What to do when a patient discloses Suicidal Thoughts: Clinical skills and System readiness

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Clara Martin Center

Julie Parker, LCMHC
Northwestern Counseling and Support Services
Disclosures

- We have no relevant financial relationships to disclose or conflicts of interest to resolve

- We will discuss no unapproved or off-label pharmaceuticals
1) Suicide Trends in VT/NH & Nation
2) Zero Suicide Initiative & VT Pilot Sites
3) Assessment
4) Resources
5) Challenges & Opportunities
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
Suicide: A Growing Problem

- CDC Vital Signs Report June 2018- A Call to action
- Suicide is the second leading cause of death for Vermonters aged 15-34 & the third leading cause of death for Vermonters aged 35-44
- Suicide rates increased in almost every state. VT had 2nd highest rate of increase since 1999
- Since 2004, Vermont suicide death rates have averaged 30% higher than the US rates
- There were 118 suicide deaths or 18.9 suicide deaths per 100,000 Vermont residents in 2016
- Vermonters use firearms to take their lives at very high rates; according to the most recent 5 years of data, 59% of Vermont suicides involve firearms, while the rest of the Northeastern US only 36% of suicide deaths involved firearms
Over the past 5 years, Vermont's suicide death rate has averaged about 30% higher than the US rate.

Source: CDC WISQARS
Percent of high school students reporting suicide measures, Vermont Youth Risk Behavior Survey: 2009-2015

- Felt sad or hopeless 2+ weeks
- Purposely hurt self without wanting to die
- Made a suicide plan, past year
New Hampshire Data

**New Hampshire All Ages Suicides: 2008 to 2017**

Data Source: Office of the Chief Medical Examiner, NH

![Graph showing the number of suicides in New Hampshire from 2008 to 2017](image)
Figure 9
The highest numbers of suicide deaths are seen in males and females in the 40 and 50 year-old age groups.

New Hampshire Resident Suicide Deaths by Age Group, 2012-2016
Data Source: CDC WISQARS®

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 to 14</td>
<td>11</td>
<td>34</td>
</tr>
<tr>
<td>15 to 19</td>
<td>13</td>
<td>61</td>
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<tr>
<td>20 to 24</td>
<td>21</td>
<td>57</td>
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<tr>
<td>25 to 29</td>
<td>19</td>
<td>65</td>
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<td>30 to 34</td>
<td>23</td>
<td>60</td>
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<tr>
<td>35 to 39</td>
<td>30</td>
<td>72</td>
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<tr>
<td>40 to 44</td>
<td>35</td>
<td>100</td>
</tr>
<tr>
<td>45 to 49</td>
<td>32</td>
<td>112</td>
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<tr>
<td>50 to 54</td>
<td>14</td>
<td>95</td>
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<td>55 to 59</td>
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<td>62</td>
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<td>60 to 64</td>
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<td>27</td>
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<td>65 to 69</td>
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<td>22</td>
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<tr>
<td>70 to 74</td>
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<td>21</td>
</tr>
<tr>
<td>75 to 79</td>
<td></td>
<td>16</td>
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<tr>
<td>80 to 84</td>
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<td>20</td>
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<tr>
<td>85 and up</td>
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</table>
Figure 2
Crude Suicide Death Rates per 100,000 in NH by Year 2008-2017.

NH and US Suicide Deaths By Year - 2008 to 2017 (Crude Rate)

<table>
<thead>
<tr>
<th>Year</th>
<th>NH Suicide Death Rate</th>
<th>US Suicide Death Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>13.6</td>
<td>11.8</td>
</tr>
<tr>
<td>2009</td>
<td>12.6</td>
<td>12.0</td>
</tr>
<tr>
<td>2010</td>
<td>14.9</td>
<td>12.4</td>
</tr>
<tr>
<td>2011</td>
<td>15.0</td>
<td>12.7</td>
</tr>
<tr>
<td>2012</td>
<td>15.3</td>
<td>12.9</td>
</tr>
<tr>
<td>2013</td>
<td>14.0</td>
<td>13.0</td>
</tr>
<tr>
<td>2014</td>
<td>18.6</td>
<td>13.4</td>
</tr>
<tr>
<td>2015</td>
<td>17.1</td>
<td>13.7</td>
</tr>
<tr>
<td>2016</td>
<td>17.6</td>
<td>13.9</td>
</tr>
<tr>
<td>2017</td>
<td>19.0</td>
<td></td>
</tr>
</tbody>
</table>

