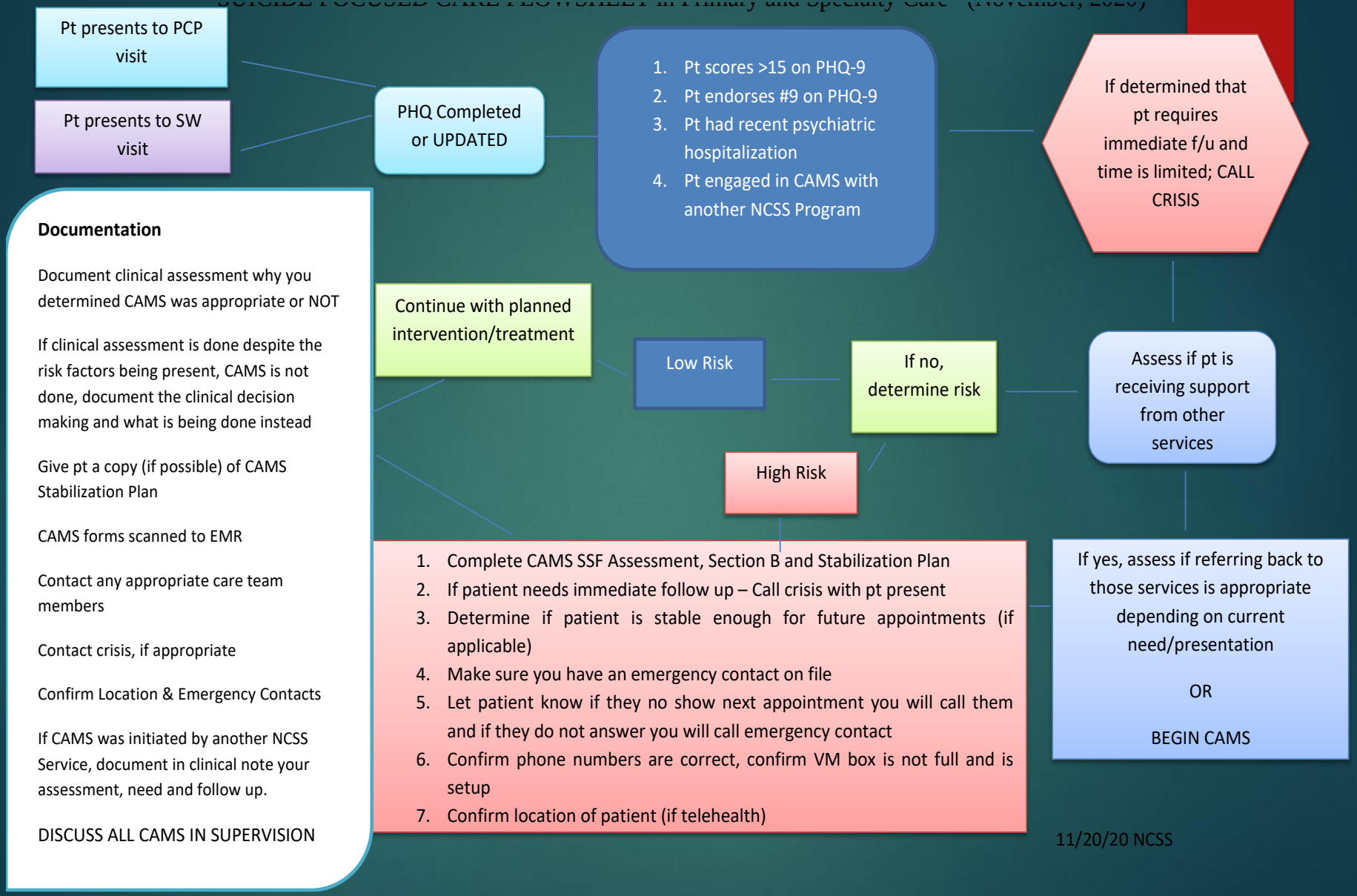
- 45% of those who have died by Suicide have seen their primary care provider 30 days prior to their death. The % is significantly higher for Elders (Ahmedani, Simon, Stewart, Beck, Waitzfelder, Rossom, et. al., 2014)
- Primary Care provides a unique access point for prevention & intervention
- It is essential that the entire clinic is part of the continuum of suicide focused care
- Continuous quality improvement opportunities in supporting suicide focused care

