

Vermont Youth Suicide Prevention Coalition (VYSPC)

January 15, 2010

Osgood Bldg-Waterbury, VT

Minutes

In attendance: Patty Baroudi-Prevention Coordinator, ADAP, Tim Williams- Youth Representative & Board Member Outright Vermont, Ella Kaplan- Outright Vermont, Mercedes Avila- Evaluator, VCHIP and Cultural and Linguistics Coordinator for Youth in Transitions Grant, Linda Livendale-Chair, American Federation for Suicide Prevention Vermont, Bill McMains- Child and Adolescent Psychiatrist, VT Department of Mental Health, Ali Siemianowski- UVM Graduate Student, Joanna Cole- NAMI Vermont, Cece Teague- Suicide Survivor, Charlie Biss- Director Vermont Child, Adolescent, Family Mental Health, Gayle Finkelstein- Vermont Poison Control, Robin Pesci- Howard Center First Call

Facilitators: Brian Remer and JoEllen Tarallo-Falk – Center for Health and Learning

Creating a Multi-Year Plan for Prevention of Suicide in Vermont

In order to inform our planning, the task for the day was to gather information from two articles produced by the Centers for Disease Control. Those two articles were Use “Promoting Individual, Family, and Community Connectedness to Prevent Suicidal Behavior” and “State Suicide Prevention Planning: A CDC Research Brief.”

“State Suicide Prevention Planning: A CDC Research Brief” talks about the importance of asking the right questions. “What sort of leadership group do we need?” “How should we frame the issue of suicide?” “Should we pursue legislative support?” Different aspects of these questions are explored in the article. Then, in a section on moving from planning to action, the article talks about the importance of maintaining continuity, addressing funding issues, and measuring success. Here are the highlights of our group’s discussion about this article from a Vermont perspective.

For this article, interviews were done in 38 states then six to eight were selected as case studies giving rise to the themes and questions above.

There is not a lot of research about how planning is carried out and what is effective. The Garrett Lee Smith grant has only been around for 5 years so this is an emerging area.

The major focus of our discussion was on the coalition as a leadership group. Every state defines a leadership groups differently. Some are more formally associated with a legislative mandate; others with more of an advisory group. We’d like to have a discussion of us as a leadership group. We think we should look to public health to take the lead in finding infrastructure since they are mandated to do prevention. We should look at existing sources of revenue and connect to our priorities.

The group agreed that in Vermont we should aim to connect the work of suicide prevention to the work of existing organizations and agencies. We can be more sustainable by incorporating suicide prevention into the work that others are already doing such as injury

control, Mental Health, and juvenile justice. Joanna suggested we look into connections to the Mental Health Criminal Justice Task Force.

Moving from paper planning to effective process is difficult. Legislative support is important and you need to be clear what you are asking. Eg. We don't want an official task force but something more action oriented.

Suicide prevention is really broader than state government. It should include government but in Maine, their efforts faded over time because it was embedded only in the governmental department system. A broader participation ensures sustainability. The more organizations involved, the more resources you bring to the table.

Questions to consider:

What sort of leadership group do we need?

How should we frame the issue of suicide as a mental health or public health problem?

Should we pursue legislative support? For what?

Key points: To move from a plan to action the following are required

- Maintaining continuity
- Addressing the funding issue
- Measuring success
- Two levels of addressing the plan: Public Health model and Mental Health planning model.
- Young adults must be involved in all aspects of suicide prevention planning.

Reducing rates in suicide is a long-term goal that can only be measured with a long-term frame on measuring success.

Strengthening families and building emotional resiliency is very important. We want to expand conversations and talk more about suicide on all levels: primary care, schools, mental health, etc. People don't want to talk about suicide and overcoming that stigma is a key feature of Umatter.

Prevention involves not just suicide because you don't know what this person's issues are leading up to. People should be able to talk more generally in a genuine way that provides a supportive atmosphere that allows you to intervene at whatever stage the person might be.

GLBTQ— are a unique audience in that family and clergy may be the hostile forces in their lives. How is this addressed in Gatekeeper training? Gay youth are a high risk group – regardless of what your personal attitudes and values are around that issue. Need to address it directly in training.

Tim mentioned that in 2009 YRBS data the report says that 4% of straight youth reported considering suicide and 26% of GLBTQ youth reported the same. The experience at Outright VT is that the statistic is closer to 50%. For this group, using family as a primary support system is generally a counter-productive strategy

Future topics:

- Statewide Injury Control Planning and how it relates to the VYSPC strategic planning.
- Lethal means restriction and Screening and Assessment as priority issues.
- VYSPC as a leadership group

The article resonated with our views about suicide. We questioned the need to decide whether to approach it as a public health or MH priority and we agreed we should approach this from both perspectives in VT.

Report out on second article:

The second article, “Promoting Individual, Family, and Community Connectedness to Prevent Suicidal Behavior,” was about the importance of having strong associations as a protective factor for suicide prevention. The article stressed the importance of connections not only between individuals, their families, and community organizations but also between community organizations and social institutions. Foci for promoting connectedness and preventing suicidal behavior include:

- Interrupting the development of fatal and nonfatal suicidal behavior
- Integrating approaches to preventing profound life stresses that may contribute to suicidal behavior and interpersonal violence
- Addressing vulnerable populations

There are four general areas of public health research and practice

- Measuring impact
- Creating and evaluating new approaches to prevention
- Applying and adapting what we know works
- Building community capacity

Here are the highlights of our group’s discussion about this article from a Vermont perspective.