Source: 2008-2016 – CDC Data; 2017 – NH OCME Data
The NH Annual Report will have all of the data that you need for our state. Here is the most current report:

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
Population Health Goal #2: Reducing Deaths from Suicide and Drug Overdose

<table>
<thead>
<tr>
<th>Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation of alcohol and other drug dependence treatment</td>
</tr>
<tr>
<td>Deaths related to suicide</td>
</tr>
<tr>
<td>Deaths related to drug overdose</td>
</tr>
<tr>
<td>Engagement of alcohol and other drug dependence treatment</td>
</tr>
<tr>
<td>30-day follow-up after discharge from ED for mental health</td>
</tr>
<tr>
<td>30-day follow-up after discharge from ED for alcohol or other drug dependence</td>
</tr>
<tr>
<td>Rate of Growth in number of mental health and substance use-related ED visits</td>
</tr>
<tr>
<td># per 10,000 population ages 18-64 receiving Medication Assisted Treatment for opioid dependence</td>
</tr>
<tr>
<td>Screening for clinical depression &amp; follow-up plan</td>
</tr>
<tr>
<td># of queries to Vermont Prescription Monitoring System by Vermont providers (or their delegates) divided by the # of patients for whom a prescriber writes prescription for opioids</td>
</tr>
</tbody>
</table>
At Risks Populations

- Individuals with medical conditions
- Individuals who are lesbian, gay, bisexual, or transgender
- Individuals in justice and child welfare settings
- Individuals who intentionally hurt themselves
- Individuals who have previously attempted suicide
- Individuals with mental and/or substance use disorders
- Members of military and veterans
- Men in midlife and older men
- Other factors- (Bullying....)

(SAMHSA, 2018)
Mission:
To create health promoting communities in which schools, Institutions of Higher Education, public and private agencies and people of all ages have the knowledge, attitudes, skills and resources to reduce the risk for suicide.

Purpose:
To support state-wide suicide prevention efforts and help local communities implement the recommendations of the Vermont Suicide Prevention Platform using data-driven evidence-based practices.

http://www.vtspc.org
ZERO SUICIDE is a commitment to suicide prevention in health and mental health care systems and is also a specific set of strategies and tools.
Zero Suicide Pilot Project in Vermont: Brief Overview

Pilot project started in spring 2015

Implementing in specific programs at three state-designated mental health treatment agencies (“DAs”)

Supported through legislative allocation to Dept. of Mental Health and VT Suicide Prevention Center

High level implementation team with multiple stakeholders

DA-specific (internal) implementation teams

Three rounds (so far) of CAMS trainings for clinicians/leaders; CALM trainings

Leader trainings; previously part of ZS CoP and CS-CoIIN

External evaluator from University of Vermont (VCHIP)
Pilot Sites

Northwest Counseling and Support Services
- Pilot Site Coordinator Steve Broer, Psy.D
  (802) 393-6450 sbroer@ncssinc.org
- Outcomes and Evaluation Julie Parker, LCMHC
- Program Manager for Outpatient, Integrative Health and Crisis Services
  (802)-393-6462 jparker@ncssinc.org

Howard Center
- Pilot Site Coordinator Beth Holden, LCMHC, LADC
- Associate Director
  (802) 488-6617 bethh@howardcenter.org

Lamoille County Mental Health
- Pilot Site Coordinator Michael Hartman, LCMHC
Zero Suicide Contacts in NH

Exeter Hospital: Deb Vasapoli: dvasapolli@ehr.org

Greater Manchester Mental Health Center: Patricia Carty: cartypat@mhcgm.org or Kristen Kraunelis: kraunelk@mhcgm.org

Manchester VA: Beth Alves: Beth.Alves@va.gov

NH Hospital Aftercare Liaison program: Shannon Murano: shannon.murano@dhhs.nh.gov
What is Zero Suicide?

“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.”

