

Communities for Change: Preventing Suicide – May 8, 2019 NIHCM Foundation Webinar

- Kathryn Santoro: [00:00:00](#) Thank you and good afternoon. I'm Kathryn Santoro, director of programming at the National Institute for Healthcare Management Foundation. On behalf of NIHCM Foundation, welcome to our webinar today. Today's webinar is the third segment in a four-part series exploring innovative strategies and evidence-based solutions to defy depth of despair and lift our society from crisis.
- Kathryn Santoro: [00:00:26](#) We're seeing this crisis manifest in rising rates of depression, suicide, and substance abuse and declining life expectancy in the United States. The suicide rate has increased almost 30% in the last two decades and is now the 10th leading cause of death. Suicide rates remain higher among veterans and LGBT youth and suicide is the second leading cause of death among people ages 15 to 24. Recent data also shows that more young people, particularly young women, are attempting suicide using poison.
- Kathryn Santoro: [00:01:03](#) How do we reduce the suicide rate? New research suggests economic policies can prevent suicide and depth of despair, that increasing the minimum wage by just 10% can prevent over a thousand suicides annually. Suicide is preventable with treatment and support, but the current trend suggests that people are not getting the care they need. Today, we'll explore a range of initiatives designed to close the gap and prevent suicide.
- Kathryn Santoro: [00:01:33](#) Before we hear from our speakers, I want to thank NIHCM's president and CEO Nancy Chockley and NIHCM staff who helped to convene this event today, including Kate Ellis, Kaitlin Smith, Alexis Lang and Kirsten Wade. We hope you all will take a moment to explore what NIHCM has supported through our grant program to raise awareness and share [inaudible 00:01:56] resources on suicide prevention and improving care for LGBTQ patients. This includes a recent reporting project in Oregon and support for a documentary public engagement campaign to raise awareness of the concept of moral injury and contribute to the reduction of veteran suicide.
- Kathryn Santoro: [00:02:16](#) For research grant, we've also supported the development of a training manual designed to help healthcare providers build a foundation of inclusive clinical skills to competently care for LGBTQ patients. You can learn more about these projects and our grant program by accessing the links on our resources tab in the webinar console or on our website. You can find biographical information for all of our speakers, along with today's agenda and copies of slides on our website. We also

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invite you to live tweet during the webinar today using the hashtag [defying despair](#).

- Kathryn Santoro: [00:02:57](#) I'm now pleased to introduce our first speaker, Richard McKeon, chief of the suicide prevention branch of the Substance Abuse and Mental Health Services Administration Center for Mental Health Services. Dr. McKeon is a passionate mental health advocate who has dedicated his career to improving mental health at the community level. He served as director of the Psychiatric Emergency Service for 11 years and was awarded an American Psychological Association congressional fellowship where he covered health and mental health policy issues for Senator Paul Wellstone. He also served on the National Action Alliance for Suicide Prevention and took part in the process of revising the National Strategy for Suicide Prevention and developing the World Health Organization's World Suicide Prevention report. Today, we're grateful he's with us to provide an overview of current data on suicide, as well as an overview of federal suicide prevention efforts. Dr. McKeon.
- Richard McKeon: [00:04:01](#) Thank you so much. It's a pleasure to be here speaking with you all. I will go over a couple of key issues and will give an overview of some of the concerning trends about suicide that we are seeing, but also about some of the things we know that we can do in response that can save lives. The views that expressed here don't necessarily reflect the views of the Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services, so just want to make that disclaimer.
- Richard McKeon: [00:04:49](#) As was kindly mentioned in the introduction, it is important to be aware that the United States does have a National Strategy for Suicide Prevention that SAMHSA as well as other federal partners are working together to implement. The national strategy is basically a document that summarizes a comprehensive approach to suicide prevention. We know that if we simply wait for people who are at risk to show up in the offices of psychologists such as myself or a psychiatrist's office, then we're not going to be able to halt the rise in suicide that's occurring nationally. We know that we need a comprehensive approach that engages multiple sectors and many people, as we all have a role to play in suicide prevention.
- Richard McKeon: [00:05:49](#) Part of the reason that that is so important is clear when you look at what the trend has been nationally. Last year, the CDC issued their Vital Signs report indicating that suicide was rising across the United States and that it was more than a mental

health concern also fully involving substance use and abuse, but also a range of other factors, as well.

Richard McKeon: [00:06:34](#)

In virtually every state, in fact, 49 of the 50 states, suicide increased over a 17-year period from 1999 to 2016. In fact, in half of those states, the increase was greater than 30%, so the slide that you see in front of you gives you an idea of those increases. The only state where suicide did not go up during that period of time was the state of Nevada, which started off with one of the highest suicide rates in the nation. They did see a decline of about 1%.

Richard McKeon: [00:07:25](#)

Suicide is a leading cause of death really across the lifespan. As this slide shows, it's actually the second leading cause of death from age 10 to age 39, trailing only accidents as a leading cause of death. After that, suicide drops as a leading cause of death to fourth between ages 40 and 49 and seventh between ages 50 and 59. That doesn't mean that the rate of suicide actually goes down during that period of life. In fact, it actually goes up, but other causes of death such as cancer and heart disease are increasing at even a greater frequency, which is why suicide drops as a leading cause, but still, as you can see, very significant, fourth and sixth.

Richard McKeon: [00:08:28](#)

It's also important to be aware of that deaths by suicide are very similar in number to deaths from opioid overdose. Opioid overdose fatalities are about 47,700 and suicides are about 47,100, so they are really twin scourges that together have been contributing to the decrease in longevity for Americans.

Richard McKeon: [00:09:07](#)

It is also important to remember that while every death by suicide is tragic, suicide deaths do not represent the full extent of the problem of suicidality. There are many suicide attempts. Thankfully, the majority of people who attempt suicide do not die by suicide. The slide in front of you shows the variation by age. Actually, suicide attempts are more frequent among young people. SAMHSA's National Survey on Drug Use and Health estimates that about 1.4 million American adults age 18 and over attempt suicide. In addition, that same household survey estimates that over 10 million American adults seriously consider suicide each and every year, so that is thankfully all those who seriously consider suicide don't attempt suicide and not all those who attempt suicide die by suicide. Otherwise, the numbers would be much higher than the tragic total that it already takes. It also shows you how broader the issue of suicide risk is.