Workflow in Primary Care

- PHQ-9 screening done at every patient visit
- Individual's score is 15 or great OR endorses #9
- Warm hand off to Embedded Social Worker
- CAMS Screening Completed
- Access need for Crisis involvement
- Safety Plan
- Schedule follow up with individual
- Confirm emergency contact
- Consult with Primary Care Provider



Critical Transitions of Care


Pt presents to PCP visit
Pt presents to SW visit
PHQ Completed or UPDATED
1. Pt scores >15 on PHQ-9
2. Pt endorses #9 on PHQ-9
3. Pt had recent psychiatric hospitalization
4. Pt engaged in CAMS with another NCSS Program
If determined that pt requires immediate f/u and time is limited; CALL CRISIS
Documentation
Document clinical assessment why you determined CAMS was appropriate or NOT
If clinical assessment is done despite the risk factors being present, CAMS is not done, document the clinical decision making and what is being done instead
Give pt a copy (if possible) of CAMS Stabilization Plan
CAMS forms scanned to EMR
Contact any appropriate care team members
Contact crisis, if appropriate
Confirm Location & Emergency Contacts
If CAMS was initiated by another NCSS Service, document in clinical note your assessment, need and follow up.
DISCUSS ALL CAMS IN SUPERVISION
Continue with planned intervention/treatment
Low Risk
If no, determine risk
Assess if pt is receiving support from other services
High Risk
1. Complete CAMS SSF Assessment, Section B and Stabilization Plan
2. If patient needs immediate follow up – Call crisis with pt present
3. Determine if patient is stable enough for future appointments (if applicable)
4. Make sure you have an emergency contact on file
5. Let patient know if they no show next appointment you will call them and if they do not answer you will call emergency contact
6. Confirm phone numbers are correct, confirm VM box is not full and is setup
7. Confirm location of patient (if telehealth)
If yes, assess if referring back to those services is appropriate depending on current need/presentation
OR
BEGIN CAMS
11/20/20 NCSS

Future Planning…

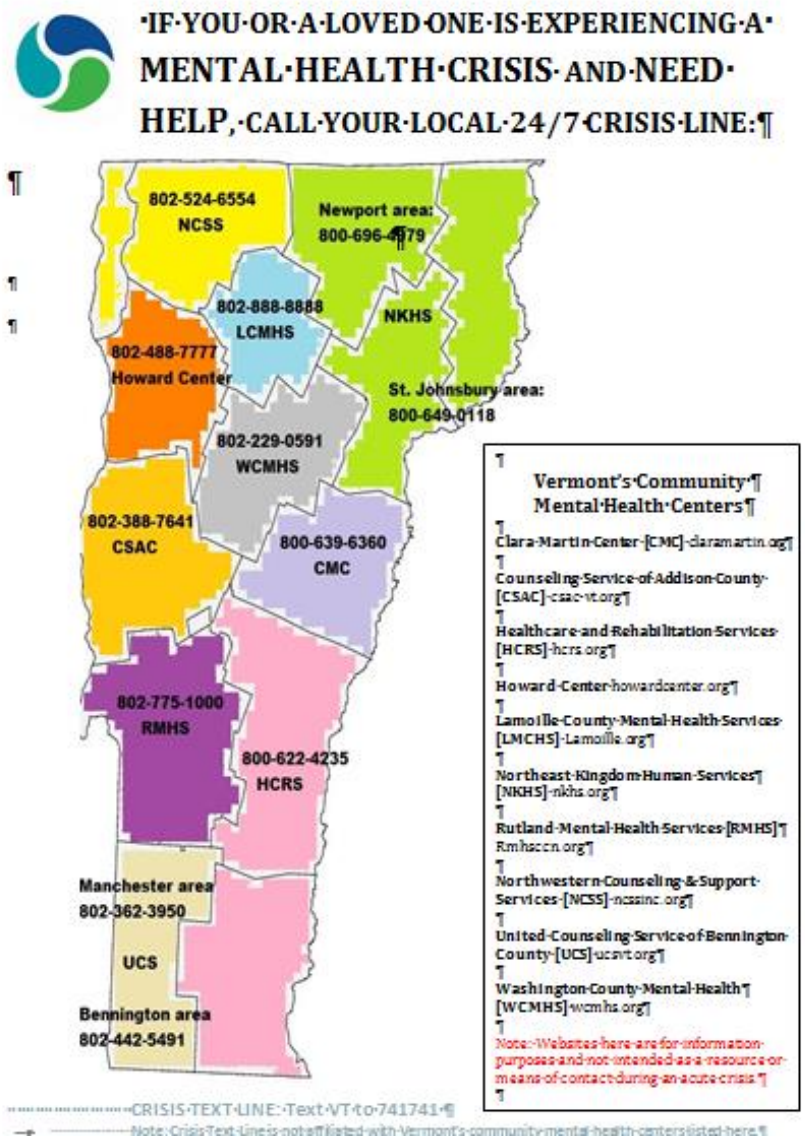
- Piloting Columbia Severity Scale workflow to help reduce "false positives"
- Train all clinic staff in mental health first aid
- Work on ways to reduce stigma around suicide focused care
- Support clinic staff with trauma informed language around suicide
- Tracking suicide focused data in EHR – including a system to make all staff aware that patient is engaged in Suicide focused care
- Piloting workflows where Social Worker is part of patient visits