Key Principles include:
• Core Values
  • Shared responsibility between primary care, mental health, emergency depts. and recovery supports is critical
• Systems Management
  • Policy/Procedures that include collaboration and communication and building a strong work force
• Evidenced Based practices
  • Screening and Suicide Risk assessment

Adapted from http://zerosuicide.sprc.org/about
WHAT PROFESSIONALS CAN DO TO SUPPORT ZERO SUICIDE

• LEAD: Make an explicit commitment to reduce deaths.
• TRAIN: Develop a competent, confident, and caring workforce.
• IDENTIFY AND ASSESS patients for suicide risk.
• ENGAGE patients at risk for suicide in a care plan.
• TREAT suicidal thoughts and behaviors directly.
• FOLLOW patients through every transition in care.
Lead and Train

- Making an explicit commitment to reduce deaths
  - Do we believe we can prevent deaths by suicide?
  - Assess staff knowledge, practice and confidence in suicide
- All primary care, emergency department, mental health providers are trained in effective suicide risk assessment and review risk of patient at each session
  - Providers who provide counseling to people at risk for suicide are trained in CALM counseling on access to lethal means
CALM: Counseling About Lethal Means
2 hours free online course
Resources

- https://www.samhsa.gov/
- http://zerosuicide.sprc.org/
Assessing for Lethality: A Direct Approach

KRISTEN E. BRIGGS, MSW
Possible barriers to talking directly about suicide?

- Time/can’t see the process through?
- Not sure what language to use?
- Not clear on process if hospitalization is needed?
- Not “my role?”
- Discomfort/fear of discomfort?
- Don’t want to put ideas in client’s head?
- Other possible barriers?
Assessment: Clinical Questions/Helpful Hints

- Feelings of depression/sadness/hopelessness?
- Feelings of guilt/shame/self-hate?
- Sense of loss of pleasure/loss of interest (anhedonia)?
- Neuro-vegetative symptoms: change in sleep (increased/decreased), change in appetite (increased/decreased)?
Assessment:
Clinical Questions/Helpful Hints

- Agitation?
- Isolation?
- Recent losses/grief?
- Experiencing any psychosis, delusions, hallucinations?
- Recent changes in medications?
- Substance abuse?
- Relationship/relational problems
Assessment:
Clinical Questions/Helpful Hints

- Legal problems?
- Financial problems?
- Recent discharge from any type of inpatient setting (medical, psychiatric, substance abuse tx)
- Thoughts of suicide?
- If suicidal, is there intent/plan/means?
Assessment:
Clinical Questions/Helpful Hints

- Is there a past history of suicidal attempts?
- Is there family history of suicide/exposure to suicide?
- Giving away possessions?
- Have there been preparations for suicide?
- Any self-harming behavior? (what is intent of the self-harm)
Assessment:
Clinical Questions/Helpful Hints

- Has there been suicide rehearsal?
- What are possible deterrents?
- What is current support network? Is your support network aware of the situation?
- Is there a plan to remove access to lethal means (guns, substances, rope, knives)? Are the weapons in a safe place? Locked up? Or should the weapons be removed from the home?
BE DIRECT

- “Are you having thoughts of killing yourself?”
- “Are you planning to kill yourself?”
- “Are you thinking about killing yourself?”
- “Do you have a plan of how/when you will kill yourself?”
- “When you self-harm, are you doing so with the intent to kill yourself or to hurt yourself?”
Self-Awareness

When assessing someone for lethality we want to reassure them that we can handle the answer and are not trying to direct their answer.

- Don’t ask the questions with dread
- Ask clarifying questions so as not to make assumptions
- Assure the person that you are there to support them
- Validate person and praise for sharing with and trusting you
For anyone demonstrating suicidality:

- Do not leave a client alone to consult.
- Use phone to contact someone and have them come to you or consult by phone.
Language to Avoid

No-suicide contracts/contracting for safety

DON’T USE THEM
Old research/information showed that contracting for safety/no-suicide contracts were or would be helpful in eliminating or lowering chances for suicide.

New research shows that this is not the case and that, aside from not being effective, it can also have other unintended negative consequences.
There is no evidence that no-suicide contracts actually work. In fact, there is quite a bit of evidence that they do not work.