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- Richard McKeon: [00:10:38](#) The next slide is from our colleagues at the National Institute of Health. It shows you annual suicide deaths. That's from back in 2016 data, as well as annual suicide attempts. They did this to identify potential settings and ways that intervention could take place. You can see over 21,000 of those who died by suicide were seen in an emergency department in the past year, 20,000 accessed healthcare, 22,000 were deaths by firearms. Typically, firearm deaths have been about 51% of the total number of deaths. You can also see for suicide attempts, some of the numbers, 110,000 in those in substance abuse treatment, 410,000 in outpatient mental health treatment just as examples of that, indicating places where we can potentially intervene.
- Richard McKeon: [00:11:49](#) I'm not going to be able to give a full rundown of all of the federal efforts to reduce suicide and they are many. My colleague, Gloria Workman, from the Veterans Administration will be talking about VA's efforts. This slide is just to give you a quick rundown of SAMHSA's efforts, which include our Garrett Lee Smith State/Tribal Youth Suicide Prevention grants, which, at this point, at least one grant has gone to every state and our evaluations have shown that counties that were implementing grant-funded activities had lower rates of suicide and suicide attempts compared to matched counties who did not.
- Richard McKeon: [00:12:37](#) We also have a Campus Suicide Prevention Program. We have what's called the Zero Suicide Initiative, which is really acting to try to strengthen suicide prevention in healthcare systems. We have a National Resource Center. We have what are called National Strategy Grants. We have a large program in tribal behavioral health that focuses on suicide prevention and substance abuse prevention called Native Connections. We have the National Suicide Prevention Lifeline, which last year answered more than 2.2 million calls and 25% of those calls were from people who are actively suicidal. We're working together with the Veterans Administration what are called Mayor's and Governor's Challenges to reduce veteran suicide in cities and states. We're also in the process of preparing a toolkit for families where there's a loved one who is at risk for suicide.
- Richard McKeon: [00:13:41](#) Let me tell you a little bit more about Zero Suicide. This is an effort that really was inspired by the success of the Henry Ford healthcare system. You can see the slide in front of you that after they launched what they called their Perfect Depression Care Program with the goal of zero suicide, they were able to substantially reduce suicide deaths among their HMO members. In fact, they had six consecutive quarters without a suicide death, so zero suicide doesn't mean no suicide ever again. What it does mean is that we give our best efforts to reducing suicide

and each month that goes by when there is not a suicide that we celebrate that because that is what we are hoping our health systems will be able to help do.

- Richard McKeon: [00:14:45](#) In addition to the findings that Henry Ford Health System, others at places like Centerstone, one of the nation's largest nonprofit community mental health centers, and in the Missouri Community Mental Health System, have found similar results in terms of reductions of suicide deaths among people in their care compared to other systems.
- Richard McKeon: [00:15:13](#) Another area that SAMHSA has really worked on across all of our programs is improving care transitions. There are lethal gaps in many systems. The period after inpatient unit and emergency department discharge, which is typically where people who have acute risk are sent is one of extremely high risk, particularly in the first 30 days.
- Richard McKeon: [00:15:37](#) Valenstein et al in a study of over 1 million veterans being treated for depression found that the period after inpatient discharge was the period of highest risk. Too often, the rates of follow-up care are poor, yet, intervention during this time has been shown to save lives and reduce suicidal behavior. For this reason, we make this a requirement in virtually all of our suicide prevention grants. This slide again just shows you the risk of suicide in the 90 days after hospital discharge broken out by psychiatric disorder.
- Richard McKeon: [00:16:22](#) This slide shows you the results of a study done by the World Health Organization in a number of different countries, five countries. It's a randomized controlled trial and it showed that those who received a brief emergency room intervention and, importantly, follow-up telephone contacts over the next 18 months had significantly lower rates of death by suicide and, in fact, actually had lower rates of death from any cause, which shows the importance of our service systems trying to incorporate this.
- Richard McKeon: [00:17:04](#) One of the interventions that is now being used in multiple settings in mental health settings in emergency rooms and in primary care offices, so it's called a Safety Planning Intervention. It used to be that mental health professionals relied on what were called no suicide contracts where somebody was going to pledge that they wouldn't kill themselves in writing. Not only was there no evidence that that worked, there was actually evidence that it was harmful. Safety planning has been shown to reduce suicide attempts in controlled scientific trials and it's basically a way of working

collaboratively with a person about what they can do to keep themselves safe, so it's all about what to do, not about what not to do.

Richard McKeon: [00:17:57](#) This is another resource that's available on the SPRC website, as well as on the Zero Suicide com website. It's on counseling on access to lethal means. This is to help providers understand how they can talk to individuals and family members regarding access to lethal means so that in a moment of acute distress, there's not accessible lethal means because if a person can get beyond those critical moments, they might well survive. This is another resource that focuses on structured follow up and monitoring, also available at the Zero Suicide website.

Richard McKeon: [00:18:47](#) SAMHSA has also been working actively to try to improve crisis services in the United States. The Crisis Now Model basically talks about what's called a call center hub, basically the idea that just like in air traffic control, there's always somebody who knows where the airplane is, that in the United States, when somebody is at risk and they contact an acute care service, somebody should always know where they are. They shouldn't be lost to contact in the days or hours following discharge. Also, the idea that there is mobile crisis intervention, a team that can go out to where the person is, rather than necessarily that the person having to go to the emergency room, as well as that there are crisis facilities, short term crisis stabilization facilities, typically 72 hour. These are some of the things called for in the Crisis Now Model.

Richard McKeon: [00:19:59](#) Now, the reality is that ubiquitous and inexpensive technology is changing nearly every other industry. It is clear that the technology exists for us to be able to stay in contact with people who are at risk and that it's important that we should be doing that. It should not be acceptable in the United States of America that in our healthcare systems we lose contact with people after they leave an emergency room or an inpatient unit. Some healthcare systems are doing wonderful work in this regard, but there's tremendous variability across the United States.

Richard McKeon: [00:20:39](#) You should also be aware that currently, the work is being done on the National Suicide Hotline Improvement Act, which was signed by the president in August. This act calls on the FCC, the VA, and SAMHSA to work together and to speak to the advisability and feasibility of a national three digit N11 number for suicide prevention, so like 911 for emergency healthcare a three digit N11 number for mental health crisis and suicide prevention care is what is being examined there. The FCC's report is due to the Congress this coming August.