What resources are available to implement this model in your community?

- Center for Health and Learnings: Vermont Suicide Prevention Center

- Your local Designated Agency (DA's): Contact information for each on next slide

Vermont Designated Mental Health Agencies



Need help?

- Talk to a family member, friend, health care provider or faith leader
- Call your local mental health agency or crisis team
- Text the Vermont Crisis Text Line:

  VT to 741741
- Call 211 or the National Suicide Prevention Lifeline: 800-273-TALK (8255)

Resources for help can be found at:

www.vtspc.org

THANK YOU FOR THE WORK YOU DO!

LCMHS
Lamoille County Mental Health Services

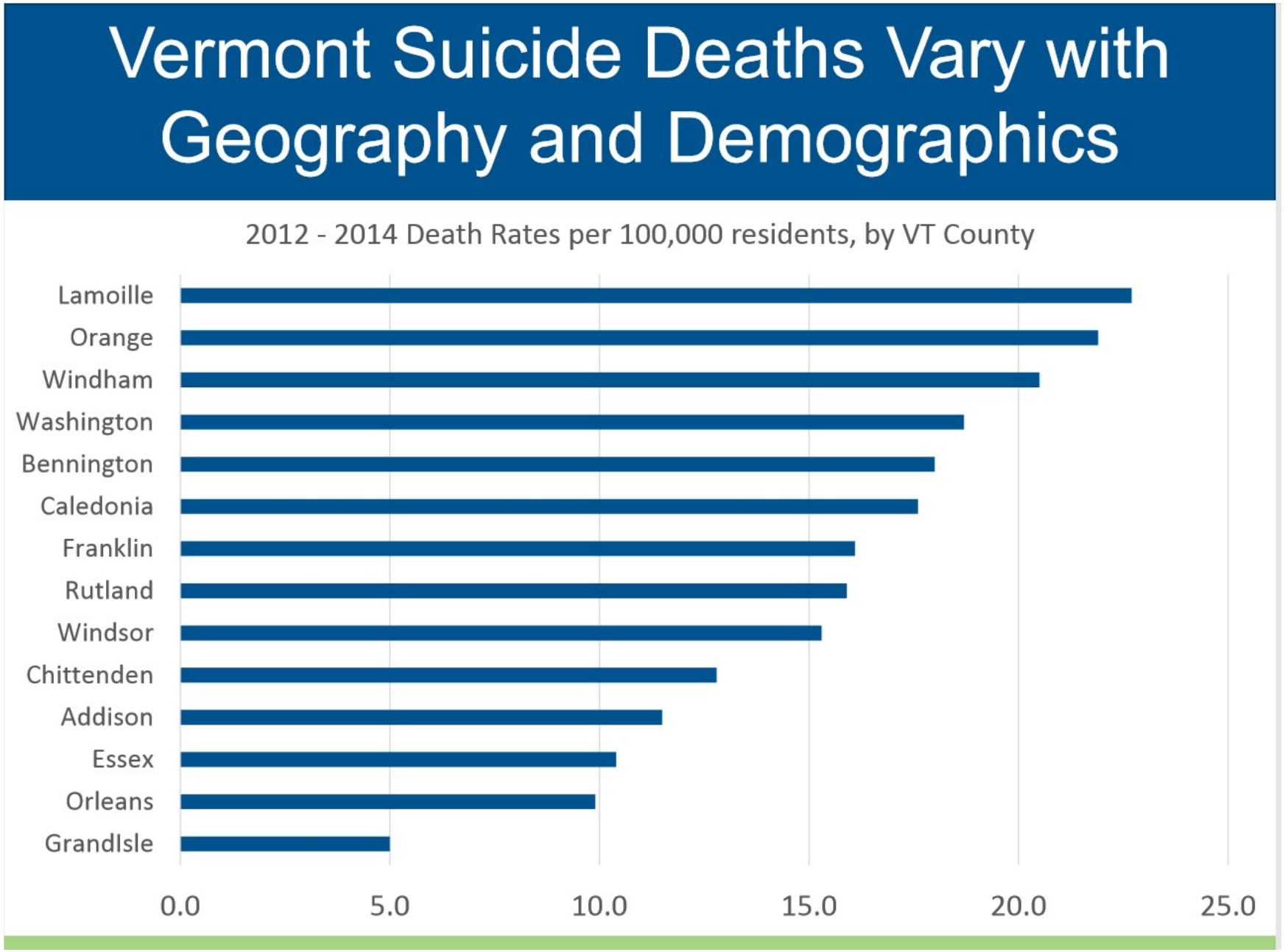
The Zero Suicide Committee Vision

A community with zero suicide.

The Zero Suicide Committee Mission

Create resources to ensure zero suicide care is available to the Lamoille Valley community through increasing awareness, training, education and collaboration.

Status of suicide deaths at the outset of Zero Suicide effort



How LCMHS helped develop intervention in Lamoille County

- Interest in taking an action
- Attending Umatter and other gatekeeper and intervention training
- Forming an internal LCMHS study group
- Finding the scope of the activities and training that could make change
- Finding the scope of challenge to meet the need for service
- Engaging as a lead organization to develop Zero Suicide in our area

Moving from current state to higher levels of concern to adopt the principals of Zero Suicide

- **Clinical Experience of helping to support persons at risk**
- **Personal Experience of family or friends**
- **Listening to families who have survived suicide**
- **Knowledge of a resolution to a dilemma - Zero Suicide as a model**
- **Clarity of mission by developing a workplan annually**
- **Integration and building Mastery via CALM, CAMS, and C-SSRS**
- **Practice adjustments across all agency programs via the LCMHS Pathway**
- **Practice improvement training all staff on the use of the LCMHS Pathway**

Moving from current state to higher levels of concern to adopt the principals of Zero Suicide