Connectedness is a key to reducing risk. A lot of our Coalition members have experience with community development, public health and mental health systems as well as educating about diversity. That experience with diversity should extend to how we reach out to and include other organizations as partners. There is an anti-oppression component of suicide prevention (sexual orientation, race, class, mental illness, disability). Suicide prevention is about a spectrum and not just about a point on the continuum where someone is thinking about ending their life.

People liked the public health model presented. Connectedness affects everyone. It’s important for all of us. It’s not good to focus on just one type of individual to define the problem. We are all impacted by suicide so it’s not good to focus on the “type” of individual who might be suicidal. Getting beyond stereotypes and increasing wellness long before a crisis occurs is critical. Suicide prevention is not just people thinking of suicide. We are all on a continuum, some populations are at more risk but we ALL need connectedness.

The rural nature of VT affect connectedness for many people.

The way suicide is portrayed in the media and the stigma that may be reinforced affects people’s ability to be connected.

National violent death reporting systems is not available in every state but the Child Fatality Review process is part of this and we do have this process in Vermont, though suicide is under reported.

There is a developmental nature of connectedness at different phases of a person's life and how outreach could be changed to reach out to people at different stages of life.

In the second half of our meeting, we brought the above conversations to the context of the Vermont Suicide Prevention Platform. We began talking about the existing objectives in the Platform in light of planning and connectedness. *(You can find a copy of the Platform on the CHL website along with other VYSPC related documents.)*

Suicide Prevention Platform Objective #1

- 1. Promote awareness that suicide is a public health problem [delete: that is preventable].
Under Rationale: Change ...suicidal behaviors can be prevented to “can be recognized.”**

What do we know or have in place for this issue?

NAMI has a course about mental health aimed at Veterans.

JoEllen mentioned Micheal Hartman's coordinating group of various initiatives which are funded by SAMHSA which could all be working together to educate about mental

What should we be doing more of?

- Focus on reducing stigma of mental illness and suicide. We're all on a spectrum "it's all of us-our friends and neighbors" We can educate youth that it could be one of their best friends who is having trouble.
- Get Charlie Biss and youth involved in developing messaging for print and radio production.
- More work with legislators about mental health as a public health issue
- Translate messages to other languages. Mercedes is a resource about the top five refugee languages. Channel 17 has been good about translating work for Gayle's poison control program.
- Across the Fence is a noontime program focusing on elders
- Vermont Public Radio
- Outreach to media about appropriate communication strategies and safe messaging

What do we need to know in order to move forward on this objective?

- Youth input on messaging and how to reach them. What stakeholders for each youth demographic do we need to get involved?
- Make a distinction for messaging at college and university systems, e.g., How college students would want to see a message. How to make messaging more visible (e.g., UVM students are not even aware of basic services.)
- We need to couple the message about the problem with the resources.

What suggestions would you make to ensure our efforts are sustainable?

- Inclusion of stakeholders
- What amount of media spending is of value? What would a budget be for media planning?
- It doesn't belong to any one entity but to all of us and everybody.

How might you measure success?

- Research models that are already measuring success.
- Use the YRBS as a longitudinal measure with hopefully a downward trend line. What percentage of youth have considered suicide?
- Assessing policies and protocols

Suicide Prevention Platform Objective #2

2. Developing broad-based support for suicide prevention

What should we be doing more of?

- Inclusion of youth and young adults in a real coalition of young adults, seniors, and military.
- Reach out to people with cultural and linguistic differences
- Promote resources that exist e.g., 211
- Use facts to bring people to the table
- Identify technology for building broad-based support drawn from other successful initiatives, e.g., smoking, drinking and driving, etc

How might we measure success?

- Hear and see more messaging about mental health
- Increased referrals
- Co-location of health and mental health services
- Who attends meetings and trainings? Is this the only group in which suicide is discussed or is it also a topic at other meeting and for other organizations or coalitions?
- Public health policy that elevates the issues e.g., requirements for schools to implement suicide prevention

Suicide Prevention Platform Objective #3

3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.

What should we be doing more of?

- Having a health system that is attractive to young adults. Possibly, more peer run than current systems.
- Timely treatment for depression and substance abuse is important
- The relationship of suicide to other issues, e.g., sex, substance abuse, etc.
- Use of media images that authentically represent mental health
- Focus on skills for identifying feelings and developing problem solving skills. Teach young people to identify and regulate their feelings so they take action. The earlier you do this developmentally, the longer it lasts.
- Whether you have mental illness or not you need those coping skills to help you get through mental illness. Whether you ever have a serious mental health condition, the coping skills are critical.

Suggestions for future meeting:

- Keep the target population in mind, age 10-23
- We will continue our discussion of the Vermont Suicide Prevention Platform

Future Resource: www.Mentalhealth.vt.gov