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- Richard McKeon: [00:21:24](#) I mentioned our youth suicide prevention efforts under the Garrett Lee Smith Memorial Act, which has shown that counties that have been implementing this important work have lower rates of youth suicide deaths and attempts than match counties who have not. I also wanted to make sure that I highlighted some of the work that we're doing with our colleagues from the VA. You'll be hearing from VA shortly. It's called the Mayor's Challenge to reduce suicide among our nation's veterans. You can see a listing of the cities participating in the Mayor's Challenge. We are also doing similar work with the nation's governors. There you see the states that are participating in that. Actually, the National Governors Association just came out with a series of recommendations for states that you might be interested in.
- Richard McKeon: [00:22:29](#) I mentioned the National Suicide Prevention Lifeline, which last year answered more than 2.2 million calls. In many places in the United States, if it's in the middle of the night or even on a Sunday afternoon, the only options if someone needs immediate help may be the lifeline or to go to the local emergency room.
- Richard McKeon: [00:22:55](#) I'm going to end there. Here are some key resources. You have the Lifeline number, our Suicide Prevention Resource Center, www.sprc.org, and the Action Alliance for Suicide Prevention at www.theactionalliance.org. Thank you for your time and attention.
- Kathryn Santoro: [00:23:15](#) Thank you so much for your leadership and commitment to improving suicide awareness and prevention. You highlighted many of the evidence-based prevention opportunities, but also some of the emerging opportunities to promote positive mental health, such as exploring new efforts using technology. I know we'll hear from Chris a little bit more on some technology efforts later. Also, on NICHM's previous webinar on mental health, we discussed some ways technology is being used to better connect patient to behavioral healthcare services, so if the audience is interested in learning more, you can view a recording of that event on our website.
- Kathryn Santoro: [00:23:59](#) Our next three speakers will now share a range of initiatives designed to prevent suicide across different communities. To learn more about efforts to prevent suicide among college students and high school and younger students, we're now joined by Nora Maloy, director of programs for the Blue Cross Blue Shield of Michigan Foundation. Blue Cross Blue Shield of Michigan Foundation is leading an innovative program to improve mental health and prevent suicides on Michigan

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college campuses. In partnership with the JED Foundation, they created the Michigan Model of Campus Mental Health to build a culture of campus wide awareness of mental health. More than a dozen Michigan colleges and universities have adopted this model and at least one other state is looking to replicate it. Nora is leading the foundation's efforts and we're so grateful she's here with us today to share this work. Nora.

- Nora Maloy: [00:24:58](#) Thank you, Kathryn. As Kathryn said, I'm with the Blue Cross Blue Shield of Michigan Foundation. We are the affiliate of Blue Cross Blue Shield of Michigan. We have an independent endowment of close to 60 million, which enables us to make grants of between \$2 and \$3 million annually throughout the state. Our mission is to improve the health and healthcare of the citizens of Michigan.
- Nora Maloy: [00:25:26](#) Today, I'd like to talk with you about why the Blue Cross Foundation has invested in two programs to address the mental health of our youth to decrease the alarming suicide rate. The two initiatives that I'd like to talk with you today are aimed at campus mental health, one at the college level, the second at the high school and below level. Both are partnership grants, meaning we solicited other partners to join in to expand the scope of the projects.
- Nora Maloy: [00:25:58](#) Last year, in Michigan, there were 1364 suicides. It was the second leading cause of death among our youth as Dr. McKeon has pointed out. 20% of students have a mental health condition, but close to half of these students haven't received any behavioral health treatment. Nationally, among our college students today, over 2 million have serious thoughts of suicide at some point during the year and 336,000 made an attempt at suicide. More specifically, our grantee, JED, has told us that 71% of colleges and universities had at least one suicide in the past academic year. 78% reported at least one attempt and 70% reported at least one psychiatric hospitalization.
- Nora Maloy: [00:27:01](#) About five years ago, the Blue Cross Foundation sought ways to address mental health and suicide among our youth. We met The JED Foundation from New York at a conference and really liked what they were doing around the country with college students. We brought in four other funders, the Flinn Foundation in Michigan Health Endowment Fund, the Community Foundation of Southeast Michigan, and the Children's Hospital Foundation to develop a Michigan Model of Campus Mental Health.

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- Nora Maloy: [00:27:30](#) With a grant of \$265,000, we brought the JED program to 12 schools, universities, colleges, and community colleges in Michigan. With JED, we designed our own campus program specific to Michigan. We asked JED to design the Michigan model, collaborating with other leaders in the field, including Healthy Minds, Active Minds and the Steed Fund. JED's Michigan model is based on a comprehensive public health approach to promoting emotional wellbeing and reducing suicide and serious substance abuse. JED believes wellbeing and suicide prevention must be seen as a campus wide responsibility, not solely the responsibility of the health and counseling centers. This includes the support of senior leadership to make emotional wellbeing and suicide prevention shared values for the entire campus community.
- Nora Maloy: [00:28:34](#) Regarding suicide, when JED works with specific schools in training faculty, staff, and students they warn faculty, staff, and students to look for students who talk about killing themselves, feelings of hopelessness, having no reason to live, being a burden to others, feeling trapped, and with unbearable pain. They're looking for students who exhibit certain behaviors, increased use of alcohol or drugs, looking for a way to end their lives, such as looking online and certain websites, withdrawing from activities, isolating from family and friends, sleeping too much or too little, visiting or calling people to say goodbye, giving away prized possessions, aggression, and fatigue. These are students who exhibit specific moods such as depression, anxiety, loss of interest, irritability, humiliation, agitation, anger, or, perhaps, sudden improvement.
- Nora Maloy: [00:29:38](#) Together, the school and JED work together collecting mental health and substance use history among incoming students, connecting students to services, having wellness and screening days conducted across campus, training on how to identify, reach out to, and, if needed, refer students who may be struggling, and implementing behavioral intervention care teams electronically, as well as feet on the ground.
- Nora Maloy: [00:30:10](#) This information is standard for all students at all JED campuses, but community college require additional support. Many community colleges do not have health or counseling centers or, if they do, they're seriously limited. JED works with schools to develop robust referral networks with their local community providers, community mental health centers, and hospitals. This includes working with schools and community providers to help identify sliding scales for students, what insurance are accepted, and to help with wait times for appointments.

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- Nora Maloy: [00:30:52](#) Since community college students often just come to campus only to attend class and then leave for jobs and family responsibilities, their primary and sometimes only contact is faculty, so JED focuses on training faculty on how to identify, reach out, and refer students who may be struggling. Also, since many students will not be on campus to attend programming outside of class, JED suggests the use of educational campaigns and public service messages online. Providing online cognitive behavioral therapy and other therapy online is another way for students to more easily access services when convenient for them.
- Nora Maloy: [00:31:39](#) In brief, at the start of the four-year JED program, they assess the resources and needs of both the school and the students. With the school, they build an interdisciplinary team. They then help the school to develop a strategic plan for mental health, which includes building a structure to identify students at risk, increase help-seeking behavior, provide mental health and substance abuse services. The assigned JED campus advisor and college interdisciplinary team continually assess progress and provide resources for continued progress. After implementation, there's a post-assessment and JED consultation. The school continues to then be a part of the JED campus learning community.
- Nora Maloy: [00:32:31](#) Of the 12 schools we fund, some of the things they do specifically unique to them are at the Mott Community College they have compiled a calendar of training programs to map existing approaches, identify gaps, and build out new programs, in addition to working on specific training around alcohol and other drug use, as well as gatekeeper training. At Northern Michigan University in Marquette, they're exploring options for teletherapy, tuition insurance, and health insurance that will cover behavioral health. Streamlining communication processes in response to student deaths is being done at Wayne State University. They work with how to deal with the aftermath of a student death. Finally, at three of our schools, Kalamazoo College, the University of Michigan Dearborn, and Western Michigan University, they're all part of the Equity in Mental Health Framework cohort that JED has developed to specifically work to address mental health and wellbeing of students of color on the campuses.
- Nora Maloy: [00:33:47](#) The second program I would like to talk to you about is TRAILS. TRAILS is a program that we expect to impact suicide. The funding collaborative is led by the Flinn Foundation in Detroit and it's being implemented by the University of Michigan Department of Psychiatry. We plan to implement TRAILS in each

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and every school in the Detroit Public School System over the next three years. There's seven funders collaborating in this funding initiative.