One study found that of people who attempted suicide in a psychiatric hospital, 65% had signed a no-suicide contract.

A survey of psychiatrists found that of those who used no-suicide contracts, 40% had a patient die by suicide or make a serious attempt even after signing such a contract.
Why not?

- If a client promises not to attempt suicide, what happens when the client actually does attempt suicide?
- Some clients may withhold such information, out of fear that the therapist will be angry at the client for having broken their promise. Yet, to most effectively help, the therapist needs to know that the client attempted suicide.
- The client needs to feel free to share such information without fear of rebuke.
Why not?

- Many clients feel mistrustful of therapists/clinicians if asked to sign a no-suicide contract.
- Clients perceive these contracts to be a way to protect the therapist, not the client.
- **No-suicide contracts do not actually protect you from a malpractice judgment, should a lawsuit occur.**
Why not?

• If suicide really could be prevented with a contract or agreement, then:
  ○ suicidal people would never need our help.
  ○ A person with suicidal thoughts would, by virtue of the no-suicide contract, call on their strengths, resources, and self-control to manage their impulses and stay safe on their own.

• The task of treatment is to help build those assets, not to presume that they already exist.
Safety Planning

Elements that must be included

- Explain the client deterrents and client’s current protective factors
- Explain the skills that the client will utilize if issues are triggered
- What is the security/removal plan for firearms/weapons/pills or any client identified means of suicide?
Safety Planning

Elements that must be included

- What is the plan with the client’s collateral support (people who are aware of concern and have been given info on how to respond if issues present/as well as emergency contact info)?

- What is the client’s knowledge of emergency resources and ability to access them?
Safety Planning
Elements that must be included

- When and whom is the next appointment scheduled for follow up?
- Who did you consult with regarding this situation?
FOLLOW UP

What’s the follow up plan for the client?
Who will be making contact with client and when?
Is client receptive to follow up?
What’s the plan if client doesn’t connect/answer calls?
Plan should involve treatment team reaching out.
Plan may include emergency services reaching out.
Proactive Emergency Plans/Crisis Plans
Self Care

- Follow up with supervisor during or after situation with client to debrief.
- EAP where available
- Whatever forms of self-care you use on your own: therapy, exercise, planned time off, nutrition, spiritual practice, etc.
SYSTEMATIC SUICIDE CARE

Bridging the Gaps

(Adapted from the National Action Alliance for Suicide Prevention, 2010)

SERIOUS INJURY OR DEATH AVOIDED

SUICIDAL PERSON

SCREEN/ASSESS for Suicidality

Collaborative SAFETY PLAN Put in Place

TREAT SUICIDALITY: Suicide-specific Treatment

Continuity of Care: FOLLOW-UP Calls, after visits, Primary Care, Emergency Dept., Inpatient
Zero Suicide

IMPLEMENTATION OF ZERO SUICIDE

*COLLABORATIVE SAFETY PLANNING and REDUCING ACCESS TO LETHAL MEANS in all settings, e.g. Emergency Department, Crisis, Community Care, etc.

- SCREEN
- SCREEN

SUICIDE ASSESSMENT (Columbia Suicide Severity Rating Scale - CSSRS)
Follow Up and Continuing Supportive Contacts

EMERGENCY DEPARTMENT SCREENING
Patient Health Questionnaire - 9 (Adapted CSSRS)

COMMUNITY & WORKFORCE TRAINING:
- LAMN, ASSIST, MNHS (Lamatter Suicide Prevention Application, Applied Suicide Intervention Support Training, Mental Health First Aid)

PEER & SURVIVOR SUPPORT, INVOlVEMENT of PEOPLE WITH LIVED EXPERIENCE

UMATTER SUICIDE PREVENTION & UNIVERSAL HEALTH PROMOTION STRATEGIES
Breaking it down..

- **Surviving**
  - Establish basic safety

- **Stabilizing**
  - Needs being met

- **Enduring**
  - Learn emotional regulation and distress tolerance

- **Understanding**
  - Improve cognitive processing & Self-care

- **Transcending**
  - Make meaning/growth

*Trauma Systems Therapy – Glenn Saxe M.D.*
Pause... Lets discuss

• Discussion
  ○ Do you have social workers/Therapists
  ○ Do you see this as a need?
  ○ Do you have a work flow to assess or screen?
  ○ What would this be like to engage patients in this way?
Columbia Suicide Severity Rating Scale

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen with Triage Points for Primary Care

Ask questions that are in bold and underlined.