- The focus of the Zero Suicide and the development of the ZS committee derived from several events.
- Primary was the very impacting suicide of a community member who was not a client, and the suicide of a long-term client. **(Clinical Experience)**
- Nearly all the members of the LCMHS ZS committee could identify as having had a family member or friend well known to them die by suicide or had made a serious attempt. **(Personal Experience)**
- Inclusion of a community member who had a family member die by suicide was another strong developmental factor. **(Listening to families)**
- The energy of this group and the welcoming by the agency (staff and administration) that pushed the development despite several distractions. **(Knowledge of a resolution to a dilemma)**

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Moving from current state to higher levels of concern to adopt the principals of Zero Suicide

- LCMHS joined the Zero Suicide Project as a pilot site sponsored by the Center for Health and Learning/Vermont Suicide Prevention Center. resource for implementation leading to completion of the Organizational Assessment , Workforce Survey, and first year work plan which clarified where we needed to focus. These have all been repeated in years, including this past year. **(Clarity of mission)**
- CAMS training further clarified a key part of how ZS could occur and be congruent with the current system of care. **(Integration and building Mastery)**
- Implementation of the basics of the Pathway to prevent suicide, including the beginning of the use of CAMS helped to illustrate better how to develop it into the clinical workflow. **(Practice adjustments)**
- The 2-4-0 (Two Questions For Zero Suicide) effort now in practice will broaden the scope of access for persons who may have suicidal thoughts, but have not evidenced those by statements of behavior. **(Practice improvement)**

Identification and responding to suicide

Have you wished you were dead or wished you could go to sleep and not wake up?

Have you actually had any thoughts about killing yourself?

Suicides by County,
Rate of per 100,000 population
1/1/21 – 9/30/21
VT Dept. of Health