Nora Maloy: [00:34:24](#) TRAILS is not technically a suicide prevention program, but a comprehensive behavioral health support to schools that recognizes that lack of access to mental health care among youth is a major contributor to adolescent suicide, especially those experiencing symptoms. TRAILS has taught us that suicide in young people is related to the fact that they lack some prefrontal cortex development, which helps with complex decision making, impulse control, and emotion regulation.

Nora Maloy: [00:34:59](#) When a teen has deeply depressive or anxious emotion, but lacks access to effective care or treatment that could help them manage or cope with those emotions, rash decisions such as the decision to commit suicide become more likely. By linking teens with effective skills based in cognitive behavioral therapy and mindfulness, the core of TRAILS, these teens will be better equipped to manage their emotions, to feel some sense of control over their self-deceiving cognitions, and very difficult feelings and will experience some hope that they will get better.

Nora Maloy: [00:35:39](#) The TRAILS program is built on a three-tiered approach. Tier one is for the vast majority of kids. It provides programming and prevention and stigma reduction. It also provides training to engage all faculty, students, and parents. Tier two is for students in need who are impacted by behavioral health problems. Finally, tier three are for students who have been identified for risk of suicide. This tier provides immediate resources and the coordination of care.

Nora Maloy: [00:36:19](#) I would be glad to provide more information on any of these programs to anyone who requests them and thank you so much.

Kathryn Santoro: [00:36:29](#) Thank you so much, Nora. As we've heard today, teen suicide has really become a major public health crisis and your work with teens and young adults is so important as we continue to try to understand the impact of things like heavy social media use and the media's depiction of suicide and we really look forward to continuing to hear the results of your efforts to inform future programs.

Nora Maloy: [00:36:57](#) Thank you.

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- Kathryn Santoro: [00:37:00](#) Sure. Our next speaker, Gloria Workman, will speak specifically to mental health treatment and suicide prevention among veterans. The VA has identified preventing veteran suicide is our highest clinical priority and embrace a comprehensive public health approach to reduce suicide. Dr. Workman is leading many of these efforts in her role as the deputy director of research and evaluation suicide prevention for the Office of Mental Health and Suicide Prevention at the Veterans Health Administration. She is a clinical psychologist with a background in community psychology and suicide prevention, as well as implementation science and she was previously responsible for developing and implementing suicide prevention initiatives at the Department of Homeland Security. Dr. Workman.
- Gloria Workman: [00:37:55](#) Thank you, Kathryn. Good afternoon to all. It's a pleasure to be here with you. Today, I'll be covering with you the VA's suicide prevention efforts. I would like to say that the views that I share with you are my own and not necessarily those of the VA's. In terms of beginning, I'd like to share with you some important figures and highlight those. Nearly 45,000 people die by suicide annually, including more than 6000 veterans. Our veterans are actually a higher risk group than non-veterans. The rate of suicide for a female veteran is 1.8 times higher than for non-veteran females. Similarly, the rate of suicide for male veterans is 1.4 higher than non-veteran males. Within the VA, within the veteran population, rather, male veterans, younger male veterans ages 18 to 34 experience the highest rate of suicide. However, older veterans ages 55 and older have the highest count for suicide, in part because we find the largest number of veterans in this older cohort. The majority, 69% approximately, of veteran suicide deaths result from firearm injury.
- Gloria Workman: [00:39:38](#) It's important to be able to recognize suicide risk in the veteran population. Risk factors known to put veterans at higher risk include a previous suicide attempt, experiencing mental health concerns, as well as substance abuse, access to lethal means, a recent loss of family or friend or even colleague at work, struggling with legal or financial problems, relationship issues, or unemployment and homelessness.
- Gloria Workman: [00:40:16](#) The goal of the VA is to minimize those risk factors and to boost the protective factors. Protective factors include access to mental health, having a sense of connectedness with family, friends, and the community, being able to problem solve when issues occur, having a sense of spirituality, a purpose in life or a mission, good health, as well as employment.

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- Gloria Workman: [00:40:53](#) Like to talk for a moment now about the public health approach. You've heard about this with other speakers. The VA also uses a comprehensive public approach to suicide prevention. In this approach, the framework has us beginning with the question of where does the problem begin. This helps us to identify where we will target our effort. How can we prevent it from occurring in the first place? Suicide prevention is our shared responsibility and suicide prevention can be helped by all. We're reaching out to our families of the veterans, as well as building community engagement and trying to change the conversation around suicide.
- Gloria Workman: [00:41:58](#) The VA is using a public health approach, sorry for the slides going back and forth, that has been developed by the National Academy of Medicine. This is a three-tiered approach with intervention being categorized into three buckets. The universal approach includes prevention strategies that are designed to reach all veterans. The selective suicide prevention interventions are designed to reach that subgroup of veterans who have been identified as having increased risk. Finally, the indicated suicide prevention strategy are designed for veterans who are known to be at high risk for suicide.
- Gloria Workman: [00:42:56](#) Examples of some of the innovative universal practices that the VA has implemented include the Mayor's Challenge, which was discussed earlier. We are assisting and supporting 24 cities in developing and implementing site-specific public health strategies to address suicide prevention. We've also partnered with PsychArmor to offer a free online training on suicide prevention. This training provides users with general information and understanding of suicide, learning on how to identify a veteran at risk for suicide, and then what action to take when one identifies a veteran who is at risk.
- Gloria Workman: [00:43:55](#) Other important innovations and strategies that the VA is implementing is Make the Connection. In this intervention, which is provided online, you will see veterans telling their story and this is important to know because understanding our veterans will help us to be able to address their needs in a more targeted way. Another intervention is Coaching Into Care. I'm really proud of this particular intervention. This is for family members, caretakers, friends, anyone who would like to improve the way in which they support veterans who they believe are at risk for suicide.
- Gloria Workman: [00:44:47](#) Another intervention and this is a selective intervention for veterans who are at some risk for suicide include improving lethal means safety. The VA is training providers in lethal means

safety counseling and safe storage is important because building in time and space between the impulse to harm oneself and the means to do so increases the likelihood of a veteran surviving. The VA wants to educate veterans and their families about safe storage of guns in a way that is really consistent with each veteran's values and priorities. What the research tells us is that reducing access to suicide methods that are highly lethal is a proven strategy for decreasing suicide rates.