<table>
<thead>
<tr>
<th>Ask Questions 1 and 2</th>
<th>Past month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1) Have you wished you were dead or wished you could go to sleep and not wake up?</strong></td>
<td>YES NO</td>
</tr>
<tr>
<td><strong>2) Have you had any actual thoughts of killing yourself?</strong></td>
<td></td>
</tr>
</tbody>
</table>

If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.

| **3) Have you been thinking about how you might do this?** | |
| e.g., “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it.” |
| **4) Have you had these thoughts and had some intention of acting on them?** | |
| as opposed to “I have the thoughts but I definitely will not do anything about them.” |
| **5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?** | |
| **6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?** | |

<table>
<thead>
<tr>
<th><strong>Lifetime</strong></th>
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</table>
Philosophical Aspects of CAMS

CAMS Clinical Procedures
- Step 1 - Early Identification of Risk
- Step 2 - Collaborative Assessment Using Suicide Status Form
- Step 3 - Collaborative Treatment Planning
- Step 4 - Clinical Tracking of Suicide Status
- Step 5 - Clinical Resolution of Suicide Status
- Growing Evidence Base for CAMS
Practical Components of CAMS

- **Suicide Status form (sit by patient)**
  - Rate pain, stress, agitation, hopelessness, self hate, Risk
  - Reasons for living/dying
    - Discuss drivers/protective factors
    - Treat meant plan
    - Clinical documentation of session
    - Continue Tracking/update sessions
    - Assessing scores
    - Three consecutive sessions with overall risk decreasing to < 3
CBT/DBT

- Cognitive Behavioral Therapy: challenging and changing unhelpful cognitive distortion and behaviors that improve emotion regulation and coping of problems.

- DBT is a type of cognitive behavioral psychotherapy developed by Marsha Lineahan to treat mood disorders, suicidal ideation, self harm and suicidal ideation for clients diagnosed with Borderline personality disorder (instability of mood, behavior, functioning)
Designated Agency & Integrated Health

- D.A. Services
  - Psychiatry Consults
  - Crisis & Mobile Outreach
  - Nursing Care Coordination
  - CRT Care Management
  - Medical Records Exchange

- NMC Partnership
  - PCP's
  - Pain Clinic
  - Emergency Dept Embedded
  - Training for Sitters Program

- NOTCH/FQ HC Social Workers Partnership

- NOTCH SAMHSA Grant For Kids

- Evidence Based Practices Across Settings
  - CAMS/Suicide
  - CBT-I/Insomnia
  - WRAP
  - EMDR

- Blueprint Community Health Team in
  - PCP's
  - MAT
  - OB/GYN
  - Planned Parenthood

- Blueprint Wellness Groups

- NMC Partnership

- NOTCH/FQ HC Social Workers Partnership
Integrated Health CAMS Flowsheet

10/05/17

Patient presents in PCP office and is identified as needing CAMS

Check if patient NCSS client; if so refer back to NCSS

If yes, refer back to NCSS

If No, complete Page 1 of CAMS SSF (Initial Session including stabilization plan)

Determined Low Risk

Continue with planned intervention/treatment; then be sure to document that in clinical note also making note at bottom of CAMS form

If determined patient is stable enough to schedule future appointment; continue to complete CAMS SSF Section B and Stabilization Plan/ Use CAMS to completion unless clinically determined otherwise; then be sure to document that in clinical note also making note at bottom of CAMS form

Determined High Risk

If determined patient needs immediate follow up and no time; Crisis should be called

Always collaborate and update all team members/care team and always discuss all CAMS in Supervision

Complete at least one CAMS session then make your own determination if clinically appropriate to continue with CAMS and/or refer out or to stop CAMS; then be sure to document that in clinical note also making note at bottom of CAMS form
Case Example: Linda