Gloria Workman: [00:45:44](#) Other strategies that we're using for veterans that have been identified a high risk in the indicated category are what is referred to as REACH VET. This is a predictive analytic program that provides VA clinicians with information about veterans at high risk. This enables the provider to speak with the veteran and to develop a tailored treatment plan and also provide enhanced veteran care. In addition, the VA, through the MIRECC group, which is listed there, the website, offers for clinicians, both VA clinicians and non-VA clinicians, free consultation for any provider working with a veteran if they have questions about assessment, risk management, or treatment. In addition, the same group, the MIRECC group at the VA offers a toolkit for therapeutic risk management of suicidal patients.

Gloria Workman: [00:46:51](#) The VA has adopted a National Strategy for Preventing Veteran Suicide. You heard Dr. McKeon referencing this. Our national strategy aligns with the 2012 National Strategy for Suicide Prevention and consists of 14 goals. This framework allows us to identify our priorities and to organize our efforts.

Gloria Workman: [00:47:18](#) In terms of leveraging the public health approach, suicide is a public health concern, but it is preventable and you've heard that today. The VA's public health approach to suicide uses prevention strategies across multiple sectors to reach veterans where they live, work, and thrive. What we know is that no single factor causes suicide and no single program or agency can end veteran suicide. It takes a team of community partners to prevent suicide. The VA is partnering outside of the VA because there are approximately 20 million veterans, but only 6 million veterans receive VA mental healthcare. It's important that we reach out into the community so we can amplify our message and reach other veterans.

Gloria Workman: [00:48:27](#) When working with veterans it's important to be able to identify warning signs. Warning signs are cause for concern. If a veteran is expressing hopelessness, mood swings, increased agitation, anxiety, they're not having restful sleep, they're voicing that there's no reason to live, there's an onset of increased anger or rage, or they're withdrawing from family or friends, this is cause

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for concern. However, if the following symptoms or signs are present, it really should result in action. These include looking for ways to kill oneself, talking about death or dying, engaging in self-destructive behavior such as carelessly handling weapons.

Gloria Workman: [00:49:23](#) You've seen this number before. If you don't have this number in speed dial in your phone, I recommend that you do. It's helpful to have it there. Just want to reemphasize the Make the Connection that provides information about veterans. They're telling their story. It really helps listeners to understand the perspective of a veteran who might be in crisis. The Coaching Into Care is for family members, caretakers, who want to be able to help and support veterans. The PsychArmor provides that free online training on how to help a veteran and take action when it's needed. I'll end with just reviewing the Community Provider Toolkit that is available that emphasizes military culture and ways to more effectively work with veterans in suicide prevention. Thank you.

Kathryn Santoro: [00:50:44](#) Thank you so much, Dr. Workman. You really drove home one of the themes of all the presentations today on the importance of a public health and community approach. It was really interesting to learn more about how the VA's reaching beyond traditional networks and care to work with the community and others to really empower them to help prevent veteran suicide.

Kathryn Santoro: [00:51:09](#) We'll next hear from Chris Bright, the director of public training for the Trevor Project to learn more about suicide prevention efforts for LGBTQ youth. The Trevor Project is the nation's leading organization that serves LGBTQ youth in the areas of suicide prevention and crisis intervention. They've recently really invested in a digital transformation to better serve young people, recently announcing that all three of their crisis service programs are available 24/7. Chris develops and oversees their internal crisis services trainings, as well as trainings and workshops throughout the country. We're so pleased that Chris is with us today to share more about this work.

Chris Bright: [00:52:02](#) Good morning or good afternoon, everyone, depending on where you are. I am here in not so sunny California today. Thank you for welcoming me. My name is Chris Bright. I am the director of public training here at the Trevor Project. In terms of pronouns, I use the pronouns he, she, or they interchangeably. We won't have much time to chat about pronouns today, but it's certainly an important part of supporting LGBTQ youth, so I wanted to mention that. All right.

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- Chris Bright: [00:52:41](#) Just real quick, I wanted to review some of the crisis services we offer at Trevor because this is a very important piece of the work that we do here. We are first and foremost a crisis intervention and suicide prevention organization. The Trevor Lifeline is our phone-focused crisis intervention service. It's available 24 hours a day, seven days a week. You'll see the number there, 866-488-7386. It's good to have that in your phone or ready to offer someone if they ever need support. We're also very excited that we recently have acquired this particular short code for our text services, which is 678678, nice and easy to remember. As was mentioned in the sharing out of my bio, we are very excited because Trevor has very recently gone 24/7 across all of our crisis intervention services, so not just a 24/7 lifeline, but also a 24/7 text and chat service. We have something called TrevorSpace, which I'm going to give you a little bit more info on in just a second. We are also a place where people can get suicide prevention in general info on supporting LGBTQ youth at our website, thetrevorproject.org.
- Chris Bright: [00:54:02](#) This right here, TrevorSpace, I wanted to just throw out there that this is a really cool peer-to-peer resource. It's a social network not unlike Facebook, for example, where young people can post and share things that are going on in their life, connect with other young people who maybe have a similar identity to them or a similar understanding of the world. That's really exciting because a lot of times, people geographically within the LGBTQ community are locked in spaces away from one another and they don't necessarily get to see themselves reflected in the world around them or the peers that they have and so this resource is another really cool place that you might be able to point an LGBTQ persons towards, particularly a young person because this service is moderated and only available for people under the age of 25.
- Chris Bright: [00:54:59](#) All right. Some interesting facts in terms of the types of topics and things that come up on our services, so the number one thing on the lifeline and/or our chat and text services, it's sort of a broad category of mental health concerns or mental-involved problems that might arise. Number two in terms of the lifeline is focused more on relationships, whereas number two on digital is more around issues of coming out. On the lifeline, we also see that number three is shares between both and that's conversations around gender identity that come up very frequently. The number four on lifeline coming out and number five on digital being relationships, so there's a bit of a swap there in those categories. Then number five on the lifeline would be family, things maybe like family rejection or lack of

support from family. On our digital services, it would be self-injury.

Chris Bright: [00:56:02](#) These topics come up really broadly and it's interesting because for a lot of folks, when they think about suicide prevention, they don't think about, for example, the coming out process for an LGBTQ person or they don't think about gender identity or necessarily about relationships or family rejection. Oftentimes, suicide prevention is linked more around one's mental health and so it's something that I want to highlight for your because it's definitely connected to the work that we do really intimately.

Chris Bright: [00:56:37](#) I want to talk a little bit about some statistics to help you understand why the LGBT community comes up so often in conversations around suicide prevention. Really, I would say suicide prevention and crisis intervention in general, so if we talk about homelessness from the perspective of a crisis intervention, a 2018 study found that LGBTQs are 2.2 times greater risk for homelessness than their heterosexual or cisgender peers. A 2015 study found that 44% of LGBTQ homeless youth are of color or Latinx.

Chris Bright: [00:57:15](#) In terms of sexual assault, a 2017 national survey of students found that 7.9% of heterosexual had experienced sexual violence compared to 38.7% of their LGBTQ peers. Whenever we see disparities like that between the general population, that raises a great, big red flag for us. A 2017 national survey found that sexual violence had taken place one or more times in the 12 months prior to the survey for 31.4% of transgender youth. Again, a big, red flag because when you compare that to cisgender youth, it's 9.8%, so a big disparity there, as well.

Chris Bright: [00:57:55](#) If we shift towards issues of assault, in a 2017 national study, 12.4% of LGBTQ students were physically assaulted, kicked, pushed, injured with a weapon in the past year based on sexual orientation, 11.2% on gender expression, and 10 based on gender in general. A 2017 national study that showed that 59.5% of LGBTQ students felt unsafe at school because of their sexual orientation, 44.6 because of their gender expression, and 35 because of their gender.

Chris Bright: [00:58:28](#) Then finally, intimate partner violence, a 2017 national study, 5.5% of heterosexual students versus 15.8 of gay and lesbian and bisexual and 14.1 of questioning students reported experiencing dating violence, which is something that comes up with this population in particular. A 2017 survey found that 56.6% of students reported hearing homophobic remarks from

their teacher or other school staff and 71% of students reported hearing negative remarks about their gender from teachers or school staff. That same survey found that 87.4% of LGBTQ students heard negative remarks specifically about transgender people. Example is using words like tranny or he/she and 45.6 heard them often or frequently.

Chris Bright: [00:59:19](#) I know statistics are dry, so thanks for going on that journey with me. Let's look at where this lead us. This leads us to the fact that all of these things combined increase this particular population's risk for suicidal ideation. When these things push a LGBTQ young person in this direction, we see that huge disparity from the general population across any member of the LGBTQ community.

Chris Bright: [00:59:53](#) LGBTQ youth suicide statistics, so you'll see that in this case, if you just read across the chart, trans youth, LGB youth, questioning youth, and heterosexual youth, you have 44% contemplating suicide, 35 attempting suicide, and 17% resulting in injury, poisoning, or overdose for trans youth. In the general category of LGB, you have 48 versus 23 versus 8. If you just continue to read across, you'll see that when you compare this to a general population, let's say, of heterosexual youth, the number is much smaller, 13% contemplated, 5% attempting, or 2% resulting in injury, poisoning, or overdose.

Chris Bright: [01:00:49](#) These things affect our community. In fact, one thing that we noticed within the suicide prevention community in general is that members of minority groups or members of groups that are often pushed to the margins of society are more likely to experience suicidal ideation, attempts of suicide, and suicide resulting in injury, poisoning, or overdose. That's why you often find organizations like Trevor whose mission it is to serve a specific population that sort of has been pushed to the margins of society.

Chris Bright: [01:01:26](#) Let's quickly talk about some best practices. One thing that I want to highlight for you all is that a study shows that one supportive person can decrease an LGBTQ risk for suicide by 30%, so someone who is open and affirming of all LGBTQ identities being exposed to particularly for a young person being exposed to an adult who has that sort of affirming stance is absolutely imperative to the health and wellbeing of young people and, in fact, can decrease the risk of suicide by 30%.

Chris Bright: [01:02:04](#) Now let's talk some best practices related to identity, things that help. One thing that helps is mirroring language and using the correct pronouns for the caller. For example, if somebody

uses the pronouns, she, hers, and her and the name that they go by is Michelle, but their parents are constantly calling them Michael and using he, him, his pronouns and then when they go to school, their teachers are constantly calling her Michael and using he, him, his pronouns, she might feel isolated and alone, like nobody out there supports her or cares about her identity or her perspective in the world.

- Chris Bright: [01:02:50](#) It's absolutely imperative that as a step forward and a step towards affirming young people or anybody within the LGBT community that we mirror language. If they say that they want to use she, her, hers pronouns, if they say that they identify as transgender or they say that they are gay or lesbian or bisexual or anywhere on that spectrum. If those sorts of things come up, mirroring the language and affirming those identities we know is a huge protective factor when it comes to reducing risk for suicide.
- Chris Bright: [01:03:22](#) We also want to normalize the exploration of gender identity and sexual orientation. The reality is young people aren't always sure exactly how they want to identify or where they're coming from and so that's an important piece here. Exploring opportunities to expand affirming experiences, so for example in your workplace, in your office, in your public life are there access to gender neutral restrooms? Is there safe access to maybe LGBT supportive or affirming groups on campus or are there trainings that might be available in your community that you could push to have in your police department, fire department, hospitals, maybe your place of work all in an effort to expand affirming experiences.
- Chris Bright: [01:04:16](#) Also please be aware of your own impulses and reactions. If you find that maybe you're not completely comfortable with a particular identity or a particular perspective, it's important to challenge that because oftentimes, those discomforts come across in life or death situations where a young person feels judged, an LGBTQ person feels isolated because they can't find someone who affirms them.
- Chris Bright: [01:04:45](#) What does not help? Well, asking questions simply out of curiosity is not particularly helpful, so just because you don't maybe understand or you're curious about a certain thing, that can make someone feel like an oddity or make someone feel like they're just curious, that you're just sort of exploring their identity because you find it fascinating as opposed to finding it valid.

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- Chris Bright: [01:05:11](#) It also doesn't help if you're discouraging or moving away from the topic of transition or sex. Young people oftentimes struggle to find any adults who are willing to give them accurate or supportive information around these identities and so if you discourage or move away from those conversations, it can often lead to increased feelings of isolation. Certainly you wouldn't want to invalidate a youth's experience based on their age. This whole notion that young people can't make decisions for themselves has also led to a great deal of fear and anxiety and isolation because young people are not being empowered to own their truth and to own their identities.
- Chris Bright: [01:05:56](#) Now, in terms of coming out, it's always good to explore both sides of the coin on this one, so the benefits and the risk of coming out because the reality is you couldn't just say to somebody you should come out or you shouldn't come out. It's a very personal decision and there are benefits and risks in this decision. There are places in the country where young people will lose their jobs or anybody will lose their jobs because of their identity. Same thing with certain school systems that might have policies or procedures that are enacted against LGBTQ folks who are out or trying to be open about their identity.
- Chris Bright: [01:06:39](#) Being out and open about your identity might also open you up to a world of support and a world of affirmation and so exploring both the risks and the benefits with someone is actually a very beneficial sort of thought exercise when someone's thinking through the process of coming out. Oftentimes, we might find ourselves saying, "Have your parents ever said anything negative or positive that might give you a hint of how they might feel about LGBTQ folks?" Or, "Have you ever noticed if your school has any space or open and affirming spaces like a GFA or gender-neutral restrooms?" Things like that will get the person thinking through the possibilities.
- Chris Bright: [01:07:22](#) Engaging callers in the setting, timing, and their post-disclosure self-care is important, so if it goes well what will you do? If it doesn't go well, how might you respond? Do you need to line up some Netflix and a bubble bath or do you need to go for a run or play with your dog or eat some pizza, things that help people process how things might go. Normalizing the stress and courage it takes to come out is important because this isn't easy. Identifying opportunities to expand support, either virtual or in person. There are places in the country where young people are hundreds of miles away from open and affirming resources and so sometimes you have to go that virtual route. What does not help would be weighing in on whether the caller

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should or shouldn't come out. It's not your decision to make for them, rather, it's the decision that they make for themselves.