- 48 year old white female Linda presents in a WHO from PCP for high PHQ9 with #9 endorsed
- Asked about suicidality, Linda answered that she thinks about it
- Initiated CAMS
- Linda is high risk for death by suicide, low wish to live, high wish to die, overall risk of suicide moderate, some reasons for living, one reason to die
- Going back to office and offering reschedule options to current pt, let front desk know may be running behind and please alert pts
- Moving meeting with Linda to private office
- Complete stabilization plan
  - Assessing access to lethal means
  - Reducing access to lethal means—involving loved one in planning, calling together
  - Calling crisis together to reduce anxiety, ensuring loved one knows about crisis line
  - Brainstorm healthy coping strategies and people to call
  - Setting up follow up appt in conjunction with next PCP appt if possible
  - Check that emergency contact information is up to date, review no show policy of calling emergency contact
- Complete documentation and share with PCP, also verbal update and shared with outside providers
Ongoing care with Linda

- Continue short term treatment for stabilization using CAMS for continued assessment and management
- May stop CAMS after 3 sessions of overall risk of suicide 3 or lower
- Refer for ongoing care at NCSS/Private Practice where CAMS can be continued if needed, sending CAMS documentation with referral
- One appointment post referral to confirm follow up care in progress
Kevin Hines “Recovery can happen”

https://www.youtube.com/watch?v=WcSU9iZv-g
Do you recharge yourself as much as you recharge your phone?
Resources

IF YOU OR A LOVED ONE IS EXPERIENCING A MENTAL HEALTH CRISIS AND NEED HELP, CALL YOUR LOCAL 24/7 CRISIS LINE:

[Map showing various crisis lines and mental health centers across Vermont]

Vermont's Community Mental Health Centers

- Clara Martin Center (CMC) - claramartin.org
- Counseling Service of Addison County (CSAC) - csacvt.org
- Health Care & Rehabilitation Services (HCRS) - hcrs.org
- Howard Center - howardcenter.org
- Lamoille County Mental Health Services (LCMHS) - lamoill.org
- Northeast Kingdom Human Services (NKHS) - nkhs.org
- Rutland Mental Health Services (RMHS) - rmhs.vt.org
- Northwestern Counseling & Support Services (NCSS) - ncscounseling.org
- United Counseling Service of Bennington County (UCS) - ucsvermont.org
- Washington County Mental Health (WCMHS) - wcmhs.org

Note: Websites here are for information purposes and not intended as a resource or means of contact during an acute crisis.
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 the National Suicide Prevention Lifeline: 800-273-TALK (8255)

Resources for help can be found at: www.vtspc.org
Resources

- **For information and education**
  - National Institute of Mental Health (NIMH)
    (866) 615-6464  [www.nimh.nih.gov](http://www.nimh.nih.gov)
  - National Institute of Mental Health Publications
    1-800-421-4211
  - Robert Wood Johnson Foundation, Depression in Primary Care
    [www.wpic.pitt.edu/dppc](http://www.wpic.pitt.edu/dppc)
  - MacArthur Initiative on Depression and Primary Care
    [www.depression-primarycare.org](http://www.depression-primarycare.org)

- **For support**
  - Depression and Bipolar Support Alliance
    [www.dbsalliance.org](http://www.dbsalliance.org)
Resources

- **VERMONT SUICIDE PREVENTION PROGRAMS**
- **Suicide Prevention Data and Surveillance Work Group** [vtspc.org/vermont-statistics-on-suicide/](vtspc.org/vermont-statistics-on-suicide/)
- **Public Health Stat**
- **Vermont Gun Shop Project (VT GSP)** [vtspc.org/gun-shop-project/](vtspc.org/gun-shop-project/)
- **Vermont 2-1-1** [www.vermont211.org](www.vermont211.org)
- **VT Suicide Prevention Center** [www.vtspc.org](www.vtspc.org)
- **Vermont Suicide Prevention Coalition** For a full list of VT Suicide Prevention Coalition Members, see: [vtspc.org/about-vtspc/coalition/](vtspc.org/about-vtspc/coalition/)
- **Vermont Child Health Improvement Program (VCHIP)** [www.med.uvm.edu/vchip](www.med.uvm.edu/vchip)
- **American Foundation of Suicide Prevention-VT Chapter**
Challenges & Opportunities

Thank You for the Work You Do!!