Chris Bright: [01:08:17](#) These are some references. I'm just about out of time and I know we have a question section coming up, so I'll just quickly go through the references, but they're there in case you need them. Then there's my contact information. I'm happy for anyone to reach out if they have any questions that we're not able to get to throughout the session. Thanks so much for your time, everyone. I know that's a whirlwind of a topic covering. We could spend many, many days talking about supporting LGBTQ identities, but for now, I'll take the 15 minutes and run with it.

Kathryn Santoro: [01:08:51](#) Thank you so much, Chris. You alluded there's a lot the healthcare community can do to improve healthcare and mental healthcare delivery for LGBTQ youth, so thank you for sharing some of those best practices. Just as a first question would just be curious other learnings or best practices that you'd share with the healthcare community to try to improve how they're working with this community.

Chris Bright: [01:09:23](#) Yeah, that's a great question. One thing that oftentimes, particularly people of trans identity experience is this sort of fear or general fear of the healthcare system because their relationships with their bodies might be more complex. Doctors or healthcare providers not having training in best practices around gender identity can play. There have been stories of doctors who will ask questions about callers' bodies that aren't really pertinent to the work that they're doing or I'll give an anecdotal example because I think it's helpful.

Chris Bright: [01:10:10](#) If I go into my doctor and I have a sore throat, but because my doctor would categorize me as someone who is a man who has sex with men, oftentimes, the conversation quickly shifts towards STIs or best practices for gay male population when the reality is I just have a sore throat because people get sore throats and maybe run a strep test and see what's going on there.

Chris Bright: [01:10:37](#) Oftentimes, when you're a member of a marginalized community and because the healthcare community puts so much time and energy into figuring out exactly how to navigate the specific risks associated with LGBTQ communities, there's often a disconnect between that and sort of a bedside manner or a supportive conversation that doesn't make someone feel other or marginalized or make them feel like a freak or like something that is not normal and valid. I think one big step that

the healthcare community can take is to say we're going to educate ourselves so that we don't have to put the onus on our LGBTQ patients to educate us about their healthcare.

- Kathryn Santoro: [01:11:30](#) Great. Thank you. To our audience, keep submitting your questions and we'll try to get through as many as we can. Our speakers, if you all want to come off of mute, we'll start our broad Q&A session. Dr. McKeon, a question for you. You mentioned some ED programs. This person's from SEQA, says, "Most ERs aren't equipped to deal with patients with suicide ideations or suicide attempts. How do we get more EDs to participate in programs or models like you mentioned?"
- Richard McKeon: [01:12:09](#) Yeah, that's a great question because there are a number of complex issues that come to bear, so one is that even though emergency departments are not ideal places for dealing with someone who has suicidal ideation or has made a suicide attempt, it is frequently the de facto place that people are automatically sent to when suicide is an issue, even though many emergency departments do not have access to a psychiatrist.
- Richard McKeon: [01:12:50](#) One issue is to divert from emergency rooms in the first place so that people who are there are those who really need to be there and hopefully to reduce some of the boarding and elongated waiting times that we sometimes see in emergency departments. This can be achieved, I think, using things like telepsychiatry or tele mental health because if sometimes in essence people are transported to the emergency room really simply to get an evaluation, but that same evaluation, that same assessment of their suicide risk because not everybody who thinks about suicide is at the same level of risk. Some may be at heightened acute risk and need hospitalization, but others may not, so having that evaluation done remotely may reduce the number of people at risk for suicide or who have suicidal thoughts being seen in the emergency room.
- Richard McKeon: [01:14:03](#) Then there's a question of the complicated workflow within the emergency department and how to incorporate that, some of the things that we know. The ED-SAFE Study, for example, showed that routine screening of universal screening for suicide risk led to a doubling of identification of suicidal people, which is important, but then the question is what happens afterwards. One challenge is to fit something like the collaborative safety planning, which is not a long intervention. It can be done in 20 to 30 minutes. If somebody can receive a collaborative safety plan in the emergency room with telephonic followup thereafter and doesn't have to wait for many hours in the

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emergency room, then that could be of benefit to everyone. A great example of this kind of approach is being taken in Colorado, where Rocky Mountain Crisis Partners is working with numerous emergency rooms around the state to do exactly that. There's more that I could say, but those are, at least, some thoughts.

Kathryn Santoro: [01:15:33](#) Great. Thank you. This question is for Nora. "What about the role of adverse childhood experiences that Detroit teens face and how well social determinants [inaudible 01:15:49] addressed by the TRAILS initiative?"

Nora Maloy: [01:15:53](#) Well, clearly that's a great question and it gets at the core essence of some of the problems that we face in Detroit. The programs we're funding in regards to behavioral health are not necessarily connected directly to adverse childhood events or the social determinants of health that deal with them because that's why folks require the behavioral health to begin with. The foundation I work for is funding several programs looking at children and their parents who experience ACEs and we hope in the future that we can direct some of the care of that and to make it available to the organizations dealing with older children and youth and mental health.

Kathryn Santoro: [01:16:52](#) Great. Thank you. This question is for the broad panel. We mentioned the recent research suggesting that economic policies such as increasing the minimum wage can have an impact on reducing suicides and this person is wondering the panel's thoughts on that, as well as opportunities for other protective [inaudible 01:17:16], make an appointment, which Dr. Workman mentioned.

Gloria Workman: [01:17:22](#) Yes, this is Gloria Workman. That's a great question. The available research does indicate that low income can impact suicide, but the literature is mixed. It does appear to be an area that's worthy of future research. There does seem to be some link with the higher minimum wage that it could be linked to suicide reduction. What we know in the VA is that employment can be a risk factor. Some good news is that for veterans anyway, they tend to have higher employment rate than non-veterans so it tends to be a protective factor for them.

Kathryn Santoro: [01:18:05](#) Okay. Do any of the other speakers want to comment on that topic? I have another question about are any best practices or unique programs for suicide prevention efforts really targeted to the rural population? I know it's come up a couple times in terms of virtual care and telehealth, but any other [inaudible 01:18:35] practices or programs?

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- Gloria Workman: [01:18:38](#) Yes, this is Gloria Workman again. I'm sorry.
- Richard McKeon: [01:18:42](#) Go ahead, Gloria.
- Gloria Workman: [01:18:42](#) The VA is having some pilots done currently to work in the rural area with veterans and they have established a telehealth hub and so trying to get these veterans who are out in rural areas synced up with the services they might need.
- Richard McKeon: [01:19:06](#) Yeah, and this is Richard McKeon from SAMHSA. I had mentioned our youth suicide prevention efforts through the Garrett Lee Smith Youth Suicide Prevention Grant Program. What we found through evaluation of that work is that I mentioned that we were heartened to learn that counties who were implementing the activities had lower rates of youth suicide than matched counties who had not. It's important to note that that funding was actually stronger in rural non-frontier areas. We don't know for sure, but it might be because in a rural, non-frontier county, there might be more resources available to prevent youth suicide than there are in a frontier, in a very isolated county. The magnitude of difficulty of organizing a comprehensive effort to prevent youth suicide may not be as great in a rural area as it would be in a large urban or suburban area that had many more providers, many more youth involved with juvenile justice or foster care, many more schools, etc. We don't know for sure, but it was a reliable finding that the positive impact was being driven largely by rural communities.
- Nora Maloy: [01:20:44](#) Yes, this is Nora and I would like to add onto this. We're currently funding a program in a rural area that works with peer-to-peer veterans. We're training veterans, not us personally, but actually the Depression Center at the University of Michigan, to train folks to identify those at suicide risk and behavioral health problems to work with other veterans in rural areas to help them and refer them on to further care.
- Chris Bright: [01:21:17](#) I can also say that, this is Chris Bright with the Trevor Project, that one of the reasons specifically for LGBTQ populations that resources like Trevor are so necessary is because there are places around the country where you may be hundreds of miles away from LGBTQ affirming doctors or LGBTQ affirming mental health programs and so you have to go into that virtual space in order to find the support that you're looking for. That means that this population is oftentimes underserved in more rural spaces because of just simply lack of access.
- Kathryn Santoro: [01:22:04](#) Great. Thank you all. We have a few questions have come in about what communities can do for children younger than the

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age of 10. What are some promising practices for early prevention and working with children? How do we foster more resilience to prevent future generations from considering suicide?

- Nora Maloy: [01:22:37](#) This is Nora. I refer the person asking the question to the website regarding TRAILS. I talked about TRAILS in regards to high school and maybe middle school, but it's also going all the way down to grade school on up. I think their tier system approach is going to help identify young kids with problems and provide support for them.
- Kathryn Santoro: [01:23:07](#) Thank you. This question is for Dr. McKeon. Some suicidologists have speculated that actual suicide rates may be plateauing because it's being reported more accurately on death certificates as stigma is declining and more people are talking about it. How would you react to that?
- Richard McKeon: [01:23:31](#) Well, it would certainly be wonderful if suicide rates in the United States were not increasing and the apparent increases were all due to improved reporting, but I think that we should not be complacent by using that as an explanation for what we've seen. The CDC has characterized suicide as a stable undercount. I would defer to colleagues at the CDC, none of whom I am aware of who have published anything offering that as an explanation for the increases that we have been seeing, so while I fervently wish that suicide in the United States was not increasing, I fear that it is. I think regardless of the extent to which improved reporting may be playing a role, the current moment demands our best and intensifying efforts to prevent suicide.
- Kathryn Santoro: [01:25:06](#) Great. Thank you. I'm going through the questions, so give me a minute. I've got another question for Dr. McKeon, a couple questions about the crisis lifeline. Could you talk a little bit about just what the increasing suicide rate, the capacity of the lifeline to handle calls and also the challenges and potential of things like these lifeline calls and chats both as interventions and also as a source of data going forward.
- Richard McKeon: [01:25:55](#) Yes, thank you. Calls to the National Suicide Prevention Lifeline have been increasing at a rate of about 15% a year, so we are very glad that people are calling and that so many people at risk are calling. That being said, there are challenges in terms of the lifeline's capacity. We describe these in detail in a document that we filed with the Federal Communications Commission as part of our responsibilities under the National Suicide Hotline Improvement Act.

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- Richard McKeon: [01:26:41](#) One of the key issues there really has to do with the importance of local crisis centers. Local crisis centers are able to get to the lifeline calls very quickly, but in areas where if a local crisis center becomes overwhelmed by the numbers of calls or even more likely, if there's not a local crisis center that's answering these calls and it has to go to our system of backup centers, then the wait could be longer for the call to be answered, an average of two minutes longer. Now, if somebody stays on the line, all the calls will be answered, but there can be a delay and the risk is that someone will not stay on the line. We were grateful when the appropriation for the lifeline was increased to allow us to bring more resources to bear on answering these calls. SAMHSA has tried in a number of different ways to help support states and communities in the development of crisis services that can be of assistance.
- Richard McKeon: [01:28:06](#) Then I would say the other thing I would say would be in terms of alternate modalities, such as chat or text. I think there's every reason to think that these are very valuable alternatives to the telephone. The lifeline does have a chat function that can be accessed through the lifeline's website. We don't have a text function, but the crisis text line does exist as a way to utilize texts in a crisis situation. Also, the Veterans Administration, the Veterans Crisis Line, which can be accessed by pressing one after calling the lifeline, also has both a chat and a text function. These are really important and we find that on the chat service that significant numbers of those who chat are thinking about suicide, as well, so it's a very important area for intervention.
- Kathryn Santoro: [01:29:23](#) Thank you. Gloria or Chris, do you want to add anything based on the work that you're doing in that area?
- Gloria Workman: [01:29:30](#) I think that Dr. McKeon mentioned that the Veteran Crisis Line has the options for chat, text, or call in and they are being utilized.
- Chris Bright: [01:29:43](#) Yeah. The only thing I would add is that particularly for a youth-focused population and at Trevor, we're specifically focused on LGBTQ youth that the advent of chat and text technology, particularly text technology is really important because young people often feel more comfortable reaching out via text than picking up the phone and calling, so we're very excited at Trevor to have recently gone to 24/7 with our text services and our chat services because it allows young people to reach out to us in a modality that they're more comfortable with.
- Kathryn Santoro: [01:30:25](#) Great. Well, we are out of time and I apologize for the questions that we didn't get to, but I will share those with the speakers

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and there are a few people who [inaudible 01:30:35] some resources, as well, so we'll make those available to our audience. Thank you to our just really excellent panel speakers for taking time out of your busy schedules to be with us. Thank you to our audience. We hope that you learned about a variety of public and private sector efforts and that you leave with ideas to take back to your work and to your communities.

Kathryn Santoro:

[01:31:00](#)

We'd appreciate it if you'd take a quick moment to share feedback from this event by completing a brief survey, which can be found on the bottom of your screen. We hope to be announcing the last webinar in our Defying Despair series soon. During this event, experts will share efforts to increase access to evidence-based treatments for addiction. Thank you all again for joining us today.